Report:
Representative to the Royal College of Physicians and Surgeons of Canada
Submitted by Brian D. Westerberg March 9, 2014

1.0 Nucleus Members:
Region 1: Erin Wright  Edmonton
Region 2: Paul Kerr  Winnipeg
Region 3: Jean-Phillipe Vaccani  Ottawa
Region 4: Dominique Dorion  Sherbrooke
Region 5: Gerald Corsten  Halifax
Vice Chair: Wayne Matthews  Calgary

Ex-officio members:
English Examination Board Co-Chair: Marty Corsten
French Examination Board Co-Chair: Marie-Jo Olivier
National In-training Exam Chair: Brian Rotenberg

2.0 Accreditation Status of Residency programs:
University of British Columbia  Accredited Program- Regular Survey  Winter 2013*
University of Calgary  Accredited Program- Regular Survey  Winter 2015
University of Alberta  Accredited Program- Regular Survey  Winter 2017
University of Manitoba  Accredited Program- Regular Survey  Winter 2014*
University of Western Ontario  Accredited Program- Regular Survey  Fall 2018
McMaster University  Accredited Program- Regular Survey  Spring 2015
University of Toronto  Accredited Program- Regular Survey  Spring 2019
University of Ottawa  Accredited Program- Regular Survey  Winter 2016
McGill University  Accredited Program- Regular Survey  Spring 2019
Université de Montréal  Accredited Program- Regular Survey  Spring 2014*
Université de Sherbrooke  Accredited Program- Regular Survey  Spring 2016
Université Laval  Accredited Program- Regular Survey  Spring 2017
Dalhousie University  Accredited Program- Regular Survey  Winter 2018

* Reviews in process

3.0 Old Business:
3.1 American Board of Otolaryngology:
No progress.

3.2 Competency Based Medical Education
A full day meeting is planned for Friday May 9, 2014 to continue progress in this area.

3.3 Guidelines for International Electives
These guidelines were agreed upon at our last meeting and are attached for information.

3.4 Membership of RCPSC Specialty Committee
Planned for July 2014 will be the addition of Dr. Manohar Bance to replace Dr. Gerard Corsten, and Dr. Johnna MacCormick to replace Dr. J-P Vaccani. Dr. Corey Moore will
come onto the Nucleus Committee as Vice-Chair; Dr. W. Matthews will advance to Chair, as Dr. Westerberg’s appointment term is completed.

3.5 **COS Review of OHNS**
A follow up report was submitted, and is attached for information.

**4.0 New Business:**

**4.1 Vision Requirements for OHNS**

Lead by Dr. D. Reid, requirements for stereoscopic vision were discussed and agreed upon at our most recent Specialty Committee meeting.

**4.2 Human Resources/Long Range planning**

Lead by Drs. Matthews and Vaccani, we continue to monitor long range implications of the number of trained OHNS Surgeons on our specialty. This is discussed in the Committee on Specialties Monitoring Report (attached).

**5.0 Specialty Documents**

Specific Standards of Accreditation (SSA):
Revised March 2013

Pre-survey Questionnaire (PSQ):
Revised March 2013

Objectives of Training (OTR):
New Version implemented July 2011

Specialty Training Requirements (STR):
Revised November 2012

FITER:
New Version implemented July 2011
Attachment 1: Guidelines for International Electives:

**Otolaryngology – Head and Neck Surgery**  
**International Elective Guideline (12/2013)**

A proposed International Elective for a Canadian Otolaryngology – Head and Neck Surgery resident should include the following information:

**Resident information:** Name, Year of Training, Emergency Contact Person

**Descriptive Title of the Elective**

**Elective Location:** Country  City / Town  Hospital, Clinic or University

**Date of Elective**

**Home Program Supervisor**

**Host Supervisor Name, Qualifications and Contact Information**  
(Canadian and Host Location)

**Registration of Elective with PGME Office**

**Notify Canadian Consulate (http://travel.gc.ca/assistance/embassies)**

**Purpose of Elective**

**Specific Objectives of Elective (CanMEDS format)**

**Brief Outline of Content of Elective**

**Confirmation of Malpractice Insurance**

**Confirmation of Travel and Evacuation Insurance**

**Statement by supervisor (or delegate) regarding local physical, environmental, communication and safety issues and appropriate mitigation strategies.**

**Appropriate vaccination.**

**Confirmation by the supervisor (or delegate) that local licensing or privileging requirements of the resident have been acquired.**

**Acceptance by the supervisor for providing appropriate supervision of the resident and evaluation of the resident’s performance in achieving the specific objectives of the elective.**

**Plan for Post-Rotation Debriefing.**
January 14, 2014

By email: specialtycommittees@royalcollege.ca

Jason Frank, MD, MA (Ed), FRCPC
Director, Specialty Education, Strategy, and Standards
Office of Specialty Education, Royal College

Dear Dr. Frank,

RE: Monitoring Report to the Committee on Specialties (COS) from Specialty Committee in Otolaryngology – Head and Neck Surgery

On behalf of the Specialty Committee in Otolaryngology – Head and Neck Surgery, I am pleased to submit a monitoring report of our discipline to you in response to the Focused Review recommendations in the spring of 2012 by the COS. The key comments the COS made were:

- future health human resources needs,
- concerns regarding the requirement for vision testing, and potential legal ramifications for program directors and faculties, and
- the accreditation status of four programs in the discipline (the two on provisional approval and the two on notice of intent to withdraw)

Since the decision from the COS for Otolaryngology – Head and Neck Surgery to proceed to a Regular Review with Monitoring Report, we have been working to strengthen and expand the foundation of the discipline in Canada. Please find following a follow-up report to the issues as requested:

1. **Future Health Needs:**

   This report is an update to the previous Physician Resource Reports to the Canadian Society of Otolaryngology – Head and Neck Surgery and Royal College OHNS Specialty Committee of May 2012 and June 2013, and was submitted by Dr. Wayne Matthews, Chair of the RCPSC OHNS Specialty Committee Human Resources Needs Subcommittee. Supporting data include projected CMA specialist to population ratios (adjusted for age and gender) from 2009 – 2030, RCPSC OHNS certification examination applications for 2012 and 2013 and CaRMS funded OHNS residency positions 2014. Referenced documents include the RCPSC Employment Report of 2013 and the 2013 CMA National Physician Survey (Surgeon Unemployment) (see Appendix for relevant statistics).

   CMA projections for FTE Otolaryngologists – Head and Neck Surgeons, based on current trends and adjusted for age and gender predict an increase in OHNS surgeons per capita from 1.61 per 100,000 population in 2009 to 2.17 per 100,000 in 2030. This represents a 35% increase of OHNS surgeons per
capita. Currently in 2013 there are 2.1 OHNS surgeons per 100,000 of population in Canada. However, this does not account for age and gender effects. The CMA adjusted estimate is 1.65 per 100,000 in 2013. The ratios are highest in Nova Scotia and Quebec and lowest in PEI, Saskatchewan and Alberta.

According to the CMA NPS results 15% of surgeons consider themselves to be underemployed. The RCPSC Employment Report states that of 17 of 55 recent OHNS graduates responded to the survey and that 5 of those 17 are “unemployed”. Therefore the report suggests that the “unemployment” rate of recent OHNS graduates is between 9% and 29%. It is assumed that those graduates experiencing employment difficulties would be more likely to respond to the survey and that the true rate is closer to 9%. This, however, is still higher than the unemployment rate among working age adults (7.2%). The number of “underemployed” surgeons in that cohort was not determined in that survey but other data and anecdotal experience suggests that many graduates are deferring entering the “job market” by extending training (fellowships).

The reasons for the current increase in OHNS surgeons per capita and un – or under –employment include an increase in medical school enrolment and OHNS Residency entry positions in the late 1990’s from approximately 20 to 30 per year, reduced emigration to the United States due to restrictions of American Board of Otolaryngology certification, deferred retirements since 2008 due to the financial crisis and slow growth of hospital resources (lack of operating room availability). Finally there does not exist any national co-ordination of workforce planning and training positions. Provincial planning exists only in Quebec and more recently in Nova Scotia. The ideal number of OHNS’s per capita has not been rigorously defined, although the WHO usually quotes a level of 1:50,000 population. Moreover, any ideal ratio assumes adequate supporting hospital resources such as hospital beds and operating rooms. Resource scarcity is currently a significant barrier to surgeon career prospects. By and large the allocation of Residency positions is left to the discretion of individual universities. Those decisions are based on several factors including, but not primarily, societal need and traditionally did not take into account the capacity of the public health system to support surgical practices.

There are currently 154 Ministry funded OHNS Resident training positions in Canada distributed across 13 university Resident training programs. Thirty-one PG-1 positions were available in 2012 and 30 in 2013. This number of training positions does not seem to be well matched to either societal need nor to the resource capacity of the public health care system.

The above data and implications were presented and extensively discussed at the Interim Council Meeting of the Canadian Society of Otolaryngology – Head and Neck Surgery in Toronto in November 2013 and the RCPSCS OHNS Specialty Committee Meeting in December 2013. It was generally agreed at both leadership meetings that the trend is real and significant. There was in principal support for greater co-ordination of Resident training at a national level with greater emphasis on population demand and health care delivery capacity. It was agreed to explore options such as rotating reductions in institutional enrolment at upcoming meetings of the CSO-HNS and RCPSC
Specialty Committee in Ottawa in May 2014.

In the meantime an apparent decline in medical student applications to Canadian OHNS programs for the 2014 CaRMS match has been noted at most programs nationally, raising the real possibility of unfilled OHNS positions in the first round CaRMS match. Most, but not all, Program Directors are committed to not entering the second round CaRMS match should they have unfilled residency slots after the first round. It remains to be seen whether student perception of reduced employment prospects in our specialty and subsequently fewer applicants for Residency positions is real and sustained. However, the Specialty Committee is of the opinion, physician resource planning for Otolaryngology – Head and Neck Surgery should not default to student perceptions for lack of specialty leadership.

2. Requirement for Vision Testing:
The Specialty Committee in OHNS has given this issue considerable consideration, in light of the experience in some programs with Residents without stereopsis. Although no unified approach has been adopted, individual programs have or are considering introducing vision-testing requirements as part of their application for OHNS Residency training.

Background Information on Stereopsis:
Stereovision is an aspect of normal, healthy vision characterized by depth perception. Both eyes must be accurately aimed at the same target (binocular vision), each taking in a unique view from its own perspective. The two separate images are processed in the brain uniting the images into one picture. The combined image appears three-dimensional (3-D) because it has the added depth dimension.

It is estimated that approximately 3% of the public is stereoblind primarily as a result of strabismus (misalignment of the eyes)1,2,3, a defect thought to not be treatable in adults. The question continues to be studied as to whether such abnormalities should prevent a person embarking on a career that requires the use of an operating microscope, arguably a complex activity that is visually demanding.4 At least for Ophthalmology (in Britain), the feeling expressed was that standards for visual acuity should be adopted.

Ethical Standards:
The requirement for a visual standard for those wishing to enter into this profession potentially comes into conflict with the Disability Discrimination Act, which prohibits discrimination on the basis of disability without good evidence. Thus there are two competing ethical principles. The first is public safety that surgeons must have the ability to operate without an unduly high complication rate; and the second is one of discrimination against individuals with a physical disability. However, there are “Bona Fide Occupational

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Requirements”, which are conditions of employment imposed in the belief that they are necessary for the safe, efficient, and reliable performance of the job:

“Bona fide occupational requirements (exigences professionnelles justifiées) -- according to the Supreme Court of Canada, are those requirements that:

- the employer has adopted for a purpose or goal that is rationally connected to the functions of the position,
- the employer has adopted in good faith, in the belief that they are necessary to fulfill the purpose or goal and
- are reasonably necessary to accomplish the purpose or goal in the sense that the employer cannot accommodate persons with the characteristics of a particular group without incurring undue hardship.”

Examples of Professions with Vision Standards:
The American Academy of Ophthalmology has suggested that a Surgeon is an occupation not open to people who have good vision in one eye only (that means no stereo vision, no binocular depth perception).

“Those considering the field [Ophthalmology] should also be aware that certain visual and motor abilities are necessary for effective clinical and surgical practice. Ideally, an ophthalmologist will have good fine motor skills, depth perception and color vision. Impairment of these abilities may interfere with the effective use of essential ophthalmic instruments, such as the indirect ophthalmoscope and the operating microscope.”

These same arguments are applicable to OHNS, a specialty that uses the microscope frequently in both the office as well as the operating room.

A number of non-medical professions, where public safety is an issue, do have visual standards (including a requirement for normal depth perception) as a bona fide occupational requirement without compelling supporting evidence, predominately in the police-enforcement area (i.e. Royal Canadian Mounted Police⁷, Royal Newfoundland Constabulary, Ontario Provincial Police⁸) and to be a pilot (i.e. Vision Requirements to Become a Military Pilot/Navigator⁹).

In Canada, there has been no universal visual standard (good visual acuity and normal depth perception) for applicants in Otolaryngology-Head and Neck surgery.
The McMaster program felt strongly that one should adopt a specific visual standard based on a past experience with one of their trainees that was ultimately found to have poor depth perception.

McMaster OHNS Residency Program Experience:

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⁹ [http://usmilitary.about.com/cs/genjoin/a/pilotvision.htm](http://usmilitary.about.com/cs/genjoin/a/pilotvision.htm)
During the McMaster CaRMS interview for Otolaryngology-Head and Neck Surgery, all applicants since 2010 were asked to do the Titmus Test to check their depth perception. The Titmus test has been proven to be effective, easy to use and valid for screening stereopsis. Of the 62 applicants that completed the test, six were felt not to have depth perception.

According to the Visual Development Lab at McMaster University, to pass the test the subject should get 9 of 9 dots correct and 3 of 3 animals, meaning that they have stereo acuity of 40 arc sec. However, the OHNS interview panel decided to relax the criteria to be if anything overly inclusive, so that they would accept 6 of 9 dots, and 2 of 3 animals for a "pass".

These results were eventually discussed at the McMaster Postgraduate Education Meeting with all the surgical program directors sitting on the committee. Dr. John Harvey, Ophthalmologist and Program Director for Ophthalmology at the time, informed the members that for their CaRMS application to the McMaster Ophthalmology residency training, the applicants must provide a written report from an Ophthalmologist stating the candidate's visual status, including stereopsis and color vision. The OHNS Residency Program Committee decided to do the same as the Ophthalmology program and required the same type of documents stating the results of their vision acuity, colour vision and stereopsis.

Furthermore, it was confirmed with CaRMS\textsuperscript{10} that some programs are currently asking for a vision examination, and if it was determined that a new specific exam type would be helpful to include as a selection option when establishing mandatory supporting documents, to inform them and they would add the requirement.

Starting in 2012, the McMaster Otolaryngology-Head and Neck Surgery program required under the section of mandatory supporting documents a report from an Ophthalmologist or Optometrist stating the applicant's visual status, including stereopsis and color vision. Having this report available to CaRMS applications does help to select those applicants that do not present a visual impairment.

In summary, the Specialty Committee has considered the issues surrounding the requirement for a vision assessment as part of the prerequisites to become a competent OHNS surgeon. While there may be no clear evidence to support a specific visual standard, we conclude that a standard for stereopsis should be adopted on the basis of providing excellent and safe patient care. This requirement could be considered as Bona Fide Occupational requirements (BFORs). There has not been a standard adopted by all programs. However, many have followed an approach similar to that adopted by McMaster University.

\textbf{3. Accreditation status:} 
At the time of the original COS review, several programs were on “intent to Withdraw” or “Provisional Approval”. The Specialty Committee looked at the

\textsuperscript{10} Personal communication, Mr. Ryan Kelly, Special Projects Coordinator / Faculty Relations Officer from CaRMS
different reasons trying to explain this status, and found no unifying reasons. Currently, all OHNS Residency Programs in Canada are “Accredited Program with Regular Survey.”

With the continuous support from the Office of Specialty Education and the Royal College staff, I am confident that we can sustain and further develop the discipline in Canada.

Regards,

Brian Westerberg, MD, FRCSC
Chair, Specialty Committee in Otolaryngology – Head and Neck Surgery
APPENDIX: Human resource needs relevant data.

**Physicians/100,000 population for Otolaryngology in Canada, 1995 to 2013**

![Graph showing the number of physicians/100,000 population for Otolaryngology in Canada from 1995 to 2013.]

Source: 2013 CMA Masterfile

**Number of physicians and physicians/100,000 population for Otolaryngology in Canada, 2013**

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Physicians</th>
<th>Phys/100K popn</th>
</tr>
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<tbody>
<tr>
<td>Newfoundland/Labrador</td>
<td>11</td>
<td>2.1</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Nova Scotia</td>
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<tr>
<td>New Brunswick</td>
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<tr>
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</table>

Source: 2013 CMA Masterfile
Otolaryngologists by gender and year, in Canada 1995 to 2013

Source: 2013 CMA Masterfile

Otolaryngologists in Canada by age and gender, 2013

Source: 2013 CMA Masterfile
### Total and Ministry funded postgraduate MD trainees in 2012/13 - Otolaryngology

<table>
<thead>
<tr>
<th>Faculty of Medicine</th>
<th>Ministry funded</th>
<th>Total</th>
<th>Faculty of Medicine</th>
<th>Ministry funded</th>
<th>Total</th>
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<td>12</td>
<td>UWO</td>
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<tr>
<td>U Laval</td>
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</tr>
<tr>
<td>U Sherbrooke</td>
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<td>U Manitoba</td>
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<tr>
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</table>

Source: 2012/13 Annual Census of Post-MD Trainees, CAPER

### Number of Otolaryngologists who retired in Canada during THREE year period of 2010 to 2012

![Bar chart showing retirement statistics by age group and gender for Otolaryngologists in Canada between 2010 and 2012.]

Source: CMA Masterfile – year over year comparisons

Note: “Retired” is based on giving up licence and is therefore excludes those who have retired from clinical practice but are still licensed; it includes physicians who have temporarily given up their licence but may return to practice at a later date.