Distributed Medical Education in Ontario: 2014 Report

Bringing care closer to home.

Council of Ontario Faculties of Medicine
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EXECUTIVE SUMMARY

More than a decade ago there was a shortage of doctors in the province. One in 11 Ontarians couldn’t find a family physician and there were lengthy wait times for specialty care; challenges to access were particularly acute in rural areas. Today, a strategic partnership of Ontario universities and government has turned this situation around. A significant investment in medical school expansion, family medicine expansion and socially responsible medical education is leading to improved community recruitment and retention of physicians, and improved access to care.

Distributed medical education (DME) embraces the concept of socially responsible medical education and is geared towards community engagement and accountability to communities. DME is the new norm for Faculties of Medicine, with more than 300 Ontario communities and thousands of community physicians involved in educating the next generation of doctors, helping to ensure that they have the skill, comfort level and interest to work in towns, villages and cities across the province. Active community participation in medical education is aligned with the province’s health care agenda.

DME is demonstrating early signs of return on investment. More Ontarians are able to access care closer to home. DME is creating a pipeline for communities to recruit physicians who will help meet their local health care needs today and in the future. DME is educationally sound and a great experience for the learner. In recognition of its educational value to learners it is now an integral component of medical training in Ontario with each Faculty of Medicine providing undergraduate and postgraduate, family medicine and specialty learning opportunities in rural and regional communities. The Faculties of Medicine in turn are solely responsible for ensuring that the highest standards of training and accreditation requirements are met.

Ontario is leading the world in educational innovation with DME as an essential element of 21st century medical education. Ontario Faculties of Medicine are committed to socially responsible medical education and sustaining the valuable community medical education resource that has been created.
INTRODUCTION

21st century medical students are as likely to be found in Perth, Ontario as in The Ottawa Hospital. In a strategic partnership with government, the Faculties of Medicine of Ontario have integrated distributed medical education (DME) into their education programs and created a new norm that allows medical students and postgraduate residents to experience and gain confidence in rural and community settings, where many of them will practice one day. Over the past decade, an integrated network of rural and community programs has arisen across the six Ontario Faculties of Medicine.

DME embraces the valuable skills and enthusiasm that community physicians bring to the role of medical teacher and supervisor. DME engages the power of communities, which are working collaboratively with the Faculties of Medicine on education and research, helping to address their local physician needs and creating innovative, locally relevant health care approaches.

DME has many shapes and sizes. Some Ontario Faculties of Medicine provide week-long community experiences for all first year medical students while others offer months-long integrated community clerkship rotations. Family medicine training is largely community-based for its full two-year duration. Some Faculties of Medicine offer entire undergraduate and postgraduate programs in rural settings. DME aligns with accreditation standards and national medical education policy directions, which recognize the value of DME to learners and society.

This report describes the Faculties of Medicine approach to DME in Ontario, demonstrating signs of success, return on investment and community impact. As will be evident in this report, there is need for a systematic, provincial approach to studying outcomes in order to strengthen and sustain the province’s investment in socially responsible medical education, and to build on the strong foundation of collaboration between the Faculties of Medicine, Ontario communities and the Ontario provincial government.
DISTRIBUTED MEDICAL EDUCATION CONTEXT

Distributed Medical Education (DME) is socially accountable medical education. It has enabled government and universities to rapidly expand enrolment, address a physician shortage and is helping to improve access to care, particularly in rural communities. DME aligns with national accreditation and medical education directives. It is no longer a separate entity; it has evolved into an important component of each Faculty of Medicine.

Social Accountability

Social accountability of medical schools is not a new concept. The World Health Organization in 1995 defined social accountability as “[Medical Schools have] the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.”1

Distributed Medical Education

DME is defined by the Association of Faculties of Medicine of Canada (AFMC) as a decentralized model of medical education utilizing a teaching and learning network that is integrated in and accountable to communities. It is further characterized by:

- Learning in context: education delivered wherever health care is delivered;
- Generalism: allows more exposure to “generalists” (not just family practice, but also general surgeons, internists, pediatricians, etc.); and
- Social responsibility.2

In Ontario, DME is broader than a generalist approach. DME includes community experiences for undergraduate and postgraduate learners, across family medicine and other specialty programs.

1 Association of Faculties of Medicine (AFMC) http://www.afmc.ca/about-social-accountability-mandate-e.php
2 AFMC DME Resource Group, May 2011.
## The DME Strategic Response

### A – Societal Need

- Patients without access to care, especially in rural areas
- Shortage of physicians

### B – Strategy (university/government collaboration)

- Government investment
- Government mandate
  - Expand undergraduate and postgraduate medical programs
  - Expand family medicine residency programs
  - Implement comprehensive DME
  - Provide diverse learning opportunities to prepare graduates to work in all settings
  - Improve transition into practice for new graduates
- National medical education directives and accreditation standards

### C – Outcomes

- Improving access to care, including rural and community settings
- New socially accountable norm for medical education
- Incredible network of engaged communities and physicians

### A1. Societal Need

More than twenty years ago, at a time of perceived physician over-supply, Ontario medical school enrolment was reduced. By the late 1990s, patients and communities across Ontario were experiencing a serious shortage of physicians. Newspapers rang out with stories about the 1 in 11 Ontarians who couldn’t find a family physician and about lengthy wait times to access specialty care.

### B1. Strategy - Medical School Expansion

The Ontario government embarked on a strategic collaboration with Ontario Faculties of Medicine to graduate more physicians, implement DME and improve access to care. As a result, medical school enrolment increased by 80%; family medicine programs are now graduating more than 500 family physicians per year (up from 200); and a new Northern Ontario Medical School (NOSM) opened with a mandate to meet the health care needs of the people of the North. Communities across the province have become actively engaged in educating undergraduate and postgraduate medical learners.
Enrolment Expansion Actuals and Projections

Source: Council of Ontario Universities

Note: Despite this growth in graduates and increased numbers of physicians in Ontario, Canada’s physician per capita ratio is lower than three-quarters of OECD member countries (Organisation for Economic Co-operation and Development).

Physician Per Capita Ratios


3 OECD’s mandate is to promote policies that will improve the economic and social well-being of people around the world.
B2. Strategy - Family Medicine Expansion
A carefully planned and executed collaboration between Ontario Faculties of Medicine, the Ontario government and the medical profession led to a dramatic change in the number of family doctors in the province and improved access to primary care. Over 2.1 million patients who, ten years ago, did not have a family doctor are now enrolled in a primary care model.

Family medicine expansion has created a cadre of family medicine faculty and learners able to propel primary care reform and the government’s action plan agenda, including initiatives such as Health Care Connect and Health Links. For more information, see the 2014 Family Medicine Expansion Report, which describes how university initiatives and primary care reform are leading to improved access for patients (http://www.cou.on.ca/publications/reports).

University Initiatives
- Residency Expansion
- Community Engagement in Education
- Medical Student Career Choice

Primary Care Reform
- Patient Enrolment
- Inter-Professional Care Models
- Family Physician Reimbursement Models

= Improved Access

B3. Strategy - DME
Ontario Faculty of Medicine family medicine programs, which are largely delivered in community-based settings, have been pioneers and leaders in Ontario’s DME evolution. Today, family medicine and other specialty programs at both undergraduate and postgraduate levels are part of the socially responsible medical education mandate.

Faculties of Medicine now operate networks of regional and rural academic and clinical activity where learners are exposed to a variety of learning and practice environments. The provincial DME committee of the Council of Ontario Faculties of Medicine (DME:COFM) has facilitated collaborative and improved efficiency initiatives such as the development of provincial policies and guidelines on Collaboration in Ontario Distributed Medical Education and participation in the national Association of Faculties of Medicine of Canada visiting electives portal.

Full details of Ontario Faculty of Medicine DME Programs and activities can be found in the attached compendium document.

C1. Outcome – Network of Engaged Communities and Physicians
In collaboration with government, the universities have established a network of interconnected medical schools that all provide rural and community experiences to learners. Over 300 Ontario communities and thousands of community physicians are involved in the DME network and contributing to significant increases in the number of medical trainee days (MTDs) provided in community hospitals across the province.
Growth in Medical Trainee Days (MTDs) in Ontario Hospitals

DME Expansion: 2001 MTD Trainee Days

Source: MOHLTC presentation to COFM, April 2014

DME Expansion: 2012 MTD Trainee Days

Source: MOHLTC presentation to COFM, April 2014
C2. Outcome – Socially Accountable Norm for Medical Education

The Ontario government currently spends 42 cents of every dollar on health care, representing a 60% increase since 2003. In addition to this unsustainable fiscal trend, government is also faced with demographic and complex health challenges. While primary care reform is heading in the right direction, challenges remain with timely access to care, access to care in rural and remote areas, and management of complex patients in community settings.

The 2010 Lancet Commission on Education of Health Professionals for the 21st Century reported that health professional education has not kept pace with the challenges of today’s health care system. They noted that educational programs have an important role to play in generating an educated workforce supply to meet the demand of professionals to work in the health system.4

DME is a strong example of universities fully engaging with Ontario communities and the Ontario government to meet the needs of the health care system by ensuring graduates are prepared to work in any setting in the province. Through DME, Ontario Faculties of Medicine and government are:

- Increasing patient access to care in underserviced, rural areas;
- Enabling community and physician engagement in medical education; and
- Providing learners opportunities to gain specific skills in rural and community settings.

The UK National Health Service (NHS) in 2011 set out an agenda for finding and spreading innovative approaches to delivering health care as an integral part of the way the NHS does business. “…simply doing more of what we have always done is no longer an option…We need to radically transform the way we deliver services.”5

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5 Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS, Dec 2011 pg. 4.
The DME value proposition is:

Involved community,

Better physician,

Better access,

Better care.

DME promotes innovation and is aligned with the concept of the patient at the centre of care. DME engages communities, physicians and patients across the province in medical education and health care delivery. DME is leading to better provision of care to patients close to home; better access and innovative approaches to care through community partnerships; confident and competent medical students and postgraduate trainees; and highly motivated and engaged community physician teachers. Ontario is leading the world in educational innovation with DME as an essential element of 21st century medical education.

C3. Outcome - Signs of Improvement in Access to Care

Fewer unattached patients

Last year, according to the Ontario Medical Association, 2.1 million more Ontario patients had access to primary health care than they did ten years ago. The proportion of Ontario residents aged 12 and over who were without a regular doctor was 8.8% in 2013. This is the second lowest proportion in Canada; the Canadian average is 15.5%. The most common reason (47.6%) provided for Canadians not having a regular doctor was that they had not looked for one.

Improving physician to population ratios

In Ontario between 2005 and 2012, the total number of doctors per 100,000 people went from 177.8 to 195.3. The number of specialists per 100,000 people in Ontario in 2011 was in line with the Canadian average, while the number of family physicians per 100,000 people was about 10% below the average. Note: In spite of these advances in physician to population ratios, Canada remains well below the average of the G7 countries with a placement as the second last in number of physicians per capita.

The Ontario Physician Human Resources Data Centre (OPHRDC) compiles data each year on physicians and postgraduate medical trainees in Ontario. Looking at a subset of physicians in Ontario - those that exited Ontario postgraduate training programs between 1992 and 2012 - OPHRDC data show that there has been an increase in the physician to patient population ratio across all Local Health Integration Networks (LHINs) in the province.

6 Access to a regular medical doctor, 2013, Statistics Canada
8 OECD Health Statistics 2013, OECD (http://www.oecd.org/health/healthdata)
Significant Improvement in Physician to Population Ratios in Ontario by LHIN in 2000 and 2012 (physicians who completed Ontario postgraduate training)

It is important to note that while the LHIN physician to patient population ratios show a solid move in the right direction, they don’t account for the provision of team-based care nor do they tell the full story for larger geographic regions of the province. For example northwestern Ontario has one of the highest physician-population ratios, yet we know there are still many communities in the north without ready access to physician services.
RETURN ON INVESTMENT (ROI)
Government, universities and communities have invested in Distributed Medical Education (DME) as a strategic direction to improve recruitment and retention of physicians in rural and community settings and improve access to care, leading to positive outcomes for communities and patients.

**Investment by:**
- Government: DME, Northern Ontario School of Medicine, family medicine expansion
- Universities: leadership, cultural shift
- Communities: engagement, physicians, hospitals

**Aligned with:**
- Patient needs (right care, right place, right time)
- Social accountability
- FMEC national medical education directives
- Accreditation requirements

**Return on DME investment – measured:**
- More physicians; more DME experiences
- Skilled, competent and confident MD graduates
- High physician and learner satisfaction

**Return on DME investment - early signs:**
- Communities able to recruit DME graduates they helped to train
- More patients with access to care closer to home
- Positive economic impact on communities

**Return on DME investment – need to study:**
- Patients receiving better care (Quality Improvement, Interprofessional teams, etc.)
- Health economic and outcomes data

**ROI CASE STUDY - Working together for a healthier North**
**Investment in the Northern Ontario School of Medicine (NOSM)**
- Ministry of Training, Colleges and Universities (MTCU): $21.5M
- Ministry of Health and Long-Term Care (MOHLTC): $13.5M
- Tuition and other fees: $ 5.1M
- Other: $ .5M
- Total $40.6M (2012-13)
“There are signs that NOSM is successful in graduating health professionals who have the skills and desire to practice in rural/remote communities and that NOSM is having a largely positive socioeconomic impact on Northern Ontario.”

More than 90 communities are involved in teaching and research in the North:

9 Strasser R, Hogenbirk J, Minore B, Marsh D, Berry S, McCready W, Graves L, Transforming health professional education through social accountability: Canada’s Northern Ontario School of Medicine, Medical Teacher, 2013: 35:490-496.
There are increased numbers of physicians working in northeastern (12% increase) and northwestern (19% increase) Ontario.

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2013</th>
<th>% Change</th>
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<tr>
<td></td>
<td>Family Physicians</td>
<td>Specialist</td>
<td>Total</td>
</tr>
<tr>
<td>LHIN 13 (North East)</td>
<td>535</td>
<td>348</td>
<td>883</td>
</tr>
<tr>
<td>LHIN 14 (North West)</td>
<td>255</td>
<td>150</td>
<td>405</td>
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Source: OPHRDC Physicians in Ontario by Specialty and LHIN

Data gathered by NOSM show that 69% of NOSM physician graduates (predominantly family physicians) are currently practicing within communities in Northern Ontario. Twenty-two percent of these locations are rural according to the Rurality Index, Ontario. When considering the subset of physician graduates who also completed their medical degree at NOSM the percentage of graduates practicing within communities in Northern Ontario increases to 94% and the percentage of rural practices increases to 33%.

Percentage of NOSM PGE Graduates Practicing, by Geographic Location (Weighted), Dec 2013

NOSM makes a largely positive economic contribution to Northern Ontario communities. NOSM contributes $36 million annually to the regional economy, and another $1.4 million circulates through local communities affiliated with NOSM programs. Once re-circulated, a total of between $67 and $82 million of new economic activity is generated. In addition, NOSM is building capacity to bring in more researchers, more research funding, and its activities are leading to the creation of more jobs. The school is supported by more than
200 staff and over 1,300 faculty.\textsuperscript{10}

\textbf{Note:} The AFMC reports that investment in academic medicine yields a strong return on investment\textsuperscript{11} for provincial governments throughout Canada, including:

- $66.1$ billion in total economic impact generated by Canada’s Faculties of Medicine and affiliated teaching hospitals. This represents $3.5\%$ of GDP in Canada.
- More than $295,000$ Faculty of Medicine and affiliated teaching hospital supported jobs throughout Canada.
- One in 60 jobs in the country is attributable to academic medicine. This represents $1.7\%$ of all employment in Canada.
- More than $13.9$ billion in government revenue generated as a result of academic medicine.

\textsuperscript{10} Exploring the Socio-Economic Impact of the Northern Ontario School of Medicine, Final Report, Centre for Rural and Northern Health Research, Lakehead University and Laurentian University, November 2009

\textsuperscript{11} The Economic Impact of Canada’s Faculties of Medicine and Health Science Partners, The Association of Faculties of Medicine of Canada, August 2014
IMPACT STORIES

IMPACT - Community Physicians
Distributed Medical Education (DME) enables learners to check out a community and test its fit as a future place to work.

WINCHESTER
POPULATION 2482

Winchester, Ontario is a small community of 2,500 people, 45 minutes south-east of Ottawa. Dr. Charles (Chuck) Adamson is Chief of Staff at the Winchester District Memorial Hospital (WDMH) where, in 2013-14, physicians and staff helped to teach close to 250 students. The hospital notes that upon graduation, many of these students turn their educational opportunity into a career at WDMH. Dr. Mary Naciuk, Family Physician and Dr. Michelle Davey, General Surgeon are two such former students.

Dr. Naciuk attended medical school and completed her postgraduate family medicine training at the University of Ottawa. During medical school she completed a mandatory one-week-in-the-country experience in Winchester, which she quickly followed with other community rotations because she found them to be a “smaller, friendly, better learning experience”. Following completion of her MD degree and family medicine training, she was recruited to work in Winchester and has practiced there for six years. Dr. Naciuk operates a family medicine practice four days per week that features work in prenatal care, geriatrics, pediatrics and palliative care. One day per week she works in the hospital emergency department, where she holds the position of Chief of Emergency Medicine.

Dr. Davey grew up in Kapuskasing, Ontario and entered the French MD program at the University of Ottawa. During a 2nd year rotation in Timmins she became more acutely aware of the physician human resource needs of northern and rural communities, which gave her an “interest early on in being more of a generalist” in her future practice. Dr. Davey completed her postgraduate general surgery training at McMaster University and was recruited to work at WDMH, where she has been for five years. She was attracted to Winchester because of the uniqueness of the small hospital experience combined with strong ties to Ottawa’s tertiary centre referrals and resources, as well as her teaching role with the University of Ottawa, Faculty of Medicine.

Drs. Adamson and Naciuk co-supervise a family medicine resident; two are matched to Winchester each year for their entire two-years of family medicine training. In general surgery, medical clerks regularly complete their core 4-week general surgery rotation at WDMH with Dr. Davey. In addition to many other medical student and resident educational experiences, the hospital also has paramedic, nursing, radiography, pharmacy and physiotherapy students, and provides high school placements.

For Drs. Adamson, Naciuk and Davey, DME provides the learners they supervise with the opportunity to check out their community and see how it fits. For the community, patients are able to receive their health care locally rather than travelling into Ottawa, which is especially beneficial to many elderly patients. Dr. Davey notes that “DME plays an important role in helping communities maintain their health care needs.” Since the advent of DME in Winchester, the hospital has grown from:
The physicians believe that two important aspects of DME are: targeted recruitment of students from smaller communities; and early DME exposure during medical school. They note that their role as DME educators is enhanced by essential teaching skills sessions that the university runs in their hospital, as well as by having strong, hospital-based administrative support to schedule a large volume of learners.

As a resident, Dr. Adamson also completed a month-long rotation near Winchester and was impressed with the friendly feel of the community. In his practice he starts each day at WDMH with inpatient rounds, emergency shifts and minor outpatient procedures. He does GP obstetrics, nursing home visits and house calls to shut-in seniors. After 36 years of practice in Winchester, Dr. Adamson is retiring. Thankfully his practice will be shared by two recent Ottawa family medicine graduates, one of whom spent a month in Winchester as a resident; the other was quickly attracted by her ability to include family medicine obstetrics as part of her practice. With his patients taken care of as he shifts into retirement mode, Dr. Adamson plans to continue working part-time for a few years in Northern Ontario, bringing residents and medical students along for the amazing experience.

<table>
<thead>
<tr>
<th>Pre-DME</th>
<th>Today</th>
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<tbody>
<tr>
<td>• 2 surgeons</td>
<td>• 3 surgeons</td>
</tr>
<tr>
<td>• 1 obstetrician</td>
<td>• 3 obstetricians</td>
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<tr>
<td></td>
<td>• 1 ENT</td>
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<td></td>
<td>• 1 cardiologist</td>
</tr>
<tr>
<td></td>
<td>• 1 general internist</td>
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<tr>
<td></td>
<td>• 3 ophthalmologists (part-time shifts)</td>
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<table>
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<tr>
<th>Physicians</th>
<th>Today</th>
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<tbody>
<tr>
<td>2 surgeons</td>
<td>3 surgeons</td>
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<tr>
<td>1 obstetrician</td>
<td>3 obstetricians</td>
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<tr>
<td>1 ENT</td>
<td>1 ENT</td>
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<tr>
<td>1 cardiologist</td>
<td>1 cardiologist</td>
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<tr>
<td>1 general internist</td>
<td>1 general internist</td>
</tr>
<tr>
<td>3 ophthalmologists</td>
<td>3 ophthalmologists (part-time shifts)</td>
</tr>
</tbody>
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DISTRIBUTED MEDICAL EDUCATION IN ONTARIO: 2014 REPORT
IMPACT - Student
A community setting provides great exposure to generalist medicine

Queen’s University, Faculty of Medicine offers an Integrated Clerkship each year to 18 clinical clerks (third year medical students). This very popular clerkship is an 18-week rotation that covers three areas - family medicine, pediatrics and psychiatry, where a clerk is based in a community family practice setting and exposed to specialty consultations in pediatrics and psychiatry. Integrated Clerkship rotations occur in Picton, Perth or Brockville/Prescott and the focus is on providing continuity of care to patients.

Eve Purdy is a 4th year medical student at Queen’s who recently completed her Integrated Clerkship rotation in Perth, Ontario, a town with a population of 6,000 located 100 km west of Ottawa and 80 km north of Kingston. While in Perth, Eve was accommodated in a nice apartment situated in town close to both her preceptor’s family practice and the Perth and Smiths Falls District Hospital. Eve’s preceptor, Dr. Ross McLean, has worked in Perth for 43 years and has been the Medical Director of the Eastern Regional Medical Education Program (ERMEP) since its inception in 2002.

Eve describes the community setting as “a very comfortable place to be a learner. Working in Perth you are surrounded by brilliant teachers who know their field, know their patients and are willing and dedicated to sharing their knowledge as teachers”. She indicated that the community setting provides students with continuity of experience that is sometimes missing in the traditional tertiary hospital setting where you tend to move around a lot and have many different supervisors. During her Integrated Clerkship she had the opportunity to see the same patients multiple times, order their tests, share the test results and help patients find other health care resources, including writing consult letters. She noted that DME is great for generalist training because you have so many opportunities to become comfortable making decisions in many different situations.

Eve believes that students choose the Integrated Clerkship because it provides:

- A very hands-on and valuable experience;
- Exposure to generalist medicine; and
- A great opportunity to try out rural practice.

Her Integrated Clerkship experience has made her consider the full spectrum of generalist options available for her future career as a physician and has re-energized her thinking around practising rural medicine. The Integrative Clerkship provided insight and helped her understand the perspective of family physicians working in a smaller community setting, which will be a valuable perspective to have throughout her future career.

“I hope community preceptors know how much we appreciate their time and efforts”, states Eve. Following her Integrative Practicum in Perth she wrote a very heartfelt and succinct thank you note:
Dear Dr. McLean

Thanks for:

1. Teaching me medicine
2. Trusting me with your patients
3. Introducing me to Perth
4. Letting me be wrong
5. Helping me get to the right answer
6. Asking my opinion
7. Demonstrating to me how to make patients feel heard
8. Having office hours that work for patients (the 7am start makes so much sense)
9. Encouraging me to be curious about patients’ personal histories
10. Stashing Fudgeos
11. Asking me hard questions
12. Not making me feel silly when I didn’t know the answer
13. But expecting that I know it next time
14. Being patient as I learn procedural skills
15. Filling out the paperwork while I finish the fun jobs
16. Showing me that people are the most interesting part of medical practice

...

63. And...inspiring me to dream big while rooting my future in discipline, curiosity, wonder, humility and purpose.

Eve’s full thank you note is posted on the Queen’s Faculty of Medicine website at http://meds.queensu.ca/blog/undergraduate/?p=1447.
IMPACT - Hospital
A large community hospital creates a unique educational jewel to help improve patient care in the community

OSHAWA
POPULATION 157,000

Wonderful things happen when a hospital and a community rally together around medical and health sciences education. Through a strong collaboration and shared goals with the Durham region community and Queen’s University, Lakeridge Health launched the Lakeridge Health Education and Research Network (the LHEARN Centre), which today welcomes more than 1,600 students per year from across Ontario in a broad range of health disciplines, including medicine, nursing, rehabilitation sciences, pharmacy, social work, etc.

According to Dr. Barry Guppy, Vice-President, Medical and Academic Affairs, a key to LHEARN’s success has been commitment at the highest level of the hospital towards a vision that academics and research are priorities that will contribute to the well-being and future health care needs of the community.

LHEARN creates a venue for a growing number of educational opportunities to happen and is a powerful enabler, allowing Lakeridge Health to be at the forefront of interprofessional education. For example, LHEARN created its own advanced cardiovascular life support (ACLS) course, responsive to the needs of Lakeridge staff and learners. This ACLS course is interdisciplinary and includes role playing where each profession steps into the shoes of another profession. These interprofessional sessions improve communication, create a friendly, professional learning environment, and promote the philosophy that “we are all working together, looking after patients together” says Dr. Randy Wax, Director of the Simulation Centre and Section Chief, Critical Care.

Involvement in distributed education and DME has provided Lakeridge Health with the opportunity to formalize key hospital and community goals. Their training, education and research efforts are focused on improving care for patients, their families and their community, making LHEARN a central component of how they achieve excellence every moment, every day.

Their new Queen’s University Family Medicine Program satellite residency program has created an immense sense of community pride. Eight family medicine residents per year spend their entire two years of training at Lakeridge Health, providing continuity of care and primary care services to the community.

LHEARN has created the best of both worlds – a clinical and educational environment, which helps with physician recruitment. A growing proportion of Lakeridge Health physicians are actively engaged in supporting the academic mandate and advancing the hospital’s profile. In 2013, 43% of physicians self-reported that they were involved as preceptors, an increase of 5% from the year before.
The number of medical trainees at Lakeridge Health also continues to grow each year, from 44 trainees in 1999-00 to 365 in 2013-14, representing more than 700% growth.

Lakeridge Health’s ability to mingle learners from multiple universities and multiple health sciences programs is a wonderfully unique feature of this community hospital. The creation of LHEARN has allowed Lakeridge Health to take a leadership role in the community, has created more pride and a new dimension to what physicians and health professionals do as providers in the community, and will lead to better health care in the Durham region.
BARRIE POPULATION 136,063

The Royal Victoria Regional Health Centre (RVH) in Barrie launched its Family Medicine Teaching Unit (FMTU) in 2009 in partnership with the University of Toronto (U of T) and the Barrie Community Family Health Team. To date the program has graduated 28 family medicine residents, with 18 of them staying in the area to set up their own practices or work in the health centre’s emergency and hospitalist departments.

A recent family medicine graduate, Dr. Devon Turner, indicates “I doubt there is a hospital site with such a state-of-the-art teaching facility where residents are able to assume the responsibility of an independent family physician while in an environment supervised by practicing family physicians.” The comprehensive specialty rotation schedule ensures residents are maximizing every learning opportunity. Residents get hands-on experience in most areas of the health centre including emergency, ICU, surgery, mental health, hospitalist medicine, obstetrics and pediatrics, as well as in the community. When residents are not on specialty rotations, they manage their own family medicine patient rosters in a purpose-built new facility adjacent to the health centre, with 22 exam rooms, office space, a classroom, procedure room and a counseling room.

Physician teachers enjoy being surrounded by sharp young medical minds. “Their energy and enthusiasm have rekindled my love for learning and encouraged me to improve my clinical skills,” says Dr. Brent Elsey, Medical Director, Barrie and Community Family Health Team. “Working with the young, bright doctors of today, I must stay on my ‘A’ game.”

“Our program, now entering its sixth year, has exceeded everyone’s expectations,” says Dr. Stu Murdoch, Chief of Family Medicine. “We knew the program would be a success because of our faculty and the new clinic. But we had no idea how successful it would be and that is because of the quality of residents. In teaching them, we have become better doctors ourselves.”

The program is having an impact on the area’s family physician shortage. Because residents have their own patient roster, more than 2,500 people now have access to a family physician. And with new residents entering the program each year, there will always be a new doctor to take over when others graduate. “In the Barrie area alone, it is estimated that 40,000 people don’t have a local family doctor,” says Janice Skot, RVH president and CEO. “For RVH to become a teaching hospital means a merging of education and healthcare excellence that has a significant, positive impact on our community.”
Dr. Jordan Shaw is one of nine family medicine residents recently completing training at RVH. “I initially chose the FMTU program at RVH because of its longitudinal design,” he says. “I actually get to care for – and follow – my patients through the whole healthcare system. Whether that’s through emergency, obstetrics, mental health or even palliative care, I feel like I have complete autonomy when it comes to my patients.”

“The faculty in this program really care about us, and about our learning opportunities,” Shaw remarks. “In fact, it is not uncommon to get a call or a text from a doctor when they are about to do a particular procedure that they think we’d be interested in and they actually let you do the procedure. An ICU doctor texted me when I wasn’t even on shift to tell me he was putting a central line in and thought it would be a great learning opportunity for me. That’s just an amazing relationship.” DME is creating these hands-on learning experiences for physicians like Dr. Shaw to train in their home community.
IMPACT - Community

Northern communities promote Aboriginal culture and traditions through DME

**M’CHIGEENG**

**POPULATION 900**

As part of its social accountability mandate to address the health needs of rural and northern communities, the Northern Ontario School of Medicine (NOSM) has developed a community engagement model where Aboriginal people provide direct input to NOSM on the development and delivery of Aboriginal curriculum. This input includes representation and participation of Aboriginal people in all aspects of the medical school, a curriculum that is reflective of Aboriginal culture and health care beliefs, and students experiencing first-hand life in an Aboriginal community.

NOSM’s community engagement approach has translated into hands-on Aboriginal experiences for NOSM students. At the end of first year, all medical students spend four weeks in an Aboriginal community completing a mandatory cultural immersion experience known as an Integrated Community Experience (ICE) placement. This placement provides clinical experience, but is more heavily weighted towards a community experience where the student is immersed into day-to-day Aboriginal cultural activities.

M’Chigeeng First Nation is one of NOSM’s 39 cultural immersion sites. Situated on Manitoulin Island about 25 kms southwest of Little Current, there are approximately 900 members living on-reserve. In the following interview Roger Beaudin, Director of the Health Clinic describes the medical student placements in his community:

**When did M’Chigeeng First Nation begin hosting NOSM medical students?**

M’Chigeeng First Nation was one of the first communities to sign on with NOSM. We’ve been involved from the very beginning. Every May we have two students come here for their four week ICE placement. They reside on-reserve and are billeted into a community member’s home. One billeting family is used the majority of the time and the students love it there. They are treated like family.

**What are the specific cultural activities that students experience in your community?**

The students gain a comprehensive overall perspective of First Nations life. The students’ cultural development includes participating in local First Nations drumming and naming ceremonies. We also teach them about traditional First Nations medicine.

Students usually spend part of their day in the health clinic, but are often out being part of the community making their own hand drum or moccasins. The students experience Great Spirit Circle teaching, which includes learning about Manitoulin Island, the culture and history, and participating in medicine walks to learn about traditional medicines growing around us. The most recent group of students spent a day up to their knees in a marshy area picking roots. They loved it. There are also lots of social activities like fishing trips and cultural tours.
What has the NOSM program meant for your community?
The cultural immersion program has been great for us. It is wonderful to be part of the medical students’ development, helping them to learn and understand the First Nations culture. It provides the students with a firsthand perspective of the struggles, addictions and social issues faced by First Nations people. At the end of their four week placement, the students give a presentation back to the community about what they’ve learned. For many, this has been the first time they’ve experienced life on a reserve. Quite commonly we notice the students have a different perception from the start to the end of their placement. Initially they can feel scared or intimidated, but by the end they are very comfortable, have a better understanding of First Nations issues and have really enjoyed the cultural experience.

We hope in the long run that our community’s involvement with NOSM will continue to help recruit health care professionals to Manitoulin Island. There is already one student from Manitoulin who graduated and is practicing family medicine back in his home community.

What are your thoughts on Distributed Medical Education (DME)?
Having students understand different cultures, especially in the North, where many First Nations struggle with many health issues, is a very good thing. These experiences allow students to see the diversity of First Nations culture and learn about traditional medicines at the same time as they learn about Western medicine. DME opens options for First Nations people. It also opens options for physicians to consider the benefits of traditional medicines.

Our DME experience with NOSM has been great. We have a very good relationship and wonderful partnership with the medical school. Our community is benefitting immensely, as, I believe, are the medical school and the students.
IMPACT – Community Research
Putting patients at the centre of care through research and quality improvement

ST. CATHARINES
POPULATION 131,400

WATERLOO
POPULATION 98,780

The establishment of the McMaster University Michael G. DeGroote School of Medicine regional campuses in Niagara and Waterloo is having a transformational effect on these communities in terms of patients’ access to physicians, as well as placing a focus on patients at the centre of care. Both campuses are involved in research and quality improvement (QI) projects that are relevant to the local populations and aimed at meeting patient needs and improving quality of care.

Dr. Matt Greenway, Research Lead & Associate Clinical Professor, Niagara Regional Campus is a family physician and PhD clinical geneticist, originally from Ireland. As Research Lead for the Niagara Regional Campus, he is helping to create a research/QI network for Niagara region faculty and learners. Building the network has been a collaborative endeavor between the medical campus and many Niagara Health System (NHS) partners. In 2013-14, there were 28 medical students involved in 44 research/QI projects. Most projects are inter-disciplinary and involve NHS and Brock University.

Dr. Greenway led the development of PRIME (Program for Improvement in Medical Education), an introductory overview of the principles of QI. In addition to medical students and residents completing PRIME, more than 230 NHS staff have been trained and another 100 community health professionals are in the process of taking the program. Those with an avid QI interest have followed up PRIME by joining an I-EQUIP project (Interprofessional Education for Quality Improvement Program). I-EQUIP is a unique collaborative in Niagara that seeks to foster a culture of continuous quality improvement in health care through academic and practice innovations.

Another I-EQUIP project at Hotel Dieu Shaver Health and Rehabilitation Centre is examining the role of the most responsible physician in preventing secondary strokes. Over 50% of Niagara stroke patients are cared for as inpatients at the Shaver. The hospital Chief of Staff has been intimately involved in the secondary stroke project, attending all project meetings, participating in QI training, and helping with the chart audits. The hospital is already seeing steady, incremental change and improvement in prevention of secondary strokes.

Dr. Greenway indicates that the medical students are very satisfied with their research/QI experiences and studies are underway to track health care outcomes and examine the impact on patients.
Dr. Andrew Costa, Research Lead & Assistant Professor, Waterloo Regional Campus is a scientist with a PhD in epidemiology from the University of Waterloo. As Research Lead for the Waterloo Regional Campus, he is leading development of a research program for the Waterloo campus medical students that is linked with the School of Pharmacy. Research projects focus on addressing local health care needs and involve community partners such as the regional cancer centre, Homewood Health Centre (mental health and addiction), Schlegel Villages (seniors care) and other hospitals and services.

The goal of the research program is to help the medical students develop literacy in research. There are evidence-based medicine (EBM) rounds and a journal club; students learn how to conduct research, and more importantly, how research can be translated into practice.

The first Waterloo, Wellington Clinical Research Symposium was held in June 2014 with over 90 participants to showcase how students, clinicians, professionals and researchers are working to improve the clinical care in the region. Topics ranged from pediatrics and senior populations to clinic and community settings and methods.

Dr. Roy Cameron, Executive Director of the Guelph-based Homewood Research Institute provided the keynote address, reflecting on Homewood’s research partnership with McMaster University. He indicated, “Our approach to building a partnership between university researchers and a treatment facility to jointly create a research program designed to improve outcomes is novel, and very exciting to those of us who are involved. McMaster is playing a lead role in working with Homewood to build a research program that will both guide practice and advance science.”

Dr. Costa is very pleased with the enthusiasm of the students and the potential for real impact on health care delivery in the region. He notes, “Physicians looking for a home for their career will consider this region, where they can also teach and conduct research as part of their practice. A culture of research, scholarship and variety in practice helps with both recruitment and retention. The community is working hard in collaboration with us and the Symposium was a good, concrete example of our success to date.”
IMPACT - Community Physician
The Schulich Distributed Education Network Journey - From undergraduate medical education to clinical faculty

Dr. Clarissa Burke was born and raised in Sarnia, Ontario. Growing up, there was no visible medical education presence in her community and even ten years ago, it was still novel for patients, physicians and staff to work with medical learners.

Dr. Burke was accepted to the Schulich School of Medicine & Dentistry in 2004 and had the opportunity to participate in the early years of an innovative program called MedQUEST that was piloted in Sarnia. Today called MedLINCS (Medical Learning in Community Settings) the program provides Schulich Medicine students with a diverse clinical and teaching opportunity in rural and regional Southwestern Ontario, where they work with community partners to provide a week-long health care exploration program to grade 10 and 11 high school students.

In the summers of 2005 and 2006, Dr. Burke helped develop the one week MedQUEST camp experience for high school students and sought buy-in from Sarnia-based medical and health professionals to provide ‘shadowing’ opportunities for students in the program. During the camp the high school students get to deliver robotic babies, suture, cast fractures and develop an understanding of the training requirements necessary to work in healthcare professions.

A research study on MedQUEST found that for the majority of participants, the program influenced their choice of post-secondary education and, for those presently occupied in a healthcare related field, MedQUEST influenced their career choice. Dr. Burke indicates that the MedQUEST program brought an early wave of learners into South-western Ontario and provided local students with a great opportunity to see what rural medicine is all about. So many communities opened their doors and have been very welcoming. In 2015, the program will run in Walkerton, Owen Sound, Seaforth, Mount Elgin, Sarnia, Chatham and Leamington.

In 2008, Dr. Burke was matched to the Schulich Family Medicine residency program. As part of her training she completed elective rotations in rural family medicine in Petrolia, general surgery in St. Thomas and obstetrics in Kitchener. All her undergraduate and postgraduate experiences in regional sites helped her make her decision that she wanted to practise in a smaller community. “Each positive community experience just builds on the previous one and led me to the community practice I have today.” The DME rotations opened her eyes to the fact that medicine is practiced at a high level in the DME sites, and that she could be a

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13 MedQUEST: A cohort outcome measure of a rural physician and healthcare profession recruitment strategy aimed at secondary school students. Tom Lacroix, Matt Wann an, Patricia Potter, Laurie Roberts, Kathy VanDinther, Sherri Moore, Roger Porcellato, Elaine Zibrowski, Southwestern Ontario Medical Education Network (SWOMEN), Schulich School of Medicine & Dentistry, Western University, London, ON, Canada, 2012.
teacher and participate in research outside
the large, urban Academic Health Science
Centres environment.

Today Dr. Burke is a full-time community-
based academic physician in Ilderton,
Ontario. She has 1500 patients and
practises in a Family Health Team (FHT)
with three other full-time family physicians;
all have academic responsibilities and work
with medical students and residents at all
times.

According to the Windsor-Essex Regional
Physician Recruitment Office and data from
the Ontario Physician Human Resources
Data Centre, the Erie St. Clair LHIN has the
lowest number of family physicians per
population of any of the 14 Ontario LHINs.
The LHIN is also facing significant attrition
due to retirement of family physicians over
the next 5-10 years.\textsuperscript{14} The South West LHIN
where Dr. Burke currently works faces
similar challenges.

Dr. Burke indicates that full-time academic
physicians are a fairly new concept in
Ilderton, however, in the past four years
government, university and community
investment have brought a new clinic and
are leading to more training in Ilderton,
which is addressing some of the challenges
in physician recruitment. The FHT is also
providing a range of services previously not
locally available, including occupational
therapy and respiratory therapy.

Today, all Schulich Medicine students
have DME experiences in community
sites. It is a part of the curriculum. DME
has created connectedness between the
Faculties of Medicine and the community
and practitioners. Dr. Burke indicates that
one next step for her community is more
integration with specialist colleagues to
open up access to specialty care, which
will be of benefit to both learners and the
communities.

\textsuperscript{14} March 13, 2014 communication from the
Windsor-Essex Physician Recruitment Office to
the Windsor Family Health Team.
IMPACT – Rural Ontario Medical Program
Twenty-five years of providing DME services in Ontario

The Rural Ontario Medical Program (ROMP) is a not-for-profit organization that encourages and facilitates community physician recruitment and learner placement in south central Ontario, funded by the Ministry of Health and Long-Term Care. ROMP assists with the placement of medical learners in one-on-one core and elective learning situations with physician preceptors.

ROMP has provided 15,000 rural rotations in its 25 years of operation across 100 communities in south central Ontario. Today, ROMP annually provides about 1,500 placements, of varying lengths, to medical students, medical clerks, postgraduate trainees, rural medicine week placements, physician assistant and other health professional students.

Total ROMP Placement Months

Dr. Peter Wells is ROMP’s Executive Director and Michelle Hunter is Program Manager of the ROMP office in Collingwood, Ontario.

DME programs and ROMP try very hard to fully integrate the learner into the community and be accountable to the community. Students are not just here for a clinical placement, they’re there to live, experience and work with the community. Community engagement in DME is essential. Community engagement means representing their voice and interests, and matching learner placements and growth to the community’s needs.

DME has a large impact on health care for communities. With DME, learners have community exposure and gain skills, the communities recruit these learners, the new graduate physicians help address access to care for that community, and then they become preceptors to the next generation of learners. DME creates a circle of care that repeats itself and creates a sustainable way for communities to be actively involved in, and manage, their own health human resource needs.

DME leads to recruitment. Non-urban communities are able to recruit the learners that come through on their ROMP rotations. The learners enjoy being there, develop a lot of skills and can see a future for themselves in the community. For example, many Royal Victoria Regional Health Centre physicians and health professionals are ones who completed a ROMP rotation(s) there.

In its first 17 years, ROMP found that it was successful (45.1%) in training physicians who later go into rural/underserved area practice in Ontario.

ROMP recently conducted a 10-year retrospective census study to evaluate the effectiveness of ROMP and explore factors that influence the location of where family physicians (FPs) practice. ROMP surveyed FPs who graduated from a family medicine program supported by ROMP from 2003
to 2014. The finding was that 70% of respondents are currently practicing in rural communities. Approximately half of the respondents originated from a rural background and half had an urban upbringing.

ROMP also found that a 1-month rural rotation is associated with a 47% recruitment rate into non-urban and rural communities; and a 2-year rotation is associated with a 70-85% recruitment rate.

There are 1300 physicians that teach with ROMP. The physicians are engaged and committed.

ROMP hosts an Annual Spring Workshop, a three day program that covers topics relating to community based rural training, faculty development and physician recruitment and retention. Faculty receive mentorship and training on many topics relevant to busy physicians who take learners into their practice.
DME LITERATURE AND FINDINGS
A seminal paper The ecology of medical care\textsuperscript{15}, found that of every 1,000 adults, 750 people perceived a personal illness of some sort in a given month. Of these, 250 people sought care from a health care professional with only a tiny fraction making their way to an academic center where most medical teaching and research take place. This paper signaled the need to increase opportunities to educate physicians in settings where much of the population experiences health care. Distributed Medical Education (DME) has been a positive response and enables medical learning outside the urban, tertiary setting.

Recruitment and Retention
An early Ontario DME study found that by increasing family medicine residents’ exposure to, and experience in Northern Ontario, more of these graduates would practise in Northern Ontario and rural areas upon completion of training.\textsuperscript{16} This finding, that DME experiences are linked to higher likelihood of practice in a smaller community, is in keeping with DME studies in other jurisdictions such as Australia and the United States.\textsuperscript{17,18,19,20} The international studies show that DME is positively associated with both recruitment and retention.\textsuperscript{21,22}

Academic Comparability and DME Strategies
Studies abroad and in Canada show that rural programs are academically comparable to their urban counterparts.\textsuperscript{21,22} Studies also suggest that there is no one single DME strategy to address a lack of rural physicians. Rather, it is a mix of personal characteristics and educational opportunities that produce rural physicians. The literature identifies the following favourable predictors\textsuperscript{23,24}:

- Rural upbringing;
- An interest in primary care / family medicine;
- Positive undergraduate rural clinical experiences; and
- Targeted postgraduate training for rural practice.

\textsuperscript{15} White KL, Williams TF, Greenberg BG. The ecology of medical care, 1961.
\textsuperscript{17} Worley P, Martin A, Prideaux D, Woodman R, Worley E, Lowe M. Vocational career paths of graduate entry medical students at Flinders University: a comparison of rural, remote and tertiary tracks. MJA 2008; Vol 188 (3).
\textsuperscript{18} Stagg P, Greenhill J, Worley PS. A new model to understand the career choice and practice location decisions of medical graduates. Rural and Remote Health 9: 1245. (Online), 2009.
\textsuperscript{22} An Assessment of the Longitudinal Integrated Clerkships at the University of Calgary Faculty of Medicine,Final Report. February 24, 2014, Joel h. Lanphear, PhD, Consultant
“Different DME models are responding to different needs of the community. In the North the communities help determine their health care needs and this is reflected in how NOSM designs and delivers education. This community engagement approach can work anywhere, with rural or urban underserved populations.” Dr. David Marsh, NOSM Associate Dean, Community Engagement and Senior Associate Dean, Laurentian University.

DME learners develop a strong level of confidence in their clinical and decision-making skills. They do particularly well in these areas on their national licensing exams. They also tend to successfully match into a postgraduate residency program that aligns with their career interests. Communities involved in DME feel a real sense of accomplishment, pride and ownership.

Measurement and Evaluation
As noted earlier in the report, there are positive signs that DME is helping improve access to care in the province. While there are many positive aspects of DME, there has not been a large scale evaluation of DME across Ontario. How well are we really doing? Where can we improve?

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<th>DME studies* have been done on:</th>
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*Note: this table only represents a sample of the studies done.

DME in Ontario requires better measurement and evaluation of outcomes with a consistent, provincial approach. Many Ontario DME programs are still relatively new and most do not have a process in place to track graduate practice locations and evaluate effectiveness of DME programs. The majority of the many successes achieved for communities and patients across the province are anecdotal. Ontario would benefit immensely from a provincial DME measurement strategy that examines recruitment and retention rates, as well as health economic and health outcomes data.
COMMITMENT TO THE PATH FORWARD

Physician Human Resources Planning
Real progress has been made in addressing the doctor shortage and access to care. National initiatives are underway for medical schools to work with government to continually monitor and plan physician numbers and needs (see below). Notwithstanding these successes, some worry today about an over-supply of physicians. As we learned from the effects of the last reduction in medical school enrolment, physician human resource planning is complex and can quickly swing from perceived surplus to a serious shortage. Given the many unpredictable factors involved, caution and careful planning are required to ensure the right supply, mix and distribution of physicians.

Future of Medical Education in Canada
The Future of Medical Education in Canada (FMEC) is a national project focused on ensuring that Canada’s medical education system continues to meet the changing needs of Canadians, both now and into the future. FMEC undergraduate and postgraduate reports recommend that the medical education system cultivate social accountability through experience in diverse learning and work environments. In fact, it is an accreditation requirement. Ontario’s Distributed Medical Education (DME) efforts are congruent with both the FMEC national direction and national accreditation standards.

Following FMEC, the Association of Faculties of Medicine of Canada and the federal Committee on Health Workforce are co-leading an effort to ensure the right number, mix and distribution of physicians to meet societal needs. A Physician Resource Planning Task Force has been established to develop a physician supply-based planning tool to generate physician supply scenarios that can account for different specialty mixes, track physician migration across jurisdictions, provide interprovincial comparisons, and make supply-projections for both rural and urban communities.
Path Forward

The six Ontario Faculties of Medicine have created a network of collaborative, interconnected DME programs and moved to a new norm for medical education. The community engagement approach, with accountability to communities, is firmly part of 21st century medical education. The key messages are:

- Ontario Faculties of Medicine are committed partners with government and Ontario communities in developing and implementing solutions to address physician and health care requirements of the province, e.g. targeted DME responses for communities with chronic physician shortages and access to care issues.
- DME is aligned with government priorities and strategies, with medical school’s social accountability and accreditation requirements, and with national directions for medical education.
- There has been a significant cultural shift in Ontario Faculties of Medicine to community engagement curricula.
- DME has fostered collaboration across the Faculties of Medicine on learner placement and support, preceptor faculty appointments, and faculty development.
- DME is moving the system in the right direction and having a positive impact on learners, community physicians, communities, patients and medical schools.
- Early signs demonstrate return on investment for government, including improved access to physicians in communities across the province.
- We are on the right path but not there yet. It is critically important to sustain and follow through on these early positive outcomes. Sustainability of relationships with communities and community physicians is essential.
- Ontario Faculties of Medicine are committed to working with government and other stakeholders to develop a DME measurement strategy that examines recruitment and retention rates, as well as health economic and health outcomes data.
- DME has created a large, at-the-ready resource of communities and physician educators able to help manage community health needs more strategically and comprehensively.
CONCLUSION

The medical education landscape in Ontario has changed dramatically in a relatively short period of time, characterized by growth and spread. In collaboration with the Ontario government, strategic goals to address the right number, mix and distribution of physicians have been implemented. As a result, since 2000 Ontario medical school enrolment has grown, a new medical school has opened in Northern Ontario with a mandate to meet the health care needs of the people of the North, and medical education is integrated into rural and community settings across the province. Today, thousands of community physicians and 300+ communities play an integral role in 21st century medical education.

Distributed Medical Education (DME) programs are having a significant impact in recruiting rural and community physicians, however, challenges of physician mal-distribution remain. According to the Ontario Auditor General, despite the overall increase in primary health care providers and specialists, access to health care is still a problem for some Ontarians.25

The educational pipeline to rural medical practice is long and complex.26 The question isn’t whether we should be doing DME, it is how can we do it better? We need to evaluate to better understand and improve the positive impact of DME underway.

There are already many signs of success where communities and patients have more access to care. There are examples of new and improved approaches to health care delivery with patients at the centre of care. We are on the right path, but with more work to do. Ontario Faculties of Medicine remain committed to the journey of educating and training physicians in the communities where many will eventually settle and provide care to the people of Ontario.

PREPARATION OF THIS REPORT

This report was commissioned by the Council of Ontario Faculties of Medicine (COFM) as an accountability document to highlight how a successful collaboration between Ontario Deans of Medicine and the Ontario Ministry of Health and Long-Term Care can transform physician human resources in the province and improve access to care.

The report was created under the leadership and contributions of the Ontario Deans of Medicine and the Distributed Medical Education Committee of COFM (DME:COFM).

- McMaster University: Dr. John Kelton, Dr. Alan Neville, Dr. Dorothy Bakker, Lee Tregwin
- NOSM: Dr. Roger Strasser, Dr. David Marsh
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- Western University: Dr. Michael Strong, Dr. Bertha Garcia
- ERMEP: Dr. Ross McLean, Sandra Whan, Jennifer Shuttleworth
- ROMP: Dr. Peter Wells, Michelle Hunter

Mary-Kay Whittaker was hired and worked closely with Michelle Cyr, Council of Ontario Universities to develop and write this report. Interviews were conducted with each medical school to gather data and information about distributed medical education. Literature was reviewed and the MOHLTC and Health Force Ontario were consulted. A special thanks to the following individuals for their expertise and contributions to the report:

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