Specific Standards for Family Medicine Residency Programs Accredited by the College of Family Physicians of Canada
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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 or not 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 which 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 onsite survey. Committee representatives conduct onsite visits to residency training programs on a six-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 Canadian Association of Interns and Residents (CAIR), 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 that it can correct any errors or omissions and respond directly to the survey team’s recommendations. The survey team also makes a recommendation about the accreditation status 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
ACCRREDITED 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 counseling 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).

Special accommodation must be provided to residents with physical/health challenges in accordance with university policies.

j) 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

k) 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**

The academic department must maintain an ongoing 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. The opinions of the residents must be among the factors considered in this review.
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. 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 improved outcomes. This review must be conducted in a
manner that respects confidentiality and must include the following:

a) An evaluation of each component of the program to ensure that the educational
   objectives are being met
b) An evaluation of resource allocation to ensure that resources and facilities are being
   utilized with optimal effectiveness
c) An evaluation of the teachers in the program
d) An evaluation of the outcomes of the residency programs, including, but not limited to:
   (i) Measurements of resident performance, including degree of variation across
       training sites
   (ii) Feedback from recent graduates who are able to reflect on their training having
        acquired a perspective on the requirements of clinical practice

**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:

a) Working with the postgraduate committee to make recommendations for overall resident assessment policy
b) Coordinating the distribution of resident assessment forms and the collection and collation of data
c) Identifying those areas pertaining to assessment that would benefit from faculty development
d) Providing a resource for reviewing and improving the process of resident assessment
e) Maintaining effective liaison with other specialty placements to communicate about objectives and resident assessment
f) Participating in the process of identifying residents who are having problems in the training program
g) 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:

a) Orient the resident to the discipline of family medicine
b) Discuss with the resident the program objectives and the resident’s own learning objectives, and design an appropriate educational plan
c) Review this plan regularly and assist the resident in finding the resources within the program necessary to meet his or her unique learning needs
d) Help the resident to:
   (i) Reflect on program choices to be made
   (ii) Understand assessment feedback
   (iii) Set and revise learning objectives
   (iv) 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 on 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 two 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, 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 able to meet 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.

   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 in order 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 vs 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 four 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 in order 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 in order 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.
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 Domains of Clinical Care and Evolving Professional Competencies
4. The Triple C 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 practise in widely varied settings. As previously noted, training should occur primarily in family practice settings 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 the 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.

In order 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 about their patients, including other specialists, 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 practising 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 underserviced 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 that 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 (e.g., 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 towards 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 (i.e., 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 practice, 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.
These discipline-specific standards for overarching enhanced skills programs are complementary to and consistent with the family medicine–specific standards and will clarify or expand on the B standards as they relate to the education of family physicians.

Introduction

The CFPC recognizes and accredits training in a variety of areas of enhanced skills within family medicine. This training normally occurs following completion of the residency training program in family medicine and could extend for a few months or a full year. The purpose of these training programs is to provide residents with additional competencies they will require in their future practice. In some cases these programs will be tailored specifically to the needs of individual residents (Category 2 programs) but in some defined areas the College has established national standards for curriculum and training (Category 1 programs).

Current Category One Programs

The currently recognized Category One programs (with national standards) are as follows:

- Emergency Medicine
- Care of the Elderly
- Family Practice Anesthesia
- Clinician Scholar
- Palliative Medicine

Category Two programs include but are not limited to the following:

- Maternity Care
- Women’s Health
- Chronic Disease

In order to be eligible for accreditation the programs must be administered directly by the postgraduate office of the department of family medicine. The programs must also comply with the general accreditation standards applicable to all residency programs, commonly known as
the B standards. In addition to these, the following guidelines apply to all enhanced skills programs.

**Overall Enhanced Skills Administrative Structure**

As previously noted, enhanced skills programs must be administered under the direction of an academic department of family medicine. As each department might oversee a number of different enhanced skills programs, it is expected that an enhanced skills residency training committee will be established and chaired by an enhanced skills director/coordinator appointed by the department of family medicine and who holds certification in family medicine. This committee will have responsibility to oversee the training in each of these programs. At minimum, the membership of this committee will consist of the enhanced skills coordinator, the coordinators of each of the Category One programs, a resident representative, and the residency program director for the department of family medicine.

The enhanced skills program committee is intended to assist the departmental enhanced skills program director in providing a centralized approach to the planning and organization of all enhanced skills educational activities. In addition, it will be responsible for setting policy around the recruitment and appointment of residents, the monitoring of program evaluation, and resident assessment, and facilitate the coordination of resources. The committee will be responsible to report to the departmental residency training committee through the enhanced skills director/coordinator.

**Individual Program Administrative Structure**

Each individual Category One program must have a program coordinator/director who is appointed by the department of family medicine and who holds certification in family medicine.

The responsibilities of the program director for the category one program mirror those of the program director of the family medicine residency program. The exceptions are that the Category One program coordinator(s) will report to the director of the enhanced skills program and will be a member of the departmental Enhanced Skills Program Committee.

Although some of the enhanced skills programs might rely heavily on other clinical/academic departments for resources and faculty, there must be a clearly defined program
committee for the enhanced skills program with defined terms of reference that will meet regularly to provide oversight for the program.

Resources

The department of family medicine must provide the necessary resources to ensure the effective administration of the educational programs under its jurisdiction.
FAMILY MEDICINE/EMERGENCY MEDICINE: STANDARDS FOR THE ACCREDITATION OF FAMILY MEDICINE/EMERGENCY MEDICINE RESIDENCY PROGRAMS

These discipline-specific standards for family medicine/emergency medicine programs are complementary to and consistent with the family medicine–specific standards and will clarify or expand on the B standards as they relate to the education of family physicians.

Introduction

All family physicians must be trained to deal with emergency medical conditions. The development of postgraduate training programs in emergency medicine will provide family physicians the opportunity to bring enhanced skills in emergency medicine to their communities. To optimize the delivery of emergency medical care to the Canadian public, these programs must utilize the resources and support of appropriate medical and surgical disciplines. The principles of family medicine and the core cognitive and affective skills of the family physician must be integrated into these training programs for special competence in emergency medicine.

The goals of Certification in Family Medicine with added competency in Emergency Medicine [CCFP(EM)] are as follows:

1. To improve the standards and availability of emergency care from practicing family physicians
2. To establish guidelines for the development and administration of training programs in emergency medicine for family physicians
3. To ensure the availability of teachers for training programs in family medicine/emergency medicine.

Curriculum

The program should provide, either within a three-year integrated training program or a one-year training program, a minimum 12-month curriculum in emergency medicine as outlined in this section. Residents must be certified in family medicine by the CFPC or have successfully completed an accredited family medicine training program.
The educational objectives for special competence in emergency medicine complement those of family medicine training. Emergency medicine objectives should therefore, be considered in association with those for family medicine.

Family physicians/emergency physicians must play the principal role in educating family medicine residents. Their teaching should be supplemented by that of family medicine-oriented specialists.

There must be opportunities for residents and educators in various health care disciplines to work together in providing care.

The family physician/emergency physician is a family physician who acquires additional skills in emergency medicine to augment family medicine training. The goal of this training is to prepare family physicians to integrate the principles of family medicine into their emergency practice. Thus, objectives for special competence in emergency medicine fall within the domain of the four principles of family medicine:

*The family physician is a skilled clinician.*

When working in the emergency department, family physicians demonstrate competence in the patient-centred clinical method. They integrate a sensitive, skillful, and appropriate search for disease with an understanding of the patient’s experience of illness.

They have expert knowledge and skills related to the wide range of common health problems and conditions of patients in the community. Their approach to health care is based on the best scientific evidence available.

They use their understanding of human development, family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

An emergency medicine (EM) resident must acquire the knowledge and skills to do the following:

1. Distinguish seriously ill patients from those with a minor illness or injury
2. Manage all life-threatening conditions competently and efficiently
3. Support and stabilize the acutely ill patient and arrange appropriate management and referral
4. Recognize, evaluate, and initiate management of non-acute illness and injury
5. Manage multiple patients concurrently, and establish appropriate treatment priorities.
6. Understand and communicate effectively to patients and families the natural history of illnesses and injuries that present as emergencies, their concurrent social and family implications, and the hospital and community resources available for continuity of care.
7. Assume progressively increasing responsibility for the management of emergency patients, and achieve or demonstrate competence in a variety of procedures related to the practice of emergency medicine. Residents must also be knowledgeable about the indications for, contraindications to, and complications of each of these procedures.

**Family medicine is community based.**

Emergency medicine serves the community and is significantly influenced by community factors. As a member of the community, the family physician working in the emergency department is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

A CCFP(EM) resident must acquire the knowledge and skills to do the following:
1. Understand the principles of the development and implementation of support emergency medical services in the community for pre-hospital care, (i.e., paramedics, ambulance service, communication systems, first aid programs, poison control, public education, organization of emergency medical services, and disaster planning)
2. Maintain a collegial relationship with consultants and family physicians.

**The family physician is a resource to a defined population.**

The family physician views his or her patients as a “population at risk,” and practises to ensure that the health of these patients is maintained. This requires the knowledge and skills to assess the effectiveness of care provided, the ability to use medical records and other information systems effectively, and the ability to plan and implement policies that will enhance patient health.

Family physicians develop effective strategies for self-directed, lifelong learning. They advocate public policy that promotes the health of their patients, and they apply the principles of wise stewardship of scarce resources in the health care system.

A CCFP(EM) resident must acquire the knowledge and skills to do the following:
1. Implement the principles of quality assurance, risk management, continuous quality improvement, and total quality management. He or she should be able to assume a leadership role in improving services and monitoring the quality of care in community-based emergency services.

2. Develop the administrative capacity to serve as a community- and hospital-based resource for the practice of emergency medicine.

*The doctor-patient relationship is central to the role of the family physician.*

Family physicians understand and appreciate the human condition, especially the nature of suffering and patients’ response to illness. They are aware of their strengths and limitations, and recognize when their own personal issues interfere with effective care.

They respect the primacy of the person. The relationship has the qualities of a covenant—a promise, by physicians, to be faithful to their commitment to the well-being of patients, whether or not patients are able to follow through on their commitments.

Family physicians are committed to ensuring continuing care for their patients. They link to community-based primary care resources.

A CCFP(EM) resident **must** acquire the knowledge and skills to:

1. Demonstrate an effective doctor-patient relationship, and apply the patient-centred clinical method in the emergency room setting.

2. Demonstrate effective communication skills with patients, families, and coworkers.

3. Make ethical decisions in the emergency department, and identify medico-legal issues as they pertain to the practice of emergency medicine.

The training program **must** provide:

1. An identifiable formal teaching program in emergency medicine. This program **must** provide clinical teaching opportunities, seminars, formal teaching rounds, and other learning opportunities necessary to achieve the objectives outlined herein. The acquisition of critical appraisal skills is essential. Programs might require residents to complete an academic project. For those residents who wish to pursue an academic project (research, literature review, quality improvement), the program should provide the opportunity to do so.
2. Opportunities for the resident to interact with various organizations, agencies, and services that deliver emergency medical care to the community.

3. Opportunities for the resident to secure appropriate, relevant training experience in other disciplines related to emergency medicine, especially to adult critical care medicine.

4. A minimum of eight months in the emergency department in the combined family medicine/emergency medicine program, with a minimum of six months in the third year. At completion of the third year of training, the resident will possess the knowledge and skills necessary to develop a leadership role in a community emergency department.

5. The equivalent of at least two months of training in emergency and/or critical care pediatrics, which may be part of the eight months of “emergency” training.

6. An educational environment which facilitates and encourages residents to maintain an ongoing responsibility in a family practice setting throughout the third year.

7. A system of evaluation, for both residents and faculty, that is congruent with the principles outlined in the B standards.

**Program Organization**

The CCFP(EM) residency training program **must** be conducted in cooperation with the university department or division of family medicine, and provide a curriculum based on the educational objectives in emergency medicine of the CFPC.

The program **must** have access to facilities of the faculty of medicine, the department of family medicine, and participating hospitals.

The training program **must** provide a CCFP(EM) program director who holds the CCFP(EM) designation. The director **must** be responsible to the postgraduate director of the department of family medicine, and **must** be appointed by that department. The residents in emergency medicine are directly responsible to this individual. The program director **must** have the responsibility and authority to assign residents to the appropriate settings and rotations.

The CCFP(EM) program director will be assisted by an emergency medicine postgraduate education committee. The committee will include representation from teaching units, full- and part-time faculty, residents, and allied health professionals with appointments in the department.
The resident representatives on the postgraduate education committee must be selected by their peers and oriented to their role and responsibilities, both as members of the committee and as resident representatives. This committee should meet at least four times a year.

The CCFP(EM) program director must be a member of the postgraduate education committee of the university department of family medicine. The family medicine postgraduate director should be a member of the emergency medicine postgraduate committee.

Resident Selection

Recognizing that emergency medicine is a part of family medicine training and practice, postgraduate directors are reminded that the goal of these programs is to provide family physicians with enhanced skills training in emergency medicine. As such, these programs are primarily intended for:

1. All recent graduates of family medicine training programs
2. Any physicians with certification from the CFPC or who is eligible to write the CCFP examination

There must be a selection committee, which should include the family medicine/emergency medicine program director, a teacher in the program who is in possession of a CCFP(EM) certification, and the family medicine postgraduate director or his or her representative.

Resources

Clinical teaching resources

The training program must provide:

1. An annual budget sufficient to cover administrative costs and educational resources.
2. Emergency medicine teaching units with facilities appropriate for the investigation and treatment of patients. The volume and variety of work in the institutions participating in the program must be sufficient to provide an adequate experience over the full range of emergency medicine. The program must ensure an adequate exposure to the full range of age, ethno-cultural, and demographic backgrounds.
3. Teaching settings in which family physicians who received certification in family medicine from the College provide a significant portion of the clinical care, and take direct responsibility for the resident’s education and teaching.
4. Experience during the third year in a community setting where family physicians, as a part of their practice profile, provide care in the emergency department and in an office.

5. Interdisciplinary experience with social workers, nursing staff, and other health professionals, focusing on their role in the comprehensive delivery of health care services in the emergency department setting.

Faculty resources

The training program must provide:

1. Qualified teaching staff in sufficient numbers, some with appointments in the department of family medicine, to supervise and teach residents

2. Teachers in the family medicine/emergency medicine residency program familiar with the four principles of family medicine as they apply to emergency medicine
CARE OF THE ELDERLY: STANDARDS FOR PROGRAMS IN CARE OF THE ELDERLY

These discipline-specific standards for care of the elderly programs are complementary to and consistent with the family medicine–specific standards and will clarify or expand on the B standards as they relate to the education of family physicians.

Introduction

The number of people and the proportion of the population older than age 65 are increasing. Elderly people, particularly those older than age 75 and who are frail or at risk for becoming frail will require increased medical care by physicians with specific training. Family physicians play an increasingly important role in the primary care of the frail elderly in the office, home, hospital, and nursing home. Others have developed their practice principally in home care or nursing home programs. Partly because of the small number of geriatricians, family physicians have also become resource persons in acute care hospitals, nursing homes, and the community, where they often act as consultants. In academic centres, family physicians are involved in teaching care of the elderly in family medicine units or are an integral part of geriatric divisions in clinical care, teaching, and research.

The target populations for this program are those certified in family medicine who are in practice or coming out of residency training and who want to refine and extend their skills and increase their involvement in the care of the elderly in their practice. Their future professional activities should include the following:

1. Primary care geriatric practice
2. Being a community resource person in a rural or urban setting
3. Program development
4. An academic career in family practice health care of the elderly

Curriculum

The training is directed toward care of the frail elderly in the context of care of seniors generally, and toward preventing frailty. The following are four broad goals:

1. Defining the discipline in terms of knowledge and attitudes
2. Refining and extending clinical skills appropriate to the discipline
3. Creating an awareness of the services available in the community with utilization of a team approach

4. Creating the skills for community leadership in the development of geriatric services and health promotion.

The core objectives for the program **must** be covered within a six-month period. The 12-month program will provide an additional six months of training in which residents may meet additional specific educational objectives in geriatrics. The training should be based on the four principles of family medicine:

**The doctor-patient relationship is central to the role of the family physician.**

The resident **must** develop and demonstrate appropriate attitudes toward the elderly in providing care. The resident should be familiar with the role of and impact on the families/caregiver in the management of the elderly, and be able to recognize and manage effectively the problems of the families/caregiver caring for the elderly. The resident should demonstrate knowledge of and insight into common ethical and legal issues in the care of the elderly.

**The family physician is an effective clinician.**

The resident **must** have theoretical knowledge of and practical experience in common clinical problems and approaches in the elderly.

**Family medicine is community-based.**

The resident **must** actively use and interact with community resources to enhance patient management.

**The family physician is a resource to a defined practice population.**

The resident **must** be able to access appropriate materials and resources and apply them in the practice to the patient’s benefit. The resident will understand the unique position of the family physician to promote research that respects patient involvement. The resident will be able to select and access evidence from the medical literature to answer patients’ questions.

The organization of the teaching program should include a combination of vertical (block) and horizontal experiences, which include the following elements:

- A seminar program specifically for residents
- Participation of residents in university geriatric journal clubs, rounds, seminars, etc.
• The realization of a research project or an in-depth literature review with presentation at the end of training
• Opportunities to develop skills in teaching and making presentations
• The resident must be exposed to and have opportunities to participate in program development or administration (e.g., program planning committees, medical advisory committees, quality assurance committees)

Program Organization

Care of the elderly programs are encouraged to develop the training program in collaboration with university divisions of geriatric medicine. The coordinator will be appointed by the department of family medicine, will report to the program director in enhanced skills for family practice, and will be a member of the postgraduate education committee of the residency training in enhanced skills for family practice and may also be on the postgraduate education committee of the department of family medicine. The residents in this care of the elderly program will report directly to this coordinator. In settings where there are also specialty residency programs in geriatrics, it is recommended that the coordinator not have responsibility for both programs.

It might be appropriate for there to be a residency training committee in care of the elderly to assist the coordinator in the administration of the program. This committee should include representation from full- and part-time faculty, residents, allied health professionals with appointments within the department, and teaching units. The resident representatives on the postgraduate education committee must be selected by their peers and oriented to their role and responsibilities, both as members of the committee and as resident representatives. This committee should meet at least four times a year.

The care of the elderly training program should be accredited based on the above objectives and principles. It should be considered enhanced training distinct from the geriatric medicine specialty training program. Only those individuals who successfully complete a program accredited by the CFPC and who hold certification in family medicine with the CFPC should receive a diploma or “attestation” from the university or the department of family medicine. The diploma or attestations should indicate that the program is accredited by the CFPC.
Resources

Clinical teaching resources

The resident must provide care in each of the following ways or settings and should include primary care/continuity of care experiences:

- Geriatric assessment and treatment ward
- Consultation in acute care hospital ward and emergency department
- Outpatient or community assessment services
- Home care
- Nursing home or long-term care facility
- Psychogeriatric service
- An inpatient or outpatient setting providing geriatric rehabilitation (may be one of the above)

Faculty resources

Qualified teaching staff, some with appointments in the department of family medicine, will be appointed to supervise and to provide teaching, including:

1. Faculty from family medicine with experience/training in care of the elderly
2. Faculty from geriatric medicine
3. Faculty from geriatric psychiatry
4. Faculty from other health care professions
FAMILY PRACTICE–ANESTHESIA: STANDARDS FOR THE ACCREDITATION OF FAMILY PRACTICE–ANESTHESIA TRAINING PROGRAMS

These discipline-specific standards for family practice–anesthesia programs are complementary to and consistent with the family medicine–specific standards and will clarify or expand on the B standards as they relate to the education of family physicians.

Introduction

The development of postgraduate training programs in anesthesia will provide family physicians with the opportunity to bring enhanced skills in anesthesia to their communities. To optimize the delivery of anesthetic services to the Canadian public, these programs must utilize the resources and support of the appropriate anesthesia, medical, and surgical disciplines. The principles of family medicine and the core cognitive and affective skills of the family physician must be integrated into these training programs for special competence in anesthesia.

The goals of the CFPC for the program in family practice–anesthesia (FP-A) are as follows:

- To improve the standards and availability of anesthetic services to rural communities in Canada from practising family physicians
- To establish guidelines for the development and administration of training programs in anesthesia for family physicians

Curriculum

The program should provide a minimum 12-month curriculum in anesthesia. The program will be open to graduates of residency training programs in family medicine or to family physicians seeking to upgrade or enhance their skills in anesthesia.

The FP-A is a family physician who acquires additional skills in anesthesia to augment family medicine training. Physicians in these programs will acquire both technical skills and cognitive knowledge related to the provision of anesthesia services to a defined population. These physicians will develop judgment and insight appropriate to their scope of practice and practice setting.

The objectives for special competence in anesthesia fall within the domains of the four principles of family medicine.
The family physician is a skilled clinician.

When providing anesthetic services, family physicians demonstrate competence in the patient-centred clinical method. They integrate a sensitive, skillful, and appropriate search for disease with an understanding of the patient’s experience of illness.

They have expert knowledge and skills related to the wide range of common health problems and conditions of patients in the community. Their approach to health care is based on the best scientific evidence available. They recognize and treat serious or rare problems as appropriate.

An FP-A resident must acquire the knowledge and skills related to the following:

- Knowledge of pharmacology, physiology, and anesthetic equipment
- Risk assessment and perioperative anesthetic care
- Technical competence in airway management and skills in obstetric, pediatric, regional, and trauma anesthesia

The section “The Scope of the Curriculum for Family Physician Anesthesia Resident Training” (page 45) contains an overview of the scope that might be included in an FP-A curriculum.

Family medicine is community based.

Anesthesia services serve the community and are significantly influenced by community factors. As a member of the community, the family physician working in an anesthesia service is able to respond to people’s changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients’ needs.

The FP-A resident must acquire the knowledge, skills, and attitudes to do the following:

- Understand the importance of good working relationships within the anesthesia service, with other hospital-based services, and with referring hospitals
- Maintain a collegial relationship with consultants and family physicians

The family physician is a resource to a defined practice population.

The family physician views his or her patients as a “population at risk,” and practices to ensure that the health of these patients is maintained. This requires the knowledge and skills to assess the effectiveness of care provided, the ability to use medical records and other information systems effectively, and the ability to plan and implement policies that will enhance patient health.
Family physicians develop effective strategies for self-directed, lifelong learning.
Family physicians advocate public policy that promotes the health of their patients.
Family physicians apply the principles of wise stewardship of scarce resources in the health care system.

An FP-A resident must acquire the knowledge and skills to do the following:

- Implement the principles of quality assurance, risk management, continuous quality improvement, and total quality management. He or she should be able to assume a leadership role in improving services and monitoring the quality of care in anesthesia services.
- Develop the administrative capacity to serve as a community- and hospital-based resource for the practice of anesthetic services.

**The doctor-patient relationship is central to the role of the family physician.**

Family physicians understand and appreciate the human condition, especially the nature of suffering and patients’ response to illness. They are aware of their strengths and limitations, and recognize when their own personal issues interfere with effective care.

They respect the primacy of the person. The relationship has the qualities of a covenant—a promise by physicians, to be faithful to their commitment to the well-being of patients, whether or not patients are able to follow through on their commitments.

Family physicians are committed to ensuring continuing care for their patients. They link to community-based primary care resources.

An FP-A resident must acquire the knowledge and skills to do the following:

- Demonstrate an effective doctor-patient relationship, and apply the patient-centred clinical method in an anesthesia service.
- Demonstrate effective communication skills with patients, families, and co-workers.
- Make ethical decisions in the anesthesia service, and identify medico-legal issues as they pertain to the practice of anesthesia.

The training program must provide:

- Formal objectives for the FP-A resident related to the overall program and its specific rotations.
• An identifiable formal teaching program for the residents in the FP-A program. This program must provide clinical teaching opportunities, seminars, formal teaching rounds, and other learning opportunities necessary to achieve the objectives outlined herein. The acquisition of critical appraisal skills is essential. Programs may require residents to complete an academic project. For those residents who wish to pursue an academic project (research, literature review, quality improvement), the program should provide the opportunity to do so.
• Opportunities for the resident to secure appropriate, relevant training experience in other areas related to anesthesia (eg, intensive care unit [ICU], critical care unit [CCU], neonatal intensive care unit [NICU]).
• Opportunities for the resident to undertake part of the training in a rural or regional setting.
• Educational opportunities which ensure residents maintain clinical responsibility in a family practice setting. Alternatives to the weekly “half-day back” may be appropriate in some centres. Provisions should be made to facilitate those trainees wishing to maintain ongoing care for their group of patients associated with the “half-day back” component of their core family medicine program. For those trainees from a program that did not have a “half-day back” system or for trainees who are experienced family physicians, an alternative experience should be available to the resident, such as spending one month under the supervision of a family physician anesthetist who still maintains comprehensive and continuing care for a group of patients. In all cases, trainees need to maintain contact with the department of family medicine, be aware of educational events in family medicine, and have opportunities to attend these events whenever possible.
• A system of evaluation, for both residents and faculty that is congruent with the principles outlined in the Red Book.

At completion of the third year of training, the resident will possess the knowledge and skills necessary to develop a leadership role in a community anesthesia department.

Program Organization

The FP-A residency training program must be conducted in cooperation with the university departments of family medicine and anesthesia and provide a curriculum based on the
educational objectives in anesthesia of the CFPC. The program must function as part of the enhanced skills program of the department of family medicine with a program director and an enhanced skills training program committee responsible for overseeing the training of all residents undertaking enhanced skills training. The program must have access to the facilities of the faculty of medicine, the departments of family medicine and anesthesia, and participating hospitals.

The FP-A training program must provide a coordinator. The coordinator must be responsible to the director of enhanced skills training for the department of family medicine and the program director of anesthesia, and must be appointed in conjunction with those departments. The FP-A residents in anesthesia must be directly responsible to the coordinator. This individual must have the responsibility and authority to assign residents to the appropriate settings and rotations.

The coordinator will be assisted by an FP-A postgraduate education committee. The committee must include representation from those participating as teachers as well as family physician-anesthetists. The resident representatives on the FP-A postgraduate education committee must include one FP-A resident, selected by his or her peers and oriented to his or her role and responsibilities, both as a member of the committee and as a resident representative. This committee should meet at least four times a year.

Individuals who have completed training should be given a diploma or other attestation of completion of training indicating the program completed and noting that the program has been accredited by the CFPC.

Resources

Clinical teaching resources

The training program must provide the following:

- Adequate support for administrative and educational resources
- Anesthesia services with appropriate facilities. The volume and variety of work in the institutions participating in the program must be sufficient to provide an adequate experience over the full range of adult, pediatric, and obstetrical anesthesia
The program **must** ensure adequate exposure to the full range of age, ethno-cultural, and demographic backgrounds.

- Teaching settings in which family physicians provide some anesthesia services
- Interdisciplinary experience, focusing on the role of the family physician–anesthetist in the comprehensive delivery of health care services

**Faculty resources**

The training program **must** provide the following:

1. Qualified teaching staff in sufficient numbers, including those with appointments in the departments of family medicine and anesthesia, to supervise and teach residents
2. Teachers in the family medicine/anesthesia residency program familiar with the 4 principles of family medicine as they apply to anesthesia as outlined in the CFPC Standards for Accreditation

**The Scope of the Curriculum for Family Physician Anesthesia Resident Training**

The availability of anesthetic and surgical services improves health care in rural communities. In addition, anesthesia in community hospitals maintains a base of expertise and skills in rural areas.

The physician’s personal responsibility for continuing medical education and skill development **must** be instilled during training. All physicians should be aware of the problems of impairment by fatigue or by chemical dependence and of the need for continuous quality improvement and peer review.

At the completion of training the FP-A resident has achieved the following core competencies:

**A. Knowledge of the discipline of anesthesia**

1. Knows the age-related differences in anatomy, physiology, and pharmacology among children beyond infancy, adults, pregnant women, and the elderly

   **Enabling objectives:**
   - Knowledge of the practice guidelines of the Canadian Anesthesiologist’s Society
• Knowledge of anatomy and physiology of the airway and the following systems: cardiovascular, respiratory, renal, hepatic, endocrine, neurologic, and hematologic

• Knowledge of pharmacology pertaining to inhalation drugs, induction agents, opioids and other common analgesics, muscle relaxants and reversal agents, local anesthetics, and cardiac resuscitation drugs

• Knowledge of commonly used therapeutic drugs and other health-related products and their interactions with anesthetic agents

2. Identifies pathophysiologic variables that have an impact on the use of anesthetic drugs and techniques

Enabling objectives:

• Knowledge of effects on pharmacology of diminished cardiovascular, respiratory, renal, hematologic, hepatic, and neurologic function

1. Can apply knowledge in creating anesthetic plans with respect to anesthetic drugs and techniques

Enabling objectives:

• Knowledge of indications and contraindications, risks and benefits of general anesthetic techniques

• Knowledge of indications and contraindications, risks and benefits of regional anesthetic techniques to include central neuro-axial blocks

• Knowledge of basic bioethical issues encountered in anesthesia practice, including informed consent

• Demonstrate skill in establishing and maintaining cardiovascular and respiratory support

B. Perioperative anesthesia care

B.1. Pre-operative risk assessment

1. Performs pre-operative risk assessment to identify medical conditions, institutional limitations, or personal limitations requiring appropriate referral of the patient
Enabling objectives:
- Demonstrates clinical skills in pre-anesthetic assessment with respect to the airway and bodily systems
- Advises patients’ re optimization of medical conditions
- Advises patients of the risks and benefits of the anesthetic plan, including plans for referring the patient

B.2. Intra-operative care
1. Demonstrates skills for the independent practice of anesthesia
   Enabling objectives:
   - Creates appropriate anesthetic plans with appropriate monitoring
   - Anticipates problems and is capable of managing them

B.3. Post-operative care
1. Demonstrates skills for post-operative care
   Enabling objectives:
   - Demonstrates appropriate choices for postoperative management including management of acute pain to include use of local anesthetic techniques and intravenous patient-controlled analgesia

C. Resuscitation and life support
1. Demonstrates skills for resuscitation and life support for critically ill children and adults
   Enabling objectives:
   - Demonstrates skill in initial resuscitation (exemplified by resuscitation courses such as PALS, NALS, ACLS, and ATLS)

D. Technical competence
1. Knows the design and function of anesthetic equipment
   Enabling objectives:
   - Provides expertise to the community related to the acquisition and maintenance of anesthetic equipment
   - Uses components of the gas machine appropriately (anesthesia delivery circuits, vaporizers, ventilators, scavenging systems)
• Uses monitors, airway equipment, and vascular access devices appropriately
• Can detect when equipment malfunctions or provides incorrect data
• Demonstrates appropriate use of anesthesia equipment, including performance of pre-anesthetic check of the gas machine according to CAS standards

2. Demonstrates a level of competence acceptable for the level of training with respect to the procedures commonly employed in anesthesia practice

   Enabling objectives:
   • Demonstrates clinical skills necessary for competent airway management with a suitable variety of alternate management skills, including invasive airway skills
   • Demonstrates clinical skills in initiating vascular access and patient monitoring—non-invasive and invasive, including arterial and central venous line insertion
   • Demonstrates clinical skills in performing regional anesthesia/analgesia techniques to include neuro-axial and peripheral nerve blocks
   • Demonstrates clinical skills necessary for management of labour analgesia and anesthesia
   • Demonstrates clinical skills necessary for the provision of anesthesia for children, excluding neonates and infants
Introduction

The major goal of the Clinician Scholar Program (CSP) is to assist in the career development of family physician clinician scholars in Canada. The program will provide a formal postgraduate medical education pathway that fulfills the existing requirements of the CFPC for residency training in family medicine and provides integrated, structured, and rigorous research/scholarly training.

There are two pathways for CSP training:

1. One to two years of additional training following completion of residency training in family medicine (depending on the incorporation of a graduate degree)

OR

2. An integrated three-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

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 will include not only the traditional areas of clinical research, but also such fields such as economics and management and social, behavioural, and information sciences as they apply to health and disease. In addition, residents who wish to pursue a career in areas of medical ethics, history or educational research or training may also qualify for this program.

Curriculum

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 be commensurate with the concept of university studies at the advanced graduate level. The quality of scholarship will be demonstrated, in part, by a high level of scientific productivity of the supervisors, mentors, and research groups assigned to participate in the CSP.

There must be a clearly worded statement outlining the goals of each CSP and the educational objectives of the residents. The generic goals and objectives for the CSP are 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 that he or she can succeed as an independent scholar.

2. The CSP should also provide an opportunity to integrate scholarship and clinical care. During the scholarly component some time may be spent in clinical activity related to the area of interest; however, the majority of time (at least 80%) must be devoted to research or scholarly activity.

Based on these generic objectives, individual educational objectives must be developed for the scholarly component for individual residents. These objectives will form an important part of the interim assessments of progress of the resident and of the verification of completion of the scholarly component of the program.

Resources

1. There must be a CSP coordinator who is responsible to the enhanced skills director.

2. There must be a CSP program committee and administrative support to assist the CSP coordinator in the planning, organization, and supervision of the program. Membership should include resident representatives, and preceptors reflecting the range of educational opportunities available. The committee will report through the enhanced skills committee to the departmental residency training committee.

3. There must be sufficient resources, including teaching faculty, technical and physical resources, and supporting services for all residents in the program to achieve the educational objectives.
4. The training environment should be rich in academic activities (e.g., journal clubs, seminar series, retreats) and supportive of translational aspects of scholarship.

5. There must be a process for ensuring that supervisors and advisory committee members are qualified to supervise CSP residents.

6. Each resident must have a designated supervisor who is an independent scholar and who fulfills the requirements of the CSP 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.

7. CSP supervisors must have established scholarly productivity (manuscripts, abstracts, presentations), an international/national reputation in the field, and experience in supervising graduate students.

8. The supervisors and the advisory committees of all CSP residents must be approved by the CSP Committee and will be responsible for:
   a) Overseeing the individual scholarly program
   b) Scholarly and clinical mentoring
   c) Evaluating scholarship competencies
   d) Interim evaluations
PALLIATIVE MEDICINE: SPECIFIC STANDARDS OF ACCREDITATION FOR A
ONE-YEAR PROGRAM OF ADDED COMPETENCE IN PALLIATIVE MEDICINE

Conjointly accredited by the Royal College of Physicians and Surgeons of Canada and the College of
Family Physicians of Canada

Introduction

The Canadian Palliative Care Association has defined palliative care this way:

“Palliative care is aimed at relief of suffering and improving the quality of life for persons who are living with or dying from advanced illness or are bereaved.”

The World Health Organization has defined palliative care as follows:

“The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life of patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness...”

An accredited program in palliative medicine will provide advanced training at a post-certification level for those physicians who wish to develop added competence in the area. These physicians will be educated to provide secondary, consultant-level expertise to support other physicians and their patients, and will receive the basic clinical training required for academic careers in palliative medicine.

Meeting the Educational Goals and Objectives of Both the CFPC and the RCPSC

A conjoint program in palliative medicine must reflect the basic educational goals and general standards of accreditation of both Colleges.

The educational framework for the CFPC is based on the four principles of family medicine:

1. The doctor-patient relationship is central to family medicine.

2. The family physician is an effective clinician.

3. Family medicine is community based.

4. The family physician is a resource to a defined practice population.

The RCPSC has established similar broad educational goals as outlined in the booklet “General Standards of Accreditation.” This document also includes reference to the CanMEDS
2000 roles of medical expert, communicator, collaborator, manager, health advocate, scholar, and professional.

Administrative Structure

There must be an appropriate administrative structure for each residency program. Interpretation:

1. There must be a program director, with qualifications that are acceptable to the two Colleges, responsible for the overall conduct of the integrated residency program. The program director must be assured of sufficient time and support to supervise and administer the program. The program director is responsible to the head(s) of the sponsoring department(s) and to the postgraduate dean of the faculty. The Colleges must be informed when a new program director is appointed.

2. There must be a coordinator or supervisor responsible to the program director at each institution or agency participating in the program. There must be an active liaison between the program director and the coordinators.

3. There must be a residency program committee to assist the program director in the planning, organization, and supervision of the program:
   a) Must include both family physicians and specialists
   b) Should include the coordinators for each major component of the program
   c) Must include representation from the residents in the program, at least one of whom must be elected by his or her peers
   d) Must meet regularly—at least quarterly—and keep minutes

4. The responsibilities of the program director, assisted by the residency program committee include the following:
   a) Development and operation of the program such that it meets the general standards of accreditation of both Colleges, and the specific standards of accreditation as set forth in this document
   b) Selection of candidates for admission to the program and the evaluation of residents in the program in accordance with policies determined by the faculty postgraduate medical education committee
c) Maintenance of 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.

d) Establishment of mechanisms to provide career planning and counselling for residents and to deal with problems such as those related to stress.

e) An ongoing review of the program to assess 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. The opinions of the residents must be among the factors considered in this review.

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. This review must include the following:

a) An assessment of each component of the program to ensure that the educational objectives are being met.

b) An assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness.

c) An assessment of teaching in the program, including teaching in areas such as biomedical ethics, medico-legal considerations, teaching and communication skills, issues related to quality assurance/improvement, equity issues, and administrative and management issues.

d) An assessment of the teachers in the program.

In addition to the responsibilities of the program director and the residency program committee listed above, the program director must submit, through the office of the postgraduate dean, an annual report to the Colleges providing information on program applicants, individuals in the program, graduates of the program, and those who have left the program without completing it. An annual report form will be sent out from the Colleges each fall requesting this information for the current academic year.

Goals and Objectives

There must be a clearly worded statement outlining the goals of the residency program and the educational objectives of the residents.
1. **Goals of the program**

The overall goals of the program:

- a) To train physicians with added competency in the area of palliative medicine who will provide primary and consultant palliative care services

  AND

- b) To provide clinical and initial basic academic training for physicians who will be going on to academic careers in palliative medicine.

2. **Educational objectives of the program**

Successful residents will acquire a broad-based understanding of the principles; philosophy; and core knowledge, skills, and attitudes of palliative medicine.

(Note: Since the Colleges use different formats for objectives, each general objective that follows has the approved Royal College format and has been linked to one of the CFPC’s four principles of family medicine as indicated.)

**General objective 1**

(Principle #1 – The Doctor-Patient Relationship)

The resident will be able to describe medical and societal attitudes towards death and dying.

**Specific objectives**

The resident will be able to:

1.1 Describe current societal attitudes about death and dying

1.2 Identify issues in death and dying relevant to different cultures, spiritual beliefs, and traditions

1.3 Describe current barriers in providing better care for the dying

1.4 Define palliative care and describe its basic principles

**General objective 2**

(Principle #1 – The Doctor-Patient Relationship)

The resident will be able to demonstrate a whole person (person-centred) approach to caring for dying patients and their families.
Specific objectives

The resident will be able to:

2.1 Describe the physical, psychological, social, and spiritual issues of dying patients and their families

2.2 Demonstrate an ability to work with the patient and family to establish common, patient-centred goals of care

2.3 Demonstrate effective communications skills in dealing with terminally ill patients and their families, including skills in delivering bad news

2.4 Demonstrate a systematic approach to working with the families of dying patients, including bereavement counseling

2.5 Demonstrate an ongoing commitment to a patient and family from the time of palliative medicine consultation for a terminal illness until a patient dies, and commitment to the family after a patient dies

General objective 3

(Principle #1 – The Doctor-Patient Relationship)
The resident will demonstrate awareness of his or her personal issues and concerns in the area of death and dying.

Specific objectives

The resident will be able to:

3.1 Describe his or her own concerns about dealing with dying patients and their families

3.2 Demonstrate an awareness of how his or her own personal experiences of death and dying have influenced attitudes

3.3 Describe strategies for managing his or her own stress in dealing with the dying

General objective 4

(Principle #2 – Effective Clinician)
The resident will be able to demonstrate effective knowledge, skills, and attitudes in dealing with the complex interplay of the physical, psychological, social, and spiritual needs of dying patients and their families.
Specific objectives

The resident will be able to:

4.1 Demonstrate consultant-level diagnostic and therapeutic skills for ethical and effective patient care
4.2 Manage pain effectively
4.3 Demonstrate advanced knowledge of the assessment and classification of pain, the neurophysiology of pain, the pharmacology of drugs used in pain and symptom management, and the pathophysiology of other symptoms
4.4 Manage other physical symptoms, especially dyspnea, constipation, skin care, mouth care, terminal agitation, delirium, and nausea and vomiting
4.5 Demonstrate a good knowledge of the current principles of cancer, its pathophysiology, and management
4.6 Identify psychological issues associated with life-threatening illness and strategies that might be useful in addressing them
4.7 Describe the process of normal grief and the features of atypical grief
4.8 Demonstrate skills in working with the families of dying patients
4.9 Demonstrate skills in providing educational counseling to dying patients and their families
4.10 Identify the social and existential needs confronting the patient and families, and strategies that might be useful in addressing them

General objective 5

(Principle #2 – Effective Clinician)

The resident will be able to collaborate as an effective member of an interdisciplinary team.

Specific objectives

The resident will be able to:

5.1 Describe the roles of other disciplines in providing palliative care
5.2 Participate in interdisciplinary care of patients, including family conferences
5.3 Communicate effectively with other team members
5.4 Demonstrate adequate skills in educating and in learning from members of the interdisciplinary team
5.5 Act as a role model for other residents and physicians
5.6 Demonstrate effective consultation and communication skills in working with referring physicians

**General objective 6**

(Principle #3 – Community Based)
The resident will be able to demonstrate requisite knowledge and skills in managing patients across different care systems.

**Specific objectives**
The resident will be able to:

6.1 Describe the models of palliative care delivery and their utilization
6.2 Describe the societal and environmental factors relevant to the care of the dying
6.3 Describe the barriers to effective care across settings
6.4 Describe the role of family physicians and specialists in the care of the terminally ill
6.5 Demonstrate the ability to work effectively in institutional and community-based palliative care programs

**General objective 7**

(Principle #3 – Community Based)
The resident will demonstrate skills in managing patients in their homes.

**Specific objectives**
The resident will be able to:

7.1 Describe the elements comprising good home care
7.2 Be knowledgeable about and able to provide home visits to dying patients
7.3 Describe the community resources available to support patients in their homes
7.4 Describe an approach to the last hours of caring in the home and the responsibilities of the physician at the time of death
7.5 Describe the physician’s role in managing patients in their homes
7.6 Describe the role of palliative care consultants
7.7 Advocate for the needs of home care patients
**General objective 8**

(Principle #4 – Resource to a Defined Patient Population)

The resident will be able to demonstrate the ability to incorporate accepted standards of palliative care into their practices.

**Specific objectives**

The resident will be able to:

8.1 Become a role model by demonstrating skillful care of the dying
8.2 Develop a proactive approach to managing patient and family expectations and needs
8.3 Assist institutional and community palliative care programs in developing standards of care consistent with accepted standards

**General objective 9**

(Principle #4 – Resource to a Defined Patient Population)

The resident will be able to incorporate evidence-based decision making in caring for dying patients and their families.

**Specific objectives**

The resident will be able to:

9.1 Access the relevant literature in helping to solve clinical problems
9.2 Apply critical appraisal skills to literature in palliative medicine

**General objective 10**

(Principle #1 – The Doctor-Patient Relationship)

The resident will be able to discuss the ethical issues confronting dying patients, their families and their physicians, including end-of-life decision making, advance directives, care planning, competency, euthanasia, and assisted suicide.

**Specific objectives**

The resident will be able to:

10.1 Outline a general framework for ethical decision making
10.2 Describe an approach to managing the particular ethical issues at the end-of-life including withdrawing or withholding therapy, advance directives, euthanasia, and assisted suicide
10.3 Demonstrate integrity, honesty, and compassion in the care of patients
10.4 Act as an effective advocate for the rights of the patient and family in clinical situations involving serious ethical considerations

Content and Organization of the Program

There must be an organized program of rotations and other educational experiences, both mandatory and elective, designed to provide each resident with the opportunity to fulfill the educational requirements and achieve competence in the program.

Residents must be provided with increasing individual responsibility, under appropriate supervision, according to their level of training, ability, and experience.

The following are the minimum educational requirements in palliative medicine. Additional experience could be required by the program director.

1. Prerequisite
   a) Completion of the educational requirements for certification by the CFPC
   OR
   b) Completion of the educational requirements for certification by the RCPSC

2. Program requirements: one year of palliative medicine. This program must include the following:
   a) A core component of at least nine months in supervised clinical experience in palliative care
   b) Oncology educational experience, unless previously done
   c) A blend of institutional and community experience
   d) Opportunity for continuity of experience across home and institutional care throughout the program
   e) Interdisciplinary care and teaching
   f) Three months of electives designed to complement core experience, taking into account previous experience and the learning needs of the resident
   g) A scholarly project

3. For satisfactory completion of the CFPC/RCPSC requirements in palliative medicine, a resident must:
   a) Have successfully completed a one-year program in palliative medicine accredited by the CFPC and the RCPSC in which the resident has been enrolled for the full year
b) Have completed a mandatory scholarly project such as a published case report, a review of the literature, or participation in a research project

c) Have attained certification by the CFPC or the RCPSC

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 educational objectives and receive full training in the program.

Learning environments must include experiences that facilitate the acquisition of knowledge, skills, and attitudes relating to aspects of age, gender, culture, and ethnicity appropriate to palliative medicine.

The program must include the following:

1. A full scope of palliative care programs:
   - Institutional (acute and chronic) palliative care units
   - Community based
   - Ambulatory care

   Teaching sites should be evaluated regularly.

2. Patient experience that:
   - Is not specific to cancer care only
   - Includes responsibility for patients at consultant and direct care levels
   - Includes sufficient numbers of patients in each setting

3. Interdisciplinary faculty including:
   - Experienced, academic palliative medicine faculty with university appointments
   - Palliative medicine consultant physicians (both family medicine and specialty medicine based)
   - Experienced teachers from other medical specialties and other disciplines such as nursing, social work, and theology

4. Support services:
   - Appropriate administrative support for the program
• Access to appropriate diagnostic resources, including ultrasound, MRI, and CT, to provide pathophysiologic correlates to symptoms
• Access to interventional radiologists for such procedures as biliary stent insertion and venous stents
• Access to anesthetists who perform nerve blocks and epidural procedures
• Palliative care counseling resources such as social workers, psychiatrists, or psychologists with special expertise in caring for dying patients and their families
• Computer technology for the purposes of literature searching, data base management, production of teaching materials, and other educational uses

Academic and Scholarly Aspects of the Program

The academic and scholarly aspects of the program must be commensurate with the concept of university postgraduate education. The quality of scholarship in the program will, in part, be demonstrated by a spirit of enquiry during clinical discussions, seminars, rounds, and conferences. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.

Interpretation:
1. Organized scholarly activities such as journal clubs, research conferences, and seminars must be a regular part of every program
2. The academic program must include organized teaching in the basic and clinical sciences relevant to palliative medicine
3. There must be a faculty member with the responsibility to facilitate the involvement of residents in research and other scholarly work
4. All programs must promote development of skills in self-assessment and self-directed lifelong learning. To promote this end, the program should provide opportunities for residents to attend conferences outside their own university

Evaluation of Resident Performance

There must be mechanisms in place to ensure the systematic collection and interpretation of evaluation data on each resident enrolled in the program.
There should be an evaluation process that meets the criteria of the two Colleges and that is timely, relevant, and congruent with the objectives of the program.

As there is no summative evaluation at a national level, it is particularly important that the evaluation of residents in the program be rigorous and well documented. Programs must have a comprehensive assessment plan including assessment criteria and methods, based on the objectives of the program.

Assessments of the performance of individual residents in the program are to be kept on file in the office of the postgraduate dean for review at the time of on-site surveys. The final evaluation will also include the mandatory scholarly project completed by the resident.

For each resident deemed by the program director to have completed the program, an Attestation of Program Completion form on University letterhead must be filed with the Colleges. These forms will be sent to the program for each resident reported on the Annual Report as completing the required one-year in the program.
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. In order to maintain the integrity of the 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.

Accredited New Program

Definition:

• An acceptable application for a residency program
• Within 24 months of a resident being enrolled, a College-mandated internal review of the program must be conducted
• This review may be delayed until the first resident enrolled in the program reaches the specialty-specific portion of the program (ie, beyond a basic clinical year or surgical foundations years) to allow assessment of the educational aspects unique to the program

Accredited Program

Definition:

• Program demonstrates acceptable compliance with standards

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

• Regular external survey in six years
• Normal university-governed internal review required at mid-cycle

In addition to the regular external surveys and normal university-governed internal reviews, follow-up might also be required by one of the following:

• Progress report
Definition:
• Specific issue(s) are identified and require follow-up only on the identified issue(s). 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 to 18 months

OR
• College-mandated internal review
  Definition:
  • 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

OR
• External review
  Definition:
  • Major issues are identified in more than one standard
  AND
  o Concerns are specialty specific and best evaluated by a reviewer from the discipline
  OR
  o Concerns have been persistent
  OR
  o Concerns are strongly influenced by non-educational issues and can best be evaluated by a reviewer from outside the university
  • A focused or complete review of the program is required
  • The review is organized by the respective College
  • The external review is conducted within 24 months

Accredited Program on Notice of Intent to Withdraw Accreditation
Definition:
• Major and/or continuing noncompliance with one or more standards which calls into question the educational environment and/or integrity of the program
• External review is conducted within 24 months by three people (two specialists and one resident)

• Residents 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

Definition:

• Decision to withdraw accreditation of a program becomes effective immediately unless there are residents enrolled in the program, in which case it 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

• A request to reinstate the accreditation of such a program will not be considered by the Accreditation Committee for at least one year following the date of the decision of the Accreditation Committee

• In those cases where accreditation has been withdrawn from a program because the program has been inactive, the one-year waiting period may be waived

  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 one year from the date of withdrawal.
GUIDELINES FOR AN APPEAL OF AN ACCREDITATION DECISION

Grounds for an Adverse Accreditation Action

Upon determination that a residency program in family medicine is not in substantial compliance with the CFPC’s published educational standards for such programs leading to certification in family medicine, the board of directors of the CFPC may, at any regular or special meeting, withdraw or withhold accreditation or place the program on probation, subject to such terms and conditions as the board may deem appropriate. A period of probation ordinarily shall not exceed two years. Withdrawal of accreditation shall be effective in accordance with the schedule to be determined by the CFPC Board.

Definition of an Adverse Action

For an existing program that has achieved the status of accreditation, an adverse action includes only the assignment of probation or withdrawal of accreditation. Neither the award of provisional status for a limited term nor determination of appropriate class size for an accredited program is an adverse action within the meaning of these procedures. For a program of medical education that has not achieved accredited status, refusal to consider it for accreditation and denial of provisional accreditation constitute adverse actions. Accreditation status of a program shall remain in effect until an adverse action becomes final.

Exclusions From Discussion

Members of the Accreditation Committee and CFPC Board who are students, residents, or faculty of the institution being reviewed will not be present during the discussion or decision making about their institution, except when they are making a presentation on behalf of their institution in the course of the appeal. Those eligible to make presentations on behalf of the appellant institution are limited to physicians, medical students, and those engaged in medical education or training.
PROCEDURE FOR IMPOSITION OF ADVERSE ACTIONS

Notice

Before consideration of an adverse recommendation by a survey committee, the CFPC shall notify the institution of the committee’s negative recommendations by written notice sent by certified mail, return receipt requested. This notice will be supported by the report of the survey committee, which will list the specific problems and deficiencies.

The institution shall be invited to appear at the Accreditation Committee meeting and to show cause why such action should not be taken. Failure to respond within 30 days of receipt of the written notice of the committee’s negative recommendation will be deemed consent by the institution to the imposition of the recommended adverse action.

Action of the Accreditation Committee

Based on all the information available to it on the day of its meeting, the Accreditation Committee will make a recommendation to the CFPC Board about the accreditation status of the program. Before consideration of any adverse recommendation, the CFPC Board shall notify the institution of the intended action by written notice and by certified mail, return receipt requested. This notice will be supported by a listing of the specific problems and deficiencies of the educational program and/or its resources for remediation of these. At a date, time, and place designated in such notice, the institution shall be invited to appear and show cause before a subcommittee of the CFPC Board why such action should not be taken. Failure to respond within 30 days of receipt of the written notice of recommended action will be deemed consent by the institution to the imposition of the recommended adverse action. The date designated for the show-cause hearing shall be at least one day before the next CFPC Board meeting.

Standard for Decision

The recommended action may be affirmed unless it is shown that there is not substantial evidence to support such action.

Subcommittee

A subcommittee designated to conduct the hearing shall be appointed by the chair of the CFPC Board from among its voting members and shall consist of three members. The chair of the
CFPC Board shall designate one of the three members of the subcommittee as chair to preside at the subcommittee hearing.

The subcommittee shall review all material on which the Accreditation Committee determination was based, including the self-study material, survey team report, and critique of the dean’s report. The subcommittee will consider such other material as may be submitted orally or in writing by the institution or program at the hearing.

After the conclusion of the hearing, the subcommittee shall make a written recommendation concerning the action that should be taken regarding the accreditation status of the educational program. This recommendation will be submitted to the CFPC Board at its next meeting. Failure or refusal of the sponsoring organization to attend the hearing will be deemed to be consent by the institution to the imposition of the adverse action.

Costs of the hearing conducted by the CFPC subcommittee shall be allocated as follows:
1. The CFPC shall bear the expenses of CFPC members and staff necessary to conduct the hearing and the expenses of providing an appropriate meeting facility for the subcommittee
2. The institution or program appealing the recommendation shall bear all the expenses involved in the development and presentation of its appeal and in the travel and other reimbursable expenses of its representatives present at the subcommittee meeting

Procedures for the CFPC Board of Directors

The CFPC Board shall consider the written recommendation of the assessment and evaluation committee and of the board subcommittee at its next meeting. The board shall adopt, reject, or modify the recommendations.

Conduct of the CFPC Board Discussion

When a recommendation of the Accreditation Committee is being considered by the board under appeal, discussion will take place before the CFPC Board, of which a quorum shall be present. The discussion will be conducted by the board’s chair. All relevant information will be considered. While strict adherence to the formal rules of evidence will not be required, irrelevant or unduly repetitious statements may be ruled out of order. The discussion of the recommendation will follow the format below:
1. Introductory statement by the CFPC Board chair
2. Oral presentation by the Accreditation Committee chair (15 minutes)
3. Oral presentation by the appellant institution (15 minutes)
4. Questions by CFPC Board members and staff, addressed to either the committee or the
   appellant institution
5. Discussion of evidence by CFPC Board (in camera)
6. Decision for action

Appeal of a Decision of the Board of Directors

When the CFPC Board makes an adverse decision when the Accreditation Committee has
recommended approval, the CFPC Board shall notify the institution of the intended action by
written notice and by certified mail, return receipt requested. This notice will be supported by a
listing of the specific problems and deficiencies of the educational program and/or resources for
remediation. At a time, date, and place designated in such notice, the institution shall be invited
to appear and show cause before a committee of the CFPC Board why such action should not be
taken. Failure of the institution to respond within 30 days of receipt of the written notice of
recommended action will be deemed consent by the institution to the imposition of the
recommended adverse action. The date designated for the show-cause hearing shall be at least
one day before the next CFPC Board meeting. The procedure for the appeal will be provided to
the subcommittee and the Board.

The accreditation status of a program shall remain in effect until the institution has
indicated that it will not appeal the board’s decision or until the appeal process is complete.

Decision on Appeal

The CFPC Board shall consider the evidence presented and make a decision based on its
judgment, as outlined in the first paragraph of these guidelines. The executive directors of the
CFPC shall notify the appellant of the decision of the CFPC board by certified mail, return
receipt requested. This decision of the CFPC Board shall be final.