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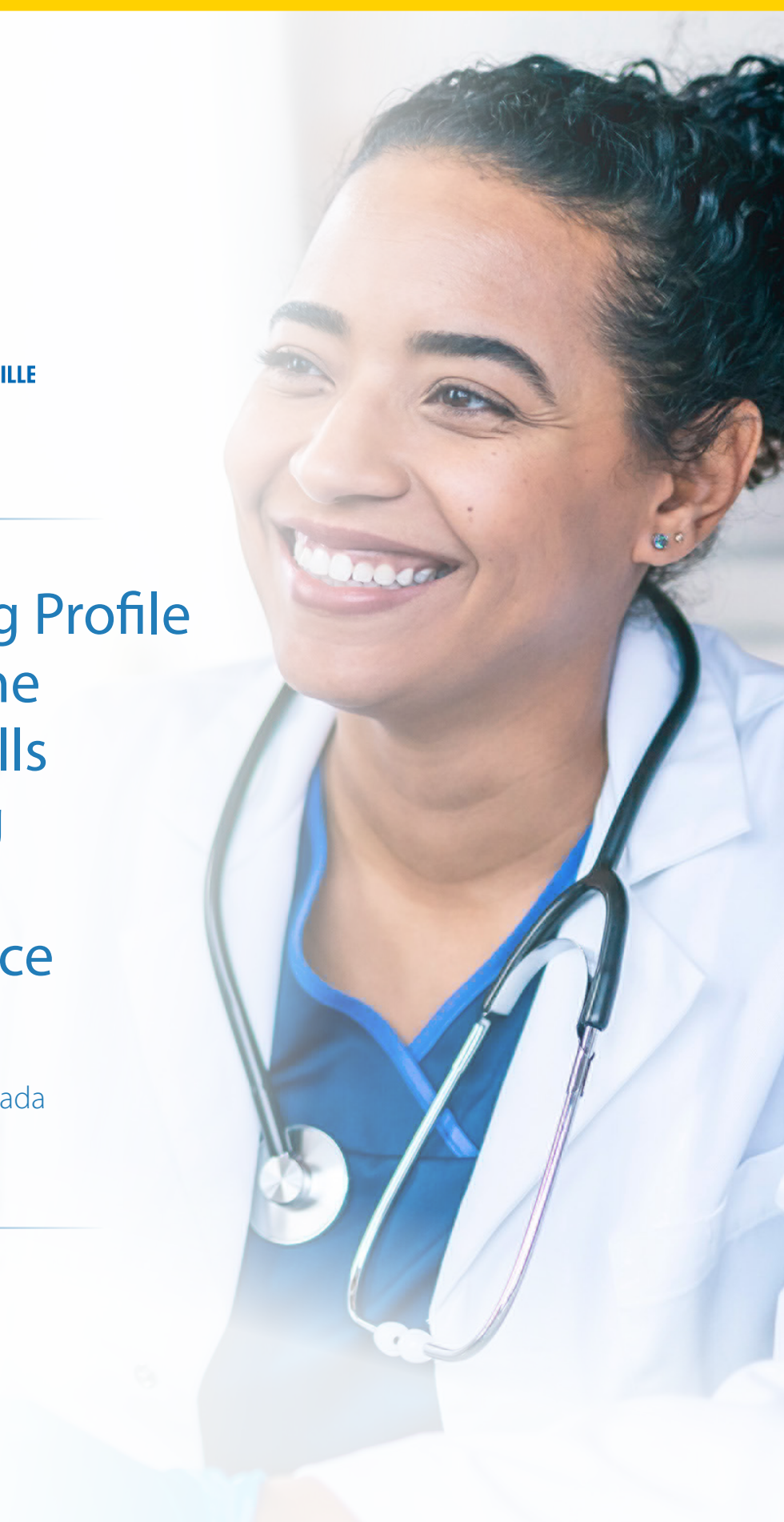
LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Residency Training Profile for Family Medicine and Enhanced Skills Programs Leading to Certificates of Added Competence

Outcomes of Training Project

College of Family Physicians of Canada

May 2021



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Introduction

What are we aiming for in family medicine residency training?

The successful end point of residency is graduate preparedness—that is, for them to be confident, competent, and able to adapt to and apply their abilities successfully in any context. This mandate is captured in the College of Family Physicians of Canada (CFPC)'s *Standards of Accreditation for Residency Programs in Family Medicine* (Red Book) as the goal of training: **to train residents who are competent to enter and adapt to the independent practice of comprehensive family medicine anywhere in Canada.**¹

The dynamic threshold of enter and adapt reflects the fundamentally generalist nature of family medicine and recognizes that residency is just a part of the learning journey that continues across a career.

In 2018 the CFPC published the *Family Medicine Professional Profile* (FMPP), which describes the collective commitment of family physicians to providing comprehensive care close to home.²

The *CFPC Residency Training Profile for Family Medicine and Enhanced Skills Programs Leading to Certificates of Added Competence* (Residency Training Profile) is based on the FMPP and elaborates on what we are aiming to achieve with family medicine residency training in Canada across all the dimensions of professional practice:

- A unique professional identity and value system as described in the Four Principles of Family Medicine³
- Family medicine competence as described in *CanMEDS—Family Medicine 2017*⁴ and the *Assessment Objectives for Certification in Family Medicine*⁵
- A comprehensive scope of practice enabled by a set of Core Professional Activities (CPAs)
- Participation in a collaborative work environment that enables the collective delivery of comprehensive and continuous care, as defined by the Patient's Medical Home vision⁶

The Residency Training Profile was developed to reflect our aspirations for a socially accountable family medicine workforce in Canada. While we adhere to the original social accountability tenets defined by the World Health Organization,⁷ in workforce and evaluation

terms, this is often described using measures of the mix, distribution, and scope of family physicians needed to meet the needs of everyone in Canada.

We are defining CPAs as tasks considered to be essential to preparing trainees for professional practice. Collectively, the CPAs in the core family medicine Residency Training Profile define a scope of training that enables residents to achieve the broad skill potential necessary for **comprehensiveness**, which is developed further in a family physician's practice through lifelong learning. Nobody does it all—or alone—but we are called upon to prepare all graduates for the diverse community practice needs across the country. After all, Certification in the College of Family Physicians of Canada (CCFP) is a Special Designation that has meaning and portability across the country.

This is a potential shift in thinking for some; residents should not require enhanced skills training simply to consolidate the core skills needed for this scope of care. It is incumbent upon us to advocate for the resources, including the time/length of training required, that routinely allow residents to consolidate the skills and confidence required for independent practice.

The Residency Training Profile clarifies that the principle aim of enhanced skills residency training leading to Certificates of Added Competence (CACs) is to enable advanced practice and health systems leadership. CAC holders are local and systems-level care champions, functioning as resources to their colleagues and communities. They support continuity and extend the role of the comprehensive family physician by providing backup and consultation to colleagues treating patients with challenging conditions, ideally integrated in a Patient's Medical Home practice environment.

Some of the CPAs covered in the enhanced skills portion of the Residency Training Profile overlap with those in the core family medicine portion. This simply reflects the fact that there are natural commonalities in the scopes of practice for family physicians with and without CACs. Where overlap in the CPAs appears, this **does not mean that a family physician requires a CAC** to conduct this activity.

How is the Residency Training Profile organized?

The Residency Training Profile represents the expected scope of training in family medicine encompassing both core family medicine and CAC-related enhanced skills training.

For core family medicine, the Residency Training Profile is organized into sections using the eight major areas of professional responsibility noted in the FMPP:

- Primary care
- Maternal and newborn care
- Home and long-term care
- Emergency care
- Hospital care
- Advocacy
- Leadership
- Scholarship

All sections should be read together as an integrated whole. The Residency Training Profile is structured in sections for ease of reference and to correspond with the FMPP, not to imply a division of professional activities. Areas of practice such as **Advocacy** or **Maternal and newborn care** are listed individually not because they are separate from primary care, but because they are activities that cut across care settings and regulatory jurisdictions.

We want to be clear with audiences outside family medicine that the work of family physicians extends beyond traditional office-based primary care and includes other dimensions of home and hospital care, such as intrapartum care. Similarly, **Leadership**, **Scholarship**, and **Advocacy** are intertwined with each other and all the clinical domains, but they are discussed individually here to give them their own focus and importance.

For CAC-related enhanced skills, the Residency Training Profile is organized into sections using the eight

Category 1 domains of care. Category 1 domains are those that are CFPC-defined and recognized and are accredited nationally:

- Addiction Medicine
- Care of the Elderly
- Emergency Medicine
- Enhanced Surgical Skills
- Family Practice Anesthesia
- Obstetrical Surgical Skills
- Palliative Care
- Sport and Exercise Medicine

Each section of the Residency Training Profile contains three features:

1. **Practice narrative:** A description, based on field research, that portrays the value, meaning, and scope of work done by family physicians in Canada across diverse practice settings.
2. **Training statement:** A statement that encapsulates where residents are expected to be in their learning journey by the end of residency, for which the CPAs provide more detail.
3. **Core Professional Activities (CPAs):** A set of professional activities or tasks for which residents will be prepared at the completion of training.

How was the Residency Training Profile developed?

The Residency Training Profile was developed under the direction of the CFPC's Family Medicine Specialty Committee, which is responsible for defining the discipline of family medicine for the purpose of setting educational standards. Independent input about the work of family physicians was gathered from

a purposive sample of family physicians, residents, medical students, professional colleagues, and members of the public using a structured narrative writing exercise.⁸ **Quotations have been included anonymously throughout this document with the written consent of participants.** Narrative data were thematically analyzed and organized according to the primary responsibilities defined in the FMPP,² resulting in the **Practice narrative** and **CPA** sections. A series of expert panel discussions and surveys helped further clarify the scope and expectations of residency training, resulting in the **Training statement** sections. The Residency Training Profile builds on field research done for the Triple C Competency-Based Curriculum⁹—the renewed approach to the delivery of family medicine education in Canada that the CFPC launched in 2011—and the assessment objectives, and it aligns with other national frameworks and guidance documents, some of which are still in development.

The dynamic nature of the health care environment and lessons learned about the evolving role of the family physician during the COVID-19 pandemic were also taken into consideration.

Once fully implemented, the Residency Training Profile will be subject to regular review and revision as part of the CFPC's Accreditation Standards Improvement Committee process, which will be informed by a formal and ongoing program evaluation.

How will the Residency Training Profile be used?

Within the standard-setting function of the CFPC, the Residency Training Profile describes the overall aim and expected scope of family medicine residency training. It is used in conjunction with other existing policy documents and frameworks of the CFPC, as outlined in **Figure 1**.



What are we aiming for in family medicine training?

Residency program accreditation

National examinations

Certification of candidates

Triple C Competency-Based Curriculum

Workplace-based assessment (CRAFT)



Family medicine identity and values

Four Principles of Family Medicine



Comprehensive scope of work

Core Professional Activities

Interdependent work arrangements

Patient's Medical Home vision

Family medicine competence

- CanMEDS-FM
- Assessment objectives

Figure 1. An integrated picture of what we are aiming for in family medicine residency training

The Residency Training Profile is a guidance document that can be used by multiple audiences and applied to various scenarios:

- **The CFPC:** The Residency Training Profile informs accreditation and certification standards. It serves as a scoping definition of comprehensiveness for standard-setting along with national evaluation and research purposes.
- **Residency program leadership:** The practice narratives bring to life the Four Principles of Family Medicine and may be an aid to learners in the development of their professional identities. The Residency Training Profile can be used as a guide for curriculum/assessment mapping and periodic review with residents.
- **Family medicine teachers:** The practice narratives bring to life the Four Principles of Family Medicine and may help learners develop their professional identities. The CPAs may be used to focus teaching on particular activities of practice combined with the CanMEDS-FM competency objectives of a learning experience.
- **Residents and medical students:** The Residency Training Profile offers a rich description of family medicine as a career. It describes the learning journey and outlines the expected threshold of preparedness for practice. It can be used to monitor and reflect on a trainee's own learning and professional identity formation.
- **Medical regulatory authorities and other health authorities:** The Residency Training Profile clarifies the scope of residency training in family medicine. It can be used to inform credentialing decisions and processes.
- **Colleagues/public:** The Residency Training Profile explains the scope of family medicine residency training, provides a rich description of the care provided by family physicians, and expresses our values and philosophy of care. It can be used to educate and advocate with the public and others on the important roles that family physicians play in the health care system.

Glossary of key terms

clinical coach: A teacher who provides role modelling, teaching, feedback, and assessment arising from the care of patients.¹⁰

continuity of care: Is a core value of family medicine that improves physicians' and patients' satisfaction and patient outcomes.¹¹ The concept of continuity of care in family medicine originally had four domains: chronological, geographical, interdisciplinary, and interpersonal.¹² It has subsequently been described as a combination of informational, relational, and management continuity. For further details see glossary terms for **informational**, **management**, and **relational continuity**.

Core Professional Activity (CPA): The CFPC defines a CPA as a task or group of tasks considered to be essential in preparing residents for professional practice.

cultural humility: A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experiences.¹³

cultural safety: An "outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care."¹⁴

entrustable professional activity: A unit of professional practice (a task or group of tasks) that can be fully entrusted to a trainee once they have demonstrated the necessary competence to execute this activity unsupervised.¹⁵

health care equity: All people, regardless of socio-economic status, gender, sexual orientation, race, ethnicity, or other social factors are able to receive high-quality, appropriate health care and achieve optimal health and length of life. Health equity may require that some people use a greater proportion of health care resources than others and necessitates the elimination of gaps in and barriers to optimal care for all.¹⁶

informational continuity: The capacity of that information to travel with the patient and throughout the health system, between providers and over time, to facilitate a continuous care experience.¹⁷

management continuity: The extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent.¹⁸

practice improvement: Uses quality improvement, practice-level data, and research to continuously improve care, the patient experience, health system efficiency, and the work experience of health care providers.¹⁹ Practice improvement aims to build a culture in health care that recognizes how everyone "has two jobs when they come to work every day: to do their work and to improve it."²⁰ Thus, it requires being reflective and curious about one's own practice and behaviour while focusing on improving patient outcomes and experiences.²¹

psychological safety: The degree to which people view their environment as conducive to interpersonally risky behaviours such as speaking up or asking for help. When psychologically safe, one holds the belief that they will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.²²

relational continuity: The ongoing relationship between a patient and health care provider(s) that allows knowledge of past health events and care, as well as the anticipated future provision of care, to inform and influence current care. This should result in care that is well suited to the patient's needs and preferences.²³

social accountability: The direction of education, research, and service activities toward addressing the prioritized health concerns of the community, region, and/or country. Priority health concerns are to be identified jointly by governments, health care organizations, health professionals, and the public.⁷

systemic or institutional racism: Consists of "patterns of behaviour, policies or practices that are part of the social or administrative structures of an organization, and which create or perpetuate a position of relative disadvantage for racialized persons."²⁴ According to the Ontario Human Rights Commission, these may "appear neutral on the surface but, nevertheless, have an exclusionary impact on racialized persons."²⁵

trauma-informed care: This approach recognizes how common trauma is and how it can affect all aspects of people's lives, including their interactions with service providers. For family physicians, taking a trauma-informed care approach involves creating a safe space for patients and acknowledging how their lived experiences can affect the social determinants of health. Rather than causing patients to relive or reflect on traumatic experiences, this approach to care emphasizes the strengths developed from surviving trauma and how that resiliency can foster healing. With Indigenous patients, this includes understanding how colonization continues to affect both Indigenous individuals and communities in Canada. By not taking a trauma-informed care approach, care providers may inadvertently cause patients to be re-traumatized and feel unsupported or blamed. This may discourage them from seeking health care and related services in the future.²⁶

underserved: Individuals and communities who do not have the opportunity to reach and obtain access to appropriate health care services based on their perceived need for care.²⁷

Primary care in the community/office setting

Practice narrative

Having a practice—that is, caring for a group of patients over time with all that this entails—is the essence of being a family physician, and it is the professional home base for other activities. Accompanying patients on their care journeys over time, getting to know them personally, and understanding what matters in the context of their lives are core to the work and professional identity of family physicians.

“ Primary care includes the day-to-day clinical in-office practice of family physicians. However, this is not limited only to dealing with point-in-time care of patients presenting with concerns/conditions. . . . While comprehensive and continuous care sound like buzzwords, they are fundamental to effective primary care; knowing a patient in the context of that patient’s circumstances and history (health and social) is essential in most accurately diagnosing and appropriately treating patients. ”

Family physicians are often their patients’ first and main point of contact with the health care system, providing flexible access through coverage arrangements as part of a commitment to comprehensive care. They have an overarching responsibility for the total care of patients and family practices are the hub of care coordination and medical documentation in an electronic medical record that also serves as a source of data for practice improvement activities.

The clinical case mix on any given day is highly varied, requiring versatility. Family physicians typically see

up to five patients per hour, in 10- to 30-minute appointments, depending on the nature of the encounters. A high degree of continuity enables multiple issues to be dealt with in a single visit. There are many behind-the-scenes patient care and practice responsibilities, integrated across multiple settings.

“ I spend a lot of time outside of the patient encounters reviewing test results, writing consultation letters, filling out forms, and making phone calls. I spend time advocating for system changes when I can see that patients’ needs are not being met. Sometimes I will travel to a nursing home, a patient’s home, or the hospital to see patients in those settings. In addition, I must spend time figuring out the billing system so I can get paid for the work. I need to manage staff in our office and manage glitches with the computers, printers breaking down, or running out of toner. I have needed to learn how to use an EMR system. ”

There is a great deal of variability in practice arrangements, but increasingly family physicians participate in group and interprofessional team practices where comprehensiveness is achieved as a shared responsibility with practice colleagues and referrals are made to other medical specialists when necessary. The point at which a referral is made is individual, and over time family physicians often develop niche areas of expertise that they share with colleagues as part of peer education or as informal consultations. Case conferences and clinical team meetings support collaborative patient care, and family physicians also work virtually to monitor and support

patients with other colleagues in a rapidly evolving clinical and technological environment. Clinical work is integrated across care settings and is combined with administrative, leadership, and teaching activities to make for a busy and layered work schedule.

“ My main activities include direct patient care or patient care by my learners under my supervision. ... My teaching roles include undergraduate learners, postgraduate family medicine learners, and faculty. I see all patients! My practice is quite varied in that regard. I have patients of all ages, genders, and ... pregnant patients. ”

Compassion and social justice are strong values motivating outreach and community engagement to ensure care is inclusive and health equity is promoted. Family physicians think and work at both the

individual patient and population health levels and seek to assess and integrate their practices in the local context and in the broader health care community. They are community champions and resources for health promotion and public education.

Training statement

All graduates can take responsibility for a practice and provide comprehensive primary care and continuity to a defined group of patients, in partnership with other health care colleagues. Care is provided in and outside the office setting to achieve continuity and comprehensiveness. They provide patient-centred, culturally safe, and trauma-informed care to all patients, contributing to health equity. They are prepared for the following CPAs.

Core Professional Activities

Manage the practice

CPA 1. Provide first-contact access and relational continuity of care as part of an overall system of care to the practice

This involves a range of related activities:

- a. Maintain a regular schedule that provides first-contact access and relational continuity for a broad range of patient care needs
- b. Provide in-person care as an essential part of patient-centred care
- c. Provide virtual care to enhance first-contact access and relational continuity for patients
- d. Plan access and outreach for patients who are unable to attend the office
- e. Participate in on-call coverage, providing medical care on evenings, weekends, or public holidays as part of a group commitment to access for the practice

CPA 2. Manage the total care of patients to provide informational and management continuity

This involves a range of related activities:

- a. Maintain an electronic medical record for each patient/encounter as part of a longitudinal patient record
 - b. Support and coordinate patient care across settings and care transitions
 - c. Follow up on patient encounters, monitoring the results of investigations, consultations, etc., and notifying patients with results, as appropriate
 - d. Complete medical forms and documentation to support patient care and reporting requirements
 - e. Manage patient medications, prescriptions, and related pharmacy communications and requests
-

CPA 3. Assess and plan for the care needs of the practice in the context of the local community

This involves a range of related activities:

- a. Use patient and practice data to support care planning for the practice
 - b. Assist the practice in responding to local disease outbreaks and other emerging public health issues
 - c. Act as a resource for health promotion and patient/public education
 - d. Collaborate with local health care organizations (public health, home care, long-term care, community services, hospitals) contributing family practice expertise to the planning and delivery of care in the community
-

CPA 4. Attend to career and practice administrative/business functions

This involves a range of related activities:

- a. Manage professional finances, supported by other professionals as necessary
 - b. Evaluate practice options and opportunities as part of career planning
 - c. Complete office billings according to local processes
 - d. Identify and attend to professional legal obligations and risks
 - e. Attend to the continuing professional development requirements for family physicians
-

CPA 5. Participate in and engage with safety processes for patients, staff, and self²⁸

This involves a range of related activities:

- a. Contribute to a psychologically safe work environment
- b. Anticipate safety concerns and take measures to reduce risk
- c. Report and act on safety concerns and incidents
- d. Disclose patient harm events to the patient and/or family as soon as they are known and document them according to organizational policies
- e. Analyze safety events and facilitate improvement as part of an interdisciplinary team that includes patients

CPA 6. Participate in collaborative and team-based care

This involves a range of related activities:

- a. Make formal, written referrals to other health care professionals
 - b. Provide shared care with other medical specialists
 - c. Make a verbal case presentation to colleagues as part of the care process
 - d. Develop patient-centred care plans in collaboration with other health care colleagues
 - e. Facilitate clinical case conferences with other health professionals
 - f. Facilitate family meetings
 - g. Support and coordinate care with family and other community-based health care professionals
 - h. Seek feedback from patients and families about their care experiences and promote an environment where concerns can be expressed and addressed
-

CPA 7. Manage self-care to support personal well-being and a sustainable practice

This involves a range of related activities:

- a. Manage time and scheduling to ensure a desirable and efficient mix of activities
 - b. Attend to personal health and well-being through a range of self-determined health promotion activities and decisions
 - c. Attend to the quality and sustainability of work life and the work environment
-

Provide comprehensive primary care and continuity across the life cycle

CPA 8. Establish a therapeutic relationship and navigate ethical issues in everyday practice

This involves a range of related activities:

- a. Adopt a patient-centred approach and work toward becoming a trusted ally over time
- b. Set limits and navigate boundaries with patients when necessary
- c. Obtain informed consent as a routine part of investigation and treatment
- d. Support patient autonomy in decision making and respect the right to refuse care
- e. Assess decision-making capacity and arrange for a substitute decision maker when necessary
- f. Respect and attend to patient privacy and confidentiality
- g. Help determine when to involve patients in clinical research activities
- h. Navigate ethical dilemmas in collaboration with patients and their families and seek resources and support from other professionals when needed

CPA 9. Provide medical care that challenges systemic racism and supports health equity with/for Indigenous peoples* and other racialized or underserved patient communities²⁹

This involves a range of related activities:

- Provide culturally and psychologically safe care experiences for patients and families
- Provide trauma-informed care experiences for patients and families
- Provide care that is sensitive to the health impact of racism and other social determinants
- Attend to language barriers and work with or facilitate access to interpreter services as required
- Attend to personal and professional development to gain knowledge, cultural humility, and self-awareness and to challenge systemic racism

CPA 10. Provide reproductive care

This involves a range of related activities:

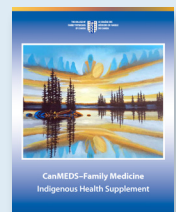
- Provide preconception risk assessment and health promotion
- Manage contraception and facilitate patient decision making about birth control
- Diagnose and manage fertility concerns
- Diagnose pregnancy and provide options through counselling
- Facilitate patient decision making and access to therapeutic abortion

CPA 11. Provide comprehensive primary care and continuity of care for children and youth

This involves a range of related activities:

- Assess children and youth presenting with undifferentiated and/or medically uncertain health issues and manage their care
- Share assessment results with parents/guardians and break bad news when necessary
- Diagnose children and youth presenting with injuries and episodic illnesses and manage their care
- Prescribe and monitor pharmaceuticals while being attentive to risks and any age-specific considerations
- Provide age-specific prevention, screening, risk assessment, and immunization as part of routine care and periodic health assessments
- Manage the care of children and youth with chronic illnesses and develop care plans with the patients, families, and others
- Manage age-specific behavioural concerns

*To help define the competencies needed to meet these expectations, the *CanMEDS–Family Medicine Indigenous Health Supplement* outlines Indigenous-specific considerations relevant to all areas of physicians' professional activity, from medical expertise to advocacy and academic pursuits.²⁵ Aiming to optimize the health outcomes of Indigenous people is part of family physicians' commitment to lifelong learning.



- h. Manage the care of children and youth with developmental disabilities
 - i. Assess and manage child safety and protection issues and attend to reporting duties when required
 - j. Provide parents with support, guidance, and health promotion advice
 - k. Refer patients to other health care professionals and co-manage patients when needed
-

CPA 12. Provide comprehensive primary care and continuity of care for adults

This involves a range of related activities:

- a. Assess adults presenting with undifferentiated symptoms and/or medically uncertain health issues and manage their care
 - b. Share assessment results with patients and break bad news when necessary
 - c. Diagnose adults with injuries and episodic illness and manage their care
 - d. Diagnose adults with occupational illness and injury and manage their care
 - e. Prescribe and monitor pharmaceuticals while being attentive to risks and any age-specific considerations
 - f. Manage the care of adults with chronic illnesses, including self-management support
 - g. Provide age-specific support, guidance, and health promotion advice
 - h. Assess and manage age-specific behavioural concerns
 - i. Provide age-specific prevention, screening, risk assessment, and immunizations as part of routine care and periodic health assessment
 - j. Assess and manage gender-specific health concerns
 - k. Manage the care of adults with complex comorbid illnesses and develop care plans with the patient, family, and others
 - l. Manage the care of adults with developmental disabilities
 - m. Refer patients to other health care professionals and co-manage patients when needed
-

CPA 13. Provide comprehensive primary care and continuity of care for older adults

This involves a range of related activities:

- a. Assess older adults presenting with undifferentiated symptoms and/or medically uncertain health issues and manage their care
- b. Share assessment results with patients and break bad news when necessary
- c. Diagnose older adults with injuries and episodic illness and manage their care
- d. Manage the care of older adults with chronic illness, frailty, and comorbidities and develop care plans with the patients, families, and others
- e. Prescribe and monitor pharmaceuticals while being attentive to risks and any age-specific considerations
- f. Provide age-specific support, guidance, and health promotion advice
- g. Manage age-specific behavioural concerns
- h. Assess cognitive and functional status
- i. Provide age-specific prevention, screening, risk assessment, and immunizations as part of routine care and periodic health assessments

- j. Facilitate advance directives and care planning with patients, families, and other key sources of support
 - k. Refer patients to other health care professionals and co-manage patients when needed
-

CPA 14. Provide palliative and end-of-life care

This involves a range of related activities:

- a. Identify the need for a transition to a palliative approach to care
 - b. Provide pain and symptom management
 - c. Address emotional and spiritual needs in collaboration with other professionals
 - d. Facilitate advance directives and care planning with patients, families, and other key sources of support
 - e. Assist with care navigation and continuity across illness transitions, providers, and settings
 - f. Assess and facilitate patient requests for medical assistance in dying
 - g. Pronounce and certify deaths in all settings—in patients' homes, in hospital, and in long-term care
 - h. Provide bereavement support and community resources
-

CPA 15. Provide mental health and addiction care

This involves a range of related activities:

- a. Provide early detection of mental health and addiction issues as part of all medical encounters
 - b. Assess the risk of substance use disorder as a routine part of safe prescribing practices
 - c. Diagnose and manage mental illness as part of an interprofessional team
 - d. Assess and monitor patients with mental health conditions for risk of suicide
 - e. Diagnose and manage substance use disorders and address harm reduction as part of an interprofessional team
 - f. Recognize and manage mental health emergencies
 - g. Recognize and manage intoxication, substance overdose, and/or withdrawal reactions
 - h. Assist with psychosocial support and health promotion advice
 - i. Refer patients when needed and assist with care navigation and continuity across providers and settings
 - j. Communicate and collaborate with families and key support individuals as appropriate
-

CPA 16. Perform medical procedures in all settings as per the [Procedure Skills in Family Medicine](#)

This involves a range of related activities:

- a. Assess indications and determine the appropriate medical procedure and setting
- b. Conduct a pre-procedure assessment and mitigate risks where necessary
- c. Prepare the patient, provide instructions, and obtain informed consent
- d. Take any needed measures for patient comfort and/or procedural sedation and anesthesia
- e. Perform the procedure and respond to unanticipated complications or emergencies
- f. Arrange after-care such as dressings/wound care as needed
- g. Provide follow-up and interpret results as required

Maternal and newborn care

Practice narrative

Family physicians think broadly about their role in human development and the lifecycle of their patients and provide support for decisions related to major events and life transitions. Being involved at critical junctures such as pregnancy and childbirth strengthens the patient-physician relationship that is central to family practice. Family physicians are family-centred, which includes involving patients' partners and other individuals when appropriate to support and educate patients and to understand patients' unique perspectives, aspirations, strengths, and health risks.

“ I have the honour to journey with my patients in their preparation and transition to parenthood. This involves supportive and counselling care to both mothers and fathers, providing for their emotional as well as physical well-being. This process starts before conception and truly only ends in cremation. As a family physician, I participate in lifelong care. There are many stages of life involved. ... My duty and responsibility are both to the physical and emotional well-being of the family unit. I have had the honour to share in many such journeys, and this is ongoing. ”

Family physicians diagnose pregnancy, provide counselling about options, and establish the expected date of delivery. They make an initial assessment of pregnancy risk and provide routine antenatal care for low-risk patients following established, evidence-based care protocols. Family physicians share antepartum care with obstetricians for patients with higher-risk pregnancies.

Family physicians provide intrapartum care for low-risk vaginal births, often supported by nurses, midwives, obstetricians, and pediatricians in a highly collaborative work environment. Family physicians assess and manage common intrapartum complications and recognize and anticipate the need for referral in emergency situations. Common procedures related to vaginal childbirth, such as assisted delivery and perineal repair, are done by family physicians; however, family physicians do not typically perform Caesarean sections, which requires additional training. When an emergency Caesarean section is required, the family physician often functions as the surgical assistant. Intrapartum care requires that the family physician be available in an on-call arrangement at the time of birth. Often there are group call arrangements that support and sustain this activity.

Family physicians who perform deliveries need to maintain their skills, which represents a significant commitment to continuing professional development. Family physicians providing intrapartum care are committed to and invested in this work, and they tend to be involved in leadership, teaching, mentorship, and advocacy related to maternal and newborn care.

Training statement

All graduates can manage a low-risk pregnancy and perform a low-risk, single vertex delivery in hospital, recognizing all emergencies and reacting appropriately in the context of geographic and resource limitations. They are prepared for the following CPAs.

Core Professional Activities

CPA 17. Provide antenatal care

This involves a range of related activities:

- a. Confirm pregnancy and estimate the due date
 - b. Conduct an initial medical and social risk assessment
 - c. Collaborate with other care providers, such as midwives and/or obstetricians, and advise patients on options for antenatal care and delivery
 - d. Explain and provide counselling on antenatal testing and genetic screening options
 - e. Provide routine antenatal care for all stages of pregnancy
 - f. Recognize and manage pregnancy-related complications
 - g. Provide shared antenatal care with obstetricians for patients with higher-risk pregnancies
 - h. Provide pregnancy-related support, guidance, and health promotion advice
-

CPA 18. Manage low-risk labour and delivery

This involves a range of related activities:

- a. Assess the status and stage of labour
 - b. Assess and manage a trial of labour after Caesarean section
 - c. Manage the induction of labour as required
 - d. Identify and manage complications and emergencies
 - e. Manage pain in labour
 - f. Conduct fetal health surveillance during labour
 - g. Perform a low-risk, vaginal vertex delivery
 - h. Perform a vacuum-assisted delivery
 - i. Manage the third stage of labour and deliver the placenta
 - j. Assess and repair the perineum up to and including second-degree lacerations
-

CPA 19. Provide postpartum care

This involves a range of related activities:

- a. Assess and manage postpartum symptoms and conditions
- b. Assess and manage postpartum mental health concerns
- c. Recognize and manage postpartum emergencies
- d. Support and provide advice about infant feeding and common difficulties
- e. Provide hospital discharge planning for both the mother and infant, including an assessment of available support and social conditions
- f. Coordinate follow-up in the community for the mother and infant
- g. Provide support, guidance, and parenting advice

CPA 20. Provide newborn care in the hospital and community

This involves a range of related activities:

- a. Assess the immediate health of the newborn and provide neonatal resuscitation when needed
- b. Provide routine newborn care, including the initial examination and screening
- c. Assess and manage common newborn symptoms and conditions
- d. Recognize and diagnose illness in a newborn
- e. Identify infants at higher risk and anticipate and react appropriately to neonatal complications
- f. Provide shared care for newborns with complex needs
- g. Provide follow-up and routine well-baby care in the community

Emergency care

Practice narrative

Acute illnesses and injuries are unpredictable and can be critical events in the lives of patients and their families. Family physicians provide emergency care as part of the provision of comprehensive care for their patients and communities.

Family physicians need to be prepared for and are involved in a range of scenarios and settings where medical emergencies occur, including:

- Emergencies in the office and in the surrounding community
- After-hours care and on-call clinics, including both virtual and in-person care
- Urgent care centres and emergency departments
- As part of a response to a natural disaster, mass-casualty event, pandemic, or other crisis

In regional and rural hospital emergency departments and urgent care centres, family physicians play a central role in the provision of emergency medical services. This is sometimes organized as shift work and other times in a more flexible arrangement where the physician moves between the office and hospital.

“ I work in the emergency room of a busy suburban hospital along with 20 to 25 colleagues. We treat patients, usually quite sick, who present to the emergency room because of a severe illness or on directives like being told by their family physician to do so. My shifts involve both daytime and nighttime work and I see everyone from babies to pregnant women to the elderly. I see all kinds of acute problems, like fractures, infections, elderly falls, heart attacks, strokes, etc. ... On a busy, long, night shift, I can see

upwards of 20 sick patients but often it's a mix of very sick, somewhat sick, and others who just need simple things like social care or prescription renewal but have nowhere to go. ”

Caring for critically ill patients and providing resuscitation in rural or remote settings can be daunting, and family physicians must draw on their clinical courage to mobilize efforts; this often involves reaching out to collaborate with other physicians, usually from other specialties, and communicating virtually (by phone or video conference). Virtual communication skills are particularly important for those who provide emergency care in rural and remote locations.

In office, home, and community settings, family physicians play important roles in providing first-contact emergency assessment and response; in coordinating care when they determine patients need to be transferred to the hospital; and in following up on emergency department visits. Family physicians support each other in on-call arrangements that offer patients access to care in potentially urgent situations, which often includes some form of virtual care for assessment and triage. They are prepared to deal with unexpected medical emergencies in the office and in other community settings.

“ Sometimes my patients are being cared for in the emergency department. Sometimes because I sent them. More often because the patients independently presented to the ER. The ER doctor or resident will phone my office or my cellphone and have questions about their medical background or instructions about the need for follow-up. Most often I will need to arrange to see a patient for follow-up either at home or in my clinic within a few days. ”

Family physicians are resources to their communities during population health crises, such as natural disasters and epidemics/pandemics, and in response to current issues, such as the opioid crisis. They use their broad skill base in versatile ways as a critical element of the health system's emergency preparedness and surge capacity.

Training statement

All graduates can manage medical emergencies and provide triage, resuscitation, stabilization, and other treatments in all care settings—including the emergency department—and react appropriately in the context of geographic and resource limitations. They are prepared for the following CPAs.

Core Professional Activities

CPA 21. Manage all patients presenting to the emergency department

This involves a range of related activities:

- a. Triage and prioritize patients and actions accordingly
- b. Assess and stabilize trauma patients and treat life-threatening complications immediately
- c. Manage common life-threatening presentations and conditions
- d. Co-manage patients with challenging, high-acuity conditions with other medical specialists and use virtual communication when necessary
- e. Manage mental health emergencies
- f. Manage all patients presenting with injury, acute illness, and acute decompensation of chronic illness
- g. Manage patients presenting with a palliative care crisis
- h. Order and interpret common investigations at the point of care, including X-rays, electrocardiograms, and laboratory tests
- i. Support the continuity and coordination of care with other care providers
- j. Plan and prepare patients for medical transport between care settings as required
- k. Plan discharge and follow-up from the emergency department and provide the patient with necessary instructions
- l. Perform emergency medical procedures according to the [Procedure Skills in Family Medicine](#)

CPA 22. Manage all patients presenting with emergent and urgent conditions in the office, home, and other community settings

This involves a range of related activities:

- a. Anticipate and plan for emergencies in the office setting
 - b. Recognize and triage urgent patient situations via virtual care and determine the course of action with patients and other care providers
 - c. Recognize and respond to unexpected emergencies in the office, home, and other community settings
 - d. Refer patients to the hospital when necessary, arrange appropriate medical transportation, and provide informational and management continuity
-

CPA 23. Contribute to community-level emergency preparedness and response

This involves a range of related activities:

- a. Contribute to local emergency, pandemic, and disaster planning
- b. Respond as needed and contribute practice resources and emergency care skills in the event of a local emergency, disaster, or pandemic

Home and long-term care

Practice narrative

Family physicians acknowledge a broad definition of home as anywhere that patients live or require care, which encompasses a range of settings including long-term care (LTC). Providing care across all these settings is a form of outreach and continuity, and ensuring that people are seen in their own environments is part of compassionate and personalized care. Cited as one of the most meaningful aspects of the family physician role, it involves caring for the most frail and vulnerable members of society, and it often requires creativity and problem-solving skills to overcome resource limitations and adapt to diverse contexts.

“ I still do one or two home visits per month. I consider them to be the most interesting, enjoyable, and often useful ways in which I care for patients. I enjoy and find invaluable the ability to see how they are coping at home and in their day-to-day lives. I enjoy and find useful the role reversal of being a guest in their home. I enjoy and find useful the way it allows me to connect to other family members, who will often show up when they get wind that the doctor is coming to visit Mum or Dad at home.”

Care in the home is essentially primary care in a different context with patients who may have complex medical and social situations, and where the focus is often on supporting patients' function, safety, and quality of life. Home visits are usually reserved for frail, elderly patients; for the provision of palliative care; and for those with limited mobility. With an aging population, family physicians' roles are evolving and they increasingly work with community-based interprofessional teams to provide intermediate

care, which is more intensive home care aimed at preventing hospitalization and supporting hospital discharge back into the community.

Family physicians often care for patients when they are admitted to an LTC facility, functioning as the most responsible physician and providing comprehensive primary care. This involves an awareness of institutional care processes, regulatory requirements, and proactive patient safety planning. Family physicians maintain access to care through a combination of regular visits and on-call availability to the clinical team between visits. Patients in LTC often require family physicians to manage comorbid chronic illness and provide memory care.

Home care and LTC involve working closely with family caregivers to establish a trusting relationship where the goals of care, care arrangements, and decision making can be navigated together. Home care and LTC are highly collaborative and are delivered in conjunction with community agencies and other professionals, most often nurses, who communicate with and access the family physician for support and decision making.

“ It also involves the communication with families if needed and working collaboratively with other professionals: physicians, physio, nurses, social workers, etc. . . . [It includes the] discussion of end-of-life care. Advocacy is demonstrated in all the areas just mentioned. Even with doing rounds on patients in long-term care, the relationship involved is important. Some patients are all alone, and giving them someone who is a constant in their life, who they know will be coming back to see them, gives them a sense of someone caring. ”

Home care and LTC are time consuming and can be difficult to provide without the proper practice team set-up and community-based home care supports. Home care and LTC care are often confined to the local practice neighbourhood, but in rural settings they can include flying in to remote and Indigenous communities as part of outreach to provide access.

Training statement

All graduates can provide comprehensive and continuity-based primary care in the community across various settings and environments outside the office, including home care and LTC. They are prepared for the following CPAs.

Core Professional Activities

CPA 24. Provide primary care for patients with complex medical needs in their homes, long-term care facilities, and other community-based settings

This involves a range of related activities:

- a. Determine when care in the home and long-term care setting is appropriate and arrange transfers of care when necessary
- b. Conduct home visits and maintain first-contact access and continuity of care in that setting
- c. Initiate and organize home care services with community agencies and care providers
- d. Respond to unplanned and urgent care needs, which often requires virtual assessment and management
- e. Facilitate advance care planning and decision making about goals of care
- f. Facilitate communication with patients and caregivers and participate in family meetings and meetings with other key support individuals
- g. Complete medical documentation and forms in accordance with local regulations
- h. Ensure personal safety in the home care setting

Hospital care

Practice narrative

Family physicians provide care to their patients in hospital as part of a commitment to continuity, and in doing so they strengthen their relationships with local colleagues from other specialties. Family physicians attend to the whole picture of the hospitalized patient and communicate with families, establish goals of care, and navigate care transitions. Family physicians pay close attention to the social realities, support needs, and coordination of care for patients who are ready for discharge back into the community.

“ First and foremost, it is the opportunity to provide continuous care to my patients during their admission to, stay in, and discharge from hospital. As such, it is tremendously relationship building between me and my patients. In these settings, it provides great professional satisfaction and it also builds the respect and relationships that I desire from my colleagues in other specialties. ”

Family physicians follow hospitalized patients either as the most responsible physician providing full care or, for those with more limited hospital privileges, supportive care focused on personal support, care coordination, and the transition back into the community upon discharge. Family physicians also work as hospitalists who provide most responsible physician-type care to hospitalized patients who are not part of their own family practices. Family physicians often provide primary care in the hospital setting for patients admitted to an alternate level of care program in the hospital, such as in-patient psychiatry, palliative care, rehabilitation, and long-term care.

The scope of care that family physicians provide in the hospital setting typically includes routine newborn

care, maternity care, and the care of adults who are ill. They handle a wide range of clinical problems in the most responsible physician role, often sharing care with other medical specialists, consulting more formally on an as-needed basis, and transferring full responsibility when necessary and as resources dictate.

“ In hospital, I am involved in the care of admitted patients to the medical ward who may have a variety of medical conditions. These patients range from the acutely unwell, to the palliative, to those who are awaiting placement in an alternate facility, such as a personal care home. ... To complete these tasks, I complete daily rounds of my patients to ensure they are progressing and receiving appropriate care. I review their clinical condition and make any necessary changes to medications, treatments, or other interventions provided by allied health colleagues. Rounds are often completed with the nurse assigned to care for the patient for that day. ”

In more rural or remote settings family physicians may be called on to assist in the operating room. While the degree of this involvement varies across the country, it is important that family physicians are able to function in this capacity as a critical factor in supporting local access to surgical care.

Family physicians' role in caring for children admitted to hospital is usually focused on the initial assessment and treatment of serious illness in the office or emergency department, along with decisions regarding hospital admission. There are some settings where family physicians play an expanded role in the care of hospitalized children.

Family physicians commonly have other important roles in the hospital setting as clinical teachers and leaders with defined positions as heads of clinical service and hospital administration.

Family physicians may move between the hospital and office setting daily, making themselves available for hospital care as needed and after hours in various local coverage arrangements.

Training statement

All graduates are able to function as the most responsible physician for hospitalized patients. They co-manage and transfer care to other specialists as needed in the context of local health systems and resources. They are prepared for the following CPAs.

Core Professional Activities

CPA 25. Provide medical care in the hospital as the most responsible physician

This involves a range of related activities:

- a. Evaluate the need for hospital admission and manage this process
- b. Conduct advance care planning, complete competency assessments for health decisions, and establish goals of care while patients are in hospital
- c. Diagnose and manage common presentations and conditions requiring hospitalization
- d. Perform family medicine consultations at the request of other hospital-based physicians
- e. Maintain a regular routine of hospital visits as appropriate to monitor and manage care
- f. Participate actively in a system that ensures continuous coverage for hospitalized patients
- g. Collaborate with the care team at the hospital to maintain continuity and coordination and ensure appropriate resource use
- h. Communicate regularly with patients and their families regarding progress and care planning
- i. Complete medical documentation and hospital charting
- j. Arrange referrals and transfers of care to other medical specialists and facilities
- k. Coordinate care and manage transitions of care with attention to discharge planning

CPA 26. Provide surgical assistance in the operating room

This involves a range of related activities:

- a. Assist with safety processes and preoperative preparation of the patient and surgical field
- b. Anticipate the flow of the surgery and prepare for the next steps by requesting instruments and required materials
- c. Anticipate difficulties during the procedure and act to avoid or mitigate them
- d. Communicate with the surgical team regarding the progress of the surgery
- e. Communicate with the postoperative care team about the surgery and any difficulties that may result in an increased risk of a complication

Advocacy

Practice narrative

Family physicians are uniquely positioned to understand the personal circumstances and aspirations of patients and communities and over time may become trusted allies.

“Family physicians are an important advocacy voice as they have close relationships with their patients and an understanding of their life circumstances, as integral to their role as family physicians, which makes them important allies and provides them important leverage for advocacy on a broader scale.”

Advocacy work is an integral part of family physicians' commitment to treating the whole person; providing high-quality care; enhancing patient safety and health equity; and addressing the social and environmental determinants of health. Family physicians engage in advocacy work at all levels: with individual patients (micro level), within the practice and community (meso level), and at provincial, national, and international (macro) levels.

“The primary purpose is to improve health, be it for an individual patient, group, or population. Often this is in the context of mitigating and managing identified social determinants of health as the situation requires. Family physicians in this advocacy role work at various levels—the micro, meso, and macro levels.”

Completing medical forms to secure resources for patients and proactively screening patients for social determinants of health are daily examples of care

delivered in the spirit of advocacy. Family physicians assist with health system navigation and push for access to appropriate resources and support. Patient advocacy requires engagement and communication with patients and families, which underpins medical assessments and management plans. Family practices reflect the circumstances of the local community in terms of the people and health issues seen. Family physicians work with other community members and organizations to identify and address root causes of illness and to improve social conditions and access to health care.

“‘How can I be of help to you?’ is a very deep and broad question that needs to be asked of every patient! Family physicians truly recognize that this question means any person, any problem, any time, any place! Our [CCFP] stands for this, as articulated in the Four Principles of Family Medicine; we must teach, live, and breathe this motto with our patients, our team members, our community, and our other stakeholders.”

At higher levels, family physicians can speak to the importance of the discipline of family medicine and its place in the provision of primary care in any health system. Family physicians lead efforts in professional, academic, and political arenas and contribute to the collective goal of delivering comprehensive care close to home.

As part of successful advocacy work, family physicians build coalitions, find partners, explain the cause, and understand and respect opposition when it is encountered. Family physicians identify their own personal conflicts and limitations and manage them as part of being effective advocates and effecting change.

Training statement

All graduates can assess and respond to the social determinants of health, build coalitions, and work with others to ensure access to care and promote health equity at the individual patient, practice, and local community levels. They are prepared for the following CPAs.

Core Professional Activities

CPA 27. Work with individual patients to secure their social and health care needs

This involves a range of related activities:

- a. Take a personal history and assess the social determinants of health as integral parts of care planning
- b. Develop a care plan with the patient that addresses the social determinants of health
- c. Provide patients with the information they need to be their own advocates and to direct their own health care decisions
- d. Provide troubleshooting and health systems navigation help and articulate the patient's needs to others when necessary
- e. Work with the patient, their family, and other care providers to secure access to care and other appropriate health and social resources

CPA 28. Speak up and take action to improve health equity, access to care, and the factors that affect health and safety at the practice or community level

This involves a range of related activities:

- a. Address inequities, gaps in access to care, and safety concerns at the practice and/or local level when needed
- b. Work with others to understand and analyze root causes of health and illness in the practice population and/or the local community
- c. Speak up to make the case for needed changes
- d. Engage with others on specific initiatives for change

Leadership

Practice narrative

Leadership is as much about day-to-day personal conduct as it is about having a formal or defined leadership position. Being trustworthy and taking responsibility for the medical care of another is a fundamental act of leadership that is built into the most responsible physician role and requires exquisite self-regulation, agency, and personal accountability. Beyond this, family physicians engage in leadership to improve and advance family practice and the academic discipline of family medicine at local to international levels. Leaders are motivated to change things for the better, so their activities are often tied to clinical work, advocacy, and scholarship.

“ Much of this work is intricately related to my own clinical work, advocacy, research, or other scholarly work. As with most family physicians, the leadership portion of my work is part of my day-to-day activities and does not stand in isolation. ”

Family physicians provide collaborative leadership on clinical teams and, by virtue of their medical expertise, may be called on to take charge of decision making in medical emergencies and more complex cases. Family physicians are flexible in their team roles according to the situation; in some cases they chair or lead a clinical team meeting, while in other situations they participate as a follower. As everyday leaders they promote effective team function, address conflicts, and attend to the quality of care provided by the practice, including through resource stewardship. They take an interest in their colleagues, serve as role models and mentors, and lead by example.

Clinical leadership for family physicians involves conceptualizing and developing care delivery through active listening and marshalling the input of others. This requires a knowledge of the health care system and involvement in many different types of meetings.

“ In my clinic I provide leadership to all my staff members. This includes regular scheduled meetings to review various red flags and problem solve around solutions. ... It involves liaising with community partners on how we provide care and [with] primary care networks in how we deliver services in our clinic and community. This may also require advocating during elections to promote issues related to primary care and patient care. ”

Over the course of their careers, family physicians often find themselves on personal leadership journeys. This may include being called on to serve at higher levels in both strategic and operational ways that require a host of administrative tasks and more advanced skills related to design and development, finance, staffing, scheduling, resource stewardship, and risk management.

“ My activities include leading a team of people in a way that motivates and supports, effective and persuasive writing and verbal communication, budget preparation and oversight, building coalitions with others to get things done, planning and chairing meetings, thinking strategically about opportunities, and having a vision for new possibilities. ”

Training statement

All graduates demonstrate personal accountability and trustworthiness in the most responsible physician role, and they can provide direction in medical emergencies and other challenging clinical situations. They function as collaborative clinical team leaders and often serve as community leaders. They have foundational abilities that prepare them for more advanced leadership roles in practice. They are prepared for the following CPAs.

Core Professional Activities

CPA 29. Develop self to provide leadership in everyday practice

This involves a range of related activities:

- a. Seek opportunities for personal growth, self-awareness, and strengthening interpersonal relationships
 - b. Cultivate habits that support resilience and coping with workplace stress
 - c. Fulfill the role of most responsible physician and lead and take responsibility for plans of care
 - d. Provide direction and facilitate medical decision making when necessary
-

CPA 30. Engage others in working toward practice- and/or system-level goals

This involves a range of related activities:

- a. Build teamwork and contribute to psychologically safe practice environments
- b. Facilitate team communication and conflict management when needed
- c. Provide support and mentorship to colleagues
- d. Analyze and engage in practice- and health system–level improvements
- e. Contribute to setting team goals and/or the direction of initiatives
- f. Take initiative and mobilize action toward achieving goals

Scholarship

Practice narrative

Scholarship is a broad term encompassing a wide range of professional activities that advance the science, evidence, and knowledge base underpinning the discipline of family medicine. These activities include teaching, quality improvement, research, and leadership to guide personal and practice improvement. As the architects of family medicine and family practice, family physicians are guided by their collective scholarly work and respond to patient and population needs.

A scholarly approach in everyday work requires family physicians to be curious, reflective, and mindful of their own practice environments and knowledge base. The scholarly work of family physicians is anchored by social accountability and an ethical obligation for practice improvement. Family physicians function as educational resources to their peers, practices, and communities.

“ My perspective as a family physician who embeds her practice in social accountability ... [is that] I have a responsibility to disseminate what I learn to others as part of being accountable to my peers in medical education and clinical work. ”

In deciding if and how best to act, family physicians seek and critically appraise evidence to answer questions and address their own knowledge gaps at the point of care. Translating this knowledge into decision aids and patient resources are some of the ways that scholarship is applied in daily practice. Family physicians contribute using their general knowledge base in addition to having niche areas of interest and expertise. They function as resources to their group practices and communities, thus enhancing the

capacity of primary care through an informal and local ecology of education. As part of their commitment to lifelong learning and professional development, family physicians reflect on their own performance and practice needs to develop personal learning plans.

“ As practising clinical family physicians, we are always employing scholarship in the broader sense of the term. When we have a clinical question and need to look up evidence or when we are trying to improve patient care—these all employ a level of questioning, gathering data, critically appraising, and deciding how we are going to act (or not act). ”

Family physicians contribute to their practices and to the future of the discipline through a continuum of practice improvement activities that use quality improvement, data, and research to continually enhance care, the patient experience, efficiencies, and the work experience of health care providers.

“ Our residency program has a strong university-based QI program, which I have received training in to ensure that I will have the skills to pass along to our residents. ... Interestingly, those few projects have been practice changing in terms of the information that they have produced. We also use our monthly standards review as a quality improvement process for our doctors at the local hospital. It is through discussion, self-reflection, and the drive to do better that we ensure our processes and qualities improve the care of our patients. ”

Family physicians participate in research throughout their careers in a variety of ways. Research roles may change and evolve, with some family physicians serving as leading clinician scientists, others as research collaborators, and all as scholarly consumers of scientific evidence.

“ Family physicians should be willing to contribute to both improving their day-to-day practices and to the future of the discipline. ... For research, family physicians can participate in multiple ways: recruiting patients, contributing data, collaborating as co-investigators, or acting as primary investigators. ”

Most family physicians are involved in some form of teaching with medical learners, peers, and other health professionals, as well as with patients, which includes public education. There is a wide scope of activity starting with the informal mentorship of learners and peers, through to clinical teaching and preceptorship, and on to more formal teaching roles as lecturers, small group facilitators, and leaders of programs or courses. Their most common role is as a clinical preceptor or supervisor—a clinical coach, to use the terminology of the CFPC’s Fundamental Teaching

Activities Framework.⁷ Family physicians teach in all the settings in which they practise, including hospital wards, emergency departments, labour and delivery suites, home care, and long-term care facilities. Family physicians serve in university-based educational roles with varying levels of engagement and involvement up to full-time academic appointments with significant educational leadership responsibilities.

Training statement

All graduates can identify their own learning needs and provide evidence-informed care. They identify practice improvement needs and can generate research questions that stem from them. Graduates evaluate and use evidence as scholarly clinicians and are aware of the contributions they can make as family medicine experts in research collaborations. They may be ready to pursue further training to serve as clinician scientists and lead investigators. Graduates can be expected to take on clinical teaching roles and have mastered the provision of patient education and instruction. They are prepared for the following CPAs.

Core Professional Activities

CPA 31. Assess, maintain, and enhance knowledge and skills to provide care that is evidence-informed and adapts to practice and community needs

This involves a range of related activities:

- a. Seek and critically appraise evidence to solve clinical problems at the point of care
- b. Conduct a guided self-assessment using practice data and external sources of feedback
- c. Create a professional learning plan to guide continuing professional development activities

CPA 32. Participate in quality improvement activities as part of practice improvement

This involves a range of related activities:

- a. Identify areas for improvement within the practice
 - b. Participate with the health care team in continuous Plan-Do-Study-Act cycles to generate and test change ideas
 - c. Obtain and analyze practice data as part of the quality improvement process
 - d. Practice resource stewardship and participate in activities that address the use of health system resources
-

CPA 33. Participate in research activities as part of advancing the discipline of family medicine

This involves a range of related activities:

- a. Generate research questions arising from practice
 - b. Define a literature search and evaluate evidence related to a research question
 - c. Contribute family medicine expertise to the development of appropriate study methods
 - d. Determine ethical considerations and the need for research ethics board review
 - e. Make scholarly presentations to peers
 - f. Collaborate as part of a research team
-

CPA 34. Teach and supervise learners in everyday practice as a clinical coach⁷

This involves a range of related activities:

- a. Embody the roles, attitudes, and competencies of a family physician in clinical work
- b. Promote and stimulate clinical reasoning and problem-solving skills
- c. Give timely, learner-centred, and constructive feedback
- d. Use program assessment tools to document observed learner performance according to the level of training
- e. Help learners engage in reflective processes to identify and address learning needs
- f. Use reflective processes to refine clinical supervision and teaching approaches to enhance learning

Family medicine Core Professional Activities

At a glance

Primary care in the community/office setting

CPA 1. Provide first-contact access and relational continuity of care as part of an overall system of care to the practice

CPA 2. Manage the total care of patients to provide informational and management continuity

CPA 3. Assess and plan for the care needs of the practice in the context of the local community

CPA 4. Attend to career and practice administrative/business functions

CPA 5. Participate in and engage with safety processes for patients, staff, and self

CPA 6. Participate in collaborative and team-based care

CPA 7. Manage self-care to support personal well-being and a sustainable practice

CPA 8. Establish a therapeutic relationship and navigate ethical issues in everyday practice

CPA 9. Provide medical care that challenges systemic racism and supports health equity with/for Indigenous peoples and other racialized or underserved patient communities

CPA 10. Provide reproductive care

CPA 11. Provide comprehensive primary care and continuity of care for children and youth

CPA 12. Provide comprehensive primary care and continuity of care for adults

CPA 13. Provide comprehensive primary care and continuity of care for older adults

CPA 14. Provide palliative and end-of-life care

CPA 15. Provide mental health and addiction care

CPA 16. Perform medical procedures in all settings as per the Procedure Skills in Family Medicine

Maternal and newborn care

CPA 17. Provide antenatal care

CPA 18. Manage low-risk labour and delivery

CPA 19. Provide postpartum care

CPA 20. Provide newborn care in the hospital and community

Emergency care

CPA 21. Manage all patients presenting to the emergency department

CPA 22. Manage all patients presenting with emergent and urgent conditions in the office, home, and other community settings

CPA 23. Contribute to community-level emergency preparedness and response

Home and long-term care

CPA 24. Provide primary care for patients with complex medical needs in their homes, long-term care facilities, and other community-based settings

Hospital care

CPA 25. Provide medical care in the hospital as the most responsible physician

CPA 26. Provide surgical assistance in the operating room

Advocacy

CPA 27. Work with individual patients to secure their social and health care needs

CPA 28. Speak up and take action to improve health equity, access to care, and the factors that affect health and safety at the practice or community level

Leadership

CPA 29. Develop self to provide leadership in everyday practice

CPA 30. Engage others in working toward practice- and/or system-level goals

Scholarship

CPA 31. Assess, maintain, and enhance knowledge and skills to provide care that is evidence-informed and adapts to practice and community needs

CPA 32. Participate in quality improvement activities as part of practice improvement

CPA 33. Participate in research activities as part of advancing the discipline of family medicine

CPA 34. Teach and supervise learners in everyday practice as a clinical coach

Addiction Medicine

Practice narrative

Family physicians with CACs in Addiction Medicine, who are recognized with the CCFP (AM) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to increase the capacity to care for those with substance use disorder and behavioural addiction through direct patient care, consultation, peer support, and education. Using a bio-psychosocial approach, family physicians with CACs in Addiction Medicine assist patients and their families on their journeys through harm reduction and recovery from addiction, which often includes treating mental illness and associated comorbidities.

Family physicians with CACs in Addiction Medicine are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

While the care of patients with addiction-related issues is a recognized part of comprehensive family practice, family physicians with CACs in Addiction Medicine provide an advanced level of care to patients with more complex or challenging conditions. This includes treating patients with substance use disorder and behavioural addiction, as well as concurrent mental health issues and related physical health effects, using non-pharmacological and pharmacological modalities. They formulate and communicate dynamic, comprehensive, patient-centred, trauma-informed treatment plans that integrate the stage of change and take into consideration patients' bio-psychosocial and spiritual

contexts. They manage patients in crises and those with potentially life-threatening conditions, such as overdose, intoxication, and withdrawal. They provide primary and secondary preventive care to adolescents. They assess workplace safety and create treatment and return-to-work plans. They provide care to patients throughout the life cycle. They work with a nuanced approach to special populations that may be particularly vulnerable to addiction disorders or over-represented among those with addiction disorders. These may include marginalized groups, patients who have experienced trauma, and those with chronic pain or mental illness.

Family physicians with CACs in Addiction Medicine are recognized for having acquired additional expertise and often receive formal referrals from colleagues. Physicians with CACs in Addiction Medicine act as resources to their family physician colleagues and to other specialists, health authorities, and the community. They support and extend the capacity of community family physicians by providing virtual/telephone support along with consultation and education.

CAC holders incorporate their advanced skills into practice in a range of ways. Many maintain comprehensive family practices and integrate their enhanced skills work into that style of practice, while some choose to enter focused practice. This decision is often based on local/regional norms of practice and what is supported by remuneration patterns. They have learned how to balance the various aspects of their practices, including changing focus and working in different locations. Regardless of their practice style, all CAC holders work to enhance the capacity for comprehensive care and to support continuity of care in their communities.

CAC holders are integral members of Patient's Medical Home-aligned practices. These team-based practices are likely to foster intraprofessional collaboration

among family physicians, but they may not always be co-located and may need to connect across great distances with physicians working together remotely or through technology to address issues of common interest and need.

They work in various clinical settings (including residential, hospital, and outpatient) and different geographical, community, academic, and political settings while adapting and adjusting their practices to meet the needs of the populations they serve. Family physicians with CACs in Addiction Medicine help develop the health workforce and deliver appropriate care when and where it is necessary.

Family physicians with CACs in Addiction Medicine work effectively in interprofessional care teams as leaders and team members. They function as high-level advocates and work with other care providers to ensure patients have access to care and services, including social, financial, and housing support. CAC holders are introduced to a range of roles and skills during residency and develop these skills further once in practice.

As clinical leaders, family physicians with CACs in Addiction Medicine are responsible for meeting the needs of the communities they serve. They

see themselves as resources for their patients and communities. In their leadership roles they maintain networks of care (professional, support and recovery) and act as a link between different points in these networks. As addiction medicine champions, they advocate for the expansion and improvement of addiction services at local, provincial, and national levels. CAC holders are involved in administrative roles, scholarship, and advocacy for their patients, the domain of practice, and system-level health. They provide a family medicine leadership presence and perspective on addiction medicine at local or regional levels in a wide range of clinical and educational leadership roles for committees, organizations, and initiatives.

Family physicians with CACs in Addiction Medicine are trained to practise evidence-based medicine and strive for continuous quality improvement. Through ongoing self-reflection, critical appraisal, and continuing professional development, those who hold these Special Designations are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. Family physicians with CACs in Addiction Medicine are lifelong learners and teachers or mentors to multiple streams of learners, including patients and their families, residents, and students. They may engage in scholarly research.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (confident, competent, and adaptive) for the following CPAs expected of family physicians with CACs in Addiction Medicine.

AM CPA 1. Provide advanced-level care and consultation for substance use disorder across the life cycle, in multiple contexts, and in unique situations

This involves a range of related activities:

- a. Treat patients using psychotherapy and other non-pharmacological and pharmacological modalities
- b. Formulate a use-reduction and relapse-prevention plan
- c. Integrate harm-reduction strategies and counselling into practice
- d. Educate patients and their circle of support about their condition, treatment options, and available resources and support them in navigating the system
- e. Interact with families and patients' social spheres/networks

- f. Assess and manage patients with high levels of bio-psychosocial instability
- g. Assess and manage problematic behaviours and substance use disorder in patients with chronic pain
- h. Communicate and enact physicians' legal responsibilities and educate patients about their responsibilities
- i. Screen for and manage concurrent and related physical health issues, including chronic pain

AM CPA 2. Diagnose and manage concurrent mental health issues in patients with substance use disorder

AM CPA 3. Manage intoxication, withdrawal, and overdose and their associated complications in patients across various settings and in a variety of populations

AM CPA 4. Collaborate in all levels of care

This involves a range of related activities:

- a. Work with the primary care team to enhance continuity of care and capacity for comprehensive care in the practice and in the community
 - b. Lead or act as a member of an interprofessional health care team
 - c. Work in partnership with service providers and government authorities as appropriate
 - d. Be a resource to colleagues through consultation and peer support
 - e. Provide leadership in program development, including quality improvement initiatives
-

AM CPA 5. Provide administrative, educational, and/or clinical leadership

AM CPA 6. Participate in the scholarly aspects of addiction medicine

This involves a range of related activities:

- a. Participate in research to advance the field of addiction medicine
 - b. Provide education related to addiction medicine to multiple levels of learners
-

AM CPA 7. Act as a resource to a community

This involves a range of related activities:

- a. Assess and respond to the needs of the communities or patient populations served by advocating with them as active partners for system-level change in a socially accountable manner
 - b. Identify and engage in community prevention initiatives
-

AM CPA 8. Manage personal professional activities

This involves a range of related activities:

- a. Maintain appropriate boundaries and practise ongoing self-care
- b. Engage in the continuous enhancement of professional activities through reflection and ongoing learning
- c. Advance the quality and safety of addiction medicine through practice improvement activities, both individually and as a part of a team

Care of the Elderly

Practice narrative

Family physicians with CACs in Care of the Elderly, who are recognized with the CCFP (COE) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to increase the capacity for the provision of care to elderly adults through direct patient care, consultations, peer support, and education. Family physicians with CACs in Care of the Elderly provide care to the older adult population and to patients with illnesses that are common in the elderly population.

Family physicians with CACs in Care of the Elderly are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

While care of the elderly is a recognized part of comprehensive family practice, CAC holders provide an advanced level of care and have more intensive involvement with patients who have complex needs that require enhanced skills for the assessment and management of patient goals of care, function, prognosis, and quality of life. They augment and support the care provided by other family physicians, other specialists, and other care providers typically around issues of frailty, complexity, comorbidity, medication assessment and management, and functional decline in the elderly. They use the principles of comprehensive geriatric assessments in all clinical encounters.

Family physicians with CACs in Care of the Elderly are recognized as having acquired additional expertise and often receive formal referrals from colleagues. These family physicians may often give consultations in the domain of care of the elderly to other family physicians, other specialists, and other health care providers. They support and extend the capacity of community family physicians by providing virtual/telephone support along with consultation and education.

CAC holders incorporate their advanced skills into practice in a range of ways. Many maintain comprehensive family practices and integrate their enhanced skills into that style of practice, while some choose to enter focused practice in elder care. This decision is often based on local/regional norms of practice and what is supported by remuneration patterns. Regardless of their practice style, all CAC holders work to enhance the capacity for comprehensive care and to support continuity of care in their communities.

CAC holders are integral members of Patient's Medical Home-aligned practices. These team-based practices are likely to foster intraprofessional collaboration among family physicians, but these doctors may not always be co-located and they may need to work together remotely or through technology to address issues of common interest and need.

Family physicians with CACs in Care of the Elderly work in a wide range of settings and manage transitions of care across numerous settings such as home care, long-term care, hospices, family practices, specialized clinics, and hospitals. Family physicians with CACs in Care of the Elderly help develop the health workforce and deliver appropriate care when and where it is necessary.

Team-based and collaborative care are integral to the care of the elderly. CAC holders work as leaders and team members with a range of health professionals within institutions and in the community and collaborate extensively with families. CAC holders are introduced to a range of roles and skills during residency and further develop these skills once in practice.

As clinical leaders, family physicians with CACs in Care of the Elderly are responsible for meeting the needs of the communities they serve. CAC holders are involved in administrative roles, scholarship, and advocacy for their patients, the domain of practice, and system-level health. They see themselves as resources to their patients and communities. They provide a family medicine leadership presence and perspective on care of the elderly at local or regional levels in a wide range of

clinical and educational leadership roles for committees, organizations, and initiatives.

Family physicians with CACs in Care of the Elderly are trained to practise evidence-based medicine and strive for continuous quality improvement. Through ongoing self-reflection, critical appraisal, and continuing professional development, family physicians with CACs in Care of the Elderly are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. Family physicians with CACs in Care of the Elderly are lifelong learners and teachers or mentors to multiple streams of learners, including patients and their families, residents, and students. They may engage in scholarly research.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (confident, competent, and adaptive) for the following CPAs expected of family physicians with CACs in Care of the Elderly.

COE CPA 1. Provide advanced-level care and consultation for issues commonly seen in older adults that affect health, physical and cognitive function, and independence

COE CPA 2. Provide care for older adults in a range of settings

This involves a range of settings:

- a. In the community (home, supportive/assisted living, office) in a primary care role or collaborative role
 - b. In long-term care
 - c. In hospital settings as a consultant or as most responsible physician (e.g., rehabilitation, acute care, post-acute hospital facility, emergency room)
-

COE CPA 3. Collaborate in all levels of care

This involves a range of related activities:

- a. Work with the primary care team to enhance continuity and capacity for comprehensive care in the practice and community
- b. Lead or act as a member of an interprofessional health care team
- c. Work in partnership with service providers and government authorities as appropriate

- d. Act as a resource to colleagues through consultation and peer support
 - e. Provide leadership in program development, including in quality improvement initiatives
-

COE CPA 4. Provide administrative, educational, and/or clinical leadership

COE CPA 5. Participate in the scholarly aspects of health care of the elderly

This involves a range of related activities:

- a. Participate in research to advance the field of health care of the elderly
 - b. Provide education related to health care of the elderly to multiple levels of learners
-

COE CPA 6. Act as a resource to a community

This involves a range of related activities:

- a. Assess the needs of one's community or patient population
 - b. Advocate as an active partner for system-level change in a socially accountable manner
-

COE CPA 7. Manage personal professional activities

This involves a range of related activities:

- a. Practise self-care
- b. Engage in practice improvement activities both individually and as a part of a team to advance the care of older adults
- c. Engage in the continuous enhancement of professional performance through reflection and ongoing learning

Emergency Medicine

Practice narrative

Family physicians with CACs in Emergency Medicine, who are recognized with the CCFP (EM) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to deliver advanced-level emergency care and increase the capacity for emergency care in the community.

Family physicians with CACs in Emergency Medicine are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

While emergency care is a recognized part of comprehensive family practice, CAC holders provide an advanced level of care and have more expertise and involvement in treating patients with complex, high-acuity needs. They also have additional skills related to managing high-volume emergency department settings. Family physicians with CACs in Emergency Medicine work in an environment that requires constant adaptation to a variable pace and variable cognitive load. They assess and manage the broadest possible range of unselected and unexpected presentations. Patients range from Canadian Triage and Acuity Scale levels 1 to 5 and come from all age groups, all cultures, and all socio-economic groups without any limitations.

These physicians are skilled in recognizing subtle signs, as their knowledge of a patient's normal state of

functioning and medical histories may be limited. They are skilled in triaging patients, managing patient and department flow, and managing multiple cases and multiple traumas simultaneously. The nature of work in an emergency department requires them to work in shifts to ensure communities have 24-7 access to care. With their skill sets they are often involved in other aspects of care, including critical care transport.

Family physicians with CACs in Emergency Medicine are recognized for having acquired additional skills and often receive formal referrals from colleagues. They support and extend the capacity of community family physicians by providing virtual/telephone support along with consultation and education. They assist community family physicians in discussions around triage, disposition, and medical transportation and accept referrals from the community, often providing support to neighbouring rural or regional communities.

CAC holders incorporate their advanced skills into practice in a range of ways. Many maintain comprehensive family practices and integrate their enhanced skills work into that style of practice, while some choose to enter focused practice. This decision is often based on local/regional norms of practice and what is supported by remuneration patterns. They have learned how to balance the various aspects of their practices, including changing focus and working in different locations. Regardless of their practice style, all CAC holders work to enhance the capacity for comprehensive care and to support continuity of care in their communities.

Family physicians with CACs in Emergency Medicine represent an integral piece of the Patient's Medical Home vision of care. They also represent a critical point of access to care for patients who do not have family physicians.

Family physicians with CACs in Emergency Medicine provide advanced-level emergency care in a range of emergency department settings, from rural hospitals to high-acuity tertiary care centres, and in other settings, such as urgent care.

They work effectively and collaboratively in interprofessional health care teams. They often take on team leadership roles in acute critical care situations. CAC holders are introduced to a range of roles and skills during residency and further develop these skills once in practice.

As clinical leaders, family physicians with CACs in Emergency Medicine are responsible for meeting the needs of the communities they serve. CAC holders are involved in administrative roles, scholarship, and advocacy for their patients, the domain of practice, and system-level health. They see themselves as resources to their patients and communities. They take on active leadership roles in the department and provide a

family medicine leadership presence and perspective on emergency care at local or regional levels in a wide range of clinical and educational leadership roles for committees, organizations, and initiatives. They work with families in crisis and advocate for access to care and the coordination of care at both patient and community levels.

Family physicians with CACs in Emergency Medicine are trained to practise evidence-based medicine and strive for continuous quality improvement. Through ongoing self-reflection, critical appraisal, and continuing professional development, family physicians with CACs in Emergency Medicine are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. Family physicians with CACs in Emergency Medicine are lifelong learners and teachers or mentors to multiple streams of learners, including patients and their families, students, and residents. They may engage in scholarly research.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (competent, confident, and adaptive) for the following CPAs expected of family physicians with CACs in Emergency Medicine.

EM CPA 1. Provide advanced-level care and consultation for all patients who present to the emergency department

This involves a range of related activities:

- a. Assess and manage patients with urgent and non-urgent presentations within the context of the emergency encounter
- b. Assess and manage patients with emergent conditions within the context of the emergency encounter
- c. Assess and manage minor and severe trauma
- d. Assess and manage critical, life-threatening presentations to the emergency facility
- e. Manage expected and unexpected end-of-life care, including palliative care, organ donation, coroner aspects of care beyond direct clinical activities, and the delivery of bad news
- f. Provide sedation and systemic analgesia when required

EM CPA 2. Manage the emergency department

This involves a range of related activities:

- a. Care for multiple critically ill patients simultaneously
 - b. Triage patients based on acuity, recognizing the ongoing need for fluidity and the re-evaluation of prioritization based on multiple environmental and patient factors
 - c. Manage workflow in the emergency department
 - d. Ensure appropriate transition of care both within and outside the emergency department
-

EM CPA 3. Collaborate in all levels of care

This involves a range of related activities:

- a. Work with the primary care team to enhance continuity of care and capacity and to contribute to comprehensive care in the practice and community
 - b. Lead or act as a member of an interprofessional health care team
 - c. Work in partnership with service providers and government authorities as appropriate
 - d. Act as a resource to colleagues through consultation and peer support
 - e. Provide leadership in program development, including quality improvement initiatives
-

EM CPA 4. Provide administrative, educational, and/or clinical leadership

This involves a range of related activities:

- a. Take a leadership role in team dynamics and departmental operations such as team debriefs
-

EM CPA 5. Participate in the scholarly aspects of emergency medicine

This involves a range of related activities:

- a. Participate in research to advance the field of emergency medicine
 - b. Provide education related to emergency medicine to multiple levels of learners
-

EM CPA 6. Act as a community resource in emergency care

This involves a range of related activities:

- a. Teach the principles of emergency medicine to health professionals and other streams of learners
 - b. Assess the needs of communities or patient populations served and, as appropriate, advocate with them as active partners for system-level change in a socially accountable manner
-

EM CPA 7. Manage personal professional activities

This involves a range of related activities:

- a. Engage in the continuous enhancement of professional activities through reflection and ongoing learning
- b. Practise self-care to mitigate risks related to shift work and a potentially hazardous work environment
- c. Advance the quality and safety of emergency medicine through participation in practice improvement activities, both individually and as a part of a team

Procedures list

Procedures should be performed with appropriate consent, the use of sterile technique and personal protective equipment as indicated, and with the knowledge of indications, contraindications, and complications. Ultrasound guidance may be used for any of the following procedures.

All procedures in lists A and B in Table 1 are within the scope of practising family physicians. All graduates will be expected and prepared to perform the procedures in list A. Graduates may be prepared to perform the procedures in list B but they are not expected of everyone with CACs in Emergency Medicine.

Table 1. Procedures relevant to emergency medicine

	List A Training expectation	List B Supplemental
Airway Procedures		
Bag mask ventilation	Yes	
Endotracheal intubation using direct laryngoscopy	Yes	
Endotracheal intubation using rescue airway technique (bougie and laryngeal mask airway)	Yes	
Endotracheal intubation using video laryngoscopy	Yes	
Insertion of nasopharyngeal airway	Yes	
Insertion of oropharyngeal airway	Yes	
Management of obstructed airway/airway foreign body	Yes	
Rapid sequence intubation	Yes	
Application of non-invasive positive pressure ventilation (NIPPV)		Yes
Awake intubation		Yes
Cricothyroidotomy/needle jet ventilation		Yes
Extubation		Yes
Management of ventilation		Yes
Anesthetic Procedures		
Procedural sedation/analgesia	Yes	
Cardiovascular Procedures		
Central venous line placement	Yes	
Defibrillation	Yes	
Electrical/chemical cardioversion	Yes	
Intraosseous line placement	Yes	
Intravenous line placement	Yes	
Transcutaneous pacing	Yes	
Arterial line placement		Yes

	List A Training expectation	List B Supplemental
Cardiovascular Procedures		
ED thoracotomy		Yes
Pericardiocentesis		Yes
Transvenous pacing		Yes
Dental Procedures		
Dry socket management	Yes	
Fractured tooth management	Yes	
Splinting of subluxated/avulsed tooth	Yes	
Ear, Nose, and Throat Procedures		
Epistaxis management	Yes	
External auditory canal foreign body removal/irrigation	Yes	
Nasal foreign body removal	Yes	
Auricular hematoma drainage		Yes
Particle repositioning techniques (Epley)		Yes
Peritonsillar abscess aspiration		Yes
Septal hematoma drainage		Yes
Gastrointestinal Procedures		
Nasogastric tube insertion	Yes	
Orogastric tube insertion	Yes	
Balloon device for tamponade of variceal bleed		Yes
Paracentesis		Yes
Musculoskeletal Procedures		
Arthrocentesis	Yes	
Cast and splint application	Yes	
Fracture reduction	Yes	
Hematoma block	Yes	
Joint reduction	Yes	
Pelvic binder placement	Yes	
Regional nerve blocks	Yes	
Extensor tendon repair		Yes
Neurological Procedure		
Lumbar puncture	Yes	

	List A Training expectation	List B Supplemental
Obstetrical/Gynecological Procedures		
Unplanned/emergent delivery	Yes	
Peri-mortem Caesarean section		Yes
Ophthalmological Procedures		
Corneal foreign body removal	Yes	
Corneal rust ring removal	Yes	
Intraocular pressure measurement	Yes	
Lateral canthotomy		Yes
Respiratory Procedures		
Needle/finger thoracostomy	Yes	
Tube thoracostomy	Yes	
Thoracentesis		Yes
Skin/Soft Tissue Procedures		
Foreign body removal	Yes	
Incision and drainage	Yes	
Simple and complex wound repair	Yes	
Wound management including burns	Yes	
Ultrasound Procedures		
Abdominal aortic aneurysm scan	Yes	
Cardiac effusion and motion	Yes	
Early pregnancy assessment	Yes	
Focused assessment with sonography in trauma (FAST)	Yes	
Advanced resuscitative ultrasound		Yes
Urological Procedures		
Urinary catheterization/bladder irrigation	Yes	
Phimosis management (dorsal slit)		Yes
Priapism management (aspiration)		Yes
Suprapubic bladder catheterization		Yes
Testicular detorsion		Yes

Enhanced Surgical Skills

Practice narrative

Family physicians with CACs in Enhanced Surgical Skills, who are recognized with the CCFP (ESS) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to provide surgical care and increase the capacity for surgical care in their communities.

Family physicians with CACs in Enhanced Surgical Skills are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

Family physicians with CACs in Enhanced Surgical Skills provide surgical care in a defined scope of practice in communities that are unable to sustain other surgical specialty services locally, including rural, remote, and Indigenous communities. They perform a wide range of emergency and elective surgical procedures that are beyond the scope of core training in family medicine, including Caesarean section and appendectomy. This helps sustain local maternity and surgical programs. Family physicians with these skills support full-service rural hospitals and may support local services provided by other specialists.

Individuals with CACs in Enhanced Surgical Skills are experts in diagnostics, in patient selection for procedures, and in preoperative, intraoperative, and postoperative decision making. They are trained surgical first responders for trauma within the regional network of care.

These family physicians are recognized as having acquired additional expertise and often receive formal referrals from colleagues. They help colleagues maintain their scopes of practice and support the capacity of rural generalist family practice. They share their expertise in the domain of surgical skills with other family physicians, other specialists, and other health care providers both locally and remotely. They provide local leadership, expertise, and technical skills related to acute and critical care (in and outside the operating room). When needed, they refer patients to other specialists who are ideally within the regional network of care. On-call work is a required part of practice to support the needs of the community and the health care team.

Family physicians with CACs in Enhanced Surgical Skills maintain comprehensive family practices and integrate their enhanced skills into their practices, which routinely includes working in hospitals and emergency departments. They have learned how to balance the various aspects of their practices, including changing focus and working in different locations.

CAC holders are integral members of Patient's Medical Home-aligned practices. They promote the value of continuous and comprehensive care in best serving patients.

These family physicians work and collaborate effectively as part of interprofessional care teams and often take on team leadership roles in acute critical care situations. In these teams they coordinate with the most responsible family physician to ensure care is patient-centred and continuous. They are accountable resources to their patients, colleagues, and communities. CAC holders are introduced to a range of roles and skills during residency and further develop these skills once in practice.

Family physicians with CACs in Enhanced Surgical Skills are leaders in the development of surgical and obstetrical networks of care in their regions. They champion the provision of care close to home and they advocate for the expansion and improvement of local surgical services. This is often pivotal in preserving and maintaining the existence of local rural hospitals. They are typically involved with administrative leadership connected to running a local surgical service. They take on active leadership roles in hospitals and provide a family medicine leadership perspective on surgical care at local or regional levels in a wide range of clinical and educational leadership roles for committees, organizations, and initiatives.

Family physicians with CACs in Enhanced Surgical Skills are trained to practise evidence-based medicine and strive for continuous quality improvement. Due to the potentially low volume of cases they see, these physicians must measure the quality of their patients' outcomes and it is crucial for them to engage in continuing professional development. Through ongoing self-reflection, critical appraisal, and continuing professional development, family physicians with CACs in Enhanced Surgical Skills are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. These family physicians are also engaged in clinical teaching and provide educational opportunities to diverse groups of interprofessional learners.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (competent, confident, and adaptive) for the following CPAs expected of family physicians with CACs in Enhanced Surgical Skills.

ESS CPA 1. Provide elective surgical care in smaller/rural communities with limited access to other surgical specialists

This involves a range of related activities:

- a. Select patients for local care within the regional system of care based on patient autonomy and the holistic risks and benefits of performing the procedure locally
- b. Manage intraoperative complications
- c. Manage postoperative complications

ESS CPA 2. Perform Caesarean sections when indicated

ESS CPA 3. Provide initial emergency care as the surgical first responder

ESS CPA 4. Collaborate in all levels of care

This involves a range of related activities:

- a. Provide surgical consultation for urgent, emergent, and critical care both peri-operatively and outside the operating room
- b. Work with the primary care team to enhance the capacity for continuous and comprehensive care in the practice and community
- c. Lead or act as a member of an interprofessional health care team

- d. Work in partnership with service providers and government authorities as appropriate
 - e. Serve as a resource to colleagues through consultation and peer support
 - f. Provide leadership in program development including quality improvement initiatives
-

ESS CPA 5. Assume leadership

This involves a range of related activities:

- a. Lead crisis management efforts and prepare for surgical and obstetrical emergencies
 - b. Lead the development and sustainability of a regional network of care
-

ESS CPA 6. Participate in the scholarly aspects of enhanced surgical skills

This involves a range of related activities:

- a. Advocate for and facilitate surgical and obstetrical educational opportunities
 - b. Participate in research to advance the field of enhanced surgical skills
 - c. Provide education related to enhanced surgical skills to multiple levels of learners
-

ESS CPA 7. Act as a resource to a community

This involves a range of related activities:

- a. Assess the needs of a community or patient population
 - b. Advocate as an active partner for system-level change in a socially accountable manner
-

ESS CPA 8. Perform point-of-care ultrasound for appropriate obstetrical and surgical patients

ESS CPA 9. Manage personal professional activities

This involves a range of related activities:

- a. Practise self-care
- b. Engage in the continuous enhancement of professional activities through reflection and ongoing learning
- c. Advance quality and safety in enhanced surgical skills through practice improvement activities, both individually and as a part of a team
- d. Document and examine outcomes in low-volume programs through a quality lens

Procedures list

All procedures in lists A and B in Table 2 are within the scope of practising family physicians. All graduates will be expected and prepared to perform the procedures in list A. Graduates may be prepared to perform the procedures in list B but they are not expected of everyone with CACs in Enhanced Surgical Skills.

Table 2. Procedures relevant to enhanced surgical skills

	List A Training expectation	List B Supplemental
Extremity Procedures		
Complex abscess drainage	Yes	
Advanced access (central line)		Yes
Carpal tunnel release		Yes
Complex wound repair (flaps and grafts)		Yes
Gastrointestinal Procedures		
Appendectomy	Yes	
Colonoscopy including polypectomy	Yes	
Diagnostic laparoscopy	Yes	
Primary uncomplicated inguinal and umbilical hernia repair	Yes	
Upper GI diagnostic endoscopy	Yes	
Hemorrhoid banding		Yes
Reproductive Procedures		
Assisted vaginal delivery	Yes (vacuum)	Yes (low and outlet forceps)
Caesarean section	Yes	
Compression sutures for postpartum hemorrhage	Yes	
Dilation and curettage (first trimester and postpartum)	Yes	
Laparoscopic sterilization (occlusion or salpingectomy)	Yes	
Manual removal of placenta	Yes	
Other obstetrical lacerations (e.g., cervical, high vaginal)	Yes	
Sterilization at Caesarean section	Yes	
Surgical management of ectopic pregnancy	Yes	
Third-degree perineal laceration repair	Yes	
Uterine balloon tamponade (e.g., Bakri)	Yes	
Fourth-degree perineal laceration repair		Yes
Non-neonatal circumcision		Yes
Tubal ligation postpartum		Yes
Vasectomy		Yes
Other Procedure		
Tonsillectomy		Yes

Family Practice Anesthesia

Practice narrative

Family physicians with CACs in Family Practice Anesthesia, who are recognized with the CCFP (FPA) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to provide anesthesia care and increase the capacity for anesthetic and surgical care in their communities.

Family physicians with CACs in Family Practice Anesthesia are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

Also known as family physician anesthetists, these individuals are trained in a defined scope of practice that goes beyond core family medicine training. They can respond and adapt to anesthetic considerations for all people, ages, life stages, and presentations—from stable to critical and from elective to emergent—based on need, skill set, and available resources. Family physician anesthetists provide pre-anesthetic consultation to establish the safety and advisability of surgery done locally. In the operating room they provide general, neuraxial, and regional anesthesia. Outside the operating room they provide labour epidurals and procedural sedation. They also provide nerve blocks as part of interventional pain management. On-call work is a required part of practice to support the needs of the community and the health care team.

These CAC holders are trained to plan and coordinate care throughout the peri-operative period, which

requires family medicine expertise in anesthesia as well as advanced abilities in communication, collaboration, leadership, and advocacy. Family physician anesthetists apply their scope and situational judgment to meet the needs and preferences of their patients and (often low-resourced) communities when making clinical decisions. They must ensure patient and procedural safety, particularly as it relates to transfer of care, escort for medical evacuation, and transport of patients in critical condition. Recognizing and applying personal and institutional limitations in the context of anesthesia care are necessary qualifications and conditions of this work.

Family physicians with CACs in Family Practice Anesthesia are recognized for having acquired additional expertise and often receive formal referrals from colleagues. They share their expertise in the domain of anesthesia with other family physicians, other specialists, and other health care providers both locally and remotely. They provide leadership, expertise, and technical skills in acute and critical care (in and outside the operating room), including in complex airway management, advanced vascular access, and the management of acute pain in patients with complex conditions and in postoperative patients.

CAC holders incorporate their advanced skills into practice in a range of ways. Many maintain comprehensive family practices and integrate their enhanced skills work into that style of practice, while some choose to enter focused practice. This decision is often based on local/regional norms of practice and what is supported by remuneration patterns. They have learned how to balance the various aspects of their practices, including changing focus and working in different locations. Regardless of their practice style, all CAC holders work to enhance the capacity for comprehensive care and to support continuity of care in their communities. Family physician anesthetists practise community-based medicine with a whole-picture, whole-patient approach.

CAC holders in Family Practice Anesthesia are integral members of Patient's Medical Home–aligned practices. They are trained to provide primary and specialized care to small, rural, and remote populations.

These family physicians work effectively and collaboratively in interprofessional health care teams. They often take on team leadership roles in acute critical care situations. They work in interdisciplinary teams and coordinate with the most responsible family physician to ensure patient-centred care is available close to home. They are accountable resources to their patients, colleagues, and communities. CAC holders are introduced to a range of roles and skills during residency and further develop these skills once in practice.

As clinical leaders, family physicians with CACs in Family Practice Anesthesia are responsible for meeting the needs of the communities they serve. CAC holders are involved in administrative roles, scholarship, and advocacy for their patients, the domain of practice, and system-level health. They see themselves as resources to their patients and communities. They take on active leadership roles in hospitals and provide a

family medicine leadership presence and perspective on anesthesia care at local or regional levels in a wide range of clinical and educational leadership roles for committees, organizations, and initiatives.

Family physicians with CACs in Family Practice Anesthesia are trained to practise evidence-based medicine and strive for continuous quality improvement. Through ongoing self-reflection, critical appraisal, and continuing professional development, family physicians with CACs in Family Practice Anesthesia are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. They are lifelong learners and teachers or mentors to multiple streams of learners, including patients and their families, students, and residents. They may engage in scholarly research.

To prepare family physician anesthesiologists for an evolving role in the health care system, training programs should have approaches and strategies in place to improve regional anesthesia training, ultrasound-guided procedures, and critical care transport.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (competent, confident, and adaptive) for the following CPAs expected of family physicians with CACs in Family Practice Anesthesia.

FPA CPA 1. Provide anesthesia care while recognizing and applying personal and institutional limitations

This involves a range of related activities:

- a. Provide peri-operative consultation, planning, coordination, and care
- b. Provide general anesthetic
- c. Provide neuraxial and regional anesthetic
- d. Provide procedural sedation
- e. Provide labour analgesia

FPA CPA 2. Provide primary and specialized care to small, rural, and remote populations

FPA CPA 3. Perform complex airway management

FPA CPA 4. Provide acute pain management in patients with complex conditions and in postoperative patients

FPA CPA 5. Collaborate in all levels of care

This involves a range of related activities:

- a. Provide anesthesia consultation for urgent, emergent, and critical care both peri-operatively and outside the operating room
 - b. Work with the primary care team to enhance continuity in and capacity for comprehensive care in the practice and community
 - c. Lead or act as a member of an interprofessional health care team
 - d. Work in partnership with service providers and government authorities as appropriate
 - e. Act as a resource to colleagues through consultation and peer support
 - f. Provide leadership in program development, including quality improvement initiatives
 - g. Lead or participate in the development and sustainability of a regional network of care
-

FPA CPA 6. Provide administrative, educational, and/or clinical leadership

FPA CPA 7. Participate in the scholarly aspects of family practice anesthesia

This involves a range of related activities:

- a. Participate in research to advance the field of family practice anesthesia
 - b. Provide education related to family practice anesthesia to multiple levels of learners
-

FPA CPA 8. Act as a community resource for anesthesia care

This involves a range of related activities:

- a. Assess the needs of a community or patient population
 - b. Advocate as an active partner for system-level change in a socially accountable manner
-

FPA CPA 9. Operate and maintain anesthetic equipment

FPA CPA 10. Perform advanced vascular access procedures

FPA CPA 11. Manage personal professional activities

This involves a range of related activities:

- a. Practise self-care
- b. Advance the quality and safety of family practice anesthesia through practice improvement activities, both individually and as a part of a team
- c. Engage in the continuous enhancement of professional performance through reflection and ongoing learning

Obstetrical Surgical Skills

Practice narrative

Family physicians with CACs in Obstetrical Surgical Skills, who are recognized with the CCFP (OSS) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to increase the capacity for obstetrical care in their communities. They provide Caesarean sections, consultations, and advanced obstetrical care as part of a community-level commitment to comprehensive care.

Family physicians with CACs in Obstetrical Surgical Skills are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

These CAC holders perform Caesarean sections and manage obstetrical emergencies in communities without consistent or local access to obstetricians, including rural and remote communities and Indigenous communities. Physicians with these skills support full-service rural hospitals and may support local services provided by other specialists.

Physicians with CACs in Obstetrical Surgical Skills are experts in obstetrical screening and diagnostics, in patient selection for procedures, and in preoperative, intraoperative, and postoperative decision making.

These family physicians are recognized as having acquired additional expertise and often receive formal referrals from colleagues. They support the capacity

of rural family physicians to provide intrapartum care. Consultations are performed in the office, the emergency room, the labour and delivery suite, and inpatient units for obstetrical and gynecological care as well as remotely; they are provided to midwives, other family physicians, and emergency department physicians. When needed, these physicians refer patients to other specialists for care, ideally within the regional network of care. On-call work is a required part of practice to support the needs of the community and the health care team.

Family physicians with CACs in Obstetrical Surgical Skills maintain comprehensive, community-based family practices and integrate their obstetrical skills work into their practices. They have learned how to balance various aspects of their practices, including changing focus and working in different locations. They work to enhance the capacity for comprehensive care and to support continuity of care in their communities. These physicians integrate their obstetrical surgical skills into comprehensive family practices as rural generalists and routinely provide hospital care, work in emergency departments, and deliver community-based primary care.

CAC holders are integral members of Patient's Medical Home-aligned practices.

These family physicians work and collaborate effectively in interprofessional care teams and often take on team leadership roles in acute critical care situations. They work in interdisciplinary teams to coordinate with the most responsible family physician to ensure patient-centred care is available close to home. They are accountable resources to their patients, colleagues, and communities. CAC holders are introduced to a range of roles and skills during residency and further develop these skills once in practice.

Family physicians with CACs in Obstetrical Surgical Skills are leaders in the development of regional obstetrical networks of care. They champion the provision of care close to home and they advocate for the expansion and improvement of local maternity services and local surgical services. This is often pivotal in preserving and maintaining the existence of local rural hospitals. They are typically involved with administrative leadership connected to running a local obstetrical service. They take on active leadership roles in hospitals and provide a family medicine perspective on surgical care at local or regional levels in a wide range of clinical and educational leadership roles for committees, organizations, and initiatives.

These family physicians are trained to practise evidence-based medicine and strive for continuous quality improvement. Due to the potentially low volume of cases they see, these physicians must measure the quality of their patients' outcomes and it is crucial for them to engage in continuing professional development. Through ongoing self-reflection, critical appraisal, and continuing professional development, family physicians with CACs in Obstetrical Surgical Skills are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. These family physicians are also engaged in clinical teaching and provide educational opportunities to diverse groups of interprofessional learners.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (competent, confident, and adaptive) for the following CPAs expected of family physicians with CACs in Obstetrical Surgical Skills.

OSS CPA 1. Perform Caesarean section and obstetrical surgical skills when indicated

This involves a range of related activities:

- a. Select patients for local care within the regional network based on patient autonomy and the holistic risks and benefits of performing the procedure locally
- b. Manage intraoperative complications
- c. Manage postoperative complications

OSS CPA 2. Manage obstetrical emergencies

OSS CPA 3. Collaborate in all levels of care

This involves a range of related activities:

- a. Provide consultation for urgent, emergent, and critical care related to obstetrical and maternity care
- b. Work with the primary care team to enhance the capacity for continuous and comprehensive care in the practice and community
- c. Lead or act as a member of an interprofessional health care team
- d. Work in partnership with service providers and government authorities as appropriate
- e. Act as a resource to colleagues through consultation and peer support
- f. Provide leadership in program development, including quality improvement initiatives

OSS CPA 4. Assume leadership

This involves a range of related activities:

- a. Lead crisis management efforts and prepare for obstetrical emergencies
 - b. Lead the development and sustainability of a regional network of care
-

OSS CPA 5. Participate in the scholarly aspects of family practice obstetrical surgical skills

This involves a range of related activities:

- a. Advocate for and facilitate surgical and obstetrical educational opportunities
 - b. Participate in research to advance the field of family practice obstetrical surgical services
 - c. Provide education related to family practice obstetrical surgical skills to multiple levels of learners
-

OSS CPA 6. Act as a resource to a community

This involves a range of related activities:

- a. Assess the needs of a community or patient population
 - b. Advocate as an active partner for system-level change in a socially accountable manner
-

OSS CPA 7. Perform point-of-care ultrasound for appropriate obstetrical patients

OSS CPA 8. Manage personal professional activities

This involves a range of related activities:

- a. Practise self-care
- b. Engage in the continuous enhancement of professional activities through reflection and ongoing learning
- c. Document and examine outcomes in low-volume programs through a quality lens
- d. Advance quality and safety in obstetrical surgical skills through practice improvement activities, both individually and as a part of a team

Procedures list

All procedures in lists A and B in Table 3 are within the scope of practising family physicians. All graduates will be expected and prepared to perform the procedures in list A. Graduates may be prepared to perform the procedures in list B but they are not expected of everyone with CACs in Obstetrical Surgical Skills.

Table 3. Procedures relevant to obstetrical surgical skills

	List A Training expectation	List B Supplemental
Extremity Procedure		
Complex abscess drainage		Yes
Reproductive Procedures		
Assisted vaginal delivery	Yes (vacuum)	Yes (low and outlet forceps)
Caesarean section	Yes	
Compression sutures for postpartum hemorrhage	Yes	
Dilation and curettage (first trimester and postpartum)	Yes	
Manual removal of placenta	Yes	
Other obstetrical lacerations (e.g., cervical, high vaginal)	Yes	
Sterilization at Caesarean section	Yes	
Third-degree perineal laceration repair	Yes	
Uterine balloon tamponade (e.g., Bakri)	Yes	
Fourth-degree perineal laceration repair		Yes
Surgical management of ectopic pregnancy		Yes
Tubal ligation postpartum		Yes

Palliative Care

Practice narrative

Family physicians with CACs in Palliative care, who are recognized with the CCFP (PC) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to increase the capacity for the provision of palliative care through direct patient care, consultations, peer support, program leadership, education, and research.

Family physicians with CACs in Palliative Care are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

While palliative care is a recognized part of comprehensive family practice, family physicians with CACs in Palliative Care provide advanced-level palliative care and consultations for patients with complex situations in both hospital and community settings. Complex management typically involves patients with serious illnesses for whom the usual approaches have failed and/or where there are challenging ethical or social issues at play. Family physicians with CACs in Palliative Care provide consultations on a range of serious illnesses including end-stage chronic disease, degenerative neurologic conditions, cancer, and end-stage psychiatric illnesses. They focus on best practices in pain and symptom management, psychosocial support, advance care planning, and goals-of-care discussions. They work with patients and their caregivers to provide information and education about

the underlying conditions, help them understand anticipatory grief, and prepare for illness transitions.

Family physicians with CACs in Palliative Care are recognized for having acquired additional expertise and education. They often receive formal referrals from colleagues. In this role as consultants, they help develop the health workforce in palliative care by supporting and building the capacity for palliative care among family physicians and other specialists. Many CAC holders identify as palliative specialists in addition to their identity as family physicians.

CAC holders incorporate their advanced skills into practice in a range of ways. Many maintain comprehensive family practices and integrate their enhanced skills work into that style of practice, while some choose to enter focused practice. This decision is often based on local/regional norms of practice and what is supported by remuneration patterns. They have learned how to balance the various aspects of their practices, including changing focus and working in different locations. Regardless of their practice style, all CAC holders work to enhance the capacity for comprehensive care and to support continuity of care in their communities.

CAC holders are integral members of Patient's Medical Home-aligned practices. These team-based practices are likely to include intraprofessional collaboration among family physicians who may not always be co-located and who may need to work together remotely or through technology to address issues of common interest and need. When providing advanced-level palliative care, there is an emphasis on coordinated and continuous care with other family physicians, including shared care with family physicians and other involved specialists. There is a critical focus on capacity building in primary care

with a strong emphasis on informal consults, support, e-consults, and assistance with care navigation.

Family physicians with CACs in Palliative Care work in all palliative care settings, including home/community settings, clinics, hospitals, hospices, and office practices and with homeless populations and patients with vulnerable housing circumstances. They also have the training needed to function as the most responsible physician in palliative care units (PCUs). PCUs are distinct from hospices in that they provide hospital-based complex symptom control and psychosocial care with goals ranging from improved symptom management enabling discharge home to end-of-life care on the unit. This is a more recent development in the delivery of palliative care and it may not be a common experience among all current CAC holders, but it is a necessary goal of residency training. In smaller regional or rural settings and in major cities, physicians with CACs in Palliative Care often work on specialty palliative care teams that may or may not include PCUs. Some specialty palliative care teams have in-patient beds outside of traditional PCUs for which these CAC holders function as the most responsible physicians. Virtual care is also expanding and is being incorporated in the delivery of palliative care across care settings.

These physicians work effectively in interprofessional care teams as leaders and team members. They typically provide consultations and/or shared care in an interprofessional palliative team model that includes a range of health professionals such as nurses, pharmacists, social workers, and psychosocial spiritual care providers (depending on the size of the program and human resources available). CAC holders are introduced to a range of roles and skills during residency and further develop these skills once in practice.

Family physicians with CACs in Palliative Care are leaders, scholars, and advocates who embrace and promote an integrated palliative approach: a compassionate, person-centred philosophy of care that looks at the whole person and family and considers physical, emotional, and spiritual needs in context. They embody family medicine values and see themselves as resources to their patients and communities. Family physicians with CACs in Palliative Care also occupy leadership roles and work to address gaps in community services and equity to ensure that all patients have access to high-quality palliative care. While they see their role primarily as consultants who support and build the capacity for family physicians and others to provide palliative care, they also advocate to link patients to the primary care providers they need.

As palliative care champions, they advocate for the expansion and improvement of services on local, provincial, and national levels. They function as high-level advocates and work with other care providers to ensure patients have access to care and services, including social, financial, and housing support.

Family physicians with CACs in Palliative Care are trained to practise evidence-based medicine and strive for continuous quality improvement. Through ongoing self-reflection, critical appraisal, and continuing professional development, those who hold these Special Designations are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. Family physicians with CACs in Palliative Care are lifelong learners and teachers or mentors to multiple streams of learners, including patients and their families, students, and residents. They may engage in scholarly research.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (competent, confident, and adaptive) for the following CPAs expected of family physicians with CACs in Palliative Care.

PC CPA 1. Provide advanced-level palliative care for those with serious illnesses and their families using counselling and non-pharmacological and pharmacological modalities

This involves a range of related activities:

- a. Assess and address symptom needs
- b. Attend to patients for whom death is imminent and be prepared for emergencies
- c. Assess for distress and resiliency and address related needs
- d. Provide supportive counselling to patients and families, including anticipatory grief counselling and bereavement counselling (introductory level)
- e. Identify refractory symptoms at the very end of life and provide continuous palliative sedation therapy (CPST) in accordance with patient goals and local or regional CPST policies
- f. Respond to requests for hastened death and explore underlying suffering; be able to discuss the differences between withholding or withdrawing life-sustaining treatments, CPST, and medical assistance in dying
- g. Make referrals and work with other consultants to manage care
- h. Facilitate complex family meetings
- i. Manage complex issues related to dying:
 - i) Manage complex family dynamics
 - ii) Facilitate discussions around end-of-life care planning
 - iii) Develop goals of care congruent with patient and family wishes
 - iv) Manage complex psychosocial and physical symptoms regardless of the patient's care site (home, hospice, hospital, or structurally vulnerably housed)

PC CPA 2. Function as most responsible physician for patients admitted to PCUs

This involves a range of related activities:

- a. Manage clinical, operational, and administrative elements of patients' care, including bed allocation and discharge planning
- b. Modify management strategies recognizing strengths and limitations of staff at various admission sites

PC CPA 3. Manage palliative care in the home (wherever patients deem home to be)

This involves a range of related activities:

- a. Coordinate with primary care providers in consultative and shared care models
- b. Assess and facilitate decision making regarding care settings and transfers based on context and availability (this includes families' support networks as well as system resources such as nursing)

- c. Assess options for additional resources
 - d. Identify care partners and build capacity for care in the home
 - e. Coordinate care and communicate care decisions
 - f. Provide virtual care as part of care support (this varies by region but is a likely reality of the future)
-

PC CPA 4. Collaborate in all levels of care

This involves a range of related activities:

- a. Lead or act as a member of an interprofessional health care team
 - b. Work in partnership with service providers and government authorities as appropriate
 - c. Act as a resource to colleagues through consultation and peer support
 - d. Provide leadership in program development including quality improvement initiatives
-

PC CPA 5. Provide consultation and peer support

This involves a range of related activities:

- a. Communicate back to the referring source
 - b. Assist in creating a care plan including advance care planning, goals of care, and decision-making
 - c. Manage transitions (related to both illness and care settings)
 - d. Assess caregiver distress and resiliency
 - e. Provide virtual care consultations including e-consults, telephone, video, etc.
-

PC CPA 6. Provide administrative, educational, and/or clinical leadership

PC CPA 7. Participate in the scholarly aspects of palliative care

This involves a range of related activities:

- a. Participate in research to advance the field of palliative care
 - b. Provide education related to palliative care to multiple levels of learners
-

PC CPA 8. Act as a resource to a community

This involves a range of related activities:

- a. Assess the needs of a community or patient population
- b. Advocate as an active partner for system-level change in a socially accountable manner

PC CPA 9. Perform procedures as appropriate (where available)

This involves a range of related activities:

- a. Ultrasound-guided paracentesis
 - b. Point-of-care ultrasound
 - c. Continuous subcutaneous infusions
 - d. Advanced wound management
-

PC CPA 10. Manage personal professional activities

This involves a range of related activities:

- a. Create boundaries and practise ongoing self-care
- b. Advance the quality and safety of palliative care through practice improvement activities, both individually and as part of a team
- c. Engage in the continuous enhancement of professional performance through reflection and ongoing learning

Sport and Exercise Medicine

Practice narrative

Family physicians with CACs in Sport and Exercise Medicine, who are recognized with the CCFP (SEM) Special Designation, are system leaders and champions in their communities. They work with other family physicians, colleagues from other specialties, and other care providers to increase the capacity for the provision of sport and exercise medicine through direct patient care, consultations, peer support, and education.

Family physicians with CACs in Sport and Exercise Medicine are committed to the values expressed in the Family Medicine Professional Profile.² They are committed to the delivery of accessible, high-quality, comprehensive, and continuous front-line health care. They embody a characteristic approach that strengthens the compassion, responsiveness, integrity, and quality of the health care system. They provide care that supports continuity and is relationship- and patient-centred, community adaptive, and collaborative.

While sport and exercise medicine is a recognized part of comprehensive family practice, CAC holders provide a comprehensive, advanced level of care and have more intensive involvement in the care of patients with complex needs in this domain. With their specialized knowledge and training, they assess and manage acute injuries and illnesses as well as chronic or not-yet-diagnosed conditions. They treat symptoms, work to restore normal movement, and aim to improve patients' function. They provide rehabilitative care to assist in the return to physical activity and provide exercise prescriptions for health promotion, including the management of specific conditions (e.g., diabetes).

Family physicians with CACs in Sport and Exercise Medicine provide advanced and expert care to patients of all ages, sexes, genders, and all abilities who

have musculoskeletal problems and exercise-related or exercise-induced medical conditions. Physicians with CACs in Sport and Exercise Medicine generally see conditions related to physical activity, overuse, and degenerative diseases.

These individuals are recognized for having acquired additional expertise and often receive formal referrals from colleagues. They also bridge a gap in care by providing appropriate referrals to allied health providers and other specialist physicians and surgeons. They help develop the health workforce by supporting and building the capacity of family physicians and others in this domain of care.

CAC holders incorporate their advanced skills into practice in a range of ways. Many maintain comprehensive family practices and integrate their enhanced skills work into that style of practice, while some choose to enter focused practice. This decision is often based on local/regional norms of practice and what is supported by remuneration patterns. Regardless of their practice style, all CAC holders work to enhance the capacity for comprehensive care and to support continuity of care in their communities.

CAC holders are integral members of Patient's Medical Home-aligned practices. These team-based practices are likely to include intraprofessional collaboration among family physicians, but they may not always be co-located and may need to connect across distances with physicians working together remotely or through technology to address issues of common interest and need.

Family physicians with CACs in Sport and Exercise Medicine work in primary care family practices, multidisciplinary sport and exercise medicine clinics, academic settings, and health care teams. They may

also work in rural and/or remote communities in individual or group practices. Family physicians with CACs in Sport and Exercise Medicine provide coverage at sporting events and support community and elite teams and their health care providers at local, regional, and national levels. They provide emergent, urgent, and non-urgent care at the field of play and often provide comprehensive care for their athlete patients.

Family physicians with CACs in Sport and Exercise Medicine work effectively in interprofessional care teams as leaders and team members with a range of health professionals including physiotherapists, occupational therapists, psychiatrists, and orthopedic surgeons. CAC holders are introduced to numerous roles and skills during residency and further develop these skills once in practice.

As clinical leaders, family physicians with CACs in Sport and Exercise Medicine are responsible for meeting the needs of the communities they serve. CAC holders are involved in administrative roles, scholarship, and advocacy for patients, the domain of practice, and

system-level health. In their practices they provide leadership related to quality improvement and professional development. They see themselves as resources to their patients and communities. They provide a family medicine leadership presence and perspective on sport and exercise medicine at local or regional levels in a wide range of clinical and educational leadership roles for committees, organizations, and initiatives.

Family physicians with CACs in Sport and Exercise Medicine are trained to practise evidence-based medicine and strive for continuous quality improvement. Through ongoing self-reflection, critical appraisal, and continuing professional development, those who hold these Special Designations are attentive to self-directed learning and self-care. Residency training is designed to build a capacity and curiosity for ongoing teaching and future educational leadership. Family physicians with CACs in Sport and Exercise Medicine are lifelong learners and teachers or mentors to multiple streams of learners, including patients and their families, students, and residents. They may engage in scholarly research.

Core Professional Activities

In addition to being prepared for the Family Medicine Core Professional Activities (CPAs), by the end of enhanced skills training residents will be prepared (competent, confident, and adaptive) for the following CPAs expected of family physicians with CACs in Sport and Exercise Medicine.

SEM CPA 1. Provide advanced-level sport and exercise medicine assessments and consultations

This involves a range of related activities:

- a. Assess and manage acute and chronic sport and exercise-related or –induced injuries, illness, and mental health conditions for patients of all ages, sexes, and genders and all levels of ability and physical activity

SEM CPA 2. Provide care for athletes and teams of all abilities and ages

This involves a range of related activities:

- a. Provide comprehensive primary care and sport and exercise medicine expert care
- b. Provide sporting event or team coverage for non-urgent, urgent, and emergent care at the field of play and while travelling with teams
- c. Conduct pre-participation assessments
- d. Provide counselling on optimal nutrition and the use of supplements
- e. Provide support on issues related to doping in sport and the therapeutic use exemption application process

SEM CPA 3. Prescribe physical activity and exercise for health enhancement, prevention, and the rehabilitation of injury as well as the prevention and treatment of chronic disease

SEM CPA 4. Collaborate in all levels of care

This involves a range of related activities:

- a. Work with the primary care team to enhance continuity and capacity and for comprehensive care in the practice and community
 - b. Lead or act as a member of an interprofessional health care team
 - c. Work in partnership with service providers and government authorities as appropriate
 - d. Act as a resource to colleagues through consultation and peer support
 - e. Provide leadership in program development, including quality improvement initiatives
-

SEM CPA 5. Provide administrative, educational, and/or clinical leadership

SEM CPA 6. Participate in the scholarly aspects of sport and exercise medicine

This involves a range of related activities:

- a. Participate in research to advance the field of sport and exercise medicine
 - b. Provide education related to sport and exercise medicine to multiple levels of learners
-

SEM CPA 7. Act as a resource to a community

This involves a range of related activities:

- a. Assess the needs of a community or patient population
 - b. Advocate as an active partner for system-level change in a socially accountable manner
-

SEM CPA 8. Perform common procedures in sport and exercise medicine

This involves a range of related activities:

- a. Soft tissue and joint injections
 - b. Sutures and wound care
 - c. Joint reductions
 - d. Immobilization techniques
-

SEM CPA 9. Manage personal professional activities

This involves a range of related activities:

- a. Practise self-care
- b. Participate in practice improvement activities both individually and as a part of a team to advance the quality and safety of sport and exercise medicine
- c. Engage in the continuous enhancement of professional performance through reflection and ongoing learning

Enhanced skills Core Professional Activities

At a glance

Addiction Medicine

AM CPA 1. Provide advanced-level care and consultation for substance use disorder across the life cycle, in multiple contexts, and in unique situations

AM CPA 2. Diagnose and manage concurrent mental health issues in patients with substance use disorder

AM CPA 3. Manage intoxication, withdrawal, and overdose and their associated complications in patients across various settings and in a variety of populations

AM CPA 4. Collaborate in all levels of care

AM CPA 5. Provide administrative, educational, and/or clinical leadership

AM CPA 6. Participate in the scholarly aspects of addiction medicine

AM CPA 7. Act as a resource to a community

AM CPA 8. Manage personal professional activities

Care of the Elderly

COE CPA 1. Provide advanced-level care and consultation for issues commonly seen in older adults that affect health, physical and cognitive function, and independence

COE CPA 2. Provide care for older adults in a range of settings

COE CPA 3. Collaborate in all levels of care

COE CPA 4. Provide administrative, educational, and/or clinical leadership

COE CPA 5. Participate in the scholarly aspects of health care of the elderly

COE CPA 6. Act as a resource to a community

COE CPA 7. Manage personal professional activities

Emergency Medicine

EM CPA 1. Provide advanced-level care and consultation for all patients who present to the emergency department

EM CPA 2. Manage the emergency department

EM CPA 3. Collaborate in all levels of care

EM CPA 4. Provide administrative, educational, and/or clinical leadership

EM CPA 5. Participate in the scholarly aspects of emergency medicine

EM CPA 6. Act as a community resource in emergency care

EM CPA 7. Manage personal professional activities

Enhanced Surgical Skills

ESS CPA 1. Provide elective surgical care in smaller/rural communities with limited access to other surgical specialists

ESS CPA 2. Perform Caesarean sections when indicated

ESS CPA 3. Provide initial emergency care as the surgical first responder

ESS CPA 4. Collaborate in all levels of care

ESS CPA 5. Assume leadership

ESS CPA 6. Participate in the scholarly aspects of enhanced surgical skills

ESS CPA 7. Act as a resource to a community

ESS CPA 8. Perform point-of-care ultrasound for appropriate obstetrical and surgical patients

ESS CPA 9. Manage personal professional activities

Family Practice Anesthesia

FPA CPA 1. Provide anesthesia care while recognizing and applying personal and institutional limitations

FPA CPA 2. Provide primary and specialized care to small, rural, and remote populations

FPA CPA 3. Perform complex airway management

FPA CPA 4. Provide acute pain management in patients with complex conditions and in postoperative patients

FPA CPA 5. Collaborate in all levels of care

FPA CPA 6. Provide administrative, educational, and/or clinical leadership

FPA CPA 7. Participate in the scholarly aspects of family practice anesthesia

FPA CPA 8. Act as a community resource for anesthesia care

FPA CPA 9. Operate and maintain anesthetic equipment

FPA CPA 10. Perform advanced vascular access procedures

FPA CPA 11. Manage personal professional activities

Obstetrical Surgical Skills

OSS CPA 1. Perform Caesarean section and obstetrical surgical skills when indicated

OSS CPA 2. Manage obstetrical emergencies

OSS CPA 3. Collaborate in all levels of care

OSS CPA 4. Assume leadership

OSS CPA 5. Participate in the scholarly aspects of family practice obstetrical surgical skills

OSS CPA 6. Act as a resource to a community

OSS CPA 7. Perform point-of-care ultrasound for appropriate obstetrical patients

OSS CPA 8. Manage personal professional activities

Palliative Care

PC CPA 1. Provide advanced-level palliative care for those with serious illnesses and their families using counselling and non-pharmacological and pharmacological modalities

PC CPA 2. Function as most responsible physician for patients admitted to PCUs

PC CPA 3. Manage palliative care in the home (wherever patients deem home to be)

PC CPA 4. Collaborate in all levels of care

PC CPA 5. Provide consultation and peer support

PC CPA 6. Provide administrative, educational, and/or clinical leadership

PC CPA 7. Participate in the scholarly aspects of palliative care

PC CPA 8. Act as a resource to a community

PC CPA 9. Perform procedures as appropriate (where available)

PC CPA 10. Manage personal professional activities

Sport and Exercise Medicine

SEM CPA 1. Provide advanced-level sport and exercise medicine assessments and consultations

SEM CPA 2. Provide care for athletes and teams of all abilities and ages

SEM CPA 3. Prescribe physical activity and exercise for health enhancement, prevention, and the rehabilitation of injury as well as the prevention and treatment of chronic disease

SEM CPA 4. Collaborate in all levels of care

SEM CPA 5. Provide administrative, educational, and/or clinical leadership

SEM CPA 6. Participate in the scholarly aspects of sport and exercise medicine

SEM CPA 7. Act as a resource to a community

SEM CPA 8. Perform common procedures in sport and exercise medicine

SEM CPA 9. Manage personal professional activities

Appendix 1: Procedure Skills in Family Medicine

Introduction

A fundamental element of all procedures in family medicine is the ability of the physician to understand their skill set and the clinical situation surrounding the management of an individual patient. There are situations in which the physician must be prepared to act emergently and other circumstances where they can evaluate whether they are the right person, at the right time, to undertake a procedure for a given patient.

Family physicians are prepared to provide a wide range of procedures and, as the nature of a physician's practice changes over time, they will adapt the procedures they provide to meet the needs of their patients. This list describes the scope of procedures that all family physicians are prepared to perform (list A). It is recognized that some of these procedures share techniques, cognitive skills, and manual skills. The list also includes numerous procedures for which family medicine residents may be trained, but residents are not expected to have been trained to perform them by the time they graduate (list B). To meet the needs of their practices and communities, residents and practising family physicians may also develop competency in additional procedures not identified in these lists.

Methodology

Procedure skills validation was done in two phases: through the Delphi approach, with a stratified random sample of physicians selected from the CFPC's membership database; and through a consensus-building approach, with a six-member expert group recommended and selected by the CFPC's Director, Certification and Examinations, and members of the Certification Process and Assessment Committee.

The list of 102 procedures that was included in the review combined several lists that CFPC committees had compiled (core skills, enhanced skills, maternity

and newborn care skills, rural and remote family medicine skills, and individual physician narratives collected through the Outcomes of Training survey).

The Delphi approach included two rounds of surveys in which participants were asked to select procedures they thought successful family medicine graduates should be prepared to do when they start independent practice. They were given an opportunity to explain why they did not include certain procedures, and they had an option to suggest other procedures (in the first survey only). Eighty-five physicians responded to both surveys. Their demographic profile is representative of the total CFPC membership.

Members of the expert group first completed the same survey that was sent to the large group and then met virtually to discuss their selection. Their focus was first to confirm if a procedure fell within the scope of family medicine and then to determine whether a resident should be prepared to provide the procedure at entry to practice. Those that met both criteria were categorized as list A procedures. Other procedures that were considered to be within the scope of family medicine but were determined not to be expected at entry to practice for all residents were included list B. Factors such as context of practice, community need, program design, and nature of the procedure were taken into consideration when making the determination. The list went through two more iterations via email. Through these iterations, numerous procedures were combined or split, 15 procedures were removed, and 10 were added. The final list has 87 procedures.

List of procedure skills in family medicine

All procedures in lists A and B are within the scope of family medicine practice. All graduates will be prepared to perform the procedures in list A. Graduates may be prepared to perform the procedures in list B, but these skills are not expected of everyone who has completed their family medicine training.

Table 4. Procedure skills in family medicine

Procedures	List A Training expectation	List B Supplemental
Diagnostic and Therapeutic Procedures		
Injections (subcutaneous, subdermal, intramuscular, intralesional)	Yes	
Procedural sedation, analgesia, and anesthesia	Yes	
Injection and aspiration of joints and bursae	Yes	
Peripheral nerve blocks (femoral cutaneous, intercostal, fracture hematoma)		Yes
Cyst aspiration (including breast)	Yes	
Diagnostic vascular access (arterial and venous)	Yes	
Therapeutic vascular access (peripheral, central, and intraosseous)	Yes	
Needle thoracentesis and paracentesis	Yes	
Needle thoracostomy	Yes	
Chest tube insertion	Yes	
Lumbar puncture (adult and child)	Yes	
Ear Procedures		
Removal of cerumen	Yes	
Removal of foreign body (ear)	Yes	
Eye Procedures		
Instillation of fluorescein	Yes	
Eye irrigation	Yes	
Removal of conjunctival foreign body	Yes	
Removal of corneal foreign body	Yes	
Slit lamp examination		Yes
Removal of embedded corneal foreign body		Yes
Removal of corneal rust ring		Yes
Gynecologic Procedures		
Pessary fitting	Yes	
Pap smear	Yes	
Endometrial aspiration biopsy	Yes	
Insertion of intrauterine device	Yes	
Colposcopy		Yes
Dilatation and vacuum aspiration/sharp curettage		Yes
Dilatation and evacuation		Yes

Procedures	List A Training expectation	List B Supplemental
Intrapartum Procedures		
Cervical ripening by prostaglandin	Yes	
Cervical ripening by catheter insertion	Yes	
Scalp electrode application	Yes	
Artificial rupture of membranes	Yes	
Normal vaginal delivery	Yes	
Uterine massage for postpartum hemorrhage	Yes	
Perform vacuum (low and outlet) extraction	Yes	
Shoulder dystocia manoeuvres	Yes	
Episiotomy and repair of first- and second-degree perineal lacerations	Yes	
Forceps (low and outlet) application		Yes
Third-degree perineal laceration repair		Yes
Fourth-degree perineal laceration repair		Yes
Amnioinfusion		Yes
Insertion of intrauterine pressure catheter		Yes
Limb/Extremity Procedures		
Immobilization of fractures (slings, splints, casts)	Yes	
Cast removal	Yes	
Reduction of displaced fractures in extremities	Yes	
Reduction of dislocations in extremities	Yes	
Nose Procedures		
Cautery for anterior epistaxis	Yes	
Nasogastric tube insertion	Yes	
Removal of nasal foreign body	Yes	
Anterior nasal packing	Yes	
Posterior nasal packing		Yes
Resuscitation Procedures		
Neonatal resuscitation techniques	Yes	
Oral and supraglottic airway insertion	Yes	
Bag-and-mask ventilation	Yes	
Endotracheal intubation	Yes	
Airway management: cricothyrotomy, transtracheal jet insufflation		Yes

Procedures	List A Training expectation	List B Supplemental
Resuscitation Procedures		
Artificial breathing devices management: ventilator, non-invasive positive pressure ventilation		Yes
Performance of electrocardiogram (ECG)	Yes	
Cardiopulmonary resuscitation (CPR)	Yes	
Emergent cardioversion and cardiac defibrillation	Yes	
Skin Procedures		
Dermoscopy		Yes
Skin and nail scraping for fungus determination	Yes	
Skin callus paring	Yes	
Incision and drainage (abscess, thrombosed external hemorrhoid, acute paronychia, infected Bartholin cyst)	Yes	
Subungual hematoma release	Yes	
Removal of foreign body from skin	Yes	
Wound debridement	Yes	
Treatment of skin lesions by electrocautery, cryotherapy, or chemical means	Yes	
Insertion of sutures (simple, mattress, and subcuticular)	Yes	
Laceration repair with skin glue	Yes	
Shave, punch, and excisional skin procedures (biopsy, treatment)	Yes	
Removal of sebaceous cyst	Yes	
Extensor tendon repair		Yes
Toenail management (wedge excision, partial and full nail removal)	Yes	
Toenail management (Vandenbos procedure, ablation of nail bed)		Yes
Ultrasound Procedures		
Point-of-care ultrasound in the emergency department		Yes
Point-of-care ultrasound in hospital		Yes
Ultrasound assistance for procedures		Yes
Point-of-care ultrasound in the office		Yes
Uro-rectal Procedures		
Placement of transurethral catheter	Yes	
Anoscopy/proctoscopy	Yes	
Fecal disimpaction	Yes	

Procedures	List A Training expectation	List B Supplemental
Uro-rectal Procedures		
Male neonatal circumcision		Yes
Vasectomy		Yes
Priapism drainage		Yes
Other Procedures		
Sexual assault forensic examination	Yes	
Tongue-tie release	Yes	
Surgical assisting (including Caesarean section)	Yes	

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