



Flexibility in Medical Training (Update 2009)

The Canadian Medical Association (CMA) believes that the medical training system must be sufficiently flexible to enable medical students to make informed career choices, accommodate resident program changes, and allow practising physicians the opportunity to re-enter training to enhance their skills and knowledge, or to enter a new sphere of practice. The system must also be able to accommodate international medical graduates (IMGs) to provide them with a reasonable opportunity to attain their postgraduate credentials and become licensed to practise in Canada. For physicians-in-training, effective career guidance and positive influences on career options (e.g., role modelling, early clinical exposure, etc.) may foster confidence with career path selection and minimize program changes during residency. A flexible and well-designed re-entry postgraduate system would be characterized by: long-term stability, sufficient and appropriate capacity, accessibility, flexibility in the workforce and accountability.

The CMA believes that, ultimately, society benefits from a flexible medical training system. These benefits may include enhanced patient care, improved access to physician services, as well as physician retention, particularly in rural and remote communities. A flexible system may also improve morale and satisfaction among students,

residents and physicians, and facilitate better career choices. This policy outlines specific recommendations to help create and maintain a well-designed system for flexibility in physician training in Canada. Commitment and action by all stakeholders, including governments, medical schools, regulatory authorities and others, is required.

The CMA believes that this policy must be considered in the context of other relevant CMA policies, including but not limited to the CMA's policies on physician resource planning, physician health and well-being, physician workforce issues and others.

Definitions

- Postgraduate trainee – Also known as a “resident,” an individual who has received his/her MD degree and is currently enrolled in an accredited program in a Canadian school of medicine that would lead to certification by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.
- Medical student – An individual enrolled in an undergraduate program in a Canadian school of medicine that would lead to an MD degree.

- International medical graduate – An individual who received his/her MD degree from a training program other than from one of Canada's undergraduate schools of medicine.
- Designated positions – Postgraduate positions within the determined complement of residency positions that are identified to meet a need other than that of accommodating the annual number of new graduates of Canadian medical schools to complete the usual training for certification and licensure. Designated positions may be identified for a variety of purposes.

The need for informed career decision-making and positive influences

Choice of practice discipline as lifelong career can be one of the most difficult aspects of physician training. Exacerbating this challenge are the vast array of available specialties, timing of choices, as well as practice considerations in terms of lifestyle and physician resource needs. The rapidly changing face of medical practice as well as the limited amount of information and time available to consider options, are also contributing factors.

A number of other forces, both positive and negative, may affect students' choices of practice specialty. These can include financial considerations in light of student debt incurred by high tuition fees and insufficient financial support.¹² The biases of faculty, family and others may also impact decisions. In addition, limited training opportunities in general, as well as a lack of flexibility to switch training programs, may also restrict choice of practice specialty. While a myriad of personal factors are acknowledged to also play contributing roles in influencing program selection, these issues are too complex to discuss here. Ultimately, students need to have access to financial support so as to reduce stress and the influence of debt on specialty choice. They also need objective information and guidance and broad clinical experiences early in their medical training as this has been identified as a critical factor in making decisions about their future careers.³

The rotating internship, abolished in the early 1990s, used to permit residency selection at a later stage in medical training. The residency program match now takes place during the final year of undergraduate studies. As a consequence of this earlier timing, some students feel pressured to make their specialty choice too early in their medical education and often before their clerkship has even begun. This can include focusing research and program electives⁴ in one specific area, rather than sampling a broad range of disciplines, to demonstrate conviction of choice to residency program directors at the time of the match. Fifty-nine percent of respondents to the Canadian Resident Matching Service's (CaRMS) 2006 post-match survey indicated they completed more than half of their electives in their first-choice discipline.⁵ This, combined with the early timing of the residency match, can lead to an uninformed choice of residency program and the realization, at a later date, that a different training program would be more suitable. Eighty percent of medical leader respondents to the 2008 Core Competency Project survey indicated that timing of career choice was the biggest challenge for career decision-making.⁶

Those residents who wish to change to new training programs may not believe they have the opportunity to do so. Thirty-seven percent of resident respondents to the Core Competency Project survey considered switching disciplines during their residency training⁷ and 39% had spoken to a faculty member about switching programs.⁸ Others who do change programs are ultimately delayed entry into the workforce as a result of their prolonged training. This problem is exacerbated by an insufficient number of re-entry postgraduate training positions and large debt that confine trainees to a single career path.

Lack of student confidence and preparedness in choosing a postgraduate training program, or lack of success in achieving a first choice in the postgraduate match, may predict subsequent program changes. A broad range of strategies must be available to help medical students make informed career choices. These include a wider

choice of electives at an earlier stage of training, positive and unbiased mentoring experiences, improved access to career information from residents, as well as career seminars and other resources.

In light of the above, the CMA recommends that:

1. the undergraduate medical school curriculum be re-designed to facilitate informed career choice and, in particular, to ensure that students enjoy a broad range of clinical experiences before they have to choose a specific discipline (i.e., via CaRMS match);
2. national career counselling curricula for both medical students and residents be developed and include the following components: national standardization; stakeholder input (students, residents and others); positive and fair role modelling by both residents and practising physicians/faculty, with appropriate professional respect among medical disciplines; and formal and informal mentorship programs;
3. a wide-range of elective opportunities be developed and communicated at a national level;
4. electives reflect a broad spectrum of experiences, including community-based opportunities;
5. clinical experiences be introduced at the earliest possible stage of undergraduate learning;
6. a national policy be implemented to ensure mandatory diversification of student elective experiences; and
7. medical schools be permitted and encouraged to model alternate systems of postgraduate learning.

The need for broad-based medical education

In order to provide medical students with the greatest options for flexibility in medical training, they should be actively encouraged to pursue a broad-based medical education. Previously, CMA advocated for a common postgraduate year (PGY1). In the 2008 Core

Competency Project survey, 77% of physician respondents, 70% of medical student respondents and 67% of program director respondents expressed support for first year residents to do a broad-based common PGY1-like rotating internship.⁹ The rationale for and importance of ensuring flexibility has been outlined in the previous sections.

Capacity of the postgraduate training system

An essential component in ensuring flexibility within the medical training system is to establish and maintain sufficient capacity at the postgraduate training level. This is necessary for the following reasons:

- Sufficient capacity may prevent highly-skilled and well-trained Canadian physicians from being forced to seek postgraduate training in the U.S. and remain there to practise medicine.
- It is necessary to provide IMGs with a reasonable opportunity to attain their postgraduate credentials and become licensed to practise in Canada. This reflects the CMA's recognition of the important contribution that IMGs have made, and continue to make, in the provision of medical services, teaching and research in Canada. Opportunities for IMGs will also permit Canadians who study medicine abroad to pursue their medical careers in Canada.
- It is essential to provide students with sufficient choice to seek the training that best matches their skills and interests as well as societal demands.
- It is crucial to provide sufficient re-entry positions to allow practising physicians to seek training in other areas of medicine to meet the demands of their communities. *[Please refer to the "Re-entry" section of this policy for more details.]*

In light of the above, the CMA recommends that:

8. mechanisms be developed to permit reasonable movement of residents within the overall residency structure and career

- counselling supports be made available to residents considering such a change;
9. the capacity of the postgraduate training system be sufficiently large to accommodate the needs of the graduating cohort, the re-entry cohort, and the training needs of international medical graduates;
 10. there be a clearly defined pool of re-entry postgraduate positions and positions for international medical graduates;
 11. government match and maintain undergraduate medical enrolment with a target of at least 120 ministry-funded postgraduate training positions per 100 Canadian medical graduates, to accommodate the training needs of the graduating cohort, the re-entry cohort and international medical graduates; and
 12. options be explored for influencing governments to support a flexible postgraduate medical education system that also meets societal needs.

Re-entry medical training system

Note: This section addresses only one kind of designated position, specifically, those for licensed physicians wishing to re-enter training after a period in practice (also known as “re-entry positions”). The re-entry positions addressed in this paper would require no return for service. Designated positions for training in return for service in a specified discipline and location is a separate entity from general re-entry.

Increased opportunity for exposure to the breadth of medical fields in undergraduate training, improved undergraduate career counselling and a postgraduate system that makes the changing of disciplines easier are some of the many aspects that should facilitate residents’ satisfaction with career choice. There will, however, inevitably be individual cases where issues of societal need, personal health, lifestyle or personal choice necessitate a change in career direction *after* postgraduate training. This requires the availability of additional postgraduate positions

allotted specifically to this sub-set.

A sufficient and stable supply of re-entry positions is needed within the postgraduate training system to enable practising physicians to enhance their skills or re-enter training in another discipline. While this may apply mostly to family physicians and general practitioners wishing to train in a specialty discipline, it can also include practising specialists wanting to sub-specialize or train in another area, which could be Family Medicine.

The additional or new training of primary care physicians, particularly in obstetrics, emergency medicine, anaesthesia, surgery, psychiatry and general internal medicine, will be of benefit to smaller communities lacking regular access to these specialty medical services. In addition, the availability of adequate re-entry positions may encourage new physicians to accept locum tenens, thus relieving overworked physicians in underserved communities. Potentially, it could help to increase a community’s long-term retention rate of established physicians.

The CMA believes that a well-designed re-entry system for Canadian postgraduate medical education would be characterized by an accessible national registry, long-term stability, sufficient and appropriate capacity, accessibility, flexibility in the workforce and accountability.

Stability

Medical students need reassurance that re-entry positions will be available if they wish to re-enter training after a period in practice. This will enable them to better plan their careers, reduce anxieties about career selection and ultimately help to meet the health care needs of society. For physicians re-entering the postgraduate training system, there must also be the guarantee that sufficient program funding will be available to ensure completion of training.

The CMA therefore recommends that:

13. a complement of clearly defined,

permanent re-entry positions with stable funding be a basic component of the Canadian postgraduate training system and that the availability of these positions be effectively communicated to potential candidates; and

14. funding for re-entry positions be specifically allocated for the entire training period.

Capacity

The CMA believes that the capacity of the postgraduate training system must be sufficiently large to accommodate the needs of the re-entry cohort and that postgraduate re-entry positions should be supernumerary to the numbers required for the graduating cohort. [*Please refer to the "Capacity of the Postgraduate Training System" section of this policy for specific recommendations.*]

Accessibility

The CMA believes that re-entry physicians should not be restricted to competing for particular disciplines for which there is an identified need in their jurisdiction. Re-entry physicians should also be able to compete for any available disciplines across all training programs. Not every discipline will be available for re-entry each year but all should be accessible over the course of a three-year period.

The CMA therefore recommends that:

15. there be accessibility within re-entry postgraduate training positions including:
 - open and fair competition at the national level among all re-entry candidates for the clearly defined pool of re-entry positions,
 - that the mix of positions available reflect the overall mix of positions in the postgraduate training system, and
 - recognizing the limited size of the re-entry pool, access to all specialties be available over a three-year period rather than on an annual basis; and
16. access to entry should be possible through

both national and regional pools of re-entry positions, with a process comparable to that currently used for the postgraduate training system.

Flexibility in the Workforce

As previously mentioned, the re-entry positions discussed in this paper would require no return for service. Designated positions for training in return for service in a specified discipline and location is a separate entity from general re-entry.

The CMA therefore recommends that:

17. physicians who have retrained through the re-entry system have the same practice opportunities as physicians entering the workforce for the first time.

Accountability

The CMA recognizes the importance of public accountability and sound fiscal management and therefore recommends that:

18. there be on-going evaluation of the re-entry system in Canadian postgraduate medical education.

¹ Kwong JC, Dhalla IA, Streiner DL, Baddour RE, Waddell AE & IL Johnson. Effects of rising tuition fees on medical school class composition and financial outlook. *CMAJ* 2002; 166 (8): 1023-8.

² 2007 National Physician Survey Data.

³ Directions for Residency Education, 2009 – A final report of the Core Competency Project. February 2009. Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada.

⁴ *Ibid*, page 23.

⁵ *Ibid*.

⁶ *Ibid*, page 59.

⁷ *Ibid*, page 27.

⁸ *Ibid*, page 60.

⁹ *Ibid*.