

Emergency Medicine Training & Practice in Canada:

Celebrating the Past & Evolving for the Future



Final Report of the Collaborative Working Group on
the Future of Emergency Medicine in Canada



About Us



About the Collaborative Working Group on the Future of Emergency Medicine in Canada

The Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM) is a trilateral partnership between the Canadian Association of Emergency Physicians (CAEP), the Royal College of Physicians and Surgeons of Canada (Royal College) and the College of Family Physicians of Canada (CFPC). The CWG-EM was implemented in 2013 to act as an advisory committee to CAEP, the CFPC, and the Royal College, with a mandate to examine the two Emergency Medicine training programs in Canada, and the health human resources issues in Canadian Emergency Medicine.



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August 2016 - A correction has been made to the graph, "Small Urban Hospital" on page 52. Under the heading "Ideal at 10 years", the numbers have been corrected from 61.6 for CCFP, 47 for CCFP (EM), and 7.2 for FRCPC-EM to 39.8 for CCFP, 67.8 for CCFP (EM), and 5.6 for FRCPC-EM.

Executive Summary



Postgraduate Emergency Medicine (EM) training and certification in Canada currently consists of two separate training pathways that are overseen by two autonomous national colleges. The Royal College of Physicians and Surgeons of Canada (Royal College) and the College of Family Physicians of Canada (CFPC) independently offer EM residency training programs with differing training requirements and objectives (FRCPC-EM and CCFP(EM), respectively). Each program was originally intended to fulfill differing societal and healthcare needs. In reality, the products of these training programs significantly overlap, and have evolved to meet population needs differently than their initially intended roles as outlined by the two colleges, leading to substantial debate within the Canadian EM community.

Project Parameters

The prime objective shared by both the Royal College and the CFPC is to ensure that expert EM graduates provide high quality EM care for patients presenting to emergency departments (EDs) across Canada. *The Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM)* was constituted in 2013 to provide recommendations to the Canadian Association of Emergency Physicians (CAEP), the CFPC, and the Royal College and was composed of seven (7) members: a Chair, and two (2) members appointed by each of CAEP, the CFPC, and the Royal College. The Terms of Reference of the CWG-EM, including roles and responsibilities, membership, and decision making process, are provided in Appendix A of the final report.

The following report describes the activities, findings, and recommendations of the CWG-EM, with the ultimate goal of outlining a path forward that enhances EM training and care in Canada. Informed by the past and present state of EM training and practice, the CWG-EM report is fundamentally focused on charting a course for the future of emergency medicine in Canada.



Project Approach

› The project involved a number of methods to capture and synthesize data for review by the CWG-EM, including:

- An analysis of historic materials, initiatives, and perspectives of the EM community – A review of relevant literature was performed in order to obtain a comprehensive understanding of previously described or published perspectives of the EM community, review the findings of relevant published studies, as well as review past initiatives on these issues.
- A comparative analysis of the CCFP(EM) and FRCPC-EM training routes – A comparison of the program goals, objectives, training pathway, and certification of both routes was completed.
- Development of key project questions – Between October 2013 and February 2014, the CWG-EM developed a series of key questions (Appendix B of the final report) that were aligned with the roles and responsibilities defined by the group's Terms of Reference. The development of these questions, subsequent research, and determination of the limited depth and breadth of information currently available, led to the decision to conduct a nation-wide survey of EM training and health human resource (HHR) needs.
- Communication with University Postgraduate Deans of Medical Education – On September 16, 2014, correspondence was distributed to all 17 Canadian Postgraduate Deans of Medical Education, requesting their perspectives on the two independent training streams for EM certification in Canada.
- A national survey of Emergency Medicine training and health human resource (HHR) needs – A survey of CCFP(EM) and FRCPC-EM certified physicians, CCFP physicians with an interest or activity in EM, CCFP(EM) and FRCPC-EM residents, and ED Chiefs was conducted in the summer of 2015. Approval for this survey was obtained from the Dalhousie University Research Ethics Board.
- Additional activities and communication with key stakeholders. During its mandate, the CWG-EM communicated with a number of groups and stakeholders. A list of communications can be found on page 27 of the final report.

Key Findings from The National Survey of EM Training and HHR Needs

The findings from the national survey of CCFP(EM) and FRCPC-EM certified physicians, CCFP physicians, EM residents from both programs, and ED Chiefs were critical in determining the current context of Canadian emergency care, perceptions on training routes, training needs, and estimated health human resources needs both currently and in the future.



Practice profiles of physicians currently practicing EM

- The primary practice settings for physicians with an EM certification are typically large and small urban settings. FRCPC-EM and dual certificants almost exclusively practice EM in large urban academic settings, while the primary practice setting of CCFP(EM) certificants are more varied across large and small urban settings. These results were consistent with the findings from EM residents, with the majority of FRCPC-EM and CCFP(EM) residents indicating a desire to practice full-time EM in an urban setting.
- The proportion of CCFP(EM) certificants with a component of Family Medicine in their practice is extremely low across all ED settings. EM practice makes up the majority of the clinical practice distribution of all physicians with an EM certification.
- CCFP (non-EM) certified physicians are most likely to provide emergency care in rural settings, and make up the large majority of physicians providing emergency care in remote and rural settings.

Alignment of training and practice

- The majority of respondents who currently practice EM (FRCPC-EM, CCFP(EM), CCFP) feel adequately prepared for clinical practice by their training route.
- The effectiveness rating of the CCFP (non-EM) program for EM practice is more likely to be rated positively in smaller centres.
- There is a strong sentiment amongst certified physicians and ED chiefs outside rural and remote settings, and trainees in both programs, that CCFP (non-EM) training alone is insufficient to gain competencies for the practice of EM. ED chiefs outside rural and remote settings and certified physicians indicated their greatest concern was with regard to CCFP (non-EM) training alone for the practice of EM in larger centres.
- Qualitative responses of survey respondents indicated that preparation for practice after graduation is dependent on training route and intended practice setting.

Reflections on the current approach to EM certification in Canada

- Survey respondents identified strengths and challenges of the dual college, dual certification approach for EM residency training. Many respondents advocated a single unified EM training program, however this was not considered feasible at this time by the CWG-EM. A qualitative analysis of the survey data revealed four key strengths and four key challenges of the current approach.

Strengths: The current approach fulfills Canadian needs, is responsive to Canada's vast geography and population distribution and is appropriate for diverse contexts, includes roles for each practitioner type, and both routes produce capable emergency physicians.

Challenges: The current approach has insufficient content exposure for both training routes, inappropriate length of training programs, inequalities between the certification routes, and misalignment of program goals with practice.

Physician distribution and staffing needs

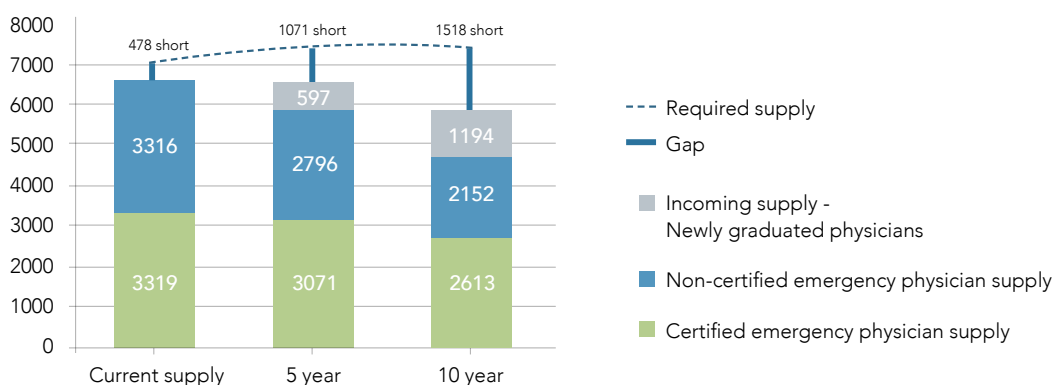
- Current physician staffing needs are not fully covered in any ED setting type.
 - ▶ Dependent on ED setting, approximately 40% (large urban academic) to 62.5% (remote) of ED Chiefs from different ED settings indicated that their staffing needs were not fully covered.
 - ▶ The most significant hours of shortfall were reported in large urban academic (11.3 hours coverage/day/ED short) and large urban non-academic (15.4 hours coverage/day/ED short) settings.
- The majority of ED Chiefs anticipate an increase in annual patient volume and a critical staffing shortage.

Implications of Findings

› Current shortfall of certified emergency physicians and projected increase in the HHR deficit over the next decade

An HHR model was constructed by the CWG-EM in order to determine the current and projected shortfall of emergency physicians over the next decade. This concluded there is a current estimated shortfall of **478 emergency physicians** in Canada. In the absence of expansion of EM residency training capacity, this shortfall is projected to rise to **1071 emergency physicians** by 2020 and to **1518 emergency physicians** by 2025. The methodology, limitations, and assumptions of this model can be found on page 66 of the final report.

National emergency physician shortfall estimate and future projections (excludes remote settings)





Misalignment of the intent of the FRCPC-EM and CCFP(EM) training routes and the reality of Emergency Medicine practice for program graduates

The surveys of physicians with an EM certification and EM residents indicated that a substantial proportion of respondents report discontent regarding the current approach to EM training and care in Canada. This undercurrent of dissatisfaction conveyed by survey respondents appears to arise from a complex multitude of factors that act to divide the EM community. Within a relatively small discipline like EM, this division is pervasive enough to potentially result in animosity between certificant types and may present significant challenges to an effective system of care.

Our survey data suggests concern exists within the EM community that some physicians are placed into a clinical role they are not prepared for upon graduation. Issues regarding preparedness for practice in a variety of settings for both CCFP(EM) and FRCPC-EM graduates appear to stem from a misalignment of the intent of training with the reality of practice.

CCFP(EM) certified physicians

The CCFP(EM) program currently consists of two years of Family Medicine, followed by one year of training in EM. The short duration of the EM training component creates a challenge for CCFP(EM) residents to meet all of the competency needs for full-time EM practice upon graduation. Qualitative survey responses indicated a need to explore the potential of increasing the exposure of CCFP(EM) residents to core EM areas and, given the ultimate career goals of this population, to explore a reduced exposure to clinical Family Medicine in CCFP(EM) residency programs.

FRCPC-EM certified physicians

Concerns were raised from survey respondents regarding the five-year duration of the FRCPC-EM program and the limited exposure of residents to aspects of clinical Family Medicine, specifically transitions of care and community care. The survey results suggest graduates of the FRCPC-EM program may benefit from an increased understanding of how the emergency care provided in ED settings integrates into an individual patient's larger continuum of care.

Status of emergency care in rural Canada

A significant amount of emergency care in rural and remote settings is currently provided by CCFP certified physicians with little specific EM training. The results from the surveys indicated a strong sentiment from the EM community (CCFP(EM) and FRCPC-EM certificants, EM residents from both programs, and ED Chiefs from larger centres) that the two year CCFP(non-EM) training program is not sufficient to appropriately prepare physicians for EM practice as a primary discipline.

Preparing for practice: Supporting a standard of care for “patient zero”

A major consideration that guided the CWG-EM's review of the data and subsequent recommendations is the concept that a central component to the practice of EM is that “patient zero”^{*} merits excellent care in all settings, irrespective of the certification of the care provider. The following set of consensus statements informed the vision and recommendations of the CWG-EM.

^{*} Patient zero is the first patient a graduate from a training program cares for post-graduation as an attending physician.




Assumptions:

1. Both EM training routes in Canada are high-quality and are effective educationally.
 2. Both EM training routes attract high-quality trainees.
 3. Canada currently needs a variety of training routes to serve the emergency care of Canadians effectively across all settings.
 4. Canada also needs focused rural EM training to effectively meet the needs of patients in this context.
 5. The two EM training programs are not identical, due to design, time, educational experiences, emphasis, and duration of training.
 6. Differences and distinctions between graduates of the two programs evolve over time, just as every professional changes their scope of practice and depth of knowledge during their career.
-

Proposed Concepts:

1. The two programs do not and cannot produce identical graduates.
2. There are qualitative and quantifiable differences between graduates of the two programs upon completion of training.
3. CCFP(EM) graduates, due to their Family Medicine (FM) background and competencies, have additional ability in clinical presentations that overlap with ambulatory FM care including but not limited to holistic communication skills, integration with the community, ambulatory psychiatry and obstetrics.
4. FRCPC-EM graduates, due to their longer dedicated training in EM, have additional abilities, including but not limited to: critical care experience, advanced resuscitation skills, advanced toxicology, pediatric EM, research and a higher level of experience with the management of critically ill patients.
5. The qualitative and quantitative differences in #4 listed above are most evident in the sickest patients and in the context of more complex and unusual emergency patient presentations and conditions.
6. Due to curriculum differences, FRCPC-EMs have additional training in some areas, including EM administration, research, and pre-hospital care.
7. Despite these significant differences, inter-College collaboration in developing competencies to provide care for all common ED presentation is required for all trainees in order to safely meet the needs of “patient zero”. It is understood that FRCPC-EM program graduates, as EM consultants, will exceed these in some areas. At the same time, the standard of care required to be clinically competent in the provision of EM care must be equivalent for both CCFP(EM) and FRCPC-EM graduates for ED presentations that are common to the settings in which they work.
8. With experience, the sophistication of EM care will exceed the aforementioned competency minimum for graduates of both EM training programs, however, FRCPC-EM graduates benefit from greater formal education and exposure upon graduation than CCFP(EM) graduates.



In moving forward, decision-makers must strive to advance approaches that serve both the EM and ED patient communities. The current reality of Canadian EM practice is that graduates of both the CCFP(EM) and FRCPC-EM programs work side by side clinically in a variety of ED settings, most commonly large urban centres. The two colleges have the ability to positively impact patient care by collaboratively developing parallel foundations of training for EM care delivery.

CWG-EM Vision and Recommendations

The following recommendations summarize the collective vision of the CWG-EM, and have been generated after careful consideration of the CWG-EM's research findings and communications with key stakeholders. The recommendations articulate a series of achievable actions that it is advised the trilateral partners undertake for the advancement of the future of Emergency Medicine training and practice in Canada.

Health human resources shortfall

There is a current estimated shortfall of **478** emergency physicians in Canada. This deficit is roughly equivalent to the student body size of an entire Canadian medical school. In the absence of expansion of EM residency training capacity, this shortfall is projected to rise to **1071 physicians** by 2020 and to **1518 physicians** by 2025.

We recommend that CAEP, the CFPC, and the Royal College work collaboratively to advocate for the significant EM residency training slot expansion necessary to address the large current and projected future shortfall of certified emergency physicians in Canada. CAEP, the CFPC and the Royal College are encouraged to work in collaboration in order to address the current and future HHR deficit in Emergency Medicine, consider 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. In addition, in consultation with both colleges, provincial Departments of Health must also work with the postgraduate offices of medical schools within their jurisdictions to increase the number of EM postgraduate training positions in Canada.

In line with its mission to promote the interests of emergency physicians and the specialty of EM in Canada, CAEP must also advocate for the growth of EM certification programs, as well as hold influential groups accountable to move this issue forward.

Alignment of the CFPC and Royal College Emergency Medicine residency training programs

Patient needs have been met with the current approach to EM certification in Canada; however, some improvements are felt to be necessary to improve efficiency and effectiveness and thus enhance care and educational resource utilization. It is envisioned that there will be a continuum of physicians from CCFP(EM) and FRCPC-EM programs staffing various types of Canadian EDs, with each physician's practice context being aligned with the competencies of the individual.

The CWG-EM is not recommending a single certification stream for EM practice, however the substantial support for this that continues to exist in the EM community underscores the need to make meaningful improvements to the status quo. We recommend that the CCFP(EM) and FRCPC-EM programs reform their objectives of training with the following goals:



FRCPC-EM program

The focus of the Royal College must be on the development of important competencies to allow graduates to deliver specialist emergency care to patients in tertiary, large urban, regional, and community hospital EDs.

- The CWG-EM feels that the Royal College’s implementation of competency-based medical education (CBME) in residency training and specialty practice by the way of Competence by Design (CBD) project can address concerns related to the FRCPC-EM program.
- In this transition to CBME, the Royal College should review the current FRCPC-EM curriculum and incorporate increased competencies relating to the relationship of emergency and primary care and the larger continuum of care external to the ED setting.
- Increased attention will need to be paid to the intended practice routes of FRCPC-EM graduates in order to achieve efficient and aligned training. For example, incorporating additional competencies for graduates seeking additional training during their Royal College residency (in areas such as education, administration, research, EMS, toxicology, etc.) and conversely focusing on pertinent competencies for those intending a purely clinical EM practice.

CCFP(EM) program

Data from the CWG-EM survey of CCFP(EM) certified physicians and residents indicates that the vast majority of graduates of the CCFP(EM) program practice or intend to practice full-time EM and not a combination of EM and clinical Family Medicine. We recommend that the CFPC focus their efforts on a review of the structure, goals, and objectives of the CCFP(EM) program in order to ensure competency at graduation and to satisfy the standard of care for “patient zero”.

- CCFP(EM) program graduates should have the necessary competencies to deliver emergency care to patients in many contexts including large urban EDs, regional and community hospital EDs, as well as smaller EDs.
- A detailed review of the curriculum of the CCFP(EM) training program from a competency based perspective is required in order to ensure the inclusion of the required competencies necessary to confidently practice full-time EM upon graduation. In the review of the CCFP(EM) program, it is important to note that while the CCFP(EM) program likely could continue to be completed in three years, the incorporation of a competency based perspective would almost certainly result in modifications to the traditional two plus one program to an alternative arrangement of program rotations and/or objectives, or alternatively, an increase the program duration for the EM training component.
- Due to the varying needs of different ED locations of CCFP(EM) certificants, some core competencies incorporated into the CCFP(EM) program should be dictated by the anticipated setting of future practice. The nature of the preceding two years of CCFP training should also be considered at the level of each individual CCFP(EM) trainee, as inter-program variability exists in the nature of this, particularly regarding whether the focus is rural or urban.



HHR needs in rural and remote settings

HHR needs in rural and remote areas are complex, and it is unlikely that the full breadth of EM staffing needs can be filled in these locations by CCFP(EM) and FRCPC-EM certified physicians in the near future. HHR planning for rural and remote areas needs to consider many more aspects of medical care than solely emergency care. A review of the CCFP (non-EM) program and the issues of EM care in rural Canada were outside of the mandate of the CWG-EM, however general recommendations related to the CCFP program and provision of EM care will be briefly communicated.

The CFPC is encouraged to review the rural/remote findings in detail 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 provision of 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.

Future collaboration of the CCFP(EM) and FRCPC-EM programs

Collaboration between the two colleges with respect to the CCFP(EM) and FRCPC-EM residency programs must 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.


We recommend 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, including but not limited to:

- Collaboration between the CFPC and the Royal College in order to clarify, co-develop, and distinguish the goals of each program, highlight their distinctions, and ultimately ensure that clinical competencies for “patient zero” are met, non-clinical competencies are achieved, and both programs are efficient and effective at meeting their goals.
- Optimizing patient care by collaboratively developing parallel foundations of EM care for both training routes, as well as the co-development of competency-based clinical care milestones for common clinical presentations.
- Establishing observer status appointments for one-another on EM relevant committees including but not limited to the Royal College Specialty Committee in Emergency Medicine and the CCFP(EM) Program Committee.

CWG-EM Data Access for Future Research Activities

The quantitative and qualitative results of the CWG-EM National Survey of EM represent a significant collective resource for the Trilateral Partners (CAEP, the CFPC, and the Royal College), as well as the Canadian EM community, both today, and in the future.

The opportunity to access the data collected by the CWG-EM should be made available for future research initiatives by any of the trilateral partners or members of the EM research community. Access to the CWG-EM survey data should be granted exclusively for the purposes of research



and improvement to the emergency care of Canadian populations, and not for any commercial purposes. A formal application process should be developed and the CWG-EM should be continued (or a new trilateral partner committee should be established) to review any requests to access raw CWG-EM survey data. Permission to access the CWG-EM survey data would require the approval of all three Trilateral Partner organizations, and approval from a Canadian Research and Ethics Board (REB). Additional factors involving access to CWG-EM survey data such as project mechanics, intellectual property, and confidentiality, would need to be defined in advance by the trilateral partners.

Examples of potential future research questions that could be answered or facilitated through the use of CWG-EM survey data are provided in Figure 23 of the final report.

Conclusions

Since the late 1970s, the training in and practice of Emergency Medicine in Canada has undergone significant transformation. Prior to the recognition of EM as a distinct discipline in Canada, EDs were typically staffed by physicians without formal EM training or a comprehensive understanding of the unique requirements of EM practice. During this time, physicians providing care in emergency rooms identified the societal need for a dedicated practice to serve the acutely ill and injured. The formation of CAEP in 1978 and the development of EM residency training programs by the Royal College and the CFPC in the early 1980's have served the emergency care needs of the Canadian public effectively. EM has since evolved into an academic discipline, and the Canadian EM community now has an international reputation of excellence in clinical care, education, and research.

As the discipline of EM continues to evolve and the emergency care needs of the Canadian public become increasingly complex, in part due to an expanding and aging population, the EM community must continue to maintain high expectations for training in and practice of competent care in all emergency settings.

The recommendations made by the CWG-EM are not a judgment on the current variation in practice experience and certification within the EM community of today, but rather represent a collective vision for the future based on findings from the first comprehensive survey of the entire Canadian EM community (including ED chiefs, practicing physicians certified in EM by either the Royal College or the CFPC, and all EM residents in training) as well as other data sources and reviews completed by the CWG-EM.

The CWG-EM has identified a significant HHR shortfall of emergency physicians, both currently and in the future, and has recommended urgent actions be taken to address this issue. In addition, we have also identified a number of practical strategies for both the Royal College and CFPC to enhance and align their EM residency training programs to enhance EM care and educational resource utilization. We have recommended that CAEP continue to be an important partner and advocate in the implementation of these recommendations.

This report and its recommendations represent an important contribution to the improvement of EM care for all Canadians by facilitating meaningful changes to EM training and practice. We thank the trilateral partners for their vision in establishing the CWG-EM and urge early engagement with all relevant stakeholders with a goal of implementation of our recommendations over the next year.

Background



Emergency Medicine Postgraduate Medical Training and Certification in Canada


Postgraduate Emergency Medicine (EM) training and certification in Canada currently consists of two separate training pathways that are overseen by two autonomous national colleges. The Royal College of Physicians and Surgeons of Canada (Royal College) and the College of Family Physicians of Canada (CFPC) independently offer EM residency training programs with differing training requirements and objectives. Each program was originally intended to fulfill differing societal and healthcare needs. In reality, the products of these training programs significantly overlap, and have evolved to meet population needs differently than their initially intended roles as outlined by the two colleges, leading to substantial debate within the Canadian EM community.

The Recognition of Emergency Medicine as a Medical Discipline

In the late 1970s, EM had not yet been recognized as a distinct discipline in Canada, and emergency departments (EDs) were typically staffed by physicians without formalized EM training or a comprehensive understanding of the unique requirements of EM practice.¹ Understanding the importance of introducing EM as a distinct discipline with advanced training, the Royal College and CFPC formed a conjoint committee, with the goal of reaching a resolution on the most suitable home college and ideal training format for the EM discipline.² The committee was unable to achieve consensus at that time, which resulted in both colleges independently launching EM residency training programs with different underlying principles and training goals.^{3,4}

In 1981, EM was granted Royal College specialty status. The EM training program (FRCPC-EM) was originally offered as a four (4) year certification as a Fellow of the Royal College of Physicians of Canada, and was expanded to five (5) years in 1993.¹ In the development of the training program, the Royal College framed the EM discipline as a stand-alone specialty and developed the corresponding EM training program as a route to produce “academic emergentologists” who would integrate both clinical and nonclinical roles (e.g., administrative, research, teaching) into their practice.^{5,6} The first FRCPC-EM certification exam held by the Royal College was in 1983.³

The CFPC created a certificate of special competence in EM and training program in 1982. The EM training program was offered as an extension of the two (2) year residency program in Family Medicine, and provided an additional year in order to obtain a certificate of special competence in Emergency Medicine [CCFP(EM)].^{1,6,7} The CFPC understood EM to be a fundamental component of primary care in smaller settings and developed the CCFP(EM) program in alignment with this principle.⁵ The CFPC



indicated that CCFP(EM) program graduates acquire additional skills in EM in order to utilize their improved skill set as a family physician within a community context.⁸ The first CCFP(EM) certification exam was held in 1982.³

Historical Debate Surrounding EM Certification in Canada

Since the inception of the two EM programs, the training in and practice of EM has become increasingly more standardized and prevalent, both in a Canadian and international context. The International Federation of Emergency Medicine (IFEM) was founded in 1989 in order to establish an association between four national EM organizations.* As of the release of this report, IFEM has expanded to include 44 full member organizations.

The increased popularity of EM practice within Canada has drawn greater attention to the unique nature of Canadian EM training and certification. The FRCPC-EM and CCFP(EM) training programs were originally configured to fulfill the needs of separate areas of emergency care. FRCPC-EM graduates were intended to operate as specialists, taking on an academic and clinical role in ED settings.³ In comparison, the CCFP(EM) training program was established with the goal to improve the EM care delivered by family physicians within their communities.⁸ In reality, the outcomes of these training programs have strayed from their initial intent. Members of the Canadian EM community have argued that the FRCPC-EM and CCFP(EM) training streams produce a “heterogeneous group of clinicians” who deliver emergency care in overlapping contexts.^{1,6}

Since the inception of both programs, there has been extensive debate concerning Canada’s two routes to EM certification. Many physicians of both certification types have articulated their concerns and opinions regarding EM training and certification, both in the *Canadian Journal of Emergency Medicine (CJEM)* and the *CAEP Communiqué* (a newsletter published by CAEP prior to the establishment of *CJEM*).⁹ The debate has been concentrated on four key themes:

- 1. Diversity of care:** The diversity of physicians providing emergency care in Canada provides insight into variances in geography, economic standing, and educational diversity within ED settings.¹⁰ Canadian EDs can be staffed by EM specialists (FRCPC-EM), family physicians with certificates of special competence in EM [CCFP(EM)], family physicians (CCFP certification), and physicians with a general license or other certification. This said, many centres and the majority of larger EDs, require formal certification in EM. Clinicians of both types of Canadian EM certification can provide EM care within a single environment, which is often the case in urban centres.¹¹ In rural or remote locations, the majority of EM care is provided by family physicians or physicians with a general license.¹ This phenomenon has raised concerns regarding standards for EM care across the country, as well as concerns regarding the interaction of physicians practicing EM in mixed certification environments.

* The British Association of Accident and Emergency Medicine (BAEM), the American College of Emergency Physicians (ACEP), the Canadian Association of Emergency Physicians (CAEP), and the Australasian College of Emergency Medicine (ACEM) (representing Australia and New Zealand).



2. **Shortage of Canadian EM certificants and availability of EM training positions:** The diversity of physicians providing EM care is further complicated by shortfalls in physicians providing care in Canadian EDs.¹⁰ Due to circumstances that include the relatively small number of EM residency positions in Canada, the imbalance between the two types of program graduates, as well as geographical and fiscal influences in emergency care, CCFP (non-EM) physicians continue to provide a significant proportion of emergency patient care. It has been argued that a significant increase in both FRCPC-EM and CCFP(EM) training positions must be implemented in order to remedy the shortage of physicians with EM training and certification in Canadian EDs.¹²
3. **Misalignment with original intent of program:** In a 1997 editorial in the CAEP Communiqué, two authors posed a question regarding the two pathways of EM certification: “Is there a difference 10 years after residency?”.⁵ The authors argued that both EM training routes have demonstrated misalignment with original program goals, and after years of practice that program intents aside, “in ‘the real world’ it is often difficult to distinguish practice patterns between CCFP(EM) and FRCPC-EM emergency physicians.”
4. **Dual versus single routes of EM certification:** A major focus of past and current debate has surrounded the dual certification structure of Canadian EM. The discussion has included two schools of thought: the new development of a unified and single training route, with both clinical and academic tracks, for EM practice and the support of the continuation of both current programs with the implementation of new measures to improve the training routes and realign them with their original program goals.

The prime objective shared by both the Royal College and the CFPC is to ensure that expert EM graduates provide high quality EM care for patients presenting to emergency departments (EDs) across Canada. The long standing and contentious issue of the current system for EM certification has resulted in challenges for medical students choosing careers and difficulty for graduates of both programs.⁶ Prior publications and initiatives attempting to address these issues have informed the work of the CWG-EM, and are outlined in the following section.

Historical Summary: Investigation of EM certification in Canada

1998

In response to the debate regarding EM training and certification on the pages of the *CAEP Communiqué*, CAEP established a task force to examine issues that were brought forward in the publication. The purpose of the task force was to consult with Canadian physicians practicing EM and determine the viability of forming a single training route for EM certification.¹³ The task force determined that consensus could not be achieved amongst the EM community at the time, and the project was therefore terminated.³



2002

In 2002, the CAEP Board of Directors tasked Dr. Douglas Sinclair and Dr. Tim Allen with producing recommendations to address health human resource (HHR) issues for EM in Canada. The subsequent report indicated that EM certified physicians were unevenly distributed across Canada. Relevant recommendations from the study included: a call for immediate increases in the FRCPC-EM training positions by the Royal College, the expansion of CCFP(EM) programs based on local need, and the support of the CFPC's plans to increase the number of family physicians in Canada.

2008-2009

At the 2008 CAEP annual conference in Victoria, a presentation on the issues with the current EM training and certification system in Canada generated significant attention.¹⁴ This prompted CJEM to solicit two editorials on the topic, one from an FRCPC-EM certified emergency physician⁷ and one from a CCFP(EM) certified emergency physician.³ These were published in 2008, and although written independently and from different perspectives, both reached similar conclusions and called upon CAEP to investigate issues regarding the parallel EM training streams. The volume of letters to the editor in response to these editorials was unprecedented in the history of CJEM, and illustrated the strong and impassioned views of the Canadian EM community on this topic.¹⁵ To address these needs, CAEP held a town hall debate involving four EM leaders with an interest in the topic at the CAEP annual conference in Calgary in 2009.¹⁴ The level of attendance at this event prompted CAEP to distribute an online survey to all CAEP members in Canada later in 2009.¹⁴ The survey was intended to evaluate satisfaction with the dual college, dual certification system in Canada, openness of the EM community to changes in the certification system, and the importance respondents placed on implementing changes to the training pathways in comparison to other issues facing EM.¹⁶

The results of the CAEP survey indicated that the majority of those responding believed that changes to the current system of EM certification in Canada would be beneficial, though family physicians (CCFP) and older respondents (40+) were more likely to disagree with this statement. The change that was most supported by survey respondents was to unify EM training under a single college and certification route, with the option to pursue additional fellowship training. This change was particularly supported by younger respondents. In terms of the importance of this issue in comparison to other issues in the EM community, the dual certification training was ranked amongst the top five issues that required CAEP's attention. The majority of respondents also supported diverting resources from other CAEP activities in order to increase attention to this issue, though this position was less supported by older respondents (40+) in comparison to younger respondents.

Although questions were raised by some in the EM community about the methodology, and thus the validity, of the CAEP survey, in light of survey findings, the following resolution was passed at the November 2009 CAEP Board of Directors meeting: "CAEP supports a re-evaluation of emergency medicine training and certification in Canada".¹²



2010

A Task Force (subsequently called “The Montreal Task Force” [MTF] as it met at the 2010 CAEP Conference in Montreal) was established by the CAEP Board of Directors in 2010 to consider CAEP’s resolution to re-evaluate EM training and certification.¹² The task force was chaired by Dr. Doug Sinclair and comprised of twenty leaders in EM that represented the wide-ranging nature of the discipline (representatives of both the Royal College and CFPC were in attendance, in addition to nominated jurisdictional representatives).^{*} The meeting of the task force lasted two hours and considered three questions relating to EM training in Canada:

1. Does the existing Emergency Medicine training and certification system in Canada, with two independent routes to certification run by two colleges, best serve the current and future needs of the Emergency Medicine community, the specialty of Emergency Medicine, and the citizens of Canada?
2. If no, should CAEP initiate and lead a process to attempt to improve the system?
3. If so, what process might best lead to success, and what are the next steps?

The task force concluded that the existing structure of two parallel training routes for EM certification did not currently meet the current and future needs of the EM specialty and of Canadians requiring emergency care. There was agreement that the reorganization of these programs would improve the standards of care of Canadian emergency settings. The task force acknowledged the risks associated with potential changes but felt that CAEP should take the lead in initiating a process for an improved method of training emergency physicians in Canada, with the Royal College and CFPC participating as key partners in the process.

The final report of the MTF stated the following:

“ There was broad support for the concept that the status quo was not acceptable, and the existence of two training programs did not serve the current and future needs of the Emergency Medicine community, the specialty of Emergency Medicine, and the citizens of Canada.

The Task Force felt that CAEP should take the lead on initiating a process that would result in a more optimal approach to the training of emergency physicians in Canada. Both the Royal College and the CFPC will need to be key partners, since they are the only bodies that can accredit postgraduate training in Canada.

”

^{*} The full MTF report and a list of the MTF members are available on the CAEP website.



The task force put forward a set of key principles to inform the process moving forward:

1. Articulation of a clear vision for educational programs in Emergency Medicine to be achieved within a defined time line.
2. Development of a set of principles to guide the program development.
3. Early engagement of key partners, including the Royal College, CFPC, and provincial sections of EM.
4. Utilize the Task Force membership in this important work, with CAEP Board direction and head office support.

As a result of the recommendations of the Montreal Task Force, the CAEP Board of Directors established the CAEP Dual College, Dual Certification Working Group (DC/DC-WG). The DC/DC-WG was established in order to assist CAEP in developing a vision for educational programs in EM and work to engage key partners in the development of guiding principles for this vision.¹²

2011

In March 2011, the CAEP Board of Directors endorsed the following vision:*

“ CAEP's vision is that of a new single Emergency Medicine residency program that would incorporate the best features of both the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (Royal College) Emergency Medicine Residency Training Programs to train both clinical and academic emergency physicians in a coordinated, efficient, and effective manner.¹² **”**

Additional high level program development principles that were aligned with this vision were generated by the DC/DC-WG and endorsed by CAEP.¹²

In May 2011, CAEP representatives met with representatives from the Royal College and CFPC in Ottawa to discuss the results of the 2009 CAEP member survey, the Montreal Task Force, and recommendations made by the DC/DC-WG.¹² The purpose of this meeting was to engage CAEP and the two colleges in a discussion of how EM training and certification could be improved in Canada given the dissatisfaction with the status quo.¹² It was determined that a single training program in EM was not felt to be a viable solution by the two colleges, however the meeting resulted in the agreement from both the Royal College and CFPC that both colleges would participate in a “rigorous and comprehensive national opinion survey” that would be distributed to certificants and trainees of both training routes.¹²

* For clarification: The Royal College and CFPC have the sole mandate to accredit postgraduate medical education in Canada. CAEP, while not having this mandate, was endorsing a new unified EM training program to be developed by the two Colleges.



2012

In May 2012, at CAEP's request, executives of CAEP, the CFPC, and the Royal College met to discuss EM training and certification in Canada. CAEP presented a document produced by the DC/DC-WG titled, "Compelling Reasons for Change to the Existing Dual College, Dual Certification Emergency Medicine Training System in Canada" to the group, which articulated the working group's findings and reasoning for the CAEP vision of a single EM residency program.¹²

At this meeting, neither the Royal College nor CFPC indicated a willingness to implement a single EM training stream. The meeting did serve however to identify the benefits and challenges of both training routes and their overlapping relationships with one another. There was agreement that:

1. The prime objective shared by all three organizations is to ensure that high quality emergency medical care is provided for patients presenting to emergency departments throughout Canada.
2. While the current system, with both the CFPC and the Royal College certifying emergency physicians, has served Canada well, challenges exist related to health human resources, education and training of future emergency physicians that must be addressed if we are to continue to meet the evolving health care needs of Canadians.
3. While the current Emergency Medicine training and certification programs of both the CFPC and the Royal College will remain in place to meet their respective training objectives, there will be an exploration of identified areas where they may collaborate and adapt to enhance efficiency and/or effectiveness in the realization of shared objectives in order to maximize the benefits that each of these programs bring to patient care and emergency physician career satisfaction.

The groups involved decided to form a "trilateral working group on the future of Canadian Emergency Medicine training and emergency physician health human resource requirements" in order to take part in further discourse regarding the issues brought forward.¹²

The Collaborative Working Group on the Future of Emergency Medicine in Canada

In response to the progress made at the CAEP/CFPC/Royal College meeting held in May 2012, a statement was released by CAEP, the CFPC, and the Royal College announcing the creation of a Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM) in July of 2012. The CWG-EM would consist of members of CAEP, CFPC and the Royal College and would address the challenges that were brought forward at the prior CAEP/CFPC/Royal College meeting.

The CWG-EM was constituted in September 2013 to provide recommendations to CAEP, the CFPC, and the Royal College and was composed of seven (7) members: a Chair, and two (2) members appointed by each of CAEP, the CFPC, and the Royal College. Each CWG-EM meeting required the presence of at least one representative from each of the three organizations.

The CWG-EM had the following five roles and responsibilities (see Appendix A for full Terms of Reference of the CWG-EM):

1. Perform an assessment of the current situation regarding each of the two EM training programs and any related local/provincial/territorial adjuncts;*
2. Based on the information obtained from the above assessment and other pertinent information, identify the challenges that exist regarding emergency physician HHR and the education and training of future emergency physicians as it relates to the evolution of Emergency Medicine and the evolving needs of Canadians;
3. Assess the efficiency and effectiveness of each program in meeting its stated training objectives, and the broader impact of this vis-à-vis the advancement of Emergency Medicine and the provision of high quality emergency medical care in Canadian EDs;
4. Identify and make recommendations regarding areas where collaboration at the national College level between the two EM training programs would be beneficial to optimize the use of educational resources and/or maximize the benefits that each of these programs provides;
5. Identify and make recommendations regarding areas where adaptation in the makeup and design of one or both EM training programs would be beneficial to optimize the use of educational resources and/or maximize the benefits that each of these programs provides.

Recommendations made by the CWG-EM required unanimous agreement by the members of the group.

CITATIONS

- 1 Steiner, 2003
- 2 Oral communication, Dr. Paul Rainsberry, Associate Executive Director, Academic Family Medicine, CFPC, January 2008 (as cited in Rutledge, 2008).
- 3 Rutledge, 2008
- 4 "The FRCPC vs. the CCFP(EM) [Letters to the Editor]", 1998
- 5 Ducharme & Innes, 1997
- 6 Hillier, McLeod, Mendelsohn, Moffat, Smallfield, Arab et al., 2011
- 7 Abu-Laban, 2008
- 8 CFPC, 2013
- 9 Ducharme & Innes, 1997; "The FRCPC vs CCFP(EM) [Letters to the Editor]", 1997-98; Etherington, 1997-98; "The FRCPC vs CCFP(EM) [Letters to the Editor]", 1998; "On unified EM training [Letters to the Editor]", 1998; and Gray, 1998 (as cited in Abu-Laban, 2008).
- 10 Lloyd, Streiner, & Shannon, 1994; Beveridge & Lloyd, 1996; and Steiner, Yoon, Goldsand & Rowe, 2001 (as cited by Steiner, 2003).
- 11 Chan, 2002 (as cited by Steiner, 2003).
- 12 CAEP, 2016
- 13 CAEP, 1998
- 14 C. Evans, personal communication, April 18, 2016
- 15 Abu-Laban & Rutledge, 2009
- 16 CAEP, 2009

* This should include, but is not necessarily limited to: a) determining what coordination exists between the CCFP(EM) and FRCPC-EM programs in Canadian medical schools, and the nature and extent of this, b) determining whether discourse exists at a national college level between the CFPC and the Royal College in relation to the makeup, design, and stated training objectives of their respective EM programs, and c) identifying and researching any local/provincial/territorial adjuncts that exist to the residency training programs that the CFPC and Royal College offer, and the current effect and expected future impact of these on the Canadian EM training milieu.

Project Methodology



The project involved a number of methods to capture and synthesize data for review by the CWG-EM, including:

1. Analysis of historic materials, initiatives, and perspectives of the EM community

Since the inception of the CCFP(EM) and FRCPC-EM programs, the training in and practice of EM has been the subject of extensive debate within the Canadian EM community. During this time, many physicians of various certification routes have brought forward their thoughts, concerns, and opinions regarding EM training and certification, particularly in the *Canadian Journal of Emergency Medicine (CJEM)* and the *CAEP Communiqué* (a newsletter published by CAEP prior to the launch of *CJEM*). An exhaustive review of the relevant literature on this topic, including scientific publications, was performed by the CWG-EM in order to obtain a comprehensive understanding of previously described or published perspectives of the EM community and to review the findings of relevant published studies.

In addition, past EM initiatives led by CAEP including the results of prior task forces and surveys and working documents and statements were investigated and included in the review.

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

In order to contextualize the foundations of the CCFP(EM) and FRCPC-EM training routes, and understand how the graduates of the programs are intended to operate in practice after graduation, a comparison of the program goals, objectives, training pathway, and certification of both routes was completed.

The material informing the comparison of the CCFP(EM) and FRCPC-EM training routes was obtained from the most recent iterations of the *CFPC's 2013 Specific Standards for Family Medicine Residency Programs Accredited by the College of Family Physicians of Canada* (The Red Book) and the Royal College's 2014 *Specialty Training Requirements in Emergency Medicine (STR-EM)* and *Objectives of Training in the Specialty of Emergency Medicine (OTR-EM)* documents. All three documents regarding both training routes are available online at the College's respective home webpages.

3. Development of key project questions

Between October 2013 and February 2014, the CWG-EM developed a series of key questions (Appendix B) that were aligned with the roles and responsibilities defined by the CWG-EM's Terms of Reference (Appendix A). The development of these questions, subsequent research, and determination of the limited depth and breadth of information currently available, led to the decision to conduct a nation-wide survey of EM training and HHR needs.



4. Communication with University Postgraduate Deans of Medical Education

On September 16, 2014, the CWG-EM Chair sent correspondence to all 17 Canadian Postgraduate Deans of Medical Education, requesting their perspectives on the two independent training streams for EM certification in Canada. The CWG-EM received 7 responses that assisted in appreciating the current climate surrounding the two training streams in postgraduate institutions. A summary of the content of these communications can be found on page 41 of the results overview.

5. National survey of Emergency Medicine training and health human resource (HHR) needs

The training and certification of physicians practicing EM in Canada is a complex and contentious issue, and has been shaped by the experiences and perspectives of stakeholders across certification types, ED settings, and generational cohorts. Acquiring an understanding of the many factors contributing to the complexity of EM training and certification was felt to be essential to the development of recommendations by the CWG-EM, as was identifying gaps in current knowledge particularly in the area of EM HHR.

As a result, four mixed methods survey instruments were developed and administered in summer 2015 to members of the Canadian EM community.

Survey Groups

EM certified physicians

944 FRCPC-EM and 2709 CCFP(EM) certified physicians with valid email addresses were identified from the Royal College and the CFPC databases respectively. These databases maintain up-to-date records on contact information for all physicians certified by the two colleges.

EM residents


513 EM residents (379 FRCPC-EM residents and 134 CCFP(EM) residents) from across the country were identified through a process led by the Royal College and CFPC (as requested by the CWG-EM) to obtain email addresses for all active residents, on an individual basis, from every EM training program in Canada.

CCFP certified physicians involved in EM care

2924 CCFP physicians believed by the CFPC to be involved in EM care were identified and their email addresses obtained. This group was comprised of all CCFP physicians who had indicated they had an interest or activity in Emergency Medicine (as per their CFPC annual membership renewal form) but who do not hold a CCFP(EM) certification. Any duplications with CCFP(EM) certified physicians were removed.

ED Chiefs

Between July 2014 and June 2015, significant effort was made by the CWG-EM to identify every ED in Canada and a contact (ED Chief or, in the case of hospitals with no Chief, the Hospital Chief of Staff). As a primary step, known regional ED Chiefs were contacted to obtain lists of contacts. For regions where there was no known contact, regional health authorities and hospitals were contacted directly and



relevant information was obtained. When email addresses were not accessible, site leads were asked to forward the links to the relevant chiefs. The primary survey method for this group was by email, however in cases where no email address could be obtained, an invitation with the link to the survey was sent through Canada Post to the ED Chief or Physician Lead of the hospital. From the above process, a total of 398 Chiefs or Chiefs of Staff were identified and invited to participate.

Methods

Four survey instruments were developed collaboratively by the CWG-EM. The development process included periodic reviews by the CEO of the CFPC, the Royal College, and President of CAEP to determine the appropriateness of the planned questions and to seek further direction when needed. Wherever possible, identically worded questions were included across all surveys for the purpose of facilitating intergroup comparisons. Each of the surveys included questions on demographics, the nature of the practice or anticipated practice of respondents, as well as questions relating to the perceived efficiency and effectiveness of the two EM training programs. An assessment of sub-specialty training and certification of Pediatric emergency physicians was not in the CWG-EM Terms of Reference and was not addressed in any of the surveys. The length of the surveys varied from 15 questions (EM Residents) to 30 questions (ED Chiefs). The landing page of the surveys provided participants with a brief background on the CWG-EM and rationale for the survey, and a description of what to expect from participation. Recipients were also informed that the surveys were entirely voluntary and that their individual responses would remain anonymous. Research Ethics Board approval for the survey methodology and the surveys themselves was obtained from the Dalhousie University Health Sciences Research Ethics Board (REB # 2015-3589) on June 17, 2015. [Full versions of each survey are provided in Appendix C.](#)

The surveys were developed in English and then, when finalized, translated into French. Both the English and French versions were entered into Opinio™, an online survey tool with a locally hosted server. The mounting and formatting of the surveys in Opinio™ was completed by a staff member of the Educational Strategy, Innovations and Development Unit (ESID), a department of the Royal College contracted by the CWG-EM to provide analytic and writing support for the project.

Prior to launching, all surveys, in both languages, were pilot tested by members of each of the respective respondent groups from a variety of regions across Canada who were identified and solicited for this role by the CWG-EM. This was to ensure accuracy of interpretation of the questions and ease of understanding, and resulted in minor tweaks before widespread deployment of the surveys. An independent comparative review of the English and French surveys was also performed to confirm the translations were accurate, and resulted in only minor editorial and formatting revisions.

Following the pilot testing, invitations to participate were sent out simultaneously by email with an embedded link to the surveys to all of the participant groups on June 26, 2015. Following the initial launch, reminders were sent out for each survey bi-weekly to participants who had not yet responded using a modified Dillman tailored design method (TDM) approach.¹ The surveys closed on August 7, 2015.



Data Preparation and Analysis

Prior to reviewing the results of collected surveys and coding of data, the entire CWG-EM participated in a self-reflection process of individual bias assessment.

Data coding

Data from the surveys were exported from the survey software into SPSS. Categorical data were coded using a pre-determined set of numerical values. All variables were labeled with brief descriptions to facilitate interpretation of the results.

Outliers

Prior to performing analyses on the data, logical checks were carried out and extreme responses/outliers were identified using scatterplots generated by SPSS. These were subsequently evaluated on an individual basis by the CWG-EM to reach consensus on their accuracy. Responses outside of obviously correct limits (e.g., a birth year of 1900) were deemed to be erroneous and removed from the analyses. In a similar fashion, some responses were recoded in a conservative fashion because of logical inconsistencies. For example, when a response indicating a predicted increase in volume was coupled with the value of the predicted increase as 0%, the former response was recoded from "increase" to "no change." [A full description of the identified outliers and the rationale for removing or recoding responses is provided in Appendix D.](#)

Quantitative data analysis


Data from the surveys were imported into SPSS and standard descriptive statistics (frequency distributions, means, medians, standard deviations and ranges) were generated for questions involving quantitative data. Additional analyses involved cross-tabulating responses by factors including certification group and practice setting as requested by the CWG-EM.

Gap analysis

The process for estimating the current and anticipated future Canadian emergency physician shortfall involved the development of a model using the following variables: current supply of EM certified physicians, current number of hours/day of coverage short, anticipated change in Emergency Physician work hours, anticipated change in ED volume, projected number of graduating EM residents, the number of Canadian EDs, and projected clinical FTE proportion for graduating EM residents. These calculations involved a number of limitations and assumptions. The implications chapter of this report provides a full description of the calculations, assumptions, and limitations involved in estimating these shortfalls (page 69).

Qualitative data analysis

Questions involving qualitative responses were exported from the survey software and uploaded into Excel where they were organized into a survey-specific template whereby each question was presented on its own sheet. Individual responses were marked by row separation, with blank spaces in adjacent columns for entering codes. As an initial step, all responses were read by a single, independent coder to obtain a general sense of the content. Following the initial read-through, the first 30 responses were



coded, leading to the development of a preliminary coding/theme map. This was developed and further refined with subgroups of the CWG-EM assigned to each of the survey groups. Subsequently, using the map, additional responses were coded and previous codes/themes were revised as appropriate; this iterative process continued until saturation was reached and no new themes emerged. Identified themes were verified via a comparison to the themes generated by a second, independent coder. Further categorization of qualitative responses was done by certification type or training program as appropriate to facilitate intergroup comparisons. The analysis concluded when a consensus on the qualitative themes was achieved.

Collation of all research data and findings

Upon the completion of initial data analysis, quantitative and qualitative data was collated into notable findings. Findings were ranked by CWG-EM members into major, minor, and very minor findings. Findings that did not achieve consensus were discussed by the larger group until consensus was achieved. The results of this process informed the final findings and recommendations of the CWG-EM.

6. Additional activities and communication with key stakeholders

During its mandate, the CWG-EM communicated with a number of groups and stakeholders:

- **Guest participation at several meetings:**
 - ▶ Presentations by the Chair, Dr. Douglas Sinclair to the CCFP(EM) and FRCPC-EM Residency Program Directors at CAEP Conference 2014 and CAEP Conference 2015.
 - ▶ Presentations by the Chair, Dr. Douglas Sinclair at the CAEP Annual General Meetings in 2014 and 2015.
 - ▶ Planned presentation by the Chair, Dr. Douglas Sinclair to the CCFP(EM) and FRCPC-EM Residency Program Directors of both the Royal College and the CFPC at the 2016 CAEP conference.
 - ▶ Planned presentation by the CWG-EM following the 2016 CAEP Annual General Meeting.
- **Communication with key stakeholders:**
 - ▶ Communication between the Chair, Dr. Douglas Sinclair, and trilateral partner leaders: CFPC President, Dr. Francine Lemire, CAEP President, Dr. Jill McEwen, and the Royal College CEO, Dr. Andrew Padmos.
 - ▶ 4 times formally via teleconference, with ongoing informal communication, feedback and engagement.
 - ▶ Québec engagement: Support and feedback from Dr. Bernard Mathieu, including invited participation in several CWG-EM meetings.
 - ▶ Engagement with Dr. Chris Evans, past CAEP president and chair, CAEP Dual College, Dual Certification Working Group.
 - ▶ Communication with the Royal College Specialty Committee in Emergency Medicine and the CFPC Emergency Medicine Program Committee.



Over the course of its mandate, the CWG-EM held a series of 29 full committee teleconferences and 5 full day in person meetings, in addition to numerous subgroup meetings and presentations. The full activities of the initiative totaled an estimated 1500* person-hours of time by CWG-EM members. The Executive Assistant to the Chair averaged 20 hours per week, and countless hours were logged during 2015 and 2016 by members of the ESID. In addition CAEP, the Royal College and the CFPC all contributed in-kind support through their respective organizations.

CITATIONS

- 1 Dillman, 2000

* Each hour of meeting time is factored by 3 in order to account for meeting preparation and travel. This is a very conservative figure.

Comparison of the CCFP(EM) & FRCPC-EM Training Routes



The data informing the following comparison of the CCFP(EM) and FRCPC-EM training routes was extracted from the most recent iterations of the CFPC's 2013 *Specific Standards for Family Medicine Residency Programs Accredited by the College of Family Physicians of Canada* (The Red Book) and the Royal College's 2014 *Specialty Training Requirements in Emergency Medicine* (STR-EM) and *Objectives of Training in the Specialty of Emergency Medicine* (OTR-EM) documents.* All three documents regarding both training routes were available online at each of the College's respective home webpages.

It is important to note that the comparison of the CCFP(EM) and FRCPC-EM programs consists of an analysis of the intent of both programs articulated by the Red Book, STR-EM, and OTR-EM. The following is not an analysis of the execution of the programs or the subsequent practice choices of program graduates. These areas will be explored in other chapters of this report.

FRCPC-EM Residency Training Pathway

Program goals

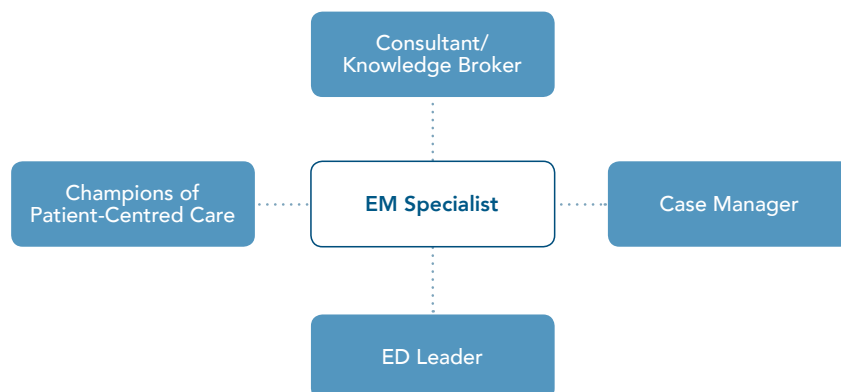
The program goals of the FRCPC-EM training pathway articulated by the OTR-EM document indicate that "upon completion of training, a resident is expected to be a competent specialist in Emergency Medicine," with the ability to adopt several essential roles within an ED.

These roles are articulated around four key themes identified by the CWG-EM: the EM specialist as consultant and/or knowledge broker, as case manager, as ED leader, and as champion of patient-centred care (Figure 1).

* The Royal College: The STR-EM and OTR-EM: The STR-EM and OTR-EM documents are intended to summarize the requirements and objectives a FRCPC-EM resident is expected to accomplish by the completion of their residency training. The STR-EM and OTR-EM documents act to direct the curriculum development of EM training programs by Canadian university faculties of medicine. The STR-EM and OTR-EM were developed by the Royal College's Specialty Committee in Emergency Medicine and are regularly reviewed and updated every six years unless otherwise specified. Changes to the STR-EM and OTR-EM documents are approved by the Specialty Standards Review Committee at the Royal College.

The CCFP: The Red Book: The Red Book was developed by the Education Department of CFPC in order to articulate the framework for the standards used by the CFPC to accredit family medicine training programs and enhanced skills residency programs such as EM in Canadian university faculties of medicine. The Red Book acts as a guiding document for standards of curriculum and training for Canadian university faculties of medicine delivering CFPC accredited programs. Each Canadian faculty of medicine that delivers a CFPC accredited program must conduct a review of the program's statement of goals and competency outcomes every two years. Specific programs are reviewed by the corresponding postgraduate program director and residency program committee in order to assess the applicability of program goals and to determine if the program is organized appropriately to allow the achievement of program goals by the residents.

Figure 1: Illustration of key themes identified in the CWG-EM work:
Emergency Medicine specialist




In fulfilling the role of consultant, the EM specialist utilizes theoretical emergency medical knowledge (including basic medical sciences and research) in their practice and provides guidance relating to their expertise. The role of case manager requires the resident to develop abilities in “prioritization, assessment, intervention, resuscitation, and further management of patients to the point of transfer,” incorporating both procedural and pharmacotherapeutic interventions alongside their clinical skills. The role of leader requires abilities in managing EDs through the organization and administration of emergency medical services, pre-hospital care, and disaster management. In order to effectively fill the role of champion of patient-centred care, EM specialists must exhibit the ability to incorporate ethical issues and the social determinants of health into the provision of patient-centred services to a diverse population. The EM specialist must also integrate these concepts into research methods, data collection, and analysis in order to appropriately represent diverse populations and their needs.

Objectives

The Royal College’s STR-EM and OTR-EM documents frame graduates as competent specialists in EM. The objectives of training are expansive, including a highly detailed list of competencies that are organized in alignment with the Royal College’s CanMEDS framework. The primary goal of the CanMEDS framework is to outline the required competencies and medical education standards for all practicing physicians in Canada. These competencies are grouped within seven CanMEDS roles, to ultimately be integrated into the role of providing competent care as a Medical Expert.

The objectives of training and corresponding competencies for the Emergency Specialist are thematically organized within the seven roles of the Royal College’s CanMEDS framework: Medical Expert (the integrating role), Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional.

With the Royal College’s OTR-EM document, each CanMEDS role is defined within an EM specialist’s scope of practice and includes specific objectives of training. Corresponding competencies that program residents are expected to achieve over their five (5) year training period are listed under each



objective. The competencies for FRCPC-EM residents are delineated as a highly specialized set of skills and contain lists of specific skills, procedures, and concepts that must be mastered in order to achieve specialist status under the Royal College.

Training pathway

As of 2016, a physician may become certified by the Royal College as an EM specialist after the completion of medical school by undertaking an additional five (5) years of EM residency training through a Royal College approved program.

There are currently fourteen (14) accredited EM residency programs that are approved by the Royal College.

Completion of the current accredited residency training program in EM includes five (5) years of approved residency training (see Figure 2). The training program must include twenty-four (24) months as a resident in the ED which includes a minimum of six (6) months as a senior resident, a minimum of four (4) months with a pediatric clinical emphasis (a portion of which is as a senior resident), and a minimum of one (1) month in a community or non-tertiary care hospital setting.

FRCPC-EM residents must also complete a minimum of four (4) months focused on areas important to EM specialty practice, including: emergency medical services (including pre-hospital care and disaster management), the administrative aspects of EM, educational skills, and research skills.

A minimum of six (6) months must be spent in critical care rotations that must include at least one (1) month (or equivalent) in anesthesiology, adult critical care, pediatric critical care and cardiac care.

A minimum of eight (8) months must be spent on rotations in other disciplines, where residents may choose from: family medicine, general surgery, internal medicine, neurosciences, orthopedics, psychiatry (including crisis intervention), obstetrics/gynecology, pediatrics, plastic surgery, traumatology, and toxicology. An additional maximum of eight (8) months of additional training in the above activities may be completed.

FRCPC-EM residents must allocate a minimum of six (6) months to attain expertise in a scholarly activity or clinical area related to the EM specialty. Project activities, objectives, and goals must be approved by the resident's home program. Examples of potential areas of expertise include: education, clinical research, health care management, pre-hospital care, pediatrics, toxicology, and critical care.

In addition, four (4) months of the resident's training may be spent on elective activities.

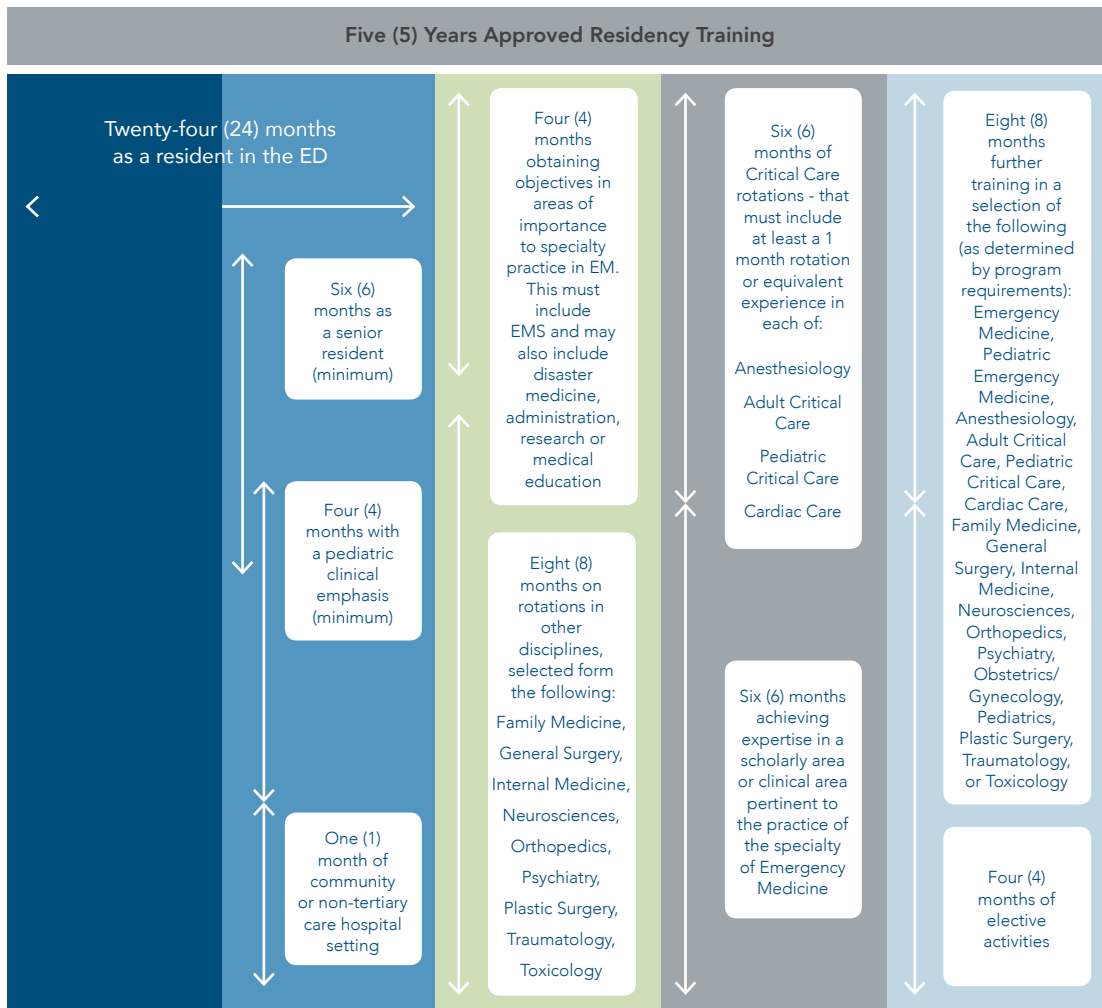
Certification

A physician who has successfully completed the five year Royal College accredited program in EM must undergo a series of regulated certification examinations and attain a pass standing. The resident must also produce a minimum of one scholarly project that is appropriate for publication in a peer-reviewed journal or presentation at a national academic meeting. After the completion of these requirements, the physician is granted a Specialist Certificate in Emergency Medicine by the Royal College (FRCPC).

After the completion of their residency training, some FRCPC-EM graduates elect to pursue continued advanced training in the form of a subspecialty (e.g., pediatric EM, toxicology) or area of focused competence (e.g. Clinician Educator).

All medical specialists certified by the Royal College are required to participate in a Maintenance of Certification Program which requires additional training in order to maintain their certification and their expertise within their specialty.

Figure 2: Components of the Royal College accredited residency training pathway in Emergency Medicine (summarizes content of the Royal College STR-EM)



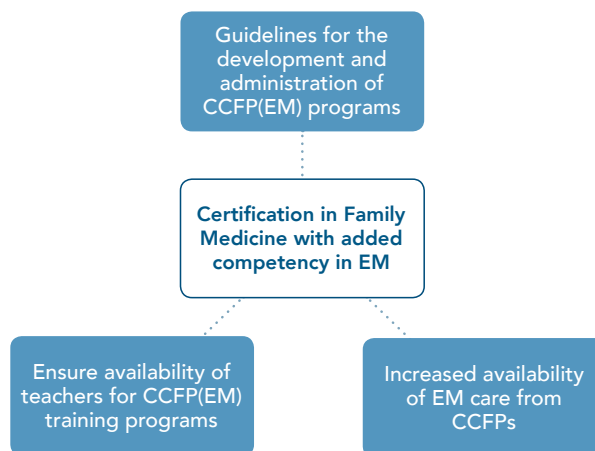
CCFP(EM) Program Training Pathway

Program goals

The program goals of the CCFP(EM) training pathway described in the Red Book do not focus on the individual physician but are instead conveyed at an overarching and systemic level, focusing on the improvement of emergency care standards and availability of care through establishing guidelines for the administration and teaching of CCFP(EM) training programs (Figure 3). More tangible practice goals for CCFP(EM) residents are developed by each training program.



Figure 3. Program goals of the CCFP(EM) program (outlined by the Red Book)

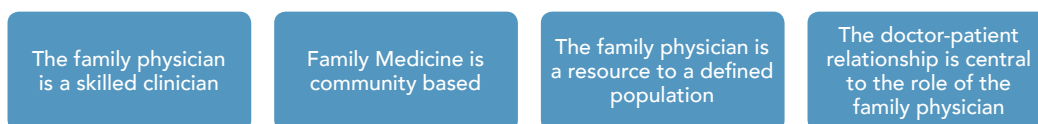



The goals of the certificate of CCFP(EM) training pathway are outlined by the CFPC:

1. To improve the standards and availability of emergency care from practicing family physicians.
2. To establish guidelines for the development and administration of training programs in Emergency Medicine for family physicians.
3. To ensure the availability of teachers for training programs in Family Medicine/ Emergency Medicine.

Objectives

According to the Red Book, all CFPC trained family physicians must have exposure to EM training during their residency. The CCFP(EM) program frames CCFP(EM) graduates as a family physician who acquires additional skills in EM in order to supplement their Family Medicine training and utilize their improved skill set within a community context to meet their social accountability mandate. Therefore, the objectives of CCFP(EM) training were developed to ground the EM practice of program graduates within the core concepts, cognitive, and affective skills of Family Medicine. In order to accomplish this blend of disciplines, the objectives for the CCFP(EM) certification are organized within the four principles of Family Medicine:





The objectives of training are listed under each principle of Family Medicine. The objectives are patient-centred and delineate a generalist skill base for EM practice. This includes skill areas such as: having an expert knowledge and skill set regarding a wide range of common health problems and conditions, the ability to manage the clinical care of patients, communicate with patients and their families effectively, understand the emergency medical services environment in relation to the community, demonstrate administrative capacity and leadership as a community and hospital-based resource, advocate for public policy that promotes the health of their patient population, and demonstrate an effective and patient-centred doctor-patient relationship.

Training pathway

As of 2016, a physician may be certified by the CFPC as a family physician with added competency in Emergency Medicine [CCFP(EM)] after the completion of medical school by undertaking a three (3) year integrated training program or a one (1) year residency training program, both options including a minimum of twelve (12) months curriculum in EM.

There are currently seventeen (17) accredited CCFP(EM) programs that are approved by the CFPC.

Completion of the current accredited CCFP(EM) residency training program includes a minimum of twelve (12) months of approved EM training (see Figure 4). Within this time allotment, the training program must include eight (8) additional months as a resident in the ED, with a minimum of six (6) months of training in the resident's third year. In addition, CCFP(EM) residents must complete two (2) months of training in emergency and/or critical care pediatrics (which may occur during the eight (8) months as a resident in the ED).

The Red Book also outlines the responsibility of faculties of medicine CCFP(EM) programs to establish a "formal teaching program in emergency medicine" that provides residents to take part in learning opportunities such as clinical teaching, seminars, formal rounds in order to achieve the program objectives. Residents in CCFP(EM) programs are also to be provided with opportunities to interact with community organizations and services that deliver emergency medical care outside of the hospital environment.

In addition, the Red Book calls upon CCFP(EM) programs for an appropriate evaluation structure that is consistent with national B standards. Finally, the Red Book brings forward the responsibility of CCFP(EM) programs to provide "an educational environment which facilitates and encourages residents to maintain an ongoing responsibility in a family practice setting" throughout their time in the EM training.

Certification

Residency-eligible candidates

In order to receive a certificate of special competence in EM from the CFPC, a CCFP(EM) resident must hold a certification in Family Medicine and be an active member of the CFPC. CCFP(EM) residents must successfully complete thirty-six (36) months of postgraduate training in Family Medicine and EM in an accredited CFPC program.



Prior to participating in certification examinations, the resident must have completed at least nine (9) of the twelve (12) months of EM training (or have no more than three (3) months of training to complete).

Upon the confirmation of the successful completion of all educational requirements by the postgraduate dean and the postgraduate EM program director of the Department of Family Medicine, the physician is granted a Certificate of Special Competence in Emergency Medicine by the CFPC.

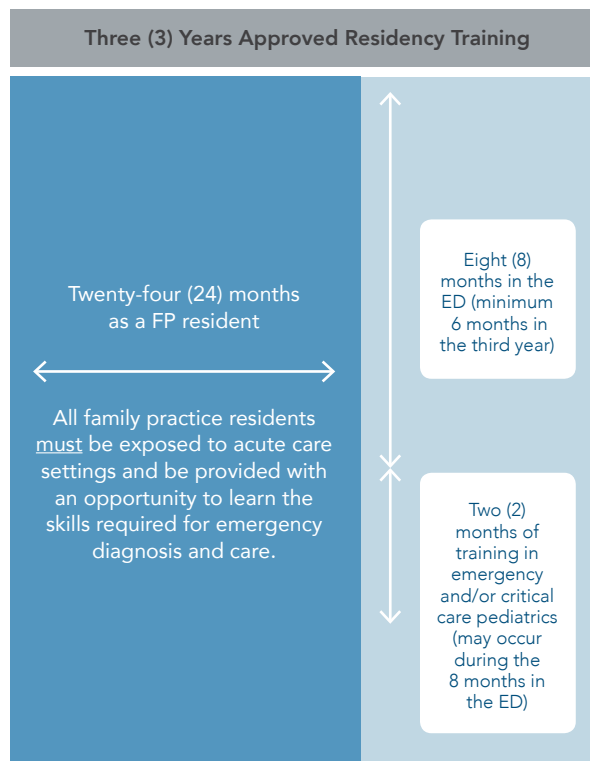
Practice-eligible candidates

All practice eligible candidates must hold an active certification of Family Medicine with the CFPC. The physician must practice a minimum of 400 hours of EM practice per year for the four (4) years (with the most recent two years of emergency practice having taken place in Canada) prior to the application date and must possess competencies in procedural skills related to EM, including cardiac and trauma life support, and have this documented by the director of their hospital ED or their medical staff superior.¹

Continuing professional development

All family physicians certified by the CFPC are required to maintain and advance their knowledge in medicine and health care delivery. Graduates must participate in continuing professional development (CPD) activities in order to remain current in their field of practice. Graduates' CPD must include education in EM for ongoing use of the designation.

Figure 4:
Components of the CFPC
accredited residency
training pathway
in Emergency Medicine





Implications of Comparison

In comparing the FRCPC-EM and CCFP(EM) training pathways, it is essential to consider the limitations of comparing programs with significant differences in their foundations of training and intended practice routes of graduates. The following comparison is mindful of the basis of these dissimilarities, while also highlighting key elements of training shared by both programs that are essential to EM practice.

Classification of physicians working in Emergency Medicine

A fundamental difference between the two program streams is the framing of the physicians being trained: the EM specialist (FRCPC-EM) and the family physician with enhanced competency in EM [CCFP(EM)].

As previously outlined, the FRCPC-EM training pathway frames program graduates as EM specialists, operating as consultants with a high level of specialized clinical knowledge and skill. In comparison, the CCFP(EM) training pathway frames program graduates as family physicians with an expanded skill set in EM, as a complement to their comprehensive Family Medicine training and an important resource for EDs requiring physician coverage. The FRCPC-EM graduate's envisioned practice is informed and operates within a comprehensive background in EM, whereas the CCFP(EM) physician is envisioned to utilize their enhanced skills in EM while operating through the patient and community oriented lens of Family Medicine.


The contrast between these classifications highlights the intent for practice and is ultimately reflected in the divergent program goals, objectives, and components of training necessary to produce competent physicians at varying contexts of practice.

Program goals, objectives, and components of training

Both the FRCPC-EM and CCFP(EM) programs strive to create competent physicians working in EM, but ascribe different purposes for the role of their program graduates within the ED.

The program goals of the two training routes are targeted at different areas of the healthcare system. The goals of the FRCPC-EM training route are highly tailored to an EM specialist's individual practice, outlining specific roles and responsibilities of a physician specialized in EM. In contrast, the goals of the CCFP(EM) training route are conveyed at a system level, aimed at establishing guidelines for the teaching of CCFP(EM) training programs and motivated by increasing availability and improving standards of emergency care.

The objectives of training of both streams were developed in order to provide program graduates with the core cognitive and procedural skills necessary to practice in EDs of differing contexts. In alignment with the context of practice of an EM specialist, the FRCPC-EM objectives of training are delineated as a specialized set of specific skills, procedures and concepts fundamental to specialist practice. The objectives are thematically organized within the seven Royal College CanMEDS roles, and integrated under the specialist role of 'Medical Expert'. In comparison, the CCFP(EM) objectives of training are framed within the principles of Family Medicine and describe an enhanced generalist set of skills that augment a family physician's practice in the ED.



Not surprisingly, the components of training are reflective of the differences between the intents of the FRCPC-EM and CCFP(EM) programs. Arising from the specialized and detailed objectives of training, the FRCPC-EM training pathway is significantly longer, requiring five (5) years of approved residency training in EM with a minimum of twenty-four (24) months spent as a resident in an ED. In contrast, the CCFP(EM) program requires three (3) years of approved residency training, the first two in Family Medicine training and the third with a focus in EM of which a minimum of eight (8) months must be spent in an ED. Both programs include pediatrics, with the FRCPC-EM residents attending mandatory rotations in both pediatric emergency care (4 months minimum) and critical care (1 month minimum) and CCFP(EM) residents attending a rotation focusing on pediatric EM and/or critical care (2 months). Beyond this, the length of the FRCPC-EM program requires residents to be exposed to several other rotations related to EM (Figure 2), advancing their preparation for the practice of EM, particularly in tertiary care centres. While some CCFP(EM) residents may be exposed to additional components of training (e.g., a CCFP(EM) resident who wishes to pursue an academic project may be provided the support to do so), these additional training opportunities are not outlined by the CFPC as mandatory components of training and therefore do not apply to all CCFP(EM) program curricula and their trainees.

Variability of programs

The FRCPC-EM training pathway outlined by the Royal College is explicitly structured and is delineated with a high level of detail regarding the expected components of training and competencies of graduating physicians. The degree of structure provided by the STR-EM and OTR-EM leaves limited room for variance between FRCPC-EM programs for the incorporation of components of training and associated competencies, though the structure provides some flexibility for a variety of approaches to meet these common education goals.

In comparison, the CCFP(EM) training pathway outlined by the CFPC delineates a generalist-focused high-level list of competencies to be achieved by a family physician practicing EM. This list of competencies acts as guiding document for CCFP(EM) programs at Canadian universities to develop the CCFP(EM) curriculum suitable for their own environments (in particular rural versus urban focused programs). The high level nature of the Red Book's standards for the CCFP(EM) program allows for the provision of context driven training targeting a social accountability mandate. While this potential avenue for variability between programs is arguably useful for environments with varying needs, it may result in increased variability between program graduates.

CITATIONS

1 CFPC, 2016

Results Overview



CAEP Definitions and Statements


Over the past two years, and completely independent of the CWG-EM initiative, CAEP has gone through a process of development, member input, and Board ratification to create definitions and statements relevant to EM in Canada. These were recently finalized and include definitions of “Emergency Medicine” and an “Emergency Physician”, and statements on the “Importance of Emergency Medicine Certification in Canada” and on “Emergency Medicine Specialists in Canada”. This material is available at the following URL: www.caep.ca/resources/caep-resources/position-statement-emergency-medicine-definitions.

Communication with University Postgraduate Deans of Medical Education

On September 16, 2014, the CWG-EM Chair distributed an email to all 17 Canadian Postgraduate Deans of Medical Education (PG Deans), requesting their perspectives on the existence of the two independent training streams for EM certification in Canada. The CWG-EM received 7 responses that assisted in appreciating the current climate surrounding the two training streams at postgraduate institutions.

The following summarizes the high-level awareness of issues facing the EM community and the recommendations made by this group.

1. Appreciation of the current provision of care in Canada by certificant type (CCFP, CCFP(EM), FRCPC-EM) and ED setting, as well as the unique skill sets of each group.
2. Reflections on the current approach to EM training and certification brought forward the notion that while the current system serves the Canadian community, there are still concerns with the present dual college, dual certification approach.
3. The current issue regarding the two certification routes requires clearly delineated roles and scopes of practice for each EM certificant type.
4. The lengths of the two programs should be reviewed.
 - a. CCFP(EM): A three year program with the first two years focused on Family Medicine has limited the breadth of experiences that can prepare trainees for EM practice to the third year of training.

- 
- b. FRCPC-EM: The program includes significant time focused on academic enrichment. For those not wishing to pursue this area, the clinical training program could be completed more efficiently in a four year program.
 - c. There is currently no program available for those wanting to practice full-time EM without an academic focus.
5. The need for a greater number of EM trained physicians in the workforce is critical. There was concern from the PG Deans regarding the reduction of training positions in EM, and the assumptions of many funding bodies considering all types of emergency physicians to be functionally the same, without acknowledgement of the distinctions between CCFP(EM) and FRCPC-EM trained physicians.
 6. Acknowledgement that differences in skill set and competence can be apparent between the two streams when graduates from the CCFP(EM) and FRCPC-EM initially enter practice, with the recognition that additional learning and development of competencies can occur in practice, and differences upon graduation often disappear over time.
 7. Voiced support of the shift to Competency Based Medical Education (CBME) by both colleges, regarded as the “next evolution in education for EM”.
 8. Recommendation for a collaborative approach between the CFPC and the Royal College to produce core foundational competencies for physicians practicing EM.

“

I would favour a training approach that recognized and addressed core competencies that all physicians intending to practice emergency medicine should possess, and that also provided additional, enhanced training to those requiring it (e.g., in research methods, leadership, administration, or specialized areas of emergency medicine). ... This approach would require a greater level of collaboration and flexibility between the two colleges than has historically existed.

”

– Statement by Participating Postgraduate Dean

CAPER Data: Total post-M.D. Emergency Medicine Trainees, 2010 – 2015

Since 1989, the Canadian Post-M.D. Education Registry (CAPER) has collected and housed statistical information on postgraduate medical education from all 17 faculties of medicine in Canada.¹ The following data was collected by CAPER.

Figure 5 illustrates the total number of Post-M.D. trainees in Emergency Medicine from 2010/11 to 2014/15. Caper data from the 2014/15 training period indicates that 522 Post-M.D. trainees (137 PGY-3 CCFP(EM), 385 FRCPC-EM) were being trained in EM during this time.



The CAPER data illustrates an upward trend in the total number of FRCPC-EM trainees, increasing by nearly one hundred (100) training positions across all 5 years of the program from 2010/11 to 2014/15. The number of CCFP(EM) training positions has fluctuated up and down over the past five years, ranging from 121 (2011/12) to 139 (2013/14) trainees participating in the 1 year of the program.

An examination of CAPER data for EM trainees in their final year of training (FRCPC-EM: PGY-5/6, CCFP(EM): PGY-3) indicates that approximately 66 FRCPC-EM residents and 137 CCFP(EM) residents were graduated as physicians with an EM certification after the 2014/15 training year (Figure 6).

Figure 5: Total post-M.D. trainees in Emergency Medicine (2010/11 – 2014/15)

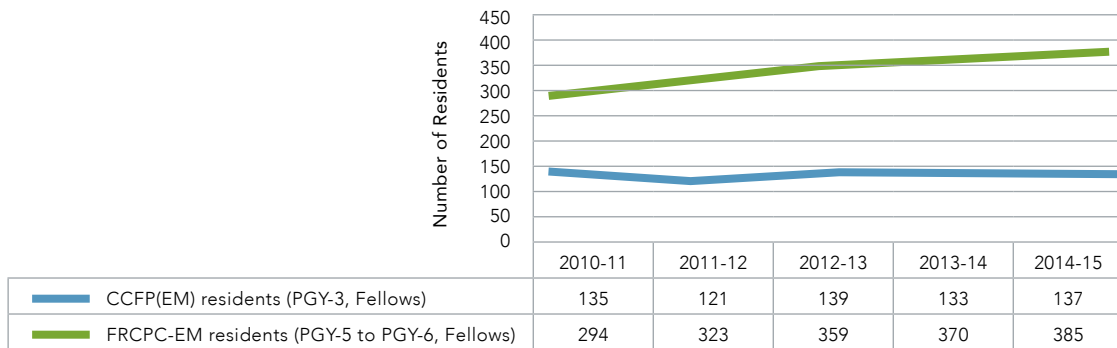
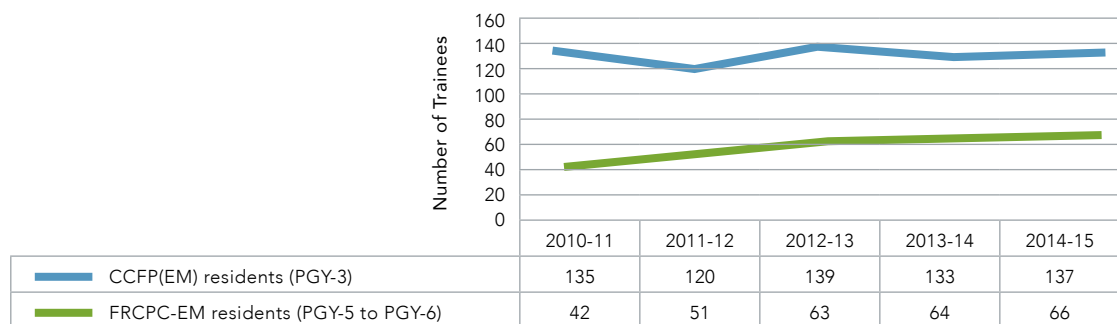


Figure 6: Total post-M.D. trainees in Emergency Medicine – final year of training (2010/11 – 2014/15)





Results from the CWG-EM National Survey of Emergency Medicine

The CWG-EM conducted a national survey about EM training and HHR needs in Canada in the summer of 2015.

Invitations and targeted surveys were sent to four groups:

- 3,536 physicians with an EM certification (CCFP(EM), FRCPC-EM, and dual certificants holding both certifications) (39.7% response rate)
- 2924* CCFP certified physicians who indicated they had an interest or activity in EM practice on their CFPC annual membership renewal form, but who did not hold a CCFP(EM) certification (9.0% response rate)[†]
- 513[‡] CCFP(EM) and FRCPC-EM residents (49.3% response rate), and
- 398[§] Emergency Department Chiefs (38.9% response rate).

The findings from the CWG-EM national survey focused on:

- The current context of EM and the practice profiles of survey respondents;
- Current and ideal physician distribution and coverage needs in Canadian EDs, as well as anticipated changes in future ED patient volumes;
- Respondent perceptions of the current stated purpose and goals of EM training routes and their alignment to the EM practice of program graduates;
- Reflections on the dual college, dual certification approach to EM training and provision of care in Canada.

Survey completion information and key demographics of respondents are highlighted in Table 1 to provide context for the participants and their responses.

* Undeliverables have been removed.

† The analysis of CCFP respondent data only included those who currently practiced EM

‡ Undeliverables have been removed.

§ Includes recipients who were potentially forwarded the link to the survey.

Table 1a: Demographics of respondents to the national survey by respondent group

| | | Invited Participants | Survey Response Rate | Mean Age (years) | Gender Breakdown | Mean Year of Most Recent Certification |
|----------------------------------|--------------------|----------------------|----------------------|------------------|----------------------------|--|
| Physicians with EM Certification | CCFP(EM) | 2693 | 34.5% | 44 | 65.6% Male 34.4% Female | 2004 |
| | FRCPC-EM | 843 | 49.0% | 43 | 66.3% Male 33.7% Female | 2003 |
| | Dual Certificants* | - | - | 57 | 88.6% Male 11.4% Female | 1994 |
| EM Residents | CCFP(EM) | 134 | 49.3% | 31 | 62.1% Male 37.9% Female | - |
| | FRCPC-EM | 379 | 49.3% | 30 | 55.9% Male 44.1% Female | - |
| CCFP (non-EM) Physicians | | 2924 | 9.0% | 42 | 63.2% Male 36.8% Female | - |
| ED Chiefs | | 398 | 38.9% | - | - | - |

* Dual certificants included in the CCFP(EM) and FRCPC-EM invitations, therefore a response rate for this group is not included.

Table 1b: Province of residence of respondents to the national survey by respondent group

| | | BC | AB | SK | MB | ON | QC | NB | PEI | NS | NL | NT | NU | YT |
|----------------------------------|-------------------|------|------|------|------|------|------|------|------|------|------|------|------|-----|
| Physicians with EM Certification | Frequency | 276 | 169 | 32 | 26 | 558 | 235 | 14 | 6 | 54 | 16 | 2 | 1 | 0 |
| | Percent | 19.8 | 12.2 | 2.3 | 1.9 | 40.2 | 16.9 | 1.0 | 0.4 | 3.9 | 1.2 | 0.1 | 0.1 | 0.0 |
| | Response Rate (%) | 43.9 | 38.5 | 46.4 | 26.5 | 36.5 | 42.3 | 26.9 | 40.0 | 42.5 | 40.0 | 22.2 | 50.0 | 0.0 |
| EM Residents | Frequency | 19 | 33 | 14 | 11 | 120 | 39 | 11 | | 3 | - | - | - | |
| | Percent | 7.6 | 13.2 | 5.6 | 4.4 | 48.0 | 15.6 | 4.4 | | 1.2 | - | - | - | |
| | Response Rate (%) | 36.5 | 38.4 | 73.7 | 40.7 | 55.5 | 32.0 | 38.0 | | 75.0 | - | - | - | |
| CCFP (non-EM) Physicians | Frequency | 21 | 15 | 4 | 12 | 59 | 25 | 7 | 1 | 5 | 3 | 0 | 0 | 1 |
| | Percent | 13.7 | 9.8 | 2.6 | 7.8 | 38.6 | 16.3 | 4.6 | 0.7 | 3.3 | 2.0 | 0.0 | 0.0 | 0.7 |
| ED Chiefs | Frequency | 17 | 14 | 6 | 8 | 38 | 42 | 3 | 1 | 7 | 16 | 0 | 0 | 1 |
| | Percent | 11.1 | 9.2 | 3.9 | 5.2 | 24.8 | 27.5 | 2.0 | 0.7 | 4.6 | 10.3 | 0.0 | 0.0 | 0.7 |

Practice Profiles of Physicians with an EM Certification

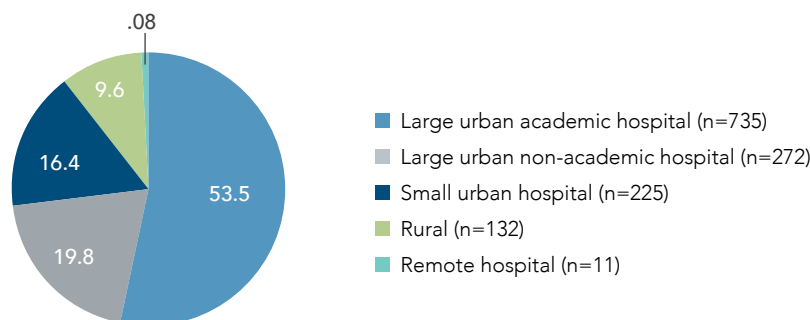
- The primary practice settings for physicians with an EM certification are typically large and small urban settings.

In order to reflect the unique circumstances and needs of the different Canadian contexts where EM is practiced, ED settings were classified into five environments based on patient volumes before the survey was distributed to respondent groups. The respondents were asked to indicate which of the following best described their own ED:

- i. large urban academic
- ii. large urban non-academic
- iii. small urban
- iv. rural
- v. remote

The majority (53.5%) of all EM certified physicians surveyed indicated that their primary setting for EM practice was in large urban academic settings (Figure 7).*

Figure 7: Emergency department settings of physicians with an EM certification (%)



- FRCPC-EM and dual certificants almost exclusively practice EM in large urban academic settings, while the primary practice settings of CCFP(EM) certificants are more varied across large and small urban settings.

As illustrated by Figure 8, the majority (82.8%) of FRCPC-EM certificants indicated that their primary EM practice occurred in large urban academic hospitals.† Similarly, the majority (71.7%) of physicians with dual certification indicated that their primary practice location was also in large urban academic hospitals. The primary practice settings indicated by CCFP(EM) certificants demonstrated more variation within the group. Finally, no FRCPC-EM or dual certificants indicated practicing in a remote hospital.

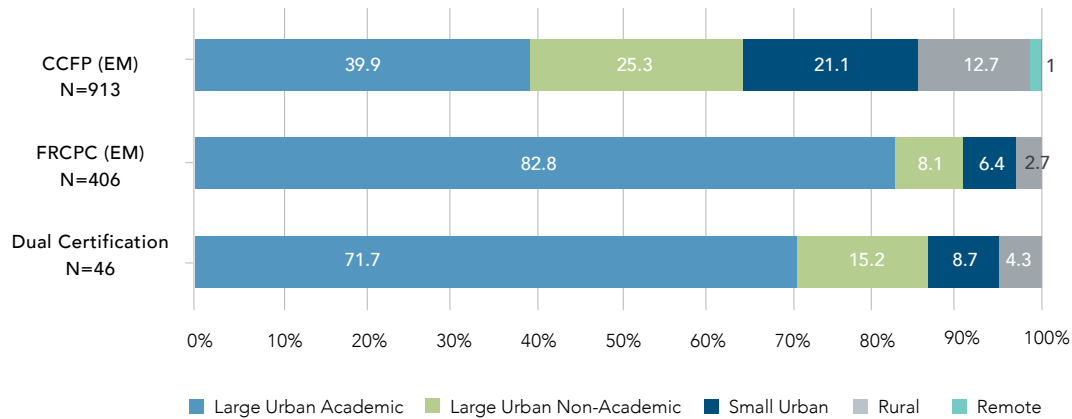
* These findings are consistent with the reports provided by ED Chiefs. The distribution of physicians reported by ED Chiefs indicate that physicians with an EM certification make up the majority of practicing physicians in large urban academic (73.3%) and large urban non-academic (67.3%) ED settings.

† These findings are consistent with the reports provided by ED Chiefs.



The primary practice settings indicated by CCFP(EM) certificants demonstrated more variation within the group. Finally, no FRCPC-EM or dual certificants indicated practicing in a remote hospital.

Figure 8: Emergency department settings of physicians with an EM certification (by certificant type)



➤ **EM takes up a significant proportion of the clinical practice distribution of physicians with an EM certification.**

Respondents with an EM certification were asked to indicate the current distribution of their work time and clinical practice across such areas as EM, Family Medicine, Critical Care, Sports Medicine, Trauma Care, and other activities.

As per Table 2, across certificant type and ED settings, the majority of clinical practice of physicians with an EM certification was spent practicing EM. The clinical practice distribution of EM was highest in large urban academic (CCFP(EM): 91%, FRCPC-EM: 91%) and large urban non-academic (CCFP(EM): 89%, FRCPC-EM: 87%) settings and lowest in remote settings (CCFP(EM): 59%*).

➤ **The proportion of CCFP(EM) certificants with a component of Family Medicine in their practice is extremely low across all ED settings.**

The percentage allocation of clinical practice to Family Medicine by CCFP(EM) certificants was low across ED settings, ranging from 3 – 36% (Table 2). CCFP(EM) certificants were most likely to practice Family Medicine in rural (18%) or remote settings (36%) and least likely to practice Family Medicine in large urban academic settings (3%). Survey data indicated that the proportion of CCFP(EM) respondents who did not practice Family Medicine were as follows:

- Large Urban Academic Hospital: 90%
- Large Urban Non-Academic Hospital: 86%
- Small Urban Hospital: 71%
- Rural Hospital: 65%
- Remote Hospital: 22%

* There were no respondents from the FRCPC-EM program who indicated they worked in a remote setting (n=0).

Table 2: Distribution of practice by certificant type and ED setting*

| | | | Large Urban Academic | Large Urban Non-Academic | Small Urban | Rural | Remote† | |
|--------------------------------|--------------------------------|---------------------------|----------------------|--------------------------|-------------|-------|---------|---|
| CCFP (EM) | Distribution of work time | 100% Clinical | 9% | 29% | 30% | 29% | 33% | |
| | | Blended practice | 91% | 71% | 70% | 71% | 67% | |
| | Blended practice distribution | Clinical Medicine | 74% | 80% | 84% | 85% | 85% | |
| | | Administrative | 11% | 12% | 8% | 10% | 11% | |
| | | Research | 4% | 1% | 1% | 1% | 1% | |
| | | Teaching‡ | 8% | 4% | 4% | 3% | 3% | |
| | | Other | 3% | 3% | 3% | 1% | 1% | |
| | Clinical practice distribution | Emergency Medicine | 91% | 89% | 82% | 75% | 59% | |
| | | Family Medicine | 3% | 4% | 9% | 18% | 36% | |
| | | Critical Care | 1% | 1% | 0% | 2% | 2% | |
| | | Sports Medicine | 0% | 1% | 0% | 1% | 0% | |
| | | Trauma Care | 1% | 1% | 1% | 0% | 1% | |
| | | Other§ | 4% | 5% | 8% | 5% | 3% | |
| | FRCPC-EM | Distribution of work time | 100% Clinical | 9% | 39% | 19% | 18% | - |
| | | | Blended practice | 91% | 61% | 81% | 82% | - |
| Blended practice distribution | | Clinical Medicine | 70% | 74% | 72% | 61% | - | |
| | | Administrative | 13% | 12% | 18% | 10% | - | |
| | | Research | 8% | 3% | 1% | 4% | - | |
| | | Teaching** | 7% | 3% | 4% | 7% | - | |
| | | Other | 2% | 8% | 5% | 18% | - | |
| Clinical practice distribution | | Emergency Medicine | 91% | 87% | 84% | 66% | - | |
| | | Family Medicine | 0% | 0% | 2% | 17% | - | |
| | | Critical Care | 3% | 2% | 2% | 0% | - | |
| | | Sports Medicine | 1% | 1% | 0% | 11% | - | |
| | | Trauma Care | 1% | 1% | 0% | 0% | - | |
| | | Other†† | 4% | 9% | 12% | 6% | - | |

* Dual certificants are excluded from the information displayed in Table 2.

† The numbers of FRCPC-EM respondents from remote ED settings were too small to report the above distributions.

‡ Outside of clinical medicine.

§ Examples of "other" clinical practice distribution areas of CCFP(EM) respondents include: consulting, transport medicine, medico-legal, FP anesthesia, chronic pain medicine, addiction medicine, clinical teaching, quality improvement, walk in clinics/urgent care, academic work, hospitalist medicine.

** Outside of clinical medicine.

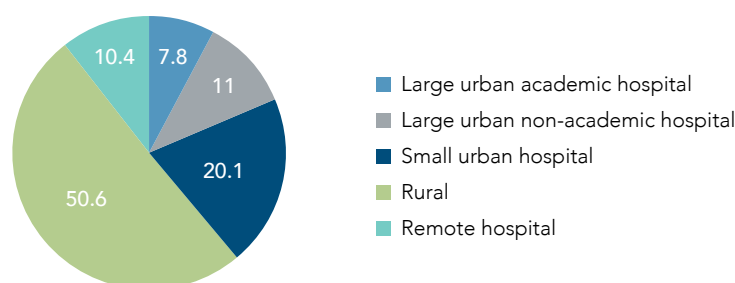
†† Examples of "other" clinical practice distribution areas of the FRCPC-EM respondents include: consulting, toxicology, pediatric EM, transport medicine, academic work, pain medicine, palliative care, medico-legal, quality improvement.

Practice Profile of CCFP Physicians Practicing Emergency Medicine*

> CCFP (non-EM) physicians who currently practice EM are most likely to practice in rural settings

As illustrated by Figure 9, survey data collected from respondents demonstrated that CCFP physicians who currently practiced EM were most likely to practice in a rural hospital setting[†].

Figure 9: Emergency department practice settings of CCFP physicians (%)



> CCFP (non-EM) physicians were more likely to devote a higher percentage of their clinical practice to Family Medicine in comparison to CCFP(EM) certificants

On average, CCFP participants devoted 47.9% of their clinical practice to EM and 39.6% to Family Medicine. The proportion of EM practiced tended to decrease with the size of the ED, whereas the proportion of Family Medicine practiced increased as the size of ED decreased.

Anticipated Practice Profiles of Emergency Medicine Residents

Survey data for EM residents was collected from both the FRCPC-EM and CCFP(EM) training programs. The response rate for the two programs was equivalent (49.3% for both). The majority of participants (73.9%) were from the FRCPC-EM program which is reflective of the higher number of FRCPC-EM residents in years PGY-1 to PGY-5, in comparison to the resident respondents taken from the CCFP(EM) PGY-3 year of training. FRCPC-EM resident respondents were evenly distributed across the PGY 1 – PGY 5 training years. Understandably, the majority (97.0%) of CCFP(EM) resident respondents were undertaking their PGY 3 training year in EM when participating in the survey.

* Survey data for CCFP physicians was collected from 256 respondents. 155 (61%) of CCFP survey participants indicated that they currently practice EM. The remainder of the report only includes the data from these 155 respondents when referring to data collected from CCFP certificants.

† Information provided by ED Chief respondents was consistent with this finding and indicated that CCFP physicians make up a larger portion of ED staff coverage in remote (92.0%) and rural (76.3%) ED settings.

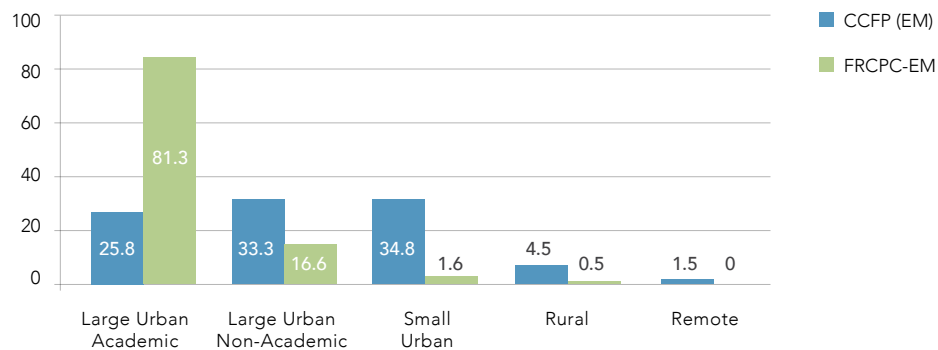


➤ The majority of EM residents desire future practice in an urban setting.

Almost two thirds (66.8%) of EM residents across both training routes reported that they would like to work in a large urban academic hospital following the completion of their residency training.

In comparing the intended practice setting of residents from the two program routes, the majority of FRCPC-EM residents reported that their preferred future work setting was in a large urban academic hospital. The preferred work setting for CCFP(EM) residents was mostly distributed across the three types of urban hospitals. A small percentage of resident respondents from both groups indicated a desire to work in rural settings (Figure 10).

Figure 10: Desired future practice locations of EM residents (%)



➤ The majority of EM residents expect to have a blended practice, with the majority of that time to be devoted to clinical medicine.

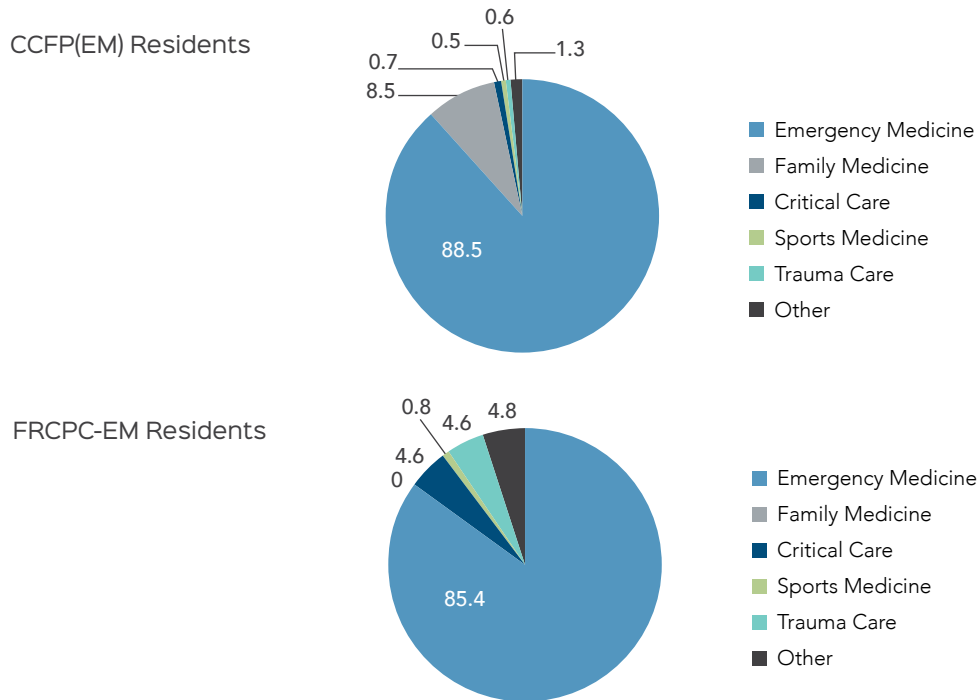
In regards to structure of work, the majority of respondents (80.3% of CCFP(EM) and 100% of FRCPC-EM) anticipated having a blended practice, meaning that they planned to spend at least some portion of their work time outside of clinical medicine. On average, participants from the CCFP(EM) program estimated that 82.5% of their work time would be devoted to clinical medicine, whereas, on average, participants from the FRCPC-EM program estimated that 68.5% of their work time would be devoted to clinical medicine.

➤ EM residents from both training routes anticipate that EM will make up the majority of their clinical practice, with a small percentage of time allocated to Family Medicine by CCFP(EM) residents.

Residents were asked to provide a breakdown of their anticipated clinical practice following certification (Figure 11). CCFP(EM) residents anticipated spending an average of 88.5% practicing EM and 8.5% practicing Family Medicine. FRCPC-EM residents estimated spending 85.4% of their clinical work practicing EM and 0.0% practicing Family Medicine, while devoting additional time to critical (4.6%) and trauma (4.6%) care.



Figure 11: Anticipated breakdown of clinical practice of EM residents (%)



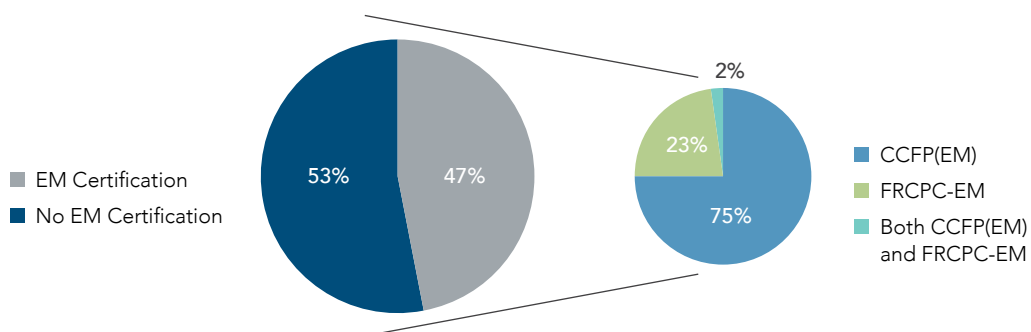
Leadership Profile of Emergency Department Chiefs

Survey data for ED Chiefs was collected from 155 respondents from EDs across Canada. Approximately one third (32.9%) of respondents described their ED as a large urban academic hospital, followed by rural (30.3%), large urban non-academic (17.1%), small urban (14.5%), and remote hospitals (5.3%). Types of patients seen by the EDs of respondents included combined adults and pediatrics (86.8%), adults only (10.5%), and pediatrics only (2.6%) settings.

➤ **Less than half of ED Chiefs respondents held an EM certification, and those with an EM certification were most likely to be CCFP(EM) trained.**

When asked if they held a Canadian EM certification, 47.4% of ED Chief respondents indicated they were certified in EM. Of those who were certified in EM, 75.3% of respondents were CCFP(EM) certified, 23.3% were FRCPC-EM certified, and 1.4% held both certifications (Figure 12). As the majority of ED Chiefs who responded to the CWG-EM survey were from smaller ED sites where chiefs without an EM certification are more common, the representation is very skewed. This limitation means that hospital category specific determinations (such as approaches at a tertiary urban centre) should take this into account and may be appropriate in choosing to focus on feedback only from ED Chiefs at such settings.

Figure 12: Canadian Emergency Medicine certifications of ED Chiefs (%)



➤ ED Chief roles in small urban, rural, and remote hospital settings were most likely to be filled by physicians with no EM certification.

ED Chiefs with a FRCPC-EM certification were most likely to take a leadership (ED Chief) role in large urban academic settings, with 82.4% of FRCPC-EM certified respondents identifying this setting as the best description of their ED setting (Table 3). ED Chiefs with a CCFP(EM) certification were similarly more likely to fulfill their role in a large urban setting, in both academic (35.8%) and non-academic (30.2%) hospitals (Table 3). In small urban, rural, and remote ED settings, ED Chief roles were most likely to be filled by physicians with no EM certification (Table 4).

Table 3: Subgroup analysis – ED setting by certification of ED Chiefs

ED Setting by Certification

| | Large Urban Academic | Large Urban Non-Academic | Small Urban | Rural | Remote | Total |
|---|----------------------|--------------------------|-------------|------------|-----------|-------|
| CCFP(EM) | 19 (35.8%) | 16 (30.2%) | 8 (15.1%) | 10 (18.9%) | 0 (0.0%) | 53 |
| FRCPC-EM | 14 (82.4%) | 2 (11.8%) | 0 (0.0%) | 1 (5.9%) | 0 (0.0%) | 17 |
| Both CCFP(EM) and FRCPC-EM Certifications | 1 (100.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 1 |
| No EM Certification | 16 (20.0%) | 8 (10.0%) | 13 (16.3%) | 35 (43.8%) | 8 (10.0%) | 80 |



Table 4: Subgroup analysis – certification of ED Chiefs by ED setting

Certification by ED setting

| | Large Urban Academic | Large Urban Non-Academic | Small Urban | Rural | Remote |
|---|----------------------|--------------------------|-------------|------------|----------|
| CCFP(EM) | 19 (38.0%) | 16 (61.5%) | 8 (38.1%) | 10 (21.7%) | 0 (0.0%) |
| FRCPC-EM | 14 (28.0%) | 2 (7.7%) | 0 (0.0%) | 1 (2.2%) | 0 (0.0%) |
| Both CCFP(EM) and FRCPC-EM Certifications | 1 (2.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| No EM Certification | 16* (32.0%) | 8 (30.8%) | 13 (61.9%) | 35 (76.1%) | 8 (100%) |
| Total | 50 | 26 | 21 | 46 | 8 |

Physician Distribution and Staffing Needs in Canadian Emergency Departments

The following section is informed by data collected from ED Chief respondents. Information collected was separated and examined by ED setting in order to reflect the unique circumstances and needs of the different Canadian contexts where EM is practiced.

➤ Current physician staffing needs are not fully covered in any ED setting type.

Responses from ED Chiefs indicated that no ED setting type, on average, had full physician coverage. More specifically:

| | |
|--------------------------|--|
| Large Urban Academic | <ul style="list-style-type: none"> • 38.9% indicated that their staffing needs were not fully covered • On average, 11.3 hours coverage/day/ED short |
| Large Urban Non-Academic | <ul style="list-style-type: none"> • 45.0% indicated that their staffing needs were not fully covered • On average, 15.4 hours coverage/day/ED short |
| Small Urban | <ul style="list-style-type: none"> • 50.0% indicated that their staffing needs were not fully covered • On average, 5.5 hours coverage/day/ED short |
| Rural | <ul style="list-style-type: none"> • 41.7% indicated that their staffing needs were not fully covered • On average, 6.4 hours coverage/day/ED short |
| Remote | <ul style="list-style-type: none"> • 62.5% indicated that their staffing needs were not fully covered • On average, 5.2 hours coverage/day/ED short |

➤ The majority of ED Chiefs anticipate an increase in annual patient volume and a critical staffing shortage.

* 68.8% of large urban academic respondents with no EM certification were from Québec, therefore the results cannot be generalized to the entire country of Canada.



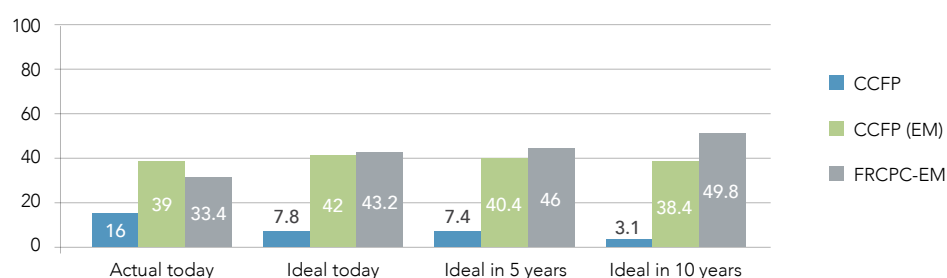
The majority of ED Chiefs in most settings (excluding remote hospitals) anticipated an increase in ED patient volume in the next five and ten years. The anticipated increase in patient volume by the majority of ED Chief respondents paired with the current shortfalls in staffing coverage, indicates the potential of worsening future staffing coverage issues in an already under resourced discipline of EM practice.

➤ Overall, all ED settings want to incorporate an increased number of Emergency Medicine trained physicians into their EDs over the next 5 – 10 years.

In connection to the current distributions of physicians practicing EM (physicians with an EM certification are more likely to practice in large urban and small urban settings whereas CCFP physicians make up the majority of staff coverage in remote and rural settings), ED Chief respondents were also asked to comment on the ideal mix of physicians currently, in five years, and in ten years' time (Figure 13). Overall, information provided by the total population of ED Chief respondents indicated the desire for an increased proportion of physicians who are certified in EM.

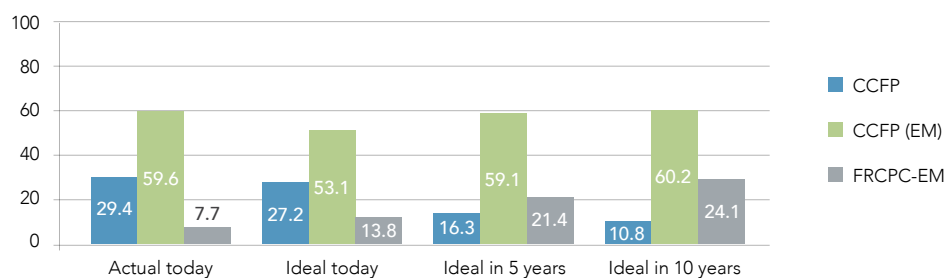
Figure 13: Ideal distributions of physicians (mean %) by emergency department setting as reported by ED Chiefs

Large Urban Academic Hospital (N=50)



Compared to current physicians distributions, ED Chiefs from large urban academic settings want fewer CCFP, approximately the same number of CCFP(EM), and an increased number of FRCPC-EM physicians in the next 10 years.

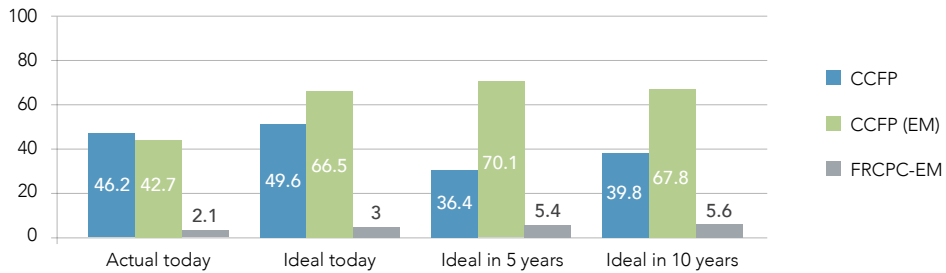
Large Urban Non-Academic Hospital (N=26)



Compared to current physicians distributions, ED Chiefs from large urban non-academic settings want fewer CCFP, approximately the same number of CCFP(EM), and an increased number of FRCPC-EM physicians in the next 10 years.

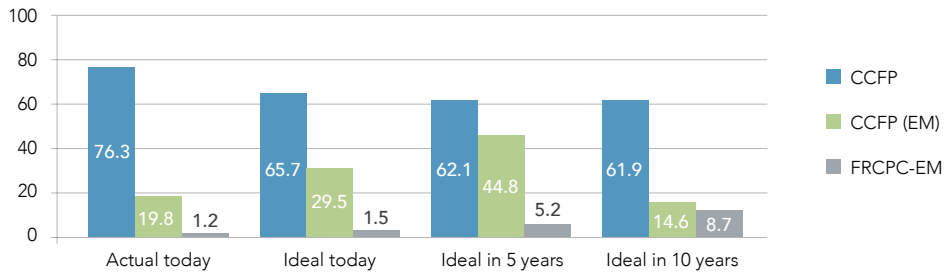


Small Urban Hospital (N=22)



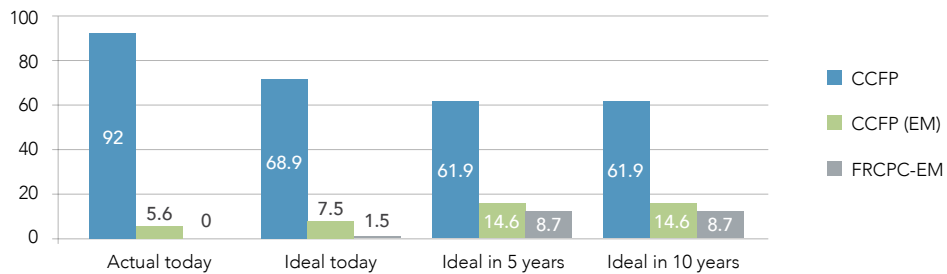
Compared to current physicians distributions, ED Chiefs from small urban settings want an increased number of CCFP, CCFP(EM), and FRCPC-EM physicians in the next 10 years.

Rural Hospital (N=46)



Compared to current physicians distributions, ED Chiefs from rural settings want fewer CCFP, a decreased number of CCFP(EM), and an increased number of FRCPC-EM physicians in the next 10 years. Note: the number of CCFP(EM) physicians was ideally increased in 5 years by ED Chiefs from this setting.

Remote Hospital (N=8)



Compared to current physicians distributions, ED Chiefs from remote settings want fewer CCFP, as well as an increased number of CCFP(EM) and FRCPC-EM physicians in the next 10 years.



Reflection of the Purpose, Goals, and Program Statements of the CCFP, CCFP(EM), and FRCPC-EM training Programs

Respondents from all four survey groups were asked to review the purpose statements of the CCFP, CCFP(EM), and FRCPC-EM certification programs and to reflect on the effectiveness of the two colleges hosting these programs in achieving stated training program goals.

The College of Family Physicians of Canada has defined the purpose, goals and product of its CCFP and CCFP(EM) program as the following:

The College of Family Physicians of Canada residency programs are dedicated to training family physicians to provide emergency care directly to all patients of all ages, with any presenting problem, at any time, and in any community in Canada. At the core family medicine training level (CCFP), this objective is part of comprehensive training. New certificants are expected to provide emergency care commensurate with the needs of their practice community, and to add progressively to their skills as required by these community needs. Enhanced skills training (CCFP(EM)) in Family Medicine in the domain of Emergency Medicine prepares family physicians to provide excellent emergency care for all patients in any emergency department in Canada, including community, regional, and academic/teaching hospital settings. The family physician with these enhanced skills may provide emergency care on a full-time practice basis, or on a part-time basis integrated with other family medicine activities. These family physicians will also add to their skills on a continuing basis according to community needs, and may go on to assume leadership roles in education, research and administration.*

The Royal College of Physicians and Surgeons of Canada has defined the purpose, goals and product of the FRCPC-EM program as the following:

Residency training leading to specialist Emergency Medicine (EM) certification and practice in Canada is done through the Royal College Emergency Medicine (EM) residency training programs. Royal College EM specialists have practices dedicated to advanced care for patients with acute and often undifferentiated health problems, across a broad spectrum of illnesses and injury in all age groups, frequently before complete clinical or diagnostic information is available. They are capable of assuming a consultant's role in the specialty and providing comprehensive emergency adult and pediatric care in academic/teaching, community or regional hospital settings. Royal College EM specialists are the only comprehensive resuscitation specialists, possessing expertise in the anatomy, physiology, pathophysiology, pharmacology and management of all acute presentations. EM specialists use their comprehensive knowledge of related fields at the interface between emergency care provision and the health care system, including toxicology, traumatology, prehospital care, and disaster preparedness. Royal College EM specialists are an academic and community resource, providing advanced clinical patient care; support to other practitioners in an emergency setting; leadership in the administration of emergency departments, emergency medical systems, health care institutions and related programs; and the conduct of relevant research and education with the goal of advancing knowledge and improving individual and/or community health outcomes.†

* Statement submitted by Dr. Connie LeBlanc, on behalf of the CFPC.

† Statement submitted by Dr. Brian Holroyd, on behalf of the Royal College Specialty Committee in Emergency Medicine.



Perspectives of physicians currently practicing EM

The following section summarizes the perspectives of physicians currently practicing EM (CCFP, CCFP(EM), and FRCPC-EM) and is illustrated in Figure 14.

- **CCFP (non-EM):** Respondent opinions regarding the CCFP training route were greatly varied, with 23.7% of respondents classifying the effectiveness of the CCFP program achieving its stated goals as effective, 28.0% as ineffective, 17.6% as very ineffective, and 19.8% as neutral in opinion.
- **CCFP(EM):** Respondent opinions regarding the effectiveness of the CCFP(EM) training route meeting stated goals were mostly positive, with 40.7% of respondents rating the route as effective and 28.5% as very effective.
- **FRCPC-EM:** Similarly, perspectives of respondents regarding the effectiveness of the FRCPC-EM training route in meeting its stated goals were positive, with 38.2% of respondents rating the alignment of stated goals and training as very effective and 35.4% as effective.

➤ Certificant groups were more likely to rate their own program favourably in comparison to the ratings of those who had been trained in other certification routes.


The perspectives on the effectiveness of the two colleges in achieving the stated training program goals of the CCFP, CCFP(EM), and FRCPC-EM certification routes were inconsistent between the certificants of the three training routes. Though the majority of respondents rated the CCFP(EM) and FRCPC-EM as effective or very effective (the CCFP ratings were more varied), each certificant group was more likely to rate the effectiveness of their own program more positively than those who had been trained in other programs. In addition, a greater percentage of physicians with FRCPC-EM training rated the effectiveness of the CCFP and CCFP(EM) programs as lower than the ratings of these programs made by the other two certificant groups.

Perspectives of CCFP(EM) and FRCPC-EM residents

The perspectives of residents (CCFP(EM) and FRCPC-EM) on the effectiveness of the CCFP, CCFP(EM), and FRCPC-EM training programs in meeting their stated program goals differed depending on the training program being examined.

- **CCFP (non-EM):** Overall, the CCFP training program was rated as very ineffective (30.5%) and ineffective (29.2%) by the resident group.
- **CCFP(EM):** Results for the CCFP(EM) training program were mixed, with 27.1% of residents rating the program as effective and 28.8% as ineffective.
- **FRCPC-EM:** The FRCPC-EM program was rated by the resident group as very effective by 58.3% of the resident group.

➤ CCFP(EM) and FRCPC-EM residents were more likely to be critical of training routes in comparison to their currently practicing counterparts



A sub-analysis of the perspectives of residents indicates that the CCFP(EM) and FRCPC-EM rated the effectiveness of the three programs in dissimilar ways (see Figure 15). Similar to the respondent group currently practicing EM, each resident group was more likely to rate the effectiveness of their own training program more positively than residents training in the other training program.

In comparing the perspectives of physicians currently practicing EM and residents training in an EM program, it is also important to note that the ratings of the resident respondent groups currently training in the CCFP(EM) and FRCPC-EM programs were less favourable of the program they were not a part of, in comparison to their currently practicing counterparts.

Perspectives of Emergency Department Chiefs

› The effectiveness rating of programs by ED Chiefs was dependent on ED setting, with the CCFP program receiving higher effectiveness ratings in smaller ED settings, and EM certification programs receiving higher effectiveness ratings in larger ED settings.

A sub-analysis of the perspectives of ED Chiefs by setting allowed for the analysis of respondent perspectives by environment.

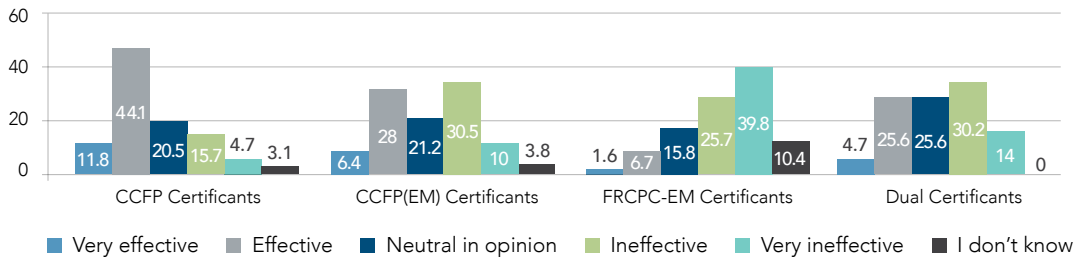
- The CCFP program was more likely to be rated as very effective or effective in smaller ED settings, such as remote (71.4%), rural (46.2%), and small urban hospitals (45.0%). Conversely, the CCFP program was more likely to be rated as very ineffective or ineffective for the practice of EM in large urban academic (50.0%) and large urban non-academic settings (47.6%).
- The CCFP(EM) program was rated as very effective or effective in the majority of all settings, rated as such by 90.5% of respondents in large urban non-academic hospitals, 85.0% in small urban hospitals, 77.8% in large urban academic hospitals, 61.5% in rural hospitals, and 57.1% in remote hospitals.
- The FRCPC-EM program was rated as very effective or effective by the majority of respondents in large urban academic hospitals (94.4%), large urban non-academic hospitals (66.7%), and rural hospitals (66.7%). 50.0% of respondents from small urban hospitals rated the FRCPC-EM program as very effective or effective. 42.9% of respondents from remote settings indicated that they did not know if the program was effective in meeting its goals.

It is important to note that a significant proportion of ED Chief respondents were from smaller centres. In order to understand how perspectives of ED Chiefs may differ by ED setting, future additional analysis of reported perspectives could be undertaken by categorizing ED Chief responses by practice setting.

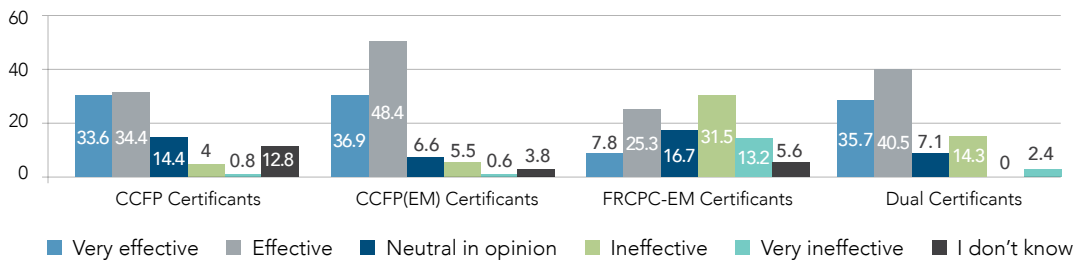


Figure 14: Perspectives of physicians currently practicing Emergency Medicine (%)

Perspectives of physicians on the effectiveness of the CCFP program in achieving stated goals (%)



Perspectives of physicians on the effectiveness of the CCFP(EM) program in achieving stated goals (%)



Perspectives of physicians on the effectiveness of the FRCPC-EM program in achieving stated goals (%)

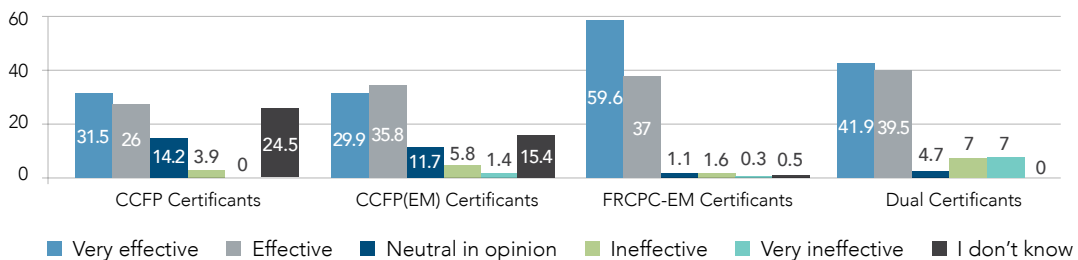
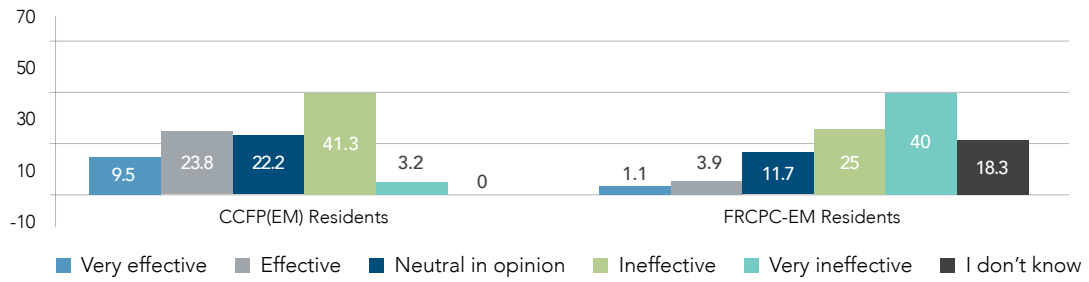


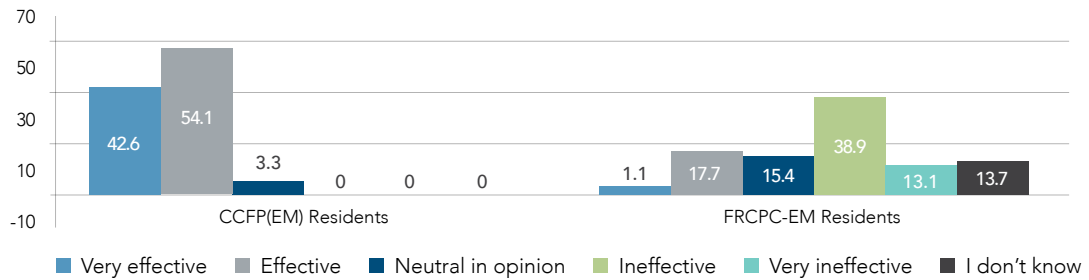


Figure 15: Perspectives of CCFP(EM) and FRCPC-EM residents (%)

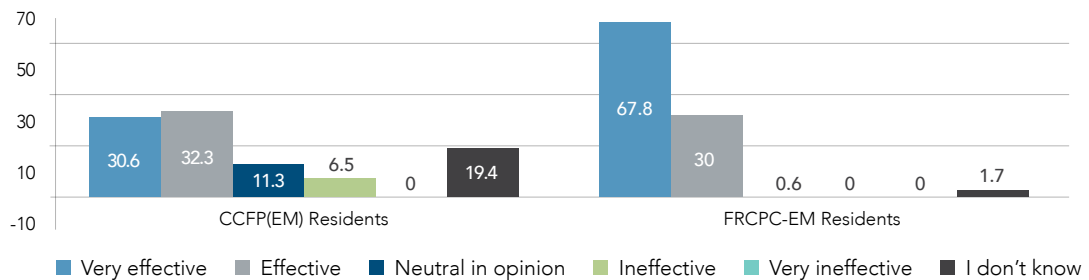
CCFP(EM) and FRCPC-EM resident perspectives on the effectiveness of the CCFP program in achieving stated goals (%)



CCFP(EM) and FRCPC-EM resident perspectives on the effectiveness of the CCFP(EM) program in achieving stated goals(%)



CCFP(EM) and FRCPC-EM resident perspectives on the effectiveness of the FRCPC-EM program in achieving stated goals (%)





The Alignment of the EM training Routes with EM Practice

Preparation for practice

In order to examine the level of preparedness of physicians working in EDs, respondents from the CCFP(EM), FRCPC-EM, and CCFP (non-EM) survey groups were asked to indicate their agreement with the statement that the training they had received adequately prepared them for their current clinical practice.

- ▶ The majority of respondents who currently practice EM feel adequately prepared for clinical practice by their training route.

The majority of participants from the CCFP(EM) (85.2%), FRCPC-EM (94.1%), dual certificant (82.9%), and CCFP (non-EM) (68.4%) indicated that they agree or strongly agree that the training they received adequately prepared them for their current clinical practice in EM.

- ▶ Respondents indicated that the preparation for practice after graduation is dependent on training route and intended practice setting.

Based on their experiences, survey respondents identified key factors influencing preparation for EM practice after graduation. A qualitative analysis of the survey data revealed two key themes observed by and drawn from the opinion of survey respondents:

Level of preparedness for EM practice can differ between training routes

- ▶ Level of preparedness to practice immediately following graduation
 - ▶ FRCPC-EM > CCFP(EM) > CCFP (non-EM)
- ▶ CCFP (non-EM) training alone does not prepare graduates for EM work
- ▶ FRCPC-EM training is rigorous and research oriented
- ▶ CCFP(EM) training is not as comprehensive as FRCPC-EM
- ▶ CCFP(EM) extra year of training is invaluable for Family Physicians practicing EM
- ▶ Over time, and with increased clinical experience, differences in competency between the certifications disappear

Competence for the practice of EM as a primary clinical discipline is dependent on setting

- ▶ FRCPC-EM: competent in large, academic settings (strengths in research and administrative skills) and may not always be effective with primary care problems or in low acuity settings
- ▶ CCFP(EM): competence to practice EM in multiple ED settings is achievable for CCFP(EM) graduates. There is a sentiment, however, that, not all CCFP(EM) physicians are fully prepared to practice in larger and tertiary settings immediately upon graduation and require further time and experience in practice to gain additional necessary competencies
- ▶ CCFP (non-EM): A rural focused FM training program is best suited for preparing trainees for EM practice in small, rural settings

Gaining Competencies in Emergency Medicine

Respondents from all four survey groups were asked to indicate their agreement that the CCFP (non-EM), CCFP(EM), and FRCPC-EM programs were effective routes to gain competencies for the practice of EM.

- The majority of respondents agreed that the CCFP(EM) and FRCPC-EM training pathways were effective routes to gain competencies in EM.

The majority of respondents from all survey groups indicated that they agree or strongly agree that the CCFP(EM) and FRCPC-EM training pathways are effective routes to gain competencies in EM.


- The effectiveness rating of the CCFP (non-EM) program for EM practice is more likely to be rated positively in smaller centres.

The CCFP program was more likely to be rated as an effective route to gain competencies in EM by physicians with an EM certification or ED Chiefs working in remote locations (Table 5). In most settings, ED Chiefs were more likely to agree that the CCFP certification was an effective program to gain competencies in EM, particularly from rural and remote settings. In contrast, there was a strong sentiment amongst certified physicians and ED chiefs outside rural and remote settings, and trainees in both programs, that CCFP (non-EM) training alone was insufficient for the full-time practice of EM.

Table 5: Level of agreement for the CCFP (non-EM) program to be rated as an effective route to develop competencies in EM

| ED Setting | Respondent Group | Strongly agree | Agree | No opinion | Disagree | Strongly disagree | I don't know |
|--------------------------|-------------------------------|----------------|-------|------------|----------|-------------------|--------------|
| Large Urban Academic | CCFP(EM)/ FRCPC-EM physicians | 3.2% | 11.7% | 7.2% | 46.3% | 30.5% | 1.0% |
| | ED Chiefs | 0.0% | 25.7% | 0.0% | 40.0% | 34.3% | 0.0% |
| Large Urban Non-Academic | CCFP(EM)/ FRCPC-EM physicians | 3.2% | 17.5% | 10.7% | 51.6% | 15.5% | 1.6% |
| | ED Chiefs | 0.0% | 15.0% | 10.0% | 60.0% | 15.0% | 0.0% |
| Small Urban | CCFP(EM)/ FRCPC-EM physicians | 2.9% | 24.4% | 10.2% | 53.7% | 7.3% | 1.5% |
| | ED Chiefs | 15.0% | 35.0% | 15.0% | 35.0% | 0.0% | 0.0% |
| Rural | CCFP(EM)/ FRCPC-EM physicians | 0.8% | 35.3% | 14.3% | 38.7% | 9.2% | 1.7% |
| | ED Chiefs | 15.4% | 59.0% | 5.1% | 15.4% | 5.1% | 0.0% |
| Remote | CCFP(EM)/ FRCPC-EM physicians | 0.0% | 45.5% | 11.1% | 22.2% | 11.1% | 0.0% |
| | ED Chiefs | 0.0% | 85.7% | 14.3% | 0.0% | 0.0% | 0.0% |

- Respondents observed factors outside of the two certification routes that influence competency.



A qualitative analysis of the survey data revealed three areas influencing competency for EM practice of graduates based on the experiences and opinions of respondents:

Individual differences

- Level of motivation
 - Interest in EM
 - Self-directed learning
 - Willingness to pursue extra training
-

Training Location

- Respondents indicated the belief that the ED setting type/location of a resident's training could influence the competency for EM practice of graduates for the location of future practice (e.g., a resident training in a rural ED may not have acquired all of the necessary competencies for practice in a large urban ED and vice versa).
-

Practice Setting

- Level of competency required of a physician practicing EM is proportional to acuity level of the hospital setting in which they practice

Reflections on the Dual College, Dual Certification Approach to EM

Respondents from all survey groups were asked to rate the ability of the current dual college, dual certification approach in Canadian EM to meet the needs of the EM practice and the Canadian public. Responses collected from the survey data can be found in Figure 16.

➤ Respondents from the CCFP (non-EM), CCFP(EM) physicians and residents, Dual certifiants, and ED Chief groups were most likely to be satisfied with the current approach to Emergency Medicine residency training.

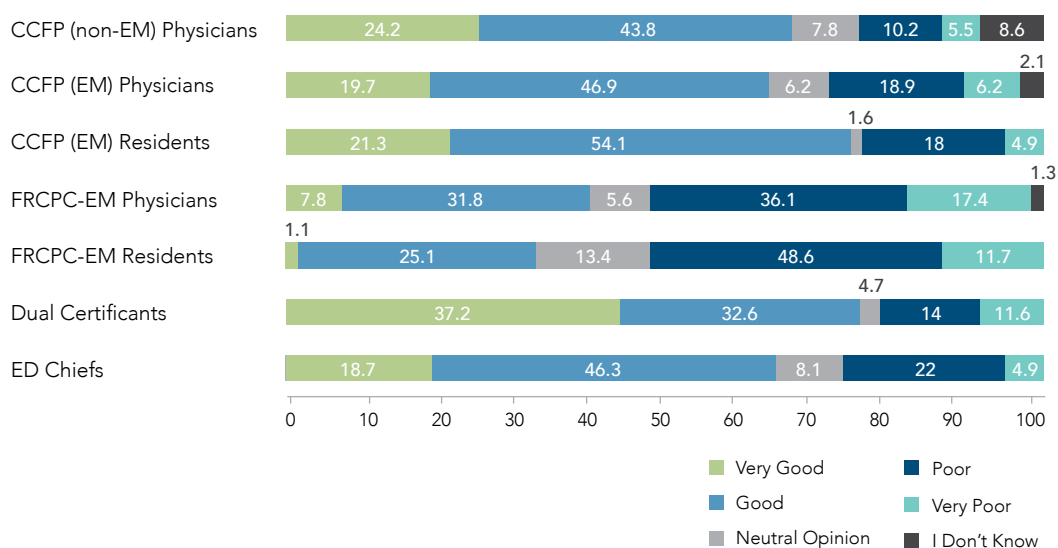
The majority of CCFP (non-EM) (68.0%), CCFP(EM) physicians (66.6%), CCFP(EM) residents (75.4%) dual certifiants (69.8%), and ED Chiefs (65.0%) rated the current approach to EM residency training as good or very good. Ratings of the current approach as poor or very poor occurred in approximately one quarter of CCFP(EM) physicians and residents, dual certifiants, and ED Chiefs and in 15.6% of CCFP (non-EM) physicians.



➤ FRCPC-EM residents and physicians were most likely to be dissatisfied with the current approach.

The majority of FRCPC-EM physicians (53.5%) and residents (60.3%) rated the current approach to EM certification as poor or very poor. Notably, FRCPC-EM residents were more likely to rate the current approach as poor or very poor in comparison to their currently practicing counterpart. Ratings of the current approach as good or very good occurred in 39.6% of FRCPC-EM physicians and 26.3% of residents.

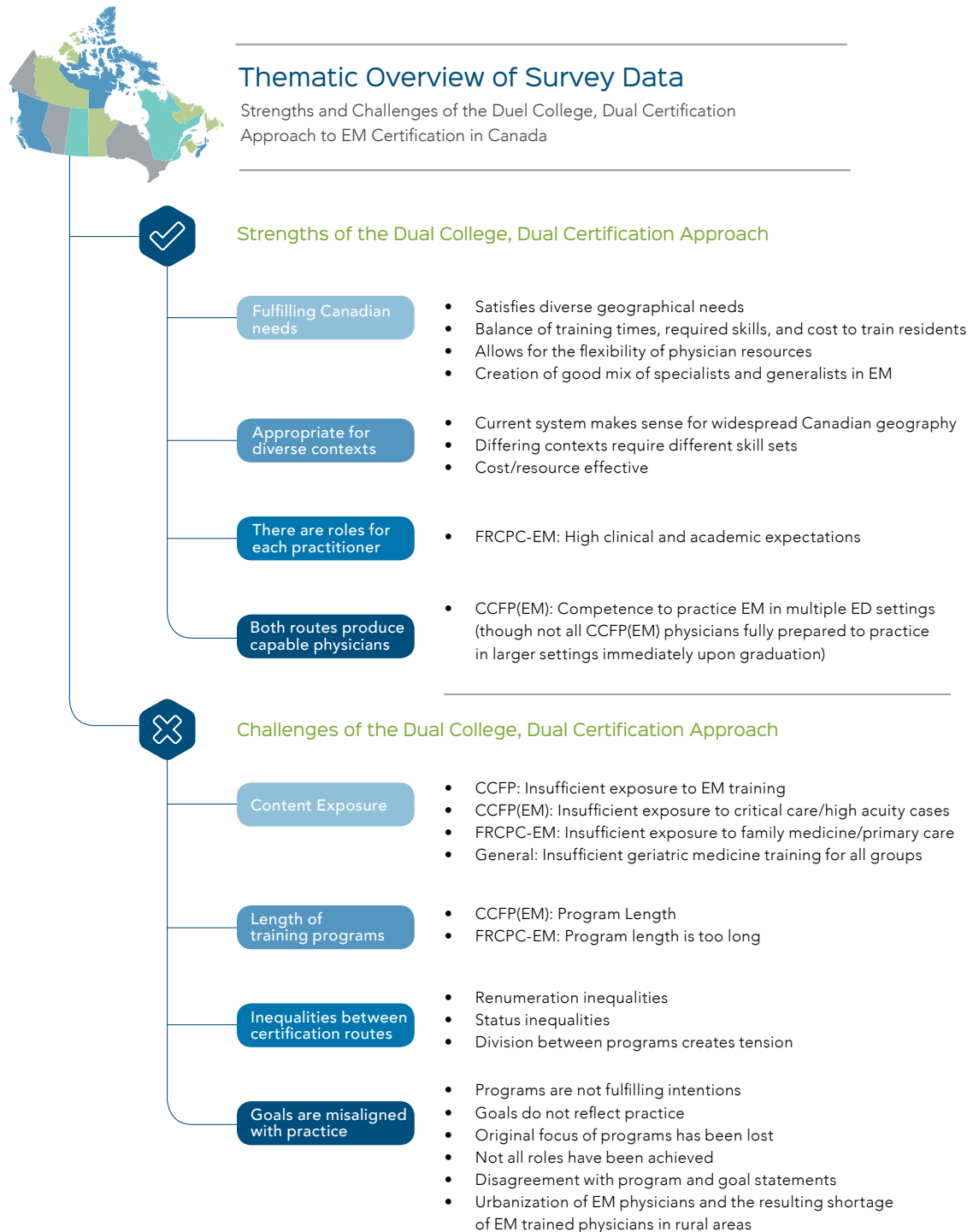
Figure 16: Respondent ratings of the ability of the current dual college, dual certification approach to Canadian Emergency Medicine to meet the needs of the Emergency Medicine practice and the Canadian public (%)



Observed strengths and challenges of the dual college, dual certification approach

Survey respondents identified both strengths and challenges of the dual college, dual certification approach for EM residency training. Many respondents advocated a single unified EM training program. A qualitative analysis of the survey data revealed four key strengths and four key challenges of the current approach. The findings are illustrated in Figure 17.

Figure 17: Respondent observations of the strengths and challenges of the current dual college, dual certification approach





Suggested improvements to Emergency Medicine training from respondents

Survey respondents recommended improvements for EM residency training. The following are the most common suggestions for improvement collected in the qualitative analysis of the survey data:

Restructure of EM training routes

- Restructure of program lengths
- Increased fellowship options for both training routes
- Suggestion of unifying to a single training pathway

Increased content exposure

- FRCPC-EM: Increased exposure to clinical family medicine training (continuity and integration of emergency care with ongoing primary care of the patient as well as increased understanding of rural EM settings)
- CCFP(EM): Increased exposure to components of EM training (e.g., critical care training/ Pediatric EM)
- General: Increased content cross-over between programs

Increased flexibility in EM training pathways

- Addition of different entry routes
- Addition of options for re-entry
- Consideration of ideal practice locations for physicians from each stream
- Customization of training to intended practice location
- Single certification exam for clinical care between two training pathways
- A need to distribute more resources (from both training streams) to rural practice locations
- Consideration for level practice preparedness depending on the EM environment and certification (e.g., CCFP with minimal EM training, often working under obligation)

The findings from this national survey of CCFP(EM) and FRCPC-EM physicians, CCFP physicians, EM residents, and ED Chiefs were critical in determining the current context of EM, perceptions on training routes, training needs, and current health human resource needs for the provision of high quality care for Canadians.

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Limitations of Methodology



The following section outlines potential limitations to the methodology of the CWG-EM's National Survey of EM Training and HHR Needs.

Sampling

CCFP physicians: The recipient list for the CCFP physicians survey was established using data collected from CCFP membership forms, which asked CCFP physicians if they had an interest or activity in EM, the result of which was that some respondents did not have activity in EM practice. This limitation was partially addressed by asking CCFP respondents if they currently practiced EM at the time of the survey and eliminating those who did not from the analysis.

ED Chiefs: Although considerable effort was made to recruit ED Chiefs from every ED in the country, it was not possible to obtain direct contact information for all sites. Furthermore, in some cases the link was forwarded on to chiefs by regional leads, and consequently, an actual denominator for invited Chiefs could not be ascertained with certainty.

Survey distribution

The CWG-EM survey was distributed using a Royal College domain name. Possible limitations to this method include that some invitations may have been prematurely deleted in error by non-Royal College physicians. Another possible limitation to this method of survey distribution is that some respondents may have assumed that there was bias in the survey design and adjusted their responses accordingly.

Limitations of the self-report methodology

While a self-report methodology has many advantages, including the richness of information collected on the lived experiences of those surveyed in the community, this methodology also increases the potential for self-reporting biases. These include skewed self-presentation, whereas the participant responds to survey questions with the intent to increase the value of his or her own or peer group presentation. Another limitation of this methodology is the capacity of respondents to accurately recall information.

Misinterpretations of questions

Some questions in the CWG-EM survey may have been misinterpreted by respondents, potentially affecting the content of their responses. Efforts were made by the CWG-EM to account for this wherever it was suspected through logical inconsistencies, as noted previously.



ED setting omissions

The CWG-EM survey did not include an option for ED Chief respondents to indicate whether or not they were reporting on a single ED site or on multiple sites. This likely resulted in some proportional misrepresentation of ED settings in the results.

In addition, it was brought to the CWG-EM's attention that some respondents practiced EM in non-hospital ED settings such as urgent care clinics. Information specific to such sites was not collected.

Generalization of ED Chief data

When asked if they held a Canadian EM certification, 47.4% of ED Chief respondents indicated they were certified in EM. The majority of ED Chiefs who responded to the CWG-EM survey were from smaller ED sites where chiefs without an EM certification are more common, resulting in a skewed representation. As a result of this limitation, hospital category specific determinations (such as approaches to a tertiary urban centre) should be adjusted for this. In interpreting the results of the CWG-EM survey, it may be most appropriate to focus on feedback only from ED Chiefs by setting.

In addition, 68.8% of large urban academic respondents with no EM certification were from Québec, thus the results from this ED setting may not be completely generalizable elsewhere in Canada.

The variability in response rates by region means that depending on the situation and issue under investigation, province specific determinations based on our data may be difficult to reach and may require further local research efforts.

Implications



Current Shortfall Of Certified Emergency Physicians and Projected Increase in the HHR Deficit Over the Next Decade

An HHR model was constructed by the CWG-EM in order to determine the current and projected shortfall of emergency physicians in Canada over the next decade.

Overview of the model

In an attempt to minimize bias from any one particular group, the perceived changes in current and future work patterns were considered from a number of different sources, including: EM certified physicians, Chiefs of EDs and EM residents. A description of how each estimate was obtained is described below.

Current physician supply

EM certified physicians

The current supply of EM certified physicians was estimated by summing the number of FRCPC-EM certified physicians with the number of CCFP(EM) certified physicians; these numbers were obtained from the Royal College database and the CFPC database, respectively. Both of these databases contain information on the number of physicians who have received EM certifications from the Colleges. The Royal College database contains data of physicians certified from 1983 – 2015, and the CFPC contains data from 1982-2015. In this model, the current supply assumes all physicians are full clinical FTE physicians, working 8 hour shifts with 13 shifts in a month.

Breakdown by setting

The EM certified physician supply by hospital setting was estimated using the data from the emergency physician survey which asked participants to indicate the setting which best described their ED.

Non-certified physicians providing emergency care

The supply of non-certified physicians providing emergency care was estimated by multiplying the median number of CCFP physicians working in an ED (as reported by the respondents from the ED Chiefs survey) by the total number of EDs in Canada.*

* Counts of EDs in Canada were provided by the Canadian Institute of Health Information and the Ministry of Québec.



Current shortfall

Using data from the survey that was sent out to ED Chiefs across the country, the current shortfall was estimated by calculating the median number of hours short/day as reported by ED Chiefs who had indicated their staffing needs are not fully met, multiplying by 30 (the average number of days per month) and dividing by 104 (the number of hours/month worked by an FTE physician; i.e. 13 shifts/month, 8 hours/shift). The number obtained from this calculation was considered the average number of physicians short per ED. In order to determine the nationwide shortfall, the average number of physicians short per ED was multiplied by the approximate number of EDs in Canada experiencing shortages in their staffing* and by the total number of EDs in Canada.†

5 and 10 year continuing physician supply estimates

The projected 5 and 10 year continuing certified physician supply estimates were calculated by subtracting the estimated number of physicians lost to attrition‡ over the specified period from the current physician supply.

5 and 10 Year potential incoming supply

An estimate of the number of residents from the FRCPC-EM and CCFP(EM) programs who will be potentially graduating and entering the workforce in 5 and 10 years was calculated using the 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. Results from the residents survey data suggest that new graduates anticipate spending approximately 70% of their time in clinical EM, therefore, the clinical FTE contribution of upcoming graduates was adjusted to take this factor into consideration. Preferred work setting as indicated in the EM residents survey was used to determine the approximate number of graduates potentially entering practice into each of the different settings.

5 and 10 Year shortfall estimates

Projected shortfall estimates for 5 and 10 years was calculated by estimating a required physician supply§ and subtracting from that the continuing physician supply and the estimated incoming physician supply.

* This number was calculated by multiplying the percentage of respondents who indicating that their staffing needs were not being fully met by the number of EDs in Canada.

† The total number of EDs is based on the number of hospitals reporting expenses in emergency across the country based on data taken from the Canadian MIS Database (excluding Québec) + the number of EDs in Québec as reported by the ministry of Québec.

‡ The number of certified physicians lost to attritions for 5 and 10 years was estimated using the data from the emergency physicians survey which asked respondents about the direction and percentage of change in their schedule work hours over 5 and 10 year periods. The number of non-certified physicians lost to attrition was estimated to be approximately ½ of the supply in large hospital settings in 5 years, and 100% in 10 years. For the smaller hospital settings, the numbers were approximated using the same % of attrition as the certified physicians.

§ The number of physicians required was estimated using the direction and % change of volume in hours of coverage as predicted by the respondents of the ED Chiefs survey in addition to the current shortfall.

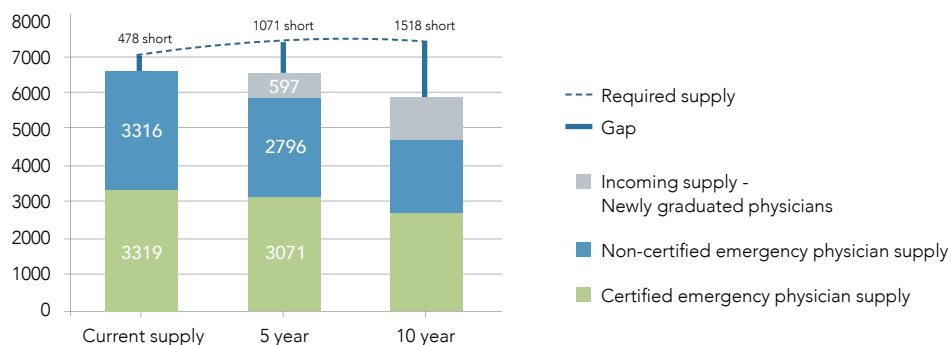


Overall Findings

Within the constraints of the limitations and assumptions of the model noted below, we estimate a current estimated shortfall of 478 emergency physicians in Canada. In the absence of expansion of EM residency training capacity, this shortfall is projected to rise to 1071 emergency physicians by 2020 and to 1518 emergency physicians by 2025 (Figure 18). Current and projected shortfalls by ED settings were also generated (Figures 19-21).

National Emergency Physician Shortfall Estimate and Future Projections

Figure 18: National emergency physician shortfall estimate and future projections (excludes remote settings)



Projected Emergency Physician Shortfalls By Emergency Department Setting

Figure 19: Projected emergency physician shortfall (Large Urban Academic Hospital)

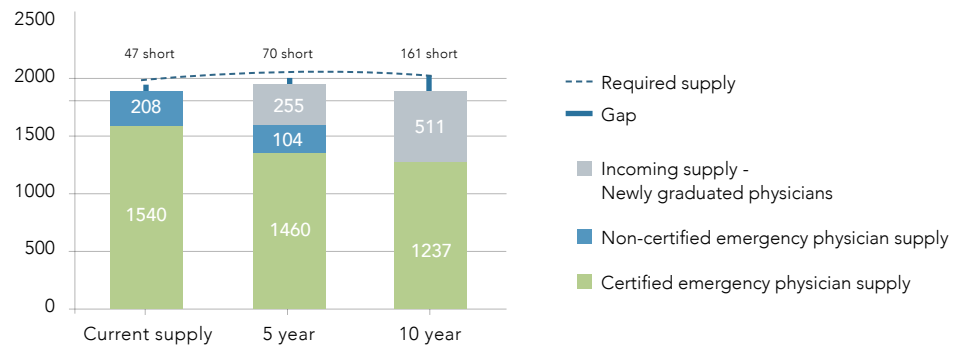


Figure 20: Projected emergency physician shortfall (Large Urban Non-Academic)

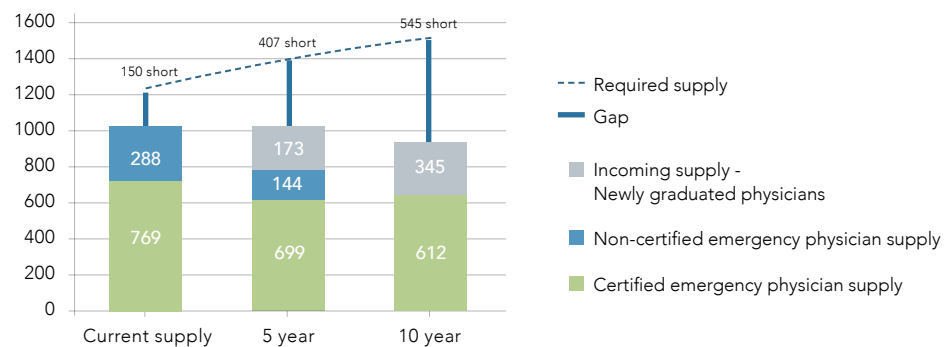




Figure 21: Projected emergency physician shortfall (Small Urban)

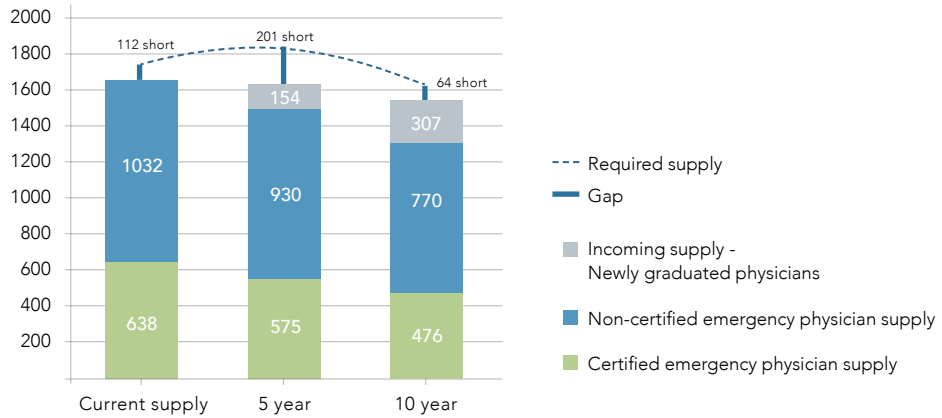
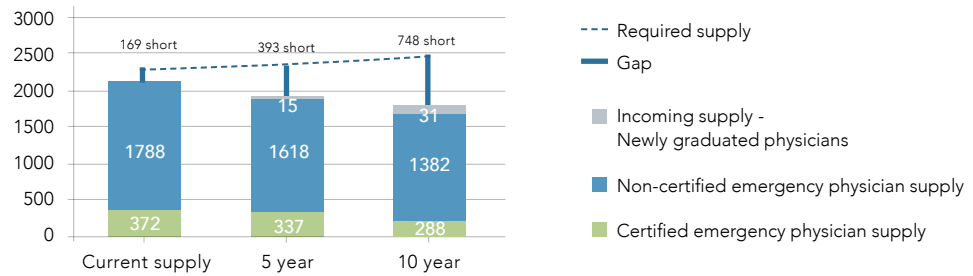


Figure 22: Projected emergency physician shortfall (Rural)





Assumptions of the model

- The current supply estimate assumes that all certified physicians are actively practicing in Canada (and does not take into consideration those who may be retired, unemployed, working outside of Canada), thus the true supply is undoubtedly lower than that provided.
- Clinical practice hours as reported in the survey sufficiently approximate reality.
- Graduating residents will practice in Canada, so again the true supply will potentially be lower than the estimated value.
- FTE physician= 104 hours/month (8 hour shifts x 13 shifts a month).
- Trends in the number of resident positions and graduates over the past 5 years will follow a similar pattern into the next 10 years.
- 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).
- In 5 years, approximately half of the non-certified physicians working in large emergency departments will remain, and in 10 years there will no non-certified emergency physicians working in large EDs.
- Non-certified physicians working in smaller hospitals will follow the same attrition patterns as certified physicians.

Limitations of the model

- The counts of EDs may be understated as multi-site organizations may contain emergency services at more than one of its sites; however, the data obtained from these individual sites may only be reflected in an overall number.
- Some of the estimates used in the calculations were based on low numbers, impacting the accuracy and generalizability of the results
- Self-reported data biases from the survey (the result of which could be that needs were over or under-estimated)
- Possible misinterpretation of questions
 - ▶ For example, Q11. What do you predict will be the percent (direction of change 5 years) in the volume of your clinical emergency work hours at the end of 5 years compared to 2015?
 - Some of the ED Chiefs may have interpreted this as their own work hours rather than their department's hour of coverage.



- Some of the ED Chiefs almost certainly provided numbers based on their role of overseeing multiple sites (resulting in, for example, a number of hours of coverage short/day that was calculated based on a number of hospitals).
- Remote hospital settings have been excluded from some of the analysis due to very low numbers and difficulty obtaining national data.
- Due to an extremely low response rate from the CCFP physicians survey and concerns that the recruitment pool for this group may not have accurately reflected the target population, the estimated number of CCFP physicians was approximated using the ED Chiefs survey data.

Tensions in the Emergency Medicine Community


The probable hidden curriculum in EM training programs

In EDs across the country, graduates from both Canadian EM training routes work together to provide clinical care. Additionally, those same physicians provide quality teaching to undergraduate and post-graduate trainees. However, the CWG-EM findings identified areas of tension between the EM certificant types, among both residents and practicing physicians. The Royal College, CFPC, and CAEP must become and remain cognisant of these areas of friction in order to optimally address the issues related to training, clinical care and scholarly work in EM.

Survey data of CCFP(EM) and FRCPC-EM certified physicians and residents indicates tensions exist in the relationship between the two certificant types. This finding was particularly noteworthy in CCFP(EM) and FRCPC-EM resident data, with trainees in a program generally being more critical of the training pathway that was not their own. The resulting potential for an early adversarial unspoken relationship between CCFP(EM) and FRCPC-EM graduates contrasts with the formal curriculums, missions, and values set by the two colleges, and is indicative of a hidden curriculum* within EM residency training. The CWG-EM believes this hidden curriculum is likely a critical issue influencing the perceptions of graduates from both the CCFP(EM) and FRCPC-EM residency training programs in an undesirable manner.

The CWG-EM survey results clearly indicate a degree of polarization exists between physicians from the CCFP(EM) and FRCPC-EM certifications. The result of categorizing individuals practicing EM by certification has, in some cases, put graduates of the CCFP(EM) and FRCPC-EM programs at odds with one another in practice. Ultimately, the CWG-EM believes the hidden curriculum has been a factor in producing inter-college resentment across a range of areas including job availability, status, intended roles, and compensation.

* "Hidden curriculum refers to unwritten, unofficial, and often unintended lessons, values and perspectives that students learn. While the 'formal' curriculum consists of the courses, lessons, and learning activities, as well as the knowledge and skills educators intentionally teach to students, the hidden curriculum consists of the unspoken or implicit academic, social, and cultural messages that are communicated to students tacitly through school affiliated activities both on and off site" (Abbott, 2014).



Experiences recounted by survey respondents indicate that inter-college resentment has surfaced in a number of ways, for example:

- Some CCFP(EM) certificants have described feeling like “second-class citizens” in their workplace settings in comparison to their FRCPC-EM colleagues.
- Some FRCPC-EM certificants have described the feeling that their extra years of training and achievement of EM specialist status results in no additional recognition in terms of job status, availability, or compensation in environments espousing a “same work, same pay” philosophy.

Dissatisfaction with the Status Quo

The surveys of physicians with an EM certification and EM residents indicated that a substantial proportion of respondents report discontent regarding the current approach to EM training and care in Canada. Approximately one in three of EM certified physicians (33.8%) and just over half of EM residents (50.8%) rated the ability of the status quo to “meet the needs of EM and the Canadian public” as “poor” or “very poor.” This undercurrent of dissatisfaction conveyed by survey respondents appears to arise from a complex multitude of factors that act to divide the EM community. Within a relatively small discipline like EM, this division is pervasive enough to potentially result in animosity between certificant types and may present significant challenges to an effective system of care.


The CWG-EM believes it is essential to develop an approach to improve collaboration and synergy between the CCFP(EM) and FRCPC-EM training programs, guided by the CWG-EM survey results and the indicators they provide about EM training and practice in Canada.

CCFP(EM) certified physicians

The CCFP(EM) program currently consists of two years of Family Medicine, followed by one year of training in EM. The short duration of the EM training component creates a challenge for CCFP(EM) residents to meet all of the competency needs for full-time EM practice upon graduation. For example, there were concerns highlighted by certified physician and ED Chief respondents regarding the preparedness of CCFP(EM) certified physicians to practice in large urban centres immediately upon graduation. Qualitative survey responses indicated a need to explore the potential of increasing the exposure of CCFP(EM) residents to core EM areas and, given the ultimate career goals of this population, to explore a reduced exposure to clinical Family Medicine in CCFP(EM) residency programs.

FRCPC-EM certified physicians

Concerns were raised from survey respondents regarding the five-year duration of the FRCPC-EM program and the limited exposure of residents to aspects of clinical Family Medicine, specifically transitions of care and community care. The survey results suggest graduates of the FRCPC-EM program may benefit from an increased understanding of how the emergency care provided in ED settings integrates into an individual patient’s larger continuum of care. The development of this knowledge may require the implementation of rotations in Family Medicine into the FRCPC-EM program, or other means for graduates to develop a strong understanding of continuity of care and care resources in the community in which they will be practicing. This includes the incorporation of enhanced competencies



related to the communication of patient referrals and consultation requests from community and rural physicians, as well as the fostering of an increased understanding of the capabilities and limitations of delivery of EM care in rural contexts.

Status of emergency care in rural Canada

A significant amount of emergency care in rural and remote settings is currently provided by CCFP certified physicians with little specific EM training. Although a review of the CCFP (non-EM) program and the complex issues of EM care in rural Canada are outside of the mandate of the CWG-EM, the CWG-EM survey findings related to the CCFP program and provision of rural EM care will be briefly communicated.

The results from the surveys indicated a strong sentiment from the EM community (CCFP(EM) and FRCPC-EM certificants EM residents from both programs, and ED Chiefs from larger centres) that the two year CCFP(non-EM) training program is not sufficient to appropriately prepare physicians for EM practice as a primary discipline. This sentiment was particularly strong from physicians certified in EM working in large and small urban ED settings. Although CCFP (non-EM) certified physician respondents indicated that they felt they were well skilled for clinical EM practice in their settings, both trainees and graduates of the CCFP(EM) and FRCPC-EM programs had a different perspective, with the large majority of respondents from urban ED settings indicating they “disagree” or “strongly disagree” that CCFP training alone is an “effective route to gain competencies for the practice of EM” (Table 5, p 59).

Misalignment of the Intent of the FRCPC-EM and CCFP(EM) Training Routes and the Reality of the Scope of Emergency Medicine Practice for Program Graduates

Our survey data suggests concern exists within the EM community that some physicians are placed into a clinical role they are not prepared for upon graduation. Issues regarding preparedness for practice in a variety of settings for both CCFP(EM) and FRCPC-EM graduates appear to stem from a misalignment of the intent of training with the reality of practice. Both the CCFP(EM) and FRCPC-EM programs strive to develop competent physicians working in EM, though ascribe different purposes for the role of their program graduates in ED settings.

The FRCPC-EM program frames graduates as EM specialists, operating clinically as consultants, as well as working in research and/or administrative roles in large urban and academic centres. In contrast, the CCFP(EM) training pathways frames graduates as family physicians with an expanded skill set in EM, as a complement to a Family Medicine clinical practice and an important component of physician coverage in remote/rural/suburban EDs. In reality, the CWG-EM survey results as well as prior published research indicate the vast majority of CCFP(EM) certified physicians do not practice broad-based Family Medicine, but rather have EM as their sole or primary clinical role. In addition, a significant proportion of FRCPC-EM graduates do not include research or administrative work in their practice (62% of FRCPC-EM participants indicated that 0% of their practice included research, and 38% of FRCPC-EM participants indicated that 0% of their practice included administrative work), while some CCFP(EM) graduates have significant academic EM careers. It is apparent that despite the stated intentions of Canada’s two EM training programs, the practice patterns of graduates from these programs overlap significantly in a manner that undermines the distinction between the programs and their products.



This misalignment between intent, training, and practice creates tension between certificants both at the onset of practice, and for some, its entire duration. This may impact the collaboration and interaction required for teams to provide excellent clinical care and direction to the evolution of EM.

Consideration of a Single Training Program in Emergency Medicine

Although the CWG-EM is not recommending a single certification stream for EM practice, both colleges should remain aware that our survey data demonstrates the presence of support in the EM community for a single training route, and a level of dissatisfaction among residents from both EM programs that is higher than what has been documented in other disciplines. In Canada, the Royal College and the CFPC accredit postgraduate training nationally, and neither college views a single EM route as a viable or appropriate option. Unifying training in other disciplines has been unsuccessful to date in Canada for several reasons including: geography, demographics, access, practice settings, and jurisdictional issues. Dual training routes in EM exist in other countries and this model continues to be viewed favourably by others as an approach to deliver good care to a geographically diverse population.¹ We recommend that both colleges work to align their training programs with their goals and with patient care needs.

Preparing for Practice: Supporting a Standard of Care for Patient Zero

A major consideration that guided the CWG-EM's review of the data and subsequent recommendations is the concept that a central component to the practice of EM is that "patient zero"* merits excellent care in all settings, regardless of the certification of the care provider.

The following set of consensus statements informed the vision and recommendations of the CWG-EM.

Assumptions:

1. Both EM training routes in Canada are high-quality and are effective educationally.
2. Both EM training routes attract high-quality trainees.
3. Canada currently needs a variety of training routes to serve the emergency care of Canadians effectively across all settings.
4. Canada also needs focused rural EM training to effectively meet the needs of patients in this context.
5. The two EM training programs are not identical, due to design, time, educational experiences, emphasis, and duration of training.
6. Differences and distinctions between graduates of the two programs evolve over time, just as every professional changes their scope of practice and depth of knowledge during their career.

* Patient zero is the first patient a graduate from a training program cares for post-graduation as an attending physician.



Proposed Concepts:

1. The two programs do not and cannot produce identical graduates.
2. There are qualitative and quantifiable differences between graduates of the two programs upon completion of training.
3. CCFP(EM) graduates, due to their Family Medicine (FM) background and competencies, have additional ability in clinical presentations that overlap with ambulatory FM care including but not limited to holistic communication skills, integration with the community, ambulatory psychiatry and obstetrics.
4. FRCPC-EM graduates, due to their longer dedicated training in EM, have additional abilities, including but not limited to: critical care experience, advanced resuscitation skills, advanced toxicology, pediatric EM, research and a higher level of experience with the management of critically ill patients.
5. The qualitative and quantitative differences in #4 listed above are most evident in the sickest patients and in the context of more complex and unusual emergency patient presentations and conditions.
6. Due to curriculum differences, FRCPC-EMs have additional training in some areas, including EM administration, research, and pre-hospital care.
7. Despite these significant differences, inter-College collaboration in developing competencies to provide care for all common ED presentation is required for all trainees in order to safely meet the needs of “patient zero”. It is understood that FRCPC-EM program graduates, as EM consultants, will exceed these in some areas. At the same time, the standard of care required to be clinically competent in the provision of EM care must be equivalent for both CCFP(EM) and FRCPC-EM graduates for ED presentations that are common to the settings in which they work.
8. With experience, the sophistication of EM care will exceed the aforementioned competency minimum for graduates of both EM training programs, however, FRCPC-EM graduates benefit from greater formal education and exposure upon graduation than CCFP(EM) graduates.

In moving forward, decision-makers must strive to advance approaches that serve both the EM and ED patient communities. The current reality of Canadian EM practice is that graduates of both the CCFP(EM) and FRCPC-EM programs work side by side clinically in a variety of ED settings, most commonly large urban centres. The two colleges have the ability to positively impact patient care by collaboratively developing parallel foundations of training for EM care delivery. Overarching foundations and corresponding clinical competencies will provide physicians with the skills needed to meet the needs of patients without political or territorial considerations.

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CWG-EM Vision & Recommendations



The following recommendations summarize the collective vision of the CWG-EM, and have been generated after careful consideration of the CWG-EM's research findings and communications with key stakeholders. The recommendations articulate a series of achievable actions that it is advised the trilateral partners undertake for the advancement of the future of Emergency Medicine training and practice in Canada.

Health Human Resources Shortfall

There is a current estimated shortfall of 478 emergency physicians in Canada. This deficit is roughly equivalent to the student body size of an entire Canadian medical school. In the absence of expansion of EM residency training capacity, this shortfall is projected to rise to **1071 physicians** by 2020 and to **1518 physicians** by 2025.

We recommend that CAEP, the CFPC, and the Royal College work collaboratively to advocate for the significant EM residency training slot expansion necessary to address the large current and projected future shortfall of certified emergency physicians in Canada. CAEP, the CFPC and the Royal College are encouraged to work in collaboration in order to address the current and future HHR deficit in Emergency Medicine, consider 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. In addition, in consultation with both colleges, provincial Departments of Health must also work with the postgraduate offices of medical schools within their jurisdictions to increase the number of EM postgraduate training positions in Canada.

In line with its mission to promote the interests of emergency physicians and the specialty of EM in Canada, CAEP must also advocate for the growth of EM certification programs, as well as hold influential groups accountable to move this issue forward.



Alignment of the CFPC and Royal College Emergency Medicine Residency Training Programs

Patient needs have been met with the current approach to EM certification in Canada; however, some improvements are felt to be necessary to improve efficiency and effectiveness and thus enhance care and educational resource utilization. It is envisioned that there will be a continuum of physicians from CCFP(EM) and FRCPC-EM programs staffing various types of Canadian EDs, with each physician's practice context being aligned with the competencies of the individual.

The CWG-EM is not recommending a single certification stream for EM practice, however the substantial support for this that continues to exist in the EM community underscores the need to make meaningful improvements to the status quo. We recommend that the CCFP(EM) and FRCPC-EM programs reform their objectives of training with the following goals:

FRCPC-EM program


The focus of the Royal College must be on the development of important competencies to allow graduates to deliver specialist emergency care to patients in tertiary, large urban, regional, and community hospital EDs.

- The CWG-EM feels that the Royal College's implementation of competency-based medical education (CBME) in residency training and specialty practice by the way of Competence by Design (CBD) project can address concerns related to the FRCPC-EM program.
- In this transition to CBME, the Royal College should review the current FRCPC-EM curriculum and incorporate increased competencies relating to the relationship of emergency and primary care and the larger continuum of care external to the ED setting.
- Increased attention will need to be paid to the intended practice routes of FRCPC-EM graduates in order to achieve efficient and aligned training. For example, incorporating additional competencies for graduates seeking additional training during their Royal College residency (in areas such as education, administration, research, EMS, toxicology, etc.) and conversely focusing on pertinent competencies for those intending a purely clinical EM practice.

CCFP(EM) program

Data from the CWG-EM survey of CCFP(EM) certified physicians and residents indicates that the vast majority of graduates of the CCFP(EM) program practice or intend to practice full-time EM and not a combination of EM and clinical Family Medicine. We recommend that the CFPC focus their efforts on a review of the structure, goals, and objectives of the CCFP(EM) program in order to ensure competency at graduation and to satisfy the standard of care for "patient zero".

- CCFP(EM) program graduates should have the necessary competencies to deliver emergency care to patients in many contexts including large urban EDs, regional and community hospital EDs, as well as smaller EDs.

- 
- A detailed review of the curriculum of the CCFP(EM) training program from a competency based perspective is required in order to ensure the inclusion of the required competencies necessary to confidently practice full-time EM upon graduation. In the review of the CCFP(EM) program, it is important to note that while the CCFP(EM) program likely could continue to be completed in three years, the incorporation of a competency based perspective would almost certainly result in modifications to the traditional two plus one program to an alternative arrangement of program rotations and/or objectives, or alternatively, an increase the program duration for the EM training component.
 - Due to the varying needs of different ED locations of CCFP(EM) certificants, some core competencies incorporated into the CCFP(EM) program should be dictated by the anticipated setting of future practice. The nature of the preceding two years of CCFP training should also be considered at the level of each individual CCFP(EM) trainee, as inter-program variability exists in the nature of this, particularly regarding whether the focus is rural or urban.

HHR Needs in Rural and Remote Settings

HHR needs in rural and remote areas are complex, and it is unlikely that the full breadth of EM staffing needs can be filled in these locations by CCFP(EM) and FRCPC-EM certified physicians in the near future. HHR planning for rural and remote areas needs to consider many more aspects of medical care than solely emergency care. A review of the CCFP (non-EM) program and the issues of EM care in rural Canada were outside of the mandate of the CWG-EM, however general recommendations related to the CCFP program and provision of EM care will be briefly communicated.


The CFPC is encouraged to review the rural/remote findings in detail 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 provision of 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.

Future Collaboration of the CCFP(EM) and FRCPC-EM Programs

Collaboration between the two colleges with respect to the CCFP(EM) and FRCPC-EM residency programs must 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.

We recommend 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, including but not limited to:

- Collaboration between the CFPC and the Royal College in order to clarify, co-develop, and distinguish the goals of each program, highlight their distinctions, and ultimately ensure that clinical competencies for “patient zero” are met, non-clinical competencies are achieved, and both programs are efficient and effective at meeting their goals.

- 
- Optimizing patient care by collaboratively developing parallel foundations of EM care for both training routes, as well as the co-development of competency-based clinical care milestones for common clinical presentations.
 - Establishing observer status appointments for one-another on EM relevant committees including but not limited to the Royal College Specialty Committee in Emergency Medicine and the CCFP(EM) Program Committee.

CWG-EM Data Access for Future Research Activities

The quantitative and qualitative results of the CWG-EM National Survey of EM represent a significant collective resource for the Trilateral Partners (CAEP, CFPC, and the Royal College), as well as the Canadian EM community, both today, and in the future.

The opportunity to access the data collected by the CWG-EM should be made available for future research initiatives by any of the trilateral partners or members of the EM research community. Access to the CWG-EM survey data should be granted exclusively for the purposes of research and improvement to the emergency care of Canadian populations, and not for any commercial purposes. A formal application process should be developed and the CWG-EM should be continued (or a new trilateral partner committee should be established) to review any requests to access raw CWG-EM survey data. Permission to access the CWG-EM survey data would require the approval of all three Trilateral Partner organizations, and approval from a Canadian Research and Ethics Board (REB). Additional factors involving access to CWG-EM survey data such as project mechanics, intellectual property, and confidentiality, would need to be defined in advance by the trilateral partners.

Examples of potential future research questions that could be answered or facilitated through the use of CWG-EM survey data are provided in Figure 23.



Figure 23: Examples of future research use of CWG-EM data

| | |
|---------------------------------------|--|
| Trends and practice patterns | Examination of outcomes data from the CCFP(EM) and FRCPC-EM residency programs. What is the pattern of practice after 5 years? 10 years? Are there differences with respect to training and practice? Do these trends align with the goals of each EM program? |
| Resource utilization models | Assessment of resource utilization by graduates from each program: Are there similarities? Are there differences? |
| Career planning | Assessment of extent to which trainees have ambiguity in career planning. |
| Changes in career paths | Assessment of change in the ultimate final career path of trainees over the course of and subsequent to their training. |
| Alignment of training and practice | Assessment of the degree to which the goals of the CCFP(EM) and FRCPC-EM program are in or out of sync with the ultimate practice patterns of their graduates. |
| Future practice profiles of graduates | Assessment of secular trends and changes regarding the practice profiles of graduates from the CCFP(EM) and FRCPC-EM programs. |
| Measuring attitudes and perspectives | Assessment of differences in attitudes and perspectives between resident trainees and graduates of the CCFP(EM) and FRCPC-EM programs. |
| HHR Projections | Completion of a more robust and detailed HHR projection, based on plans/expectations of residents and practice pattern differences between the CCFP(EM) and FRCPC-EM programs. |

Conclusion



Meeting the Future Emergency Care Needs of Canadians

Since the late 1970s, the training in and practice of Emergency Medicine in Canada has undergone significant transformation. Prior to the recognition of EM as a distinct discipline in Canada, EDs were typically staffed by physicians without formal EM training or a comprehensive understanding of the unique requirements of EM practice. During this time, physicians providing care in emergency rooms identified the societal need for a dedicated practice to serve the acutely ill and injured. The formation of CAEP in 1978 and the development of EM residency training programs by the Royal College and the CFPC in the early 1980's have served the emergency care needs of the Canadian public effectively. EM has since evolved into an academic discipline, and the Canadian EM community now has an international reputation of excellence in clinical care, education, and research.

As the discipline of EM continues to evolve and the emergency care needs of the Canadian public become increasingly complex, in part due to an expanding and aging population, the EM community must continue to maintain high expectations for training in and practice of competent care in all emergency settings.

The CWG-EM has identified a significant HHR shortfall of emergency physicians, both currently and in the future, and has recommended urgent actions be taken to address this issue. In addition, we have also identified a number of practical strategies for both the Royal College and CFPC to enhance and align their EM residency training programs to enhance EM care and educational resource utilization. We have recommended that CAEP continue to be an important partner and advocate in the implementation of these recommendations.

This report and its recommendations represent an important contribution to the improvement of EM care for all Canadians by facilitating meaningful changes to EM training and practice. We thank the trilateral partners for their vision in establishing the CWG-EM and urge early engagement with all relevant stakeholders with a goal of implementation of our recommendations over the next year.

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Tables & Figures

Table 1a: Demographics of respondents to the national survey by respondent group.

Table 1b: Province of residence of respondents to the national survey by respondent group.

Table 2: Distribution of practice by certificant type and ED setting.

Table 3: Subgroup analysis – ED setting by certification of ED Chiefs.

Table 4: Subgroup analysis – certification of ED Chiefs by ED setting.

Table 5: Level of agreement for the CCFP (non-EM) program to be rated as an effective route to develop competencies in EM.

Figure 1: Illustration of key themes identified in the CWG-EM work: Emergency Medicine specialist.

Figure 2: Components of the Royal College accredited residency training pathway in Emergency Medicine (summarizes content of the Royal College STR-EM).

Figure 3: Program goals of the CCFP(EM) program (outlined by the Red Book).

Figure 4: Components of the CFPC accredited residency training pathway in Emergency Medicine.

Figure 5: Total post-M.D. trainees in Emergency Medicine (2010/11 - 2014/15).

Figure 6: Total post-M.D. trainees in Emergency Medicine – final year of training (2010/11 - 2014/15).

Figure 7: Emergency department settings of physicians with an EM certification (%).

Figure 8: Emergency department settings of physicians with an EM certification (by certificant type).

Figure 9: Emergency department practice settings of CCFP physicians (%).

Figure 10: Desired future practice locations of EM residents (%).

Figure 11: Anticipated breakdown of clinical practice of EM residents (%).

Figure 12: Canadian Emergency Medicine certifications of ED Chiefs (%).

Figure 13: Ideal distributions of physicians (mean %) by emergency department setting as reported by ED Chiefs.

Figure 14: Perspectives of physicians currently practicing Emergency Medicine (%).

Figure 15: Perspectives of CCFP(EM) and FRCPC-EM residents (%).

Figure 16: Respondent ratings of the ability of the current dual college, dual certification approach to Canadian Emergency Medicine to meet the needs of the Emergency Medicine practice and the Canadian public (%).

Figure 17: Respondent observations of the strengths and challenges of the current dual college, dual certification approach.

Figure 18: National emergency physician shortfall estimate and future projections (excludes remote settings).

Figure 19: Projected emergency physician shortfall (Large Urban Academic Hospital).

Figure 20: Projected emergency physician shortfall (Large Urban Non-Academic).

Figure 21: Projected emergency physician shortfall (Small Urban).

Figure 22: Projected emergency physician shortfall (Rural).

Figure 23: Examples of future research use of CWG-EM data.

Appendix A

Collaborative Working Group on the Future of Emergency Medicine in Canada: Terms of Reference

- › CAEP/CFPC/Royal College Collaborative Working Group on the Future of Emergency Medicine in Canada
- › Terms of Reference
- › Approved September 2013
- › Updated and Approved October 2015
- › Updated and Approved May 2016

Membership

The CAEP/CFPC/Royal College Collaborative Working Group on the Future of Emergency Medicine in Canada (the "CWG-EM") will be composed of seven (7) members, including the Chair and two (2) members appointed by each of CAEP, the CFPC, and the Royal College;

Chair

Douglas 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, CCPE

The CWG-EM shall be constituted by September 15, 2013, and shall first meet as soon as possible after this date.

Five members of the Committee, including the Chair, shall constitute quorum; but each meeting must have at least one representative from CAEP, the CFPC, and the Royal College.

The recommendations of the working group require unanimous consent of the members of the group.



Accountability

- (i) The CWG-EM is the advisory to the Board of Directors of CAEP, the CFPC, and the Royal College.

Roles and Responsibilities

- (i) Perform an assessment of the current situation regarding each of the two EM training programs and any related local/provincial/territorial adjuncts;
- (ii) Based on the information obtained from the above assessments and other pertinent information, identify the challenges that exist regarding emergency physician HHR, and the education and training of future emergency physicians as it relates to the evolution of emergency medicine and the evolving needs of Canadians;
- (iii) Assess the efficiency and effectiveness of each program in meeting its stated training objectives, and the broader impact of this vis-à-vis the advancement of emergency medicine and the provision of high quality emergency medical care in Canadian EDs;
- (iv) Identify and make recommendations regarding areas where collaboration at the national College level between the two EM training programs would be beneficial to optimize the use of educational resources and/or maximize the benefits that each of these programs provides;
- (v) Identify and make recommendations regarding areas where adaptation in the makeup and design of one or both EM training programs would be beneficial to optimize the use of educational resources and/or maximize the benefits that each of these programs provides.

Meetings and Reporting

- (i) The CWG-EM shall meet as often as necessary
- (ii) The CWG-EM shall make recommendations to CAEP, the CFPC, and the Royal College no later than December 15 2014.

*This should include, but is not necessarily limited to: a) determining what coordination exists between the CCFP(EM) and FRCPC-EM programs in Canadian medical schools, and the nature and extent of this, b) determining whether discourse exists at a national college level between the CFPC and the Royal College in relation to the makeup, design, and stated training objectives of their respective EM programs, and c) identifying and researching any local/provincial/territorial adjuncts that exist to the residency training programs that the CFPC and Royal College offer, and the current effect and expected future impact of these on the Canadian EM training milieu.

Appendix B



Guiding Questions that Informed the CWG-EM Work Plan

| Q number: | 1 st Set of Questions: |
|-----------|---|
| 1 | Is there a definition of the role of EM as a discipline in Canada that we can all agree to? |
| 2 | Is the purpose/goal of each route to EM certification in Canada the same? How are they different? |
| 3 | What is our conception then of how the graduates of each program practice EM to serve Canadians? |
| 4 | How should the two EM routes to certification then respond, based on #1-3 above? |

| Q number: | 2 nd Set of Questions: |
|-----------|---|
| 1.1 | What is a reasonable forecast for future patient volumes in Canadian EDs? |
| 1.2 | Current trends in ED visit volumes? |
| 1.3 | What factors may alter / influence patient volumes (i.e. gov't initiatives to create alternate care locations, changes in primary care)? |
| 2.1 | What are the related Emergency MD HHR needs to meet patient care / volume demands? |
| 2.2 | What are factors that could significantly influence these projections (i.e. addition of alternate care providers, changes in practice patterns - fewer or more shifts/MD)? |
| 3.1 | What is current # of emergency care providers and what are current rates of attrition and provision of new EM MDs? |
| 4.1 | What are factors that may contribute to disruptive change in delivery of emergency care and thus may influence EM MD HHR needs (i.e. new technology)? |
| 4.2 | How can we prepare with the most flexibility to meet these unknown and variable possibilities? |
| 5.1 | What is the current Canadian ED workforce, and what are the current & projected future Emergency Physician HHR needs? |
| 5.2 | How many physicians are practicing in each ED in each Canadian province and territory? |
| 5.3 | What is the training and hours worked by physicians across all EDs in Canada? |
| 5.4 | What is the distribution of certification levels among the current emergency physician workforce in total, and in relation to the nature of their ED (low volume, medium volume or high-volume centres) and hours worked? |
| 5.5 | What, if any, strategies exist in the provinces or territories relating to influencing or optimizing the deployment of emergency physicians? |
| 5.6 | What, if any, any provincial or territorial strategies exist in relation to present or future emergency physician HHR? |
| 5.7 | What is the current emergency physician HHR shortfall and training required/desired to meet this? |
| 5.8 | What is the projected emergency physician HHR shortfall in the next 3/5/10 years, and what training is required/desired to meet this? |
| 6.1 | What is the current status of intercollege/interprogram collaboration/coordination specific to emergency medicine? |
| 6.2 | What collaboration/coordination exists between the two Colleges regarding their EM programs? |
| 6.3 | What collaboration/coordination exists at the level of the individual CFPC and RCPS programs at various sites? |
| 6.4 | What if any strategies exist to co-ordinate the number of trainees in each EM program in order to address current and future HHR needs in emergency medicine? |

2nd Set of Questions (continued):

| | |
|-----|---|
| 7.1 | What is the current status regarding alternative, adjunct, or novel EM programs in Canada? |
| 7.2 | What alternative, adjunct, or novel EM programs exist in each province, either at the university level or the private sector? |
| 7.3 | For each identified program: what were the reasons for the development of the program, what are the goals of these programs, and how successful has the program been in meeting its' goals? |

| Q number: | 3 rd Set of Questions: |
|-----------|---|
| 1.1 | Who (demographics) provides care in Emergency settings across Canada currently? |
| 1.2 | What percentage of their time do they spend at this work? |
| 1.3 | What is their training? Did they feel well prepared? |
| 1.4 | Would more of different training have changed anything for them? |
| 1.5 | What do they do to remain current? |
| 1.6 | Are they members of CAEP? Why or why not? |
| 1.7 | What is the most significant problem they face in their efforts to provide excellent clinical EM care? |
| 2.1 | What are the practice patterns and perspectives of graduates from each Canadian EM training program? |
| 2.2 | What is the practice pattern (proportion/hours in clinical EM/clinical other/academic) of FRCPC emergency physicians? |
| 2.3 | What is the practice pattern (proportion/hours in clinical EM/FM/clinical other/academic) of CCFP(EM) emergency physicians? |
| 2.4 | What training do graduates of each program feel is needed for EM practice in various locations and levels/types of EDs in Canada? |
| 2.5 | Do graduates of each program feel the training they received met the needs of their current practice? |
| 2.6 | What are the opinions of graduates of each program regarding the link between FM and EM, and the ideal role of each college in EM training & certification in Canada? |
| 3.1 | What are the intentions and perspectives of trainees in each Canadian EM training program? |
| 3.2 | What are the opinions of trainees in each EM program regarding the DC/DC issue? |
| 3.3 | What are the future practice intentions of trainees in each EM program? |
| 3.4 | How well to trainees feel their program meets their intended future practice plans? |
| 3.5 | What are the opinions of trainees in each program regarding the efficiency/effectiveness of their training program in meeting its stated goals? |
| 3.6 | What are the opinions of trainees in each EM program on the amount of Family Medicine training in their program? |
| 3.7 | What are the opinions of trainees in each EM program on the amount of elective/selective time in their program? |
| 4.1 | What are the perspectives of university Postgrad Deans on the issues in EM? |
| 4.2 | What are opinions of Postgrad Deans at Canadian universities regarding the DC/DC issue, its link to competency-based education, and whether changes could be made to emergency physician training without reducing the total EM funding envelope? |
| 5.1 | What are the perspectives of EM leaders on the issues in EM? |
| 5.2 | What are the opinions of Academic Department of EM Chairs, ED Heads, Provincial Medical Association EM Section Heads, EM Program Directors, and Regional EM Heads on the DC/DC issue? |
| 6.1 | What are the perspectives of medical students with an interest in EM on the issues in EM? |
| 6.2 | What are the opinions of medical students with an interest in EM regarding the DC/DC issue, how they choose the program they will apply to, and whether the existing DC/DC situation is perceived as complicating their decision making process? |

Appendix C

CWG-EM National Survey on Emergency Medicine (Full Surveys in English and French)



> Collaborative Working Group Survey for EM Certified Physicians

Introduction

This survey is being carried out by the Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM). The CWG-EM is endorsed by, and is a partnership between The College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Canadian Association of Emergency Physicians. The role of the CWG-EM is to perform an assessment of the current and future emergency physician health human resource needs within Canadian health care, including an assessment of the two Emergency Medicine (EM) training programs and their ability to meet these needs. This work includes surveys of emergency physicians, emergency department chiefs and EM residents. Your candid responses to the questions that follow will facilitate that work. All responses will be compiled, analyzed, and interpreted by the CWG-EM by subgroup. Thank you in advance for taking the time to complete this survey.

Demographics

1. What is your year of birth? _____
Select year of birth
2. What is your gender?
 - Female
 - Male
3. What is your province of residence? _____
Select a province or territory

British Columbia
Alberta
Saskatchewan
Manitoba
Ontario

Québec
New Brunswick
Nova Scotia
Prince Edward Island
Newfoundland and

Labrador
Yukon
Northwest Territories
Nunavut



4. Did you complete a Canadian residency in Emergency Medicine?
 - Yes
 - No

5. What Canadian Emergency Medicine (EM) certification do you hold?
 - CCFP(EM)
 - FRCPC-EM
 - Both CCFP(EM) and FRCPC-EM

6. What year did you obtain your most recent EM certification?
_____ Select year of certification

7. Do you currently practice clinical Emergency Medicine?
 - Yes
 - No

Practice Characteristics

8. What is the distribution of your overall work time?
 - _____ %Clinical Medicine
 - _____ %Administrative
 - _____ % Research
 - _____ % Teaching Outside of Clinical Medicine
 - _____ %Other _____

TOTAL 100%

9. What is the distribution of your CLINICAL practice:
 - _____ % Emergency Medicine (within the emergency department)
 - _____ % Family Medicine (outside the emergency department)
 - _____ % Critical Care
 - _____ % Sports Medicine
 - _____ % Trauma Care
 - _____ % Other. Please Specify: _____

TOTAL 100%

10. Which of the following BEST describes your emergency department?
 - o Large urban academic hospital
 - o Large urban non-academic hospital (e.g., may provide teaching but without other research or academic programs)
 - o Small urban hospital (e.g., may provide teaching but without other research or academic programs)
 - o Rural (e.g., may provide teaching but without other research or academic programs)
 - o Remote hospital (e.g., may provide teaching but without other research or academic programs)



ED Characterization

11. What is the approximate annual volume in your Emergency Department? _____
12. Do you work at a university affiliated teaching hospital where residents and/or medical students are on rotation in your emergency department?
 - Yes
 - No
13. If you practice Emergency Medicine, how many scheduled clinical hours per month do you work in the emergency department? _____ hours per month
14. The following questions relate to onsite dedicated emergency department coverage. You will be asked to predict change in the volume of your clinical emergency work hours 5 years from today and 10 years from today. Please note that changes for 5 years and 10 years should be estimated uniquely and are not expected to be incremental.

What do you predict will be the direction of change in the volume of your clinical emergency work hours at the end of 5 years compared to 2015?

- Increase
- Decrease
- Unchanged [skip next question if selected]

COMMENTS: _____

15. A) What do you predict will be the percent increase in the volume of your clinical emergency work hours at the end of 5 years compared to 2015? _____%
- B) What do you predict will be the percent decrease in the volume of your clinical emergency work hours at the end of 5 years compared to 2015? _____%
16. What do you predict will be the direction of change in the volume of your clinical emergency work hours at the end of 10 Years compared to 2015?
 - Increase
 - Decrease
 - Unchanged [skip next question if selected]

COMMENTS: _____

17. A) What do you predict will be the percent increase in the volume of your clinical emergency work hours at the end of 10 years compared to 2015? _____%
- B) What do you predict will be the percent decrease in the volume of your clinical emergency work hours at the end of 10 years compared to 2015? _____%



EM residency

18. Please indicate your agreement for the following statements:

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

- a) The training I received adequately prepared me for my current clinical practice.
- b) The training I received adequately prepared me for my current non-clinical practice (i.e. research, teaching, leadership, etc.).

19. What, if any changes, would you have made in the training you received to better prepare you for your current practice?

COMMENTS: _____

Using the scale below please indicate your agreement with the statement that the Canadian Emergency Medicine certification training programs listed meets the needs of the following types of emergency departments:

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

20. Tertiary Urban:

- CCFP(EM):
- FRCPC-EM:

21. Non-Tertiary Urban:

- CCFP(EM):
- FRCPC-EM:

22. Community:

- CCFP(EM):
- FRCPC-EM:

23. Rural:

- CCFP(EM):
- FRCPC-EM:

COMMENTS: _____



24. Please indicate your agreement with the following statement: The following programs are effective routes to gain competencies to the practice of Emergency Medicine.

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

- a) CCFP
- c) CCFP(EM)
- d) FRCPC-EM

COMMENTS: _____

25. Please indicate your agreement to the following statements:

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

- a) There is an appropriate amount of exposure to clinical family medicine training within the CCFP(EM) program.
- b) There is an appropriate amount of exposure to clinical family medicine training within the FRCPC-EM program.
- c) There is an appropriate amount of exposure to clinical Emergency Medicine in the CCFP(EM) program.
- d) There is an appropriate amount of exposure to clinical Emergency Medicine in the FRCPC-EM program.
- e) My training program provided an appropriate amount of combined elective/selective time.
- f) My training program provided me with options for the various types of practice I can become involved in.
- g) My Emergency Medicine training program was effective in helping me meet my training goals and future career plans.

COMMENTS: _____



26. Please indicate your thoughts on the existence of a perceived or real difference in the abilities of physicians with CCFP certification, CCFP(EM) certification, and FRCPC-EM certification *immediately after completing their residency*, to meet the clinical and, (if appropriate) teaching/academic needs of your emergency department and to practice Emergency Medicine at a level that meets your emergency department's requirements and standards of care.

Program goals

27. The College of Family Physicians of Canada has defined the purpose, goals and product of its CCFP and CCFP(EM) program as the following:

The College of Family Physicians of Canada residency programs are dedicated to training family physicians to provide emergency care directly to all patients of all ages, with any presenting problem, at any time, and in any community in Canada. At the core family medicine training level (CCFP), this objective is part of comprehensive training. New certificants are expected to provide emergency care commensurate with the needs of their practice community, and to add progressively to their skills as required by these community needs. Enhanced skills training (CCFP(EM)) in Family Medicine in the domain of Emergency Medicine prepares family physicians to provide excellent emergency care for all patients in any emergency department in Canada, including community, regional, and academic/teaching hospital settings. The family physician with these enhanced skills may provide emergency care on a full-time practice basis, or on a part-time basis integrated with other family medicine activities. These family physicians will also add to their skills on a continuing basis according to community needs, and may go on to assume leadership roles in education, research and administration.

A. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns



B. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP(EM) training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____

28. The Royal College of Physicians and Surgeons of Canada has defined the purpose, goals and product of the FRCPC-EM program as the following:

Residency training leading to specialist Emergency Medicine (EM) certification and practice in Canada is done through the Royal College Emergency Medicine (EM) residency training programs. Royal College EM specialists have practices dedicated to advanced care for patients with acute and often undifferentiated health problems, across a broad spectrum of illnesses and injury in all age groups, frequently before complete clinical or diagnostic information is available. They are capable of assuming a consultant's role in the specialty and providing comprehensive emergency adult and pediatric care in academic/teaching, community or regional hospital settings. Royal College EM specialists are the only comprehensive resuscitation specialists, possessing expertise in the anatomy, physiology, pathophysiology, pharmacology and management of all acute presentations. EM specialists use their comprehensive knowledge of related fields at the interface between emergency care provision and the health care system, including toxicology, traumatology, prehospital care, and disaster preparedness. Royal College EM specialists are an academic and community resource, providing advanced clinical patient care; support to other practitioners in an emergency setting; leadership in the administration of emergency departments, emergency medical systems, health care institutions and related programs; and the conduct of relevant research and education with the goal of advancing knowledge and improving individual and/or community health outcomes.

Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the FRCPC-EM training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____



We would like your opinion on current Emergency Medicine training and certification in Canada. Please consider the statement below and select the response that best reflects your sentiments:

The ability of the current dual college dual certification approach in Canadian Emergency Medicine to meet the needs of EM and the Canadian public is:

- a) Very Good: I have no concerns
- b) Good: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Poor: I have some concerns
- e) Very Poor: I have many concerns

29. If you are generally satisfied with current EM training and certification in Canada, please outline why, and why it should be maintained: _____

30. If you have any concerns with current EM training and certification in Canada, please outline why, and what changes you would suggest: _____

Thank you for taking time to complete this survey.

Appendix C (Cont'd)



› Enquête du Groupe de travail collaboratif auprès des médecins certifiés en médecine d'urgence

Introduction :

La présente enquête est réalisée par le Groupe de travail collaboratif sur l'avenir de la médecine d'urgence au Canada. Le Groupe de travail collaboratif est issu d'un partenariat entre le Collège des médecins de famille du Canada, le Collège royal des médecins et chirurgiens du Canada et l'Association canadienne des médecins d'urgence. Son rôle consiste à effectuer une évaluation des besoins actuels et futurs en matière de ressources humaines dans le domaine de la médecine d'urgence au sein du secteur canadien des soins de santé, y compris évaluer les deux programmes de formation en médecine d'urgence et leur capacité à satisfaire ces besoins. Ce travail comprend des enquêtes auprès des médecins d'urgence, des chefs des services d'urgence et des résidents en médecine d'urgence. Vos réponses franches aux questions qui suivent faciliteront ce travail. Toutes les réponses seront compilées, analysées et interprétées par un sous-groupe du Groupe de travail collaboratif. Nous vous remercions à l'avance de prendre le temps de participer à cette enquête.

Données démographiques

1. Quelle est votre année de naissance? _____

Sélectionnez votre année de naissance.

2. Quel est votre sexe?

- Femme
- Homme


3. Dans quelle province habitez-vous? _____

Choisissez une province ou un territoire.

Colombie-Britannique
Alberta
Saskatchewan
Manitoba
Ontario

Québec
Nouveau-Brunswick
Nouvelle-Écosse
Île-du-Prince-Édouard
Terre-Neuve-et-Labrador

Yukon
Territoires du Nord-Ouest
Nunavut

- 
4. Avez-vous effectué une résidence en médecine d'urgence au Canada?
 - Oui
 - Non

 5. Quel certificat canadien en médecine d'urgence (MU) détenez-vous?
 - CCMF(MU)
 - FRCPC-MU
 - CCMF(MU) et FRCPC-MU

 6. En quelle année avez-vous obtenu votre certificat le plus récent en médecine d'urgence?
 _____ Sélectionnez l'année de la certification.

 7. Pratiquez-vous actuellement la médecine d'urgence dans un environnement clinique?
 - Oui
 - Non

Caractéristiques de la pratique

8. Quelle est la distribution de vos tâches au travail?
 - _____ % : médecine clinique
 - _____ % : tâches administratives
 - _____ % : recherche
 - _____ % : enseignement hors de la pratique clinique
 - _____ % : autres tâches (veuillez préciser : _____)

TOTAL 100%

9. Comment se décline votre pratique CLINIQUE?
 - _____ % Emergency Medicine (within the emergency department)
 - _____ % Family Medicine (outside the emergency department)
 - _____ % Critical Care
 - _____ % Sports Medicine
 - _____ % Trauma Care
 - _____ % Other. Please Specify: _____

TOTAL 100%

10. Lequel des énoncés suivants décrit le MIEUX le contexte de votre service des urgences?
 - o Grand hôpital universitaire en milieu urbain
 - o Grand hôpital non universitaire en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
 - o Petit hôpital en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
 - o Établissement en milieu rural (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
 - o Hôpital en région éloignée (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)



Description du service des urgences

11. Quel est le volume annuel approximatif de votre service des urgences? _____
12. Travaillez-vous dans une université affiliée à un hôpital d'enseignement où les résidents ou étudiants en médecine font des rotations dans votre service des urgences?
 - Oui
 - Non
13. Si vous pratiquez la médecine d'urgence, combien d'heures de pratique clinique compte votre horaire de travail par mois au service des urgences? _____ heures par mois
14. Les questions qui suivent ont trait à votre pratique au service des urgences. On vous demandera de prévoir l'évolution de votre charge de travail dans votre service des urgences d'ici cinq ans puis d'ici dix ans. Veuillez noter que les changements prévus dans cinq et dans dix ans doivent être estimés mais non cumulés.

Selon vous, de quelle façon le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences changera-t-il d'ici cinq ans, par rapport à 2015?

- Il augmentera
- Il diminuera
- Il restera le même (si tel est le cas, sautez la prochaine question)

COMMENTAIRES : _____

15. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences [augmentera-t-il/diminuera-t-il] d'ici cinq ans, par rapport à 2015? _____
16. Selon vous, de quelle façon le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences changera-t-il d'ici dix ans, par rapport à 2015?
 - Il augmentera
 - Il diminuera
 - Il restera le même (si tel est le cas, sautez la prochaine question)

COMMENTAIRES : _____

17. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences [augmentera-t-il/diminuera-t-il] d'ici dix ans, par rapport à 2015? _____



Résidence en médecine d'urgence

18. Veuillez indiquer dans quelle mesure vous êtes d'accord avec les énoncés ci-dessous.

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

e) La formation que j'ai reçue m'a adéquatement préparé à ma pratique clinique actuelle.

f) La formation que j'ai reçue m'a adéquatement préparé à ma pratique actuelle dans un environnement autre que clinique (à savoir, la recherche, l'enseignement, la direction, etc.).

19. Quels changements (le cas échéant) auriez-vous souhaité voir dans la formation que vous avez reçue pour mieux vous préparer en vue de votre pratique actuelle?

COMMENTAIRES : _____

À partir de l'échelle ci dessous, veuillez indiquer si vous êtes d'accord avec l'énoncé voulant que les programmes de formation en médecine d'urgence au Canada énumérés répondent aux besoins des types suivants de service des urgences :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

20. Soins tertiaires urbains :

- CCMF(MU) :
- FRCPC-MU :

21. Soins non tertiaires urbains :

- CCMF(MU) :
- FRCPC-MU :

22. Soins communautaires :

- CCMF(MU) :
- FRCPC-MU :

23. Soins en milieu rural :

- CCMF(MU) :
- FRCPC-MU :

COMMENTAIRES : _____



24. Veuillez indiquer dans quelle mesure vous êtes d'accord avec les énoncés qui suivent. Les programmes ci-dessous constituent des parcours efficaces pour acquérir les compétences nécessaires à la pratique de la médecine d'urgence :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

- a) CCMF
- g) CCMF(MU)
- h) FRCPC-MU


COMMENTAIRES : _____

25. Veuillez indiquer si vous êtes d'accord avec les énoncés suivants :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

- h) Le programme pour l'obtention du certificat du Collège des médecins de famille du Canada en médecine d'urgence [CCMF(MU)] offre une formation en médecine familiale clinique suffisante.
- i) Le programme pour l'obtention du titre d'Associé du Collège royal des médecins et chirurgiens du Canada en médecine d'urgence (FRCPC-MU) offre une formation en médecine familiale clinique suffisante.
- j) Le programme pour l'obtention du certificat du Collège des médecins de famille du Canada en médecine d'urgence [CCMF(MU)] offre une formation en médecine d'urgence suffisante.
- k) Le programme pour l'obtention du titre d'Associé du Collège royal des médecins et chirurgiens du Canada en médecine d'urgence (FRCPC-MU) offre une formation en médecine d'urgence clinique suffisante.
- l) Mon programme de formation a offert une quantité adéquate de cours obligatoires et de cours facultatifs.
- m) Mon programme de formation m'a offert plusieurs options pour divers genres de pratique clinique que je suis susceptible d'exercer.
- n) Mon programme de formation en médecine d'urgence m'a aidé à atteindre mes objectifs en matière de formation et de cheminement de carrière.

COMMENTAIRES : _____



26. Veuillez indiquer ce que vous pensez de la différence perçue ou réelle, le cas échéant, entre les compétences des médecins détenant la désignation CCMF, la désignation CCMF(MU) et la certification FRCPC-MU *immédiatement suivant la fin de leur résidence* pour combler les besoins cliniques et pédagogiques (si approprié) dans votre service des urgences, et pour pratiquer la médecine d'urgence à un niveau qui satisfait aux exigences et normes de votre établissement.


Objectifs des programmes

27. Le Collège des médecins de famille du Canada a défini la raison d'être, les objectifs et les produits de ses programmes menant aux désignations CCMF et CCMF(MU) de la façon suivante :

Les programmes de résidence du Collège des médecins de famille du Canada visent à former les médecins de famille afin qu'ils puissent directement prodiguer des soins d'urgence aux patients de tous âges présentant quelque problème de santé que ce soit, à tout moment et dans toutes les collectivités du Canada. Cet objectif est l'un des buts généraux visés par la formation en médecine familiale menant à la désignation CCMF (certificat du Collège des médecins de famille du Canada). On attend des médecins ainsi formés qu'ils puissent prodiguer les soins d'urgence que requiert la pratique dans la collectivité, puis qu'ils rehaussent leurs compétences en fonction des besoins de la collectivité qu'ils desservent. Une formation plus poussée en médecine familiale dans le domaine de la médecine d'urgence [CCMF(MU)] prépare les médecins de famille en vue d'offrir des soins d'urgence de grande qualité à tous les patients se présentant au service des urgences, partout au Canada, que ce soit en contexte communautaire, dans un établissement régional, dans un hôpital universitaire, etc. Un médecin de famille possédant ces compétences avancées peut prodiguer des soins d'urgence à temps plein, ou à temps partiel de concert avec les autres activités de la médecine familiale. Ces médecins de famille rehaussent leurs compétences de façon continue, en fonction des besoins de la collectivité, et peuvent en venir à remplir des fonctions de dirigeants dans les domaines de l'éducation, de la recherche et de l'administration.

A. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup




B. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF(MU) décrits précédemment

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____

28. Le Collège royal des médecins et chirurgiens du Canada a défini la raison d'être, les objectifs et les produits de son programme menant à la certification du Collège royal en médecine d'urgence (FRCPC-MU) de la façon suivante :

Au Collège royal, les programmes de résidence en médecine d'urgence (MU) mènent à la certification et au permis d'exercer à titre de spécialiste dans cette discipline particulière. La pratique des spécialistes ainsi formés au Collège royal en médecine d'urgence est vouée aux soins avancés destinés aux patients présentant des problèmes de santé aigus et souvent indifférenciés et pour lesquels aucune information clinique ou diagnostique n'est encore disponible. Ces médecins sont en mesure de tenir un rôle de conseillers dans ce domaine spécialisé, et de prodiguer des soins d'urgence complets aux adultes et aux enfants tant en contexte d'enseignement universitaire ou de santé communautaire que dans les centres hospitaliers régionaux. Les spécialistes en médecine d'urgence du Collège royal sont les seuls à être spécialisés dans toutes les interventions de réanimation, possédant de l'expertise en anatomie, en physiologie, en pathophysiologie et en pharmacologie ainsi que dans le traitement de toute affection aiguë. Ces spécialistes du Collège royal misent sur leurs vastes connaissances dans des domaines connexes en faisant le lien entre la médecine d'urgence et les autres domaines de la santé, notamment la toxicologie, la traumatologie, les soins préhospitaliers et la préparation aux situations de crise. Les spécialistes en médecine d'urgence du Collège royal constituent une réelle ressource pour la collectivité et le secteur de l'enseignement : ils prodiguent des soins cliniques avancés aux patients, ils appuient les autres praticiens des services d'urgence, ils tiennent des rôles de leadership dans l'administration des services et systèmes de médecine d'urgence, des établissements de soins de santé et des programmes connexes, ils mènent des travaux de recherche pertinents et ils enseignent dans le but de faire progresser les connaissances et d'améliorer les résultats de santé des patients et de la collectivité entière.



Veillez indiquer votre opinion en ce qui concerne l'efficacité du Collège royal à réaliser les objectifs du programme de formation FRCPC-MU décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____

29. Nous aimerions connaître votre opinion en ce qui concerne la formation et la certification en médecine d'urgence au Canada. Veuillez réfléchir à l'énoncé qui suit et indiquer la réponse qui correspond le mieux à votre point de vue.

La possibilité de pouvoir présentement obtenir une certification en médecine d'urgence au Canada auprès de l'un ou l'autre des deux collèges pour combler les besoins de la population canadienne en matière de soins d'urgence est :

- a) Une très bonne chose : cela ne soulève aucune préoccupation
- b) Une bonne chose : cela ne soulève que de légères préoccupations
- c) Mon opinion est plutôt neutre
- d) Une mauvaise chose : cela soulève quelques préoccupations
- e) Une bien mauvaise chose : cela soulève de nombreuses préoccupations

30. Si vous êtes généralement satisfait de la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez indiquer pourquoi, et pour quelles raisons elle devrait rester ainsi : _____

31. Si vous êtes préoccupé concernant la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez en indiquer les raisons et proposer les changements qui s'imposent : _____

Nous vous remercions d'avoir pris le temps de participer à cette enquête.

Appendix C (Cont'd)



› Collaborative Working Group Survey for CCFP Certified Physicians

Introduction:

This survey is being carried out by the Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM). The CWG-EM is endorsed by, and is a partnership between The College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Canadian Association of Emergency Physicians. The role of the CWG-EM is to perform an assessment of the current and future emergency physician health human resource needs within Canadian health care, including an assessment of the two Emergency Medicine (EM) training programs and their ability to meet these needs. This work includes surveys of emergency physicians, emergency department chiefs, and EM residents. Your candid responses to the questions that follow will facilitate that work. All responses will be compiled, analyzed, and interpreted by the CWG-EM by subgroup. Thank you in advance for taking the time to complete this survey.

Demographics

1. What is your year of birth? _____
Select year of birth
2. What is your gender?
 - Female
 - Male
3. What is your province of residence? _____
Select a province or territory

British Columbia
Alberta
Saskatchewan
Manitoba
Ontario

Québec
New Brunswick
Nova Scotia
Prince Edward Island
Newfoundland and

Labrador
Yukon
Northwest Territories
Nunavut



4. Do you currently practice clinical Emergency Medicine?

- Yes
- No

5. What is the distribution of your overall work time:
(Please break down into a percentage totaling 100%)

- _____ %Clinical Medicine
- _____ %Administrative
- _____ % Research
- _____ % Teaching Outside of Clinical Medicine
- _____ %Other _____

TOTAL 100%

6. What is the distribution of your CLINICAL practice:

- _____ % Emergency Medicine (within the emergency department)
- _____ % Family Medicine (outside the emergency department)
- _____ % Critical Care
- _____ % Sports Medicine
- _____ % Trauma Care
- _____ % Other. Please Specify: _____

TOTAL 100%

7. Which of the following BEST describes your emergency department?

- o Large urban academic hospital
- o Large urban non-academic hospital (e.g., may provide teaching but without other research or academic programs)
- o Small urban hospital (e.g., may provide teaching but without other research or academic programs)
- o Rural (e.g., may provide teaching but without other research or academic programs)
- o Remote hospital (e.g., may provide teaching but without other research or academic programs)

Emergency Department Characterization

8. If you practice emergency medicine, what is the approximate annual volume in your emergency department? _____

9. Do you work at a university affiliated teaching hospital where residents and/or medical students are on rotation in your emergency department?

- Yes
- No



10. If you practice Emergency Medicine, how many on site clinical hours per month do you work in the emergency department? _____ hours per month

The following questions relate to onsite dedicated emergency department coverage. You will be asked to predict your department's change in coverage 5 years from today and 10 years from today. Please note that changes for 5 years and 10 years should be estimated uniquely and are not expected to be incremental.

11. What do you predict will be the direction of change in the volume of your clinical emergency work hours at the end of 5 years compared to 2015?

- Increase
- Decrease
- Unchanged [skip next question if selected]

COMMENTS: _____

12. What do you predict will be the percent increase in the volume of your clinical emergency work hours at the end of 5 years compared to 2015? _____%

13. What do you predict will be the percent decrease in the volume of your clinical emergency work hours at the end of 5 years compared to 2015? _____%

14. What do you predict will be the direction of change in the volume of your clinical emergency work hours at the end of 10 Years compared to 2015?

- Increase
- Decrease
- Unchanged [skip next question if selected]

COMMENTS: _____

15. What do you predict will be the percent increase in the volume of your clinical emergency work hours at the end of 10 years compared to 2015? _____%

16. What do you predict will be the percent decrease in the volume of your clinical emergency work hours at the end of 10 years compared to 2015? _____%



EM Residency Programs

17. Please indicate your agreement for the following statements:

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

The training I received adequately prepared me for my current clinical practice.

18. How much time did you spend in clinical Emergency Medicine in your residency, in months or month-equivalents if distributed? _____

19. What, if any changes, would you have made in the training you received to better prepare you for your current practice?

COMMENTS: _____

20. Have you undertaken additional structured training to enhance your skills in the provision of clinical care in the emergency department?

- a) None
- b) Accredited CFPC Enhanced skills programs:
- c) Other structured Emergency Medicine training (type and duration) _____
- d) Other structured training (type and duration): _____

COMMENTS: _____

21. What accredited CFPC enhanced skills program did you undertake and for how long?

[displayed if "b" selected in #18]

- Emergency Medicine _____(months)
- Anesthesia _____(months)
- Other: _____(months)

22. What other structured Emergency Medicine training did you take? (Indicate type and duration in months) [displayed if "Emergency Medicine" selected in #19]

- Type: _____
- Duration (in months): _____

23. What other structured training did you complete? (Indicate type and duration in months)

[displayed if "c" selected in #18]

- Type: _____
- Duration (in months): _____



24. Please indicate your agreement with the following statement: The following programs are effective routes to gain competencies to the practice of Emergency Medicine:

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

- a) CCFP
- b) CCFP(EM)
- c) FRCPC-EM

COMMENTS: _____

25. Please indicate your thoughts on the existence of a perceived or real difference in the abilities of physicians with CCFP certification, CCFP(EM) certification, and FRCPC-EM certification immediately after completing their residency, to meet the clinical and, (if appropriate) teaching/academic needs of your emergency department and to practice Emergency Medicine at a level that meets your emergency department's requirements and standards of care.

Program goals

26. The College of Family Physicians of Canada has defined the purpose, goals and product of its CCFP and CCFP(EM) program as the following:

The College of Family Physicians of Canada residency programs are dedicated to training family physicians to provide emergency care directly to all patients of all ages, with any presenting problem, at any time, and in any community in Canada. At the core family medicine training level (CCFP), this objective is part of comprehensive training. New certificants are expected to provide emergency care commensurate with the needs of their practice community, and to add progressively to their skills as required by these community needs. Enhanced skills training (CCFP(EM)) in Family Medicine in the domain of Emergency Medicine prepares family physicians to provide excellent emergency care for all patients in any emergency department in Canada, including community, regional, and academic/teaching hospital settings. The family physician with these enhanced skills may provide emergency care on a full-time practice basis, or on a part-time basis integrated with other family medicine activities. These family physicians will also add to their skills on a continuing basis according to community needs, and may go on to assume leadership roles in education, research and administration.



- A. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP training program:
- a) Very effective: I have no concerns
 - b) Effective: Any concerns I have are minor
 - c) I am neutral in my opinion on this matter
 - d) Ineffective: I have some concerns
 - e) Very ineffective: I have many concerns
- B. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP(EM) training program:
- a) Very effective: I have no concerns
 - b) Effective: Any concerns I have are minor
 - c) I am neutral in my opinion on this matter
 - d) Ineffective: I have some concerns
 - e) Very ineffective: I have many concerns

27. The Royal College of Physicians and Surgeons of Canada has defined the purpose, goals and product of the FRCPC-EM program as the following:

Residency training leading to specialist Emergency Medicine (EM) certification and practice in Canada is done through the Royal College Emergency Medicine (EM) residency training programs. Royal College EM specialists have practices dedicated to advanced care for patients with acute and often undifferentiated health problems, across a broad spectrum of illnesses and injury in all age groups, frequently before complete clinical or diagnostic information is available. They are capable of assuming a consultant's role in the specialty and providing comprehensive emergency adult and pediatric care in academic/teaching, community or regional hospital settings. Royal College EM specialists are the only comprehensive resuscitation specialists, possessing expertise in the anatomy, physiology, pathophysiology, pharmacology and management of all acute presentations. EM specialists use their comprehensive knowledge of related fields at the interface between emergency care provision and the health care system, including toxicology, traumatology, prehospital care, and disaster preparedness. Royal College EM specialists are an academic and community resource, providing advanced clinical patient care; support to other practitioners in an emergency setting; leadership in the administration of emergency departments, emergency medical systems, health care institutions and related programs; and the conduct of relevant research and education with the goal of advancing knowledge and improving individual and/or community health outcomes.



Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the *FRCPC-EM training program*:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____

28. We would like your opinion on current EM training and certification in Canada. Please consider the statement below and select the response that best reflects your sentiments:

The ability of the current dual college dual certification approach in Canadian Emergency Medicine to meet the needs of EM and the Canadian public is:

- a) Very Good: I have no concerns
- b) Good: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Poor: I have some concerns
- e) Very Poor: I have many concerns

29. If you are generally satisfied with current EM training and certification in Canada, please outline why, and why it should be maintained: _____

30. If you have any concerns with current EM training and certification in Canada, please outline why, and what changes you would suggest: _____

Thank you for taking time to complete this survey.

Appendix C (Cont'd)



› Enquête du Groupe de travail collaboratif auprès des médecins possédant la certification CCMF

Introduction :

La présente enquête est réalisée par le Groupe de travail collaboratif sur l'avenir de la médecine d'urgence au Canada. Le Groupe de travail collaboratif est issu d'un partenariat entre le Collège des médecins de famille du Canada, le Collège royal des médecins et chirurgiens du Canada et l'Association canadienne des médecins d'urgence. Son rôle consiste à effectuer une évaluation des besoins actuels et futurs en matière de ressources humaines dans le domaine de la médecine d'urgence dans le cadre des soins de santé au Canada, y compris évaluer les deux programmes de formation en médecine d'urgence et leur capacité à satisfaire ces besoins. Ce travail comprend des enquêtes auprès des médecins d'urgence, des chefs des services d'urgence et des résidents en médecine d'urgence. Vos réponses franches aux questions qui suivent faciliteront ce travail. Toutes les réponses seront compilées, analysées et interprétées par un sous-groupe du Groupe de travail collaboratif. Nous vous remercions à l'avance de prendre le temps de participer à cette enquête.

Données démographiques

1. Quelle est votre année de naissance? _____
Sélectionnez votre année de naissance.

2. Quel est votre sexe?

- Femme
- Homme

3. Dans quelle province habitez-vous? _____
Choisissez une province ou un territoire

| | | |
|----------------------|-------------------------|---------------------------|
| Colombie-Britannique | Québec | Yukon |
| Alberta | Nouveau-Brunswick | Territoires du Nord-Ouest |
| Saskatchewan | Nouvelle-Écosse | Nunavut |
| Manitoba | Île-du-Prince-Édouard | |
| Ontario | Terre-Neuve-et-Labrador | |

4. Pratiquez-vous présentement la médecine d'urgence clinique

- Oui
- Non

5. Quelle est la distribution de vos tâches au travail?

(Veuillez décliner vos tâches en pourcentage afin d'en venir à un total de 100 %)

- _____ % : médecine clinique
- _____ % : tâches administratives
- _____ % : recherche
- _____ % : enseignement hors de la pratique clinique
- _____ % : autres tâches (veuillez préciser : _____)

TOTAL 100%

6. Comment se décline votre pratique CLINIQUE?

- _____ % : médecine d'urgence (en salle d'urgence)
- _____ % : médecine familiale (hors de la salle d'urgence)
- _____ % : soins intensifs
- _____ % : médecine sportive
- _____ % : soins en traumatologie
- _____ % : autres (veuillez préciser : _____)

TOTAL 100%

7. Lequel des énoncés suivants décrit le MIEUX le contexte de votre service des urgences?

- o Grand hôpital universitaire en milieu urbain / Grand hôpital non universitaire en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
- o Petit hôpital en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
- o Établissement en milieu rural (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
- o Hôpital en région éloignée (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)

Description du service des urgences

8. Si vous pratiquez la médecine d'urgence, quel est le volume annuel approximatif de votre service des urgences? _____
9. Travaillez-vous dans une université affiliée à un hôpital d'enseignement où les résidents ou étudiants en médecine font des rotations dans votre service des urgences?
- Oui
 - Non



10. Si vous pratiquez la médecine d'urgence, combien d'heures de pratique clinique effectuez-vous sur place, par mois, au service des urgences? _____heures par mois

Les questions qui suivent ont trait à votre pratique au service des urgences. On vous demandera de prévoir l'évolution de votre charge de travail dans votre service des urgences d'ici cinq ans puis d'ici dix ans. Veuillez noter que les changements prévus dans cinq et dans dix ans doivent être estimés mais non cumulés.

11. Selon vous, de quelle façon le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences changera-t-il d'ici cinq ans, par rapport à 2015?

- Il augmentera
- Il diminuera
- Il restera le même (si tel est le cas, sautez la prochaine question)

COMMENTAIRES : _____

12. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences augmentera-t-il d'ici cinq ans, par rapport à 2015?
_____%

13. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences diminuera-t-il d'ici cinq ans, par rapport à 2015?
_____%

14. Selon vous, de quelle façon le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences changera-t-il d'ici dix ans, par rapport à 2015?

- Il augmentera
- Il diminuera
- Il restera le même (si tel est le cas, sautez la prochaine question)

COMMENTAIRES : _____

15. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences augmentera-t-il d'ici dix ans, par rapport à 2015?
_____%

16. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences diminuera-t-il d'ici dix ans, par rapport à 2015?
_____%



Programmes de résidence en médecine d'urgence

17. Veuillez indiquer dans quelle mesure vous êtes d'accord avec les énoncés ci-dessous.

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

La formation que j'ai reçue m'a adéquatement préparé à ma pratique clinique actuelle.

18. Combien de temps avez-vous consacré à la médecine d'urgence clinique pendant votre résidence, en mois (ou l'équivalent après distribution)? _____

19. Quels changements (le cas échéant) auriez-vous souhaité voir dans la formation que vous avez reçue pour mieux vous préparer en vue de votre pratique actuelle?

COMMENTAIRES : _____

20. Avez-vous suivi de la formation structurée supplémentaire pour rehausser vos compétences en prestation de soins cliniques en contexte de service des urgences?

- e) Aucune
- f) Des programmes de perfectionnement des compétences du Collège des médecins de famille du Canada : _____
- g) Autre formation structurée en médecine d'urgence (type et durée) : _____
- h) Autre formation structurée (type et durée) : _____

COMMENTAIRES : _____

21. Quel programme de perfectionnement des compétences agréé du Collège des médecins de famille du Canada avez-vous suivi, et pendant combien de temps? [afficher si « b » est sélectionné à la question 18]

- En médecine d'urgence _____(mois)
- En anesthésie _____(mois)
- Autre : _____(mois)

22. Quelle autre formation structurée en médecine d'urgence avez-vous suivie? (type et durée en mois) [afficher si « autre formation structurée en médecine d'urgence » est sélectionné à la question 18]

- Type : _____
- Durée (en mois) : _____



23. Quelle autre formation structurée avez-vous suivie? (type et durée en mois) [afficher si « d » est sélectionné à la question 18]

- Type : _____
- Durée (en mois) : _____

24. Veuillez indiquer dans quelle mesure vous êtes d'accord avec les énoncés qui suivent. Les programmes ci-dessous constituent des parcours efficaces pour acquérir les compétences nécessaires à la pratique de la médecine d'urgence :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

- l) CCMF
- m) CCMF(MU)
- n) FRCPC-MU

COMMENTAIRES : _____

25. Veuillez indiquer ce que vous pensez de la différence perçue ou réelle, le cas échéant, entre les compétences des médecins détenant la désignation CCMF, la désignation CCMF(MU) et la certification FRCPC-MU *immédiatement suivant la fin de leur résidence* pour combler les besoins cliniques et pédagogiques (si approprié) dans votre service des urgences, et pour pratiquer la médecine d'urgence à un niveau qui satisfait aux exigences et normes de votre établissement.

Objectifs des programmes

26. Le Collège des médecins de famille du Canada a défini la raison d'être, les objectifs et les produits de ses programmes menant aux désignations CCMF et CCMF(MU) de la façon suivante :

Les programmes de résidence du Collège des médecins de famille du Canada visent à former les médecins de famille afin qu'ils puissent directement prodiguer des soins d'urgence aux patients de tous âges présentant quelque problème de santé que ce soit, à tout moment et dans toutes les collectivités du Canada. Cet objectif est l'un des buts généraux visés par la formation en médecine familiale menant à la désignation CCMF (certificat du Collège des médecins de famille



du Canada). On attend des médecins ainsi formés qu'ils puissent prodiguer les soins d'urgence que requiert la pratique dans la collectivité, puis qu'ils rehaussent leurs compétences en fonction des besoins de la collectivité qu'ils desservent. Une formation plus poussée en médecine familiale dans le domaine de la médecine d'urgence [CCMF(MU)] prépare les médecins de famille en vue d'offrir des soins d'urgence de grande qualité à tous les patients se présentant au service des urgences, partout au Canada, que ce soit en contexte communautaire, dans un établissement régional, dans un hôpital universitaire, etc. Un médecin de famille possédant ces compétences avancées peut prodiguer des soins d'urgence à temps plein, ou à temps partiel de concert avec les autres activités de la médecine familiale. Ces médecins de famille rehaussent leurs compétences de façon continue, en fonction des besoins de la collectivité, et peuvent en venir à remplir des fonctions de dirigeants dans les domaines de l'éducation, de la recherche et de l'administration.


C. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

D. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF(MU) décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____



27. Le Collège royal des médecins et chirurgiens du Canada a défini la raison d'être, les objectifs et les produits de son programme menant à la certification du Collège royal en médecine d'urgence (FRCPC-MU) de la façon suivante :

Au Collège royal, les programmes de résidence en médecine d'urgence (MU) mènent à la certification et au permis d'exercer à titre de spécialiste dans cette discipline particulière. La pratique des spécialistes ainsi formés au Collège royal en médecine d'urgence est vouée aux soins avancés destinés aux patients présentant des problèmes de santé aigus et souvent indifférenciés et pour lesquels aucune information clinique ou diagnostique n'est encore disponible. Ces médecins sont en mesure de tenir un rôle de conseillers dans ce domaine spécialisé, et de prodiguer des soins d'urgence complets aux adultes et aux enfants tant en contexte d'enseignement universitaire ou de santé communautaire que dans les centres hospitaliers régionaux. Les spécialistes en médecine d'urgence du Collège royal sont les seuls à être spécialisés dans toutes les interventions de réanimation, possédant de l'expertise en anatomie, en physiologie, en pathophysiologie et en pharmacologie ainsi que dans le traitement de toute affection aiguë. Ces spécialistes du Collège royal misent sur leurs vastes connaissances dans des domaines connexes en faisant le lien entre la médecine d'urgence et les autres domaines de la santé, notamment la toxicologie, la traumatologie, les soins préhospitaliers et la préparation aux situations de crise. Les spécialistes en médecine d'urgence du Collège royal constituent une réelle ressource pour la collectivité et le secteur de l'enseignement : ils prodiguent des soins cliniques avancés aux patients, ils appuient les autres praticiens des services d'urgence, ils tiennent des rôles de leadership dans l'administration des services et systèmes de médecine d'urgence, des établissements de soins de santé et des programmes connexes, ils mènent des travaux de recherche pertinents et ils enseignent dans le but de faire progresser les connaissances et d'améliorer les résultats de santé des patients et de la collectivité entière.

Veillez indiquer votre opinion en ce qui concerne l'efficacité du Collège royal à réaliser les objectifs du programme de formation FRCPC-MU décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____



28. Nous aimerions connaître votre opinion en ce qui concerne la formation et la certification en médecine d'urgence au Canada. Veuillez réfléchir à l'énoncé qui suit et indiquer la réponse qui correspond le mieux à votre point de vue.

La possibilité de pouvoir présentement obtenir une certification en médecine d'urgence au Canada auprès de l'un ou l'autre des deux collèges pour combler les besoins de la population canadienne en matière de soins d'urgence est :

- a) Une très bonne chose : cela ne soulève aucune préoccupation
 - b) Une bonne chose : cela ne soulève que de légères préoccupations
 - c) Mon opinion est plutôt neutre
 - d) Une mauvaise chose : cela soulève quelques préoccupations
 - e) Une bien mauvaise chose : cela soulève de nombreuses préoccupations
29. Si vous êtes généralement satisfait de la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez indiquer pourquoi, et pour quelles raisons elle devrait rester ainsi : _____
30. Si vous êtes préoccupé concernant la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez en indiquer les raisons et proposer les changements qui s'imposent : _____

Nous vous remercions d'avoir pris le temps de participer à cette enquête.

Appendix C (Cont'd)



› Collaborative Working Group Survey for EM Residents

Introduction:

This survey is being carried out by the Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM). The CWG-EM is endorsed by, and is a partnership between The College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Canadian Association of Emergency Physicians. The role of the CWG-EM is to perform an assessment of the current and future emergency physician health human resource needs within Canadian health care, including an assessment of the two Emergency Medicine (EM) training programs and their ability to meet these needs. This work includes surveys of emergency physicians, emergency department chiefs (or, when not applicable, hospital chiefs of staff), and EM residents. Your candid responses to the questions that follow will facilitate that work. All responses will be compiled, analyzed, and interpreted by the CWG-EM by subgroup. Thank you in advance for taking the time to complete this survey.

Please respond to the following questions according to your current thoughts and intentions. It is recognized these could change in the future.

Demographics

1. What is your year of birth? _____

Select year of birth

2. What is your gender?

- Female
- Male

3. What is your province of residence? _____

Select a province or territory

British Columbia

Alberta

Saskatchewan

Manitoba

Ontario

Québec

New Brunswick

Nova Scotia

Prince Edward Island

Newfoundland and

Labrador

Yukon

Northwest Territories

Nunavut



4. To what extent do you agree with the following statement:
My choice between the FRCPC-EM and CCFP(EM) training programs was clear to me at the time I applied to the program.

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

COMMENTS: _____

5. What Emergency Medicine program are you currently enrolled in?

- CCFP(EM)
- FRCPC-EM

6. What is your post-graduate year? _____

Select PG Year

7. What practice-type(s) do you foresee upon completion of your residency program?

- _____ %Clinical Medicine
- _____ %Administrative
- _____ % Research
- _____ % Teaching Outside of Clinical Medicine
- _____ %Other _____

TOTAL 100%

8. When you start to practice, how do you anticipate the breakdown of your practice?

- _____ % Emergency Medicine (within the emergency department)
- _____ % Family Medicine (outside the emergency department)
- _____ % Critical Care
- _____ % Sports Medicine
- _____ % Trauma Care
- _____ % Other. Please Specify: _____

TOTAL 100%

9. Which of the following describes the type of Emergency Department that you would like to work in after you complete your residency program?

- o Large urban academic hospital
- o Large urban non-academic hospital (e.g., may provide teaching but without other research or academic programs)



- o Small urban hospital (e.g., may provide teaching but without other research or academic programs)
- o Rural (e.g., may provide teaching but without other research or academic programs)
- o Remote hospital (e.g., may provide teaching but without other research or academic programs)

EM Residency Programs

10. Please indicate your agreement to the following statements:

- Strongly Disagree
 - Disagree
 - No opinion
 - Agree
 - Strongly Agree
 - I don't know
-
- o) There is an appropriate amount of exposure to clinical family medicine training within the CCFP(EM) program
 - p) There is an appropriate amount of exposure to clinical family medicine training within the FRCPC-EM program.
 - q) There is an appropriate amount of exposure to clinical Emergency Medicine in the CCFP(EM) program.
 - r) There is an appropriate amount of exposure to clinical Emergency Medicine in the FRCPC-EM program.
 - s) My training program provides an appropriate amount of combined elective/selective time.
 - t) My training program provides me with options for the various types of clinical practice I can become involved in.
 - u) My Emergency Medicine training program will be effective in helping me meet my training goals and future career plans.

COMMENTS: _____



11. Please indicate your agreement with the following statement: The following programs are effective routes to gain competencies to the practice of Emergency Medicine:

- Strongly Disagree
- Disagree
- No opinion
- Agree
- Strongly Agree
- I don't know

- a) CCFP
- o) CCFP(EM)
- p) FRCPC-EM

COMMENTS: _____

12. Please indicate your thoughts on the existence of a perceived or real difference in the abilities of physicians with CCFP certification, CCFP(EM) certification, and FRCPC-EM certification immediately after completing their residency, to meet the clinical and, (if appropriate) teaching/academic needs of your emergency department and to practice Emergency Medicine at a level that meets your emergency department's requirements and standards of care.

Program goals

13. The College of Family Physicians of Canada has defined the purpose, goals and product of its CCFP and CCFP(EM) program as the following:

The College of Family Physicians of Canada residency programs are dedicated to training family physicians to provide emergency care directly to all patients of all ages, with any presenting problem, at any time, and in any community in Canada. At the core family medicine training level (CCFP), this objective is part of comprehensive training. New certificants are expected to provide emergency care commensurate with the needs of their practice community, and to add progressively to their skills as required by these community needs. Enhanced skills training (CCFP(EM)) in Family Medicine in the domain of Emergency Medicine prepares family physicians to provide excellent emergency care for all patients in any emergency department in Canada, including community, regional, and academic/teaching hospital settings. The family physician with these enhanced skills may provide emergency care on a full-time practice basis, or on a part-time basis integrated with other family medicine activities. These family physicians will also add to their skills on a continuing basis according to community needs, and may go on to assume leadership roles in education, research and administration.



E. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

F. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP(EM) training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____

14. The Royal College of Physicians and Surgeons of Canada has defined the purpose, goals and product of the FRCPC-EM program as the following:

Residency training leading to specialist Emergency Medicine (EM) certification and practice in Canada is done through the Royal College Emergency Medicine (EM) residency training programs. Royal College EM specialists have practices dedicated to advanced care for patients with acute and often undifferentiated health problems, across a broad spectrum of illnesses and injury in all age groups, frequently before complete clinical or diagnostic information is available. They are capable of assuming a consultant's role in the specialty and providing comprehensive emergency adult and pediatric care in academic/teaching, community or regional hospital settings. Royal College EM specialists are the only comprehensive resuscitation specialists, possessing expertise in the anatomy, physiology, pathophysiology, pharmacology and management of all acute presentations. EM specialists use their comprehensive knowledge of related fields at the interface between emergency care provision and the health care system, including toxicology, traumatology, prehospital care, and disaster preparedness. Royal College EM specialists are an academic and community resource, providing advanced clinical patient care; support to other practitioners in an emergency setting; leadership in the administration of emergency departments, emergency medical systems, health care institutions and related programs; and the conduct of relevant research and education with the goal of advancing knowledge and improving individual and/or community health outcomes.



Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the FRCPC-EM training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____

15. We would like your opinion on current EM training and certification in Canada. Please consider the statement below and select the response that best reflects your sentiments:

The ability of the current dual college dual certification approach in Canadian Emergency Medicine to meet the needs of EM and the Canadian public is:

- a) Very Good: I have no concerns
- b) Good: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Poor: I have some concerns
- e) Very Poor: I have many concerns

16. If you are generally satisfied with current EM training and certification in Canada, please outline why, and why it should be maintained: _____

17. If you have any concerns with current EM training and certification in Canada, please outline why, and what changes you would suggest: _____

Thank you for taking time to complete this survey.

Appendix C (Cont'd)

› Enquête du Groupe de travail collaboratif auprès des résidents en médecine d'urgence

Introduction :

La présente enquête est réalisée par le Groupe de travail collaboratif sur l'avenir de la médecine d'urgence au Canada. Le Groupe de travail collaboratif est issu d'un partenariat entre le Collège des médecins de famille du Canada, le Collège royal des médecins et chirurgiens du Canada et l'Association canadienne des médecins d'urgence. Son rôle consiste à effectuer une évaluation des besoins actuels et futurs en matière de ressources humaines dans le domaine de la médecine d'urgence au sein du secteur canadien des soins de santé, y compris évaluer les deux programmes de formation en médecine d'urgence et leur capacité à satisfaire ces besoins. Ce travail comprend des enquêtes auprès des médecins d'urgence, des chefs des services d'urgence et des résidents en médecine d'urgence. Vos réponses franches aux questions qui suivent faciliteront ce travail. Toutes les réponses seront compilées, analysées et interprétées par un sous-groupe du Groupe de travail collaboratif. Nous vous remercions à l'avance de prendre le temps de participer à cette enquête.

Veuillez répondre aux questions suivantes en fonction de vos opinions et intentions. L'on reconnaît que celles-ci pourraient changer.

Données démographiques

1. Quelle est votre année de naissance? _____

Sélectionnez votre année de naissance.

2. Quel est votre sexe?

- Femme
- Homme

3. Dans quelle province habitez-vous? _____

Choisissez une province ou un territoire.

Colombie-Britannique

Alberta

Saskatchewan

Manitoba

Ontario

Québec

Nouveau-Brunswick

Nouvelle-Écosse

Île-du-Prince-Édouard

Terre-Neuve-et-Labrador

Yukon

Territoires du Nord-Ouest

Nunavut



4. Dans quelle mesure êtes-vous d'accord avec l'énoncé suivant :
Mon choix entre le programme pour l'obtention du titre d'Associé du Collège royal des médecins et chirurgiens du Canada en médecine d'urgence (FRCPC-MU) et le programme pour l'obtention du certificat du Collège des médecins de famille du Canada en médecine d'urgence [CCMF(MU)] était clair au moment où j'ai présenté une demande d'inscription au programme.

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

COMMENTAIRES : _____

5. Quel programme en médecine d'urgence suivez vous actuellement?

- CCMF(MU)
- FRCPC-MU

6. En quelle année de troisième cycle êtes vous? _____

Sélectionnez l'année.

7. Quel pourcentage de tâches prévoyez-vous exécuter après votre programme de résidence?

- _____ % : médecine clinique
- _____ % : tâches administratives
- _____ % : recherche
- _____ % : enseignement hors de la pratique clinique
- _____ % : autres tâches (veuillez préciser : _____)

TOTAL 100%

8. Au début de votre carrière, comment prévoyez-vous répartir votre pratique CLINIQUE?

- _____ % : médecine d'urgence (en salle d'urgence)
- _____ % : médecine familiale (hors de la salle d'urgence)
- _____ % : soins intensifs
- _____ % : médecine sportive
- _____ % : soins en traumatologie
- _____ % : autres (veuillez préciser : _____)

TOTAL 100%



9. Lequel des contextes de pratique suivants décrit le type de service des urgences dans lequel vous souhaiteriez travailler après votre programme de résidence?

- o Grand hôpital universitaire en milieu urbain
- o Grand hôpital non universitaire en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
- o Petit hôpital en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
- o Établissement en milieu rural (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
- o Hôpital en région éloignée (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)

Programmes de résidence en médecine d'urgence

10. Veuillez indiquer si vous êtes d'accord avec les énoncés suivants :

- Fortement en désaccord
 - En désaccord
 - Pas d'opinion
 - D'accord
 - Fortement d'accord
 - Je ne sais pas
- v) Le programme pour l'obtention du certificat du Collège des médecins de famille du Canada en médecine d'urgence [CCMF(MU)] offre une formation en médecine familiale clinique suffisante.
- w) Le programme pour l'obtention du titre d'Associé du Collège royal des médecins et chirurgiens du Canada en médecine d'urgence (FRPC-MU) offre une formation en médecine familiale clinique suffisante.
- x) Le programme pour l'obtention du certificat du Collège des médecins de famille du Canada en médecine d'urgence [CCMF(MU)] offre une formation en médecine d'urgence suffisante.
- y) Le programme pour l'obtention du titre d'Associé du Collège royal des médecins et chirurgiens du Canada en médecine d'urgence (FRPC-MU) offre une formation en médecine d'urgence clinique suffisante.



- z) Mon programme de formation offre une quantité adéquate de cours obligatoires et de cours facultatifs.
- aa) Mon programme de formation m'offre plusieurs options pour divers genres de pratique clinique que je suis susceptible d'exercer.
- bb) Mon programme de formation en médecine d'urgence m'a aidé à atteindre mes objectifs en matière de formation et de cheminement de carrière.

COMMENTAIRES : _____

11. Veuillez indiquer dans quelle mesure vous êtes d'accord avec les énoncés qui suivent. Les programmes ci-dessous constituent des parcours efficaces pour acquérir les compétences nécessaires à la pratique de la médecine d'urgence :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

- a) CCMF
- q) CCMF(MU)
- r) FRCPC-MU

COMMENTAIRES : _____

12. Veuillez indiquer ce que vous pensez de la différence perçue ou réelle, le cas échéant, entre les compétences des médecins détenant la désignation CCMF, la désignation CCMF(MU) et la certification FRCPC-MU *immédiatement suivant la fin de leur résidence* pour combler les besoins cliniques et pédagogiques (si approprié) dans votre service des urgences, et pour pratiquer la médecine d'urgence à un niveau qui satisfait aux exigences et normes de votre établissement,



Objectifs du programme

13. Le Collège des médecins de famille du Canada a défini la raison d'être, les objectifs et les produits de ses programmes menant aux désignations CCMF et CCMF(MU) de la façon suivante :

Les programmes de résidence du Collège des médecins de famille du Canada visent à former les médecins de famille afin qu'ils puissent directement prodiguer des soins d'urgence aux patients de tous âges présentant quelque problème de santé que ce soit, à tout moment et dans toutes les collectivités du Canada. Cet objectif est l'un des buts généraux visés par la formation en médecine familiale menant à la désignation CCMF (certificat du Collège des médecins de famille du Canada). On attend des médecins ainsi formés qu'ils puissent prodiguer les soins d'urgence que requiert la pratique dans la collectivité, puis qu'ils rehaussent leurs compétences en fonction des besoins de la collectivité qu'ils desservent. Une formation plus poussée en médecine familiale dans le domaine de la médecine d'urgence [CCMF(MU)] prépare les médecins de famille en vue d'offrir des soins d'urgence de grande qualité à tous les patients se présentant au service des urgences, partout au Canada, que ce soit en contexte communautaire, dans un établissement régional, dans un hôpital universitaire, etc. Un médecin de famille possédant ces compétences avancées peut prodiguer des soins d'urgence à temps plein, ou à temps partiel de concert avec les autres activités de la médecine familiale. Ces médecins de famille rehaussent leurs compétences de façon continue, en fonction des besoins de la collectivité, et peuvent en venir à remplir des fonctions de dirigeants dans les domaines de l'éducation, de la recherche et de l'administration.

- G. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

- H. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF(MU) décrits précédemment :

- a) Très efficace : je n'en doute pas



- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____

14. Le Collège royal des médecins et chirurgiens du Canada a défini la raison d'être, les objectifs et les produits de son programme menant à la certification du Collège royal en médecine d'urgence (FRCPC-MU) de la façon suivante :

Au Collège royal, les programmes de résidence en médecine d'urgence (MU) mènent à la certification et au permis d'exercer à titre de spécialiste dans cette discipline particulière. La pratique des spécialistes ainsi formés au Collège royal en médecine d'urgence est vouée aux soins avancés destinés aux patients présentant des problèmes de santé aigus et souvent indifférenciés et pour lesquels aucune information clinique ou diagnostique n'est encore disponible. Ces médecins sont en mesure de tenir un rôle de conseillers dans ce domaine spécialisé, et de prodiguer des soins d'urgence complets aux adultes et aux enfants tant en contexte d'enseignement universitaire ou de santé communautaire que dans les centres hospitaliers régionaux. Les spécialistes en médecine d'urgence du Collège royal sont les seuls à être spécialisés dans toutes les interventions de réanimation, possédant de l'expertise en anatomie, en physiologie, en pathophysiologie et en pharmacologie ainsi que dans le traitement de toute affection aiguë. Ces spécialistes du Collège royal misent sur leurs vastes connaissances dans des domaines connexes en faisant le lien entre la médecine d'urgence et les autres domaines de la santé, notamment la toxicologie, la traumatologie, les soins préhospitaliers et la préparation aux situations de crise. Les spécialistes en médecine d'urgence du Collège royal constituent une réelle ressource pour la collectivité et le secteur de l'enseignement : ils prodiguent des soins cliniques avancés aux patients, ils appuient les autres praticiens des services d'urgence, ils tiennent des rôles de leadership dans l'administration des services et systèmes de médecine d'urgence, des établissements de soins de santé et des programmes connexes, ils mènent des travaux de recherche pertinents et ils enseignent dans le but de faire progresser les connaissances et d'améliorer les résultats de santé des patients et de la collectivité entière.

Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège royal à réaliser les objectifs du programme de formation FRCPC-MU décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____



Nous aimerions connaître votre opinion en ce qui concerne la formation et la certification en médecine d'urgence au Canada. Veuillez réfléchir à l'énoncé qui suit et indiquer la réponse qui correspond le mieux à votre point de vue.

La possibilité de pouvoir présentement obtenir une certification en médecine d'urgence au Canada auprès de l'un ou l'autre des deux collèges pour combler les besoins de la population canadienne en matière de soins d'urgence est :

- a) Une très bonne chose : cela ne soulève aucune préoccupation
 - b) Une bonne chose : cela ne soulève que de légères préoccupations
 - c) Mon opinion est plutôt neutre
 - d) Une mauvaise chose : cela soulève quelques préoccupations
 - e) Une bien mauvaise chose : cela soulève de nombreuses préoccupations
15. Si vous êtes généralement satisfait de la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez indiquer pourquoi, et pour quelles raisons elle devrait rester ainsi : _____
16. Si vous êtes préoccupé concernant la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez en indiquer les raisons et proposer les changements qui s'imposent : _____

Nous vous remercions d'avoir pris le temps de participer à cette enquête.

Appendix C (Cont'd)



› Collaborative Working Group Survey for Emergency Department Chiefs

Introduction:

This survey is being carried out by the Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM). The CWG-EM is endorsed by, and is a partnership between The College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Canadian Association of Emergency Physicians. The role of the CWG-EM is to perform an assessment of the current and future emergency physician health human resource needs within Canadian health care, including an assessment of the two Emergency Medicine (EM) training programs and their ability to meet these needs. This work includes surveys of emergency physicians, emergency department chiefs (or, when not applicable, hospital chiefs of staff), and EM residents. Your candid responses to the questions that follow will facilitate that work. All responses will be compiled, analyzed, and interpreted by the CWG-EM by subgroup. Thank you in advance for taking the time to complete this survey.

ED Characteristics

1. What is your role?

- Chief of Staff
- Chief of Emergency Department
- Other: _____

2. Do you hold a Canadian Emergency Medicine certification?

- Yes: CCFP(EM)
- Yes: FRCPC-EM
- Yes: Both CCFP(EM) and FRCPC-EM
- No. Please indicate your certification(s): _____

3. In what Province or Territory is your emergency department located?

- | | | |
|------------------|----------------------|-----------------------|
| British Columbia | Québec | Labrador |
| Alberta | New Brunswick | Yukon |
| Saskatchewan | Nova Scotia | Northwest Territories |
| Manitoba | Prince Edward Island | Nunavut |
| Ontario | Newfoundland and | |



4. What types of patients are seen in your emergency department? (choose one):
 - Adults only
 - Pediatrics only
 - Both Adults and Pediatrics

5. What are your approximate annual number of emergency department visits?
_____ visits per year

6. Which of the following BEST describes your emergency department?
 - o Large urban academic hospital
 - o Large urban non-academic hospital (e.g., may provide teaching but without other research or academic programs)
 - o Small urban hospital (e.g., may provide teaching but without other research or academic programs)
 - o Rural (e.g., may provide teaching but without other research or academic programs)
 - o Remote hospital (e.g., may provide teaching but without other research or academic programs)

7. What funding model for emergency physician remuneration do you have?
 - -fee for service _____
 - -alternate payment plan _____
 - -blended plan (mix of above) _____

COMMENTS: _____

EM Physician Coverage

8. Is your emergency physician coverage dedicated to the emergency department 24 hours on site? (not callback)
 - Yes
 - No

9. How many on site emergency physicians (physicians dedicated to serving the emergency department exclusively) hours of coverage does your Emergency Department have per 24 hours? (e.g. five 8 hour intake shifts = 40 hours of coverage) _____ hours of coverage

Future change in coverage

10. The following questions relate to onsite dedicated emergency department coverage. You will be asked to predict your department's change in coverage 5 years from today and 10 years from today. Please note that changes for 5 years and 10 years should be estimated uniquely and are not expected to be incremental.



What do you predict will be the direction of change in the volume of your clinical emergency work hours at the end of 5 years compared to 2015?

- Increase
- Decrease
- Unchanged [skip next question if selected]

COMMENTS: _____

11. A) What do you predict will be the percent increase in the volume of your clinical emergency work hours at the end of 5 years compared to 2015? _____%

B) What do you predict will be the percent decrease in the volume of your clinical emergency work hours at the end of 5 years compared to 2015? _____%

12. What do you predict will be the direction of change in the volume of your clinical emergency work hours at the end of 10 Years compared to 2015?

- Increase
- Decrease
- Unchanged [skip next questions if selected]

COMMENTS: _____

13. A) What do you predict will be the percent increase in the volume of your clinical emergency work hours at the end of 10 years compared to 2015? _____%

B) What do you predict will be the percent decrease in the volume of your clinical emergency work hours at the end of 10 years compared to 2015? _____%

14. Select any of the factors that have changed or are anticipated to change the number of emergency physician (EP) needs, in your Emergency department:

- alternate care providers
- emergency department closures
- government initiatives
- other: _____

COMMENTS: _____

15. A) What was the direction of change (or what do you anticipate to be the direction of change) regarding the impact of alternate care providers?

- Increase
- Decrease
- Unchanged

COMMENTS: _____



B) What was the direction of change (or what do you anticipate to be the direction of change) regarding the impact of emergency department closures?

- Increase
- Decrease
- Unchanged

COMMENTS: _____

C) What was the direction of change (or what do you anticipate to be the direction of change) regarding the impact of government initiatives?

- Increase
- Decrease
- Unchanged

COMMENTS: _____

D) What was the direction of change (or what do you anticipate to be the direction of change) regarding the impact of other needs?

- Increase
- Decrease
- Unchanged

COMMENTS: _____

Current ED Staffing

16. What is the total number of EM physicians working the following shifts in a 4 week period?
(Please count each physician only once)

- ___ Working clinically 0-4 shifts/4 weeks
- ___ Working clinically 5-8 shifts/4 weeks
- ___ Working clinically 9-12 shifts/4 weeks
- ___ Working clinically 13-16 shifts/4 weeks
- ___ Working clinically 17+ shifts/4 weeks
- ___ TOTAL # EM physicians in your ED

17. How many physicians in your Emergency Department have the following certifications?
(Count each physician only once)

- ___ (number) CCFP certification
- ___ (number) CCFP(EM) certification
- ___ (number) FRCPC-EM certification
- ___ (number) Dual Certification FRCPC-EM/CCFP(EM)
- ___ (number) ABEM certification without FRCPC/CCFP(EM)
- ___ (number) Other (list _____)
- ___ TOTAL



18. Are your current emergency physician (EP) staffing needs fully covered?
- Yes
 - No
19. If No, how many hours per day of EP coverage are you short? _____hours per day
20. Is your emergency department adequately staffed by physicians with a skillset that aligns with the patient population of your department?
- Yes
 - No

COMMENTS: _____

21. Based on your local definition of full time clinical work in your emergency department (e.g. typically 12-14 shifts per month), how many Full Time Equivalent (FTE) emergency physicians do you anticipate will retire or leave from your group in:
- 5 Years: _____(# FTE)
 - 10 Years: _____(# FTE)
22. Based on your local definition of full time clinical work in your emergency department (e.g. typically 12-14 shifts per month), what do you predict are the number of new FTE (Full Time Equivalent) emergency physicians you will need in:
- 5 Years: _____(# FTE)
 - 10 Years: _____(# FTE)
23. What is the direction of change in the predicted numbers of new FTE emergency physicians needed compared to today?

| | Increase | Decrease | No change |
|-------------|----------|----------|-----------|
| In 5 years | | | |
| In 10 years | | | |

Certification Assessment

24. What would be the ideal mix of physician certification to meet the needs of your Emergency department?

Please enter the % of physicians within each category that would compose the ideal mix of physician certification today, in 5 years, and in 10 years.



| | Today | In 5 years | In 10 years |
|----------|-------|------------|-------------|
| CCFP | | | |
| CCFP(EM) | | | |
| FRCPC-EM | | | |
| TOTAL % | | | |

Using the scale below please indicate your agreement with the statement that the Canadian Emergency Medicine certification training programs listed meets the needs of the following types of emergency departments:

- a. Strongly Disagree
- b. Disagree
- c. No opinion
- d. Agree
- e. Strongly Agree
- f. I don't know

25. Tertiary Urban:

- CCFP(EM):
- FRCPC-EM:

26. Non-Tertiary Urban:

- CCFP(EM):
- FRCPC-EM:

27. Community:

- CCFP(EM):
- FRCPC-EM:

28. Rural:

- CCFP(EM):
- FRCPC-EM:

COMMENTS: _____

29. Please indicate your agreement with the following statement: The Following programs are effective routes to gain competencies to the practice of Emergency Medicine:

- a. Strongly Disagree
- b. Disagree
- c. No opinion
- d. Agree
- e. Strongly Agree
- f. I don't know

- 
- s) CCFP
 - t) CCFP(EM)
 - u) FRCPC-EM

COMMENTS: _____

30. Please indicate your thoughts on the existence of a perceived or real difference in the abilities of physicians with CCFP certification, CCFP(EM) certification, and FRCPC-EM certification *immediately after completing their residency*, to meet the clinical and, (if appropriate) teaching/academic needs of your emergency department and to practice Emergency Medicine at a level that meets your emergency department's requirements and standards of care.
- _____
- _____
- _____

Program goals

31. The College of Family Physicians of Canada has defined the purpose, goals and product of its CCFP and CCFP(EM) program as the following:

The College of Family Physicians of Canada residency programs are dedicated to training family physicians to provide emergency care directly to all patients of all ages, with any presenting problem, at any time, and in any community in Canada. At the core family medicine training level (CCFP), this objective is part of comprehensive training. New certificants are expected to provide emergency care commensurate with the needs of their practice community, and to add progressively to their skills as required by these community needs. Enhanced skills training (CCFP(EM)) in Family Medicine in the domain of Emergency Medicine prepares family physicians to provide excellent emergency care for all patients in any emergency department in Canada, including community, regional, and academic/teaching hospital settings. The family physician with these enhanced skills may provide emergency care on a full-time practice basis, or on a part-time basis integrated with other family medicine activities. These family physicians will also add to their skills on a continuing basis according to community needs, and may go on to assume leadership roles in education, research and administration.

- I. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP training program:
- a) Very effective: I have no concerns
 - b) Effective: Any concerns I have are minor
 - c) I am neutral in my opinion on this matter
 - d) Ineffective: I have some concerns
 - e) Very ineffective: I have many concerns



J. Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the CCFP(EM) training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____

32. The Royal College of Physicians and Surgeons of Canada has defined the purpose, goals and product of the FRCPC-EM program as the following:

Residency training leading to specialist Emergency Medicine (EM) certification and practice in Canada is done through the Royal College Emergency Medicine (EM) residency training programs. Royal College EM specialists have practices dedicated to advanced care for patients with acute and often undifferentiated health problems, across a broad spectrum of illnesses and injury in all age groups, frequently before complete clinical or diagnostic information is available. They are capable of assuming a consultant's role in the specialty and providing comprehensive emergency adult and pediatric care in academic/teaching, community or regional hospital settings. Royal College EM specialists are the only comprehensive resuscitation specialists, possessing expertise in the anatomy, physiology, pathophysiology, pharmacology and management of all acute presentations. EM specialists use their comprehensive knowledge of related fields at the interface between emergency care provision and the health care system, including toxicology, traumatology, prehospital care, and disaster preparedness. Royal College EM specialists are an academic and community resource, providing advanced clinical patient care; support to other practitioners in an emergency setting; leadership in the administration of emergency departments, emergency medical systems, health care institutions and related programs; and the conduct of relevant research and education with the goal of advancing knowledge and improving individual and/or community health outcomes.

Please indicate your opinion regarding the effectiveness of the college in achieving the stated goals of the FRCPC-EM training program:

- a) Very effective: I have no concerns
- b) Effective: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Ineffective: I have some concerns
- e) Very ineffective: I have many concerns

COMMENTS: _____

33. We would like your opinion on current EM training and certification in Canada. Please consider the statement below and select the response that best reflects your sentiments:



The ability of the current dual college dual certification approach in Canadian Emergency Medicine to meet the needs of EM and the Canadian public is:

- a) Very Good: I have no concerns
- b) Good: Any concerns I have are minor
- c) I am neutral in my opinion on this matter
- d) Poor: I have some concerns
- e) Very Poor: I have many concerns

34. If you are generally satisfied with current EM training and certification in Canada, please outline why, and why it should be maintained: _____

35. If you have any concerns with current EM training and certification in Canada, please outline why, and what changes you would suggest: _____

Thank you for taking time to complete this survey.

Appendix C (Cont'd)

› Enquête du Groupe de travail collaboratif auprès des chefs de service des urgences

Introduction :

La présente enquête est réalisée par le Groupe de travail collaboratif sur l'avenir de la médecine d'urgence au Canada. Le Groupe de travail collaboratif est issu d'un partenariat entre le Collège des médecins de famille du Canada, le Collège royal des médecins et chirurgiens du Canada et l'Association canadienne des médecins d'urgence. Son rôle consiste à effectuer une évaluation des besoins actuels et futurs en matière de ressources humaines dans le domaine de la médecine d'urgence au sein du secteur canadien des soins de santé, y compris évaluer les deux programmes de formation en médecine d'urgence et leur capacité à satisfaire ces besoins. Ce travail comprend des enquêtes auprès des médecins d'urgence, des chefs des services d'urgence et des résidents en médecine d'urgence. Vos réponses franches aux questions qui suivent faciliteront ce travail. Toutes les réponses seront compilées, analysées et interprétées par un sous-groupe du Groupe de travail collaboratif. Nous vous remercions à l'avance de prendre le temps de participer à cette enquête.

Caractéristiques du service des urgences

1. Quel est votre rôle?


- Chef du personnel
- Chef du service des urgences
- Autre : _____

2. Détenez vous un certificat canadien en médecine d'urgence?

- Yes: CCFP(EM)
- Yes: FRCPC-EM
- Yes: Both CCFP(EM) and FRCPC-EM
- No. Please indicate your certification(s): _____

3. Dans quelle province (ou territoire) votre service des urgences est il situé?

| | | |
|----------------------|-------------------------|---------------------------|
| Colombie-Britannique | Québec | Territoires du Nord-Ouest |
| Alberta | Nouveau-Brunswick | Nunavut |
| Saskatchewan | Île-du-Prince-Édouard | Yukon |
| Manitoba | Nouvelle-Écosse | |
| Ontario | Terre-Neuve-et-Labrador | |

- 
4. Quels types de patients voyez vous dans votre service des urgences? (faites un choix) :
- Uniquement des adultes
 - Uniquement des enfants
 - Des adultes et des enfants
5. Combien de visites votre service des urgences reçoit il approximativement par année?
_____ visites par année
6. Lequel des énoncés suivants décrit le MIEUX le contexte de votre service des urgences?
- o Grand hôpital universitaire en milieu urbain
 - Grand hôpital non universitaire en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
 - Petit hôpital en milieu urbain (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
 - Établissement en milieu rural (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
 - Hôpital en région éloignée (on peut y enseigner, mais non affilié à des programmes d'enseignement ou de recherche)
7. Quel modèle de financement avez vous adopté pour rémunérer les médecins d'urgence?
- – honoraires à l'acte _____
 - – autre mode de paiement _____
 - – un mélange des deux _____

COMMENTAIRES : _____

Couverture du service des urgences par des médecins d'urgence

8. Les médecins d'urgence qui couvrent votre service des urgences sur place travaillent-ils exclusivement pour votre service? (sans faire partie d'un système de suppléance de gardes)
- Oui
 - Non
9. Combien d'heures par jour les médecins d'urgence (les médecins qui travaillent exclusivement pour le service des urgences) couvrent ils sur place votre service des urgences? (p. ex., cinq quarts de 8 heures = 40 heures de couverture) _____ heures de couverture

Changements à venir dans les heures consacrées au service des urgences

10. Les questions qui suivent ont trait à votre pratique au service des urgences. On vous demandera de prévoir l'évolution de votre charge de travail dans votre service des urgences d'ici cinq ans puis d'ici dix ans. Veuillez noter que les changements prévus dans cinq et dix ans doivent être estimés mais non cumulés.

Selon vous, de quelle façon le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences changera-t-il d'ici cinq ans, par rapport à 2015?

- Il augmentera
- Il diminuera
- Il restera le même (si tel est le cas, sautez la prochaine question)

COMMENTAIRES : _____



11. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences [augmentera-t-il/diminuera-t-il] d'ici cinq ans, par rapport à 2015?
12. Selon vous, de quelle façon le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences changera-t-il d'ici dix ans, par rapport à 2015?
- Il augmentera
 - Il diminuera
 - Il restera le même (si tel est le cas, sautez la prochaine question)

COMMENTAIRES : _____

13. Selon vous, dans quelle proportion (%) le nombre d'heures que vous consacrerez à la pratique clinique au service des urgences [augmentera-t-il/diminuera-t-il] d'ici dix ans, par rapport à 2015? _____ %
14. Sélectionnez les facteurs qui ont modifié ou qui pourraient modifier le nombre d'médecins d'urgence nécessaires dans votre service des urgences :
- autres fournisseurs de soins de santé (augmentation/diminution des besoins en médecins d'urgence)
 - fermetures du service des urgences (augmentation/diminution des besoins en médecins d'urgence)
 - initiatives gouvernementales (augmentation/diminution des besoins en médecins d'urgence)
 - autre : _____ (augmentation/diminution des besoins en médecins d'urgence)
 - autre : _____ (augmentation/diminution des besoins en médecins d'urgence)
 - autre : _____ (augmentation/diminution des besoins en médecins d'urgence)

COMMENTAIRES : _____

15. Quelle direction a prise la modification (ou quelle direction prendra-t-elle) selon l'incidence des facteurs liés aux besoins en médecins d'urgence ?
- Augmentation des besoins
 - Diminution des besoins
 - Besoins inchangés

COMMENTAIRES : _____

Dotation actuelle du service des urgences

16. Combien de médecins d'urgence travaillent le nombre de quarts suivants sur une période de quatre semaines? (Prière de tenir compte de chaque médecin une seule fois)
- ___ travaillent cliniquement de 0 à 4 quarts sur 4 semaines
- ___ travaillent cliniquement de 5 à 8 quarts sur 4 semaines
- ___ travaillent cliniquement de 9 à 12 quarts sur 4 semaines
- ___ travaillent cliniquement de 13 à 16 quarts sur 4 semaines
- ___ travaillent cliniquement plus de 16 quarts sur 4 semaines
- ___ Nombre total d'médecins d'urgence au sein de votre service des urgences



17. Combien de médecins de votre service des urgences détiennent les certificats suivants?
(Tenir compte de chaque médecin une seule fois)

- ____ (nombre) de certificats CCMF
- ____ (nombre) de certificats CCMF(MU)
- ____ (nombre) de certificats FRCPC-MU
- ____ (nombre) de certificats FRCPC-MU/CCMF(MU)
- ____ (nombre) de certificats ABEM sans FRCPC/CCMF(MU)
- ____ (nombre) autre (liste _____)
- ____ TOTAL

18. Vos besoins de dotation actuels en médecins d'urgence sont-ils pleinement satisfaits?

- Oui
- Non

19. Dans la négative, combien d'heures par jour vous manquent-ils? ____ heures par jour

20. Votre service des urgences est-il doté d'un nombre adéquat de médecins possédant les compétences nécessaires pour répondre aux besoins des patients de votre service?

- Oui
- Non

COMMENTAIRES : _____

21. En se basant sur votre définition locale du travail clinique à temps plein dans votre service des urgences (p. ex., habituellement de 12 à 14 quarts par mois), combien de médecins d'urgence en équivalents temps plein (ETP) prendront leur retraite, selon vous, ou quitteront votre groupe d'ici :

- 5 ans : ____ (ETP)
- 10 ans : ____ (ETP)

22. En se basant sur votre définition locale du travail clinique à temps plein dans votre service des urgences (p. ex., habituellement de 12 à 14 quarts par mois), de combien de nouveaux médecins d'urgence en équivalents temps plein (ETP) prévoyez-vous avoir besoin d'ici :

- 5 ans ____ (ETP)
- 10 ans ____ (ETP)

23. Comparativement à aujourd'hui, que peut-on prévoir comme changement dans le nombre requis de nouveaux médecins d'urgence?

| | Augmentation | Diminution | Aucun changement |
|-------------|--------------|------------|------------------|
| Dans 5 ans | | | |
| Dans 10 ans | | | |



Évaluation des certificats

24. Quelle serait la combinaison idéale de certificats en médecine pour satisfaire les besoins de votre service des urgences?

Veuillez indiquer les % de médecins de chaque catégorie qui composeraient la combinaison idéale de certificats en médecine aujourd'hui, dans 5 ans, et dans 10 ans.

| | Aujourd'hui | Dans 5 ans | Dans 10 ans |
|----------|-------------|------------|-------------|
| CCMF | | | |
| CCMF(MU) | | | |
| FRCPC-MU | | | |
| TOTAL % | | | |

À partir de l'échelle ci dessous, veuillez indiquer si vous êtes d'accord avec l'énoncé voulant que les programmes de formation en médecine d'urgence au Canada énumérés répondent aux besoins des types suivants de service des urgences :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

25. Soins tertiaires urbains : :

- CCFP(EM):
- FRCPC-EM:

26. Soins non tertiaires urbains :

- CCFP(EM):
- FRCPC-EM:

27. Soins communautaires :

- CCFP(EM):
- FRCPC-EM:

28. Soins en milieu rural :

- CCFP(EM):
- FRCPC-EM:

COMMENTAIRES : _____



29. Veuillez indiquer dans quelle mesure vous êtes d'accord avec les énoncés qui suivent. Les programmes ci-dessous constituent des parcours efficaces pour acquérir les compétences nécessaires à la pratique de la médecine d'urgence :

- Fortement en désaccord
- En désaccord
- Pas d'opinion
- D'accord
- Fortement d'accord
- Je ne sais pas

- a) CCMF
- b) CCMF(MU)
- c) FRCPC-MU


COMMENTAIRES : _____

30. Veuillez indiquer ce que vous pensez de la différence perçue ou réelle, le cas échéant, entre les compétences des médecins détenant la désignation CCMF, la désignation CCMF(MU) et la certification FRCPC-MU immédiatement suivant la fin de leur résidence pour combler les besoins cliniques et pédagogiques (si approprié) dans votre service des urgences, et pour pratiquer la médecine d'urgence à un niveau qui satisfait aux exigences et normes de votre établissement.

Objectifs des programmes

31. Le Collège des médecins de famille du Canada a défini la raison d'être, les objectifs et les produits de ses programmes menant aux désignations CCMF et CCMF(MU) de la façon suivante :

Les programmes de résidence du Collège des médecins de famille du Canada visent à former les médecins de famille afin qu'ils puissent directement prodiguer des soins d'urgence aux patients de tous âges présentant quelque problème de santé que ce soit, à tout moment et dans toutes les collectivités du Canada. Cet objectif est l'un des buts généraux visés par la formation en médecine familiale menant à la désignation CCMF (certificat du Collège des médecins de famille du Canada). On attend des médecins ainsi formés qu'ils puissent prodiguer les soins d'urgence que requiert la pratique dans la collectivité, puis qu'ils rehaussent leurs compétences en fonction des besoins de la collectivité qu'ils desservent. Une formation plus poussée en médecine familiale dans le domaine de la médecine d'urgence [CCMF(MU)] prépare les médecins de famille en vue d'offrir des soins d'urgence de grande qualité à tous les patients se présentant au service des urgences, partout au



Canada, que ce soit en contexte communautaire, dans un établissement régional, dans un hôpital universitaire, etc. Un médecin de famille possédant ces compétences avancées peut prodiguer des soins d'urgence à temps plein, ou à temps partiel de concert avec les autres activités de la médecine familiale. Ces médecins de famille rehaussent leurs compétences de façon continue, en fonction des besoins de la collectivité, et peuvent en venir à remplir des fonctions de dirigeants dans les domaines de l'éducation, de la recherche et de l'administration.

A. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup


B. Veuillez indiquer votre opinion en ce qui concerne l'efficacité du Collège des médecins de famille du Canada à réaliser les objectifs du programme de formation CCMF(MU) décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____

32. Le Collège royal des médecins et chirurgiens du Canada a défini la raison d'être, les objectifs et les produits de son programme menant à la certification du Collège royal en médecine d'urgence (FRCPC-MU) de la façon suivante :

Au Collège royal, les programmes de résidence en médecine d'urgence (MU) mènent à la certification et au permis d'exercer à titre de spécialiste dans cette discipline particulière. La pratique des spécialistes ainsi formés au Collège royal en médecine d'urgence est vouée aux soins avancés destinés aux patients présentant des problèmes de santé aigus et souvent indifférenciés et pour lesquels aucune information clinique ou diagnostique n'est encore disponible. Ces médecins sont en mesure de tenir un rôle de conseillers dans ce domaine spécialisé, et de prodiguer des soins d'urgence complets aux adultes et aux enfants tant en contexte d'enseignement universitaire ou de santé communautaire que dans les centres hospitaliers régionaux. Les spécialistes en médecine d'urgence du Collège royal sont les seuls à être spécialisés dans toutes les interventions de réanimation, possédant de l'expertise en anatomie, en physiologie, en pathophysiologie et en pharmacologie ainsi que dans le traitement de toute affection aiguë. Ces spécialistes du Collège royal misent sur leurs vastes connaissances dans des domaines connexes en faisant le



lien entre la médecine d'urgence et les autres domaines de la santé, notamment la toxicologie, la traumatologie, les soins préhospitaliers et la préparation aux situations de crise. Les spécialistes en médecine d'urgence du Collège royal constituent une réelle ressource pour la collectivité et le secteur de l'enseignement : ils prodiguent des soins cliniques avancés aux patients, ils appuient les autres praticiens des services d'urgence, ils tiennent des rôles de leadership dans l'administration des services et systèmes de médecine d'urgence, des établissements de soins de santé et des programmes connexes, ils mènent des travaux de recherche pertinents et ils enseignent dans le but de faire progresser les connaissances et d'améliorer les résultats de santé des patients et de la collectivité entière.

Veillez indiquer votre opinion en ce qui concerne l'efficacité du Collège royal à réaliser les objectifs du programme de formation FRCPC-MU décrits précédemment :

- a) Très efficace : je n'en doute pas
- b) Efficace : je n'ai que de légers doutes
- c) Mon opinion est plutôt neutre
- d) Inefficace : j'en doute un peu
- e) Très inefficace : j'en doute beaucoup

COMMENTAIRES : _____

33. Nous aimerions connaître votre opinion en ce qui concerne la formation et la certification en médecine d'urgence au Canada. Veuillez réfléchir à l'énoncé qui suit et indiquer la réponse qui correspond le mieux à votre point de vue.

La possibilité de pouvoir présentement obtenir une certification en médecine d'urgence au Canada auprès de l'un ou l'autre des deux collèges pour combler les besoins de la population canadienne en matière de soins d'urgence est :

- a) Une très bonne chose : cela ne soulève aucune préoccupation
- b) Une bonne chose : cela ne soulève que de légères préoccupations
- c) Mon opinion est plutôt neutre
- d) Une mauvaise chose : cela soulève quelques préoccupations
- e) Une bien mauvaise chose : cela soulève de nombreuses préoccupations

34. Si vous êtes généralement satisfait de la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez indiquer pourquoi, et pour quelles raisons elle devrait rester ainsi : _____

35. Si vous êtes préoccupé concernant la formule actuelle de formation et de certification en médecine d'urgence au Canada, veuillez en indiquer les raisons et proposer les changements qui s'imposent : _____

Nous vous remercions d'avoir pris le temps de participer à cette enquête.

Appendix D



Identified Survey Outliers and Rational for Removal

CWG-EM Surveys- Outliers Summary Rationales for Recoding or Deletion

| CERTIFIED EMERGENCY PHYSICIANS SURVEY | |
|--|---|
| Emerg. Phys. Q1 - Birth year | Remove response (= "1900") o Erroneous submission (spoiled response) as no emergency physician is 115 years old. |
| Emerg. Phys. Q11 - Annual patient volume | It appears as though emergency physicians may have misunderstood or misinterpreted this question (or they are simply unaware as to the realities of patient volume in their workplace). o 15 responses provided greatly surpassed the highest value given from the ED Chiefs (~250,000). Because it is expected that ED Chiefs have a greater sense of their ED volume, we omitted any emergency physician responses that exceeded this amount (responses omitted ranged from 300,000 - >141,000,000). |
| Emerg. Phys. Q13 - Scheduled clinical hours per month hours per month | The following responses were removed: o (500 hours) o (500 hours) o (700 hours) |
| Emerg. Phys. Q14 – 5yrs Direction of change | Recoded 34 responses from increase to no change. Rationale: These participants predicted an increase in volume, however indicated a 0% increase in the subsequent question. Recoded 2 responses from decrease to no change. o 139170 o 139705 Rationale: These participants predicted a decrease in volume, however indicated a 0% decrease in the subsequent question. |
| Emerg. Phys. Q15a – 5 yrs - Percent increase in volume of clinical emergency work hours | 2 responses were removed: o -100 hours o -10 hours Rationale: Responses to this question should not be negative. Deleted 32 responses Rationale: Indicated a 0% increase in volume. Responses changed to "no change" in previous question. |
| Emerg. phys. Q15b – 5 yrs - Percent decrease in volume of clinical emergency work hours | Deleted 2 responses Rationale: Indicated a 0% increase in volume. Responses changed to "no change" in previous question. |



Certified Emergency Physicians Survey (continued):

| | |
|---|--|
| Emerg. Phys. Q16 – 10 yrs Direction of Change | <p>Recoded 9 responses from increase to no change.</p> <p>Rationale: These participants predicted an increase in volume, however indicated a 0% increase in the subsequent question.</p> <p>Recoded 43 responses from decrease to no change.</p> <p>Rationale: These participants predicted a decrease in volume, however indicated a 0% decrease in the subsequent question.</p> |
| Emerg. Phys. Q17a – 10 yrs - Percent increase in volume of clinical emergency work hours | <p>Deleted 9 responses</p> <p>Rationale: Indicated a 0% increase in volume.</p> <p>Responses changed to “no change” in previous question.</p> |
| Emerg. Phys. Q17b – 10 yrs - Percent decrease in volume of clinical emergency work hours | <p>Deleted 43 responses</p> <p>Rationale: Indicated a 0% increase in volume.</p> <p>Responses changed to “no change” in previous question.</p> |
| Emerg. Phys. Q17b– 10 yrs - Percent decrease in volume of clinical emergency work hours | <p>Removed the following responses</p> <ul style="list-style-type: none"> o (-100 hours) o (-50 hours) o (-30 hours) o (-20 hours) o (-20 hours) o (-20 hours) <p>Rationale: Again, responses to this question should not be negative.</p> |
| ED CHIEFS SURVEY | |
| ED Chief. Q10 – 5 yr Direction of change | <p>Recoded 8 responses from increase to no change.</p> <p>Rationale: These participants predicted an increase in volume, however indicated a 0% increase in the subsequent question.</p> |
| ED Chief. Q11a – 5 yrs Percent increase in volume | <p>Case-wise deletion: 8 responses</p> <p>Rationale: Indicated a 0% increase in volume.</p> <p>Responses changed to “no change” in previous question.</p> |
| ED Chief. Q12 – 10 yrs Direction of change | <p>Recoded 2 responses from increase to no change.</p> <p>Rationale: These participants predicted an increase in volume, however indicated a 0% increase in the subsequent question.</p> <p>Recoded the 2 responses from decrease to no change.</p> <p>Rationale: These participants predicted a decrease in volume, however indicated a 0% decrease in the subsequent question.</p> |
| ED Chief. Q13a – 10 yrs Percent Increase in volume | <p>Case-wise deletion: 2 responses</p> <p>Rationale: Indicated a 0% increase in volume.</p> <p>Responses changed to “no change” in previous question.</p> |
| ED Chief. Q13b – 10 yrs Percent decrease in volume | <p>Case-wise deletion: 2 responses</p> <p>Rationale: Indicated a 0% decrease in volume.</p> <p>Responses changed to “no change” in previous question.</p> |



| CCFP PHYSICIANS SURVEY | |
|--|---|
| CCFP phys. Q8 – Annual Patient Volume | Case-wise deletion o (Response = 500,000) Rationale: Cross-referenced with other responses from this participant (i.e. ED setting = remote hospital.) |
| CCFP phys. Q10 – Scheduled clinical hours per month | Case-wise deletion o (Response = 780) Rationale: (780 hours – not possible when there are only 744 hours in a month with 31 days.) |
| CCFP phys. Q11 – Direction of Change (5 years) | Recoded 2 responses from increase to no change. Rationale: These participants predicted an increase in volume, however indicated a 0% increase in the subsequent question. Recoded the 2 responses from decrease to no change. Rationale: These participants predicted a decrease in volume, however indicated a 0% decrease in the subsequent question. |
| CCFP phys. Q12a – 5 yrs Percent increase in volume of clinical emergency work hours | Case-wise deletion: 2 responses Rationale: Indicated a 0% increase in volume. Responses changed to “no change” in previous question. |
| CCFP phys. Q12b – 5 yrs Percent decrease in volume of clinical emergency work hours | Case-wise deletion: 2 responses Rationale: Indicated a 0% decrease in volume. Responses changed to “no change” in previous question. |
| CCFP phys. Q13 – Direction of Change (10 years) | Recoded 38 responses from increase to no change. Rationale: These participants predicted an increase in volume, however indicated a 0% increase in the subsequent question. |
| CCFP phys. Q14a – 10 yrs Percent increase in volume of clinical emergency work hours | Case-wise deletion o -100 o -10 Rationale: Responses to this question should not be negative. Case-wise deletion - 38 responses Rationale: Indicated a 0% increase in volume. Responses changed to “no change” in previous question. |
| CCFP phys. Q19a – Accredited CFPC Enhanced skills program: EM Months | Case-wise deletion: o (200 months) o (25 months) Rationale: It is a 12 month program; therefore 12 months should be the maximum number of months. |

The Collaborative Working Group on the Future of Emergency Medicine in Canada (CWG-EM)

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We invite you to view the full report online by visiting one of our trilateral partner websites (CAEP, CFPC or Royal College) or by the following link:

www.caep.ca/resources/collaborative-working-group-final-report

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