FEDERATION OF NATIONAL SPECIALTY SOCIETIES OF CANADA
FÉDÉRATION NATIONALE DES SOCIÉTÉS DE SPÉCIALISTES DU CANADA

FNSSC STATEMENT

National Specialty Societies (NSS) and the Royal College of Physicians and Surgeons of Canada (RCPSC) Need for Collaboration

Purpose

This FNSSC statement is addressed to 2 audiences: (1) all NSS and their Executive committees, (many of whom are members of the FNSSC) and (2) the RCPSC, its Executive, management and members of the Professional Development Committee (PDC). The statement aims to create a focused dialogue between these parties on sponsorship management and the proposed Maintenance of Certification (MOC) program changes. It is hoped this will result in a consensus on fair & transparent frameworks with improved communication processes. Such a framework should address the challenges faced by practicing physicians and the funding necessary to provide high quality educational sessions while ensuring that the integrity and unbiased delivery of these learning sessions are not sacrificed towards external interests.

Introduction

The MOC program's emphasis on maintaining high quality CPD has served to advance learning strategies and the professional goal of improving patient outcome across the field of specialty medicine since its inception in 2000. The FNSSC, other NSS and the RCPSC share much common ground in support of the MOC program; a commitment to advancing the health of Canadians; the pursuit of excellence in CPD; as well as the importance of lifelong learning and its role in the self regulation of each specialty.

The MOC framework is multifaceted and includes information governing the programs, the providers, and the physician. The framework has recently been revised in an attempt to

reflect feedback from the RCPSC Fellows and the review of the CPD research literature. It is intended to: reduce complexity; integrate education research on learning strategies; be more result oriented; and expand on CPD activities. Certain of these changes have become cause for concern amongst a number of National Specialty Societies and we believe they need revision and/or clarification in order to accomplish these intentions.

Through this statement FNSSC members acknowledge the significance of the MOC program. They hereby commit to pursue a course of action to address the implications of the changes for the NSS. They also plan to engage the RCPSC and other NSS, in a spirit of partnership and collaboration, for the purpose of CME and the financial health of these societies to carry forward their mandates to represent and advance the best interests of specialty medicine in their respective domains.

Context

The RCPSC, through its Professional Development Committee (PDC), has been examining for some time how society and we presume, medical specialty societies, can best be served by changes in the MOC program. Dialogue began, specific to the issue of ‘Tagging’ with the creation of the Accreditation Review Committee (ARC) whose purpose was to determine whether the changes to the guidelines could be made acceptable to the RCPSC, the FNSSC and to its individual members. After 6 months and a significant number of meetings, the RCPSC accreditation sub-committee, chaired by Dr. Ted Tofflemire, reached a consensus of ‘best thinking’ and new guidelines on ‘Tagging’ were developed, to be presented to the PDC. The newly proposed structure was summarily rejected by the PDC without apparent justification, inviting the serious question of whether the FNSSC’s ARC committee was ever in a position of negotiating an agreement with the accreditation sub-committee.

Further concerns arise with the NSS consultation process in regards to the overall proposed changes to the MOC Accreditation Framework (from six to three categories), which

commenced with email communications starting only on May 31st 2010. With limited feedback given the summer ‘slowdown’, the Royal College relied on a series of brief presentations (1-2 hours) in live and teleconference format only. This provided little opportunity for discussants to fully consider a united position that could be relayed to the Royal College. These short timelines and this truncated process gave no real opportunity to provide meaningful and detailed feedback on the changes which have become a serious concern.

These combined situations have underlined the urgent need for a collaborative process to manage the framework and take authority over the final decision while considering the needs and requirements of the RCPSC and other NSS. It is clear that the existing consultation process is lacking in effectiveness and transparency.

Discussion

1. Sponsorship recognition

There have been serious concerns about the issue of sponsor recognition during the educational programs of various specialty societies. There are a number of ways to recognise sponsors at national and regional meetings. We believe that it is the prerogative of the NSS, and not that of the RCPSC, to recognize their sponsors in a clear, transparent and honest way. The current guidelines create an undue interference in the funding of the specialty societies and can have a negative effect on the capability and sustainability of our societies.

At present many specialty organizations also find themselves seriously challenged to differentiate the RCPSC’s most recent position on ‘Tagging’ from the conditions that still allow external/corporate recognition for ‘co-sponsored, or as they are now referred to, ‘co-developed symposiums’, that are eligible for Section One accreditation.

The sponsorship funds that we receive for our programs are instrumental in keeping our societies vibrant and active in producing not only CME but also programs such as guidelines, public education and policy statements for which we have no source of funding. The provincial

and federal governments provide little, if any, grant money to produce and deliver CME across Canada.

We understand and strongly believe that sponsors should not, in any way, participate or influence the preparation of scientific programs and have put principles in practice to this end. All presentations and associated materials are reviewed before being delivered and program evaluations are put in place to provide feedback to faculty and to ensure unbiased presentations.

We recognise that not all NSS want, or choose, to tag sponsors to specific CME activities. This is their right and respected opinion. However, many others rely on this sponsorship to support their CPD activities and could not produce such programs without this type of funding. We also believe that those NSS who chose to ‘tag’, now or in the future, should have the right to do so, providing the appropriate RCPSC guidelines are followed. We also believe that the RCPSC PDC should concern itself with the principles that govern unbiased CME activities, such as follows;

1. The NSS will perform specialty guided needs assessments
2. The NSS will create the program to be delivered at their annual and/or other meetings
3. The NSS will choose the faculty and will be responsible for their compensation
4. The NSS will review the presentations to ensure there is no bias. This will include review of slides, flyers and other materials, prior to the meeting
5. The NSS will ensure that the sponsor is not on the Scientific Review Committee when receiving educational grants from sponsors, such as pharmaceuticals, banks, CIHR and Government
6. The NSS will ensure that the assessment of speakers is made after their presentation by asking participants if the presentation was biased – the society will then feed this information back to the faculty

An agreement can be reached if our efforts are concentrated on the unbiased principles of CME rather than on the semantics of sponsorship recognition. We believe that by addressing the issue behind the restrictions instead of limiting sponsors is a much more transparent and ethical manner to proceed.

If the RCPSC is aware of problems with the practices of any of the NSS that do not meet these criteria, it should engage with them directly such that their accredited provider status is in question.

The RCPSC should not hinder or otherwise intrude on the highly ethical sponsorship relationships and practices that other NSS' have cultivated over the last decade. We therefore request that at the very least the RCPSC immediately implement the guidelines that were developed by the sub-committee in consultation with, and having the approval of, the FNSSC.

2. Section changes – new framework grid

The revised framework has been collapsed into a three section grid and includes credit limits for some formerly uncapped activities, as well as increases in credits for other sections. In the opinion of the RCPSC, the changes have the greatest potential impact on physician practice and patient care. Some activities are not assigned credits based on time, but rather on the completion of projects, activities, programs or courses.

While realizing that not all NSS are concerned to the same extent, the reorganization is problematic in certain areas. Having 3 sections as opposed to the previous 6 sections appears to be more difficult to understand and harder to use without proper clarification. The following is a list of our questions and concerns:

1. There is a lack of availability of CPD modalities (simulations, self assessments, etc.), specifically in certain fields that disadvantage medical vs. surgical specialties. Where

129 are the resources to support development of new 'Section 3' accreditable programs?
130 If sponsorship is being systematically discouraged by the RCPSC by a ban on
131 certain forms of recognition, is this to be self-funded by the NSS? Notwithstanding
132 two presentations at the RCPSC's recent Accredited Provider Conference
133 suggesting there is no conclusive evidence to recommend any one mode of learning
134 activity over another, there continues to be a new emphasis emanating from within
135 the RCPSC on Section 3 as the preferred learning modality.
136 2. The Executive summary for the MOC program Evaluation briefly touches on the "lack
137 of availability" of accredited self-assessment programs or performance metrics but
138 felt that these were not deemed to be limitations to participation in the MOC program.
139 We would argue that the science of assessment in practicing physicians is too limited
140 to make this anything other than a pilot project at this stage.
141 3. How does the RCPSC suggest new assessment activity programs should be
142 funded? Given the emphasis on these types of programs in the new options grid, it
143 appears that all Fellows may have to participate in these types of activities to earn all
144 the necessary credits.
145 4. By regrouping accredited and non accredited activities together the RCPSC is
146 undermining the amount of work providers put into accredited group learning. Many
147 specialty societies are confused by the apparent willingness to now provide
148 equivalent recognition to non-accredited 'group learning' programs as they do to
149 accredited co-developed programs within the 'new' Section. The definition of a non
150 accredited activity is required.
151 5. It is not clear where peer assessment programs would go, and how to deal with
152 provinces who assign different credit values to these programs.

153 6. With respect to the credit allocation, there is a sense that the new grid is too
154 confusing in comparison to the pre-existing framework and that certain of the credit
155 maximums cited, for example in trainership and CPG development, are too low.
156 7. Section 1 is unclear. Do the 250 hour maximums include the 50 unaccredited hours,
157 or are those 50 hours done over and above, for a total of 300 credits?
158 8. We don't believe that there is adequate empirical data to support all the differential
159 weightings assigned.
160 9. Based on a recent performance improvement program by one major specialty
161 society some societies are not convinced that the increased number of credits/hour
162 for assessment activities will provide enough incentive for participation due to the
163 time required to pull the patient chart data in this type of program. Of note, other
164 societies are very pleased with the increased credits assigned for practice audits. Is
165 there a common ground that can be found?
166
167 Given the timelines of these changes and the existing confusion surrounding them, we
168 recommend a revision of the framework in response to NSS feedback which should separate
169 the accredited from the unaccredited activities within the grid and remove the cap on section 1
170 Group learning activities. Funding should also be considered for content experts to co-develop,
171 with the RCPSC, Section 3 Assessment Modules for programs and appropriate tools for each
172 specialty. We also believe that the implementation of the proposed changes should be delayed
173 until a pilot project is developed to assess these changes and determine the suitability for
174 practicing physician.

175 **CONCLUSION**

176 We encourage the RCPSC to collaborate with the FNSSC and other NSS to resolve the
177 MOC and sponsorship recognition. We are committed to:

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179 1. Collaborate with all NSS and the RCPSC

180 2. Stand firm on our belief that all forms of sponsorship are a society right; provided the
181 RCPSC CME guidelines are followed and request that the RCPSC immediately
182 implement the guidelines that were developed by the sub-committee in consultation
183 with, and the approval of the FNSSC.

184 3. Pursue dialogue and identify ways of seizing opportunities to enhance cooperation and
185 address the challenges faced by NSS

186 4. Be involved in the progress of the MOC program with respect to its framework and
187 implementation

188 As demonstrated by this initiative the FNSSC is committed to enhance greater overall
189 cooperation in the creation of a viable MOC program and workable sponsorship recognition
190 guidelines. The RCPSC needs to expand its scope of reference to include the uniqueness of
191 each NSS.

192 The development of our health professionals and their progress within each specialty is
193 a priority for all parties involved. Looking beyond the academics and the administrators we need
194 to consider our practicing physicians and how we can best serve them and the health of
195 Canadians.

196 We are calling on the RCPSC to accept this statement of our concerns and commit to
197 discuss and resolve the aforementioned issues.

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199 Respectfully submitted
200 On behalf of FNSSC members
201 Ottawa, November 22, 2010