

College of Medicine Policy

Policy Name:	CPGME Resident Assessment, Progression/Promotion, Remediation, Probation, Suspension and Dismissal/Withdrawal Policy for Competency-Based Medical Education Residency Programs
Application/Scope:	All Postgraduate Medical Education Residents in Competency-Based Medical Education Residency Programs
Approved (Date):	
Review Date:	
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Approved By:	

BACKGROUND

The Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC) in conjunction with Max Rady College of Medicine, Rady Faculty of Health Sciences at the University of Manitoba have the responsibility to ensure that postgraduate trainees are competent and prepared for practice.

Competency-based medical education (CBME) is a method of training physicians to become competent by focusing on explicit abilities or capabilities (competencies) and using these competencies as a means of organizing residency education. In essence, CBME is an outcomes-based approach to postgraduate medical education that focuses on competencies required for practice (Snell et al., 2014).

Assessment is the process of gathering and analyzing information in order to measure a physician's competence or performance and to compare it to defined criteria. With respect to competency-based medical education, the processes of resident assessment, progression and promotion are guided by the following principles:

- Every discipline has specific **Entrustable Professional Activities (EPAs)** and associated **milestones** providing discrete markers of competence that are clearly articulated and that incorporate the CanMEDS/CanMEDS-FM Roles
- Competencies are sequenced progressively (**Competence Continuum**) in such a manner that specific, distinct, yet integrated stages of training, with categorization of **milestones** and **EPAs** within each stage, are employed to mark increasing progression of the trainee on a continuum of competence toward independence in practice
- Learning experiences are organized to allow the trainee to acquire competencies and to demonstrate entrustment within a **hybrid model** of competency-based, timed rotations
- Learning is guided by real-time, high quality feedback from multiple observations
- Teaching faculty act as academic advisors/coaches for the purpose of trainee improvement

- Competency-based assessment for learning is focused on milestone/EPA observations in the clinical setting/workplace
- Decisions regarding promotion and progression of trainees through stages of training is determined by a Competence Committee/Resident Progress Subcommittee, responsible for regular review of learner progress using highly integrative data from multiple EPA and milestone observations and timely feedback as well as other assessment data
- The development of trainee competence, entrustment and independence must be demonstrated and recorded in an electronic portfolio (VENTIS)
- All decisions pertaining to the assessment and the potential outcomes for trainees must be justified and must be documented
- The process for assessment and progression must be clear and must be applied uniformly
- It is important that the process for identification of those trainees who might be in academic difficulty is timely, transparent, fair and unbiased
- The process must allow the resident to be heard and to respond to issues related to academic or other challenges within a reasonable period of time
- There must be open, ongoing and timely communication between trainees and their supervisors
- The process must maintain the principle of mutual accountability whereby progress through training is a joint responsibility of the resident and the Residency Program

DEFINITIONS

Academic/Faculty Advisor/Primary Preceptor/Coach/Mentor – is a faculty member who establishes a longitudinal relationship with a resident for the purpose of monitoring and advising with regards to educational progress

Academic Year – is the time interval that commences July 1st and finishes June 30th and constitutes thirteen four-week blocks of training for residents. In a hybrid competency-based medical education model of learning, a trainee may be out-of-phase and may have a starting date other than July 1st and will be promoted to the next stage of training based on attainment of milestones, EPAs and competencies

Anonymous Materials – materials/information where the authorship has not been disclosed

Block – is one of thirteen time intervals within each academic year. With the exception of Block one, Block seven (Holiday Season break) and Block thirteen, all blocks consist of four-week intervals of training and are considered equivalent for the purpose of scheduling educational activities for trainees in the hybrid competency-based medical education model

CanMEDS/CanMEDS-FM – the RCPSC and CFPC frameworks describing the seven physician roles: 1. Medical Expert/Family Medicine Expert; 2. Communicator; 3. Collaborator; 4. Leader; 5. Health Advocate; 6. Scholar; 7. Professional

CFPC- College of Family Physicians of Canada

CMPA – Canadian Medical Protective Association

Competence – is the array of abilities across multiple domains or aspects of physician performance

Competence by Design (CBD) – is the RCPSC transformational change initiative aimed at implementing a CBME approach to residency training

Competence Committee – is the committee responsible for assessing the progress of trainees in achieving the specialty-specific requirements of a program

Competence Continuum – is the series of integrated stages in competency-based medical education curriculum, including: 1. Transition to Discipline; 2. Foundation of Discipline; 3. Core of Discipline; 4. Transition to Practice

Competency – is an observable ability of a health care professional that develops through stages of expertise from novice to master

Competency-Based Medical Education – is an outcomes-based approach to the design, implementation, assessment and evaluation of a medical education program using an organizing framework of competencies

Competent – possessing the required abilities in all domains at a particular stage of medical education or practice

CPGME – (Max Rady) College (of Medicine) Postgraduate Medical Education

CPSM – College of Physicians and Surgeons of Manitoba

Dismissal – is the termination of the trainee's enrollment in the training program due to academic, professionalism and/or other reasons

Educational Handover – is a process by which information about a trainee's performance is shared with future supervisors in order to facilitate guidance and progress

Entrustable Professional Activity (EPA) – is a “unit of professional practice” that is comprised of measurable tasks and abilities (milestones). Once sufficient competence is achieved, this task is “entrusted to the unsupervised execution by the trainee”. There are residency-specific EPAs that are linked to a specific stage of the competence continuum and integrate multiple CanMEDS milestones from various CanMEDS Roles relevant to that stage. As the trainee progresses through the stages, the residency-specific EPAs become progressively more complex, reflecting the resident's achievement of more complex milestones

Formative Assessment - is a process of assessment that provides real-time feedback to trainees and faculty about how well the resident is progressing in each area being assessed. This information supports the ongoing learning and development for the residents. Furthermore, it may provide diagnostic information regarding the need for Remediation

Incomplete Rotation – means that the trainee has completed less than the minimum seventy-five per cent time span of the rotation required in order to ensure patient safety, appropriate

supervision and opportunities for observation and assessment

ITAR – In-training Assessment Report is a tool for assessment at the end of each rotation/clinical learning experience for Family Medicine trainees

Field Note - is a tool utilized in Family Medicine for the real-time recording of resident assessment and feedback

Milestone – is a defined, observable marker of a trainee's ability along the developmental continuum of training. Residency-specific EPAs are comprised of multiple milestones. CanMEDS milestones illustrate the expected progression of competence. Milestones are used for teaching and assessment

MRA – Mid-rotation Assessment

PARIM – Professional Association of Residents and Interns of Manitoba

PGME Education Advisory Committee (PGME-EAC) – is the subcommittee of the PGME Executive Committee which is responsible for reviewing and approving all major decisions related to trainee progression and promotion by the Competence/Resident Progress Committees and by Program Directors, especially those related to possible Remediation, Probation, Suspension and Dismissal/Withdrawal from the Residency Program. The PGME-EAC deals with issues of a clinical, academic or professional nature

Probation – is an interval/period of training during which the trainee is expected to correct areas of serious clinical or academic challenges or concerns about professional conduct that are felt to jeopardize successful completion of the Residency Program. Probation implies the possibility of Dismissal from the Residency Program if sufficient improvement in performance is not identified at the end of the Probation Period. It is comprised of a formal program/plan of individualized educational support, assessment and monitoring designed to assist the trainee in correcting identified serious performance deficiencies

Probation Plan – is a formal document approved by the PGME Education Advisory Committee and the Associate Dean, PGME detailing the terms, possible outcomes and specific conditions of the Probation Period

RCPSC – Royal College of Physicians and Surgeons of Canada

Remediation – is an interval of training consisting of a formal program of individualized educational support, assessment and monitoring which is designed to assist a trainee in correcting identified areas of performance deficiencies. The goal of Remediation is to maximize the chance that the trainee will successfully complete the Residency Program

Remediation Plan/Focused Learning Plan – is a formal document outlining the details pertaining to the competencies on which the trainee will focus, the resources required and the Remediation Supervisor during the Remediation

RORP – Report of Resident Progress is a summative narrative report documenting resident assessment and progress in the Residency Program

Resident Progress Subcommittee – is the committee responsible for coordinating resident assessment in Family Medicine. The Resident Assessment and Evaluation Lead is Chair of this committee

Rotation – is an interval of time, usually consisting of a portion (two weeks) of a block to multiple blocks to which residents are assigned for training. Rotations may consist of consecutive blocks or may be fractionated over longer periods of time as in the case of longitudinal rotations. Learning experiences are organized to allow the trainee to acquire competencies and to demonstrate entrustment within a **hybrid model** of competency-based, timed rotations

RPC/RTC/PEC – Residency Program Committee/Residency Training Committee/Postgraduate Education Committee

Site (Stream) Lead – refers to that faculty member in Family Medicine most accountable for and knowledgeable of the progress of residents within their respective Educational Site (Stream)

Summative Assessment - is a process of assessment that is based on multiple sources of feedback on the global performance of the trainee over a specified period of time or over a stage of training

Supervisor – Clinical – is the physician to whom the resident reports during a given interval of time, such as an on-call shift

Supervisor – Rotation – is a member of the teaching faculty who has direct responsibility for the resident's academic program activities, such as meeting the milestones and competencies during the rotation

Suspension – is the temporary removal of a resident from clinical and academic activities

Trigger Event – is any event that sets a course of action in motion. Previous decisions are revisited and new needs are recognized. With respect to resident training, assessment and progression, the trigger event might be related to failure of the trainee to achieve the required clinical or academic competencies or might be related to the trainee's professional conduct. This could lead to a series of actions, including Remediation, Probation, Suspension or Dismissal/Withdrawal from the Residency Program

Triple C Curriculum – is a competency-based curriculum reflecting the CanMEDS-FM framework and the Evaluation Objectives in Family Medicine. The three components of Triple C include: 1. Comprehensive educational patient care; 2. Continuity of education and patient care; 3. Centred in Family Medicine

WRHA – Winnipeg Regional Health Authority

Working Days – include Monday through Friday and exclude weekend days, statutory holidays and acknowledged University of Manitoba closure days

1. PURPOSE

- 1.1 Outline the policies and procedures for the fair and transparent assessment and progression of postgraduate trainees within the competence continuum of competency-based medical education
- 1.2 Outline the policies and procedures for managing postgraduate trainees with areas of deficiency in their attainment of milestones/EPAs. The policies and procedures include the following:
 - 1.2.1 Remediation
 - 1.2.2 Probation
 - 1.2.3 Suspension
 - 1.2.4 Dismissal/Withdrawal from the Residency Program

2. POLICY STATEMENTS – ASSESSMENT

- 2.1 For each Residency Program, there must be a framework of clearly-articulated competencies for the residents
- 2.2 Competencies are organized as EPAs and associated milestones, as follows:
 - 2.2.1 For **RCPSC** specialty programs (Competence by Design or CBD), the EPA and associated milestones are discipline-specific as developed by each RCPSC Specialty Committee
 - 2.2.1.1 Competencies are sequenced in a series of integrated stages known as the CBD Competence Continuum, which mark phases of increasing competence and independence, as follows:
 - 2.2.1.1.1 Transition to discipline
 - 2.2.1.1.2 Foundations of discipline
 - 2.2.1.1.3 Core of discipline
 - 2.2.1.1.4 Transition to practice
 - 2.2.1.2 CBD is a hybrid between time-free and time-dependent training as follows:
 - 2.2.1.2.1 Rotations exist and are treated as a resource for the acquisition of competencies
 - 2.2.1.2.2 Progression through training stages is flexible and is suited to the individual trainee's development and acquisition of competencies

- 2.2.1.2.3 Achievement of milestones is prioritized over time spent in training with respect to resident promotion and subsequent completion of the Residency Program
- 2.2.1.2.4 The hybrid model maintains and recognizes the service imperative in residency education
- 2.2.2 For the **CFPC Family Medicine Program**, the EPAs and milestones must cover the required essential skills and other elements of the Evaluation Objectives of Family Medicine and must demonstrate competency in all CanMEDS-FM roles and across all Domains of Clinical Care in Family Medicine
- 2.2.3 The milestones must be used to design educational activities for trainees and to teach specific abilities
- 2.2.4 The EPAs, which integrate multiple milestones must be used in the assessment of residents
- 2.2.5 The EPAs and associated milestones for the Residency Program must be distributed to all residents and faculty in a timely manner prior to the commencement of the educational activities
- 2.2.6 The EPAs and milestones must be reviewed regularly by the Residency Program Committee
- 2.3 For all Residency Programs, the residents must receive regular and timely feedback on their performance and progress by means of performance-based assessment tools as well as by direct observation
- 2.4 Resident assessment in a competency-based medical education framework must comply with the following:
 - 2.4.1 With respect to **RCPSC CBD Residency Programs**, the following apply:
 - 2.4.1.1 Resident learning and assessment are guided by real-time high quality feedback from multiple direct and indirect observations conducted by clinical supervisors, other residents (on- or off-service), other health care professionals and patients
 - 2.4.1.1.1 Teachers/preceptors will observe trainee clinical activities (EPA observation) and must provide face-to-face concrete feedback (coaching), thereby creating frequent “low-stakes” assessments of focused clinical tasks
 - 2.4.1.1.2 Trainees will participate in clinical activities and seek high-quality observations on their progress towards achieving EPAs
 - 2.4.1.1.3 Either the observer or the trainee can initiate an EPA observation
 - 2.4.1.1.4 Achievement of EPAs are determined using multiple observations,

made by multiple observers, in multiple contexts

2.4.1.1.4.1 The recommended number of observations for an EPA is determined by the Specialty Committee for the discipline

2.4.1.2 Trainee assessment feedback information must be concrete and actionable and must be recorded/documentated in the resident's portfolio in order to facilitate the educational changes and progression

2.4.1.2.1 No anonymous materials may be used in any assessment or disciplinary proceeding or action involving the resident. The Associate Dean, PGME may inquire or investigate into matters raised by anonymous materials

2.4.1.3 A variety of formative and summative resident assessment tools are utilized by the RCPSC CBD Residency Programs, including, but not limited to the following:

2.4.1.3.1 Direct and indirect observation

2.4.1.3.2 Multiple source feedback

2.4.1.3.3 Structured Assessments of a Clinical Encounter (STACER)

2.4.1.3.4 Technical skills review/procedure logs

2.4.1.3.5 Patient outcomes

2.4.1.3.6 Simulation

2.4.1.3.7 Objective Structured Clinical Examination (OSCE)

2.4.1.3.8 Oral case presentation

2.4.1.3.9 Written assigned questions

2.4.1.3.10 Learning plan

2.4.1.3.11 Multiple choice questions testing (MCQ) (including the RCPSC examinations)

2.4.1.3.12 Short answer testing (including the RCPSC sub-specialty examinations)

2.4.1.3.13 For consistency, the RCPSC has developed four standardized national templates for assessment of competence, as follows:

2.4.1.3.13.1 EPA Observation Form

2.4.1.3.13.2 Procedural Competencies Form

- 2.4.1.3.13.3 Multiple Source Feedback Form
- 2.4.1.3.13.4 Narrative Observation Form
- 2.4.1.4 Each resident must have an Academic Advisor (Coach) for supervision and support of residents with respect to progression through the stages of residency training
 - 2.4.1.4.1 For Residency programs with a small number of residents the Program Director may be the Academic Advisor
- 2.4.1.5 Decisions on resident achievement of EPAs and progression are determined at a group decision-making process of the Competence Committee
- 2.4.2 With respect to the **CFPC Family Medicine Program**, the following apply:
 - 2.4.2.1 Assessment and feedback for the Family Medicine trainee should lead to guided self-assessment, reflection, revision of learning plans as necessary and gradual achievement of mastery in the required competencies
 - 2.4.2.1.1 All pertinent activities, both clinical and non-clinical should be assessed and the assessment should be specific to the activities
 - 2.4.2.1.2 The level of performance expected for each activity should be clearly defined and clearly understood by the resident and the preceptor-assessor
 - 2.4.2.2 Assessment and feedback for the Family Medicine trainee must be timely and must occur on a regular basis, as follows:
 - 2.4.2.2.1 Daily assessment of learning activities
 - 2.4.2.2.2 Mid-rotation assessment (MRA) is very important as it is intended to be formative in order to guide the resident toward successful attainment of competencies
 - 2.4.2.2.3 End-of-rotation/clinical learning experience summative assessment must occur with the resident on a face-to-face basis and must be documented on the ITAR
 - 2.4.2.2.4 Summative reports (RORP) must be completed on a semi-annual basis
 - 2.4.2.3 Assessment and feedback for the Family Medicine trainee must include face-to-face meetings with the resident to review and discuss their progress
 - 2.4.2.4 Trainee assessment feedback information must be concrete and actionable and must be recorded/documentated in the resident's portfolio in order to facilitate the educational changes and progression

- 2.4.2.4.1 No anonymous materials may be used in any assessment or disciplinary proceeding or action involving the resident. The Associate Dean, PGME may inquire or investigate into matters raised
- 2.4.2.5 The following tools are utilized for assessment/feedback for the Family Medicine trainee:
 - 2.4.2.5.1 Direct observation of resident clinical interactions by the preceptor and documentation in field notes/daily assessments
 - 2.4.2.5.1.1 A sufficient number of field notes should be generated to provide and document meaningful, formative assessment and feedback
 - 2.4.2.5.2 Case discussion and record review
 - 2.4.2.5.3 Mid-rotation Assessment (MRA)
 - 2.4.2.5.4 ITAR (at completion of rotation/clinical learning experience or every three blocks for longer clinical learning experiences) for summative assessment
 - 2.4.2.5.5 Summative reports (RORP) are completed by the Primary Preceptor/ Site Director
 - 2.4.2.5.6 Periodic summative reports reflect the current level of competence achieved by the resident and must not reflect past difficulties that have been managed satisfactorily
- 2.4.2.6 Each resident must have a Primary Preceptor/Faculty Advisor whose role is as follows:
 - 2.4.2.6.1 Orientation of the resident to Family Medicine
 - 2.4.2.6.2 Designing an appropriate educational plan for the resident
 - 2.4.2.6.3 Review the resident's educational plan/program choices on a regular basis
 - 2.4.2.6.4 Assisting the resident in understanding assessment feedback
 - 2.4.2.6.5 Setting and revising learning objectives for the resident
 - 2.4.2.6.6 Reporting on the resident's progress at the Site Resident Progress Committee (SRPC) meeting
 - 2.4.2.6.7 Defining career plans
- 2.4.2.7 Decisions on resident achievement of competencies and progression are determined at a group decision-making process of the Family Medicine

Resident Progress Subcommittee

- 2.4.3 Assessments are the property of the University of Manitoba and the resident and that information will be kept confidential unless there might be a threat to patient safety in the process
- 2.4.4 The decision to allow appropriate disclosure of resident assessment information (Educational Handover) to future Rotation Supervisors to facilitate guidance and progress rests with the trainee's Residency Program Committee
- 2.4.5 The trainee may **not** appeal individual formative assessments which provide data on performance **but** are aggregated for use in progress decisions
- 2.4.6 The trainee may appeal summative assessments which aggregate data from multiple sources

3. PROCEDURES – ASSESSMENT

- 3.1 With respect to **RCPSC CBD Programs**, the following procedures apply:
 - 3.1.1 Prior to commencement of the rotation, the following apply:
 - 3.1.1.1 The resident must review the pertinent EPAs and associated milestones covered on the rotation/clinical learning experience
 - 3.1.1.2 The resident should meet face-to-face with the Rotation Supervisor to review the EPAs and associated milestones and the clinical, academic and professional expectations and duties for the rotation/clinical learning experience
 - 3.1.2 During the rotation, the following apply:
 - 3.1.2.1 The resident receives assessment and feedback for achievement of the pertinent EPAs and milestones from multiple observations. The assessment information must be immediately documented by the observers in the resident's portfolio
 - 3.1.3 At the completion of the rotation, the following apply:
 - 3.1.3.1 The resident must meet face-to-face with the Rotation Supervisor for an exit interview to discuss the resident's performance in general on the rotation and to provide immediate feedback which will be discussed with the resident in more detail at a meeting with the resident's Academic Advisor (Coach)
 - 3.1.4 With respect to the Academic Advisor (Coach), the following apply:
 - 3.1.4.1 The Academic Advisor must review individual resident assessments and portfolios for each assigned resident
 - 3.1.4.2 The Academic Advisor must meet at least quarterly (every three months)

with each assigned resident to conduct comprehensive reviews of performance and to review, discuss and facilitate the implementation and follow-up of Individualized Learning Plans

- 3.1.4.2.1 The Academic Advisor must formally document the details of the resident meetings
- 3.1.4.3 The Academic Advisor must prepare quarterly summary review reports (RORP) and recommendations to the Competence Committee in order to determine the progress of residents in the Residency Program
- 3.1.4.4 The Academic Advisor liaises directly with the Residency Program Director and Competence Committee to help inform decisions related to a resident's progress
- 3.1.5 With respect to EPA achievement, the following apply:
 - 3.1.5.1 If the resident is deemed to have achieved an EPA (EPA is "*achieved*"), then that means that all of the milestones associated with that EPA are considered to have been achieved
 - 3.1.5.2 If the EPA has not yet been achieved (EPA is "*in progress*"), the component milestones associated with that EPA can be reviewed individually ("*unpacked*") in order to identify the particular challenge and to address the learning difficulty so as to provide concrete input and feedback to the trainee
- 3.2 With respect to the **CFPC Family Medicine Program**, the following procedures apply:
 - 3.2.1 Prior to commencement of the rotation/clinical learning experience, the following apply:
 - 3.2.1.1 The Family Medicine resident must review the pertinent EPAs, associated milestones and competencies covered on the rotation/clinical learning experience
 - 3.2.1.2 The Family Medicine resident should meet face-to-face with the Rotation Supervisor to review the EPAs, associated milestones and competencies and the clinical, academic and professional expectations and duties for the rotation/clinical learning experience
 - 3.2.1.2.1 During Family Medicine block time, it is the Primary Preceptor who is the resident's Rotation Supervisor
 - 3.2.2 During the rotation/clinical learning experience, the following apply:
 - 3.2.2.1 The Family Medicine resident receives assessment and feedback for achievement of the pertinent EPAs, milestones and competencies from multiple observations, recorded/documented in field notes (at least one field note per day during core rotations). The assessment information must

be documented immediately in the resident's portfolio

3.2.3 At the mid-point of the rotation/clinical learning experience, the following apply:

3.2.3.1 The Rotation Supervisor must complete an MRA and in the case where the resident is considered to have "*significant concerns about progress*", must discuss it at a face-to-face meeting with the resident in order to address the specific areas of deficiency that require improvement by the completion of the rotation

3.2.3.1.1 During Family Medicine block time, it is the resident's Primary Preceptor/Faculty Advisor who completes the MRA

3.2.4 At the completion of the rotation/clinical learning experience, the following apply:

3.2.4.1 The Rotation Supervisor will incorporate the resident assessment information, including that from field notes, relevant learning experiences and clinical assessment to complete the ITAR which must be available to the resident on VENTIS within twenty working days of the last day of the rotation

3.2.4.1.1 During Family Medicine block time, it is the Primary Preceptor/Faculty Advisor who completes the ITAR

3.2.4.1.2 The resident must provide verification of having read the ITAR. This implies neither agreement nor acceptance of the assessment rating on the part of the resident

3.2.4.1.3 Refusal by the resident to sign the ITAR is considered unprofessional conduct

3.2.4.2 The Rotation Supervisor must discuss the ITAR at a face-to-face meeting with the resident, preferably prior to the last day of the rotation/clinical learning experience

3.2.4.2.1 During Family medicine block time, it is the resident's Primary Preceptor/Faculty Advisor who is meets with the resident

3.2.5 Summative reports (RORP) are completed by the resident's Primary Preceptor/Faculty Advisor on a regular, predetermined basis (at least semi-annually) and must be based on multiple independently documented observations from several observers in different situations and must be compiled and judged by more than one clinical faculty

3.2.6 Periodic summative reports are completed by the Resident's Primary Preceptor and reflect the current level of competence achieved by the resident and do not reflect past difficulties that have been managed satisfactorily

3.3 In the case of **Incomplete Rotations**, the following apply:

- 3.3.1 Should a resident fail to complete seventy-five per cent of a rotation, then the Rotation Supervisor and/or Home Program Director must record this as an incomplete rotation
- 3.3.2 In order to receive credit for the rotation, the resident must complete a supplementary rotation, taking the original incomplete and the supplementary rotation credits into account
- 3.3.3 The exact nature and duration of a supplementary rotation may vary depending on the nature of the original rotation and the proportion missed, but shall not exceed the duration of the original rotation. This will be determined by the Rotation Supervisor and the Home Residency Program Director

4. POLICY STATEMENTS – PROGRESSION/PROMOTION

- 4.1 With respect to the **RCPSC CBD Residency Programs**, the following principles apply:
 - 4.1.1 Learners progress through their residency education program at their own pace
 - 4.1.2 With regular feedback and coaching, each resident will achieve the EPAs and related milestones within their current stage of training, within a predictable training timeframe
 - 4.1.3 Progression decisions on EPA achievement and promotion to the next stage of training are determined away from the individual teacher-learner interaction, as follows:
 - 4.1.3.1 The Academic Advisor/Program Director meets with the trainee at least quarterly to review progress in achieving the required competencies
 - 4.1.3.2 Residency Program Competence Committee (subcommittee of the RPC) is responsible for the group decision-making process of determining learner achievement of EPAs and progression through the stages of training toward certification by the RCPSC

Appendix 1 – Terms of Reference Competence Committee

- 4.1.3.2.1 Each Competence Committee reports to the respective Residency Program Committee and is responsible for the following:
 - 4.1.3.2.1.1 Monitoring the progress of each resident in demonstrating achievement of the EPAs or independent milestones within each stage of the Residency Program
 - 4.1.3.2.1.2 Synthesizing the results from multiple assessments, observations and other evidence as uploaded in the portfolio to make decisions related to the following:
 - 4.1.3.2.1.2.1 The promotion of residents to the next stage of training

- 4.1.3.2.1.2.1.1 On an exceptional basis, trainees may be identified who are eligible for an accelerated learning trajectory
- 4.1.3.2.1.2.2 The review and approval of individual learning plans developed to address areas for improvement
- 4.1.3.2.1.2.3 Determining readiness to challenge the RCPSC examinations
- 4.1.3.2.1.2.4 Determining eligibility for certification and readiness to enter independent practice on completion of the **transition to practice stage**
- 4.1.3.2.1.2.5 Making decisions in the spirit of maintaining patient safety, including weighing a trainee's progress in terms of what they can safely be entrusted to perform with indirect supervision
- 4.1.3.2.1.2.6 Determining that a trainee is "*failing to progress*" within the Residency Program and that the trainee may require Remediation, Probation, Suspension or Dismissal/Withdrawal from the Residency Program
- 4.1.3.2.1.2.7 Monitoring the outcome of any learning or improvement plan established for an individual resident
- 4.1.3.2.1.2.8 Maintaining confidentiality and promoting trust by sharing information only with individuals directly involved in the development and implementation of learning or improvement plans
 - 4.1.3.2.1.2.8.1 Some Competence Committee discussions must be appropriately disclosed (Educational Handover) to future supervisors to provide focused support and guidance for residents
- 4.1.3.2.2 Composition of the Competence Committee may vary depending on the number of trainees in the Residency Program.
- 4.1.3.2.3 The Competence Committee is ordinarily chaired by a member of the clinical teaching faculty who is **not** the Program Director
- 4.1.3.2.4 The size of the Competence Committee should reflect the number of residents (at least three members for smaller programs)
- 4.1.3.2.5 Members are normally from the RPC or Clinical Supervisors associated with the program
- 4.1.3.2.6 The Program Director serves as a member of the Competence Committee

- 4.1.3.2.7 A member “external” to the teaching faculty such as another Program Director, a faculty member from a different discipline or a member of the public is recommended
- 4.1.3.2.8 The Academic Advisor may be used to summarize resident progress for the Competence Committee
- 4.1.3.2.9 The Competence Committee must meet at least semi-annually, although more frequent meetings may be required as regularly scheduled or called on an ad hoc basis as determined by the Chair
- 4.1.3.2.10 Meetings may be face-to-face or virtual or a combination of the two
- 4.1.3.2.11 The Competence Committee reports outcomes of discussions to the Residency Program Committee in a timely manner in order to ensure fairness and appropriate sequencing of training experiences
- 4.1.3.2.12 The trainee may appeal progress decisions of the Competence Committee
- 4.1.3.3 Major progression and promotion decisions, including the trainee’s final portfolio documenting achievement of competencies must be verified and approved by the Residency Program Director and the Associate Dean, PGME
- 4.1.3.4 All decisions leading to Remediation, Probation, Suspension or Dismissal/Withdrawal from the Residency Program must be reviewed and approved by the PGME Education Advisory Committee (PGME-EAC) prior to approval by the Associate Dean, PGME. With respect to the PGME-EAC, the following apply:
 - 4.1.3.4.1 Responsible for Review and approval of Competence Committee/Resident Progress Committee decisions for residents in academic difficulty with respect to the following:
 - 4.1.3.4.1.1 Remediation
 - 4.1.3.4.1.2 Probation
 - 4.1.3.4.1.3 Suspension
 - 4.1.3.4.1.4 Dismissal/Withdrawal from Residency Program
 - 4.1.3.4.2 Advisory to Competence Committees/Resident Progress Subcommittee, Residency Program Committees, Program Directors and the Associate Dean, PGME in addressing matters related to residents in academic difficulty or breaches of professional conduct
 - 4.1.3.4.3 The PGME-EAC will review and provide recommendation related to the following:

- 4.1.3.4.3.1 The process by which the need for Remediation, Probation or individualized learning plan was determined
- 4.1.3.4.3.2 The quality of the proposed Remediation, Probation or individualized learning plan
- 4.1.3.4.4 Membership of the PGME-EAC includes the following:
 - 4.1.3.4.4.1 The Chair, appointed by the Associate Dean, PGME
 - 4.1.3.4.4.2 A minimum of five teaching faculty members
 - 4.1.3.4.4.3 Three residents representing PARIM
 - 4.1.3.4.4.4 Core Curriculum Lead
 - 4.1.3.4.4.5 PGME Lead
 - 4.1.3.4.4.6 Ex officio members, including the following:
 - 4.1.3.4.4.6.1 Director, Education and Faculty Development
 - 4.1.3.4.4.6.2 Associate Dean, PGME Student Affairs
 - 4.1.3.4.4.6.3 Associate Dean, **Professionalism**
 - 4.1.3.4.4.7 The PGME-EAC meets at least bi-monthly, although more frequent meetings may be required as regularly scheduled or called on an ad hoc basis as determined by the Chair
 - 4.1.3.4.4.8 Conflict of interest: A PGME-AEC member, including the Chair, must declare a potential conflict of interest with any case presented for review. The Designated Chair will determine an appropriate course of action. Potential conflicts of interest could include, but are not limited to the following:
 - 4.1.3.4.4.8.1 Any PGME-AEC member having a close personal relationship with a resident under review
 - 4.1.3.4.4.8.2 Clinical teacher or resident directly involved in a rotation/learning experience of concern
 - 4.1.3.4.4.9 In all cases, members of the PGME-EAC will have access to all documents, resident portfolios and files
 - 4.1.3.4.4.9.1 All resident information reviewed and all documents prepared by members of the PGME-EAC are confidential
- 4.1.3.4.5 The trainee may appeal decisions of the PGME-EAC

(PGME-EAC)

4.2 With respect to the **CFPC Family Medicine Program**, the following principles apply:

4.2.1 Progression and promotion decisions are determined away from the individual teacher-learner interaction, as follows:

4.2.1.1 The Family Medicine resident must meet with their Primary Preceptor/Faculty Advisor at least semi-annually to discuss progress towards the essential Family Medicine skills and competencies and to develop an individualized learning plan (**Periodic Review of Resident Progress meeting**)

4.2.1.1.1 A summary report of the semi-annual meeting with the resident must be documented in the resident's portfolio in a timely manner (Periodic Review of Resident Progress or RORP)

4.2.1.2 Decisions on resident achievement of competencies and progression are determined at group decision-making processes of the Site Resident Progress Committees (SRPC) which report centrally to the Resident Progress Subcommittee of the Family Medicine Postgraduate Education Committee (PEC)

Appendix 2 – Terms of Reference Resident Progress Subcommittee

4.2.1.2.1 With respect to resident progression, the Resident Progress Subcommittee has the following functions:

4.2.1.2.1.1 Reviewing resident assessments presented by Site Leads in order to make recommendations to the Family Medicine Program Director regarding the following:

4.2.1.2.1.1.1 Promotion

4.2.1.2.1.1.2 Eligibility for the Certification Examination in Family Medicine

4.2.1.2.1.1.3 Confirmation of Completion of Training

4.2.1.2.1.1.4 Recommending to the PGME Education Advisory Committee (PGME-EAC) and the Associate Dean, PGME via the Family Medicine Program Director with respect to Remediation Plans/Learning Plans and Probation Plans

4.2.1.2.1.1.5 Determining the need for appropriate disclosure of resident information (Educational Handover) to Rotation Supervisors of future rotations/clinical learning experiences

4.2.1.2.1.1.6 Reviewing resident requests for accommodations and making appropriate recommendations to the Family Medicine Program Director

- 4.2.1.2.2 Resident Progress Subcommittee membership includes the following:
 - 4.2.1.2.2.1 Chair: Postgraduate Faculty lead, Resident Assessment and Evaluation
 - 4.2.1.2.2.2 Site leads from all Family Medicine Sites (Streams)
 - 4.2.1.2.2.3 One Inter-Professional faculty member
 - 4.2.1.2.2.4 Four Chief Residents as selected by the Chief Resident Group
 - 4.2.1.2.2.5 Family Medicine Program Director
 - 4.2.1.2.2.6 Postgraduate Education Secretary
- 4.2.1.2.3 A quorum of the Resident Progress Subcommittee consists of the Chair, two residents and two Site leads
- 4.2.1.2.4 The Resident Progress Subcommittee meets at least quarterly but may meet more frequently at the call of the Chair
- 4.2.2 The trainee may appeal decisions of the Resident Progress Subcommittee
- 4.2.3 Major progression and promotion decisions, including the Family Medicine resident's final portfolio documenting achievement of competencies must be verified by means of a Certificate of Completion by the Family Medicine Program Director and the Associate Dean, PGME
- 4.2.4 All decisions leading to Remediation, Probation, Suspension or Dismissal/Withdrawal from the Residency Program must be reviewed and approved by the PGME Education Advisory Committee (PGME-EAC) prior to approval by the Associate Dean, PGME (see 4.1.3.4)
- 4.2.5 The trainee may appeal decisions of the PGME-EAC

5. PROCEDURES – PROGRESSION/PROMOTION

- 5.1 With respect to the **RCPSC CBD Residency Programs**, the following procedures apply:
 - 5.1.1 Trainees are selected for a planned Competence Committee meeting by the Chair, the Program Director or their delegate
 - 5.1.1.1 Each trainee must be discussed at least semi-annually
 - 5.1.1.2 Trainees may be selected for review based on any one of the following criteria:
 - 5.1.1.2.1 Regularly timed review

- 5.1.1.2.2 A concern has been flagged on completed assessment(s)
- 5.1.1.2.3 Completion of stage requirements and eligible for promotion or completion of training
- 5.1.1.2.4 Requirement to determine readiness for the RCPSC examination
- 5.1.1.2.5 Concern regarding a significant delay in the trainee's progress or academic performance
- 5.1.1.2.6 Decision required regarding possible significant acceleration of the trainee's progress
- 5.1.1.3 There should be at least fifty per-cent attendance to achieve quorum, with an absolute minimum of three Clinical Supervisors for smaller Competence Committees
- 5.1.1.4 Each trainee selected for the discussion at the Competence Committee meeting is assigned to a designated **primary reviewer**, who is typically the trainee's Academic Advisor and who completes a detailed summary review of observations and other assessments or reflections included within the trainee's portfolio
- 5.1.1.5 The primary reviewer must consider the trainee's recent numerical data, comments and other valid sources of information (OSCE; in-training examination performance; other)
- 5.1.1.6 The primary reviewer will provide a succinct synthesis and impression of the trainee's progress to the Competence Committee
- 5.1.1.7 The primary reviewer proposes a resolution on the trainee's status going forward
- 5.1.1.8 All other Competence Committee members (**secondary reviewers**) are responsible for reviewing and discussing the trainee's progress
- 5.1.1.9 During the Competence Committee meetings, the following apply:
 - 5.1.1.9.1 The primary reviewer presents relevant synthesis of information pertaining to the trainee under discussion, including reports from the portfolio and sharing important quotes from any observational comments about the trainee and concludes by proposing a **status** and recommended action for the trainee going forward in the Residency Program, as follows:
 - 5.1.1.9.1.1 Trainee is "*progressing as expected*". Possible recommendations for action might include the following:
 - 5.1.1.9.1.1.1 Monitor learning

- 5.1.1.9.1.1.2 Modify learning plan by means of additional focus on EPAs and milestones
- 5.1.1.9.1.1.3 Promotion to next stage of Residency Program
- 5.1.1.9.1.2 Trainee is “*not progressing as expected*”. Possible recommendations for actions might include the following:
 - 5.1.1.9.1.2.1 Modify Learning Plan
 - 5.1.1.9.1.2.2 Remediation
- 5.1.1.9.1.3 Trainee’s performance on a previously attained EPA indicates that “*EPA entrustment is no longer appropriate*”. Possible recommendations for action might include the following:
 - 5.1.1.9.1.3.1 Modify Learning Plan
 - 5.1.1.9.1.3.2 Remediation
- 5.1.1.9.1.4 Trainee has demonstrated “*failure to progress*”. Possible recommendations for action might include the following:
 - 5.1.1.9.1.4.1 Remediation
 - 5.1.1.9.1.4.2 Probation
 - 5.1.1.9.1.4.3 Dismissal/Withdrawal from Residency Program
- 5.1.1.9.1.5 Trainee’s “*progress is accelerated*”. Possible recommendations for action might include the following:
 - 5.1.1.9.1.5.1 Modify Learning Plan
 - 5.1.1.9.1.5.2 Promotion to next stage of Residency Program
- 5.1.1.9.1.6 Trainee’s status is “*inactive*” (Leave of Absence or Suspension). Possible recommendations for action might include the following:
 - 5.1.1.9.1.6.1 Monitor learner for expected return from Leave of Absence or Suspension
 - 5.1.1.9.1.6.2 Remediation
 - 5.1.1.9.1.6.3 Probation
 - 5.1.1.9.1.6.4 Dismissal/Withdrawal from Residency Program
- 5.1.1.9.2 The Competence Committee members vote on the recommendations of the primary reviewer

- 5.1.1.9.3 Decisions can be deferred in additional information is required, but the deferred decision must be revisited within four weeks
- 5.1.1.9.4 A status decision on the trainee is recorded in the Competence Committee's archives
- 5.1.1.10 As soon as possible after the Competence Committee decision, the Academic Advisor, Program Director or other appropriate delegate will discuss the decision of the Competence Committee with the trainee. Changes to the trainee's learning plan, assessments or rotation schedule are developed and implemented as soon as feasible
- 5.1.1.11 The trainee may appeal decisions of the Competence Committee
- 5.1.2 Major progression and promotion decisions, including the trainee's final portfolio documenting achievement of competencies and promotion to certification must be approved and verified by the Residency Program Director and the Associate Dean, PGME prior to submission to the RCPSC
- 5.1.3 All decisions leading to Remediation, Probation, Suspension or Dismissal/Withdrawal from the Residency Program must be reviewed and approved by the PGME Education Advisory Committee (PGME-EAC) prior to approval by the Associate Dean, PGME (see 4.1.3.4)
- 5.2 With respect to the **CFPC Family Medicine Program**, the following procedures apply:
 - 5.2.1 Residents and their Primary Preceptor/Faculty Advisor schedule semi-annual Reviews of Resident Progress meetings to discuss the following:
 - 5.2.1.1 Information prepared by the resident with respect to reflection and self-assessment covering skill dimensions and CanMEDS-FM competencies (Periodic Review of Resident Progress (RORP) Form)
 - 5.2.1.2 Resident continuity with patients
 - 5.2.1.3 Communication from other preceptors
 - 5.2.1.4 Follow-up on previous action plans
 - 5.2.1.5 Status of program requirements
 - 5.2.2 The goal of the resident-Primary Preceptor discussion is as follows:
 - 5.2.2.1 Reaching consensus regarding the resident's progress
 - 5.2.2.2 Establishing action plans for the resident
 - 5.2.3 The action plan is documented in the Periodic Review of Resident Progress (RORP) Form

- 5.2.4 The Site Program Administrator (Assistant) ensures that Program Requirements and EPA Tracking Tool (if applicable) information in the Periodic Review of Resident Progress (RORP) Form is updated
- 5.2.5 Following the Review of Resident Progress meeting, the Primary Preceptor/Faculty Advisor reports on resident progress at the Site Resident Progress Committee (SRPC) meeting
- 5.2.6 All Site Resident Progress Committees (SRPC) report centrally to the Resident Progress Subcommittee of the Family Medicine Postgraduate Education Committee (PEC) which meets quarterly with respect to the following:
 - 5.2.6.1 Reviewing resident assessments presented by Site (Stream) Leads in order to make recommendations to the Family Medicine Program Director regarding the following:
 - 5.2.6.1.1 Promotion of residents across all sites in the Family Medicine Program
 - 5.2.6.1.2 Eligibility for the Certification Examination in Family Medicine
 - 5.2.6.1.3 Confirmation of Completion of Training
 - 5.2.6.1.4 Recommending to the PGME Education Advisory Committee (PGME-EAC) and the Associate Dean, PGME via the Family Medicine Program Director, Remediation and Probation Plans, Suspension and Dismissal/Withdrawal from the Family Medicine Program
 - 5.2.6.1.4.1 Providing oversight of resident Remediation and Probation Plans
 - 5.2.6.1.5 Determining the need for appropriate disclosure of resident information to Rotation Supervisors of future rotations/clinical learning experiences
 - 5.2.6.1.6 Reviewing resident requests for accommodations and making appropriate recommendations to the Family Medicine Program Director
 - 5.2.6.2 Discussions of the Resident Promotion Subcommittee are confidential
 - 5.2.6.2.1 Minutes of the Resident Promotion Subcommittee do not include the name of the resident under discussion, only the resident's student number
 - 5.2.6.3 Decisions of the Resident Promotion Subcommittee are reached by majority vote
 - 5.2.6.4 Decisions of the Resident Promotion Subcommittee will determine the **status** and recommended action for the trainee in the Family Medicine

Program going forward, as follows:

5.2.6.4.1.1 Trainee is “*progressing as expected*”. Possible recommendations for action might include the following:

5.2.6.4.1.1.1 Monitor learning

5.2.6.4.1.1.2 Modify learning plan by means of additional focus on EPAs and milestones

5.2.6.4.1.1.3 Promotion to next stage of Residency Program

5.2.6.4.1.2 Trainee is “*not progressing as expected*”. Possible recommendations for actions might include the following:

5.2.6.4.1.2.1 Modify learning plan

5.2.6.4.1.2.2 Remediation

5.2.6.4.1.3 Trainee has demonstrated “*failure to progress*”. Possible recommendations for action might include the following:

5.2.6.4.1.3.1 Remediation

5.2.6.4.1.3.2 Probation

5.2.6.4.1.3.3 Dismissal/Withdrawal from the Residency Program

5.2.6.4.1.4 Trainee’s “*progress is accelerated*”. Possible recommendations for action might include the following:

5.2.6.4.1.4.1 Modify learning plan

5.2.6.4.1.4.2 Promotion to next stage of Residency Program

5.2.6.4.1.5 Trainee’s status is “*inactive*” (Leave of Absence or Suspension). Possible recommendations for action might include the following:

5.2.6.4.1.5.1 Monitor learner for expected return for Leave of Absence or Suspension

5.2.6.4.1.5.2 Remediation

5.2.6.4.1.5.3 Probation

5.2.6.4.1.5.4 Dismissal/Withdrawal from Residency Program

5.2.6.5 Decisions on resident progression/promotion are recorded in the Resident Progress Subcommittee archives/minutes

5.2.6.6 Decisions on resident progression/promotion are documented in the

resident's portfolio

- 5.2.7 Major progression and promotion decisions, including the trainee's final portfolio documenting achievement of competencies, Eligibility for the Certification Examination in Family Medicine and Completion of Training must be approved and verified by the Family Medicine Program Director and the Associate Dean, PGME prior to submission to the CFPC
- 5.2.8 All decisions leading to Remediation, Probation, Suspension or Dismissal/Withdrawal from the Residency Program must be reviewed and approved by the PGME Education Advisory Committee (PGME-EAC) prior to approval by the Associate Dean, PGME (see 4.1.3.4)

6. POLICY STATEMENTS – REMEDIATION

- 6.1 Remediation represents a formal, individualized learning opportunity intended to guide the resident towards successful attainment of clinical, academic or professional competencies
- 6.2 The decision for a trainee to undergo Remediation is determined by the Competence Committee for RCPSC CBD Residency Programs or the Resident Progress Subcommittee for the CFPC Family Medicine Program based on one of the following:
 - 6.2.1 Trainee "*is not progressing as expected*"
 - 6.2.2 Trainee has demonstrated "*failure to progress*"
 - 6.2.3 Trainee's status is "*inactive*" but it has been determined that the resident requires a focused learning plan in order to achieve the required competencies upon return from a Leave of Absence or Suspension
- 6.3 The PGME Education Advisory Committee (PGME-EAC) and the Associate Dean, PGME must review and approve all Remediation Plans prior to commencement
- 6.4 The Remediation Plan/Focused Learning Plan will focus on ensuring that the learning experiences are organized to immerse the trainee in authentic practice conditions
- 6.5 The trainee should be actively involved and engaged in the development of the Remediation Plan/Focused Learning Plan
- 6.6 Once developed, the Remediation Plan/Focused Learning Plan becomes a mandatory feature of the resident's training
 - 6.6.1 The resident's participation in the Remediation Plan/Focused Learning Plan is a prerequisite for ongoing participation in the Residency Program
- 6.7 Progress during Remediation is based on documentation of competency attainment rather than on successful completion of time-based rotations

6.7.1 Time-based rotations will continue to be an organizing structure for residency training

6.7.1.1 Depending on the individual circumstance, Remediation might lead to an extension of the resident's training

6.7.1.1.1 Limits to overall training duration for the resident requiring extension of training will be based on discipline-specific guidelines regarding the typical duration of overall training as well as the typical duration of each stage of the Competence Continuum

6.8 In the event that the Residency Program Director determines that a Leave of Absence (LOA) is necessary for a trainee during the Remediation, then the Remediation Program is considered incomplete

6.8.1 The Remediation Plan/Focused Learning Plan will be redesigned upon the trainee's return from the LOA

6.9 The trainee may appeal Remediation decisions

7. PROCEDURES – REMEDIATION

7.1 The Residency Program Director must submit a formal request for Remediation to the PGME-AEB within ten working days of the “trigger event” decision of the RCPSC CBD Residency Program Competence Committee/CFPC Family Medicine Program Resident Progress Subcommittee

7.1.1 The reason(s) for the request for Remediation must be included in the submission

7.2 The Residency Program Director must submit a formal **Remediation Plan/Focused Learning Plan**, in conformity with **Remediation Plan/Focused Learning Plan Agreement** to the PGME-EAC within twenty working days of the notification of the Program Director of the “trigger event” decision of the RCPSC CBD Residency Program Competence Committee/CFPC Family Medicine Program Resident Progress Subcommittee. The Remediation Plan/Focused Learning Plan must include the following:

7.2.1 Identified competencies on which to focus during Remediation

7.2.2 Time frame for elements of the Remediation Program

7.2.2.1 Time-based rotations continue to be an organizing structure for residency training

7.2.3 The specific resources being deployed for competency attainment during the Remediation

7.2.4 Remediation Supervisor: is the trainee's Academic Advisor for RCPSC CBD Residency Programs or Faculty Advisor/Primary Preceptor for the CFPC Family Medicine Program

- 7.2.5 Potential outcomes, as follows:
 - 7.2.5.1 With respect to competency attainment, the following apply:
 - 7.2.5.1.1 Competency “*Achieved*”
 - 7.2.5.1.2 Competency “*In progress*”
 - 7.2.5.2 With respect to progress in training, the following apply:
 - 7.2.5.2.1 Trainee is “*progressing as expected*” and has successfully completed the Remediation
 - 7.2.5.2.2 Trainee is “*not progressing as expected*” and requires further Remediation
 - 7.2.5.2.3 Trainee has demonstrated “*failure to progress*” and requires further Remediation, Probation or Dismissal/Withdrawal from the Residency Program
- 7.3 The PGME Education Advisory Committee (PGME-EAC) must review all submitted formal Remediation Plans/Focused Learning Plans in a timely manner and must reach a consensus with respect to one of the following:
 - 7.3.1 Approval of the Remediation Plans/Focused Learning Plans without revision
 - 7.3.2 Revision and approval of the Remediation Plans/Focused Learning Plans
- 7.4 The PGME-EAB must communicate all Remediation Plan/Focused Learning Plan decisions to the respective Residency Program Directors
- 7.5 The Associate Dean, PGME must approve all Remediation Plan/Focused Learning Plan decisions prior to implementation
- 7.6 The Remediation Supervisor is responsible for monitoring the trainee’s progress during the Remediation, as follows:
 - 7.6.1 Assessment feedback information from Clinical Supervisors and other teaching faculty is reviewed by the Remediation Supervisor
 - 7.6.2 The Remediation Supervisor must meet with the trainee regularly to discuss their progress with respect to the Remediation/Focused Learning Plan
 - 7.6.3 The Remediation Supervisor must report the trainee’s progress, including the outcome of the Remediation to the Residency Program Competence Committee/Family Medicine Resident Progress Subcommittee
- 7.7 The Residency Program Competence Committee/Family Medicine Resident Progress Subcommittee must review the trainee’s progress in order to decide on the outcome of the Remediation and the **status** of the trainee as follows:

- 7.7.1 Trainee is “*progressing as expected*” and has successfully completed the Remediation
- 7.7.2 Trainee is “*not progressing as expected*” and requires further Remediation
- 7.7.3 Trainee has demonstrated “*failure to progress*” and requires one of the following:
 - 7.7.3.1 Further Remediation
 - 7.7.3.2 Probation
 - 7.7.3.3 Dismissal/Withdrawal from the Residency Program
- 7.8 The Residency Program Director must complete the Assessment and Outcome portions of the **Remediation Agreement Document** for review and approval by the PGME-EAC and the Associate Dean, PGME

8. POLICY STATEMENTS – PROBATION

- 8.1 Probation is a formal process in which the trainee is **expected** to correct areas of serious clinical or academic challenges or concerns about professional conduct that are felt to jeopardize successful completion of the Residency Program
- 8.2 The decision for a trainee to undergo Probation is determined by the Competence Committee for RCPSC CBD Residency Programs or the Resident Progress Subcommittee for the CFPC Family Medicine Program based on one of the following:
 - 8.2.1 Trainee has demonstrated “*failure to progress*” status despite following the Remediation Plan/Focused Learning Plan and it has been determined that further Remediation is not an option
 - 8.2.2 There is a significant and immediate concern with respect to the trainee’s professional conduct
 - 8.2.2.1 In situations where the incident or “trigger event” related to a trainee’s professional conduct requires immediate action, the Residency Program Director or delegate has the option of implementing the Probation procedures in advance of the Competence Committee/Resident Progress Subcommittee discussion
 - 8.2.3 In situations where the “trigger event” leading to possible Probation might pose a threat to the well-being or safety of patients, colleagues, students, staff and/or the trainee himself/herself, the Program Director or delegate must consider immediate Suspension of the trainee as an interim measure prior to the Competence Committee/Resident Progress Subcommittee Probation discussion and decision (see Suspension)
- 8.3 The PGME Education Advisory Board (PGME-EAB) and the Associate Dean,

- PGME must review and approve all Probation Plans prior to commencement
- 8.4 The trainee's participation in the Probation Plan is a prerequisite for ongoing participation in the Residency Program as follows:
- 8.4.1 The Program Director must meet with the trainee to discuss the Probation
- 8.4.1.1 The Program Director must discuss the Probation Plan with the trainee
- 8.4.1.2 The Program Director should advise the trainee to meet with the Associate Dean, PGME Student Affairs for counselling
- 8.4.2 In circumstances where the reason for Probation is related to issues of professionalism, the trainee **must** meet with the Associate Dean, **Professionalism** for counselling
- 8.4.3 The trainee must fully comply with the conditions specified in the Probation Plan
- 8.4.4 The trainee must fully comply with any other conditions prescribed by the PGME-EAB and Associate Dean, PGME for the Probation
- 8.5 During Probation, the trainee is **not** allowed to apply for transfer to another Residency Program
- 8.6 Progress during Probation is based on documentation of competency attainment and correction of serious deficiencies rather than on successful completion of time-based rotations
- 8.6.1 Time-based rotations will continue to be an organizing structure for residency training
- 8.6.1.1 Depending on the individual circumstance, Probation might lead to an extension of the resident's training
- 8.6.1.1.1 Limits to overall Residency Program training duration for the resident requiring extension of training will be based on discipline-specific guidelines regarding the typical duration of overall training as well as the typical duration of each stage of the Competence Continuum
- 8.7 In the event that the Residency Program Director determines that a Leave of Absence (LOA) is necessary for a trainee during the Probation, then the Probation Program is considered incomplete
- 8.7.1 The Probation Plan will be redesigned upon the trainee's return from the LOA
- 8.8 The trainee may appeal **only** the outcome decision at the conclusion of the Probation

9. PROCEDURES – PROBATION

- 9.1 The Residency Program Director must submit a formal request for Probation to the PGME-AEC within fifteen working days of the “trigger event” decision of the RCPSC CBD Residency Program Competence Committee/CFPC Family Medicine Program Resident Progress Subcommittee
 - 9.1.1 The reason(s) for the request for Probation must be included in the submission
- 9.2 The Residency Program Director must submit a formal **Probation Plan**, in conformity with **Probation Plan Agreement Document** to the PGME-EAC within fifteen working days of the notification of the Program Director of the “trigger event” decision of the RCPSC CBD Residency Program Competence Committee/CFPC Family Medicine Program Resident Progress Subcommittee. The Probation Plan must include the following:
 - 9.2.1 Identified competency deficiencies on which to focus during Probation
 - 9.2.2 Time frame for elements of the Probation Program/duration of the Probation (see 8.6)
 - 9.2.2.1 Time-based rotations continue to be an organizing structure for residency training
 - 9.2.3 The specific resources being deployed for competency attainment during the Probation
 - 9.2.4 Probation Supervisor: is the trainee’s Academic Advisor for RCPSC CBD Residency Programs or Faculty Advisor/Primary Preceptor for the CFPC Family Medicine Program
 - 9.2.5 Potential outcomes, as follows:
 - 9.2.5.1 With respect to competency attainment, the following apply:
 - 9.2.5.1.1 Competency “*Achieved*”
 - 9.2.5.1.2 Competency “*In progress*”
 - 9.2.5.2 With respect to progress in training, the following apply:
 - 9.2.5.2.1 Trainee is “*progressing as expected*” and has successfully completed the Probation
 - 9.2.5.2.2 Trainee is “*not progressing as expected*” and requires further Probation or Dismissal/Withdrawal from the Residency Program
 - 9.2.5.2.3 Trainee has demonstrated “*failure to progress*” and requires further Probation or Dismissal/Withdrawal from the Residency Program

- 9.3 The PGME Education Advisory Committee (PGME-EAC) must review all submitted documents and materials pertaining to all requests for Probation **and** the formal Probation Plans from the Program Director in a timely manner and must reach a consensus with respect to the following:
 - 9.3.1 Approval of the request for Probation
 - 9.3.2 If the request for Probation is approved, then the PGME-EAC must reach a consensus with respect to one of the following:
 - 9.3.3 Approval of the Probation Plan without revision
 - 9.3.4 Revision and approval of the Probation Plan
- 9.4 The PGME-EAC must communicate the Probation Plan decision to the Residency Program Director
- 9.5 The Associate Dean, PGME must approve the Probation Plan decision prior to implementation
- 9.6 The Program Director must meet with the trainee to discuss the approved Probation Plan
- 9.7 The Program Director must discuss the approved Probation Plan with the Probation Supervisor prior to implementation
- 9.8 The Probation Supervisor is responsible for monitoring the trainee's progress during the Probation, as follows:
 - 9.8.1 Assessment feedback information from Clinical Supervisors and other teaching faculty is reviewed by the Probation Supervisor
 - 9.8.2 The Probation Supervisor must meet with the trainee regularly to discuss their progress with respect to the Probation Plan
 - 9.8.3 The Probation Supervisor must report the trainee's progress, including the outcome of the Probation to the Residency Program Competence Committee/Family Medicine Resident Progress Subcommittee
- 9.9 The Residency Program Competence Committee/Family Medicine Resident Progress Subcommittee must review the trainee's progress in order to decide on the outcome of the Probation and the **status** of the trainee as follows:
 - 9.9.1 Trainee is "*progressing as expected*" and has successfully completed the Probation
 - 9.9.2 Trainee is "*not progressing as expected*" and requires one of the following:
 - 9.9.2.1 Further Probation

- 9.9.2.2 Dismissal/Withdrawal from the Residency Program
- 9.9.3 Trainee has demonstrated “*failure to progress*” and requires one of the following:
 - 9.9.3.1 Further Probation
 - 9.9.3.2 Dismissal/Withdrawal from the Residency Program
- 9.10 The Residency Program Director must complete the Assessment and Outcome portions of the **Probation Agreement Document** for review and approval by the PGME-EAC and the Associate Dean, PGME

10. POLICY STATEMENTS – SUSPENSION

- 10.1 Suspension of a trainee may be imposed as an interim measure for determination of the best definitive course of action in the following circumstances:
 - 10.1.1 There is a breach of the policies, by-laws or codes of conduct and/or suspension of clinical privileges by one of the following:
 - 10.1.1.1 University of Manitoba
 - 10.1.1.2 WRHA
 - 10.1.1.3 CPSM
 - 10.1.2 There is reasonable suspicion of improper conduct of such a nature that the continued presence of the trainee in the Residency Program would pose a threat to the well-being or safety of patients, colleagues, students, staff and/or himself/herself
 - 10.1.3 There is reasonable suspicion of improper conduct of such a nature that the continued presence of the trainee in the Residency Program would pose a threat to University of Manitoba, WRHA or other property
 - 10.1.4 Failure of the trainee to agree to or comply with an approved Remediation or Probation Plan
- 10.2 When a resident is placed on Suspension, the following principles apply:
 - 10.2.1 Licensure and registration with CPSM are **inactivated**
 - 10.2.2 Payment through WRHA might be suspended
 - 10.2.3 Medical malpractice coverage (CMPA) might be suspended
 - 10.2.4 Time-based rotations will continue to be an organizing structure for residency training
 - 10.2.4.1 Depending on the individual circumstance, Suspension might lead to an

extension of the resident's training

10.2.4.1.1 Limits to overall Residency Program training duration for the resident requiring extension of training will be based on discipline-specific guidelines regarding the typical duration of overall training as well as the typical duration of each stage of the Competence Continuum

- 10.3 The Program Director should advise the trainee to meet with the Associate Dean, PGME Student Affairs for counselling
- 10.4 In circumstances where the reason for Suspension is related to issues of Professionalism, the trainee **must** meet with the Associate Dean, **Professionalism** for counselling
- 10.5 The trainee may appeal the decision for Suspension from the Residency Program
- 10.6 The University of Manitoba has the authority to implement a **Disciplinary Suspension** in accordance with the **Student Discipline By-Law**

11. PROCEDURES – SUSPENSION

- 11.1 In a situation where a “trigger event” warrants Suspension of a trainee, the Residency Program Director, acting on behalf of the Residency Program Committee, must immediately notify the Department Head and the Associate Dean, PGME through formal documentation (email or hard copy), the following:
 - 11.1.1 The “trigger event” leading to the Suspension
 - 11.1.2 The request for the trainee’s interim Suspension pending determination of the appropriate subsequent course of action
- 11.2 The Residency Program Director must inform the trainee immediately through formal documentation (email or hard copy) of a request for Suspension
- 11.3 The trainee should be provided the opportunity of a face-to-face meeting with the Residency Program Director to discuss the following:
 - 11.3.1 Reason(s) for the Suspension
 - 11.3.2 Expected duration of the Suspension
 - 11.3.3 Expected outcomes of the Suspension
- 11.4 The request for the trainee’s Suspension must be reviewed by the Associate Dean, PGME who will determine the course of action as follows:
 - 11.4.1 Denial of the request for Suspension
 - 11.4.2 Affirmation of the Suspension on an interim basis pending further investigation
 - 11.4.3 Recommendation of proceeding directly to Remediation, Probation or

Dismissal/Withdrawal from the Residency Program

- 11.5 Where a Suspension of the trainee is affirmed, the Associate Dean, PGME must conduct a timely investigation of matters related to the “trigger event” that led to the Suspension and thereafter must make a final decision as to how the matters should be addressed
 - 11.5.1 The Associate Dean, PGME has the option of requesting the assistance of the PGME-EAC in the investigation and the final decision with respect to the Suspension
- 11.6 When the trainee is placed on or taken off Suspension, the CPGME Office must ensure the following:
 - 11.6.1 Notification of CPSM regarding licensure and registration of the trainee
 - 11.6.2 Notification of WRHA regarding payment and medical malpractice coverage (CMPA)
 - 11.6.3 Notification of PARIM through immediate formal documentation (email or hard copy) that the trainee has been placed on Suspension

12. POLICY STATEMENTS – DISMISSAL/WITHDRAWAL

- 12.1 A trainee may be dismissed from the Residency Program under the following circumstances:
 - 12.1.1 Competence Committee/Resident Progress Subcommittee decision on the basis of a trainee’s progress, as follows:
 - 12.1.1.1 Trainee is persistently “*not progressing as expected*” despite having undergone Remediation and/or Probation
 - 12.1.1.2 Trainee has demonstrated persistent “*failure to progress*” and Remediation and/or Probation was considered **not** to be an option
 - 12.1.1.3 Failure of the trainee to agree to or comply with an approved Remediation or Probation Plan
 - 12.1.1.4 Trainee’s status is “*inactive*” (Leave of Absence (LOA) or Suspension) and it has been determined that successful return to or completion of the Residency Program is unlikely
 - 12.1.2 The trainee has exceeded or is reasonably expected to exceed the time specified by the CFPC or the respective Specialty Committee of the RCPSC as a maximum time of training for the Residency Program, pro-rated for part-time training and approved LOA
 - 12.1.3 There is reasonable suspicion of improper conduct of such a nature that the continued presence of the trainee in the Residency Program would pose a threat to the well-being or safety of patients, colleagues, students, staff and/or

himself/herself

- 12.1.4 There is reasonable suspicion of improper conduct of such a nature that the continued presence of the trainee in the Residency Program would pose a threat to University of Manitoba, WRHA or other property
- 12.1.5 The trainee is considered unsuitable for practice on the basis of behavior that would be considered inconsistent with reasonable standards of professionalism, ethics, competence and judgment in conformity with the **Professional Unsuitability By-Law** adopted by the University of Manitoba and the professional and ethical standards of the CPSM
- 12.2 The trainee may voluntarily withdraw from the Residency Program prior to the decision for Dismissal or at any time for reason(s) independent of Dismissal
 - 12.2.1 A trainee who voluntarily withdraws from the Residency Program may reapply for future postgraduate training at the University of Manitoba
- 12.3 The Program Director should advise the trainee to meet with the Associate Dean, PGME Student Affairs for counselling
- 12.4 In circumstances where the reason for Dismissal is related to issues of professionalism, the trainee **must** meet with the Associate Dean, **Professionalism** for counselling
- 12.5 The trainee may appeal the decision for Dismissal from the Residency Program

13. PROCEDURES – DISMISSAL/WITHDRAWAL

- 13.1 The Residency Program Director, after consultation with the Residency Progress Committee/Competence Committee/Resident progress Subcommittee must submit a formal request for Dismissal/Withdrawal from the Residency Program to the Associate Dean, PGME within five working days of notification to the Program Director of the “trigger event” for Dismissal/Withdrawal from the Residency Program, including the following:
 - 13.1.1 Reason(s) for the request
 - 13.1.1.1 The trainee must receive a copy of the documented request
- 13.2 The Associate Dean, PGME must immediately notify the Chair of the PGME-EAC of the request for Dismissal/Withdrawal from the Residency Program
- 13.3 The Chair convenes a meeting of the PGME-EAC to review and to consider approval of the request for Dismissal/Withdrawal within ten working days of notification by the Associate Dean, PGME
 - 13.3.1 If the PGME-EAC upholds the Dismissal/Withdrawal, then the Chair of the Committee informs the Associate Dean, PGME, immediately through formal

documentation

- 13.4 The Associate Dean, PGME must present the decision regarding Dismissal/Withdrawal at the CPGME Executive Committee for final review and approval
 - 13.4.1 If the CPGME Executive Committee upholds the decision for Dismissal, then the trainee will be dismissed immediately from all further postgraduate training at the University of Manitoba and may **not** reapply for future postgraduate training at the University of Manitoba
- 13.5 When the trainee is dismissed or withdraws from the Residency Program, the CPGME Office must ensure the following:
 - 13.5.1 Notification of the CPSM by formal documentation regarding licensure and registration
 - 13.5.2 Notification of WRHA regarding payment and medical malpractice coverage (CMPA)
 - 13.5.3 Notification of PARIM by formal documentation (email or hard copy) that the trainee has been dismissed/has withdrawn within twenty-four hours of such Dismissal/Withdrawal