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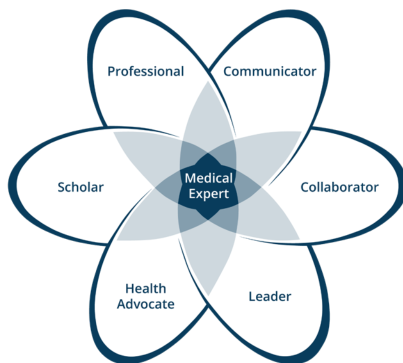
CanMEDS Project Foundational Report
Executive Summary
October 12, 2023

What consultations have already taken place?

- Fall 2021 – Emerging concepts survey, literature review and environmental scan
- 2022 – Development of the CanMEDS Steering Committee and National Advisory Board
- 2022 - Open call for members of the Expert Working Groups (EWG), ePanels, and Indigenous Learning Circle
- 2023 – CanMEDS bilingual webinar series, EWG interim reports
- Current – Open Call for public feedback



The current Framework is comprised of seven Roles, 27 key competencies, and 89 enabling competencies. Current Roles: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, Professional.

Emerging concepts being explored:
Anti-racism, Equity/Diversity/Inclusion, Humanism, Planetary health (climate/ecological crisis), Virtual care, Data-informed medicine.

Common recommendations so far:

- Include an additional 15 key and 70 enabling competencies to the revised framework. The most prominent concepts are related to anti-racism, Equity, Diversity, Inclusion, Indigeneity, and Accessibility (EDIIA), anti-oppression, and addressing power differences, hierarchy, patriarchy, and cultural safety.
- The CanMEDS '*diagram*' needs to be revised – what Role(s) should be centered? How can hierarchy be avoided?
- Should Roles remain as 'nouns' (e.g., Professional, Leader, Advocate, etc.) or become 'verbs' (e.g., professionalism, leadership, advocacy, etc.) for more direct French translation.
- Improved communication about each role and how they relate to each other.

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- Remove outdated words and concepts.
- Include a glossary of key terms.
- Recognize and address complexity at a micro and macro level.
- Importance of collaboration and shared decision-making.
- Addition of communication between colleagues in the work environment.
- Remove 'health' from Health Advocate.
- Replace the term ‘altruism’.
- Increase emphasis on the ‘manager’ part of the Leader Role.
- Add the roles of ‘Educator’ and of Physician as person’ which includes concepts of professional identity and the importance of personal values that influence identity, learning and care.

Next steps

2023-24 – Continuing consultations
2025 – Draft Framework circulated for feedback
2026 – New Framework launched with faculty development resources
2026-27 – Ongoing supports for implementation

Are we on the right track? Complete the CanMEDS Project Open Call to let us know if we are missing anything.

Optional: For more details, please read the full CanMEDS Project Foundational Report below.

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Background

The CanMEDS physician competency framework is an outline of the abilities needed for all physicians and medical learners in Canada. The competencies in the CanMEDS framework are broadly applicable to all Canadian physicians and learners from medical school, residency, and throughout medical practice. This framework is updated regularly. The current update started in 2022 and has included thus far:

a) a review of new or emerging concepts that may impact physician training and practice in the future, published in the Canadian Medical Education Journal (2022-2023), and

b) the initial work of thirteen expert working groups (EWGs), each comprising a representative group of health professionals, learners, content experts and members of relevant groups.

There are seven Role EWGs representing the original CanMEDS Roles (Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, Professional) and six 'Theme' EWGs (Anti-racism, Data-informed medicine, Equity/Diversity/Inclusion, Humanism, Planetary health, Virtual care), the latter addressing six of eleven themes from the emerging concepts review described above. It was felt that inclusion of these emerging concepts in education and health care would influence revisions of the CanMEDS competency framework to keep it current and address today's societal issues.

To facilitate the EWG process, each group was asked to provide an interim report, describing their work done in the first half of 2023. The results of all EWG reports will be shared with all other groups to assist in the integration of new concepts and revision of current competencies. This synthesis looks at the interim reports of these EWGs.

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CanMEDS Project Synthesis of Expert Working Group Interim Reports

Linda Snell MD MHPE FRCPC MACP FRCP (London)

Overview of documents and questions

The seven Role EWG interim reports were asked to address the following: what major changes are recommended; are there new or different connections with other CanMEDS Role(s); which of emerging concepts are particularly relevant and why; are there unresolved issues/discussion points; are there questions for their e-panel; and general comments.

The six theme interim reports were asked to address the following: what are the key terms & definitions; where, in current CanMEDS is this concept particularly relevant and why; what changes are recommended to 2015 key/enabling competencies; what new key/enabling competencies are recommended; what are the top 3 priorities that should be reflected in the Series 1 release; are there unresolved issues/discussion points; and general comments.

Methods

There was a review of both quantitative data (for example counting frequency of comments, number of new key or enabling competencies proposed) and narrative data, using thematic analysis* for this qualitative component. Briefly, the thematic analysis involved several deep reads of all documents, inductive and deductive primary coding, then defining themes and connections. The individual doing the qualitative analysis is a clinician educator with longstanding experience with the CanMEDS framework and competency-based education as a clinical supervisor, curriculum developer, contributor to and editor of prior CanMEDS frameworks. This individual tried to recognize and mitigate any bias this experience may have introduced.

Results

All seven Role EWG reports directly addressed the questions outlined above. The six Theme EWG reports were more variable in format, length, and content. Also, not all Role or Theme EWGs proposed revised competencies.

There were, however, some common themes related to the *content* of an updated framework. With regards to new or revised content, the most common and most prominent theme recommended related to concepts to be integrated around anti-racism, EDIIA, indigenous health, anti-oppression, and addressing power differences, hierarchy, patriarchy, and cultural safety. A second major theme related to the ‘physician as person’, inclusion of concepts of professional identity and the importance of personal values that influence identity, learning and care. Other notable points were the need to recognize and address

complexity at a micro and macro level; the importance of collaboration and shared decision-making; the addition of communication between colleagues in the work environment; the suggestion to remove 'health' from Health Advocate; to replace the term 'altruism'; to increase emphasis on the 'manager' part of the Leader Role; and to add the roles of 'Educator' and of Physician as person'.

Redundancy of concepts was a concern and the need for cross EWG discussion was emphasized. There was concern from some groups about 'what would happen to concepts 'that don't make it in' and a suggestion that these are not lost as they would prove useful during implementation and future education about the framework. With regards to mapping emerging concepts with Roles, almost all emerging concepts were thought to have links in most Roles, with reciprocal recognition, in that there is recognition by Role EWG's to incorporate most relevant themes, and recommendation by theme EWGs for integration into most relevant Roles. In addition, many Roles recognized that their competencies are linked with other Roles. All of this points to a future need for a decision on where some concepts will 'live'.

There was also discussion about whether the Roles should remain as 'nouns' (e.g., Professional, Leader, Advocate, etc.) or whether they should become 'tasks' (e.g., professionalism, leadership, advocacy, etc.) however it was recognized that this would not work well for all Roles.

Many groups recommended re-thinking and re-visioning the CanMEDS '*diagram'* or concept map, although there was no consensus at this early stage about what this would look like. Ideas from various groups ranged from removing Medical Expert from the center but keeping it 'integrative', and putting Professional, professional identity, anti-racism, or the physician as person at the center. Other suggestions for the diagram included a complete change in the visual concept, e.g. using a 'tree' not a 'flower', or using an umbrella for overarching or cross-cutting concepts. There was also a request to avoid 'hierarchy' in a future diagram.

There were also common themes regarding the *process* of developing, publishing, and implementing C25. Regarding the future publication, there is a perceived need for a longer preamble as a reminder what CanMEDS is for and that it addresses competencies across the education continuum, through training and practice, and to provide better background to the "less tangible" concepts. The preamble should also introduce concepts that cross over multiple Roles. There was a recognition that the wording needs to be generic to address all disciplines and that outdated words and concepts need updating. Within each Role, it was

recognized that the definitions and descriptions will be longer as likely with significant revisions. The need for a glossary was emphasized and many groups provided definitions of key terms and concepts.

As not all EWGs submitted revised competencies for their reports, an accurate count of the new competencies recommended is not possible. However, for context, CanMEDS 2015 comprised 7 Roles, 27 key competencies and 89 enabling competencies. Although only half of the EWGs (Role and Theme) included specific recommendations for new competencies, these totaled an additional 15 key and 70 enabling competencies. Of note, many recommended additions may, in the end, be integrated into current ones.

Summary

The synthesis of the EWG interim reports has highlighted some limitations in the current design, and pointed out where content additions or structural changes may be needed. The changes recommended include (a) the need to integrate emerging concepts broadly (as for anti-racism or EDIA), or in a focused manner into relevant Roles, and (b) emphasizing new or different connections needed between current CanMEDS Roles. The importance of cross discussion between groups and the need to reach a consensus will influence the future design process.

* Kiger M, Varpio L. Thematic Analysis of Qualitative Data: AMEE guide #131. Med Teacher 2020, 42(8); 846-54.

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CanMEDS Project mid-point reflection and member checking:
THEMATIC ANALYSIS OF PROJECT LEADERSHIP MEETINGS

Nancy Fowler, MD, CCFP, FCFP

Purpose

This section of the CanMEDS Foundational Report is a thematic analysis of conversations held at the following CanMEDS Project leadership meetings, intended to demonstrate key topics of discussion:

- CanMEDS Project Expert Working Group (EWG) Co-chairs meeting on April 6, 2023
- CanMEDS Project Expert Working Group (EWG) Co-chairs meeting on May 25. 2023
- CanMEDS Project Anti-Racism EWG and Steering Committee meeting April 25, 2023
- CanMEDS Project National Advisory Board meeting on April 19, 2023

Personal Statement (of potential biases)

I am a white, straight, cis-gendered woman from Ontario, born in Canada and who grew up in a comfortable middle-class household in an educated family. I have held positions of leadership in medical education for many years now. My privilege is significant. I aspire to be an ally and have prioritized social justice work in my career. I put a lot of stock in education as a change agent, which is why I am here.

Methodology

Each meeting transcript was reviewed a minimum of three times – the first as an end-to-end read-through; the second to identify and 'colour code' themes in an emergent fashion; and the third time to make field notes and capture highlights/potential actions.

Themes, highlights and notes were recorded on a grid and summarized in the following thematic categories consistently present in all meetings: Voice (yellow); Going Well (green); Questions/Concerns/Risks (red); Suggestions (grey); Key Concepts (dark blue); Aspirations (turquoise). Copies of the coded transcripts and summary grids are attached for reference.

Summary of Findings

A summary of findings is presented here according to the thematic categories identified:

1. **VOICE: Whose voices are present in the analysis and project? Whose voices are missing?**

"People [patients] that disproportionately have more bad experiences in the healthcare system, we should hear their voice a lot and do better."

A review of meeting attendance, introductions and statements indicate good diversity of physician voices (Black; Indigenous; LGBTQ2S+; stage of career; type of specialist; geographic location) across leadership meetings with positive comments made about this and a

successful experience of "safe space". Residents are present in small numbers, with a clear statement about their desire to be heard and seen as change leaders. Participation is heavily focused on physicians with few 'others', mostly on the CanMEDS Project National Advisory Board. There was no participation by anyone with a stated perspective regarding disability and so this may be an underrepresented voice in leadership. There is some but limited patient involvement on a few groups and this is valued where present. The most consistent concern about 'voice' in this project is about patients, with a priority to engage patients from structurally disadvantaged groups - those who experience poor care as the result of racism/oppressive practices and institutions with some suggestions for where and how to access these audiences (I.e. refugee clinics). The CMA has a 'Patient Voice' program and are willing to collaborate.

2. ASPIRATIONS: What are the goals, hopes and aspirations for this project? Why are we doing this work?

"We must explicitly define our core goal as physicians, as being about providing high quality healthcare in a rights-based way to everyone. We have to center those furthest behind first. And so, to me, that is the main reason to have a refresh of CanMEDS."

This cannot be just another version of CanMEDS. We are at a "watershed moment" where we

are not asking 'if' but 'how'? There is a call for transformative change in medicine starting by acknowledging white supremacy and the resulting trauma as a core determinant of health. Fundamentally, this is about health and improving health and access to health care for systemically disadvantaged peoples. **For clarity, CanMEDS remains a 'physician training framework**' but it is about more than competence in terms of what is 'centred' and valued as an outcome. It must "have teeth" and be positioned as a standards-informing document for accreditation and certification. This version aims to shift medical culture and create a "culture of humility" using education as a tool for transformation. We must come out strongly re-defining excellence in health care with human rights/anti-oppression at the core as the "why" of this work.

3. CONCEPTS - What is the 'vision' of CanMEDS? What are the most important new or changing concepts?

"This is about health, right? The reason to be focused on anti-racism, social justice, is actually that it has a huge impact on health. Right? And that's why it's our business and that's why the training of specialty physicians and Family doctors in Canada needs to incorporate all of that."

The next version of CanMEDS cannot be business as usual. Our understanding of health and illness has been fundamentally altered by critical events (Truth and Reconciliation; the death of George Floyd; the pandemic). This creates an imperative for rights-based change and action in medicine and medical education. This is about re-defining excellence in care to

reflect our current understanding of the health/human impacts of oppression/white supremacy. Overall, the concept is that CanMEDS remains a 'physician training framework' which has impact because it informs standards and sets norms for physician behaviour. There was a lot of discussion about centring and de-centring "what should be at the centre? Should there be a centre?" There is support for centering values that support human rights and anti-racism/colonization and de-centring "medical expert" as a colonial legacy. There is strong objection to the CanMEDS diagram as a visual, mainly because of the "expert "centre. There is also concern about defining competencies as the main/only desired learning outcome. Competencies are seen as necessary but insufficient to achieve the necessary

culture shift in medicine and medical education. There is a desire for more integration and recognition of complexity and a connection to planetary health in the organization of the framework. There is a desire for a holistic and person-centred perspective that respects and integrates other types and sources of knowledge. Physicians will need new types of knowledge – critical race theory and an understanding of oppression and how it impacts health. There is strong interest in 'professional identity formation' as an "outcome" or "container" for CanMEDs, recognizing that there are many layers to professional identity (as a physician; as a particular type of physician; as a team member).

4. GOING WELL: What do you appreciate or value about the project to date? What is going well?

"This has made the space a lot safer for me, just hearing the comments of the Steering Committee and your feedback and your willingness to listen to bold and transformative sort of ideas. Because like I said earlier, it's always a worry when you come into a space that you're unfamiliar with and it's a colonial institution as are all our medical institutions and organizations."
There is appreciation of the open and listening stance of the steering committee. There is recognition of the value and potential impact of investing in the CanMEDS Project.

5. CHALLENGES, RISKS & CONCERNS: What is causing difficulty? Concerns about the project to date.

"From the perspective of those who are structurally marginalised, this project will be a failure if it doesn't fundamentally reimagine itself and have fundamentally different expectations."

The overriding concern or fear for many involved is that we will miss a critical opportunity for change, and loose trust and engagement out of not having enough courage of conviction and not being action oriented. This can't just be a pretty document. The flip side of this is recognition of pervasive change fatigue in the health and medical education system at present and the fear that this will undermine change efforts. Consider some form of

appreciative inquiry of "what is working for us now?" Some tension between the desire to "blow it up" vs. a more incremental approach to change but overall, a strong recognition of the imperative for change.

The inherent complexity is overwhelming our clarity at times. We cannot lose sight of what we are aiming to do and we must be clear in our goals and offer practical guidance to learners and programs. We cannot afford to go too fast (and miss listening) or too slowly (and miss taking action) as both will lose trust with the very groups we seek to serve.

Process and governance concerns remain about 'who decides' on final direction and content and will the dynamic revert to the usual dominant groups.

6. SUGGESTIONS & GUIDANCE: Specific suggestions for what to start, stop, or change? Ways to approach project development?

Here are several specific suggestions that garnered support during discussions:

- Adjust language: Stop using the phrase "equity deserving groups" and suggest "systemically or systematically disadvantaged groups".
- Be explicit that 'centering' anti-racism and human rights is about health and health outcomes associated with the trauma impacts of racism, colonization, and other forms of oppression.
- Stop using the term 'humanism' because of its association with enlightenment (no alternative offered so this may be a point for future discussion).
- Groups need to know what is going on in other groups and how to cross-reference their developments.
- A suggestion that a future CanMEDS Project Summit could be set up as a landmark event.
- A piece of advice regarding the creation of a next framework concept: "Don't let perfect be the enemy of good." Let's get a "first worst" draft out there soon to be more action oriented.

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Indigenous Learning Circle Summary Report

Lisa Richardson, MD, MA, FRCP
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The Indigenous Learning Circle and the CanMEDS Steering Committee will ensure a mechanism to incorporate the competencies in Indigenous health recently developed by the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, and the National Consortium for Indigenous Medical Education into the developing frameworks.

Foundational Reading

National Consortium for Indigenous Medical Education
Advancing Indigenous medical education and leadership in health care.

Indigenous Health Primer
Learn essential knowledge about Indigenous health in this rich compendium including case studies of Indigenous experiences and insights from Indigenous Fellows.

Indigenous Health Values and Principles Statement, Second Edition
Learn about the health values important to Indigenous People and how the CanMEDS framework relates to them with actionable principles that guide culturally safe health care.

CanMEDS–Family Medicine Indigenous Health Supplement
This Indigenous supplement to the CanMEDS-FM 2017 competency framework will help family physicians provide high-quality care that aligns with the needs and circumstances of Indigenous peoples living in Canada.

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Equity, Diversity, Inclusion, and Accessibility Interim Report

Prepared by: Dr. Ritika Goel, member of the Anti-Racism Expert Working Group.
Modified from the interim report prepared by Dr. Kannin Osei-Tutu and Dr. Paula Cashin as Co-chairs of the Anti-Racism Expert Working and
Strategic Advisors, Equity, Diversity, Inclusion and Accessibility

CanMEDS 2025 affords us the opportunity to think critically and propose a vision for the practice of medicine which is rooted in social justice, anti-racism, anti-oppression, and cultural safety, promoting a broader cultural shift which is necessary for the profession. As a profession and a health system, we participate daily in the perpetuation of structural violence upon those most marginalized amongst us, particularly those who are racialized, and live at the intersections of marginalization because of our race, ethnicity, religion, sex, gender identity, social class, ability, immigration status and more.

A new model of CanMEDS would seek to centre values such as anti-oppression, anti-racism, and social justice, rather than medical expertise. It would prioritize bidirectional relationships with patients, providers, communities, the land, the health system, and society at large rather than the individual physician as a gatekeeper of professionalized knowledge. With this new model, we can reflect a stance of humility over hubris, and demonstrate how we as physicians must be constantly seeking to learn, explore, critically reflect, and grow.

Existing competencies can be re-organized and modified under a new model which would also feature the teaching of critical reflection and self-reflexivity, as well as understanding of equity and advocacy, so as to allow physicians to more effectively engage in community-led social change. Such a model of CanMEDS would allow medical schools to appropriately embed and infuse lenses of social justice, anti-oppression, advocacy and equity throughout their teaching, and thereby teach future physicians how to incorporate such thinking into all of their clinical, teaching and research work.

The Anti-Racism Expert Working Group has formed a consensus definition of anti-racism to guide the work of CanMEDS Renewal 2025.

"Anti-racism is an explicit stance, a process and a systematic method of analysis requiring a proactive course of action for individuals, institutions, and societies to undertake. Anti-racism sheds light on the structures of racism rooted in the justification of colonization, slavery, and white supremacy, with manifestations at the individual, interpersonal and systemic levels. Anti-racism actively seeks to identify, remove, prevent, and mitigate racially inequitable outcomes and power imbalances and change the structures that sustain inequities. Anti-racism is deeply rooted in anti-oppression, which analyzes the world through the lens of power, including the historical and ongoing structures of racism, white supremacy, settler colonialism, heteropatriarchy, capitalism, ableism, classism, sexism, homophobia, transphobia and more. Anti-racism and anti-oppression call for action on the manifestations of oppression based on race, ethnicity, religion, sex, gender identity, sexual orientation, socioeconomic status, immigration status and more. Anti-

racism in medicine and healthcare requires us to examine, acknowledge and work to mitigate and dismantle the deep roots and manifestations of racism and other intersecting oppressive structures in our day-to-day work."

The Model

In our deliberations, the following themes have emerged pertaining to the existing CanMEDS Framework and our vision for a renewed model that reflects the needs of our communities:

1. **De-centering medical expertise** – The ongoing centering of medical expertise over all other facets of medical care and being a physician reinforce and promote the hidden curriculum in medical education which states that critical aspects of medical practice such as advocacy, collaboration and communication are less important. We are proposing a shift towards a model that centres values. These values must be reflected throughout competencies but ideally also clearly visualized as the centre or foundation of all that we do in medicine. Some values that could be included in this foundation:

    - Anti-Racism – to name the pervasive nature of racism and the need for an explicit stance of anti-racism which requires constant learning and unlearning.
    - Anti-Oppression – to recognize the structures of oppression that are all around us, and that we in healthcare, as physicians, often perpetuate and benefit from.

    - Social Justice and Equity – to orient our work whether clinical, teaching, research or advocacy towards social justice, for the benefit of communities, especially those most marginalized amongst us.
    - Shared Humanity – to recognize the fundamental dignity and worth of all individuals and to name the humanity of both the provider and the patient in front of them as connected.
    - Inclusive Compassion – to name the actions through which we signal safety and provide non-judgemental, anti-oppressive healthcare.
    - Cultural Safety/Humility – to name the need to promote safety for our patients and maintain humility in ourselves as providers about the experiences and identities of others, especially those most marginalized amongst us.
    - Decolonization – to name the explicit colonial history of this land and the need to orient ourselves always towards decolonizing our minds and our institutions.
    - Other concepts discussed include social accountability, trauma-informed care, intersectionality.

2. **Focusing on relationships**
    - Patients (or alternatively using terminology of people to de-medicalize) – Naming the centrality of the relationship between physician and in order to truly provide high equality, anti-oppressive, culturally safe healthcare.
    - Providers – Naming and working to mitigate the power imbalances between physicians and other healthcare providers.
    - Health system – Naming the context within we operate and our need to interact within that system while also engage in systems change work at this level.
    - Land/Earth – Naming our relationship to the land and the need to foster that relationship, as well as the earth to name our responsibility for stewardship and addressing structural issues such as planetary health.
    - Community – Seeing ourselves as accountable not just to individual patients/people but to communities that we serve, and being able to better recognize the health challenges and needs of communities to better serve them with solutions at the community/institutional/societal level.
    - Society – Seeing ourselves as accountable to society at large and being able to recognize the health challenges and needs of society, as well as the societal challenges such as structural oppression, housing, poverty, unemployment, decent work that require social change.
    - Globe – Seeing ourselves as interconnected with people/communities across the world.

3. **Demonstrating connection to the past and the future** – A new CanMEDS model would include:
    - A recognition of history in terms of the power structures that have come into existence over centuries which shape everything we do daily eg. White supremacy, heteropatriarchy, capitalism.
    - A recognition of the ancestors that come before us.
    - A recognition of the future and the need to thereby steward the land and promote values of social justice for a better world.

4. **Demonstrating the aspects of physicians as skills we practice, learn and grow in, as opposed to static roles** – this is required in both the visual representation as well as the language used and allows us to reflect the activities we think highly effective physicians engage in:
    - Learning and doing (or Learn and Do), rather than Medical Expert.
    - Teaching, reflecting and exploring (or Teach, Reflect and Explore), rather than Scholar.
    - Communicating (or Communicate), rather than Communicator.
    - Collaborating (or Collaborate), rather than Collaborator.
    - Advocating (or Advocate), rather than Health Advocate.

- Role modelling (or Role Model), rather than Professional.

5. **Ongoing Debate about re-defining 'Leader' and leadership**
    - The Expert Working Group has had significant discussion on the Leader role, and some have expressed discomfort with the reinforcement of power hierarchy in the current model of this role.
    - Some discussion has included thinking about how management, facilitation, engagement and advocacy can be promoted while not assuming physicians should inherently lead.
    - Ongoing discussion will continue until the group nears a consensus position.

6. **Physician as educator**
    - A group member has proposed whether the specific role of 'educator' (or its appropriate verb format) should be separated out as distinct from the existing roles.
    - Ongoing discussion will continue until the group nears a consensus position.

The Competencies

Competencies by definition must flow from the model proposed. Any modified version of the model will by definition require a re-organization of the existing competencies. We will also need to modify as well as add competencies to ensure that anti-racism and anti-oppression are infused throughout. Notably, a focus on skills such as critical reflection must be fundamental to any modified version of CanMEDS.

The Process

As the Anti-Racism Expert Working Group has met throughout this process, we have reflected on a few aspects of the process that may be useful to the larger work. We have greatly appreciated the opportunity to meet and be in space together to share, reflect and discuss. We have however felt it would be valuable to better understand the scope of the work, and collaborate with other related working groups, such as the EDI and Social Justice group. As we have been working on alternatives for the CanMEDS model, we wish to honour the work being done by other Expert Working Groups and look to the steering committee to propose a process by which the work can be synthesized. Ideally, there would be a structure

that would allow us to come together but also then focus our work on specific mandates. There may be some utility in engaging consultants with expertise in strategic planning for large institutions that also have firm grounding in anti-oppression and anti-racism to help support this work.

In conclusion, there is an urgent need to deconstruct and reconstruct the CanMEDS framework. The proposed changes will bring about a transformative shift in healthcare education and practice, emphasizing core values over an emphasis on the physician as a

medical expert. Our vision for the way forward involves collaborative efforts among healthcare professionals, educators, regulatory bodies, and policymakers. By challenging the status quo and embracing courageous actions and bold leadership, we can build a healthcare system that actively combats systemic inequities and promotes social justice rather than further perpetuating systems of oppression.

Prepared by: Dr. Ritika Goel, member of the Anti-Racism Expert Working Group.
Modified from the interim report prepared by Dr. Kannin Osei-Tutu and Dr. Paula Cashin, co-chairs of the Anti-Racism Expert Working Group for CanMEDS 2025 on behalf of all members:

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