FACULTY OF MEDICINE

# DEAN'S TASK FORCE ON MD UNDERGRADUATE CURRICULUM RENEWAL

APPENDIX F | MAY 2010

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THE UNIVERSITY OF BRITISH COLUMBIA

# Stakeholder Input

## Contributing to the development of a social responsibility and accountability framework and graduate exit outcomes

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## Summary

The UBC Faculty of Medicine has begun a process of curriculum renewal for the MD Undergraduate Program. Members both internal and external to UBC have been recruited to serve on a Dean's Task Force for Curriculum Renewal (DTFCR). This study was intended to gather a wide set of perspectives from key stakeholders across multiple sectors pertaining to the social responsibility and accountability of the MD Undergraduate Program for consideration by the Task Force. It is the DTFCR recommendation that this report contribute to the development of the social responsibility framework of the medical school and the description of future graduates.

Members of the DTFCR assisted in developing an interview framework and identified sectors and possible key informants to be interviewed (n=18). Purposeful sampling was sued to ensure input from multiple viewpoints (geographical, underserved, academic, and research communities, patient and public). In either a phone or face-to-face interview, stakeholders were asked to comment on the societal needs that the MD Undergraduate Program should be aiming to address, the roles future physicians will need to play in order to meet those needs, as well as the knowledge, attributes, and skills every medical student should have at graduation. A framework analysis of the interview data was completed, with the research report being reviewed by the DTFCR to aid them in the development of the draft recommendations for the social responsibility and accountability framework of the MD Undergraduate Program. The study's protocol was reviewed and approved by The UBC Behavioral Research Ethics Board (Review # H09-02679).

Stakeholder Input

To meet society's needs the MD Undergraduate Program must graduate generalist and specialist physicians as well as clinician researchers. The program must also train physicians who will work in diverse communities and populations of practice including urban, rural, remote and underserved. The growing diversity of the population and the continually changing context of medical practice must be considered in the training of future physicians.

The following are predominant themes brought forward by key stakeholders:

Training physicians including physician supply, the need for generalists, sustainable primary care, and flexibility

Meeting population and societal needs including population health, population diversity, underserved populations, the health care system, health promotion, global health, physician's role in society and students understanding and caring about societal needs

Defining physician relationships including patient-physician relationships, inter-professional care, and community partnerships

Competencies of future physicians including the undifferentiated graduate with general competencies, clinical competence, communication skills, scholarship and research skills, problem solving and decision making, physicians as educators, physicians as counsellors, behavioural competence, commitment to lifelong learning, adapting to future trends in patient treatment, adapting to a culture of mass information, adapting to a culture of increasing complexity, questioning attitude, innovation, professionalism, ethical standards, self motivation and governance, self-reflection and care

Social responsibility and the Faculty of Medicine Including having a clear vision and mission that is shared with the community; meeting the broad spectrum of health needs of British Columbians; committing to sustaining social accountability over time by continually evaluating and responding to society's changing needs; and recognizing that meeting societal need is secondary to training clinically competent physicians

Barriers to meeting societal needs beyond the Faculty of Medicine's control
Recognizing that society's health needs cannot be met through medical education alone and there are significant challenges beyond the faculty's direct control; and show leadership by articulating these barriers and working to align external factors that motivate students with the needs that need to be met.

The social responsibilities articulated by stakeholders potentially impact admissions processes, program sites, as well as curriculum itself. For social accountability, the Faculty of Medicine must articulate its responsibility framework, and develop a process for reporting on short term activities as well as longer term outputs.

## Section A: Background, objectives and methods

### Background

In response to the LCME/CACMS 2008 accreditation report[1] and the 2009 external review of the Faculty of Medicine,[2] Dean Gavin Stuart has established a Dean's Task Force for Undergraduate Curriculum Renewal (DTFCR). The DTFCR is charged with producing a formal strategic and implementation plan for Doctor of Medicine (MD) curriculum reform at the University of British Columbia (UBC). Recruited by curriculum renewal co-chairs Joanna Bates and Angela Towle, the Task Force members are comprised of volunteers representing a broad group of sectors, both internal and external to the UBC Faculty of Medicine.

### Objectives

The future curriculum framework must be aligned with society's needs and graduate physicians who are able to meet those needs. The objectives of this study were first to provide input to the DTFCR to inform the development of a social responsibility and accountability framework, and second to gather data contributing to the definition of what our future graduates look like through the establishment of exit competencies.

### Methods

The members of the DTFCR, contributing as part of their professional volunteer role on this committee, helped the research team to develop an interview framework (Appendix 1) as well identify potential individuals for interview. The research team, consisting of members of the Curriculum Renewal Secretariat, used this input to initiate a process of purposeful sampling across multiple sectors and geographical locations throughout British Columbia. Eighteen identified key informants were charted against the following sectors and locations to ensure representation from each area: government, health system, universities, specialists, family medicine, allied health, public, underserved, aboriginal, multicultural, research, basic science, professional organizations, urban, rural, undergraduate medical education, postgraduate medical education, Northern British Columbia, Fraser Valley, Vancouver Island, Interior British Columbia. Key stakeholders were invited via email to participate in a phone or face-to-face interview, and consent was collected by the research team. Interviews were carried out, recorded, and transcribed by the same research assistant. A framework analysis of the interview data was undertaken by initially grouping all of the responses for each question, and then categorizing responses into recurrent themes and sub topics. The study's protocol was reviewed and approved by The UBC Behavioral Research Ethics Board (Review # H09-02679).

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[1] UBC Faculty of Medicine - 2008 LCME/CACMS Accreditation Report. Available from: http://www.med.ubc.ca/education/md_ugrad/Program_Information/accreditation.htm.

[2] UBC Faculty of Medicine - 2009 External Review. Available from: http://www.med.ubc.ca/about_us/strategic_plan/External_Review.htm.

## Section B: Input to Social Responsibility

### Training Physicians

1) Physician Supply

*The UBC MD Undergraduate Program needs to…*

i. Address the overall shortage of physicians by producing enough graduates to meet the basic needs of society
ii. Produce physicians to serve in diverse locations
iii. Produce physicians to provide care in underserved populations and communities
iv. Address shortages in specific disciplines by training a broad spectrum of physicians
v. Consider and produce the workforce that the province will require in the future

Quotes: Appendix 3-1

2) Need for Generalists

*The UBC MD Undergraduate Program needs to…*

i. Address the current shortage and continued decline of generalists by producing more general internists, general surgeons and family physicians
ii. Shift the training of physicians towards generalism in order to counterbalance the current overpopulation of specialty disciplines
iii. Contribute to re-establishing generalism as significant in the culture of medicine by emphasizing the value of generalist disciplines

Quotes: Appendix 3-2

3) Sustainable Primary Care

*The UBC MD Undergraduate Program needs to…*

i. Train enough primary care physicians to ensure our primary care system is sustainable

Quotes: Appendix 3-3

4) Flexibility

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who are flexible to address the uncertainty of future need
ii. Structure a flexible and adaptable undergraduate program to better prepare graduates for a professional world of future uncertainty

Quotes: Appendix 3-4

## Meeting Population and Societal Needs

5) Population Health

*The UBC MD Undergraduate Program needs to…*

i. Look beyond disease focused training in the context of the single doctor-patient relationship and orient future physicians towards population health
ii. Graduate physicians who are well grounded in population health approach and will be tuned to broader health needs of people in their community.

Quotes: Appendix 3-5

6) Population Diversity

*The UBC MD Undergraduate Program needs to…*

i. Consider the growing diversity of society and special populations for the training of medical professionals with respect to diverse ages, cultural backgrounds, socioeconomic backgrounds, living contexts, educational backgrounds, disability as well as sex and gender.
ii. Address the demographic trend of the aging population by training physicians who:
    a. Are well versed in elder care, chronic disease, and population health
    b. Understand and are proactive in meeting the needs for seniors care
    c. Fill current shortages of gerontologists
iii. Address the increasing cultural diversity of society by training physicians who:
    a. Are culturally sensitive and understand health issues and needs from diverse cultural perspectives
    b. Have empathy and understand how to interact appropriately and effectively with patients from diverse cultures
    c. Are knowledgeable of the cultural make up of people within their community
iv. Consider the role and involvement of internationally trained medical professionals in medical education and in the training of physicians at UBC
v. Ensure graduates provide care with an understanding and consideration of the socioeconomic determinants of health
vi. Train physicians to meet the diverse needs and understand the unique challenges of different geographical populations, in particular urban versus rural
vii. Ensure graduates understand the influence of sex and gender on health and illness as well as on treatment and provision of health care.
viii. Prepare graduates to interact and meet the health care needs of people with diverse educational backgrounds
ix. Train graduates to appreciate that a 'one size fits all' approach is inadequate to serve a diverse population and that individuals will need tailored treatments.
x. Ensure that the medical school class reflects the diversity of the population they will be serving and the demographics of the province as a whole

xi. Encourage, support, and provide opportunities for students from diverse or underserved populations to attend medical school
xii. Avoid admitting a homogenous class of entitled individuals

Quotes: Appendix 3-6

7) Underserved Populations

*The UBC MD Undergraduate Program needs to…*

i. Train a broad spectrum of physicians to meet the wide range of need within underserved populations, for example aboriginal, remote, and urban eastside communities.
ii. Sensitize students to the health needs of different underserved populations
iii. Provide students with first hand experience working within underserved populations by establishing partnerships within these communities
iv. Recognize that better health care for first nations communities is an important goal throughout B.C. as well as Canada, and train physicians who will serve the aboriginal population and contribute to addressing health care issues pertinent in this community.
v. Ensure that graduates understand the impact of poverty on health
vi. Support, encourage and admit students to the medical school class who represent underserved populations

Quotes: Appendix 3-7

8) The Health Care System

*The UBC MD Undergraduate Program needs to…*

i. Incorporate and encourage quality assurance, patient safety and best practice within the undergraduate program
ii. Spend time in the undergraduate curriculum addressing the role physicians play as managers within the health care system
iii. Graduates physicians who:
    a. Have a broad understanding of the health care system including the Canada Health Act and what it means
    b. Are committed to a continuum of care that is relationship-based in order to address the decline in continuity of care
    c. Understand their role and responsibility within the publicly funded and publicly accountable health care system and contribute back to it
    d. Understand the difficulties around sustainability of the health care system and practice medicine in such a way that influences and assists with the sustainability of the system

Quotes: Appendix 3-8

9) Health Promotion

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who, in addition to considering immediate treatment and diagnosis, also take into account the broader trends of health promotion
ii. Help shift the concept of practice from individual disease treatment, to the promotion of healthy living in communities
iii. Ensure graduates have the skills to act as health advocates who encourage and promote healthy living to their patients and the public

Quotes: Appendix 3-9

10) Global Health

*The UBC MD Undergraduate Program needs to…*

i. Establish a coherent vision of international responsibility, clearly defining what role the medical school plays globally
ii. Graduate physicians that have a broad understanding of global health needs and issues and how these influence British Columbia and Canada.
iii. Set aside places in the medical class for students from underdeveloped or disadvantaged countries

Quotes: Appendix 3-10

11) Physicians Role in Society

*The UBC MD Undergraduate Program needs to…*

i. Ensure graduates understand their special obligation to society by embedding social responsibility in the curriculum
ii. Graduate physicians who:
    a. Understand that by definition physicians are community leaders acting as public role models and pillars of society
    b. Recognize that in their influential position they are servants of society not 'masters' of society.
    c. Will be trusted by, and serve as advocates within their communities

Quotes: Appendix 3-11

12) Understanding and Caring About Societal Needs

*The UBC MD Undergraduate Program needs to…*

i. Graduates physicians who:
    a. Have a baseline knowledge of the changing needs of society
    b. Are mindful of society in addition to the individual
    c. Genuinely have interest in helping people

Quotes: Appendix 3-12

## Defining Physicians Relationships

13) Patient-Physician Relationships

*The UBC MD Undergraduate Program needs to…*

i. Define what an appropriate patient-physician relationship looks like in a culture of increasingly technological care
    a. Emphasize during medical training the importance of relationships to avoid producing 'technicians' who solve problems
ii. Instill in graduates the importance of human connection in physician-patient relationships and the positive influence it can have on their patients health
iii. Graduate physicians who will engage their patients as partners in making decisions about their health care
iv. Equip graduates with the skills they need to have appropriate relationships with their providers

Quotes: Appendix 3-13

14) Inter-professional Care

*The UBC MD Undergraduate Program needs to…*

i. Understand and consider the role of inter-professional care as a model of future care delivery
ii. Foster a shift in medical culture towards recognizing how doctors play a role as members of a team, and not always leaders of the team
iii. Establish the habits and skill sets required for inter-professional care early in the program
iv. Consider an inter-professional core competency framework that includes communication, personal power management and conflict resolution.
v. Graduate physicians who:
    a. Function NOT as individual identities, but as part of inter-professional teams
    b. Understand their role in inter-professional teams, and know when to lead and when to be led
    c. Understand the scope of practice of other professionals, where these overlap, and how they can be utilized to benefit the patient
    d. Have an understanding of the breadth of the health care system and the skills to communicate horizontally, coordinating care across professions and specialties
    e. Respect and value other professionals, in particular their expertise and skills in diagnosis and problem solving
    f. Trust in the help of team members to cope with difficulties surrounding practice

Quotes: Appendix 3-14

15) Community Partnerships

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
   a. Understand the importance of community partnerships and recognize that public agencies have different roles and expertise from the medical profession (provide patient support and information rather than health care services)
   b. Will build partnerships with community agencies and leaders within a broad definition of inter-professional care
   c. Will work with organizations within the community to establish a practice that is responsive to community health needs.

Quotes: Appendix 3-15

## Competencies of Future Physicians

16) Undifferentiated Graduates with General Competencies

*The UBC MD Undergraduate Program needs to…*

i. Ensure graduates have the general skills and competencies to enter any postgraduate program
ii. Consider the new generation entering medical school and equip them with the general skills they will need to follow multiple career paths
iii. Train undifferentiated generalists
iv. Deter an early focus on sub specialty careers

Quotes: Appendix 3-16

### Knowledge

17) Clinical Competence

*The UBC MD Undergraduate Program needs to…*

i. *Graduate physicians who:*
   a. Are clinically competent
   b. Above all else have basic medical knowledge
   c. Can provide health care to individual patients

Quotes: Appendix 3-17

### Skills

18) Communication Skills

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who are able to communicate with their patients effectively so that patients understand what the physician intends to convey
ii. Ensure communication skills are addressed in the curriculum

Quotes: Appendix 3-18

19) Scholarship and Research Skills

*The UBC MD Undergraduate Program needs to…*

i. Graduate clinical researchers and scientists for the advancement of biomedical knowledge
ii. Graduates physicians who:
    a. Have an understanding of research, defined as current knowledge and an appreciation for future knowledge
    b. Have a broad understanding of current research methodologies and the skills to critically analyze and evaluate studies
    c. Understand how research informs their medical practice

Quotes: Appendix 3-19

20) Problem Solving and Decision Making

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
    a. Can think creatively to solve immediate problems
    b. Are able to think long term and understand the impact their decisions will make over time

Quotes: Appendix 3-20

21) Physicians as Educators

*The UBC MD Undergraduate Program needs to…*

i. *Graduate physicians who:*
    a. Will be educators and teachers amongst their fellow physicians

Quotes: Appendix 3-21

22) Physicians as Counsellors

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who are:
    a. Counselors of healthy living rather than technicians solving immediate problems
    b. Supporting  lifestyle behavior change of individuals and groups
    c. Perceptive and understanding of patients situations working  at both a personal and societal level to intervene and bring about change

Quotes: Appendix 3-22

## Behaviours

23) Behavioural Competence

*The UBC MD Undergraduate Program needs to…*

i. Ensure graduates meet standards of behavioural competencies including, integrity, honesty, empathy, sympathy, morality, and altruism
ii. Value behavioural competencies as an integral part of the program, providing the foundation for effective and safe practice
iii. Consider the role admissions plays in ensuring graduates meet the standards of behavioural competencies
iv. Consider behavioral competencies that may need to be selected for in the admissions process rather than acquired during the program

Quotes: Appendix 3-23

24) Commitment to Lifelong Learning

*The UBC MD Undergraduate Program needs to…*

i. Graduates physicians who:
    a. Understand that a commitment to lifelong learning and continuing education is fundamental to sustaining high quality practice and patient relationships
    b. Constantly review their practice to ensure it is up to date

Quotes: Appendix 3-24

25) Adapt to Future Trends in Patient Treatment

*The UBC MD Undergraduate Program needs to…*

i. Recognize that genetics will increasingly be the basis of diagnosis and treatment
ii. Respond to the current and future trend of personalized patient care by ensuring graduates are well grounded in genetics knowledge and emerging research methodologies.

Quotes: Appendix 3-25

26) Adapt to a Culture of Mass Information

*The UBC MD Undergraduate Program needs to…*

i. Recognize that with the vast and increasing amount of available information we aren't able to teach graduates everything they will need to know
ii. Train graduates how to find and apply knowledge rather than acquire it
iii. Graduate physicians who:
    a. Have critical appraisal skills to determine if a piece of information is valid or invalid
    b. Can function within a context of mass information

c. Are able to help patients navigate through the significant amount of information available to them
d. Fill a 'gatekeeper' role in an advisory sense to ensure patients access good, reliable and current information

Quotes: Appendix 3-26

27) Adapt to a Culture of Increasing Complexity

*The UBC MD Undergraduate Program needs to…*

i. Ensure graduates have the skills to deal with the increasing complexity of health care issues, technology, available treatments, and understandings of disease
ii. Graduate physicians who assist patients in navigating a complex health care system

Quotes: Appendix 3-27

28) Questioning Attitude

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
   a. Do not accept knowledge without questioning
   b. Have an continually curious attitude

Quotes: Appendix 3-28

29) Innovation

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
   a. Are innovators in developing new approaches, strategies, and solutions to society's health care needs

Quotes: Appendix 3-29

30) Professionalism

*The UBC MD Undergraduate Program needs to…*

i. Ensure graduates understand what it means to be a professional
ii. Positively influence the development of medical students in becoming professional practitioners

Quotes: Appendix 3-30

31) Ethical Standards

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
   a. Will reflect society's highest ethical standards for clinical care

b. Encapsulate society's best values demonstrating ethical behavior and decision making

Quotes: Appendix 3-31

32) Self-motivation and Governance

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
   a. Are self-motivated to keep up to date with changes in medical practice, the health care system and patient and societal needs
   b. Understand the meaning of self governance

Quotes: Appendix 3-32

33) Self-reflection and Care

*The UBC MD Undergraduate Program needs to…*

i. Graduate physicians who:
   a. Have the skills for self reflection
   b. Have self awareness and appreciate that their own experience may not reflect the majority of the population's experience
   c. Engage in self care and nurturing of their family
   d. Are aware of, and can clearly articulate the scope of their expertise

Quotes: Appendix 3-33

## Social Responsibility and the Faculty of Medicine

34) The Social Responsibility Mandate of UBC Faculty of Medicine

*The UBC MD Undergraduate Program needs to…*

i. Have a clear vision and mission that is shared with the community
ii. Meet the broad spectrum of health needs of British Columbians
iii. Commit to sustaining social responsibility and accountability over time by continually evaluating and responding to society's changing needs
iv. Recognize that meeting societal need is secondary to training clinically competent physicians

Quotes: Appendix 3-34

## Barriers to meeting societal needs beyond the Faculty of Medicine's control

35) Beyond the Faculty of Medicine

*The UBC MD Undergraduate Program needs to…*

i. Recognize that society's health needs cannot be met through medical education alone and that there are significant challenges beyond the faculty's direct control (i.e. pay structures, career opportunities, etc.).
    a. Show leadership by articulating these barriers and working to align external factors that motivate students with society's needs that must be met

Quotes: Appendix 3-35

## Section C: Implications and Next Steps

A working group on social responsibility and accountability will be established in April 2010. They will use this report along with other relevant documentation and input to define and establish a revised social responsibility and accountability framework for the undergraduate MD program. Subsequent to the completion of their work in July 2010 a working group on exit outcomes will utilize the social responsibility and accountability framework to establish the exit outcomes and enabling competencies of the program. The social responsibility and accountability and exit outcomes frameworks will inform the work of concurrent working groups on curriculum design, assessment and admissions.

To ensure that the program's exit competencies are working to meet society's changing needs the governance structure of the revised program will include a social responsibility and accountability committee or task force to facilitate continued revision of the social responsibility and accountability framework.

Draft terms of reference for the previously mentioned working groups can be found in the Appendix G.

## Appendix 1: Interview Framework

**THE UNIVERSITY OF BRITISH COLUMBIA**
**FACULTY OF MEDICINE**

Key Informant Interview Questions
Dean's Task Force on Curriculum Renewal

1) What do you feel are some of the most important societal needs, current and future, that the MD undergraduate program and curriculum should aim to address? For example, you might consider local, provincial, national or international needs. Do you feel that some needs are more important than others for the program to aim towards in the next 10-20 years? Why or why not? If yes, can you identify the 3 most important goals from your point of view?

2) Considering the societal needs you listed in the previous question, what do you feel are some of the key roles our graduates might need to play in order to meet those needs?

3) What do you feel are the key attributes, knowledge or skills that every medical student should have when they graduate? For example attributes such as empathy, or adaptability to society's changing needs; areas of knowledge such as population health, or experience and skills such problem-solving skills or skilled in using technology to access information. Why do you feel that this is important for every medical student?

4) Can you suggest any one else you think we should interview?

## Appendix 2: Interview Quotes

### 1) Physician Supply

a. *There is an overall shortage of doctors in terms of numbers in the province, we need more physicians*
b. *We need to provide the physicians that are required for the health care system in British Columbia and to some extent throughout Canada*
c. *People have an expectation that they should be able to see a physician when they want to see one, so providing enough graduates to fulfill the basic needs of society. There are a lot of people who would like some access to a physician who don't have it right now.*
d. *Point number one is that we need to train more physicians, society needs more physicians*
e. *We haven't got enough doctors. So we're facing a shortage that could be into the several thousands in Fraser Health in the next 4 or 5 years.*
f. *There are shortages in geographical areas*
g. *We have to train physicians to fill the particular niches that are becoming apparent in our society, one is clearly smaller communities, I won't particularly say too much about rural isolated I'll just say smaller communities, because they all aren't necessarily rural or isolated, so smaller communities, and special population needs. There is as much of a need for physicians to fulfill some of the downtown core and disadvantaged populations in cities as there is for rural isolated aboriginal peoples. So there are special populations that are well advertised across Canada as being a special need.*
h. *There are shortages in specific disciplines*
i. *We need to make sure we're matching the career trajectories of the students with what the needs are*
j. *Because program is so big and the only one in the province we have a particular responsibility to make sure that mandate is interpreted broadly to include family physicians, specialists, public health people, teachers, researchers, and contributors to international health*
k. *We need a very broad scope of physicians which differentiates us from other medical schools that may focus on one type like family physicians or specialists*
l. *Specifically, the graduate output doesn't fit what we need*
m. *The undergrad program needs to attempt to help produce the workforce that the province is going to require in the future*
n. *There are a couple of other populations that I think we need to consider training people to advantage them to pick careers in that area, and one is geriatrics. That will be very foreseeable in the future that type of need because of the baby boomers, and the increased age, courtesy of medicine actually. And there are two other one is probably child health and adolescence. So in that respect I think the medical school has to pay careful attention to how it trains, and what it sends its graduates into in terms of those kinds of specifics.*
o. *I think you need to turn out a huge number of doctors so we can service all those people who can't get doctors in British Columbia. And there's a retirement issue right, isn't it that the average age of abdominal surgeons is 55 or something and all intend to retire in the next 5 years. So I think there's a huge problem that way, we don't have enough doctors for people who want them, and so number is the biggest societal need I think. And of course if you have more of them they'll be forced to go into underserviced areas, which would also solve the other problem which is that there are areas that are not very well serviced at all*

### 2) Need for Generalists

a. *There are areas where there are not enough family physicians, not enough family physicians with extra skills to deliver babies, perform minor surgeries, and give anesthetic, not enough specialists with a broad based skill that can function in these communities in a way that they need.*
b. *We need more generalists, and more family physicians*
c. *Society needs more generalists; there has been a decline in generalists. The trend is that we're seeing far more specialists compared to generalists*
d. *We need to help support and promote primary care by training the appropriate number of general internists, general surgeons and as well as family physicians. We need to continue our commitment to generalism and to family medicine in particular*
e. *We need to make a shift right now towards primary care and generalist type of training. We've done all the sub specialty stuff it's there, and now it's over populated, and so we need to swing back to generalist, whether or not they're primary care.*
f. *What we've got currently are too few of the type of physician who would be interested in the primary health care and prevention side, and particularly coming out of the UBC program, that program tends to create specialists. The reasons for that should be pretty obvious; firstly, with the exception of the new distributed program all of the MD's coming out of UBC has really been generated in the urban centre of Vancouver, the program has been set up, whenever it was set up, to deliver a certain type of graduate. That program itself I think tends to favor the specialist, but then they get influenced by those teaching them who are usually specialists in their own right so it becomes self perpetuating. I think there is room for curriculum reform that focuses on what the physician who is going to generalize and focus on what some of the primary care needs are, that sort of curriculum is a different curriculum*
g. *We need to value and emphasize generalists and the 'jack of all trades' rural doctors. When we graduate someone from medicine, knowing that is that first building block in their training program towards being licensed for independent practice, we need to make sure we are emphasizing the value of generalists in the system*
h. *There is currently a lot of the pressure on young residents, incentives etc, encouraging sub specialty careers. Primary care, general internal medicine, general surgery, are not currently valued, and there are big barriers towards thinking about how would you do things differently*
i. *Generalists aren't necessarily the careers that students find most attractive*
j. *If we keep emphasizing research aspects, academics, centre of excellence we will continue to encourage people when they are looking at postgraduate opportunities to have the mentality that 'I'm nobody if I'm not published specialist' and 'you're too smart to be a GP'*
k. *There's so much bashing of family doctors, if you only ever did 2 weeks of family practice during your undergrad, you don't even have an understanding when you're, for example, a nephrologist of what a family doctor has to deal with*
l. *What I think is also important, I believe it's about the culture of medical education, and certainly about the culture of medicine, and that is that generalism is as important as specialism. This notion that specialty is better and therefore trumps in many ways, I think is out of proportion and there needs to be a rebalancing, and the rebalancing is simply the acknowledgement that we have generalist and we have specialists and the health system requires probably more generalists than specialists, or super specialists. Those super specialists are super, but the profession of being a physician, and the medical education of physicians I*

*think should be pointed to generalism. So family medicine is terribly important, it is seen as slightly fluffy because it's general, but it's not general its scope, it's broad and it's a generalist discipline. So we have family medicine that needs to increase in terms of its significance in the culture of medicine because family medicine touches the lives of more of the public than specialists do. And so truly if you have your patient as partner, and the patient as the focus, family medicine would become key and critical. I know people would say at this point that it is key and critical, but you know and I know that there's what's said and then there's the sub context. The sub context or sub text doesn't support that and it needs to. The same with general specialist, so we need more recognition of the value of those general specialists, the general surgeons, the general internists. We know for example in internal medicine, that that profession is not thriving, and it's not thriving because it isn't well regarded. It is overburdened, and as a medical student, as they find out which disciplines are healthier and happier than other, they self select. And so it truly is a rebalancing with the population health needs at the centre, the patient at the centre.*

3) Sustainable Primary Care

a. *There is increasingly compelling evidence that a robust primary system may be the most important thing in the health care system to improve a populations health, for example the work by Barbara Starfield to demonstrate when you have higher indicators of quality of primary care you have a healthier population – less morbidity, people live longer, fewer complications of treatment and drugs. Maintaining and ensuring that primary care is sustainable is a top need of our society. We have a vital responsibility to train enough family physicians to ensure our primary care system is sustainable to serve rural populations*

4) Flexibility

a. *The time it takes to implement change, and for students to go through program and be practicing we should be focused on 2020, what will the needs be then? We need to create a flexible workforce, because we don't know what the needs will be. Flexibility is a key concept that is counter to what is seen in students that are very focused and come into program with fixed idea of what medicine is like or what they will be doing. The program is reinforcing the idea of certainty and predictability, which the profession and world is not about. There is a mismatch between big area of uncertainty and needing to create people who are going to be flexible and adaptable by putting them through a program that is not flexible or adaptable.*
b. *How does a young doctor know they are doing well, see the warning signs, keep up to date, and handle ambiguity? This is a challenge for young students when they're educated in a milieu of certainty and then thrown into an environment of uncertainty – we haven't worked out yet how to prepare students for the environment of uncertainty which is going to be their future*
c. *Graduates must be able to deal with uncertainty and ambiguity*
d. *Their ability to be flexible is going to be very important, and to recognize that people are going to need tailored treatments*
e. *Physicians need to adaptable and flexible to societies changing needs, to future uncertainty for example technology and the advancing delivery of health care, as well as to the variance of individual patients*

### 5) Population Health

a. *Orientation of the medical school needs to be towards population health, not just disease focused training. Physicians need to be well grounded in population health approach with the focus not just on diseases but the health and well being of people living in a community.*
b. *The key role is to focus on primary care, population health, groups of people. At the moment, the Canadian way, at least the BC way, is the single doctor-patient relationship. That has its place, it is important, but it shouldn't be important to the exclusion of all else. So a focus on population, population health, a focus on distribution of resources in a way that makes best sense to groups of people rather than just focusing on the individual.*
c. *Graduates must have knowledge around the broader aspects of health needs, population health*

### 6) Population diversity

a. *Looking at stats and the population profile, our province is getting older*
b. *With a BC context, a broad understanding of issues around aging and frailty will be necessary*
c. *The aging population needs to be at the top of the list as far as societal needs. There are recent reports from the Alzheimer's association of the incredible increase in Alzheimer's and dementia over the next 30 year as well as reports that these are the first years that the baby boomer are starting to retire*
d. *Last year I heard a report say that the number of gerontologists in Canada was minimal in terms of what we actually need. But I think that although there's a need for gerontologist, every family physician needs to be well versed on elder care, chronic disease, and also health promotion because that's the other priority we see is the need to work harder at prevention so people are aging healthier.*
e. *We need to pay attention to this demographic trend, not that the entire curriculum can be about gerontology, but a lot of the bases for chronic health problems are laid very early in life, so it's about health promotion and prevention throughout life but also not forgetting about the huge number of older people we will have as well.*
f. *With the changing demographics I would be really aware of doctors continuing to develop their own understanding of chronic disease and aging and the needs that go along with that*
g. *Just a few days ago they released the profound need that's going to be presented with regard to dementia and the need for care strategies and big frameworks and I think that as an individual doctor its important to work within that individual framework in terms of people who are coming to see you but also there's huge potential for advocacy and looking at those things as well as the needs of the caregivers. They were talking about this being an unprecedented time, and it goes beyond that individual patient as well, these are family conditions and its really important to work in terms of the family*
h. *Another current trend is that clearly we have this huge generational bulge that occurring around seniors and the need for more proactive seniors care because we have this enormous bulge that's coming up on us. And we've got to get better at serving their needs in different ways.*
i. *Our society is becoming increasingly diverse, and will continue to. With respect to that graduates need to be able to provide culturally safe and culturally sensitive care, and this is going to be increasingly important because without that people are not going to feel comfortable coming forward for health care.*
j. *There is an increased number of immigrants who are unfamiliar with health care system and this raises many questions. How does the program prepare physicians to respond to immigrant and refugee area*

*needs? This will be quite important. What kind of partnerships does the program have with the multicultural and immigrant community? If any? This group (immigrants and refugees) deals with a lot of sensitivities – gender issues, sexuality etc. What training will occur to prepare students to approach these health issues? How do you sensitize physicians about that? How do you train them to ask questions in different ways? To interact effectively and appropriately? What kind of partnerships can you make with communities about these issues? How do physicians get practicum training working with a diverse community? Providing information to newcomers in their own languages, and translating materials on health topics. How does a physician as part of their training get to understand some of the issues that go beyond an illness perspective, but a health promotion and cultural perspective?*

k. *We need to train physicians to be culturally sensitive, and to be comfortable in having a powerful role as an advocate*
l. *What could be the role of internationally trained medical professionals? They can't really practice in Canada right now. What role can the UBC program have for them? What could the curriculum be doing to use and involve them? Perhaps in education?*
m. *One of the things that I've seen so profoundly is the impact of the socioeconomic determinants of health, and that's such a huge thing and one of the things I've encountered over and over again is that medical professionals, you know here of course we're speaking directly about doctors, but when people encountered problems it had so much to do with how they grew up, where they grew up, how they were living at that time, poverty and all of those things. People often didn't have the internal as well as external resources to follow through on the suggestions that their doctors provided in terms of health and all of those things, and I think that a lot of people would say, 'oh my doctor says I should do this with regard to chronic conditions and managing and exercise and diet', but they for whatever reason didn't have that internal framework to make that work. And so I think for me that's really an important area to focus, and that's nothing new, but an area of continued need I think.*
n. *Graduates are going to need to be aware of and focused on some of the underlying determinants of health, and appreciate that particular groups may not have the same access to health because of those determinants.*
o. *One of the problems our population is going to face in the future is that we have growing diversity. Diversity in health care needs as a result of different society backgrounds, different racial backgrounds.*
p. *We have a mixture of rural, semi-urban populations which create their own stresses on the health care system. Clearly what you can delivery for somebody who is 1 out of 100 in 3,000 square miles is quite different for somebody who is falling over their neighbors as soon as they turn around.*
q. *There needs to be recognition that health care needs to be tailored to not only ethocultural diversity but also in relation to influences of sex and gender (and by sex I mean the biological differences and variations, and gender more the social influences on the way men and women do health and health practices and how that might influence their access to health care). Sex and gender influence not only health and illness, but also the way we should be treating and providing health care as well, and sometimes we haven't always taken that into consideration – and that can be as far as prescribing antibiotics or drugs for example if the drugs trials have been on 200 lb males, and they give a female the same dose because they're an adult – they will overdose*
r. *In this question we have to deal with the different educational standards of the population that we deal with, and part of that is based on their background life, but part of that is based on the various levels of access to education that exist in people of different income capability. Those that are lacking in education compared to others often have greater health care needs; they're the ones that you probably do need to reach*

*out to help prevent, because actually a lot of prevention is education itself. They're the ones that we fail to prevent ill health and therefore they're the one who come to be the demanders on the health care system*

s. *Physicians must be sensitized to the needs of immigrants and refugees who are coming to Canada with very different experiences*
t. *They need knowledge of who is living in the Lower mainland. What does it look like?*
u. *Transnational competence requires graduates to have analytical, emotional, and communicative skills*
v. *Students must demonstrate emotion and empathy when interacting with the different cultures and belief systems of immigrants and refugees*
w. *Graduates must have empathy and understanding with the people they are working with, not just as individuals but also with cultural sensitivity and an understanding of their circumstances*
x. *Particularly in our province with an enormous and growing immigrant population graduates must understand the needs of different groups and reflect on the balance of those needs and being part of British Columbia, and being part of Canada*
y. *Graduates must appreciate that particular groups may not have the same access to health.*
z. *Graduates need to appreciate diversity, for example the needs of first nations people might be different than other groups - a 'one size fits all' mentality is not going to work and health care providers must recognize that people are going to need tailored treatments*
aa. *It's so hard because as a doctor you have to be a technical expert on disease and health and all of those things but at the same time it's so important to take into account the context of the patient, and that awareness I think is extremely important for doctors*
bb. *I tend to feel pretty strongly that new doctors need to better understand special populations and the nuances of some of those issues that are often lost on them. I think that's a critical element of them better understanding special populations and how they got to be special, some of the politics around disability are really not understood by physicians in terms of is disability a disability at all, or is it just in the spectrum of what's normal in life. You know you go from this very technical perception from the medical community that would suggest that you eliminate disability all the way to the absolute other extreme of that in that disability is just normal and everyday part of life and you don't try to eliminate it at all. So I think those understandings are important when we look at special populations for example disabled, plus a variety of others that are lifelong issues that they can be more aware of like mental health which is so critical and is so deeply ties to well being*
cc. *We need to educate physicians with a broad understanding of the challenges people face in rural communities*
dd. *Graduates ability to be flexible is going to be very important, and to recognize that people are going to need tailored treatments*
ee. *Are there students in the program who come from underserved communities and populations? If they aren't what opportunities can be made to shift to that? This is a question of recruitment and admissions*
ff. *If we want our medical practitioners to connect with their patients and be grounded in the community they're serving, we may to think about what communities we're drawing medical students from. As medical education becomes more expensive, we need to think about how to encourage and support underrepresented groups attending medical school. This is more of a challenge for the medical school rather than the students in considering socioeconomic, cultural, and geographic barriers. UBC hasn't really looked at this in a hard way. We have an aboriginal track, but there are other underserved groups that are not addressed.*

gg. *If you've got a diverse population that you're trying to serve, that you do need a diverse group of health care professionals to look after them*

hh. *I was from a very small town and had never been with so many privileged people. The PBL was a very big shock for me, I didn't think that anyone in my group wanted to listen to my opinions and that had never been a type of environment that I had been in before. So it felt like a very dangerous time for me when I first started medical school. It seemed like the group that I got into medical school with were very homogeneous, I think specifically for aboriginal students there's more now than there was then, but I know also there wasn't dedicated spots for aboriginal students when I got in, now there is, I sit on the admissions committee for those dedicated spots, and I know a lot of the time those students feel resentment from the larger group as a whole because 'you're aboriginal' or 'you're not smart enough'. I think building some kind of sense of community, because it is a very entitled group of people, and I think sometimes, especially with our aboriginal students, that they do fall through the cracks and that's felt to be the fault of the students, where from my own personal experience it's probably just as much, if not more, a factor of how they felt in the environment that they were in. So I would say, that's one of the weaknesses, and in a way, I don't think it's gotten any better, because now the tuition has been raised so much and I know they've done all of these studies to say that it would change the demographic of people who went into medical school – but my band funded me to go, and it was $3500/year when I went, no band in all of BC would fund a student for $15000 per year now, they could send four people through an undergrad for that, and it's now justifiable. It creates a more of an elitists structure, and I think that's the biggest fault is that it doesn't feel like a socially accountable structure because it's not the demographic of the province as a whole. We have a lot more aboriginal applicants now, but a lot of aren't necessarily from smaller isolated communities, so these are people who have probably already been living in a major centre who've had the opportunities that some of the non aboriginal counterparts who are applying have at the same time.*

## 7) Underserved Populations

a. *Its less about we need a certain percentage of students going into this or dealing with that, but about how can we ensure we have a broad spectrum of people with a broad spectrum of skills to go out and meet that wide spectrum of needs. For example, aboriginal, remote communities, downtown eastside.*

b. *In our region in particular (interior) there is a real interest in better health care for first nations communities, and not only in our region but also a really important goal throughout BC and Canada*

c. *There are huge health care issues there that we haven't done a good job at. In the downtown lower eastside there's addiction, mental health issues, homelessness, aboriginals, single women, youth. Urban aboriginals always seem to get lost in the discussion. The main focus is usually on reserves. What are the health needs of the different populations within the communities? How are you setting up community partnerships to keep a ongoing dialogue? How do you provide the training? How do undergrads get sensitized to these issues, and get comfortable working with these different groups, and contribute? What kind of advocacy and knowledge building can the undergrad program provide?*

d. *In BC there is a huge discrepancy between the levels of health outcomes of our various populations, a discrepancy in outcomes in certain populations*

e. *In particular we know the outcomes in rural vs. urban, and aboriginal vs. non-aboriginal are two huge areas where I would say society would start to want us to be making some inroads*

f. *The health of British Columbians as a whole is a need, specifically for myself the health of first nations*

*people in British Columbia, a bigger difference can be made in this type of work*

g. *Serving the aboriginal population, and helping aboriginals, understanding how they work amongst themselves to support their own health care will be very important*
h. *The impact of just poverty alone, you know the impact when you talk about kind of population trend and population health, the impact of poverty on health is so dramatic and yet we're still arguing about it, and physicians can step up in public ways to talk about, as long as they understand it, so I think it's important for them to really get a true sense of the impact poverty. So many of the students come from fairly privilege places and have no real sense at all of what poverty is let alone deep poverty, let alone generational poverty and its impact on people's health and well being and mental health. So I think that kind of stuff is critical that they get experience with poverty.*
i. *Are there students in the program who come from underserved communities and populations? If they aren't what opportunities can be made to shift to that? This is a question of recruitment and admissions (aboriginal/immigrants etc)*
j. *If we want our medical practitioners to connect with their patients and be grounded in the community they're serving, we may to think about what communities we're drawing medical students from*
k. *As medical education becomes more expensive, we need to think about how to encourage and support underrepresented groups attending medical school. This is more of a challenge for the medical school rather than the students as we face socioeconomic, cultural, and geographic barriers*
l. *UBC hasn't really look at this in a hard way. We have an aboriginal track, but there are other underserved groups that are not addressed*
m. *If you've got a diverse population that you're trying to serve, that you do need a diverse group of health care professionals to look after them*

### 8) The Health Care System

a. *There has been a decline in continuity of care. We need more of a continuum of care that is relationship based*
b. *We need to look at the concepts of quality assurance and patient safety. What are we doing at the academic undergraduate level to encourage and incorporate these types of thought processes, for example how much teaching is there about patient safety initiatives? We understand we need to do a better job, is this taught comprehensively at the undergraduate level?*
c. *An area that society is expecting us to do a better job would be in the quality of services that we provide, both a safety and error perspective, and also from the perspective of generally doing the best that can be done, we would probably recognize that there are gaps in those areas as well*
d. *Physicians need to understand it's not just about whether they work a 6 hour shift or an 8 hour shift, but that they are part of the commitment to Canadian health care. They are part of the publicly funded and publicly accountable health care system and must understand the roles and responsibilities within that, and contribute back to it*
e. *Students should have a concept of management within the health care system. Nursing does a better job than medical schools. They understand there is need for nurse managers within the system, and they encourage and mentor students in those roles, we don't do that in medical school. There needs to be a greater emphasis on management, the concept of medical management and leadership is not taught in*

*medical school. There is a role for physician advocates within the system, and there is need to look at how the system operates and who manages that, and physicians should be encouraged to be physician managers, not just an 'admin' throw away*

f. *I'm not sure when we give them these managerial skills. We may want to consider how they are going to be stewards of the health care system when cost constraints are going to become more important*
g. *We don't spend a lot of time on the role that these folks play in the actual management of the health care system. From an academic point of view, from a patient care point of view we do examine and teach and organize and all of that but I don't really know how well we do with physicians as managers of the health care system, I don't think we do as much as we could be doing*
h. *Students need to know what the Canada Health Act is and what it means*
i. *I hope graduates coming out of medical school will have an understanding of the extraordinary difficulties around sustainability of the health care system, and will be able to practice their medicine in that context to the extent that they can influence and assist with* the sustainability of the system. Graduates will also need an understanding and skills around translation, and knowledge exchange components
j. Graduates must have a broad understanding of the health care system

9) Health Promotion

a. *Focus should not be on disease orientated practice dealing with patients one on one in the privacy of their office but increasingly meeting with groups of people helping people with chronic illnesses extend their independent living, help motivate people to take care of themselves whether they have disease or not. Physicians need to be agents of promoting healthy lifestyles, taking a broad approach and being active in the community*
b. *With regards to disease prevention, the dialogue needs to shift from a way to save money to how are we going to improve people's lives?*
c. *Physicians need to encourage people to be involved in their own health care and use modes of lifestyle prevention strategies*
d. *Often the focus is treatment and diagnosis, and that is obviously still important, but equally important is their role in health promotion and health education.*
e. *Physicians are health advocates, educating and teaching patients and the public*
f. *General health promotion, from a variety of perspectives, more and more of our research tells us how tied personal well being is to better health. I find it quite frustrating that physicians are still in this place of focusing of fixing the problem of the moment without looking at the broader trends of health promotion. And just from a strictly societal demographic, unless we begin to help people learn to manage their health care better, it's going to be highly problematic very soon, and very very much so 20 years from now when our new graduates are going to be absolutely swamped with seniors with huge amounts of health problems*

10) Global Health

a. *We are global players by virtue of where BC is situated. Some students have taken an interest and are taking it on, but we don't have a coherent vision of what our international responsibility is as a medical school, or what role the medical school has globally as far as training practitioners who can work in less developed and with marginalized populations*

b. *Graduates coming out of leading medical schools must have some broad understanding of global health needs and global health issues. While we talk about provincial needs, we don't just live inside British Columbia, we live in a vast world where we're impacted by other influences from around the world – so we need to be aware of our contributions as a wealthy nation to underdeveloped nations and global health inspectors, and also the impact that folk from other parts of the world have on disease frequencies and so on in this part of Canada.*
c. *I'm in favor of international health; I'm in favor of any one medical school in the developed countries providing support, if not direct health care to underdeveloped countries.*
d. *The idea of a 'global' university, i.e. meeting more international needs. It is a nice idea, but we need to have our house sorted first. Our obligations should be first to the province, then nation, then the world*
e. *I think we should take students from underdeveloped countries. I don't think we do particularly at the moment, they have to come through another system, but I think a certain number of places should be set aside for direct entry for students from very disadvantaged countries.*

## 11) Physicians Role in Society

a. *Physicians have a social contract, a special obligation to society. It's almost looking at it the way business schools treat ethics in their curriculum, and I know there's medical ethics but I'm just drawing the example to the social accountability that physicians have that should be embedded in curriculum the way ethics are embedded in curriculum. I know that solo practice isn't as much of an issue, but I'm sure that that lingers on to some extent, so the more that we can paint that picture that even though you are an independent practitioner you do have a social accountability, and more than likely you are going to see yourself practicing with more than one physician, and more than one health care provider, that is your new reality.*
b. *People look to physicians to provide leadership, they are advocates for a particular community*
c. *Physicians play a community leadership role, and must have the ability, and be willing to accept a community leadership role as part of their practice model. This will be more pervasive in the future.*
d. *For particular students they are going to be leaders within the community, I'm not sure what proportion of aboriginal students for example that we have at UBC but those are going to be the folk who are going to have an incredibly important role in their communities and their role there is a leadership role, a preventative role. They are the folk who will be trusted and understood by the members of their communities. You need to be there in the community to truly understand and to win trust, and for someone that is not from that culture, and not from that society, that's not just going to happen over a two week elective*
e. *I was talking with one of my friends who went to UBC medical school not too long ago, and she just took a leadership course, and it really struck me that she didn't feel she was much of a leader, and just from my place in society, like I am a physician, I've been educated, you may not think you're a leader, but you actually are because of all of things that you stand for, and I think a lot of us forget that.*
f. *Graduates must develop the habits that allow them to be a role models. In playing a public role, you must also be a role model*
g. *Physicians have an important role as pillars of society. By definition physicians will have leadership roles in society, and must be able to exercise that morally, ethically and responsibly*
h. *It is an honor, and you are in a specific place in society when you get into medical school*
i. *I'm sure that if I was actually involved in the training of physicians there would be lots of pieces within*

*that context to help reinforce the social contract and remind people of the special role physicians have, and in having that role, how their accountability is even greater.*

j. *Society needs doctors to understand that they're servants of society, not the masters of society. I think society needs doctors to understand that.*
k. *Coming to the area of the advocacy, knowing that doctors have huge influence and power, and to really use that well, especially when people have that aptitude*

## 12) Understanding and Caring About Societal Needs

a. *Graduates need to be well informed, and have baseline knowledge of what the health and societal needs are. Physicians and medical schools need to stay on top of the changing social context*
b. *I would like to see us create people who are equipped to think about society as well as think about the individual. Think about distributive justice and things like that. And I don't think we get a lot of that in medical education programs that I've seen.*
c. *We have to also look at training physicians in a way that allows them to come out the other end caring about society. Currently a lot of physicians do what they do because the rewards are structured to reward them for doing what they're doing, and I suppose the corollary of that is that if they're not rewarded to do what they do they won't do it, and we do see a bit of that. We see very little altruism. An undergraduate MD program can't fix all those problems, but it can at least put some effort into some of the 'softer' side of medical caring, which is not about high end knowledge, which is not about high end academia, and it probably isn't necessarily best to deliver to the straight A student coming out of the previous program they were in.*
d. *I remember talking to friends in med school and asking them 'why did you decide to become a doctor' and hearing, 'well I have good grades, and its kind of a good field to get into, so I thought why not?' That is almost verbatim what I hear from these people and it really comes out in their practice. When I was interacting with people with Parkinson's and their families I always advocated for the medical school home interviews, and it was interesting to hear feedback from people after because they said we can totally tell who's interested in helping people and who's in it for the money and the prestige, and its not an easy profession at all, its so challenging. I think in order to stay connected and to really help people, especially if you're a family doctor, its really important to actually be interested in helping people. Remembering the basics of the medical profession, the do no harm, and trying to help, very basic, but I think quite fundamental and very easy for those things to be lost in the swirl of all the complexity of society and medical treatment, and people themselves*
e. *I'm always challenged when I'm answering these types of questions because I think it's impossible for the doctor to do everything. And so I'm always kind of torn between, well they need the technical expertise and I know just anecdotally from some medical students who of course are now doctors that some of the bear a lot of frustration when they're being trained in terms of the social side of things. Like ok we need to know the technical stuff and I understand of course that poverty in a problem, but I don't need a full year of lectures telling me that that's an issue. So there's a real challenge there and it has to come down to that person really understanding those issues and then developing the technical expertise as well as the social intelligence*

### 13) Patient-Physician Relationships

a. *I think it always come back to remembering why doctors are there and the profound role that they play, and the value that even if there's nothing that they can do medically for a person the human connection is so extremely important. The placebo effect is very powerful, and just the belief that something can help you, will actually help you, for example I think that a good relationship with a doctor, a family doctor or the confidence that a specialist can evoke in a person and they're family is real power that can be used for the good*

b. *We need to have a good look at the idea of relationships between patients and their providers – what does that look like? What skills does a physician need to have an appropriate relationship with their provider so we don't just fall into training technocrats but we recognize that the relationship is vitally important to care as well as to patients. As we get increasingly technological in our care, communication can suffer, and some of the challenges in the future are going to be issues around communication*

c. *I can't remember the last time a doctor just asked me 'so how is everything? How's your life?' Trying to view you as rather than a technician of what the problem you have today that I need to fix, but how is your health care, and how are you managing it, and am I even having a conversation with you?*

d. *When you talk to patients about what's important qualities in their physicians they'll talk about them being good technicians, good diagnosticians, good at providing therapy, but they also talk about the relationship. When patients complain about their physicians they'll complain often about the relationship. We need to consider the types of students we're admitting to medical school – the way we're training them, because we may be teaching them that the relationship is not important by the way we train them*

e. *It is important that physicians are able and willing to involve patients in making decisions about their health care – away from paternalism, see patients as partners in decision making process. This is particularly important in prevention and health care promotion, involving patients in decision making.*

f. *Graduates coming out of our leading medical schools have an enormous responsibility to engage their patients indecisions and to do it in an ethical and meaningful manner, and what I mean by that is for example the role of drug companies in influencing practice, the role of drug companies in influencing outcomes of research, and that might be good – not necessarily bad, but who sponsored trials, who sponsored the development of a particular product, was is done in an appropriate peer reviewed, ethically acceptable understandable type of manner*

### 14) Inter-professional Care

a. *Models of care delivery will be different in the future and society is going to be seeking more multidisciplinary and team care. Society will be seeking nurse practitioners and physician assistants because physicians are expensive to train and employ, how best can we use these resources? The university needs to get their head around these concepts. Team based care needs to be considered and is important because you can't be everything for everybody*

b. *Increasingly health care is team based, and the team based approach is that way health care is going to be done in the future. The current model is a physician of private practice essentially running a business. We are moving more towards team based practices and clinics, business orientation won't be as pronounced, but the ability to work in interdisciplinary teams and acknowledging the value of those other team members will be essential.*

c. *Physicians being able to work in interprofessional teams is a fundamental societal need*
d. *Then in terms of how we deliver health care we know that in the future we are going to be doing that more on an interprofessional basis and that's because again, it's about social accountability, the patient is centre but as a partner, and so it's a shifting in terms of how physicians have practiced in the past. That's very subtle but very real, and that needs to happen. I know for example the Royal College will say we're already doing that, we have our core competencies etc., and yet that's not sufficient, so it's unbundling that and making that more tangible.*
e.
f. *The piece of embedding the interprofessional goes hand in hand with the culture shift that we need to see, and by culture shift I mean is 'doctor as director' and 'doctor as a critical member of a team not always the leader of the team, huge culture shift there. The writing on interdisciplinary care is 40 years old, actual landing of that on the ground is notThis doesn't mean they are always the person in charge, they need to be involved in the decision making about health care*
g. *As the health care system becomes more complex, physicians will have to understand the breadth of the health care system so that they function less in isolation, and more in a horizontal manner within the health care system. Whether that is team based care or inter professional care, or working within an IT framework that allows more free communication between providers, with increase in specialization there needs to be an increase in communication between those silos, that's going to be an important skill. For example there is a stroke clinic, a diabetes clinic, a falls clinic etc etc, and the patient is divided into infinitesimal bits, and it comes back to looking after the whole patient, and how do we coordinate all that care?*
h. *One of the things that society would expect of the caregivers is the understanding that they would not be functioning as independent entities, but in inter professional teams, any curriculum would need to reflect that. I think that is in fact the major disappointment that I would have with the current curriculum is that although it was described in 1997 to create teams of learners that would work together on health care problems, I don't think it's been able to achieve quite that target. I don't think you'll be able to address other societal needs unless you start to think in those terms.*
i. *Graduates are going to need to be able to build community partnerships, work with communities, work with individuals, and work with interdisciplinary teams because it's not just going to be a physician who going to save the day in first nation communities. That's where we get into the concept of inter-professional teams, and first nations is one place where its particularly relevant, but it's also relevant in elder care.*
j. *Considering physicians roles in interdisciplinary teams really talks about the scopes of practices that other professions have, how sometimes they will overlap with a physicians scope of practice and how that gets managed for the benefit of the patient. The other overlay on that, to build on the scope of practice concept, so that you can build your interdisciplinary team, and you know where you begin and end and where your colleague profession begins and ends when you're treating a single patient, is the thought process of understanding the needs of you community or your service delivery catchment area.*
k. *Not only do physicians need to take their role in leadership, but they also need to take their role in follow ship, and they also need to take their role as members of a team. Most physicians if you sit down and talk to them will understand that the nurses are quite important and that the social workers are quite important, and the various other allied health professions, they're all essential components of the team. The physician writes orders, and someone else does the work, that's not quite true…but without those other members of the team it just wouldn't work. So I think medical students needs to understand their role in a*

*team, they need to value the other team members, learn to value the other team members. They also need to learn how to deal with issues when they go wrong, and they also need to learn that they don't do that themselves, there's a certain amount amongst physicians, there's a certain amount on deity, 'I can cope, I've been given this great skill and I'm looking after people's lives', that's not what its about. When coping is difficult, recognize that there are other members of the team around you who can help. I don't think we do that well, I don't think we train people for that well. So some of the softer caring, empathy sides of this need to be drawn out.*

l. *And to be slightly probably controversial I actually think we need to train our physicians to be leaders, I'm not very interested in the team approach and everybody has to be a good team player, because in the world of medicine, the buck still starts with the physician and I think it always will, yes you can learn how to be a team player when you finally find yourself in your particular work place with whoever you're going to be working with. You either build the team yourself, or you become part of the team, and all the rest of it. I actually think that physicians should be trained as forms of leaders, not as generic team players. So I firmly believe that we've done a disservice in potentially trying to influence our students that they're a member of the health care team just the same as everybody else because they're not. And if you don't train leaders, who's going to be the leader? Someone has to be the leaders in health care delivery, health care policy and all the rest of it, and I think we've done ourselves a disservice. And I think they should get some of that training in medical school, I'm not sure how we would do that, put them in places where they have to know what it feels like to build a team or something like that, but the word leadership is missing I think in a big respect from our undergraduate curriculum and I think it's a mistake*

m. *There is a debate of different roles and responsibilities of health professionals that will become a critical debate over the next few years. Some is related to cost, for example physicians are costly and expensively trained to do some things. More routine procedures can be done by nurse practitioners and nurses, why pay docs to do it? The concept of encouraging grads to go to remote and rural areas when realistically nurse practitioners will be able to provide a lot of the care for those populations and refer on the complex cases. In terms of providing patient care physicians should focus on complex problems, chronic, long term, multi disease and system problems, while simple cough and colds can be handled by health professionals that are less costly to the system*

n. *Physicians have to start to see themselves as people, who possess a certain component of the skills to solve problems, and that others may have overlapping and other skills – and physicians are most likely the most expensive of those who possess those skills .Society is looking for other alternatives and physicians need to understand that that's an issue for them. For example, when would we want to be using 'physician extenders,' nursing practitioners etc and how would we train physicians to work with these folks, we don't do that right now at all*

o. *Graduates must respect what other professionals bring to the table in diagnosis and problem solving. It's important that habits of inter-professional interaction be established early for example Primary Health Care Homes (Northern Health) brings together a number of disciplines working together on a level playing field; the doctor isn't 'god'. Patients are dealt with in groups; there are group visits around chronic illness. Physicians will need to be comfortable giving presentations and comfortable dealing with question and answer in a group, not protected by the privacy of a door with one on one patient conversation. This is a very different kind of skill set*

p. *Work has been done on setting out competencies in an inter-professional framework, and so they will need those core competencies. They are about communication, they are about power management, they are about*

*conflict resolution and so when we teach psychologist, sociologists other professions that work with the public, they are keenly aware of their personal power and how power is managed between individuals and among individuals. I'm not so sure that power is a topic specific to physicians' education, so when you talk about physicians acting as members of a team from the core competencies, if you are actually trained regarding communication, dispute resolution, you will also be trained about how you manage personal power. I don't think that's happening, and it will be really critical to successful inter-professional practice. I mean some people, and probably people today as they enter medical school they may have a lot of inter-professional skills anyway, they may not. What I don't know is how technology is changing how we interact, and so I don't think we should assume that people know how to behave with each other.*

q. *Graduates must have the knowledge of where they play a role or not in inter-professional teams, and knowledge of where they might lead or be lead within inter-professional teams. They've been through the experience of working with teams of like professionals to solve problems in their curriculum, but they haven't actually done that on an inter professional basis in terms of solving patient problems*

r. *Graduates must demonstrate leadership and collaboration in the context of interdisciplinary and inter-professional care*

### 15) Community Partnerships

a. *The development of partnerships as well for doctors to really understand their role in that system is extremely important. I referred to partnerships, I should make it more explicit the connection to work with the agencies that are there who have expertise and a distinct role from the from the medical professional, they're not offering health care services, but helping to support people and provide information to them that often doctors don't have the time to do and in some cases shouldn't do, there's a clear role for the societies' as well. I should just make that connection more explicit because there's so much expertise at various levels that really linking up people with one another in support groups and all of those things.*

b. *A piece when we talk about our primary health care charter and our integrated health care networks and who makes up a team in that context, on that service delivery model we've got other NGO providers that would be really beneficial to the patient, and if the doctor, or the doctors practice, as the potential hub for patient contact is thinking interdisciplinary that is broader than just the education system professions, so the nurses, nurse practitioners, the PT's and OT's, so if we can look broader of what defines their interdisciplinary team to the people in Heart and Stroke, to the people in community, to the aboriginal leaders because there's a cultural need there for integrated service. If they can look broader when they're defining interdisciplinary care and the members of their team it would be very beneficial for the patients in their catchment area. They don't build partnerships with these groups right now because they're busy, like crazy, but still part of reducing your workload is about building your team. When they set up their practices how do they set them up to reach the needs of the population in the area in which they serve? Do they sit in their office and construct it that way? Or do they actually go out and with organizations within the community and help set up a practice that actually is responsive to their community health needs, and that shared services is the way to go.*

c. *I think it's important to stay focused on the doctor not putting themselves as being all things to all people, and it's important to stay focus on your specific role within that health care system, and of course health is impacted by socioeconomic and there are so many other factors and so of course it ends up being linked to other sectors as well. But to retain that focus on health and realize that health also involves where you live,*

*and kind of connecting people outside, but the importance of partnerships and know that sometimes the most important thing you can do is make a referral to a good agency or government service*

### 16) Undifferentiated Graduates with General Competencies

a. *We need to be able to demonstrate that our graduates have the capability to go along any career path. They need generalizable skills and competencies that underpin any particular content topic area*
b. *Our students need to be able to go into any of the postgraduate areas easily in any community. I think we should still continue to graduate generalist students, undifferentiated generalists, and I think the school should do as much as they can to not have students focusing on sub specialty careers early in medicine, so I think the whole four years should be geared towards very much a generalist training.*
c. *Graduates need to be competent in terms of basic medical sciences in their clerkship to be able to enter any postgraduate stream. They need exposure to all of the disciplines that make up medicine, this makes them well rounded in an undifferentiated sense and value all of those components*
d. *With the new generation coming through medical school the expectation is that people will have a variety of careers in their lives and we need to give them the general skills to deal with that*
e. *The underpinning to the graduate system, is that yes at the end of med school we graduate an undifferentiated medical student who then embarks on the second phase of their educational component then developing the specific skill set of whatever that is going to be*

### 17) Clinical Competence

a. *One of the generic things that we are expecting of our graduates is that they're clinical competency, and have knowledge to do that stuff.*
b. *Grads must have the core areas of medical knowledge*
c. *Basic medical knowledge is absolutely fundamental, and is even more important than societal needs*
d. *The technical competence, the actual knowledge of body system and how things work and of course that a very standard things, medical students get frustrated that 'they're taking us too far away from the technical aspects' with more social content, but I think that always needs to be fundamental*
e. *For me I suppose core knowledge about where the body works, how it doesn't work in dysfunction, and how we treat those things would be key attributes that every medical student should have, and I know that seems obvious, but it's not always achieved.*
f. *Graduates must be able to provide health care to individual patients*

### 18) Communication Skills

a. *I think the other thing that we've got to do is equip doctors to have better communication skills, I said earlier that a lot of prevention is about education, and a lot of education is about strong, good communication. Get the messages out there in a way that the public can understand. Don't talk to them about the disasters that are going to happen if they don't give up smoking, tell them the benefits of giving up smoking, and tell them in a way that they can understand. If you make it very medical, people just turn off and don't understand. So recognize that there's a way of talking to people that could be considered communication because there's a bit of understanding on the other side, talking at people is not*

*communication. I think communication skills in most medical education programs, I don't know about UBC, are not taught at all. And if they are taught they're given 10 minutes here, 10 minutes there, not very much. And that sort of communication skill can be delivered very well to the student who is following the patient longitudinally because they will live the communication. Of course it does rely on the teacher having those communication skills which isn't always the case*

b. *They need to be better communicators, we need to teach them to be better able to talk with their patients*

19) Scholarship and Research skills

a. *Graduates must have an understanding of research, not because they're doing it but an understanding or an appreciation for it. I'll define research in this context as current knowledge, and an appreciation of future knowledge. I would hope that our folk coming out of UBC would have an understanding of the importance new basic science research as well as clinical research, and the applicability of both of the above to their practice, the necessity of maintaining a degree of currency and understanding of those areas in order that they can immediately be applied to their patient groups. I would hope graduates think about new opportunities for treatment, what new treatments mean and continue to look at and have an understanding of trials of new therapies and new technologies and to continue to ask are these really having a value in a holistic sense from a patient standpoint, but also in an economic sense*

b. *I hope our graduates coming out of UBC are going to have a broad understanding of research methodologies. Not necessarily that they've done it all, but that they understand the language and they can look at any one of a large number of studies, they can look at a multifactorial study, and they can look at a series of clinical trials, and they can themselves form and impression, an evaluation of the validity of the studies to which they are referring and then provide that information as a gatekeeper to their patient populations but they can also assess the validity of applying that knowledge in their own practice – they need to understand something about meta analysis.*

c. *I don't know what the numbers are here but in the UK, 75% of the graduates from the medical program went into family practice. I'm not sure what the numbers are here, I don't think it's quite as many. So its my understanding that those going on to specialty training are always going to be a minority or somewhat of a minority, so given your comment that the doctors need to be broad based and service many interests of the community, I think of course the research aspect really only is most relevant, not entirely relevant for hospital physicians and those who become specialists in their field which will only ever a relatively small number of your graduating class, perhaps 20-25%, but those people need to have exposure to research and need to understand how research informs medicine. So I don't think you can really expect them to practice effectively for a lifetime after they leave medical school without having a good knowledge of current research methodology and how research informs medical practice.*

d. *There is a societal need for clinical researchers and scientists for the advancement of biomedical knowledge*

20) Problem Solving and Decision Making

a. *I think understanding the long impact of decisions, for example in palliative care, and not just thinking well ok this person needs a feeding tube but then they stay on it forever because their family is so worried about taking it off and killing them. So I think with the ballooning of need that's coming and the exhausting of the resources that we have its not just a matter of throwing money into these things, I think*

*with people its really important to look at our individual actions for doctors to think what will be the impact if I do this, what will be the impact over time for this individual and this family. And that's of course not something they're left to do on their own, there's a whole system to help them deal with that, but I think that ability to really think long term is a really important attribute. Its not just about immediate problem solving and doing something in the moment, its really thinking long term, and this is going to be a huge challenge with all the expansion of options available for people.*

b. *Graduates must be able to think creatively to solve problems*

### 21) Physicians as Educators

a. *Graduates will need to be educators and teachers amongst their fellow physicians*

### 22) Physicians as Counsellors

a. *They are going to need to be involved in supporting behaviour change, of individuals and groups. That's around lifestyle behaviours, and those kind of counseling things*
b. *I think more and more they have the resources available to them to get the technical knowledge that they need, so accessing information is becoming easier and easier for students as opposed to having to rely on they memory. So its shifting a little bit for them in terms of being able to use more holistic skills, and really I think we need to teach them to be less technicians and a little bit more counselors to be able to help people be healthier, and not just this tiny focus on whatever the issue of the day is.*
c. *There are just so many things, because there's also doctor's perceptiveness and understanding of how problems develop and how you learn to intervene on that as opposed to just providing advice, which often or most usually doesn't work. And also the holistic sense, and that comes back to the socioeconomic, just the perspectives of people and how they end up in the situations that they're in, and how you then work on that level to really bring about change, you know on that personal as well as societal level*

### 23) Behavioral Competence

a. *Standards of integrity, honesty, being able to understand the professional socialization and the requirements of being a physician are critical things to build into the program as they provide the foundation for effective and safe practice. We need to try and ensure that our graduates have those behavioral traits, and it would be easier if we know they have them when they come in*
b. *These are things that we can teach, but are also characteristics that we may need to select for more than teach. People have to come with them in order to demonstrate after they become physicians*
c. *Issues of empathy, sympathy, understanding, you can't just teach folk those qualities but they need to understand the importance of those various qualities and hopefully express them. Hopefully that's part of the reason we accepted them into medicals school in the first place.*
d. *Empathy is a really important skill set. And we can teach empathy, it is a skill set that we can help people gain. I'm not sure that we spend time doing that, but it is something we can teach others*
e. *Of course we all want our doctors to be empathic don't we? I'm not sure you can teach empathy, and I'm not sure you can even interview and decide someone is empathic in an entry interview. I mean there must have been studies done on the relative empathy of a cross sample of medical students versus the rest of*

*society, and I don't know what the answer to those surveys are, but I suspect they're not very different, but I would say empathy would b e nice thing to have.*

f. *I think the politically correct things like, empathy or adaptability to society's changing needs kind of irrelevant to be honest. Like if I have lung cancer or bowel cancer, I want the doctor to pick out that I have a change in bowel habit or I'm coughing blood, I don't really care about their empathy, I just want them to be an efficient diagnostician and be able to follow an existing decision making tree, and so the last example you listed (experience and skills such problem-solving skills or skilled in using technology to access information) knowing what resources are available to the out there, knowing how to access that information, how to plug into it and how to get their patients that information. That quantitative knowledge, and scientific knowledge is not very easy to pick up anecdotally, and that knowledge usually forms the core foundation of their lifelong learning. Whereas I think, to be honest, you can pick up population health skills by reading a couple books, it's not very technical. Societies needs, adaptability, blah, blah, blah, its easier for someone to learn that as a postgraduate, or to pick that up in their life experience. People do pick up those things in their life experience, they react to the conditions around them and hopefully they become more empathic with experience. I think empathy is probably far better taught when working as a physician they kill their first patient than trying to teach them in a lecture or a small group setting. But that basic knowledge, they'll never look at that again, they'll never see again, and want to know again.*

g. *Doctors need to know how to manage themselves and the complex situations that they're a part of, you know when they're faced with extreme need and crisis and people yelling at them, all of those things,*

h. *Graduates must have a good sense of moral compass. I see family physicians that would rather get into the 'botox'. I'm not sure if this is a curriculum issue, or how we select for medical students in the first place. It encompasses the concept of altruism. I see people early in their medical career, leaving the service component of it and entering into the more lucrative parts. Similar things happen with specialists for example plastic surgeons willing to do breast augmentation, but less willing to get up at 2am to put someone's face back together after a bar fight*

### 24) Commitment to Lifelong Learning

a. *At the undifferentiated medical school degree level students need to understand the commitment to lifelong learning. Graduates should leave with the skills that if they want to pursue credible and evidence based research during clinical years they can do so*

b. *Physicians must continue their education as lifelong learners*

c. *Your education doesn't end when you leave medical school and start clinical practice. The need for continuing education, its not just a requirement of the college its much more than that, its absolutely fundamental to your ability to sustain good high quality practice, and good high quality relationships with patients*

d. *Physicians must constantly review what they do and making sure its best practice. This links to the idea of lifelong learners*

e. *Graduates must understand the necessity of being a lifelong learner, and exemplify the quality standard of always being up to date*

25) Adapt to Future Trends in Patient Treatment

a. *There is a current and future genetics trend. Increasingly genetics is going to underpin more and more of our diagnosis and treatment, so students will need a good knowledge of that*
b. *Graduates need to understand how research informs medicine and need to know that we're heading towards a genomic world when personalized medicine will become the law, we will all have our genome sequenced and will want to know likelihood of diseased based on what our genes for xyz are, that's really exploding as sequencing of genomes becomes cheaper and faster. The doctors need to understand the research tools that we use to collect those data because they have to be able to critically analyze information they've been presented with, and so we need to give them the skills to be able to analyze that kind of research information because its much more relevant to medicine than it ever used to be and will become increasingly relevant and patients will demand that knowledge.*

26) Adapt to a Culture of Mass Information

a. *We aren't going to be able to teach our students everything they know*
b. *With the vast amount of information available we won't be able to teach students everything, but we need to teach them how to know when something is valid and invalid, how to find information, how to address their anxieties about the vast amount of information that is available.*
c. *There is tons of new information each day, and patients struggle with this as well, it's important that graduates help patients navigate through it*
d. *Its more than evidence based medicine and just teaching them to critically appraise something. It's more of a sociologic or philosophical approach to information and rather than just 'here's how you can tell from a good piece or a bad piece of information'. What do we do when we're in this context with so much information available to patients and providers, and how do we actually function in that as opposed to just 'is this a valid or invalid piece of information'. There are vast amounts of disjointed information. It's not that they should just assess whether something is valid or invalid, but how to function in that milieu of significant amounts of information coming at them from all corners*
e. *The gatekeeper role that physicians have to play now is working in an advisory sense with patients as consumers or customers. Physicians have to ensure that folk have access to good information, to reliable information and to current information.*
f. *I think to a certain extent we have to move away from students acquiring knowledge content, but more being trained to find out where it is, and how to use their knowledge, as opposed to acquiring it. To get away from the static learning process where you have to memorize what you're supposed to know and then you apply it, I think we can move away from that safely now, its all out there, and so they need to have skills of knowing where the right information is, knowing how to get it easily, and then the application of that knowledge. We're still a little bit biased towards putting content in front of them, and not training them quite so much as to how to actually apply it.*
g. *I am thinking more broadly in terms of skills because what I recognize is that the half life of medical education knowledge is so short that it is the kind facilitatory skills that need to be addressed – we need to teach students how to care for people and we need to give them knowledge, but we also need to equip them to deal with the current and future nature of practice that is changing and knowledge is changing. Its more the kind of facilitatory skills as much as what kind of knowledge do they need to have. It's about*

*relationships, it's about information, it's about change*

h. *To me being able to evaluate new knowledge in a critical fashion is probably the single most fundamental components of their learning because society is now at a stage where facts are so widely dispersed in society and available often to the lay public before they're even available to the physicians. Physicians don't have a good way of advising the public on whether or not the facts are real and how do you translate facts into knowledge*
i. *Graduates must have the skills to further knowledge and to critically appraise information and research*

### 27) Adapt to Culture of Increasing Complexity

a. *Looking in to the future, we will be handling multiple complex care issues based in the communities*
b. *The other thing I was thinking about in terms of societal needs is that everything is becoming more complex. Whether it's because of technology or the changes in the understanding of disease and the available treatments and so I was thinking about an important societal need being the doctor kind of encouraging people to learn how to navigate a complex (health care) system*

### 28) Questioning Attitude

a. *They need to continuously I suppose more than anything to keep questioning, and be continuously curious, accepting that the knowledge of 2010 is not going to be the knowledge of 2011 or 2012*
b. *Students should not accept things as being right without thinking about it. Is this really true and why? Medicine is quite different from professions that you have to accept the authority of people who are senior to you. Graduates need to have honest skepticism and questioning.*
c. *Graduates must continue to question, continue to being at the cutting edge*

### 29) Innovation

a. *When I think about what I would hope for graduates is that I think what we're needing are some new and innovative approaches, we've tried things that have worked in the main population and then hoped that they will work in first nations communities and they haven't, so I guess I would be hoping that graduates have the ability to be innovators and really be helping us figure out what are the better approaches.*
b. *We need people who are able to come up with new solutions to societies problems and who are involved in research, inquiry, and problem solving*
c. *Those kinds of things with the changing demographics the influence of technology it's going to be really important to really put together new strategies, because what's been happening so far is kind of on its way out in terms of sustainability, like there has to be a new way of working, especially with the disconnection of families, and all the smaller families, and different kinds of families and all of those things are really going to challenge the medical professional 'the doctor' even more so than they currently are challenged by*

### 30) Professionalism

a. *Graduates need to know what it means to be a professional. They need to be demonstrative to public,*

*accountable, transparent, and gain public respect. They should never take it for granted. Expectations are higher now, for example just because you're a doctor does not necessarily competent*

b. *What makes a professional? What makes a person a professional person? What makes them practice medicine in an ethical and altruistic manner? Can we train them into that in four years? No, but you can influence them. I think we still have to do a little bit more of medicine as a profession, health care practice is a professional world, it's not just a job, it's not just you have to go to work in morning, do you work, get your money and run. I know I sound old fashioned, I don't think its old fashioned, I think it should be an inherent part of that's why you come into medicine. You won't get away with it and you will become disappointed, demoralized, and frustrated if you don't understand what the whole thing might mean for a lifelong career.*

### 31) Ethical Standards

a. *Physicians are going to be the folk who are going to need to look at the quality of care they deliver. They will need to be on an ongoing basis the 'gatekeepers' or 'stewards' of the highest ethical acceptable standards of clinical care in our society*

b. *Graduate must reflect society's best values, demonstrating ethical behavior and decision making*

### 32) Self-motivation and Governance

a. *Graduates must be self motivated to keep up to date and abreast of changes not only in medical practice but also the health care system and the needs of patients and the community*

b. *The understanding of what it means to be self governing needs to happen at the undergraduate level. We can't wait until post grad to train people about that.*

### 33) Self-reflection and Care

a. *Graduates must have skills for self reflection, knowing when its time to change, knowing how to change, recognizing their personal role in the provision of health care – Who are they? What are they? Is this what they should be doing? When should they be moving on? Why are they moving on? It's really an issue of sustainability perhaps as much as anything to get those skills of self reflection, self care, and self understanding which will allow them to have deeper and more genuine relationships with their patients if they know themselves. Self knowledge, self reflection, being a mindful student will equip them for times of change*

b. *Graduates need to be able to assess the caring and nurturing of themselves and their families and be able to deal with the stresses that relate to themselves and their families - self reflection, self care*

c. *In general the students tend to be in a very privileged, upper middle class, and quite understandably, they're in a highly academic situation in which they've competed to get there, and yet that's the kind of stuff that we want to break down. They need to have some personal skills, around understanding themselves and their own experience and how it may not be representative of much of the population and you have to flush that lens out a little bit, some self awareness*

d. *Some students feel they are entitled which is partly generational and the hidden curriculum. For example, in DPAS community learning, in dealing with community agencies, students are frustrated in scheduling*

*etc, they are learning a lesson that the world doesn't revolve around them and are frustrated that they can't control everything*

e. *Doctors must have an awareness of what you cannot do, and to be really clear about that*

### 34) The Social responsibility and accountabilityMandate of UBC Faculty of Medicine

a. *The program needs a clear vision of where it's going, and be able to share that with the community*
b. *We are paid by the people of BC, and being the only medical school, our primary responsibility is that we try to make certain that we are meeting the needs of British Columbians, but those needs to be interpreted broadly.*
c. *Creating the appropriate health human resources mixed to serve the people of BC is vital*
d. *Often schools are judged on what kind of specialties, or how many students do fellowships, but really the health indicators for the province should be viewed as just as much of an indicator I think*
e. *We need to consider how social accountability will be sustained over time and how the school will continue to respond to the changing needs of the community as well as the changing face of who the physicians are. There must be an ongoing commitment of the program to shift with communities changing needs and impart that knowledge to students*
f. *First and foremost the curriculum needs to focus on the skills physicians need to do their job. Social considerations are very important, but are secondary to developing the medical knowledge and expertise that they will need*

### 35) Barriers to meeting societal needs beyond the Faculty of Medicine's control

a. *There are big challenges outside the faculty's direct control, for example how can we help develop better technical support so people can consult from afar? And how can we cope with the changes and aspirations of the generation so they don't end up being the sole obstetrician in a town of 20,000? How do we help create a lifestyle and on call that is acceptable for them? If we are going to exercise our social responsibility in terms of leadership we still need to articulate these things and not just accept the status quo as it is. Our social responsibility mandate will require us to step up to the plate and engage in the debates around these things, show some leadership. This may be seen as controversial or going against the profession, but will be another way of us beginning to fulfill our social responsibility obligations.*
b. *You can only do so much through education, there's much more to meeting the needs than what you achieve through the education program, we need to be realistic of how the education program can contribute to meeting those needs, there are other things that need to happen i.e. pay structures, career opportunities etc. students are very driven by the need to pay off debts and make money etc. and unless those things are aligned we're always going to be struggling to persuade students to meet some of the needs that they currently don't feel are attractive from their perspective*
c. *We have to also look at training physicians in a way that allows them to come out the other end caring about society. Currently a lot of physicians do what they do because the rewards are structured to reward them for doing what they're doing, and I suppose the corollary of that is that if they're not rewarded to do what they do they won't do it, and we do see a bit of that. We see very little altruism. An undergraduate MD program can't fix all those problems, but it can at least put some effort into some of the 'softer' side of medical caring, which is not about high end knowledge, which is not about high end academia, and it*

*probably isn't necessarily best to deliver to the straight A student coming out of the previous program they were in.*