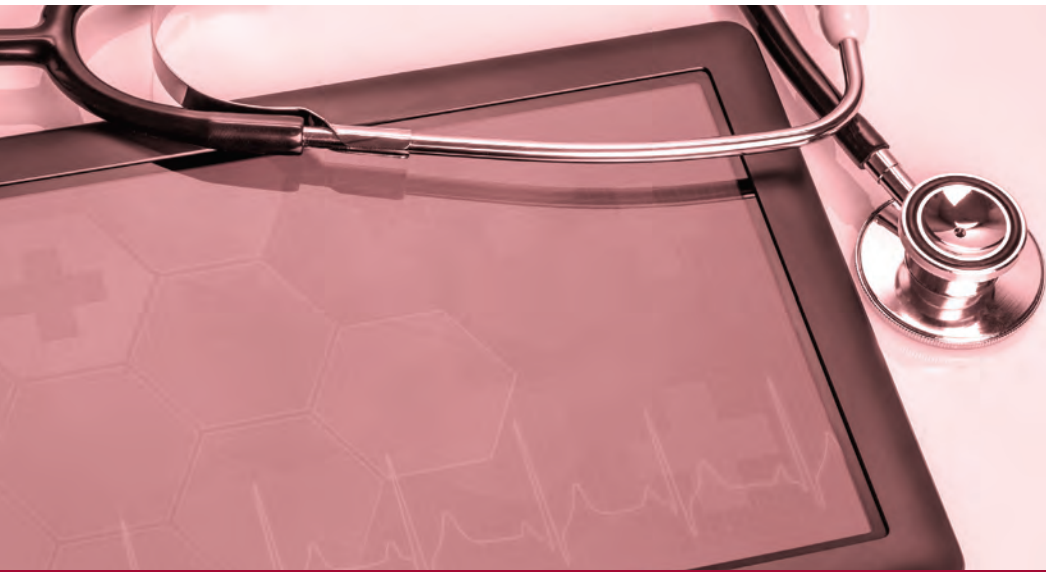


THE COLLEGE OF  
FAMILY PHYSICIANS  
OF CANADA



LE COLLÈGE DES  
MÉDECINS DE FAMILLE  
DU CANADA



# Specific Standards for Family Medicine Residency Programs Accredited by the College of Family Physicians of Canada

THE RED BOOK

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## OVERVIEW OF THE ACCREDITATION PROCESS

The purpose of the accreditation of residency programs by the College of Family Physicians of Canada (CFPC) Accreditation Committee is twofold: to attest to the educational quality of accredited programs and to ensure sufficient uniformity and portability to allow residents from across Canada to qualify for the CFPC examinations as residency eligible candidates. Accreditation is voluntary and is conducted at the request of faculties of medicine at Canadian universities. The CFPC considers for accreditation only family medicine and enhanced skills residency programs based in departments of family medicine at Canadian university faculties of medicine. Programs in palliative medicine are also considered for accreditation under a conjoint process with the Royal College of Physicians and Surgeons of Canada (RCPSC).

In this document, the words “**must**” and “should” have been chosen with care. Use of the word “**must**” indicates that the Accreditation Committee considers meeting the standard to be absolutely necessary if the program is to be accredited. Use of the word “should” indicates that the attribute is considered highly desirable and that the committee will judge whether its absence may compromise substantial compliance with all the requirements for accreditation.

These standards are sometimes deliberately stated in a fashion that is not amenable to quantification or to precise definition. This is because the nature of the evaluation is qualitative in character and can be accomplished only through the exercise of professional judgment by qualified persons.

The CFPC recognizes the potential for restriction by regulations that are too rigid, and therefore promotes free communication between the College, the medical schools, and the residents as a good safeguard against undue rigidity. All residents **must** have the opportunity to reach their full potential and innovation is encouraged in achieving this goal.

## ORGANIZATION OF THE PROCESS

The accreditation of residency training programs is the responsibility of the CFPC's Accreditation Committee. To be accredited, programs **must**, in the judgment of the Committee, meet the national standards set forth in this document.

The Committee's accreditation process is based on two elements: an assessment of an application for accreditation that describes the residency program and its resources, and an on-site survey. Committee representatives conduct onsite visits to residency training programs on a 6-year cycle or as recommended.

Prior to each survey visit, the College contacts the postgraduate office of the school in question to arrange the date of the survey, to discuss pre-survey documentation, and to develop a schedule for the visit. The survey team selected by the College's Accreditation Committee usually includes, at a minimum, two committee members and a dean of postgraduate medical education from a Canadian medical school. In addition, the team is often accompanied by representatives from other organizations, such as the Federation of Medical Regulatory Authorities of Canada (FMRAC), the Resident Doctors of Canada (RDoc), or the Fédération des médecins résidents du Québec (FMRQ), as well as by CFPC staff members.

Following the survey team's visit, a survey report is drafted and returned to the university within six weeks of the conclusion of the visit. This report contains the survey team's observations and recommendations. It is provided to the university so it can correct any factual errors or omissions. The survey team also makes a recommendation about the accreditation status and follow-up of the training program, which is provided to the university and to the College's Accreditation Committee. The report of the survey team and the response of the training program are reviewed at the first meeting of the Accreditation Committee following the completion of the report and receipt of the program's response. The university and the training program are invited to send representatives to this meeting to discuss the content of the report with the committee directly. During that meeting, the category of approval of the program is determined and communicated to the program.

The accreditation decision will be based on the recommendations and observations in the survey report and on the response of the university to the accuracy of the report.

Responses from the university intended to correct identified deficiencies can be communicated to the committee but will not directly influence the accreditation decision. Information about changes or projected changes could influence the nature of the follow-up. The College has in place an appeal process, which a training program can use in the case of an adverse decision. Details of this appeal process are provided at the end of this document.

## INTRODUCTION TO *THE RED BOOK*: FAMILY MEDICINE

The general standards for the accreditation of postgraduate training programs, commonly known as the B Standards, define the standards common to all postgraduate medical training in Canada and are agreed to by the three postgraduate medical education accrediting agencies: the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada (RCPSC), and the Collège des médecins du Québec (CMQ). These discipline-specific standards for family medicine are complementary to and consistent with the B Standards and will clarify or expand on the B Standards as they relate to the education of family physicians. The standards by which programs will be evaluated are a combination of the general standards and those outlined in this document.



## **SPECIFIC STANDARDS FOR FAMILY MEDICINE RESIDENCY PROGRAMS ACCREDITED BY THE CFPC**

### **STANDARD B.1: ADMINISTRATIVE STRUCTURE AND SUPPORTS**

A residency program **must** be based in an academic department of family medicine within a university faculty of medicine and have an administrative structure that enables the central program to govern all the various distributed residency training sites in an efficient and equitable way. The following general guidelines will apply to all residency programs under the direction of university departments of family medicine. A minimum of 24 months of training is required to complete the program.

#### **Postgraduate Program Director**

1. The postgraduate program director **must** hold certification in family medicine and be in good standing with the College of Family Physicians of Canada (CFPC) or with the Collège des médecins du Québec (CMQ). The postgraduate program director is responsible for all of the postgraduate educational activities of the university department of family medicine, including the residency program in family medicine and any enhanced skills programs that might be administered under the governance of the department of family medicine.
2. The postgraduate program director **must** be assured of sufficient time and support to supervise and administer the program. He or she is responsible to the head of the department concerned and to the postgraduate dean of the faculty of medicine. The College **must** be informed by the university postgraduate office when a new postgraduate program director is appointed.

#### **Postgraduate Program Director and the Residency Program Committee**

3. There **must** be a residency program committee to assist the postgraduate program director in the planning, implementation, organization, supervision, and evaluation of all the postgraduate family medicine programs.
4. The responsibilities of the postgraduate director, assisted by the residency program committee, include the following:

- a) Developing and operating the program such that it meets the general and specific standards of accreditation as set forth in this document
- b) Designing and implementing learning opportunities for residents to attain all competencies as outlined by the CFPC
- c) Selecting candidates for admission to the program
- d) Overseeing the assessment system to determine competence of the residents in the program in accordance with policies determined by the faculty, postgraduate medical education committee, and the CFPC
- e) Ensuring that residents are involved in the governance of the department and in the residency program, including the election of the chief resident, resident involvement in program committees, and resident involvement in program planning and evaluation
- f) Maintaining an appeal mechanism. The residency program committee should receive and review appeals from residents and, where appropriate, refer the matter to the faculty postgraduate medical education committee or faculty appeal committee
- g) Establishing mechanisms to provide career planning and counselling for residents
- h) Instituting mechanisms to deal with problems such as those related to resident health and well-being, including stress, intimidation, or harassment
- i) Creating a written policy governing resident safety related to travel and patient encounters, including house calls, after-hours consultations in isolated settings, and patient transfers (eg, Medevac). The policy should allow residents discretion and judgment regarding their personal safety and ensure residents are appropriately supervised during all such clinical encounters. The policy **must** specifically include educational activities (eg, identifying risk indicators)
- j) Special accommodation **must** be provided to residents with physical/health challenges in accordance with university policies
- k) Ensuring that there is an identified faculty member with the responsibility to facilitate and supervise the involvement of residents in research and other scholarly work
- l) Maintaining a link with the undergraduate program in order to demonstrate continuity of education

## Training Sites

5. There **must** be a site coordinator at each geographic site or program stream—including sites offering electives—who is responsible to the postgraduate program director and/or enhanced skills program coordinator. An active liaison between the postgraduate program director and the site coordinators **must** be maintained.

## Program Evaluation

An important aspect of a successful competency-based educational program is the program's commitment and ability to monitor itself for quality, particularly with respect to the learners' educational outcomes, and to make the necessary curricular modifications that will result in continuous improvement. The academic department **must** maintain an ongoing cyclical review of the residency training program to evaluate the quality of the educational experience and to review the resources available in order to ensure that maximal benefit is being derived from the integration of the components of the program. This will include, but is not limited to, the internal review conducted by the postgraduate dean's office. A designated committee (residency program committee or other) **must** be responsible for the planning and monitoring of this process, and should document related outcomes. The opinions of the residents **must** be among the factors considered in this review. This review **must** be conducted in a manner that respects confidentiality of residents and faculty. Appropriate faculty–resident interaction and communication **must** take place in an open and collegial atmosphere so that a free discussion of the strengths and weaknesses of the program can occur without hindrance. The process **must** include the following:

1. An evaluation of each component of the program, both centrally and at each site, to ensure that the educational objectives are being met, with specific attention to the domains of care, continuity of care, the academic program, and the scholarly program, both within family medicine and other educational experiences
2. An evaluation of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness across all sites
3. An evaluation of the teachers in the program with evidence that teachers receive feedback in a timely manner

4. An evaluation of the outcomes of the residency programs that includes but should not be limited to:
  - a) Measurements of resident performance, including degree of variation across training sites and education experiences
  - b) Feedback from recent graduates who are able to reflect on their training having acquired a perspective on the requirements of clinical practice
5. An evaluation of the quality of the different learning environments
6. Demonstration that the program uses the collected information to improve the quality of the various components of the program

### **Postgraduate Resident Assessment Coordinator**

Each program should identify a person or persons who will have the responsibility of coordinating resident assessment. The role of resident assessment coordinator could be the responsibility of a single person or of a committee. The resident assessment coordinator should be a member of the residency postgraduate committee.

The responsibilities of this individual or committee should include the following:

1. Working with the postgraduate committee to make recommendations for overall resident assessment policy
2. Coordinating the distribution of resident assessment forms and the collection and collation of data
3. Identifying those areas pertaining to assessment that would benefit from faculty development
4. Providing a resource for reviewing and improving the process of resident assessment
5. Maintaining an effective liaison with other specialty placements to communicate about objectives and resident assessment
6. Participating in the process of identifying residents who are having problems in the training program
7. Furnishing feedback to preceptors about the quality of their assessments of the residents assigned to them. These responsibilities could be shared among a number of individuals, including a program committee for resident assessment

## Faculty Advisor

Each resident **must** have a faculty advisor. In many cases the role of preceptor is merged with that of advisor, but all residents should have the option of having an advisor who is not directly responsible for assessing that resident.

The role of the faculty advisor is to:

1. Orient the resident to the discipline of family medicine
2. Discuss with the resident the program objectives and the resident's own learning objectives, and design an appropriate educational plan
3. Review this plan regularly and assist the resident in finding the resources within the program necessary to meet his or her unique learning needs
4. Help the resident:
  - a) Reflect on program choices to be made
  - b) Understand assessment feedback
  - c) Set and revise learning objectives
  - d) Define career plans

## STANDARD B.2: GOALS AND OBJECTIVES

The goals of the residency program and the competencies to be acquired by residents **must** be clearly worded.

1. Clearly defined competency-based curriculum outcomes that reflect the six essential skill dimensions of competence and the CanMEDS–Family Medicine (CanMEDS-FM) roles **must** be in place and **must** be consistent with the CFPC [Triple C Curriculum](#).
2. The specific educational outcomes and competencies that are to be achieved in each educational experience **must** be defined.
3. All residents **must** receive a copy of the curriculum goals and the desired learner competency outcomes upon beginning the program. All faculty in the program **must** also receive a copy.
4. The statement of goals and competency outcomes **must** be reviewed at least every 2 years by the postgraduate program director and the residency program committee to determine the continued appropriateness of the goals and to ensure they are reflected in the organization of the program and the assessment of the residents.

## STANDARD B.3: THE LEARNING ENVIRONMENT

There **must** be an organized program of educational experiences, both mandatory and elective, designed to provide each resident with the opportunity to fulfill the educational requirements and achieve the competencies defined by the program.

1. The program **must** be organized such that residents are given increasing professional responsibility, under appropriate supervision and according to their level of training, ability/competence, and experience.
2. Service responsibilities, including educational experiences provided by other clinical services or departments, **must** be assigned in a manner that ensures residents are able to attain their educational objectives, recognizing that many objectives can be met only by the direct provision of patient care. Service demands **must** not interfere with the ability of the residents to follow the academic program.
3. The program **must** provide an equivalent opportunity for each resident to take advantage of those elements of the program best suited to meeting his or her educational needs.
4. The program should provide an adequate opportunity for residents to pursue elective educational experiences.
5. The program **must** provide a learning environment that is safe and supportive of its residents. Faculty–resident interaction and communication **must** occur in an open and collegial atmosphere, such that the tenets of acceptable professional behaviour and the assurance of dignity in the learning environment are maintained at all times.
6. Discussion about the strengths and weaknesses of a program **must** occur freely and in a manner that is without repercussions to residents. An accessible and non-threatening mechanism **must** be in place to ensure that allegations of unprofessional behaviour hindering the learning environment can be investigated impartially. Program directors, faculty, other teachers, and residents **must** be educated about appropriate behaviour in the learning environment and, specifically, against intimidation and other abusive behaviour.

## STANDARD B.4: RESOURCES

There **must** be sufficient resources, including teaching faculty, the number and variety of patients, physical and technical resources, and the supporting facilities and services necessary, to provide the opportunity for all residents in the program to achieve the defined competencies.

### Clinical Teaching Sites

1. The overall educational experience **must** provide an adequate patient volume and variety to allow residents an opportunity to experience all aspects of family practice, including intrapartum care. Teaching practices **must** allow a resident to acquire the identity of a family physician. There **must** be an opportunity for continuity of care to allow residents to observe the natural progression of disease, as well as a requirement that residents be available to and responsible for a group of patients over time. The practice **must** be organized in such a manner that residents can build and maintain a defined panel of patients. Resident responsibility should be such that patients recognize the resident as one of their personal physicians and that residents are directly responsible for the delivery of care to those patients with whom they are identified.
2. Clinical services and other resources used for teaching **must** be organized to achieve the desired competencies.
  - a) Teaching staff **must** exercise the double responsibility of providing high-quality, ethical patient care and excellent teaching. Staff members who fail to meet these obligations, as judged by the internal evaluation procedures of the faculty, should be relieved of teaching duties.
  - b) Learning experiences that demonstrate how practices respond to population health needs **must** be offered.
  - c) There **must** be an experience-based learning process that provides training in collaboration with other physicians, particularly in the referral/consultation process and shared models of care.



- d) A portion of each resident's training should take place in sites involving practitioners from other health professions to facilitate acquisition of the competencies necessary for good interprofessional collaboration.
3. There **must** be ready access to a university-level collection of medical texts, journals, and point-of-care resources, as well as access to instruction in the use of these resources. There **must** be appropriate access to and instruction in hardware and software for information management. Residents **must** also learn to function in clinical settings where such resources are not routinely available. The required skills include resource selection and mechanisms for access (eg, technology versus books) at the point of care to support the delivery of high-quality patient care.

### **Faculty**

4. All family physician teachers who have a major responsibility in the teaching and assessment of residents **must** hold Certification in Family Medicine (CCFP) or hold a specialist certificate in family medicine from the CMQ, and hold academic appointments in the university's department of family medicine.

This does not preclude the appointment of family physicians with other or equivalent qualifications. However, any family physician teacher who has an important responsibility in the teaching and assessment of residents who is appointed to a university department of family medicine but who does not hold certification in family medicine with the CFPC should seek certification within 4 years of appointment.

### **Faculty Evaluation**

5. Programs **must** have in place a formal and fair mechanism to evaluate faculty that **must** follow defined and published criteria. This process **must** have in place a mechanism for obtaining resident comments and other objective criteria related to such areas as teaching, clinical work, and scholarly activity. Faculty evaluation should not be conducted solely for promotion or disciplinary purposes; rather, it should be done regularly and in a formative manner, and should encourage the faculty member to perform self-evaluations and set objectives for his or her own development.

## Faculty Development

6. a) Faculty should be knowledgeable about the principles and theories of teaching and learning, and other appropriate educational theory and techniques. This **must** be ensured through an effective program of faculty development.
- b) Program directors, faculty, other teachers, and residents should be educated about appropriate behaviour in the learning environment and about intimidation and other abusive behaviour.
- c) Each department of family medicine **must** plan and implement faculty development activities for its teachers.
  - (i) Faculty development should be appropriate to the departmental context. That is, faculty development activities should be planned according to the department's mission, goals, and objectives.
  - (ii) Available resources in the larger university setting should also be considered in program planning.
  - (iii) Faculty development should be faculty centred. Faculty development should be based on the needs of individual full-time and part-time teachers, and should encourage a commitment to their self-directed and lifelong learning.
  - (iv) Faculty development programming should include a variety of content areas, teaching methods, and activities to meet diverse departmental needs, and should be evaluated on an ongoing basis.
  - (v) Faculty development should be actively supported and promoted. Each department should allocate human and financial resources to faculty development programming to ensure its success. Moreover, each department should develop an appropriate administrative structure to oversee the development and implementation of faculty development programming, and should collaborate with key players in the university and other professional organizations to ensure that appropriate faculty development opportunities are available.

## Scholarly Activity

7. A satisfactory level of research and scholarly activity **must** be maintained among the departmental faculty identified with the program, as evidenced by the following:
  - a) Peer-reviewed research funding
  - b) Publication of original research in peer-reviewed journals and/or publication of review articles, etc.
  - c) Involvement by faculty and residents in current research projects
  - d) Recognized innovation in medical education, clinical care, or medical administration

## STANDARD B.5: CLINICAL, ACADEMIC, AND SCHOLARLY CONTENT OF THE PROGRAM

The goal of the residency program is to develop family physicians who are competent to begin the independent practice of comprehensive family medicine anywhere in Canada. Residency education **must** provide both the clinical and academic/scholarly content to enable learners to achieve this level of competence. The CFPC has provided resources to assist programs in designing curricula that reflect a competency-based approach to family medicine education. The following documents provide programs with a guide to the competencies that **must** be acquired, and with the clinical and academic experiences that enable residents to acquire them:

1. [The CanMEDS-FM competency framework](#)
2. [Defining competence for the purposes of certification by the College of Family Physicians of Canada: The evaluation objectives in family medicine](#)
3. [The Scope of Training for Family Medicine Residency](#)
4. [The Triple C Competency-based Curriculum](#)

### The Clinical Context for Learning

Family medicine residency training programs **must** model comprehensive care that is centred in family medicine and **must** train residents to this standard. The focus **must** be on comprehensive family practice, with the provision of continuing care to an identified group of patients.

Continuity is an important principle in family medicine education: continuity of patient and family care, continuity in the educational environment, and continuity of instruction and teachers.

The curriculum should be flexible to allow residents to develop the special skills they will need to practice in widely varied settings. As previously noted, training should occur primarily in family practice settings and be taught and supervised by family medicine faculty. Other medical specialty services offer unique clinical resources that can be used to facilitate and enhance the family practice experience. Such experiences need not be provided as blocks of time but can and should be integrated as much as possible into the family medicine context of learning. These experiences should reflect the clinical domains that describe the comprehensive nature of family medicine and include work in ambulatory and inpatient services or day hospitals, emergency services, community

services or seminars with marginalized populations, and scholarly work. If residents are not taught by family medicine faculty, they should be placed in a clinical context in which the preceptors understand and respect the role and educational needs of family medicine learners. The family medicine residency program **must** plan and approve these experiences in consultation with the other specialty departments involved.

Family medicine residency training **must** occur in clinical settings that enable residents to learn the competencies required. The experiences arising from time immersed in family practice settings are vital to the development of a resident's overall competence and identity as a family physician. Family practice settings **must** provide residents with the opportunity to experience both the roles of the family physician and the scope of family practice. Residents **must** be able to establish a small practice of their own for which they would assume major responsibility for integrating the full care of those patients with whom they have continuing relationships. Family practice experiences should be organized to reflect appropriate patterns of practice, and residents **must** work together with and be supervised by effective family physician role models. It is expected that residents will be engaged in core family medicine clinical experiences throughout their training program.

While the curriculum **must** always provide for a sufficient continuity of learning context and continuity of preceptors, sufficient exposure to different contexts of practice that reflect different population health needs **must** also be provided.

Just as practising family physicians work largely in office settings, so residents **must** be based primarily in family practice office settings. Residents **must** provide clinical care across different settings: hospital, long-term care facilities, and home care settings, as well as in the office. Residents **must** provide care to patients at every stage of life, from birth to death. This includes care of children and adults, men and women, the elderly, and palliation and end-of-life care. A sufficient clinical experience in a rural practice setting **must** be provided to all residents to ensure that the competencies and experience necessary to serving the needs of rural communities are acquired.

To learn the comprehensive nature of family medicine, family practice-based patient care activities **must** comprise the majority of the resident's clinical experience. Ideally, a resident's family practice experience would make up more than half of a resident's clinical experience each week, with the exception of off-service experiences that might require more intensive exposure to meet defined competencies. In addition to actual office-based patient contacts, this practice-centred experience

can include weekend clinics or rounds, hospital visits to patients admitted through the practice, and other patient care activities directly related to the patients of the practice. Residents **must** maintain continuing responsibility for their patients in various settings—such as hospital, home, and long-term care institutions. Residents **must** be involved in providing after-hours care as part of their patient care responsibilities during their core family practice experiences. Residents **must** learn to communicate verbally and in writing with other health care professionals, including other specialists, about their patients, and **must** learn how to follow up on their referrals.

The overall practice-based experience should provide a reasonable balance of acute and chronic care, ambulatory care, and hospital care. It should also provide a breadth of involvement with patients from all age groups and in a sufficient variety of clinical domains, including obstetrical patients.

There **must** be a progression of responsibility and activities as a resident advances through the program, ultimately approaching the level of function expected of a practicing family physician. Therefore, within the context of learning defined above, residents **must** have appropriate exposure to the following domains of care:

#### Emergency care

Residents **must** be exposed to acute care settings and be provided with an opportunity to learn the skills required for emergency diagnosis and care.

#### Care of children and adolescents

Residents **must** have exposure to a volume of pediatric patients that will allow them to study children's normal growth and development and to learn the diagnosis and management of common pediatric and adolescent problems that present in the family practice setting. Training in neonatal resuscitation **must** be provided.

#### Maternity care (antepartum, intrapartum, postpartum)

The resident **must** gain confidence and competence in maternity care by following pregnant patients and conducting deliveries with family physician role models. Competencies include the common procedures during labour and delivery that permit the resident to complete low-risk deliveries independently. Residents **must** be competent in managing obstetrical emergencies.

### Care of the elderly

Residents **must** be able to provide comprehensive care for the elderly. They **must** also be familiar with the atypical presentation of illness in this unique population and with the management of common geriatric and psychogeriatric problems—both physical and psychological—in hospital, institution, and community settings such as the patient’s home.

### Care of Aboriginal populations

Residents **must** develop the skills to work with and provide appropriate care for Aboriginal populations.

### Palliative medicine (end-of-life care)

Residents **must** gain the competencies to provide care for patients and their families in the home and in institutions at the end of life. Residents should acquire competencies in collaborative models that assist with patient management.

### Care of marginalized or disadvantaged or underserved populations

Residents **must** develop the skills to work with and provide appropriate care for a variety of marginalized or disadvantaged populations (ie, inner-city, the poor, the homeless, recent immigrants, etc.).

### Behavioural medicine (mental health care)

Residents **must** be involved in the delivery of collaborative mental health care. Programs **must** provide appropriate experiences for residents in crisis management dealing with acute psychiatric illness, and the management of patients and families with behavioural and emotional difficulties.

## **The Academic Program**

There **must** be a well-organized and comprehensive academic program that complements the clinical learning activities of the residents. It should engage residents in the delivery of the content to enhance their teaching and learning skills, including the development of skills as autonomous

learners. It **must** make use of a variety of teaching methods and take into account the range of learning styles among the resident group.

The academic program **must** be coordinated through the residency program committee and be delivered in a consistent manner to all residents at all sites.

While acknowledging that different sites will have different resources to support the program, an effort **must** be made to ensure the governing goals of the program are addressed in all sites and are adapted to the clinical and teaching resources available at each site.

### **Scholarly Activity**

The academic program **must** include organized activities that stimulate and reinforce relevant enquiry (eg, journal clubs, seminars, or didactic sessions.) Key concepts in biostatistics, critical appraisal, and biomedical ethics **must** be taught, and their application to practice **must** be promoted. This academic program should be designed to supplement and enhance the experiential learning offered to residents in both their family practice and other clinically based or educational experiences.

The quality of scholarship in the program should, in part, be demonstrated by a spirit of enquiry during clinical discussions, experiences outside of family medicine, and conferences. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states, and the application of current knowledge to practice.

The demands of clinical learning **must** not interfere significantly with residents' ability to participate in the academic program. Attendance at key academic activities **must** be assured by freeing residents from other duties.

There **must** be easy access to biomedical information resources in print or electronic form, including textbooks, journals, and indexes, at the level of a university or major hospital library collection. There **must** be easy access to core biomedical information resources during evenings and weekends.

Residents **must** be given opportunities to develop effective teaching skills through organized activities focused on teaching techniques. Residents should have opportunities to teach and to become role models to junior residents and medical students.



A satisfactory level of scholarly activity **must** be maintained within the program by activities such as:

1. A funded research program
2. Publications, including articles in peer-reviewed journals, books, and curriculum materials, etc.
3. Residents' involvement in research projects
4. Participation in relevant committees, including research committees, research ethics boards, etc.
5. A faculty member whose responsibility it is to facilitate residents' involvement in research and other scholarly activity, such as resident projects

## STANDARD B.6: ASSESSMENT OF RESIDENT PERFORMANCE

There **must** be an effective in-training assessment program in place that helps the resident, the preceptors, and the program plan, and that monitors the progress of individual residents throughout their training toward the achievement of the competence expected for the start of independent practice. This competence is defined as demonstrating competence in the six essential skill dimensions and the phases of the clinical encounter, throughout the seven CanMEDS-FM roles, over a sufficient sample of the priority topics, themes, core procedures, and competencies, as defined by the evaluation objectives and CanMEDS-FM.

### General Considerations

1. The in-training assessment system **must** be competency-based and mainly formative in nature, with honest, helpful, and timely feedback provided to each resident. It should not be punitive. Emphasis should be placed on gradually achieving mastery in the required competencies. Assessment and feedback **must** lead to guided self-assessment, reflection, and revision of learning plans as necessary.
2. Assessment and feedback **must** not be limited to the end of an activity or a clinical experience. They **must** occur frequently, at least by the middle of a placement, in time for behaviour change to occur, and, ideally, on a daily basis or immediately after an activity, whenever pertinent. Periodic reviews and summative assessments based on all the documented assessments available at the time **must** be completed. These **must** include face-to-face meetings with the resident to review and discuss their progress, both regularly and when a specific need arises.
3. Assessment and feedback **must** be documented and reflect resident performance with respect to the competencies in question. Although both qualitative and quantitative data should be documented, the emphasis should be on the former.
4. All pertinent activities, both clinical and non-clinical, should be assessed, and the assessment should be specific to the activities, clearly reflecting the competency objectives of family medicine. The level of performance expected for each activity should be clearly defined and clearly understood by both the resident and the preceptor-assessor. The methods to be used for assessment **must** also be clearly defined and mutually understood.

5. Assessment processes are more effective when based on individual resident learning plans or contracts. Programs should develop and regularly review a written plan with each resident that addresses both the educational objectives of the training program and the specific learning needs and goals of each resident.
6. The assessment system should permit very early identification (ie, well before any summative assessment) or self-identification of residents who are not progressing as expected. Their training, supervision, and assessment should be modified appropriately and they should be considered separately until the difficulties are resolved.
7. Residents **must** be informed when serious concerns exist and **must** be given an opportunity to correct their performance.

### **Specific Considerations**

1. Assessment **must** place emphasis on situations and patients with problems that correspond to the range and variety of family medicine practice. It **must** also concentrate on the competencies most important to family medicine as described by the Evaluation Objectives and CanMEDS-FM.
2. Methods of assessment and documentation:
  - a) The principal instrument for assessment should be the preceptor-resident unit. This unit should assess a single patient interaction or other clinical or para-clinical situation and document the assessment appropriately. Direct observation is a fundamental tool; however, case discussion and record review are also important for clinical assessments. Assessment of non-clinical activities is important and requires other methods of documentation.
  - b) Other performance assessments of various kinds should also be used where appropriate, and **must** be added for residents deemed to be “not progressing as expected.”
  - c) Field notes and daily assessments:
    - (i) Programs should use field notes (or equivalent) to gather qualitative comments on resident performance during daily clinical practice and should integrate them into their regular teaching and supervision. They should generate a sufficient number of field notes to provide and document meaningful, formative assessment and feedback.

- (ii) Comments on clinical supervision or other activities should be case specific; focus on the one, most significant aspect of the case; lead to reflection and feedback; and provide recommendations for future similar cases (change or no change). This “daily” feedback should not make final judgments on overall competence, readiness to practise, or readiness to progress; rather, it is meant to contribute on a more micro level to summative assessments.
- (iii) Field notes can be compiled in a portfolio to be added to all other pertinent information for consideration when completing periodic summative assessments.

### **Summative Reports and Decisions on Progress**

1. Summative reports and decisions on progress **must** be completed on a regular, predetermined basis. They **must** be based on multiple independently documented observations from several observers in different situations, and be compiled and judged by more than one clinical faculty.
2. Periodic summative reports, including the final one to the College, should reflect the current level of competence achieved by the resident and should not reflect past difficulties that have been dealt with satisfactorily.

### **Confirmation of Completion of Training**

The program will be asked to attest to the College that:

“The resident has demonstrated competence in the six essential skill dimensions and the phases of the clinical encounter, throughout the seven CanMEDS-FM roles, over a sufficient sample of the priority topics, themes, core procedures, and competencies, as defined by the evaluation objectives and CanMEDS-FM and we therefore judge the resident competent to start the independent practice of family medicine.”

**SPECIFIC STANDARDS FOR FAMILY MEDICINE ENHANCED SKILLS RESIDENCY PROGRAMS ACCREDITED BY THE CFPC**

The standards outlined in this document have been aligned with the *General Standards Applicable to All Residency Programs – B Standards* and are the specific standards for family medicine enhanced skills residency programs accredited by the CFPC.

For clarity and simplicity, in all official accreditation documents the Accreditation Committee has decided to use set terms and acronyms to distinguish names of roles or committees.

Family Medicine Program Director	FMPD
Enhanced Skills Program Director	ESPD
<u>Category 1 Program Directors</u>	
FM/Emergency Medicine Program Director	EM-PD
Care of the Elderly Program Director	CoE-PD
Family Practice-Anesthesia Program Director	FPA-PD
Palliative Care Program Director	PC-PD
Clinician Scholar Program Director	CS-PD
Sport and Exercise Medicine Program Director	SEM-PD
Family Medicine Residency Program Committee	RPC
Enhanced Skills Residency Program Committee	ES-RPC
FM/Emergency Medicine Residency Program Committee	EM-RPC
Care of the Elderly Residency Program Committee	CoE-RPC
Family Practice–Anesthesia Residency Program Committee	FPA-RPC
Palliative Care Residency Program Committee	PC-RPC
Sport and Exercise Medicine Residency Program Committee	SEM-RPC
Clinician Scholar Program Residency Program Committee	CSP-RPC

## SPECIFIC STANDARDS FOR FAMILY MEDICINE ENHANCED SKILLS RESIDENCY PROGRAMS ACCREDITED BY THE CFPC

The following specific standards for family medicine enhanced skills programs are complementary to and consistent with the core family medicine standards and will clarify or expand on the B Standards as they relate to the education of family physicians in enhanced skills.

### Introduction

The normal scope of practice of family medicine involves providing care at the enhanced skill level in many domains of care. Many family physicians acquire these enhanced skills during practice, in response to the needs of their patients and their communities. The College of Family Physicians of Canada accredits a variety of postgraduate training programs that permit physicians, either immediately following core family medicine training or as a return from practice, to acquire defined sets of added competencies in a concentrated fashion. These programs clearly lead to the acquisition of the added competencies that permit the successful candidate to practise at the enhanced skill level in a domain of care, but the intent is that they do this as family physicians, within the context of family medicine.

The [Four Principles of Family Medicine](#) remain an essential guide to the training and practice of all family physicians, including those whose practices have evolved to the enhanced skill level:

1. Family physicians with enhanced skills are skilled clinicians who use a generalist approach, providing and planning care while taking into account all of the patient's needs.
2. Family physicians with enhanced skills are based in communities where they are able to respond directly to the patients' needs and to community needs, and where they can adapt to changing circumstances. They are able to navigate in both primary and secondary care—an important attribute in our health care system—and it is not uncommon for them to be involved in providing tertiary care where needed.
3. Family physicians with enhanced skills are a resource to defined practice populations. For example, patients who are seen in the emergency department or long-term care facilities are defined practice populations.
4. The physician–patient relationship is central to the role of a family physician with enhanced skills. A trusting and actively developed physician–patient relationship is just as important in episodic/short-term care as it is in a long-term relationship.

Enhanced skills training in family medicine prepares family physicians to provide care in a particular domain for all patients, from the straightforward to the most complex. They are prepared to provide this care in any setting in Canada and internationally, from the local community level to regional institutions and academic/teaching settings. The family physician with enhanced skills may provide care in their domain on a full-time practice basis or on a part-time basis integrated with other family medicine activities. These family physicians will also add to their skills on a continuing basis according to community needs, and may go on to assume leadership roles in education, research, and administration.

Along with the clinically based Category 1 enhanced skills programs, the CFPC also accredits the Clinician Scholar Program. The major goal of the Clinician Scholar Program is to assist in the career development of family physician clinician scholars in Canada. The program was created to provide a formal postgraduate medical education pathway that fulfills the existing requirements of the CFPC for residency training in family medicine and provide integrated, structured, and rigorous research/scholarly training. Individuals who complete the program should have acquired a solid grounding as a clinician scholar and/or researcher. For the purpose of this program, scholarly work includes not only the traditional areas of clinical research, but also should be inclusive of scholars interested in advancing their skills among the full range of scholarship, as defined by the four elements of Ernest Boyer's model of scholarship\* (the scholarship of discovery, integration, application, and teaching).

### **Length of Training**

Training in the various enhanced skills programs can last for anything from a few months to one year, with the exception of the Clinician Scholar Program.

There are two possible pathways for Clinician Scholar Program training:

1. One to 2 years of additional training following completion of residency training in family medicine, either at the end of residency or with re-entry from practice
- OR
2. An integrated 3-year program, at the conclusion of which the resident will be eligible for certification in family medicine and an attestation of completion of training as a clinician scholar

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\* Boyer EL. *Scholarship Reconsidered: Priorities of the Professoriate*. Princeton, NJ: Carnegie Foundation for the Advancement of Teaching. 1990

The following standards relate to all the individual Category 1 and 2 programs as well as to the central enhanced skills program, which serves in an organizational, governance and administrative capacity, analogous to the central family medicine program in relation to its individual sites.

Please note that there may be cases where the standards around the clinical aspects of a program do not fully correspond to the expectations for the Clinician Scholar Program. For these standards and whenever possible, the wording has been adapted to be inclusive of the Clinician Scholar Program.

### **Current Category 1 Programs**

The currently recognized Category 1 programs (ie, those with national standards) are as follows:

- Family Medicine/Emergency Medicine
- Family Medicine/Care of the Elderly
- Family Practice–Anesthesia
- Family Medicine Clinician Scholar
- Family Medicine/Sport and Exercise Medicine
- Family Medicine/Palliative Care

Examples of Category 2 programs may include (but are not limited to) the following:

- Maternity Care
- Global Health
- Women’s Health
- Addictions Medicine



## STANDARD B.1: ADMINISTRATIVE STRUCTURE AND SUPPORTS

### Central Enhanced Skills Administrative Structure

Enhanced skills residency programs **must** be based in an academic department of family medicine within a university faculty or school of medicine. There **must** be an administrative structure that enables the central enhanced skills program to govern all the individual Category 1 and 2 enhanced skills programs.

The enhanced skills program director **must** report to the family medicine program director and **must** sit on the family medicine residency program committee. He/she **must** hold certification in family medicine and **must** be in good standing with the CFPC (or with the CMQ if in Quebec). The enhanced skills program director **must** be responsible for all Category 1 and 2 programs. The enhanced skills program director **must** have sufficient time and support to supervise and administer the program.

The enhanced skills residency program committee **must** be chaired by the enhanced skills program director. The membership of this committee **must** include the directors of each of the Category 1 and 2 programs, an elected or appointed resident representative, and the family medicine program director.

The enhanced skills residency program committee is intended to assist the enhanced skills program director in providing a centralized and coordinated approach to the planning and organization of all enhanced skills educational activities. In addition, among other roles, the committee will be responsible for:

1. Setting a central policy around the recruitment and appointment of residents, acknowledging that individual Category 1 residency program committees may establish their own recruitment approaches
2. Monitoring of individual program evaluation and resident progress
3. Facilitating the coordination of resources
4. Ensuring adherence to policies around resident assessment and providing a resource to individual programs for evaluating, reviewing and improving the processes for resident assessment
5. Identifying aspects of enhanced skills programs that would benefit from faculty development and working with those responsible for faculty development in the planning and delivery of relevant sessions.

The committee will report to the family medicine residency program committee through the enhanced skills program director. The committee **must** meet at least four times per year to sufficiently carry out the responsibilities identified in these standards. Clear, detailed meeting minutes **must** be maintained.

### **Individual Program Administrative Structure**

Each individual Category 1 program **must** have a program director or co-program director who is appointed by the department of family medicine, in accordance with the department's appointments and promotions committee's criteria. The individual Category 1 program directors **must** fully understand and act in accordance with the educational needs of residents in family medicine enhanced skills residency training and the standards for enhanced skills programs outlined in this document. Significant efforts **should** be made to appoint a director who holds certification in family medicine, but an individual with an equivalent credential (ie, FRCP) in another discipline can be appointed. In some cases it may also be appropriate to have co-program directors, one from family medicine and the other from a Royal College program. In the case of the Clinician Scholar Program, the director or co-director may be someone with the credentials required for academic supervision at a graduate level by the university's school of graduate studies.

Category 1 and 2 program directors **must** report to the enhanced skills program director. For Category 2 programs with no designated program director, this responsibility **must** automatically fall to the enhanced skills program director.

Each Category 1 program **must** have a clearly defined residency program committee (or academic Clinician Scholar Program committee) with terms of reference, even though some enhanced skills programs might rely heavily on other clinical/academic departments for resources and faculty. There is no mandatory requirement for Category 2 programs to have an individual residency program committee but they may choose to do so if this is felt to be helpful to the program and program director.

The membership of each Category 1 enhanced skills residency or academic Clinician Scholar Program committee **must** include a resident representative member, either elected or appointed. Committee responsibilities **must** include:

1. Ensuring the program meets the general and specific standards of accreditation as set forth in this document
2. Overseeing the recruitment and selection of residents in accordance with the policy established by the central enhanced skills residency program committee
3. Ensuring provision of clinical and academic learning opportunities for residents

4. Adhering to relevant postgraduate medical education, university graduate school, and department of family medicine policies
5. Ongoing review and evaluation of the program
6. Monitoring/overseeing the assessment of resident progress (see Standard B6)

Each Category 1 residency or academic Clinician Scholar Program committee **must** meet regularly at a frequency—a minimum of three times per year—that allows it to meet its responsibilities and maintain clear, detailed meeting minutes to provide oversight for the program. The committee will report to the enhanced skills residency program committee through the Category 1 program director.

## **Program Evaluation**

### Central enhanced skills program evaluation

The academic department **must** maintain an ongoing cyclical review of the enhanced skills residency training programs to evaluate the quality of the educational experience and to review the resources available in order to ensure that maximal benefit is being derived from the integration of the components of the program. This will include, but is not limited to, the internal review conducted by the postgraduate dean's office. A designated committee (RPC/ES-RPC or other) **must** be responsible for the planning and monitoring of this process, and should document related outcomes. The opinions of the residents **must** be among the factors considered in this review.

### Individual enhanced skills program evaluation

An important aspect of a successful competency-based educational program is the program's commitment and ability to monitor itself for quality, particularly with respect to the learners' educational outcomes, and to make the necessary curricular modifications that will result in continuous improvement. Individual enhanced skills program reviews **must** be carried out regularly and are to be conducted in a manner that respects confidentiality of residents and faculty. Appropriate faculty/resident interaction and communication **must** take place in an open and collegial atmosphere so that a free discussion of the strengths and weaknesses of the program can occur without hindrance. The review process **must** include the following:

1. An evaluation of each component of the program, to ensure that the educational objectives are being met with specific attention to the curriculum, the academic program, the scholarly program, and other educational experiences
2. An evaluation of resource allocation to ensure that resources—financial, human, and educational—and facilities are being utilized with optimal effectiveness
3. An evaluation of the teachers in the program with evidence that teachers receive feedback in a timely manner; in smaller programs, these evaluations may need to be blended with those

from other learners to ensure confidentiality for residents and to allow for timely feedback to teachers

4. An evaluation of the outcomes of the individual enhanced skills residency programs, which includes but should not be limited to:
  - a) Measurements of resident performance, such as performance on examinations
  - b) Resident satisfaction with the education experiences
5. An evaluation of the quality of the different learning environments
6. Demonstration that the program uses the collected review information to improve the quality of the various components of the program

When possible, feedback should be gathered from recent graduates who are able to reflect on their training, having acquired a perspective on the requirements of clinical and/or academic practice.

When Category 1 enhanced skills programs are inactive for more than 3 years, the postgraduate medical education office **must** automatically complete an internal review of the program within 6–9 months of a resident beginning and inform the College once this review has been completed. It is not necessary to send the report to the CFPC Accreditation Committee.

### **Role of the Faculty Advisor**

Each resident **must** have a faculty member who fills the following role:

1. Orients the resident to the Category 1 or 2 enhanced skill and its connection with the discipline of family medicine
2. Discusses the program objectives with the resident
3. Discusses and revises the resident's own learning objectives, and designs or provides input to the design of an appropriate educational plan
4. Reviews this plan regularly and assists the resident in finding the resources within the program necessary to meet his or her unique learning needs
5. Helps the resident:
  - a) Reflect on program choices to be made
  - b) Understand assessment feedback
6. Advises residents on career plans
7. Promotes resident wellness and well-being
8. Maintains appropriate documentation reflecting all of the above activities

If the role of preceptor or program director is merged with that of faculty advisor, the resident **must** have the option of having a second faculty advisor who is not directly responsible for making summative assessment decisions about that resident. This advisor could be from outside the

enhanced skills domain but should be from within family medicine, recognizing that for smaller programs this may not always be feasible.

## STANDARD B.2: GOALS AND OBJECTIVES

The educational objectives for added competence in each enhanced skills program **must** complement those of family medicine training. The overall goals and objectives for both Category 1 and 2 enhanced skills programs **must** be organized around the [CanMEDS-FM roles](#). In addition, specific educational outcomes and competencies that are to be achieved in each educational experience must also be defined and organized under CanMEDS-FM.

The domain-specific competencies for Category 1 programs and the generic family medicine enhanced skills competencies, which apply to both Category 1 and Category 2 programs, must be included in the overall program goals and objectives and in specific learning-experience objectives, where appropriate. These competencies should be included separately and mapped to CanMEDS-FM or listed under the most appropriate CanMEDS-FM role(s). The curriculum must be purposefully designed to ensure residents are provided sufficient opportunity to meet all program goals and objectives, including all relevant domain-specific and family medicine enhanced skills competencies.

The statement of goals and competency outcomes **must** be reviewed periodically (ie, at least every 2 years) by each Category 1 residency program committee. The results of this review must be reported to the enhanced skills residency program committee and through the enhanced skills program director to the family medicine residency program committee as part of regular reporting. This is to ensure the goals and competencies of each Category 1 enhanced skills program remain appropriate and are reflected in the organization of the program and the assessment of residents.

For Category 2 programs, a statement of goals and competency outcomes **must** be reviewed and approved by the Category 2 program director or enhanced skills program director on a cycle relevant to the size and nature of the program. The Category 2 program director/enhanced skills program director **must** report this approval to the enhanced skills residency program committee. It is the responsibility of the enhanced skills program director to ensure this review occurs.

All enhanced skills residents **must** receive a copy of (or have electronic access to) the curriculum goals and the desired competency outcomes on beginning the program. All faculty in the program **must** also receive (or have electronic access to) a copy.

## STANDARD B.3: LEARNING ENVIRONMENT

There **must** be an organized program of educational experiences, both mandatory and elective, designed to provide each resident with the opportunity to fulfill the educational requirements and achieve the competencies defined by the program.

The program **must** be organized such that residents are given the appropriate balance of autonomy and supervision according to their level of training, ability/competence, and experience.

Service responsibilities, including educational experiences provided by other clinical services or departments, **must** be assigned in a manner that ensures residents are able to attain their educational objectives, recognizing that many objectives can be met only by the direct provision of patient care. Service demands **must not** interfere with the ability of the residents to follow the academic program.

The program **must** provide an equal opportunity for each resident to take advantage of those elements of the program best suited to meeting his or her educational needs, including elective educational experiences.

The program **must** provide a learning environment that is safe and supportive of its residents. Faculty–resident interaction and communication **must** occur in an open and collegial atmosphere, such that the tenets of acceptable professional behaviour and the assurance of dignity in the learning environment are maintained at all times.

Discussion about the strengths and weaknesses of a program **must** occur freely and in a manner that is without repercussions to residents.

An accessible and non-threatening mechanism **must** be in place to ensure that allegations of unprofessional behaviour hindering the learning environment can be investigated impartially. Program directors, faculty, other teachers, and residents **must** be educated about appropriate behaviour in the learning environment and, specifically, against intimidation and other abusive behaviour.

## STANDARD B.4: RESOURCES

There **must** be sufficient resources to provide the opportunity for all residents in the program to achieve the defined competencies, including:

1. A sufficient number of teaching faculty
2. A sufficient number and variety of educational experiences
3. Physical and technical resources
4. Supporting facilities and services

### Clinical or Academic Teaching Environment

There **must** be an adequate volume and variety of educational experiences to acquire the required competencies.

The enhanced skills teaching environments **must** allow residents to maintain their identity as a family physician.

There **must** be continuity of education in the clinical environment of the enhanced skills based on the principles laid out in Triple C Part 1 pages 23–24: [www.cfpc.ca/uploadedFiles/Education/PDFs/WGCR\\_TripleC\\_Report\\_English\\_Final\\_18\\_Mar11.pdf](http://www.cfpc.ca/uploadedFiles/Education/PDFs/WGCR_TripleC_Report_English_Final_18_Mar11.pdf)

Clinical services and other resources used for teaching **must** be organized to maximize the opportunities for the resident to achieve the required competencies.

In clinical settings, teaching staff **must** exercise the double responsibility of providing high-quality, ethical patient care and excellent teaching and supervision.

There **must** be an experience-based learning process that allows for clinical training in a collaborative manner.

There **must** be ready-access to and instruction in current information technology relevant to the specific enhanced skills field.

There **must** be easy access to and instruction in current biomedical information resources in print or electronic form, including textbooks, journals, point-of-care resources, and indexes, at the level of a university or major hospital library collection.



There **must** be access to and instruction in the use and management of these resources when needed.

There **must** be easy access to core biomedical information resources during evenings and weekends.

## **Faculty**

Family medicine faculty who have a major responsibility in the teaching and assessment of residents **must** hold Certification in Family Medicine (CCFP) and hold an appointment in a university's department of family medicine (or equivalent in an accredited University).

Faculty from other disciplines **must** understand and respect the role and the educational needs of family medicine enhanced skills learners.

For Clinician Scholar Program faculty, each resident **must** have a designated supervisor who is an independent scholar and who fulfills the requirements of the Clinician Scholar Program residency program committee and, where appropriate, the graduate school of the university. The supervisors for residents enrolled in graduate programs **must** be approved by the faculty of graduate studies. Clinician Scholar Program supervisors **must** have established scholarly productivity (manuscripts, abstracts, presentations), an international/national reputation in the field, and experience in supervising graduate students.

## **Faculty Evaluation**

Programs **must** have in place a formal and fair mechanism to evaluate faculty that **must** follow defined and published criteria aligned with the policies of the institution. This process **must** include a mechanism for obtaining resident comments and other objective criteria related to such areas as teaching, clinical work, and scholarly activity. Faculty who provide regular teaching and clinical supervision should receive regular feedback about their performance at a frequency that protects the anonymity of the residents. Faculty evaluation should not be conducted solely for promotion or disciplinary purposes; rather, it should be done regularly and in a formative manner, and should encourage the faculty member to perform self- and peer evaluations and set objectives and plans around his or her own personal development.

## **Faculty Development**

There **must** be an effective program of faculty development offered by the university, the department of family medicine and/or enhanced skills programs. The department of family medicine, while not being solely responsible for the delivery of such a program, **must** ensure that the faculty development needs of all the family medicine enhanced skills teachers—both those from

family medicine and from other disciplines—are being met. The delivery of such faculty development activities will occur at multiple levels for most departments. Faculty development activities **must** be planned according to the department’s mission, goals, and objectives. Faculty development **must** be actively supported and promoted at the level of the enhanced skills program, department, and university.

### **Scholarly Activity**

Enhanced skills faculty **must** be provided with the opportunity to maintain activities in research and scholarly work.

## STANDARD B.5: CLINICAL, ACADEMIC, AND SCHOLARLY CONTENT OF THE PROGRAM

### Introduction

The goal of the enhanced skills residency program is to train family physicians to provide care at an advanced skill level in any particular domain as part of their practice of family medicine. The program **must** design and provide the clinical, academic, and scholarly activities that help all trainees achieve the necessary competencies, as defined for the Category 1 programs by: (i) the domain-specific competencies, (ii) the generic family medicine enhanced skills competencies, and (iii) any program-specific competencies (see Appendix 1); and for the Category 2 programs by (i) the generic family medicine enhanced skills competencies and (ii) program-specific competencies. See also Appendix 6 for the Clinician Scholar Program.

### Clinical Content for Category 1 Programs

The choice and sequence of core and elective learning activities should optimize trainees' experiences in the progressive achievement of the required competencies. They should be adjusted as a function of particular learning needs that may be identified during the training.

### Academic Content for Category 1 Programs

There **must** be a well-organized and comprehensive academic program that complements residents' core learning activities. The academic program should engage residents in the delivery of the content to enhance their teaching and learning skills, including the further development of their skills as autonomous, lifelong learners. The academic program **must** make use of a variety of teaching methods and take into account the range of learning styles among the resident group.

The academic program **must** be coordinated through the relevant Category 1 enhanced skills residency or Clinician Scholar Program committee and be delivered in a consistent manner to all residents in that program.

The demands of clinical learning **must** not interfere with a resident's ability to participate in the academic program. Attendance at academic activities **must** be ensured by freeing residents from other duties.

For the Clinician Scholar Program, the curriculum for the program will be driven in large part by resident interest, learning needs, and career objectives. Opportunities for scholarly study can and should include a range of research or professional interests, such as clinical research, bioethics, and

educational research and theory, and will need the support of appropriate preceptors in each area. The clinical, academic, and scholarly content of the program must meet the level of advanced graduate studies. The quality of scholarship will be demonstrated, in part, by the high level of scientific productivity of the supervisors, mentors, and research groups assigned to participate in the Clinician Scholar Program. There must be a clearly worded statement outlining the goals of each Clinician Scholar Program and the educational objectives of the residents.

The Clinician Scholar Program **must** provide an opportunity to integrate scholarship and clinical care such that clinician scholars are able to maintain their family medicine competencies.

#### **Academic Content for Category 2 Programs**

Where relevant, there **must** be a well-organized and comprehensive academic program that complements residents' core learning activities.

#### **Scholarly Content for Clinical Category 1 Programs**

The choice and sequence of scholarly activities should optimize trainees' experiences in the progressive achievement of the required competencies.

## STANDARD B.6: ASSESSMENT OF RESIDENT PERFORMANCE

### Assessment Program

There **must** be an effective in-training assessment program in place that helps the resident, the preceptors, and the individual program's residency program committee—or, where there is no residency program committee, the central enhanced skills residency program committee—plan and monitor the progress of individual residents throughout their training toward the achievement of the added competencies in family medicine that have been identified as enhanced skills for each domain of care.

Assessment **must** concentrate on the domain-specific, family medicine enhanced skills—generic, and program-specific competencies for each program:

1. **Domain-specific competencies** (for Category 1 programs)  
Priority topics and their key features in a domain of care are national standards that are available for all Category 1 enhanced skills programs. (Key features will be available by the end of 2016.) The competencies related to the priority topics for the Category 1 clinical programs can be found in the appendices at the end of this document.
2. **Family medicine enhanced skills competencies** (for all enhanced skills programs)  
Nationally agreed upon generic competencies required for all family medicine enhanced skills practitioners are based on the Four Principles of Family Medicine paradigm (available by the end of 2016/early 2017).
3. **Program-specific competencies** (for Category 2 programs and may be included for Category 1 programs)
  - a) Enhanced skills training programs that do not have national standards (ie, Category 2 programs) should clearly identify the competencies to be achieved through their own program, usually based on the specific needs of a local population. In all cases, the programs should follow the general considerations for assessment as outlined for core family medicine training.
  - b) Those programs with domain-specific competencies (ie, Category 1 programs) may also identify additional program-specific competencies based on the needs of a local population, if appropriate.
  - c) Programs that define program-specific competencies have the same responsibility to offer curricula and assess achievement as they do for national standards.

For the non-clinical components of the Clinician Scholar Program, assessment should be based on the standards and requirements of the university's graduate school and may reflect Charles Glassick's six standards of excellence in scholarship,<sup>†</sup> which state that scholars whose work is published or rewarded must:

1. Have clear goals
2. Be adequately prepared
3. Use appropriate methods
4. Achieve outstanding results
5. Communicate effectively
6. Reflectively critique their work

The program **must** identify how residents are assessed for each educational experience.

For clinical experiences, assessment and feedback **must** be integrated with daily supervision, teaching, and learning, and **must** be documented using field notes or an equivalent (eg, encounter cards, daily evaluations). Information relating to assessment and feedback **must** be compiled in an appropriate fashion to record a trainee's progress toward and achievement of added competence.

Periodic reviews of resident progress, based on all available assessment information at the time, **must** be completed and discussed with the resident on a regular, predetermined basis to effectively monitor the resident's progress toward the level of competency expected upon completion of training.

There **must** be a well-articulated process for decision-making regarding a resident's progress, including completion of training. Judgments about progress and completion should be based on multiple independently documented observations from several different observers in different situations, and any such judgments **must** be made by a suitable designated group of clinical faculty (ie, not by a single faculty member).

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<sup>†</sup> Glassick CE. Boyer's expanded definitions of scholarship, the standards for assessing scholarship, and the elusiveness of the scholarship of teaching. *Acad Med.* 2000 Sep; 75(9):877-80. PMID: 10995607

Each enhanced skills program **must** also ensure:

1. The assessment process allows for the identification and support of residents who are in difficulty in a timely fashion
2. Residents are informed in a timely way of any serious concerns regarding performance
3. Residents in difficulty are provided with the remediation support and opportunity to correct their performance, including additional time and/or educational experiences, as appropriate and in line with local postgraduate medical education policies
4. Any resident requiring remediation, probation, and/or additional training experience is provided with a documented plan detailing objectives of the remediation; the learning experiences scheduled to allow the resident to achieve these objectives; the assessment methods to be employed; the potential outcomes and consequences; and the methods by which a final decision will be made around passing or failing a period of remediation or probation, in line with local postgraduate medical education policies

### **Coordination of Resident Assessment**

Each Category 1 and 2 enhanced skills program **must** identify a person who is responsible for coordinating resident assessment in their program. This role could be filled by the Category 1 or Category 2 enhanced skills program director, depending on the specific needs of the program.

This role should include responsibility for:

1. Coordinating resident assessment, including the collection and collation of data
2. Monitoring learner progress, developing assessment strategy, and determining the adequacy of assessment tools being used
3. Maintaining an effective liaison with other specialty placements to communicate about objectives and resident assessment
4. Furnishing feedback to preceptors about the quality of the assessments of the residents assigned to them
5. Participating in the process of identifying residents who are having problems in the training program

The central enhanced skills residency program committee should be responsible for:

1. Ensuring policies around resident assessment are adhered to
2. Identifying those areas pertaining to assessment that would benefit from faculty development
3. Providing a resource for evaluating, reviewing, and improving the processes for resident assessment in each of the programs

## **Confirmation of Achievement of Competency**

For those Category 1 programs leading to a Certificate of Added Competence (CAC) from the College of Family Physicians of Canada, achievement of competence **must** be documented in detail for the domain-specific competencies and the family medicine enhanced skills competencies. Evidence of this achievement **must** be maintained by a system that is accessible to the trainee and to the program at all times.

The program **must** ensure that each resident has demonstrated the satisfactory achievement of the added competencies identified as necessary for the competent provision of care at an enhanced level in the specified domain of care.

For residents completing training in Category 1 clinical programs, the Category 1 enhanced skills program director will be asked to attest to the College that:

“The resident has demonstrated achievement of the competencies required for their domain, as well as achievement of the general family medicine enhanced skills competencies, and is therefore competent to practise independently in the area of their enhanced skill.”

For residents completing the Clinician Scholar Program, the Clinician Scholar Program director will be asked to attest to the College that:

“The resident has demonstrated excellence in the priority topics specific to clinician scholarship and has acquired the knowledge, skills, and attitudes fundamental to embarking on a scholarly career in health.”



## APPENDIX 1

### **Family Practice–Anesthesia, Enhanced Skills Level: Priority Topics for the Assessment of Competence**

The family physician with enhanced skills (added competence) in Family Practice–Anesthesia should be able to deal competently with the following clinical problems/situations, and provide appropriate anesthesia when indicated. The detailed expectations for each topic are described by the key features (which will be available by the end of 2016).

#### **Specific clinical situations**

1. Airway: complex
2. Acutely ill or injured
3. Pediatric anesthesia
4. Obstetrical anesthesia
5. Operating room emergencies and complications
6. Pre-anesthetic/surgery assessment
7. Vascular access
8. Acute pain management
9. Procedural sedation
10. Spinal and epidural anesthesia
11. Regional anesthesia (provisional topic to be further defined)
12. Ventilators (and equipment)
13. General anesthesia (routine)
14. Postoperative care

#### **Competencies that are not problem specific**

15. Know and apply limits of capacity (own and those of milieu)
16. Is vigilant, decisive, methodical, and calm in difficult situations
17. Self-directed learning
18. Team (working with)

#### **Generic priorities for assessment of competence**

The most commonly identified priorities for generic competencies in Family Practice–Anesthesia (enhanced skills level) are the six Essential Skills of Family Medicine:

1. Professionalism
2. Patient-centred approach
3. Communication skills
4. Clinical reasoning skills
5. Selectivity
6. Procedure skills

## APPENDIX 2

### Health Care of the Elderly, Enhanced Skills Level: Priority Topics for the Assessment of Competence

The family physician with enhanced skills (added competence) in Care of the Elderly should be able to deal competently with the following clinical problems/situations for patients in all contexts of care, from basic through complex. The detailed expectations for each topic are described by the key features (which will be available by the end of 2016).

#### Specific clinical situations

1. Cognitive Impairment
2. Frailty continuum/spectrum
3. End-of-life care
4. Falls and mobility issues
5. Delirium
6. Depression/anxiety
7. Urinary incontinence
8. Decision making and capacity
9. Medical conditions
10. Appropriate prescribing
11. Family and informal care supports
12. Organizing care using community resources
13. Care in different settings (eg, home, outpatient, long-term, acute hospital)
14. Pain
15. Driving issues
16. Goals of care
17. Communication
18. Teams (working with)

#### Generic priorities for assessment of competence

The five most commonly identified priorities for generic competencies in Care of the Elderly (enhanced skills level) are five of the six Essential Skills of Family Medicine (exception: Procedure skills):

1. Professionalism
2. Patient-centred approach
3. Communication skills
4. Clinical reasoning skills
5. Selectivity

## APPENDIX 3

### **Sport and Exercise Medicine, Enhanced Skills Level: Priority Topics for the Assessment of Competence**

The family physician with enhanced skills (added competence) in Sport and Exercise Medicine should be able to deal competently with the following clinical problems/situations. The detailed expectations for each topic (or sub-topic) are described by the key features (which will be available by the end of 2016) for each topic and sub-topic.

#### **Specific clinical situations**

1. Arthropathy (mono- and polyarthropathy, particularly osteoarthritis)
2. Coaches/parents/teachers
3. Competitive athletes (individuals, teams; all medical issues; stopping activity)
4. Concussion
5. Competitive and recreational athletes with a disability
6. Event management
7. Exercise prescription (adapted to specific populations, for health promotion, and for prevention)
8. Medical and environmental issues related to exercise
9. Exercise: rehabilitation and return to physical activity (post-injury or illness; setting limitations)
10. Exercise: pre-participation evaluation (athletes, non-athletes)
11. Gender-specific issues
12. Injections and aspirations of joints and soft tissues
13. Nutrition/supplements/doping (performance enhancement; safety of; risk of doping infraction)
14. On-field intervention
15. Musculoskeletal conditions
16. Pediatric/adolescent athletes

#### **Competencies that are not problem specific**

17. Acting as a consultant (resource to colleagues)
18. Diagnostic and medical imaging

### **First group of priority sub-topics for musculoskeletal conditions**

1. Localized or regional musculoskeletal pain of undetermined etiology
2. Localized or regional musculoskeletal pain with a diagnosed etiology
3. Injured knee (without obvious fractures)
4. Shoulder that is painful or unstable (not an acute injury)
5. Ankle sprains
6. Hip and groin pain (non-acute, non-injury)

### **Specific locations to be aspirated or injected**

1. Joints:
  - a) Shoulder (eg, GH, AC, SA)
  - b) Knee
  - c) Ankle
  - d) A small joint (eg, MCP)
2. Spaces: Carpal tunnel
3. Soft tissues:
  - a) Bursa (eg, olecranon, calcaneal, greater trochanter, pes anserine)
  - b) Peri-tendon (eg, de Quervain)
  - c) Enthesis (eg, epicondylitis, plantar fascia)

### **Generic priorities for assessment of competence**

The most commonly identified priorities for generic competencies in Sport and Exercise Medicine (enhanced skills level) are the six Essential Skills of Family Medicine:

1. Professionalism
2. Patient-centred approach
3. Communication skills
4. Clinical reasoning skills
5. Selectivity
6. Procedure skills

## APPENDIX 4

### **Palliative Care, Enhanced Skills Level: Priority Topics for the Assessment of Competence**

The family physician with enhanced skills (added competence) in Palliative Care should be able to deal competently with the following clinical problems/situations for patients in all contexts of palliative care, from basic through complex. The detailed expectations for each topic are described by the key features (which will be available by the end of 2016).

#### **Specific clinical situations**

1. Pain
2. Families
3. Goals of care
4. (Working as a) Team
5. Nausea/vomiting/bowel obstruction
6. Imminent death
7. Despair/suffering
8. (Using) Community resources
9. Breathlessness
10. Delirium
11. Depression/anxiety
12. Palliative sedation therapy
13. Maintaining clinician's own well-being
14. Emergencies in palliative care
15. Hastened death
16. Anorexia/cachexia/nutrition/fatigue
17. Non-malignant terminal illness

#### **Generic priorities for assessment of competence**

The five most commonly identified priorities for generic competencies in Palliative Care (enhanced skills level) were five of the six Essential Skills of Family Medicine (exception: Procedure skills):

1. Professionalism
2. Patient-centred approach
3. Communication skills
4. Clinical reasoning skills
5. Selectivity

## APPENDIX 5

### Emergency Medicine, Enhanced Skills Level: Priority Topics<sup>‡</sup> for the assessment of competence

The family physician with enhanced skills (added competence) in Emergency Medicine should be able to deal competently with the following clinical problems/situations for patients in all contexts of emergency care, from basic through complex. The detailed expectations for each topic are described by the key features (which will be available by the end of 2016).

1. Airway management
2. Shock/dehydration
3. Multiple trauma
4. Shortness of breath
5. Decreased level of consciousness
6. Chest pain
7. Abdominal pain
8. Arrhythmias
9. Asthma/chronic obstructive pulmonary disease (COPD)
10. Ischemic heart disease
11. Toxicology
12. Pediatric fever
13. Headache
14. Seizures
15. Analgesia/sedation
16. Anaphylaxis
17. Eye: red eye, loss of vision
18. First trimester bleeding
19. Common fractures/musculoskeletal (MSK) injury
20. Suicide risk

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<sup>‡</sup>These priority topics and their key features for emergency medicine were first developed before the most recent competency project, and have been used for more than 15 years to direct assessment and examination development. The key features have all been revised as part of the current project. A review of the priority topics themselves is planned, using the updated approach.

21. Environmental
22. Lacerations
23. Deep venous thrombosis (DVT)/pulmonary embolus
24. Delirium/agitation
25. Abuse (domestic)
26. Burns
27. Cerebrovascular accident (CVA)
28. Pulmonary edema
29. Eclampsia (pre)
30. Gastrointestinal bleed
31. Multiple patients
32. Infectious diseases
33. Continuous quality improvement (CQI)
34. Critical appraisal
35. Emergency medical systems (EMS)

## APPENDIX 6

### The Clinician Scholar Program

For the Clinician Scholar Program, because the curriculum for the program will be individualized in large part by resident interest, learning needs, and career objectives, it is not possible or desirable to define mandatory priority topics. Instead, it is preferable to state some of the generic goals, objectives, and principles for the Clinician Scholar Program as outlined below:

1. At the end of the scholarly component of the program, the individual will be expected to have acquired the knowledge, skills, and attitudes fundamental to embarking on a scholarly career in health. In most cases, further training specific to the candidate's field of interest will be required so he or she can succeed as an independent scholar.
2. The Clinician Scholar Program must provide an opportunity to integrate scholarship and clinical care. This could mean that Clinician Scholar Program residency training is done part-time over more than one year (ie, half time for 2 years), not only because this is the cyclical nature of research/scholarship (preparing grant applications, ethics applications, and/or manuscript submissions, along with wait periods, etc.) but also because this will allow clinician scholars to maintain family medicine competencies within their clinical practices.
3. While there are several ways of organizing the Clinician Scholar Program, there are some advantages to promoting the program for family physicians returning from practice.
4. Clinician Scholar Program training should be inclusive of scholars interested in advancing their skills among the full range of scholarship as defined by Charles Boyer's model of scholarship<sup>§</sup> (scholarship of discovery, integration, application, and teaching).

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<sup>§</sup> Boyer EL. Scholarship Reconsidered: Priorities of the Professoriate. Princeton, NJ: Carnegie Foundation for the Advancement of Teaching, 1990



## CATEGORIES OF ACCREDITATION

The following are definitions of the categories of accreditation. Programs are advised that the Accreditation Committee will not consider any major changes or new programs unless recommendations for such changes or programs are accompanied by written approval of the departmental postgraduate committee and the faculty of medicine postgraduate committee.

Each program considered by the Accreditation Committee is granted an accreditation status or category of accreditation as outlined below. To maintain the integrity of the family medicine programs (the core 2-year program and the enhanced skills program), the Accreditation Committee does not separately accredit individual components of a program; rather, the category of accreditation applies to the program as a whole.

### **Denial of accreditation**

Definition: The Accreditation Committee denies an accreditation status to a program.

This can occur in two situations:

1. An application by a program that has not previously been accredited
2. A program that has previously had accreditation withdrawn applies for re-accreditation

The decision to deny accreditation is usually based on evidence that the program is not in substantial compliance with accreditation standards.

### **Deferred decision**

Definition: The Accreditation Committee does not make a decision regarding the accreditation status of an existing, new, or previously accredited program.

The Accreditation Committee may defer a decision, usually pending the request for and submission of additional required information.

### **Accredited new program**

Definition: The Accreditation Committee accepts an application from a residency program that has not previously been accredited.

Within 24 months of a resident being enrolled, a College-mandated internal review of the program **must** be conducted.

### **Accredited program with regular cycle review**

Definition: The Accreditation Committee finds a program demonstrates acceptable compliance with standards.

Follow-up of the program will occur through the following:

1. Regular external survey in 6 years
2. Normal university-governed internal review required at mid-cycle

### **Accredited program with required follow-up**

Definition: In addition to the regular external surveys and normal university-governed internal reviews, and to ensure continuous quality improvement, the Accreditation Committee decides an accredited program requires follow-up with one of the following:

1. Progress report: When specific issues are identified and require follow-up only on the identified issues, a progress report is required; a complete review of the whole program is not required. The written progress report is produced by the program director and is due within 12-18 months.
2. College-mandated internal review: When major issues are identified in more than one standard, an internal review of the program is required and is conducted by the university. The internal review is due within 24 months.
3. External review: A focused or complete external review of the program is required when major issues are identified in more than one standard and concerns are specialty specific and best evaluated by a reviewer from the discipline; OR when concerns have been consistent; OR when concerns are strongly influenced by non-educational issues and can best be evaluated by a reviewer from outside the university. The external review is organized by the respective College and is conducted within 24 months.

### **Accredited program on notice of intent to withdraw accreditation**

Definition: The Accreditation Committee finds major and/or continuing noncompliance with one or more standards that calls into question the educational environment and/or integrity of the program.

An external review is conducted within 24 months by three people (two specialists and one resident). Residents who are in the program or already contracted to enter the program, as well as all applicants to the program, **must** be advised immediately by the program director of the status of the program. At the time of the review, the program will be required to show why accreditation should not be withdrawn.

### **Withdrawal of Accreditation**

A decision to withdraw accreditation of a program becomes effective immediately unless there are residents enrolled in the program, in which case the withdrawal becomes effective at the end of the academic year in which the decision is taken. No credit will be given by the respective college to any residents for training taken in a program once the accreditation of the program has been withdrawn. The Accreditation Committee will not consider a request to reinstate the accreditation of such a program for at least 1 year following the date of the decision to withdraw accreditation.

Accreditation will be immediately withdrawn from a program that becomes inactive following a notice of intent to withdraw accreditation.

A school may voluntarily withdraw a program but may not reapply for accreditation for at least 1 year from the date of withdrawal.

## **GUIDELINES FOR AN APPEAL OF AN ACCREDITATION DECISION**

**(Section under review)**