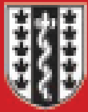


The College of
Family Physicians
of Canada

Le Collège des
médecins de famille
du Canada

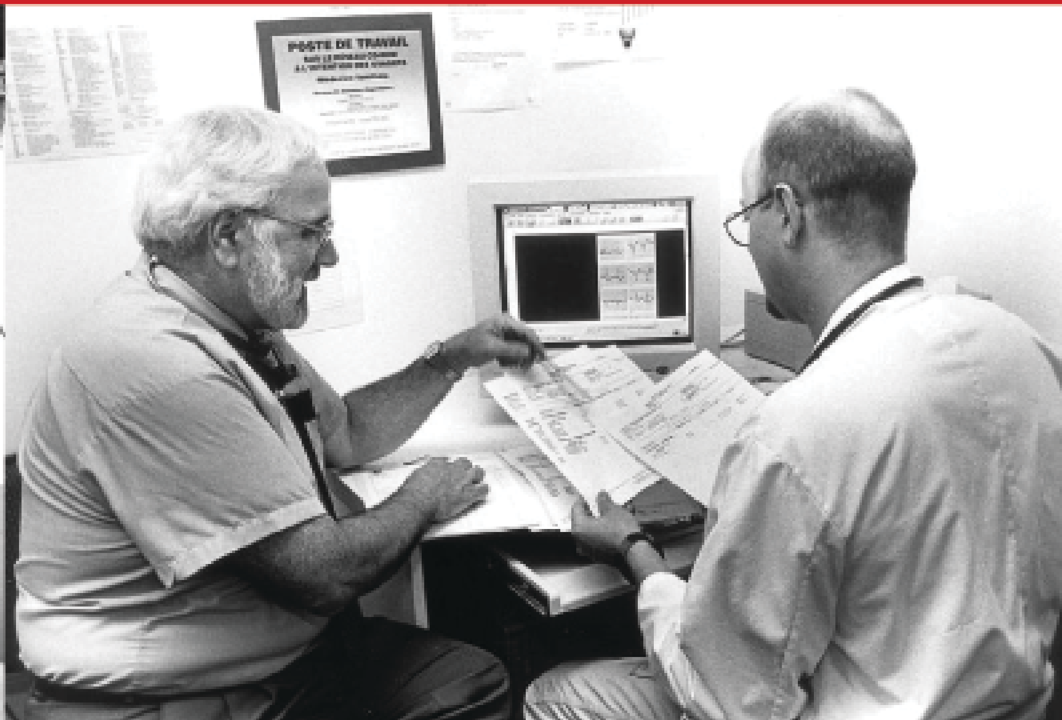
STANDARDS FOR ACCREDITATION OF RESIDENCY TRAINING PROGRAMS

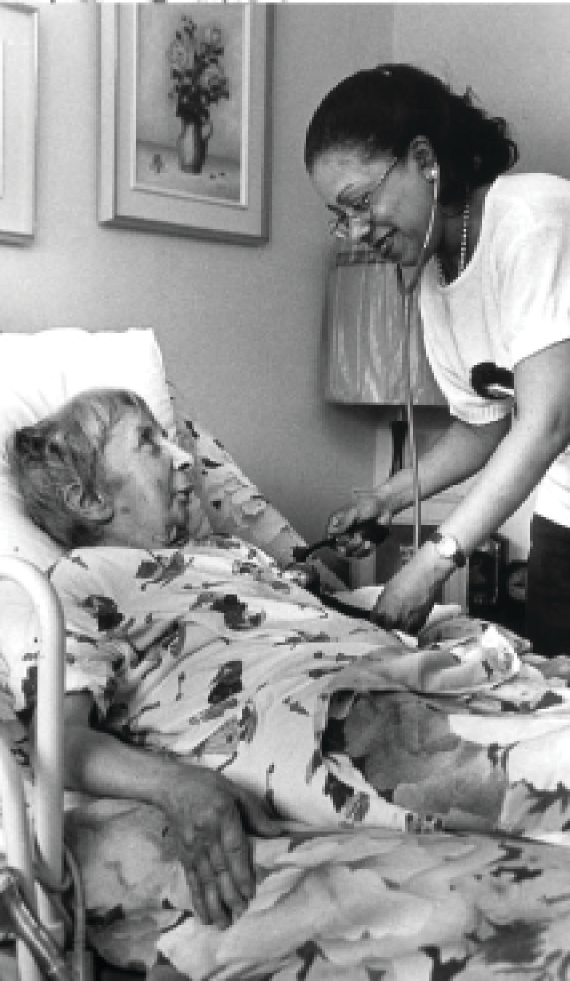
Family Medicine

Enhanced Skills

Emergency Medicine

Palliative Medicine





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Introduction

A

OVERVIEW OF ACCREDITATION PROCESS

The purpose of the accreditation of residency programs by the 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, emergency 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.

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.

B

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 Licensing Authorities of Canada, the Canadian Association of Interns and Residents, or the Fédération des médecins résidents du Québec, 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 may 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 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 may influence the nature of the follow-up.

The College has in place an appeal process that a training program can use in the case of an adverse decision. Details of this appeal process are provided in Appendix D of this publication.

C
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.

NEW APPROVAL

An application for accreditation of a program is usually granted new approval. An internal review of the program by the faculty postgraduate medical education committee is expected to take place within two years of the granting of new approval. The report of the internal review and supporting documentation should follow the format as outlined under the category of provisional approval (see Mandated Internal Review).

FULL APPROVAL

Full approval is granted to residency programs that meet the standards of accreditation of the College of Family Physicians of Canada. In addition, the university and the program are expected to have systems in place to identify and correct deficiencies at intervals between onsite surveys. In the interval between surveys, programs with full approval may be requested to submit reports of progress toward the solution of problems identified during the last survey. Major changes should be reported to the Accreditation Committee, which in turn may recommend an onsite visit or an internal review.

The term of this approval is six years.

PROVISIONAL APPROVAL

Provisional approval is granted to programs that have many strong components but also have problems that require defined follow-up. These problems may be either with a program-wide difficulty in meeting the standards of accreditation of the College of Family Physicians of Canada or with certain training sites that do not meet the standards.

Provisional approval is granted for no more than three years. Follow-up will be by one of the following options:

Mandated Internal Review

The mandated internal review process would be that normally used by the university for the conduct of its own internal assessment. For mandated internal reviews the postgraduate dean should provide the review team with the usual materials available for a regular internal review but in addition the team should be provided with a written report from the residents in the program, prepared by the resident representative(s) on the residency program committee commenting on:

i. strengths of the program

ii. weaknesses previously identified in the program and the resident's perception of how well these have been dealt with,

iii. any other significant changes in the program since the last review.

Mandated internal review reports are to be submitted to the Accreditation Committee by the postgraduate dean and must be in the format of the regular survey report and must include a narrative report that addresses each of the standards of accreditation. This report must not include a recommendation on the accreditation status for the program.

Modified Internal Review

This would be similar to a regular internal review, but would include, as a member of the review team, a family medicine educator, who holds a teaching appointment at another accredited family medicine program. This would be a requirement in those circumstances where the concerns of the Committee were judged to be of a nature that would require the review of an expert in the discipline. The university would be asked to communicate to the committee the findings of the internal review process relative to designated problems.

Special Survey

The Committee may mandate a special survey when there are serious concerns regarding the ability of the program to meet the standards of accreditation or when exceptional circumstances indicate that an on-site program review is warranted. A special survey involves a visit to the training program by a minimum of two surveyors appointed by the Accreditation Committee. Prior to the special survey the university will be asked to update the information provided in the most recent pre-survey questionnaire and to provide written documentation as to how they have addressed the areas of concern previously identified by the Accreditation Committee.

Assuming the program has adequately addressed the problem areas identified, and that no other major changes have occurred in the program, full approval will be granted for the remainder of the six-year period until the date of the next normally scheduled survey visit.

NOTICE OF INTENT TO WITHDRAW ACCREDITATION

Notice of intent to withdraw accreditation may be granted to those programs that are already on provisional approval and have failed to provide evidence within the required time frame that they have met the accreditation standards specified by the Accreditation Committee. It may also be applied to those programs that have multiple major problems that prevent them from meeting the accreditation standards of the College. The term of notice of intent to withdraw accreditation will be at the discretion of the Committee but will be no longer than two years. Should the program continue to be unable to provide satisfactory evidence that the accreditation standards have been met, accreditation will be withdrawn. 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.

WITHDRAWAL OF ACCREDITATION

Accreditation will be withdrawn if, during the term of notice of intent to withdraw accreditation, the program has not been able to remedy the major deficiencies leading to notice of intent to withdraw accreditation and provide evidence of this to the Accreditation Committee. A 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 College for training taken in a program once the accreditation of the program has been withdrawn.

INACTIVE

Training programs are declared inactive if they have in place the resources to meet the College's basic guidelines for accreditation, but at the time of an onsite survey visit do not have any registered residents.

The original category of approval will be reinstated once residents are again registered in the program and an internal review and satisfactory report has been submitted to the Accreditation Committee. If a program is inactive on two successive survey visits, it will be surveyed during the first year that students are subsequently enrolled.

General Standards

A
PRINCIPLES AND OBJECTIVES

THE FOUR PRINCIPLES OF FAMILY MEDICINE

The effective family physician brings a unique set of qualities and skills to a unique practice setting, keeps these up to date, and applies them by using the patient-centered clinical method to maintain and promote the health of patients in his or her practice.

The standards of accreditation of training programs in family medicine are based on the effective teaching of the following four principles of family medicine:

THE FAMILY PHYSICIAN IS A SKILLED CLINICIAN.

Family physicians demonstrate competence in the patient-centered clinical method: they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians have expert knowledge and skills related to the wide range of common health problems and conditions of patients in the community, and of less common but life-threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

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

Family physicians are also adept at working with patients to reach common ground on the definition of the problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Clinical problems presenting to a community-based family physician are not preselected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. The family physician will see patients with chronic diseases; emotional problems; acute disorders, ranging from those that are minor and self-limiting to those that are life-threatening; and complex biopsychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.

FAMILY MEDICINE IS COMMUNITY-BASED.

Family medicine is based in the community and is significantly influenced by community factors. As a member of the community, the family physician 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 family physician may care for patients in the office; the hospital, including the emergency department; other health care facilities; or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION.

The family physician views his or her practice as a "population at risk," and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients' health.

Family physicians have effective strategies for self-directed, lifelong learning.

Family physicians have the responsibility to advocate public policy that promotes their patients' health.

Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources. They consider the needs of both the individual and the community.

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 sickness. Family physicians are aware of their strengths and limitations, and recognize when their own personal issues interfere with effective care.

Family physicians 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 cognizant of the power imbalance between physicians and patients, and of the potential for abuse of this power.

Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on their relationship and to promote the healing power of their

interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.

LEARNING OBJECTIVES

These four principles of family medicine have major implications for the nature of postgraduate family medicine residency programs. The College believes unequivocally that experience in family practice **must** form the basis for any residency program. The involvement of colleagues in other medical disciplines and health professions **must** always be guided by the goals and principles of family medicine.

1. There **must** be a statement of the overall goals of the program. In addition, there **must** be specific educational objectives with respect to knowledge, skills, and attitudes for each rotation or other educational experience. The goals and objectives should be reflected in the planning and organization of the program and in the evaluation of residents.
2. The statement **must** identify the methods by which residents are to be evaluated.
3. All residents and faculty **must** receive a copy of the current goals and objectives.
4. The statement of goals and objectives **must** be reviewed periodically by the postgraduate director and the residency program committee to determine the appropriateness of the objectives and how well they are reflected in the organization of the program and the evaluation of residents.

B

LEARNING ENVIRONMENT

The learning environment is an important and often overlooked component of a training program. The CFPC believes that a supportive learning environment requires respect for learners, a respect for their learning objectives and a willingness to help them achieve those objectives. It is important, therefore, that a program build a collegial environment and be able to ensure that the family physician and specialty physician teachers with whom the residents interact share a respect for the discipline of family medicine.

The director of postgraduate education, taking into consideration the advice of the family medicine postgraduate committee, will be responsible for determining the number of residents that the program can teach effectively. Selection of residents should be the responsibility of the postgraduate education committee of the department of family medicine. The postgraduate director of the program **must** have the ability to assign residents to those settings and rotations deemed appropriate for the training of family medicine residents, and to provide equitable access to all training and educational experiences for all residents in the program.

The department of family medicine should ensure that resources are available to meet the health and safety needs of residents and, in particular, to recognize and provide counselling for stress-related problems among residents.

Faculty/resident interaction and communication **must** occur in an open and collegial atmosphere, such that the tenets of acceptable professional behavior 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 behavior hindering the learning environment can be investigated impartially.

C

EVALUATION

I) PROGRAM EVALUATION

A clear and systematic process for a program-wide evaluation **must** be in place in order to ensure that the educational objectives have been achieved. Input from and participation by residents **must** be an essential part of this system. Programs **must** demonstrate the ability to implement changes in any component in response to program evaluation.

Faculties of medicine **must** have in place an effective system of internal review. Internal review is an essential part of the accreditation process. It is an important mechanism for providing the postgraduate residency education committee and the residency program with information necessary to improve the quality of the program. It should permit identification of strengths and weaknesses and the recommendation of changes within the program.

Internal reviews **must** be conducted at regular intervals between external reviews by the College of Family Physicians of Canada. While programs are expected to have mechanisms to monitor activities and experiences regularly, this more formal review should follow a process similar to that used by the CFPC's accreditation process. Whenever appropriate, this review should be done as part of the university-wide internal review.

II) RESIDENT EVALUATION

Each residency program **must** have a resident evaluation system that focuses on the teaching and learning of the four principles of family medicine and the specific educational objectives of the program. The most effective evaluation processes are based on individual resident learning plans or contracts and programs are encouraged to develop a written plan for each resident that can be the focus for regular progress reviews. The educational plans should be developed primarily from the educational objectives of the training program but also address the specific learning needs of each resident and their individual goals.

1. Each resident **must** have a faculty advisor.
2. Residents **must** be included in designing and implementing the evaluation process.

3. Evaluation forms for all clinical rotations **must** be specific to the discipline of family medicine and reflect the four principles of family medicine.

4. The system **must** focus on both formative and summative evaluation.

5. The system **must** document resident learning with both qualitative and quantitative information.

6. The system **must** include information collected from a variety of evaluation techniques and processes over the time of the training program. These should include chart reviews, direct observations, case discussions and might also include both written and/or oral examinations.

7. The system **must** include a focus on clinical skills and make use of a variety of direct observations of clinical encounters some of which should be electronically recorded (video/audio/other) and reviewed with residents.

8. The Evaluation process **must** include an opportunity for resident additions to the defined learning objectives.

9. The program **must** ensure and be able to demonstrate the variety and range of patients and patient problems encountered by each resident during all their clinical family medicine experiences.

10. Observations **must** involve a variety of patients and **must** sample different types of skills including history-taking, physical examination, procedural skills, doctor-patient relationship and dealing with difficult patients.

11. First and second year residents **must** have the equivalent of four direct observations of a patient encounter each month of their block-time family medicine rotation and at least once per month during their half-day return for continuity of care.

12. The required direct observations **must** be documented (a minimum of 32 direct observations over 2 years).

13. The evaluation **must** be submitted, signed by the resident and evaluator, to the evaluation coordinator within a reasonable and defined period of time.

Resident Evaluation Coordinator
Each program should identify a person, or persons, who will have the responsibility of coordinating resident evaluation. The role of the coordinator could be the responsibility of a single person or of a committee. The responsibilities of this individual or committee should include the following elements:

- working with the Postgraduate Committee to make recommendations for overall resident evaluation policy
- coordinating the distribution of resident evaluation forms, collection and collation of data
- identifying those areas pertaining to evaluation that would benefit from faculty development
- providing a resource for reviewing and improving the process of resident evaluation
- establishing effective liaison with other specialty rotations to communicate around objectives and resident evaluation
- participating in the process of identification of residents who are having problems in the training program

- furnishing feedback to preceptors with regard to the quality of their assessments of the residents assigned to them

These responsibilities may be shared among a number of individuals including a program committee for resident evaluation. The evaluation coordinator should be a member of the residency postgraduate committee.

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 evaluating that resident. The role of the faculty advisor is to:

- orient the resident to the discipline of family medicine
- discuss with the resident the program objectives as well as the resident's own learning objectives and design an appropriate educational plan
- review this plan regularly and assist the resident in finding the resources within the program necessary to meet their unique learning needs
- help the resident:
  - understand the four principles of family medicine
  - reflect on program choices to be made
  - understand evaluation feedback
  - set and revise learning objectives
  - define career plans

III) FACULTY EVALUATION

Programs **must** have in place a formal and fair mechanism to evaluate faculty that **must** follow defined and published criteria. This process should 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 only for promotion or disciplinary purposes. It should be done regularly and in a formative manner, and should encourage the faculty member to do self evaluation and to set objectives for his or her own development.

D
FACULTY DEVELOPMENT

1. Faculty should be knowledgeable about the principles of experiential learning and other appropriate educational theory and techniques. This **must** be ensured through an effective program of faculty development.
2. Program directors, faculty, other teachers, and residents should be educated about appropriate behavior in the learning environment and about intimidation and other abusive behavior.

3. Each department of family medicine must plan and implement faculty development activities for its teachers.

   3.1 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. Available resources in the larger university setting should also be considered in program planning.

   3.2 Faculty development should be faculty centered.

   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. 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.

   3.3 Faculty development should be actively supported and promoted.

   Each department should allocate human and financial resources to faculty development programming in order to guarantee 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.

E

SCHOLARLY ACTIVITY

1. The quality of scholarship in the program should, in part, be demonstrated by a spirit of enquiry during clinical discussions, 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.
2. 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 experiences or rotations.
3. The demands of clinical service **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.
4. 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.
5. Residents **must** be given opportunities to develop effective teaching skills through organized activities focused on teaching techniques.

6. Residents should have opportunities to teach and to become role models to junior residents and medical students.

7. 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.

8. There should be a faculty member whose responsibility it is to facilitate residents' involvement in research and other scholarly activity, such as resident projects.

Standards for the Accreditation of Family Medicine Residency Programs

Please note that the following guidelines and requirements are in addition to the general standards governing program accreditation which have been outlined previously in this publication.

A
CURRICULUM

INTRODUCTION

The curriculum should be guided by the following educational principles:

1. Family 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.

2. Programs **must** demonstrate that effective experiential learning of continuity of patient care occurs within the program. Residents **must** have a group of patients for whom they assume significant responsibility over an extended period of time and in different patient care settings. Residents **must** learn the skills of coordinating the interprofessional care of patients with multisystem illness, including the maintenance and use of high-quality health care records and other forms of communication. Residents **must** develop an appropriate attitude toward the establishment of enduring relationships with and ongoing commitments to their patients. Development of such an attitude should be incorporated into block time. It is also recommended that residents on rotations other than family medicine should be released for a half-day each week so they can follow their own identified group of family practice patients.

3. The curriculum should be flexible to allow residents to develop the special skills they will need to practice in widely varied settings.

Programs should organize block rotations in other clinical disciplines when the concentration of time and experience would be relatively advantageous. Such experience could include disciplines such as internal medicine, surgical specialties, obstetrics, geriatrics, psychiatry, pediatrics, and emergency medicine. Within these block rotations, residents should have time protected for horizontal experiences relevant to the block, as well as the half-day release to their family practice offices. These experiences might include work in ambulatory clinics or day hospitals, community services or seminars, and scholarly work. The department of family medicine will plan and approve these experiences in consultation with the specialty departments involved. Programs should provide opportunities for residents to select other experiences that meet their individual learning needs.

CURRICULUM CONTENT

CURRICULUM GUIDELINES RELATED TO THE FAMILY PHYSICIAN IS AN EFFECTIVE CLINICIAN.

The experiences arising from time spent in family practice settings are vital to the development of effectiveness as a family physician. Family practice time **must** provide residents with the opportunity to experience both the role of the family physician and the scope of family practice. The program **must** ensure that residents maintain meaningful contact with their professional discipline throughout the program.

Block time in family practice **must** occur in both years. A minimum of eight months of a two-year program **must** be spent based in a family medicine teaching practice, and at least one block should consist of four continuous months in the same teaching practice. The first year **must** include at least two months of family practice block time. These two months should be consecutive. During block time in family practice, residents **must** assume major responsibility for integrating full care for those patients with whom they have continuing relationships. Block time should be organized to reflect appropriate patterns of practice, and residents **must** work together with effective family physician role models.

All family medicine residents **must** spend a minimum of 8 weeks in a rural family practice as part of their core family medicine experience.

The College of Family Physicians discourages family medicine block rotations of less than 2 months (8 consecutive weeks) as short exposures to a particular practice do not normally allow a resident to develop any meaningful levels of continuity, or responsibility. Exceptions to this would be an introductory month to a practice in which the resident will remain attached for continuity of care and where the resident will be returning for a longer experience later in their program.

Just as practicing family physicians work largely in office settings, so residents **must** be based primarily in an office setting. Practice-based patient care activities **must** comprise a minimum of six half-days each week. In addition to actual office-based patient contacts, such time can include weekend clinics or rounds, hospital visits to patients admitted through the practice, and other practice-based patient care activities. 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. After hours care must be limited to patients for which the family practice service would normally be responsible.

To promote active reflection and deeper understanding of important concepts, block time **must** also have an academic component. Each week, time should be allocated to a variety of activities, including seminars and didactic teaching, horizontal electives, free study time, and protected time for work on practice audits and research projects. Time should be provided for horizontal electives, and these experiences may comprise up to three half-days a week. Their selection should be guided by relevance to patient care in family practice. For example, dermatology, emergency care, surgical procedures, adolescent medicine, and behavioral medicine are relevant electives.

The practice-based experience should have a reasonable balance of acute and chronic care, ambulatory and hospital care. It should also provide a breadth of involvement with patients who are from all age groups and have a variety of problems, including obstetrical patients. There **must** be a progression of responsibilities and activities as a resident moves through the program, ultimately approaching the level of function expected of a family physician in practice.

Life Cycle
The family practice settings in which residents obtain their training should include a wide range of age groups and clinical problems, including care of dying patients. Residents should not be limited to a practice that is too heavily skewed toward any particular age group or special interest area. Should residents be assigned to such a practice, the program **must** make provision to ensure that such residents are able to meet any deficiencies in learning opportunities.

Care of Children and Adolescents
The family medicine settings in which residents are based for eight months of their training **must** have an adequate volume of office visits by children and adolescents to allow residents 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.

Other clinically based experiences caring for children should be added as a supplement, and should allow a concentrated experience in common childhood health problems that may require secondary level care. Ideally this training should be ambulatory and involve care of pediatric emergencies as well as some experience in outpatient clinics. Because adolescents attend physicians’ offices infrequently, clinical experiences should extend beyond the office to outpatient clinics, school-based clinics, reproductive health clinics, and street clinics. Any time spent on a hospital pediatric ward should expose residents to a wide range of pediatric and adolescent problems, and include hospital management of those illnesses that commonly present to family physicians. Training in neonatal resuscitation **must** be provided.

Care of Adults
Specialty rotations in internal medicine should be arranged to supplement the family practice experience, and should include both ward-based and ambulatory-based experiences. Experience should include the assessment and care of the acutely ill. Family medicine residents should receive training only on wards in which they will see a wide variety of internal medicine problems appropriate to family practice. Hospital-based block rotations on family practice wards are valuable experiences, but these will be considered part of the hospital-based experience and not part of the eight-month block experience in office-based family practice.

To provide effective care, residents **must** become knowledgeable about the special health care requirements specific to men and women. The family practices in which residents are trained should have an adequate patient base to allow experience of these health areas.

Click Here for An Approach to Maternity Care Education for Canadian Family Medicine Residents

Although family physician teachers may not include obstetrics in their practice, residents in training programs **must** have the opportunity to follow some (preferably six or more) obstetrical patients to term and through labor and delivery throughout the course of the two-year program. In addition, residents **must** have an adequate specialty experience in obstetrics, which focuses on labor and delivery. It is important that this learning occur in a setting in which family physicians are also working. Residents **must** also gain experience in gynecological problems related to family practice in outpatient settings.

Residents **must** be well acquainted with important physical and psychosocial aspects of men's and women's health care, including occupational health, family planning, spousal abuse, sexual assault, and sexual abuse. Residents **must** become familiar with gender-based differences in the management of common health problems in men and women. This area of training can be enhanced by a wide range of horizontal experiences in occupational health clinics, family planning clinics, rape crisis centers, women's shelters, and women's health clinics, and by other related experiences.

Care of the Elderly
Residents **must** learn the special skills, knowledge, and attitudes related to care of the elderly. Residents **must** be able to do a comprehensive functional and clinical assessment of the frail elderly, including assessment of mental function. They **must** also be familiar with the atypical presentation of illness and with the management of common geriatric and psychogeriatric problems, both physical and psychological, in hospital, institutional, and community settings. Residents should learn to be effective team members by participating in a multidisciplinary geriatric team. A variety of resources, including family medicine and specialty faculty with expertise and training in care of the elderly, should be available to residents. It is expected that family practice block time will include an opportunity for residents to care for ambulatory elderly patients in the home and the office. In order to meet these objectives, programs should make use of ambulatory clinics, long-term care programs, and hospital rotations, as well as family practice settings.

Palliative and End of Life Care
Residents **must** learn the skills, knowledge, and attitudes related to the management of physical, psychological, social and spiritual needs of dying patients and their families. Residents **must** be familiar with medical and societal attitudes towards death and dying.

OTHER CLINICAL SKILLS

Surgical and Procedural Skills
Residents in family practice settings **must** have an opportunity to learn surgical and procedural skills that can be practiced appropriately in the family practice office, or in outpatient or emergency department settings. These skills should be taught by family physicians if possible, but learned in specialty horizontal experiences if necessary. Surgical and procedural skills can be learned in a variety of different settings and programs should make use of block or horizontal experiences in such areas as surgery, emergency medicine, dermatology, and treatment of musculoskeletal problems.

Residents should also have the opportunity to learn other skills of particular interest or relevance to their career plans. They should be encouraged to learn the general principles of surgical procedures so that they can add to their skills once they have graduated from the training program. There should be an opportunity in either a

surgical rotation or other setting to learn the principles of pre- and postoperative care, and to develop the ability to recognize patients requiring acute surgical intervention.

Behavioral Medicine

Residents in family medicine **must** have an opportunity to learn behavioral medicine relevant to family medicine. Behavioral medicine may be taught in a variety of settings and formats. These should include a strong orientation to interviewing skills and the doctor-patient relationship within the context of the family practice office setting. These experiences should be supplemented by seminars, as well as by other horizontal and block rotations that may be deemed appropriate. Programs should work closely with the department of psychiatry to develop appropriate rotations and experiences for residents in crisis management, short-term psychotherapy, and family counselling. Programs may wish to integrate other appropriate health care workers in a complementary role in the teaching of residents, however, family physicians must provide and coordinate core teaching.

Emergency Care

Residents in family medicine **must** have an opportunity to learn and experience the delivery of care in acute care settings, including the emergency department. Acute care settings provide the resident with an opportunity to learn the skills of triage and surgical assessment, a variety of procedural skills related to trauma management, managing medical emergencies, and working with a team. The setting selected for this training should provide experience with a wide variety of patient problems in children, adolescents, adults, and the elderly. These sites should also provide an opportunity for residents to work with family physicians who include emergency medicine as part of their professional activity. Supervision of the residents should be done by both emergency physicians and family physicians.

CURRICULUM GUIDELINES RELATED TO FAMILY MEDICINE IS COMMUNITY BASED.

Residents **must** learn and experience the role of the family physician in settings other than the office. For hospital care this can be best achieved through the residents admitting their own patients from their family practice setting and permitting residents' to follow them, when appropriate, in hospital. In this context residents **must** learn the skills of referral and consultation. Such skills can be enriched through the use of inhospital family practice rotations, and through resident interaction with specialty trainees in the hospital. Residents should also learn about the cost-effective use of resources and the physician's role in hospital committees through participation and formal teaching. Residents **must** have a minimum of 2 months experience maintaining clinical responsibility for their family medicine patients in hospital settings in which their family physician preceptors are the primary providers of inpatient care.

Residents **must** learn the principles of home care for patients with chronic illness, dying patients, and elderly patients.

Residents in family medicine **must** learn how to identify and respond effectively to the needs of communities. This can be accomplished through introducing residents to the role of the family physician in urban, rural and remote areas.

Residents **must** have knowledge of and be willing to draw upon the community's resources, such as medical consultants, other health professionals, and community agencies.

Residents **must** become familiar with the medicolegal and medical/ethical issues relevant to family practice and should become knowledgeable about licensure requirements and their responsibilities as professionals.

The residency training program will provide a curriculum in family medicine ethics with the following minimum characteristics:

1. The teaching of a knowledge base of the relevant bioethics and medicolegal literature pertaining to ethical issues inherent in family practice.

2. The teaching of analytical skills in a systematic and comprehensive manner suitable to the identification and resolution of ethical issues inherent in family practice.

3. The perspective of the teaching program should be one of clinical relevance and should therefore focus on ethical issues confronted daily in family practice (such a program presupposes a more theoretical undergraduate exposure to ethics in medicine). To this end, it should be:

   - integrated as much as possible into existing clinical training of family phyisicians

   - developed in parallel with a faculty development program, so that teachers of family medicine can effectively accomplish this integration

   - provided in a multi-disciplinary context

4. There **must** be a formal evaluation of the attitudes, knowledge and skills pertinent to the ethics of family medicine.

CURRICULUM GUIDELINES RELATED TO THE FAMILY PHYSICIAN IS A RESOURCE.

The family physician **must** be able to function as a resource to his/her practice population.

To fulfill their role, physicians **must** be able to evaluate new knowledge critically and interpret its relevance to the practice and the community. Residents **must** be taught the basic principles of critical appraisal and apply these in daily practice and in the preparation of seminars and presentations.

Each residency program **must** demonstrate a commitment to integrating the tools of information management into patient care, teaching and research.

This will require that the program have an organized approach to promoting the use of, and fostering the teaching of informatics. Essential elements of this commitment will include:

1. Providing residents and faculty with ready access to the tools of information management in the areas where they usually conduct patient care.
2. Developing, implementing and evaluating a resident curriculum and faculty development program in family medicine informatics.

Family physicians **must** be able to assess their own skills, knowledge, and practices through practice audit and other quality assurance activities. Residents **must** learn the basic principles of quality assurance, including setting standards, measuring performance against those standards, and follow-up to ensure they were met; residents **must** participate in practice audit activities during residency training.

Family physicians should be able to manage efficiently the business aspects of practice, including scheduling, office supplies and equipment, personnel, on-call systems, medical records, etc. Residents **must** be taught the basic principles of, and have the opportunity to participate in, practice management decisions, particularly in community practice rotations. Residents **must** learn the skills related to managing information, such as health care records and other forms of patient information.

Family physicians have a responsibility to provide preventive medical care to their patients of all ages. Residents **must** learn the principles of preventive care and be able to implement appropriate screening and patient education activities in their teaching practices.

CURRICULUM GUIDELINES RELATED TO THE DOCTOR-PATIENT RELATIONSHIP.

The special nature of the doctor-patient relationship in family medicine will be learned primarily during the time in family practice, although an effort **must** be made to integrate this essential principle into the entire program. Guided reflection on clinical experience is essential to learning in this area. This type of learning requires particular kinds of patient care experiences, including responsibility for providing continuing care for a group of patients over a period of many months; faculty support and guidance to prevent difficult experiences from being negative or overwhelming; and opportunities for discussing patient-physician relationship issues with experienced, skilled, and sensitive teachers of family medicine.

Time for reflection and reading about the doctor-patient relationship is important, and residents **must** be encouraged to expand their self-awareness in the context of providing patient care.

Among the knowledge, skills, and attitudes that **must** be included are the following:

- Understanding of the patient-centered clinical method
- Understanding of the conventional biomedical model and its limitations, and an awareness of nonmedical determinants of disease and illness
- Understanding of the distinction between disease and illness; awareness of the physician’s different roles, ranging from technical expert to healer; and

self-awareness of personal strengths and weaknesses, and of one's own personal response under stress

- Understanding of basic concepts of human growth and development
- Understanding of the basic concepts of an effective doctor-patient relationship
- Understanding of the common ethical issues confronting physicians in the day-to-day care of patients
- Understanding of systems theory and of the importance of the family and social context in the genesis and treatment of illness
- Understanding of the place of intimacy in the doctor-patient relationship, and of the potential for abuse of the relationship
- Effective communication skills
- An appropriate attitude towards the establishment of enduring relationships and ongoing commitment to patients.

B

PROGRAM ORGANIZATION

A residency training program in family medicine **must** be based in a university department of family medicine, from which the total training of all residents registered in that program can be developed and coordinated in collaboration with other relevant disciplines within the medical school.

Each department **must** have an individual identified as the director of postgraduate education, who is responsible for overseeing all of the postgraduate educational activities of the family medicine residency program. The postgraduate director **must** have adequate time and support to supervise and administer the postgraduate education program. The residency postgraduate director is responsible to the head of the department of family medicine and to the postgraduate dean of the faculty of medicine.

The family medicine postgraduate director **must** hold certification in family medicine (CCFP).

The postgraduate director of the department of family medicine will be assisted by a postgraduate education committee, which will 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 family medicine postgraduate education committee of the department **must** have the responsibility to develop a clear curriculum plan. Such a plan **must** include objectives relating to knowledge, skills, and attitudes, and be based upon the educational objectives and the four principles of family medicine defined by the CFPC.

The postgraduate education committee should be responsible for selecting candidates for admission to the program. The selection will be in accordance with policies determined by the university department of family medicine.

All health care facilities offering resident training experiences (other than elective experiences) **must** have an affiliation agreement or a letter of understanding with the relevant faculty of medicine, and should be encouraged to receive accreditation by the Canadian Council on Health Services Accreditation (CCHSA).

C
RESOURCES

CLINICAL TEACHING RESOURCES

The department of family medicine **must** have sufficient financial resources, administrative structure, and accountability to ensure that its educational program is effectively administered throughout all the training sites affiliated with that department.

Each residency training program **must** provide appropriate family practice teaching settings for the training of residents. Such practices may be family practice teaching units staffed by geographic full-time family physician teachers appointed within the department of family medicine, or community practices staffed by family physician teachers with part-time appointments within the department of family medicine. All or part of the residents' family practice experience may occur in either kind of setting.

Such practices **must** provide an adequate patient volume and variety to allow residents an opportunity to experience all aspects of family practice, including obstetrical care.

Teaching practices **must** allow a resident to acquire the identity of a family physician. The resident's time in family practice **must** be in a setting that allows the resident to undertake all the tasks and responsibilities outlined in the introduction to this section. There should be an opportunity for continuity of care to allow residents to observe the natural history of disease, and 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 a defined panel of patients during their time in their primary teaching center. 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.

Such practices should demonstrate effective practice management and quality assurance programs.

The teaching sites **must** have in place the appropriate equipment and technology to teach residents effectively and to assess their skills as family physicians. Such equipment may include one-way mirrors and video or audio equipment.

FACULTY RESOURCES

Family medicine should be taught by family physicians whose philosophy and practice are consistent with the aims and aspirations of family medicine, as defined by the four principles.

1. All full-time family physician teachers **must** hold certification in family medicine (CCFP) and hold academic appointments in the university Department of Family Medicine. This does not preclude the appointment of family physicians with other or equivalent qualifications. However, any full-time family physician teacher, appointed to a university Department of Family Medicine, who does not hold certification in family medicine with the College of Family Physicians of Canada should seek certification within four years of appointment.
2. All part-time family physician teachers **must** hold qualifications acceptable to the College of Family Physicians of Canada, which would normally be certification in family medicine (CCFP). All such teachers, who do not hold certification in family medicine, should be encouraged to obtain certification with the College of Family Physicians of Canada (CCFP) within four years of appointment.
3. In a community practice, staffed by part-time family physician teachers, at least one of these teachers **must** be a certificant in family medicine. One of the certificants **must** be responsible for the co-ordination of resident education in the practice.
4. All family physician teachers required to hold certification in family medicine **must** maintain their certification.
5. The ratio of supervisors to residents during any family practice clinical experience should be no less than 1 supervisor to 4 residents. The cohort of supervisors **must** consist of family physician teachers whose practices are based in the teaching unit and who can function as role-models for the residents.
6. Specialty and other health professional teachers should have university appointments in keeping with their academic responsibilities. These teachers may have appointments in departments of family medicine when appropriate. Specialty areas should be taught by family physicians with special skills and by family practice oriented specialists (including other health-care professionals). Specialist teachers should be those who are familiar with the problem solving skills and orientation of family practice, and who are directly involved with family physicians in daily practice.

Standards for the Accreditation of Family Medicine/Emergency Medicine Residency Programs

Please note that the following guidelines and requirements are in addition to the general standards governing program accreditation which have been outlined previously in this publication.

A

CURRICULUM

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 the College of Family Physicians of Canada in emergency medicine (EM) are:

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 CONTENT

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 into their emergency practice the principles of family medicine.

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-centered 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 EM resident **must** acquire the knowledge and skills to:

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.

An EM resident **must** acquire the knowledge and skills to:

1. understand the principles of the development and implementation of support emergency medical services in the community for prehospital 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 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 scare resources in the health care system.

An EM resident **must** acquire the knowledge and skills to:

1. implement the principles of quality assurance, risk management, continuous quality improvement, and total quality management. He/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.

An 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 co-workers.
3. make ethical decisions in the emergency department, and identify medicolegal 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 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.
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 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 on pages 9-11.

B

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 College of Family Physicians of Canada. 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 certification in family medicine with a certificate of special competence in emergency medicine. 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 by the College of Family Physicians of Canada 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/her representative.

C
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 are certificants of 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 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 4 principles of family medicine as they apply to emergency medicine as outlined on pages 25-27.

Standards for the Accreditation of Residency Programs in Enhanced Skills for Family Practice

Please note that the following guidelines and requirements are in addition to the general standards governing program accreditation which have been outlined previously in this publication.

A

CURRICULUM

INTRODUCTION

Graduates of the family medicine residency programs will have a comprehensive clinical and academic education that should prepare them for a full service family practice in most urban or rural communities in Canada. There may however be a need for some family physicians to bring enhanced skills to adequately serve communities or practice settings that have special needs or lack certain medical services and resources. These communities or practice settings vary widely in terms of the skills and knowledge they may require whether they are rural, urban or remote.

While some of these needs can be met by already accredited programs in areas like emergency medicine, palliative care and care of the elderly, there is a wide range of other areas that need to be addressed. These include maternity care, anesthesia, surgery and many other more specific or special skills. The program in Enhanced Skills for Family Practice is intended to provide an academic base within Departments of Family Medicine to plan and oversee a range of enhanced skills learning opportunities not only for graduates of family medicine residency programs but also for physicians currently in practice who wish to upgrade their skills or acquire new skills to meet the needs of the populations they serve.

CURRICULUM CONTENT

The curriculum for enhanced skills for family practice will include two kinds of training options. The first or Category 1 options will include training programs that have nationally accepted standards in areas like care of the elderly. (see Appendix A) The second type of program or Category 2 programs will include programs that address locally or even personally defined goals and educational objectives. While these programs may have defined curricula within the university in which they are offered, they will not have nationally accepted standards. Both Category 1 and Category 2 programs **must** meet the general standards of accreditation of the College related to resident and program evaluation, learning environment and faculty development.

The length of the training experience would depend on the objectives to which the program and the physician seeking training have agreed. In the case of those areas for which nationally accepted standards exist, the length of time in training may be defined but for those with training goals in other areas, the length of training can be open for negotiation.

The kind of training that would fit within the jurisdiction of the Enhanced Skills Program might be as follows:

- A one-year program in family medicine anesthesiology (Category 1)
- Care of the elderly programs (6 or 12 months) (Category 1)
- Other programs of at least 6 months in duration or longer in areas such as: HIV disease, aboriginal health, women's health, and other areas deemed valuable or relevant by university departments of family medicine or the communities they serve. (Category 2)

The specific standards for each Category 1 program will be provided as appendices to this document.

B

PROGRAM ORGANIZATION

The Enhanced Skills for Family Practice Program **must** be conducted in cooperation with the academic department of family medicine and provide an academic and administrative base from which the training in enhanced skills can be planned, coordinated, and evaluated in accordance with the General Standards of Accreditation of the College of Family Physicians of Canada.

A program director who holds certification in family medicine with the College of Family Physicians **must** be appointed to oversee the training of all residents or others undertaking enhanced skills training. The role of program director may be fulfilled by the family medicine residency postgraduate director or may be another individual appointed by the family medicine program. The program director will be a member of the postgraduate resident education committee of the Department of Family Medicine. He/She will be responsible to oversee the quality of training being provided and will evaluate and when necessary intervene on behalf of the trainees to ensure that a high quality of education is being delivered and that the trainees' objectives are being achieved.

The enhanced skills program director will also ensure that appropriate family physician and specialist teachers have been identified to deliver the specific skills training required in each enhanced skill area. When necessary, a coordinator for each enhanced skill area may be appointed from amongst these teachers.

The enhanced skills program director **must** be assisted by a postgraduate education committee that will include representation from among those participating as teachers or coordinators for each relevant skill area. Coordinators of Category 1 programs must be represented on this committee.

Individuals who have completed training in the enhanced skills program should be given a university diploma or other attestation of completion of training indicating the skills learned and/or the program completed (i.e., Care of the Elderly or FP/Anesthesiology etc.) and noting that the program has been accredited by the College of Family Physicians of Canada.

C
RESOURCES

CLINICAL TEACHING RESOURCES

A program of this nature will need to have the means to build effective liaison with a variety of communities and clinical services in order to achieve its mandate. The program **must** therefore have sufficient financial and human resources to ensure that its educational programs are effectively administered.

The program should be able to provide a range of educational programs of varying length. While meeting the needs of residents is important it is also important that the program be able to meet the needs of the community at large. For this reason there **must** be in place a mechanism to identify and provide resources to practicing physicians who, in order to better serve the health care needs of their communities, require upgrading of their skills and knowledge or the acquisition of new skills. In addition to meeting the needs of family medicine residents, practicing physicians and communities, the program will need to have access to a wide range of clinical teaching resources and be in a position to evaluate and liaise with those services and specialty departments to ensure they can meet their educational goals and objectives.

FACULTY RESOURCES

The director of the enhanced skills program **must** have an appointment in the Department of Family Medicine and be a certificant in family medicine. The other faculty resources that will be needed for this program will vary considerably given the wide range of clinical areas that may be required to meet the objectives of the program and its trainees. Family physician teachers should meet the requirements for family medicine residency program faculty noted above. Specialty teachers should have an orientation and interest in family medicine education and be able to demonstrate an ongoing and effective communication with the program. This will be particularly important in the case of those programs for which national standards exist.

APPENDIX A

Standards for Programs in Care of the Elderly

Please note that the following guidelines and requirements are in addition to the general standards governing program accreditation and the standards for residency training in enhanced skills for family practice which have been outlined previously in this publication.

CURRICULUM

INTRODUCTION

The number of people and the proportion of the population over age 65 are increasing. Elderly people, particularly those over 75 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 centers, 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 family medicine certificants in practice or coming out of residency training 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:

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 CONTENT

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 family/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 (for example, program planning committees, medical advisory committees, quality assurance committees, etc.)

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 may 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 could 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 College of Family Physicians of Canada 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 College of Family Physicians of Canada.

RESOURCES

CLINICAL TEACHING RESOURCES

The resident **must** provide care in each of the following ways or settings: These 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. These will include:

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.

APPENDIX B

Standards for the Accreditation of Family Practice-Anesthesia (FP-A) Training Programs

Please note that the following guidelines and requirements are in addition to the general standards governing program accreditation and the standards for residency training in enhanced skills for family practice which have been outlined previously in this publication.

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 College of Family Physicians of Canada for the program in Family Practice—Anesthesia (FP-A) are:

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

CURRICULUM CONTENT

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 domain 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-centered 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.

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

- knowledge of pharmacology, physiology and anesthetic equipment
- risk assessment and peri-operative anesthetic care
- technical competence in airway management and skills in obstetric, pediatric, regional and trauma anesthesia.

Appendix 1 contains an overview of the scope which might be included in a 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

- 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.

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

- implement the principles of quality assurance, risk management, continuous quality improvement, and total quality management. He/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.

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

- demonstrate an effective doctor-patient relationship, and apply the patient-centered 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 medicolegal 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 (e.g., ICU, CCU, 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 centers. For 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, provisions should be made to facilitate this. 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 College of Family Physicians of Canada. 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 (see Red Book). 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 a 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/her 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.

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 College of Family Physicians of Canada.

RESOURCES

CLINICAL TEACHING RESOURCES

The training program must provide:

- 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 an 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 FPA in the comprehensive delivery of health care services.

FACULTY RESOURCES

The training program must provide:

- Qualified teaching staff in sufficient numbers, including those with appointments in the departments of family medicine and anesthesia, to supervise and teach residents.
- 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.

Appendix 1

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 Family Practice Anesthesia 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.

3. 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
- demonstrates skill in establishing and maintaining cardiovascular and respiratory support

B. Peri-Operative 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 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, vapourizers, 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 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 – noninvasive 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

APPENDIX C

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

I Introduction

The Canadian Palliative Care Association has defined palliative care as:

> *"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:

> *"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.

II 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.

III 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 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. This committee:

    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:

    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:

        i. an assessment of each component of the program to ensure that the educational objectives are being met;

ii. an assessment of resource allocation to ensure that resources and facilities are being utilized with optimal effectiveness;

iii. an assessment of teaching in the program, including teaching in areas such as biomedical ethics, medicolegal considerations, teaching and communication skills, issues related to quality assurance/improvement, equity issues, and administrative and management issues; and

iv. 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.

IV 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 are:

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.

(**NB-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 College of Family Physicians of Canada 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.

<u>Specific Objectives</u>

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; and
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-centered) 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 counselling; and
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 to the family after a patient dies.

General Objective 3
(Principle #1 - The Doctor-Patient Relationship)

The resident will demonstrate awareness of his/her personal issues and concerns in the area of death and dying.

Specific Objectives

The resident will be able to:

3.1 describe his/her own concerns about dealing with dying patients and their families;
3.2 demonstrate an awareness of how his/her own personal experiences of death and dying have influenced attitudes; and
3.3 describe strategies for managing his/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 may 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 counselling to dying patients and their families; and
4.10 identify the social and existential needs confronting the patient and families, and strategies that may 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; and
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; and
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; and
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; and
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; and
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; and
10.4 act as an effective advocate for the rights of the patient and family in clinical situations involving serious ethical considerations.

V 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 fulfil 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 may be required by the program director.

1. Pre-requisite

    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:

    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; and
    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; and
    c. have attained certification by the CFPC or the RCPSC.

VI Resources

There must be sufficient resources including teaching faculty, the number and variety of patients, physical and technical resources, as well as 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 such as biliary stent insertion and venous stents
    - access to anesthetists who perform nerve blocks and epidural procedures
    - palliative care counselling 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

VII 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 life-long learning. To promote this end, the program should provide opportunities for residents to attend

conferences outside their own university.

VIII 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 to be completing the required one year in the program.

APPENDIX D

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 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 listed above for the subcommittee and 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.