EMERGENCY MEDICINE TRAINING AND PRACTICE IN CANADA:
Celebrating the Past and Evolving the Future

CWG-EM
Final Report Presentation and Discussion

June 6, 2016
The Collaborative Working Group on the Future of Emergency Medicine in Canada:

A trilateral partnership:
THE CWG-EM MEMBERS

Chair
Doug Sinclair, MD, CCFP(EM), FRCPC

CAEP Members
Riyad B. Abu-Laban, MD, MHSc, DABEM, FRCPC
Peter Toth, MD, MSc, CCFP(EM)

CFPC Members
Constance LeBlanc, MD, CCFP(EM), MA(Ed), CCPE
Pamela Eisener-Parsche, MD, CCFP, FCFP, CCPE

Royal College Members
Jason R. Frank, MD, MA(Ed), FRCPC
Brian Holroyd, MD, MBA, FCFP, FACEP, FRCPC
1. Development of key project questions

2. Analysis of historic materials, initiatives, and perspectives

3. Comparative analysis of CCFP(EM) and FRCPC-EM training routes

4. Communication with Postgraduate Deans of Medical Education

5. National survey of EM training and HHR needs

6. Additional activities and communication with key stakeholders
NATIONAL SURVEY ON EM TRAINING AND HHR NEEDS:

- CCFP(EM) and FRCPC-EM certified physicians
- Emergency Department Chiefs
- CCFP(EM) and FRCPC-EM residents
- CCFP physicians with an interest or activity in EM
## Demographics of Respondents

<table>
<thead>
<tr>
<th>Category</th>
<th>Invited Participants</th>
<th>Survey Response Rate</th>
<th>Mean Age (years)</th>
<th>Gender Breakdown</th>
<th>Mean Year of Most Recent Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians with EM certification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCFP(EM)</td>
<td>2693</td>
<td>34.5%</td>
<td>44</td>
<td>65.6% Male 34.4% Female</td>
<td>2004</td>
</tr>
<tr>
<td>FRCP-EM</td>
<td>843</td>
<td>49.0%</td>
<td>43</td>
<td>66.3% Male 33.7% Female</td>
<td>2003</td>
</tr>
<tr>
<td>Dual Certificants</td>
<td>-</td>
<td>-</td>
<td>57</td>
<td>88.6% Male 11.4% Female</td>
<td>1994</td>
</tr>
<tr>
<td>EM Residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCFP(EM)</td>
<td>134</td>
<td>49.3%</td>
<td>31</td>
<td>62.1% Male 37.9% Female</td>
<td>-</td>
</tr>
<tr>
<td>FRCP-EM</td>
<td>379</td>
<td>49.3%</td>
<td>30</td>
<td>55.9% Male 44.1% Female</td>
<td>-</td>
</tr>
<tr>
<td>CCFP (non-EM) Physicians</td>
<td>2924</td>
<td>9.0%</td>
<td>42</td>
<td>63.2% Male 36.8% Female</td>
<td>-</td>
</tr>
<tr>
<td>ED Chiefs</td>
<td>398</td>
<td>38.9%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
PRACTICE PROFILES OF PHYSICIANS CURRENTLY PRACTICING EM

ED settings of physicians with an EM certification

- **CCFP (EM)**
  - N=913
  - Large Urban Academic: 39.9%
  - Large Urban Non-academic: 25.3%
  - Small urban: 21.1%
  - Rural: 12.7%
  - Remote: 1%

- **FRCP-EM**
  - N=406
  - Large Urban Academic: 82.8%
  - Large Urban Non-academic: 8.1%
  - Small urban: 6.4%
  - Rural: 2.7%

- **Dual Certification**
  - N=46
  - Large Urban Academic: 71.7%
  - Large Urban Non-academic: 15.2%
  - Small urban: 8.7%
  - Rural: 4.30%
## Profile of Practicing EM Physicians

<table>
<thead>
<tr>
<th>Clinical Practice Distribution</th>
<th>Large Urban Academic</th>
<th>Large Urban Non-Academic</th>
<th>Small Urban</th>
<th>Rural</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCFP (EM)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>91%</td>
<td>89%</td>
<td>82%</td>
<td>75%</td>
<td>59%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>3%</td>
<td>4%</td>
<td>9%</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Trauma Care</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>5%</td>
<td>8%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>FRCPC-EM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>91%</td>
<td>87%</td>
<td>84%</td>
<td>66%</td>
<td>-</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>17%</td>
<td>-</td>
</tr>
<tr>
<td>Critical Care</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>-</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>11%</td>
<td>-</td>
</tr>
<tr>
<td>Trauma Care</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>9%</td>
<td>12%</td>
<td>6%</td>
<td>-</td>
</tr>
</tbody>
</table>
PROFILE OF PRACTICING EM PHYSICIANS

ED settings of physicians with a CCFP certification

- Large urban academic hospital: 50.6%
- Large urban non-academic hospital: 11%
- Small urban hospital: 20.1%
- Rural hospital: 7.8%
- Remote hospital: 10.4%
ALIGNMENT OF TRAINING AND PRACTICE

• The majority of respondents feel adequately prepared for clinical practice by their training route.

• There is a strong sentiment amongst EM certified physicians outside rural and remote settings, that CCFP (non-EM) training alone is insufficient to gain competencies for the practice of EM.
<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
<th>Average Coverage/day/ED Short</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Urban</td>
<td>38.9%</td>
<td>11.3 hours</td>
</tr>
<tr>
<td>Academic</td>
<td></td>
<td>ED short</td>
</tr>
<tr>
<td>Large Urban</td>
<td>45.0%</td>
<td>15.4 hours</td>
</tr>
<tr>
<td>Non-Academic</td>
<td></td>
<td>ED short</td>
</tr>
<tr>
<td>Small Urban</td>
<td>50.0%</td>
<td>5.5 hours</td>
</tr>
<tr>
<td>Rural</td>
<td>41.7%</td>
<td>6.4 hours</td>
</tr>
<tr>
<td>Remote</td>
<td>62.5%</td>
<td>5.2 hours</td>
</tr>
</tbody>
</table>
SURVEY REFLECTIONS ON THE CURRENT APPROACH TO EM CERTIFICATION IN CANADA

Strengths

✓ Current approach fulfills Canadian needs.
✓ Diverse contexts: responsive to geography and population distribution.
✓ Roles for each practitioner.
✓ Both routes produce capable emergency physicians.

Challenges

✓ Insufficient content exposure for both training routes.
✓ Inappropriate length of training programs.
✓ Inequalities between certification routes.
✓ Misalignment of program goals with practice.
NATIONAL EMERGENCY PHYSICIAN SHORTFALL

Estimate and future projections:

Current Supply: 3319

5 year: 3071

10 year: 2613

478 short
1071 short
1518 short

- Required supply
- Gap
- Incoming supply - Newly graduated physicians
- Non-certified emergency physician supply
- Certified emergency physician supply
Current supply estimate

Non-certified Emergency Physicians
(Median # of CCFP physicians per ED × # of EDs in Canada)

Certified Emergency Physicians
(#FRCPC-EM certified physicians + #CFPC(EM) certified physicians)

Current Supply Assumptions:
1. All certified physicians are actively practicing in Canada
2. All certified physicians are full clinical FTE working 8 hour shifts with 13 shifts/month
Current shortfall estimate

Average # of EM physicians short per ED  
Medium # of hours short per day x 30 days/month  
104 hours/month

Number of EDs reporting staffing shortages  
the % of EDs in Canada reporting staffing shortages as reported in ED Chief survey results  
the number of Emergency Departments in Canada

1. All certified physicians are full clinical FTE working 8 hour shifts with 13 shifts/month (i.e. 104 hours/month)
Projected 5 and 10 year supply estimate

Continuing physician supply estimate
Current supply estimate - physicians lost to attrition

Potential incoming supply estimate
moving average of the number of successful, Canadian residency trained candidates over the past 5 years and then multiplied by 5 for 5 years and 10 for 10 years

Projected Supply Assumptions:
1. Trends in the number of resident positions and graduates over the past 5 years will follow a similar pattern into the next 10 years.
2. Incoming physicians will devote approximately 70% of their practice to the clinical practice of EM (this is based on the responses from the EM residents survey)
Required physician supply estimate - Projected 5 and 10 year physician supply

An estimate derived from the predicted change in volume of hours of coverage as reported in the ED Chiefs survey in addition to the current shortfall.

Current Shortfall Assumptions:
1. All certified physicians are full clinical FTE working 8 hour shifts with 13 shifts/month (i.e. 104 hours/month)
CWG-EM VISION AND RECOMMENDATIONS

- HHR shortfall
- Alignment of EM training programs
- Future research activities
- Ongoing collaboration between trilateral partners
- HHR needs in rural and remote ED settings
CAEP, the CFPC and the Royal College are encouraged to work in collaboration in order to address:

- The current and future HHR deficit in EM
- The right balance of physicians needed to fill this deficit
- And advocate for growth in the programs as defined by the types of graduates needed for a variety of ED settings.
RECOMMENDATIONS: HHR SHORTFALL - OTHER CONSIDERATIONS

• That it is the responsibility of provincial ministries, Faculties of Medicine and their PGME offices in also addressing the HHR issue as they control resources for PGME and,

• That there is a responsibility for the FRCPC-EM and the CCFP(EM) programs to advocate for PGME allocations that will address HHR deficits.
RECOMMENDATIONS: FRCPC-EM

• Develop competencies to enable graduates to deliver specialist emergency care to patients in tertiary, large urban, regional, and community hospital EDs.

• Review FRCPC-EM curriculum and incorporate increased competencies relating to emergency and primary care and the larger continuum of care external to the ED setting.

• Increase attention to the intended practice routes of FRCPC-EM graduates in order to achieve efficient and aligned training.
• Survey respondent data of CCFP(EM) certified physicians and residents indicates that the vast majority of CCFP(EM) graduates intend to or practice full-time EM and not a combination of EM and clinical Family Medicine.

• Review the structure, goals, and objectives of the CCFP(EM) program to ensure competency at graduation and satisfy the standard of care for ‘patient zero’ (from a competency based perspective)

• That core competencies incorporated into the CCFP(EM) program be dictated by the anticipated setting of future practice.
RECOMMENDATIONS: RURAL/REMOTE

• CFPC is encouraged to review the rural/remote survey findings and, as many CCFP certified physicians fulfill critical ED staffing needs in these settings, consider modifications to the CCFP program in order to ensure that required competencies for emergency care are attained by program graduates intending to work in these settings.

• We recommend that the CFPC, the Society of Rural Physicians of Canada, and other key stakeholders continue to work collaboratively towards solutions for the provision of optimal emergency care in rural Canada.
RECOMMENDATIONS: INTER-COLLEGE COLLABORATION

• That Collaboration between the two colleges be implemented and actioned towards the goal of achieving clinical competence for every resident, for their ultimate practice trajectory and setting, at the completion of training.

• That the two Colleges make specific and meaningful changes to collaborate on issues related to their EM training programs and the future evolution of Canadian EM education and certification.
RECOMMENDATIONS: COLLABORATION

Collaboration includes, but is not limited to:

• Clarify, co-develop, and distinguish the goals of each program; highlight program distinctions; ensure clinical competencies for “patient zero” are met and non-clinical competencies are achieved; and, both programs are efficient and effective.

• Develop parallel foundations of EM care for both training routes and co-develop competency-based clinical care milestones for common clinical presentations.

• Establish observer status appointments for one-another on EM relevant committees.
RECOMMENDATIONS: FUTURE RESEARCH

• Results of the CWG-EM National Survey of EM represent a significant collective resource for the Trilateral Partners and the Canadian EM community both today and in the future.

• Ensure the trilateral partners or the EM research community has access to the CWG-EM data for future research initiatives.
Special thanks to-

Dr. Francine Lemire, Executive Director and CEO, College of Family Physicians of Canada

Dr. Jill McEwen, President, Canadian Association of Emergency Physicians

Dr. Andrew Padmos, CEO, Royal College of Physicians and Surgeons of Canada

~and thank you for joining us today~
"It always seems impossible until it’s done."

- Nelson Mandela