THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA

LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Standards of Accreditation for Residency Programs in Family Medicine

JULY 2018

VERSION 1.2

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

The College of Family Physicians of Canada

2630 Skymark Avenue, Mississauga, ON L4W 5A4

Telephone: 905-629-0900 | Toll-free: 1-800-387-6197

Email: accreditation@cfpc.ca

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How to cite this document

College of Family Physicians of Canada. *Standards of Accreditation for Residency Programs in Family Medicine*. Mississauga, ON: College of Family Physicians of Canada; 2018.

Acknowledgements

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Program Goals and Guiding Principles

Goals of training

The goal of core family medicine residency programs is to train residents who are competent to enter and adapt to the independent practice of comprehensive family medicine anywhere in Canada.

The goal of training for enhanced skills (ES) programs in family medicine is to develop additional skills and, in some instances, added competence to support and extend the delivery of comprehensive, community-adaptive care by family physicians.

Achieving these goals is a responsibility that is shared between the resident and the program, where the program provides the necessary learning and assessment opportunities and the resident engages as a proactive learner who is ultimately responsible for the attainment of professional competence.

Attainment of these goals is a complex proposition given Canada's diverse people, geography, resources, demographics, socio-cultural environments, and community disease profiles. Residency aspires to prepare family physicians who are good generalists, adaptive, flexible, and community-oriented with broad and deep medical knowledge and a willingness to work to the limits of their abilities in conditions of medical uncertainty to meet patient care needs.

The wide variety of practice settings and care models across the country, as well as the need to respond to unexpected and emerging health care needs, requires family physicians to function flexibly and contribute their generalist abilities in all practice arrangements. As such, core family medicine programs are responsible for enabling all graduates to provide comprehensive care at an individual level upon completion, as described in the College of Family Physicians of Canada's (CFPC) Family Medicine Professional Profile.[1]

All programs are required to prepare family physicians to engage and work effectively with diverse people and populations, including those who experience barriers to care. The CFPC recognizes the role systemic racism plays in the health and social disparities experienced by Indigenous people in Canada, as described in *Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada*.[2] Along with this recognition and in light of the *Truth and Reconciliation Commission of Canada: Calls to Action*,[3] it is important for family physicians to attain specific competencies in Indigenous health to provide the best care to this population.

Residency training prepares graduates to assess community, practice, and personal learning needs, and to take the initiative to define their learning plans accordingly. The program fosters generalist abilities, including community-adaptive competence, by providing a range of planned core, elective, and selective experiences across multiple contexts, including but not limited to rural practice. Across the country, family physicians acquire enhanced skills to meet their community's needs, with some pursuing extended enhanced skills (ES) residency training. Developing context-specific competencies starts in residency, in both core and ES training programs, but requires

learning that extends beyond this period and is supported by effective continuing professional development (CPD) and mentorship in practice.

Programs are encouraged to be creative, scholarly, and show leadership. The accreditation standards presented here aim to promote quality and consistency, but they are not prescriptive—programs will organize and design to optimize local realities and strengths. Programs will study their effectiveness in meeting the goal of training, cultivating an environment committed to continuous quality improvement in the spirit of collaboration with each other, the CFPC, and other health care stakeholders, which recognizes our shared responsibility for excellence in the training of family physicians.

Guiding principles

The CFPC, through its Family Medicine Specialty Committee, has approved the use of a number of curriculum and assessment documents for residency programs to achieve the stated training goals. These guide the design and development of a residency program's plan, or blueprint, and form the basis of many of the training standards in family medicine.

Curriculum

All family medicine residency program curricula, including those for enhanced skills, are designed according to the Triple C Competency-Based Curriculum,[4] which was conceptualized around four directives: providing comprehensive education and patient care, providing continuity of education and patient care, being centred in family medicine, and being competency-based.

Triple C's main frameworks—CanMEDS–Family Medicine 2017: A competency framework for family physicians across the continuum (CanMEDS-FM)[5] and the Defining competence for the purposes of certification by the College of Family Physicians of Canada: The evaluation objectives in family medicine (evaluation objectives)[6]—articulate different dimensions of competence in family medicine. They can be used to develop and map learning objectives, learning experiences, and assessment strategies. While CanMEDS-FM[5] was originally developed as the principal curriculum framework and the evaluation objectives[6] were created to define assessment, they inform each other and together guide a fulsome approach to developing competence in family medicine.

The program curriculum uses an effective combination of hands-on clinical experience and academic programming organized to promote and assess increasing responsibility toward readiness for independent practice.

The essential features of a Triple C curriculum, described here in more detail, integrate the various CFPC framework and guidance documents.

Comprehensive education and patient care

Comprehensiveness in family medicine is the broad base of professional activity and ability defined by the CFPC's Family Medicine Professional Profile[1] and is the expected scope of training for

residency programs. Comprehensiveness also refers to the holistic approach that family physicians use to understand and manage patient health and health concerns, and is a feature of expertise described in CanMEDS-FM.[5] Programs prepare residents for comprehensive practice that fully incorporates both meanings.

Enhanced skills training programs extend the comprehensive skills of family physicians by further developing community-adaptive and context-specific competencies, while maintaining competence across a broad scope of practice. Enhanced skills training supports and promotes comprehensiveness by integrating holistic assessment approaches into focused practice domains, and by modelling leadership for practice arrangements that deliver integrated, continuity of care for patients. The clinical contexts that support enhanced skills development may differ from those used in the core family medicine residency program but are in line with the Triple C competency-based approach. Learning experiences promote patient-centredness, addressing the patient's medical and psychosocial needs in all settings including acute, chronic, and ambulatory—often employing and further developing collaborative skills with and within health care teams.

Continuity of education and patient care

Continuity is a critical feature of family practice that improves patients' experiences of care and health outcomes. Family physicians form compassionate, meaningful, and therapeutic professional relationships with patients and patients' families and loved ones. This is particularly important for those with chronic, complex, and comorbid illnesses. It is within these ongoing relationships and unfolding narratives that illness and suffering are recognized, understood, and mitigated and patient-centred assessment and decisions occur. Continuity happens within episodic care, care transitions, and across time, encompassing dimensions of interpersonal relationships, flow of patient information, and the organization of care services within the health care system. In enhanced skills programs continuity of care remains a process in which a patient develops a relationship with a physician that is designed to optimize their health care and tailored to the patient's individual medical and psychosocial needs. All programs, including enhanced skills, ensure that residents appreciate the health care benefits of, have responsibility for, and gain substantial experience in continuity of care. During core training residents take on the role of the family physician and are responsible for the continuous care of a group of patients, through which they experience the joys and challenges of family medicine while developing capabilities for relationship-based care.

At the heart of well-designed programs is a continuous educational relationship between the resident and a family physician preceptor who provides support, mentorship, guidance, and competency coaching. Preceptors, carefully chosen for their teaching abilities, are role models for comprehensive family practice. Optimally, the preceptor offers a CFPC Patient's Medical Home[7]–type environment as the community of practice surrounding the resident, which fosters the resident's professional identity as a family physician and promotes a culture of collaboration, quality, and scholarship.

Centred in family medicine

Learning experiences are centred in family medicine when they:

- Focus on the professional activities described in the [Family Medicine Professional Profile](1)[1]
- Promote the development of CanMEDS-FM competencies[5]
- Develop knowledge and skills described by the [evaluation objectives](evaluation-objectives)[6]
- Involve family physicians as teachers
- Promote the philosophy of care articulated by the [four principles of family medicine](four-principles)[8]

Experience in the family practice setting is a priority, and this is supplemented as necessary with relevant, concentrated experiences in specific care domains and/or settings to ensure the development of comprehensive, generalist abilities. The specific combination of learning experiences, planned and implemented by the program, are based on an assessment of local service needs, resources, practice patterns, and educational strengths. Family physicians have the primary leadership and teaching roles; working in a supportive, collaborative environment with other health care colleagues to deliver the educational program.

Enhanced skills programs remain centred in family medicine and aspire to expose residents to preceptors who model the integration of enhanced skills into comprehensive practice as a way to assist patients within their 'Patient's Medical Home' and support continuity of care. Enhanced skills programs are centred in family medicine through the teaching and supervision provided by family physicians in both comprehensive family medicine and focused practice environments. Clinical learning experiences are relevant to the practices, contexts, and settings of family physicians with enhanced skills. The enhanced skills programs actively support residents in maintaining and integrating their comprehensive family medicine skills.

Assessment of competence in family medicine programs

Competence in family medicine is complex, fluid, and dynamic, changing over time based on many factors, including practice context, individual interest, experience and response to community/practice needs. Thinking about the role of core family medicine and enhanced skills training, competence can be conceptualized as follows:

Core competence: This refers to being competent to enter and adapt to the independent practice of comprehensive family medicine anywhere in Canada.

Upon entering practice, residents are capable of the responsibilities outlined in the [Family Medicine Professional Profile](1)[1] The many competencies required to support this work are outlined in CanMEDS-FM[5] and programs are designed to develop these competencies according to the [Triple C Competency-Based Curriculum](triple-c)[4] Competence is assessed across multiple dimensions, as defined in CanMEDS-FM[5] and the [evaluation objectives](evaluation-objectives)[6] It is expected that there is a program of assessment using a [Continuous Reflective Assessment for Training (CRAFT) approach](craft)[11] that maps, facilitates, monitors, and informs decisions about the progressive achievement of competence for residents.

In this definition, independent practice refers to safe, autonomous, and self-regulated practice without the requirement for supervision. It does not refer to an individual or solo model of care, as

family medicine is recognized as inherently collaborative and team-based. This is the competence required to be eligible for Certification in the College of Family Physicians of Canada (CCFP).

Community-adaptive competence: This refers to the ongoing adaptation of competence and development of context-specific competencies occurring in response to patient, practice, and community needs. It is influenced by personal talents and interests. It builds on core competence, starting in residency, according to individual experiences, and continues to be developed across the educational continuum. Programs prepare all residents with this ability by ensuring they experience a range of practice contexts, especially challenging, lower-resource environments. Where the CFPC has done work to discern context-specific competencies (e.g., *Priority Topics and Key Features for the Assessment of Competence for Rural and Remote Family Medicine*[9]), programs will use them to inform the design of those learning experiences.

There are various ways to achieve additional, context-specific competencies, including personal experience, mentorship, CPD, and formal enhanced skills training.

For accreditation purposes, enhanced skills training is organized into two residency program categories. Category 1 Enhanced Skills programs must use and are accredited based on national, CFPC–defined and recognized, domain-specific competencies for assessment. Category 2 programs have local, university-based, domain-specific competencies defined for the purpose of assessment.

Along with the clinically based Category 1 Enhanced Skills programs, the CFPC surveys Clinician Scholar Programs as part of the overall accreditation of enhanced skills programs. These programs are designed to prepare individuals with the knowledge, skills, and attitudes to embark on a scholarly career in health care and provide an opportunity to integrate scholarship and clinical care. Programs include a range of scholarly activities, as defined by Ernest Boyer's model of scholarship[10] (the scholarship of discovery, integration, application, and teaching).

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

- At the end of the scholarly component of the program, the individual will be expected to have acquired the knowledge, skills, and attitudes fundamental to embarking on a scholarly career in health. In most cases, further training specific to the candidate's field of interest will be required so they can succeed as an independent scholar.

- The Clinician Scholar Program must provide an opportunity to integrate scholarship and clinical care. This could mean that Clinician Scholar Program residency training is done part-time over more than one year (e.g., half time for two years), not only because this is the cyclical nature of research/scholarship (preparing grant applications, ethics applications, and/or manuscript submissions, along with wait periods, etc.), but also because this will

allow clinician scholars to maintain family medicine competencies within their clinical practices.

- While there are several ways of organizing the Clinician Scholar Program, there are some advantages to promoting the program for family physicians returning from practice.

- Clinician Scholar Program training should include scholars interested in advancing their skills among the full range of scholarship, as defined by Ernest Boyer's model of scholarship[10] (scholarship of discovery, integration, application, and teaching).

Summary of key resources

1. Family Medicine Professional Profile:[1] This describes the professional activities of family physicians and defines the scope of residency training. This further clarifies comprehensiveness and centredness in family medicine within the Triple C curriculum.
2. *CanMEDS–Family Medicine 2017: A competency framework for family physicians across the continuum*:[5] This family physician competency framework is organized by Roles and describes the competencies required to fulfill work described in the Family Medicine Professional Profile.
3. Triple C Competency-based Curriculum:[4] Triple C is a competency-based curriculum for family medicine residency training based on the CanMEDS-FM framework and the evaluation objectives in family medicine. It has three components: comprehensive education and patient care; continuity of education and patient care; centredness in family medicine.
4. A Vision for Canada – Family Practice: The Patient's Medical Home:[7] The PMH is the CFPC's vision for a model of comprehensive, patient-centred family practice. This is an aspirational model of family practice, serving as an exemplar for preceptor and teaching clinic recruitment and selection in residency programs. (The PMH model is being refreshed in 2018.)
5. Defining competence for the purposes of certification by the College of Family Physicians of Canada: The evaluation objectives in family medicine:[6] This document guides the assessment of competence in family medicine, at the start of independent practice, for the purposes of certification by the CFPC. It describes the skills and behaviours that are indicative of competence.
6. *Continuous Reflective Assessment for Training (CRAFT) – A national programmatic assessment model for family medicine*:[11] The CFPC describes CRAFT as a cohesive approach to programmatic, competency-based assessment for residents in training. It is designed to meet the expectations of the speciality-specific CanMEDS-FM Roles[5] and the CFPC's four principles of family medicine[8] relative to the CFPC's competency-based residency training guidelines.
7. Fundamental Teaching Activities in Family Medicine: A Framework for Faculty Development:[12] This framework outlines teaching activities to guide self-reflection and CPD, helping family medicine programs, departments, and faculty members develop curricula for faculty development.

Standards Organization Framework

Level	Description
Domain	Domains defined by the Future of Medical Education in Canada Postgraduate (FMEC PG) Accreditation Implementation Committee introduce common organizational terminology, to facilitatealignment of accreditation standards across the medical education continuum.
Standard	The overarching outcome to be achieved through the fulfillment of the associated requirements.
Element	A category of the requirements associated with the overarching standard.
Requirements	A measurable component of a standard.
	A specific expectation used to evaluate compliance with a requirement (i.e., to demonstrate that the requirement is in place). Mandatory indicators must be met to achieve full compliance with a requirement. Exemplary indicators provide improvement objectives beyond the mandatory expectations and may be used to introduce indicators that will become mandatory over time. Indicators may have one or more sources of evidence, not all of which will be collected through the onsite accreditation review (e.g., evidence may be collected via the institution/program profile in the CanAMS

The *Standards of Accreditation for Residency Programs in Family Medicine* are a national set of standards maintained by the CFPC for the evaluation and accreditation of family medicine residency programs. These standards apply to both family medicine and enhanced skills programs unless otherwise stated. The standards aim to provide an interpretation of the General Standards of Accreditation for Residency Programs[13] as they relate to the accreditation of programs in family

medicine,* and to ensure that these programs adequately prepare residents to meet the health care needs of their patient population(s) upon completion of training.

The standards include requirements applicable to residency programs and learning sites† and have been written in alignment with a standards organization framework, which aims to provide clarity of expectations while maintaining flexibility for innovation.

Family medicine programs include:
- The core two-year family medicine program
- The central enhanced skills program, which oversees Category 1 and Category 2 programs

The currently recognized Category 1 programs are:
- Family Medicine/Emergency Medicine
- Family Medicine/Care of the Elderly
- Family Practice Anesthesia
- Family Medicine Clinician Scholar
- Family Medicine/Sport and Exercise Medicine
- Family Medicine/Palliative Care

Upon successful completion of a Category 1 program, residents are eligible to apply for a Certificate of Added Competence (CAC).
Residents completing Category 2 programs are not eligible for CACs.

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* This document has been written to encompass the *General Standards of Accreditation for Residency Programs* (i.e., this document does not need to be read in conjunction with the *General Standards of Accreditation for Residency Programs*).
† There are also standards applicable to learning sites within the *General Standards of Accreditation for Institutions with Residency Programs.*

STANDARDS

DOMAIN: PROGRAM ORGANIZATION

The *Program Organization* domain includes standards focused on the structural and functional aspects of the residency program, which support and provide structure to meet the *General Standards of Accreditation for Residency Programs.*[13] The Program Organization domain standards aim to:

- Ensure the organizational structure and personnel are appropriate to support the residency program, teachers, and residents;
- Define the high-level expectations of the program director and residency program committee(s); and
- Ensure the residency program and its structure are organized to meet and integrate the requirements for the education program; resources; learners, teachers and administrative personnel; and continuous improvement domains.

STANDARD 1: There is an appropriate organizational structure, with leadership and administrative personnel to support the residency program, teachers, and residents effectively.

Requirement(s)	Indicator(s)
1.1.1: The program director is available to oversee and advance the residency program.	1.1.1.1: The program director has adequate protected time to oversee and advance the residency program, consistent with the postgraduate office guidelines and in consideration of the size and complexity of the program.
	1.1.1.2 The program director is accessible and responsive to the input, needs, and concerns of residents directly or through the appropriate channels.
	1.1.1.3: The program director is accessible and responsive to the input, needs, and concerns of teachers and members of the residency program committee directly or through the appropriate channels.
	1.1.1.4: The family medicine program director is accessible and responsive to the needs and concerns of all site directors and the enhanced skills program director.
	1.1.1.5 (Enhanced Skills): The enhanced skills program director provides adequate oversight and support to the Category 1 and 2 enhanced skills program directors and their enhanced skills residency program committees.
	1.1.1.6: The enhanced skills program director and the site directors have a reporting responsibility to the family medicine program director.
	1.1.1.7 (Enhanced Skills): The Category 1 and 2 program directors have a reporting responsibility to the enhanced skills program director.
1.1.2: The program director has appropriate support to oversee	1.1.2.1: The faculty of medicine, postgraduate office, and academic lead of the discipline provide the family medicine program director and the enhanced skills program director with sufficient support, autonomy, and resources for effective operation of the residency program.

and advance the residency program.	1.1.2.2: Administrative support is organized and adequate to support the program director (the family medicine program director and enhanced skills program directors), the residency program, and residents.
	1.1.2.3: Each program director and residency program committee have access to resources and data/information to support the monitoring of resident performance, residency program review, and continuous improvement.
1.1.3: The program director provides effective leadership for the residency program.	1.1.3.1: The program director (the family medicine program director and enhanced skills program directors) fosters an environment that empowers members of the residency program committee, residents, teachers, and others as required to identify needs and implement changes.
	1.1.3.2: Each program director advocates for equitable, appropriate, and effective educational experiences.
	1.1.3.3: Each program director communicates with residency program stakeholders effectively.
	1.1.3.4: Each program director anticipates and manages conflict effectively.
	1.1.3.5: Each program director respects the diversity and protects the rights and confidentiality of residents and teachers.
	1.1.3.6: Each program director demonstrates active professional engagement in medical education.
	1.1.3.7 [Exemplary]: Each program director demonstrates and/or facilitates commitment to educational scholarship and innovation to advance the residency program
	1.1.3.8 [Royal College of Physicians and Surgeons (Royal College) Requirement]: The program director and/or delegate attend at least one specialty committee meeting per year in person and/or remotely.
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Element 1.2: There is an effective and functional residency program committee structure to support the program director in planning, organizing, evaluating, and advancing the residency program.

Requirement(s)	Indicator(s)
1.2.1: The residency program committee structure is composed of appropriate key residency program stakeholders.	1.2.1.1: Major academic, clinical, and administrative components, including relevant administrative learning sites, are represented on the residency program committees [(RPC) (family medicine RPC, site RPCs, enhanced skills RPC, Category 1 RPCs, and Category 2 RPCs, when relevant)].
	1.2.1.2: There is an effective, fair, and transparent process for residents to select their representatives on each residency program committee, ensuring adequate input from all distributed sites.
	1.2.1.3: There is an effective process for individuals involved in resident wellness and safety program/plans to provide input to each residency program committee
	1.2.1.4 [Exemplary]: There is an effective process for individuals responsible for quality of care and patient safety at learning sites to provide input to each residency program committee.
	1.2.1.5 [Exemplary]: In meeting its social accountability mandate, each residency program committee seeks input from Indigenous, rural, and vulnerable population groups.
	1.2.1.6 (Enhanced Skills): The enhanced skills residency program committee has representation from all Category 1 and 2 program directors or their designates.

1.2.2: The residency program committee has a clear mandate to manage and evaluate key functions of the residency program.	1.2.2.1: There are clearly written terms of reference that address the composition, mandate, roles, and responsibilities of each member; accountability structures; decision-making processes; lines of communication; and meeting procedures, which are reviewed on a regular basis.
	1.2.2.2: The mandate of the residency program committees is to oversee planning and organizing the core residency and enhanced skills programs, including selection of residents, educational design, policy and process development, safety, resident wellness, assessment of resident progress, and continuous improvement.
	1.2.2.3: Meeting frequency is sufficient for the committee to fulfill its mandate.
	1.2.2.4: The residency program committee oversees a competence committee (or equivalent) responsible for reviewing residents' readiness for increasing professional responsibility, promotion, and transition to practice.
1.2.3: There is an effective and transparent decision-making process that includes input from residents and other residency program stakeholders.	1.2.3.1: Members of the residency program committee are actively involved in a collaborative decision-making process, including regular attendance at and active participation in committee meetings where appropriate.
	1.2.3.2: The residency program committee actively seeks feedback from residency program stakeholders, discusses issues, develops action plans and follows-up on identified issues.
	1.2.3.3: There is a culture of respect for residents' opinions by the residency program committee.
	1.2.3.4: Actions and decisions are communicated in a timely manner to the residency program's residents, teachers, and administrative personnel, and with the academic lead of the discipline, or equivalent, as appropriate.

STANDARD 2: All aspects of the residency program are collaboratively overseen by the program director and the residency program committee.

Element 2.1: Effective policies and processes to manage residency education are developed and maintained.

Requirement(s)	Indicator(s)
2.1.1: The residency program committee has well-defined, transparent, and functional policies and processes to manage residency education.	2.1.1.1: The process of policy and process development, adoption, and dissemination is transparent, effective, and collaborative.
	2.1.1.2: There is a mechanism to review and adopt postgraduate office and learning site policies, and to develop required program- and discipline-specific policies or components.
	2.1.1.3: The residency program's policies and processes address residency education in all learning sites, as outlined in the General Standards of Accreditation for Residency Programs[13] and the specific standards of accreditation for the discipline.
	2.1.1.4: Residents, teachers, and administrative personnel have access to the policies and processes.
	2.1.1.5: The residency program committee regularly reviews and makes necessary changes to policies and processes.
2.1.2: There are effective mechanisms to collaborate with	2.1.2.1: There is effective communication between the residency program and the postgraduate office.

the division/department, other programs, and the postgraduate office.	2.1.2.2: There are effective mechanisms for the residency program to share information and collaborate with the division/department, as appropriate, particularly with respect to resources and capacity.
	2.1.2.3: There is collaboration with the faculty of medicine undergraduate medical education program and with continuing professional development programs, including faculty development, as appropriate.
	2.1.2.4: There is collaboration with other health professions to provide educational experiences for learners across the spectrum of health professions.

Requirement(s)	Indicator(s)
2.2.1: There is a well-defined and effective process to select the residency program's learning sites.	2.2.1.1: There is an effective process to select, organize, and review the residency program's learning sites based on the required educational experiences and in accordance with the centralize policy(ies) for learning site agreements.
	2.2.1.2: Where the faculty of medicine's learning sites are unable to provide all educational requirements, the residency program committee, in collaboration with the postgraduate office, recommends and helps establish inter-institution affiliation (IIA) agreement(s) to ensure residents acquire the necessary competencies.
2.2.2: Each learning site has an effective organizational structure to facilitate education and communication.	2.2.2.1: Each administrative learning site has a site director and appropriate administrative support responsible to the residency program committee.
	2.2.2.2: There is effective communication and collaboration between the residency program committee and the site directors for each learning site.
	2.2.2.3 (Enhanced Skills): Each enhanced skills program has a program director who sits on the enhanced skills residency program committee, and has appropriate administrative support.
2.2.3: The residency program committee engages in operational and resource planning to support residency education.	2.2.3.1: There is an effective process to identify, advocate for, and plan for resources needed by the residency program.

DOMAIN: EDUCATION PROGRAM

The *Education Program* domain includes standards focused on the planning, design, and delivery of the residency program, with an overarching outcome being to ensure that the residency program prepares residents to be competent to begin independent practice.

STANDARD 3: Residents are prepared for independent practice.

Element 3.1: The residency program's educational design is based on outcomes-based competencies and/or objectives that prepare residents to meet the needs of the population(s) they will serve in independent practice.

Requirement(s)	Indicator(s)
3.1.1: Educational competencies and/or objectives are in place to ensure residents progressively meet all required standards for the discipline and address societal needs.	3.1.1.1: The competencies are designed to meet the goals of training defined in the Program Goals and Guiding Principles.
	3.1.1.2: The competencies address each of the Roles in the CanMEDS-FM Framework.
	3.1.1.3: The competencies articulate different expectations for the resident during training.
	3.1.1.4: Local and regional community and societal needs are considered in the design of the residency program.
	3.1.1.5 *[Exemplary]: The Indigenous context is considered in the design of the residency program's competences.*

Element 3.2: The residency program provides educational experiences designed to facilitate **residents' a**ttainment of the outcomes-based competencies and/or objectives.

Requirement(s)	Indicator(s)
3.2.1: The residency program's competencies and/or objectives are used to guide the educational experiences while providing residents with opportunities for increasing professional responsibility at each stage or level of training.	3.2.1.1: The educational experiences are defined specifically for and/or are mapped to each of the competencies.
	3.2.1.2: The educational experiences are chosen at both the program and site level to ensure residents meet the family medicine goals of training
	3.2.1.3: The educational experiences are appropriate for residents' stage or level of training and support residents' achievement of increasing professional responsibility.
	3.2.1.4: The educational experiences allow residents to attain the required level of competency to transition to independent practice.
	3.2.1.5: The educational experiences provide opportunities for the development of competence in continuity of care.
	3.2.1.6: The educational experiences provide opportunities for the development of competence in comprehensive care.
	3.2.1.7: The educational experiences are centred in family medicine.
	3.2.1.8: The educational experiences ensure there is continuity of education.
	3.2.1.9: The educational experiences provide opportunities for the development of community-adaptive competence.
	3.2.1.10: The educational experiences provide opportunities for the development of competence in the care of rural, Indigenous, and underserved populations.
	3.2.1.11 *[Exemplary] (Enhanced Skills)*: *The enhanced skills programs fully integrate the* Triple C Competency-Based Curriculum.

3.2.2: The residency program uses a comprehensive curriculum plan, which is specific to the discipline, and addresses all the CanMEDS/CanMEDS-FM Roles.	3.2.2.1: In planning the curriculum, the residency program makes appropriate use of relevant educational opportunities.
	3.2.2.2: There is a clear curriculum plan (e.g., curriculum map) that describes the educational experiences for residents.
	3.2.2.3: The curriculum plan addresses expert instruction and experiential learning opportunities for all the CanMEDS-FM Roles, with a variety of learning activities.
	3.2.2.4: There is a curriculum plan that describes the experiences that ensure residents meet the goals of training.
	3.2.2.5: The curriculum plan incorporates all program educational objectives.
	3.2.2.6: There is innovation in curriculum design and planning for residency program development in response to emerging local and national trends and societal needs.
	3.2.2.7: The curriculum plan for family medicine requires a minimum of 24 months of training.
3.2.3: The educational design allows residents to identify and address individual learning objectives.	3.2.3.1: Individual residents' educational experiences are tailored to accommodate their learning needs and future career aspirations while meeting the goals of training for family medicine.
	3.2.3.2: The residency program fosters a culture of reflective practice and lifelong learning among its residents.
3.2.4: Residents' clinical responsibilities are assigned in a way that supports the progressive acquisition of competencies and/or objectives, as outlined in the CanMEDS/CanMEDS-FM Roles.	3.2.4.1: The expectations of residents at each level or stage of training meet the requirements of the specific standards for the discipline.
	3.2.4.2: Residents' clinical responsibilities are assigned based on level or stage of training and their individual level of competency.
	3.2.4.3: Residents' clinical responsibilities, including on-call duties, provide opportunities for progressive experiential learning.
	3.2.4.4: Residents are assigned to particular educational experiences in an equitable manner, such that all residents have opportunities to meet their educational needs and achieve the expected competencies of the residency program.
	3.2.4.5: Residents' clinical responsibilities do not interfere with their ability to participate in mandatory academic activities.
	3.2.4.6: Residents' clinical educational experiences are organized to facilitate responsibility for continuity of care.
3.2.5: The educational environment supports and promotes resident learning in an atmosphere of scholarly inquiry.	3.2.5.1: Residents have access to, and mentorship for, a variety of scholarly opportunities, including research and quality improvement.
	3.2.5.2: Residents are provided with protected time to participate in scholarly activities, including but not limited to research, teaching, and quality improvement.
	3.2.5.3: Residents have opportunities to attend conferences within and outside their university to augment their learning and/or to present their scholarly work.
	3.2.5.4: Resident scholarly activity includes support for the development of their competency as teachers.
3.2.6: The residency program provides formal training in continuous improvement with opportunities for residents to apply their training in a project or clinical setting.	3.2.6.1: Residents can apply the science of continuous improvement to improve patient care and safety.
	3.2.6.2: Residents contribute to a culture that promotes quality improvement and use of data to inform practice improvement.
	3.2.6.3: Residents recognize and can respond to harm from health care delivery, including patient safety incidents.

3.2.6.4: Residents adopt strategies that promote patient safety and contribute to solutions to address human and system factors.

3.2.6.5 *[Exemplary]: Residents are able to undertake quality improvement initiatives, including using practice-based data.*

Element 3.3: Teachers **facilitate residents' attainment of competencies and/or objectives.**

Requirement(s)	Indicator(s)
3.3.1: Resident learning needs, stage or level of training, and other relevant factors are used to guide all teaching, supporting resident attainment of competencies and/or objectives.	3.3.1.1: Teachers use experience-specific competencies and/or objectives to guide educational interactions with residents.
	3.3.1.2: Teachers align their teaching appropriately with residents' stage or level of training and individual learning needs and objectives.
	3.3.1.3: Teachers contribute to the promotion and maintenance of a positive learning environment.
	3.3.1.4: Teachers reflect on the potential impacts of the hidden curriculum on the learning experience.
	3.3.1.5: Residents' feedback to teachers facilitates the adjustment of teaching approaches and learner assignment, as appropriate, to maximize the educational experiences.
	3.3.1.6: An identified teacher works longitudinally with the resident to assist him/her in reflecting on progress toward achieving competence for independent practice as described in the competency-coach definition in the FTA Framework.

Element 3.4: There is an effective, organized system of resident assessment.

Requirement(s)	Indicator(s)
3.4.1: The residency program has a planned, defined and implemented system of assessment.	3.4.1.1: The system of assessment is based on residents' attainment of experience-specific competencies and/or objectives.
	3.4.1.2: The system of assessment clearly identifies the methods by which residents are assessed for each educational experience.
	3.4.1.3: The system of assessment clearly identifies the level of performance expected of residents based on level or stage of training; for family medicine, at a minimum, this applies to promotion and completion of training.
	3.4.1.4: The system of assessment includes identification and use of appropriate in-training assessment tools and processes tailored to the residency program's educational experiences, with an emphasis on direct observation where appropriate.
	3.4.1.5: The system of assessment ensures that for completion of training, residents are assessed on achievement of the CFPC evaluation objectives.
	3.4.1.6: The system of assessment is based on multiple assessments of residents' competencies during the various educational experiences and over time, by multiple assessors, in multiple contexts.
	3.4.1.7: Teachers are aware of the expectations for resident performance based on level or stage of training and use these expectations in their assessments of residents.
	3.4.1.8: The system of assessment is designed around a process of continuous reflective assessment, with a focus on guided periodic review of progress.
3.4.2: There is a mechanism in place to engage residents in	3.4.2.1: Residents receive regular, timely, meaningful, in-person feedback on their performance.

regular discussions for review of their performance and progression.	3.4.2.2: The program director and/or an appropriate delegate meet(s) regularly with residents to discuss and review their performance and progress.
	3.4.2.3: There is appropriate documentation of residents' progress toward attainment of competencies, which is available to the residents in a timely manner.
	3.4.2.4: Residents are aware of the processes for assessment and decisions around promotion and completion of training.
	3.4.2.5: The residency program fosters an environment where formative feedback is actively used by residents to guide their learning.
	3.4.2.6: Residents and teachers have shared responsibility for recording their learning and achievement of competencies for their discipline at each stage of training.
	3.4.2.7: Periodic reviews of resident performance are used to guide development of learning plans and adapt educational experiences to meet a resident's educational needs.
3.4.3: There is a well-articulated process for decision-making regarding resident progression, including the decision on satisfactory completion of training.	3.4.3.1: The competence committee (or equivalent) regularly reviews residents' readiness for increasing professional responsibility, promotion, and transition to practice based on the program's system of assessment.
	3.4.3.2: The competence committee (or equivalent) makes a summative assessment regarding residents' readiness for certification and independent practice, as appropriate.
	3.4.3.3: The program director provides the respective College with the required summative documents for exam eligibility and for each resident who has successfully completed the residency program.
	3.4.3.4 [Exemplary]: The competence committee (or equivalent) uses diverse assessment data to make effective decisions on resident progress.
3.4.4: The system of assessment allows for timely identification of and support for residents who are not attaining the required competencies as expected.	3.4.4.1: Residents are informed in a timely manner of any concerns regarding their performance and/or progression.
	3.4.4.2: Residents who are not attaining the required competencies as expected are provided with the required support and opportunity to improve their performance, as appropriate.
	3.4.4.3: Any resident requiring formal remediation and/or additional educational experiences is provided with: • a documented plan detailing objectives of the formal remediation and their rationale; • the educational experiences scheduled to allow the resident to achieve these objectives; • the assessment methods to be employed; • the potential outcomes and consequences; • the methods by which a final decision will be made as to whether the resident has successfully completed a period of formal remediation; and • the appeal process.

DOMAIN: RESOURCES

The *Resources* domain includes standards focused on ensuring resources are sufficient for the delivery of the education program and ultimately to ensure that residents are prepared for independent practice. The Resources domain standards aim to ensure the adequacy of the residency program's clinical, physical, technical, human, and financial resources.

STANDARD 4: The delivery and administration of the residency program are supported by appropriate resources.

Element 4.1: The residency program has the clinical, physical, technical, and financial resources to provide all residents with the educational experiences needed to acquire all competencies.

Requirement(s)	Indicator(s)
4.1.1: The patient population is adequate to ensure that residents experience the breadth of the discipline.	4.1.1.1: The residency program provides access to the volume and diversity of patients appropriate to the discipline.
	4.1.1.2: The residency program provides access to diverse patient populations and environments, in alignment with the community and societal needs for the discipline, and may include but are not limited to rural, Indigenous, and underserved populations.
	4.1.1.3: Learning environments are organized to enable residents to experience continuity with and responsibility for a group of patients.
4.1.2: Clinical and consultative services and facilities are organized and adequate to ensure that residents experience the breadth of the discipline.	4.1.2.1: The residency program has access to the diversity of learning sites and scopes of practice specific to the discipline.
	4.1.2.2: The residency program has access to appropriate consultative services to meet both residents' competency requirements and the delivery of quality care.
	4.1.2.3: Resident training takes place in functionally inter- and intra-professional learning environments that prepare residents for collaborative practice.
	4.1.2.4: [Exemplary]: The residents have significant experience in a Patient's Medical Home *model learning environment.*
4.1.3: Diagnostic and laboratory services and facilities are organized and adequate to ensure that residents experience the breadth of the discipline.	4.1.3.1: The residency program has access to appropriate diagnostic services and laboratory services to meet both residents' competency requirements and the delivery of quality care.
	4.1.3.2: Residents have opportunities to train in environments where resources are limited.
4.1.4: The residency program has the necessary financial, physical, and technical resources.	4.1.4.1: There are adequate financial resources for the residency program to meet the general and specific standards for the discipline.
	4.1.4.2: There is adequate space for the residency program to meet educational requirements.
	4.1.4.3: There are adequate technical resources for the residency program to meet the specific requirements for the discipline.
	4.1.4.4: Residents have appropriate access to adequate facilities and services to conduct their work, including on-call rooms, workspaces, Internet, and patient records.
	4.1.4.5: The program director, site directors, enhanced skills program directors, residency program committees, and administrative personnel have access to

	adequate space, information technology, and financial support to carry out their duties.
	4.1.4.6: There are adequate technical resources to support and encourage distance/online learning and communication.
4.1.5: There is appropriate liaison with other programs and teaching services to ensure that residents experience the breadth of the discipline.	4.1.5.1: There is coordination with other residency programs to share educational resources, provide educational experiences to residents from other programs, and to obtain feedback on these experiences.
	4.1.5.2: There is coordination with other residency programs to ensure that appropriate teaching and assessment for family medicine residents are provided.

Element 4.2: The residency program has the appropriate human resources to provide all residents with the required educational experiences.

Requirement(s)	Indicator(s)
4.2.1: The number, credentials, competencies, and duties of the teachers are appropriate to teach the residency curriculum, supervise and assess trainees, contribute to the program, and role model effective practice.	4.2.1.1: The number, credentials, competencies, and scope of practice of the teachers are adequate to provide the breadth and depth of the discipline, including required clinical teaching, academic teaching, assessment, and feedback to residents.
	4.2.1.2: The number, credentials, competencies, and scope of practice of the teachers are sufficient to supervise residents in all clinical environments, including when residents are on-call and when providing care to patients, as part of the residency program, outside of a learning site.
	4.2.1.3: There are sufficient competent individual supervisors to support a variety of resident scholarly activities, including research as appropriate.
	4.2.1.4: There is a designated individual who facilitates the involvement of residents in scholarly activities, including research as appropriate, and who reports to the residency program committee.
	4.2.1.5: For the core family medicine program, all family physician teachers who have a major responsibility in the teaching and assessment of residents hold (or are pursuing) Certification in the College of Family Physicians of Canada (CCFP) or hold (or are pursuing) a specialist certificate in family medicine from the Collège des médecins du Québec (CMQ), and hold academic appointments in the university's department of family medicine.
	4.2.1.6: The family medicine program director, the enhanced skills program director, and all individuals in leadership positions in the department hold (or are pursuing) certification and are in good standing with the CFPC or with the CMQ.
	4.2.1.7 (Enhanced Skills): All program directors hold the CCFP Special Designation. Any Category 1 or 2 enhanced skills program directors who do not hold the CCFP Special Designation are able to demonstrate in-depth knowledge and understanding of the needs of residents in family medicine and maintain accountability to the enhanced skills program director.

DOMAIN: LEARNERS, TEACHERS, AND ADMINISTRATIVE PERSONNEL

The *Learners, Teachers, and Administrative Personnel* domain includes standards focused on supporting teachers, learners, and administrative personnel—"people services and supports." The Learners, Teachers, and Administrative Personnel domain program standards aim to ensure:

- A safe and positive learning environment for all (i.e., residents, teachers, patients, and administrative personnel);
- Recognition of value and support for administrative personnel;
- Fair treatment of and support for residents through progression of their residency program

STANDARD 5: Safety and wellness are promoted throughout the learning environment.

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Requirement(s)	Indicator(s)
5.1.1: Residents are appropriately supervised.	5.1.1.1: Residents and teachers at all learning sites follow the central policy(ies) and any program-specific policies regarding supervision of residents, including ensuring the physical presence of the appropriate supervisor, when mandated, during acts or procedures performed by the resident.
	5.1.1.2: Teachers are available for consultation for decisions related to patient care in a timely manner.
	5.1.1.3: Teachers follow the mechanism for disclosure of resident involvement in patient care and for patient consent for such participation.
5.1.2: Residency education occurs in a safe learning environment.	5.1.2.1: Safety is actively promoted throughout the learning environment for all those involved in the residency program.
	5.1.2.2: There is an (are) effective resident safety policy(ies), aligned with the central policy(ies) and modified, as appropriate, to reflect physical, psychological, and professional resident safety concerns. The policy(ies) include(s), but is (are) not limited to: - Travel - Patient encounters (including house calls) - After-hours consultation - Patient transfers (e.g., Medevac) - Complaint management[‡] - Fatigue risk management\ - Housing and accommodation when residents are off-site - During remediation
	5.1.2.3: The policy regarding resident safety addresses both situations and perceptions of lack of resident safety effectively and provides multiple avenues of access for effective reporting and management.

[‡] Complaints may include those made by a resident (e.g., regarding their learning environment) as well as complaints made regarding a resident.

	5.1.2.4: Concerns with the safety of the learning environment are appropriately identified and remediated.
	5.1.2.5: Residents are supported and encouraged to exercise discretion and judgment regarding their personal safety, including fatigue.
	5.1.2.6: Residents and teachers are aware of the process to follow if they perceive safety issues.
	5.1.2.7: Administrators at all teaching sites are well aware of the process to follow when they or their residents perceive safety issues.
5.1.3: Residency education occurs in a positive learning environment that promotes resident wellness.	5.1.3.1: There is a positive learning environment for all involved in the residency program.
	5.1.3.2: There is an (are) effective resident wellness policy(ies), aligned with the central policy(ies) and modified, as appropriate, to reflect discipline-specific physical, psychological, and professional resident wellness concerns. The policy(ies) include(s), but is (are) not limited to absences and educational accommodation.
	5.1.3.3: The processes regarding identification, reporting, and follow-up of resident mistreatment are applied effectively.
	5.1.3.4: Residents have access to and are aware of confidential support services to manage stress (e.g., financial, psychological, etc.) and illness.
	5.1.3.5: Residents are supported and encouraged to exercise discretion and judgment regarding their personal wellness.
	5.1.3.6: Residents are supported through all phases of their assessment, including when in difficulty, during remediation, and during probation.
	5.1.3.7 *[Exemplary]: There is a resilience and wellness committee structure where residents take a leadership role.*

STANDARD 6: Residents are treated fairly and supported adequately throughout their progression through the residency program.

Element 6.1: The progression of residents through the residency program is supported, fair, and transparent.

Requirement(s)	Indicator(s)
6.1.1: There are effective, clearly defined, transparent, formal processes for the selection and progression of residents.	6.1.1.1: Processes for resident selection, promotion, remediation dismissal, and appeals are applied effectively, transparent, and aligned with applicable central policies.
	6.1.1.2: The residency program encourages and recognizes resident leadership.
6.1.2: Support services are available to facilitate resident achievement of success.	6.1.2.1: The residency program provides formal, timely career planning and counselling to residents throughout their progression through the residency program.
	6.1.2.2: There is access to mentorship to help facilitate residents' professional development, career planning, and wellness.
	6.1.2.3: Residents have access to a faculty adviser/ competency coach.

STANDARD 7: Teachers deliver and support all aspects of the residency program effectively.

Element 7.1: Teachers are assessed, recognized, and supported in their development as positive role models for residents in the residency program.

Requirement(s)	Indicator(s)
7.1.1: Teachers are regularly assessed and supported in their development.	7.1.1.1: There is an effective process for the assessment of teachers involved in the residency program, aligned with applicable central processes, that balances timely feedback with preserving resident confidentiality.
	7.1.1.2: The system of teacher assessment ensures recognition of excellence in teaching and continuous improvement and is used to address performance concerns.
	7.1.1.3: Resident input is a component of the system of teacher assessment.
	7.1.1.4: Faculty development for teaching that is relevant and accessible to the program is offered on a regular basis.
	7.1.1.5: There is an effective process to identify, document, and address unprofessional behaviour by teachers.
	7.1.1.6 [Exemplary]: The residency program actively collaborates with the central faculty development office, as appropriate, to identify and address priorities for faculty development within the discipline.
	7.1.1.7 [Exemplary]: The Fundamental Teaching Activities framework is used in the faculty development process.
	7.1.1.8 [Exemplary]: There is multisource feedback for teachers.
	7.1.1.9 [Exemplary]: There is a faculty development program that supports teachers in receiving feedback.
	7.1.1.10 [Exemplary]: There is defined support for teachers regarding resident assessment as well as resident remediation processes.
	7.1.1.11 [Exemplary]: Faculty development programs are informed by teacher assessments.
7.1.2: Teachers in the residency program are effective role models for residents.	7.1.2.1: Teachers exercise the dual responsibility of providing quality, ethical patient care; and excellent supervision and teaching.
	7.1.2.2: Teachers contribute to academic activities of the residency program and institution, which may include, but are not limited to lectures, workshops, examination preparation, and internal reviews.
	7.1.2.3: Teachers are supported and recognized for their contributions outside the residency program, which may include, but are not limited to peer reviews, medical licensing authorities, exam boards, specialty committees, accreditation committees, and government medical advisory boards.
	7.1.2.4: Teachers contribute to scholarship on an ongoing basis.
	7.1.2.5: The residency program promotes and supports resiliency and well-being for their teachers.
	7.1.2.6: The residency program considers quality improvement role-modelling and engagement when selecting teaching practices.

STANDARD 8: Administrative personnel are valued and supported in the delivery of the residency program.

Element 8.1: There is support for the continuing professional development of residency program administrative personnel.

Requirement(s)	Indicator(s)
8.1.1: There is an effective process for the selection and professional development of the residency program administrative personnel.	8.1.1.1: The job description(s) for residency program administrative personnel outlines the mandate, expectations, time allocation, reporting, and accountability for the role and are applied effectively.
	8.1.1.2: Residency program administrative personnel are selected based on the central criteria and guidelines.
	8.1.1.3: Residency program administrative personnel receive professional development, provided centrally and/or through the residency program, based on their individual learning needs.
	8.1.1.4: Residency program administrative personnel receive feedback on their performance in a fair and transparent manner.
	8.1.1.5: The residency program promotes and supports resiliency and well-being for their administrative personnel.
	8.1.1.6: Administrative personnel are supported and able to access resources when dealing with residents in distress.

DOMAIN: CONTINUOUS IMPROVEMENT

The *Continuous Improvement* domain includes standards focused on ensuring a culture of continuous improvement is present throughout the residency program, with the aim of ensuring continuous improvement of residency programs.

Note: To reinforce and create clarity with respect to the expectations related to continuous improvement, the Requirements under the Element mimic the continuous improvement cycle (Plan, Do, Study, Act).

STANDARD 9: There is continuous improvement of the educational experiences, to improve the residency program and ensure residents are prepared for independent practice.

Element 9.1: The residency program committee reviews and improves the quality of the residency program.	
Requirement(s)	Indicator(s)
9.1.1: There is a process to review and improve the residency program.	9.1.1.1: There is an evaluation of each of the residency program's educational experiences, including the review of related competencies.
	9.1.1.2: There is an evaluation of the learning environment.
	9.1.1.3: The program evaluates the potential impact of the hidden curriculum on the residency program.
	9.1.1.4: Residents' achievements of competencies and/or objectives are reviewed.
	9.1.1.5: The resources available to the residency program are reviewed.
	9.1.1.6: Residents' assessment data are reviewed.
	9.1.1.7: The feedback provided to teachers in the residency program is reviewed.
	9.1.1.8: The residency program's leadership at the various learning sites is assessed.
	9.1.1.9: The residency program's policies and processes for residency education are reviewed.
	9.1.1.10: Program evaluation includes a review of data and information collected from all family medicine and enhanced skills learning sites and streams of training.
9.1.2: A range of data and information is reviewed to inform evaluation and improvement of the residency program and its components.	9.1.2.1: Information from multiple sources, including feedback from residents, teachers, administrative personnel, and others as appropriate, is regularly reviewed.
	9.1.2.2: Information identified by the postgraduate office's internal review process and any data centrally collected by the postgraduate office are accessed.
	9.1.2.3: Mechanisms for feedback take place in an open, collegial atmosphere.
	9.1.2.4 [Exemplary]: A resident e-portfolio (or equivalent tool) is used to support residency program review and continuous improvement.
	9.1.2.5 [Exemplary]: Education and practice innovations in the discipline in Canada and abroad are reviewed.

	9.1.2.6 [Exemplary]: Patient feedback to improve the residency program is regularly collected/accessed.
	9.1.2.7 [Exemplary]: Feedback from and data on graduates once in practice are regularly collected/accessed to improve the residency program.
	9.1.2.8 [Exemplary]: Programs regularly evaluate how effective they are in preparing the residents to meet the health care needs of the populations they serve.
9.1.3: Based on the data and information reviewed strengths are identified and action is taken to address areas identified for improvement.	9.1.3.1: Areas for improvement are used to develop and implement relevant and timely action plans.
	9.1.3.2: The program director and residency program committee share the identified strengths and areas for improvement (including associated action plans) with residents, teachers, administrative personnel, and others as appropriate, in a timely manner.
	9.1.3.3: There is a clear and well-documented process to evaluate the effectiveness of actions taken, and to take further action as required.

GLOSSARY OF TERMS

Term	Description
academic lead of the discipline	The individual responsible for a clinical department/division (e.g., department chair, division lead).
administrative personnel	Postgraduate and program administrative personnel, as defined below.
Assessment	A process of gathering and analyzing information on competencies from multiple and diverse sources to measure a physician's competence or performance and compare it with defined criteria.[14]
Attestation	Verification of satisfactory completion of all necessary training, assessment, and credentialing requirements of an area of medical expertise. Attestation does not confer certification in a discipline.[14]
Category 1 and 2 enhanced skills programs	Category 1 enhanced skills programs must use and are accredited based on national CFPC–defined and recognized domain-specific competencies for assessment. Category 2 programs will have local, university-based domain-specific competencies defined for the purpose of assessment. Upon successful completion of a Category 1 program, residents are eligible to apply for a CAC. Residents completing Category 2 programs are not eligible for CACs. (The exception to this is the Clinician Scholar Program, which is recognized as a Category 1 program).
Central	This term applies to policies, processes, guidelines, and/or services developed by a faculty of medicine, postgraduate office, and/or postgraduate education committee, and applied to more than one residency program.
Certification	Formal recognition of satisfactory completion of all necessary training, assessment, and credentialing requirements of a discipline, indicating competence to practise independently.[14]
CFPC	College of Family Physicians of Canada
CMQ	Collège des médecins du Québec
competence	The array of abilities across multiple domains of competence or aspects of physician performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stage of training or practice. Competence is multi-dimensional and dynamic; it changes with time, experience, and settings.[15]
competency (competencies)	An observable ability of a health professional related to a specific activity that integrates knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development.[15]
competency coach	The teacher who acts as an educational adviser for a learner over the long term, and who is focused on the development and achievement of learning plans, guiding and reviewing portfolios, etc.
competent	Possessing the required abilities in all domains of competence in a certain context at a defined stage of medical education or practice.[15]
continuing professional development	An ongoing process of engaging in learning and development beyond initial training, which includes tracking and documenting the acquisition of skills, knowledge, and experiences.
continuous improvement	The systematic approach to making changes involving cycles of change (i.e., Plan, Do, Study, Act) that lead to improved quality and outcomes. It is used as an internal tool for monitoring and decision making (e.g., What are the

	strengths and weaknesses of the residency program? How can we improve our system of assessment?).
continuum of research	The various ways that family physicians, learners and family medicine researchers engage in research and the varying intensities of such engagement.[16]
Dean	The senior faculty officer appointed to be responsible for the overall oversight of a faculty of medicine.
Discipline	Specialty and/or subspecialty recognized by one of the certification colleges.[17]
division/department	A department, division, or administrative unit around which clinical and academic services are arranged.
Domain(s) of competence	Broad, distinguishable areas of competence that together constitute a general descriptive framework for a profession(s).[17]
educational accommodation	Recognizing that people have different needs and taking reasonable efforts to ensure equal access to residency education.
Evaluation	A process of employing a set of procedures and tools to provide useful information about medical education programs and their components to decision makers (R.I.M.E. Framework[18]). This term is often used interchangeably with assessment when applied to individual physicians, but is not the preferred term.[14]
Equitable	Used in the context of having and/or allocating resources, and refers to the fair and impartial distribution of resources.[19]

faculty adviser	The role of the faculty adviser is to:
	• Orient the resident to the discipline of family medicine
	• Discuss with the resident the program objectives and 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 to:
	    o Reflect on program choices to be made
	    o Understand assessment feedback
	    o Set and revise learning objectives
	    o Define career plans

faculty development	That broad range of activities institutions use to renew or assist teachers in their roles.[20]
faculty of medicine	A faculty of medicine, school of medicine, or college of medicine under the direction of a Canadian university/universities.
fatigue risk management	A set of ongoing fatigue prevention practices, beliefs, and procedures integrated throughout all levels of an organization to monitor, assess, and minimize the effects of fatigue and associated risks for the health and safety of health care personnel and the patient population they serve. [This is a working definition , and is under further development.]
hidden curriculum	A set of influences that function at the level of organizational structure and culture, affecting the nature of learning, professional interactions, and clinical practice. [As defined in the FMEC MD Education Project Collective Vision.][21]
independent practice	Practice in which physicians are licensed to be accountable for their own medical practice that is within their scope of practice and that normally takes place without supervision.
Institution	Encompasses the university, faculty of medicine, and postgraduate office.
Inter-institutional Agreement (IIA)	A formal agreement used in circumstances where a faculty of medicine requires residents to complete a portion of their training under another recognized

	Faculty of Medicine, in alignment with policies and procedures for IIAs as set by the Royal College , CFPC, and/or CMQ.
internal review	An internal evaluation conducted to identify strengths of, and areas for, improvement for the residency program and/or the faculty of medicine.
interprofessional	Individuals from two or more professions (e.g., medicine and nursing) working collaboratively with shared objectives, decision-making responsibilities, and power to develop care plans and make decisions about patient care (CanMEDS/CanMEDS-FM).[5]
intra-professional	Two or more individuals from within the same profession (e.g., medicine), working together interdependently to develop care plans and make decisions about patient care (CanMEDS/CanMEDS-FM)[5].
learning environment	The diverse physical locations, contexts, and cultures in which residents learn.[22]
learning site	A hospital, clinic, or other facility that contributes to residents' educational experiences. In family medicine learning sites vary in purpose. There are sites that have both clinical teaching and administrative responsibilities (administrative learning sites) and sites that are primarily limited to clinical teaching (clinical learning sites).
Mentorship	Guidance, often around career planning, professional development, and wellness, offered to residents from individuals who are not involved in their assessment.
Mistreatment	Unprofessional behaviour involving intimidation, harassment, and/or abuse.
Objective	An outcomes-based statement that describes what the resident will be able to do upon completion of the learning experience, stage of training, or residency program.
postgraduate administrative personnel	Individuals who support the postgraduate dean in coordination and administration related to the oversight of residency programs, including the postgraduate manager.
postgraduate dean	A senior faculty officer appointed to be responsible for the overall conduct and supervision of postgraduate medical education within a faculty of medicine.
postgraduate education committee	The committee (and any subcommittees as applicable) overseen by the postgraduate dean that facilitates the governance and oversight of all residency programs within a faculty of medicine.
postgraduate manager	Senior administrative personnel responsible for supporting the postgraduate dean and providing overall administrative oversight of the postgraduate office.
postgraduate office	A postgraduate medical education office under the direction of a faculty of medicine, with responsibilities for residency programs.
program administrative personnel	Individuals who support the program director by performing administrative duties related to planning, directing, and coordinating the residency program.
program director	The individual responsible and accountable for the overall conduct and organization of the residency program. The individual is accountable to the postgraduate dean and academic lead of the discipline. The enhanced skills program director is responsible and accountable for the overall conduct and organization of the overarching enhanced skills residency program. The individual is accountable to the family medicine program director. Category 1 and 2 program directors are responsible and accountable for the overall conduct and organization of the individual enhanced skills programs. These individuals are accountable to the enhanced skills program director.
protected time	A designated period of time granted to an individual for the purposes of performing a task and/or participating in an activity.

residency program	An accredited residency education program in one of Canada's nationally recognized disciplines, associated with a recognized faculty of medicine and overseen by a program director and residency program committee.
residency program committee	The committee and subcommittees, as applicable, overseen by the program director, that support the program director in the administration and coordination of the residency program.
residency program stakeholder	A person or organization with an interest in and/or who is impacted by the residency program.
Resident	An individual registered in an accredited residency program following eligible undergraduate training leading to certification or attestation in a recognized discipline.[14]
Resource	Includes educational, clinical, physical, technical, and financial materials and people (e.g., teachers and administrative personnel) required for the delivery of a residency program.
Royal College	Royal College of Physicians and Surgeons of Canada
scholarly activity	Scholarship includes the scholarship of discovery (includes original research), the scholarship of integration (synthesis of information), the scholarship of application (results that can be shared with or reviewed by peers), and the scholarship of teaching.[10]
site coordinator	The coordinator/supervisor with responsibility for residents at a learning site. In family medicine, site coordinators are the administrative staff who are responsible for organizing the teaching and learning activities at a learning site or clinic.
site director	In family medicine, this is the individual responsible and accountable for the conduct and organization of the residency program at a particular site. The individual is accountable to the family medicine program director.
social accountability	The direction of education, research, and service activities toward addressing the priority health concerns of the community, region, and/or nation. Priority health concerns are to be identified jointly by governments, health care organizations, health professionals, and the public.[23]
Teacher	An individual responsible for teaching residents. "Teacher" is often used interchangeably with terms such as supervisor and preceptor.
Teaching	Includes formal and informal teaching of residents, including the hidden curriculum.
Wellness	A state of health, namely, a state of physical, mental, and social well-being, that goes beyond the absence of disease or infirmity.[24]

Appendix: Appeal of CFPC Residency Accreditation Committee decisions on accreditation status

1. Introduction

This policy describes the process and procedures that will be followed to ensure a standardized mechanism in the event of an appeal of a College of Family Physicians of Canada's (CFPC) Residency Accreditation Committee (RAC) decision on accreditation status.

2. Scope

Based on the criteria and as per the procedure noted below, postgraduate deans, on behalf of each of their family medicine residency programs (core and enhanced skills), are granted the opportunity to make a single appeal of a decision only on any of the following accreditation status decisions made by the CFPC Residency Accreditation Committee:

- Accredited on Notice of Intent to Withdraw
- Withdrawal of Accreditation
- Denial of accreditation

3. Policy

An appeal must be based on the same information available to the RAC at the time of the program review at their committee meeting; changes or improvements in the program following the completion of these reviews will not be considered in the appeal.

4. Permitted Grounds for Appeal

The CFPC Residency Accreditation Committee will consider appeals based only on one or more of the following grounds:
- that there were procedural errors which resulted in substantial unfairness
- that the criteria for the decision about the accreditation status of a program were misapplied by the RAC
- that the RAC failed to adequately consider evidence presented to the survey visit team

5. Procedures

5.1. A written request for reconsideration of a decision of the CFPC Residency Accreditation Committee must be submitted by the postgraduate dean (hereafter referred to as "the Appellant") to the CFPC Accreditation Department within 10 business days of the date of the letter transmitting the Residency Accreditation Committee's decision (i.e. decision letter). Requests received after 10 business days will not be considered. To be considered complete, the request must a) clearly describe the reasons for the appeal, based on point 4. above; and b) must include a formal confirmation that the Appellant agrees to be bound by the appeals process (including the final decision). The Appeal will be managed by the CFPC

Accreditation Department in a timely manner so that the process does not exceed a time period longer than five months from beginning to end.

5.1.1. The CFPC Accreditation Department will review the request for reconsideration to ensure the request is complete (i.e. contains all necessary documentation, rationale for the appeal).

5.1.2. If it is not, the CFPC Accreditation Department will confer with the Appellant to complete the necessary documentation for the request for reconsideration within 10 business days.

5.1.3. Upon receipt of a request for reconsideration, the CFPC Accreditation Department will promptly notify the RAC Chair and voting members of the RAC that there is a request for reconsideration of their decision.

5.2. The request for reconsideration, with all submitted supporting documentation, is sent to the voting members of the Residency Accreditation Committee for review and reconsideration within 10business days of receipt of the complete request. The CFPC Accreditation Department will provide the Residency Accreditation Committee with the information which was available at the time of its decision along with the request for reconsideration from the Appellant, including the rationale for the request.

5.2.1. Within 20 business days of the materials being sent to the RAC, a discussion will be organized by teleconference. Upon review and discussion of the request for reconsideration and materials provided, the RAC will decide whether it will uphold its initial decision on accreditation status.

5.2.2. If the RAC does not uphold its initial decision and decides to change its decision on accreditation status, the Accreditation Department will notify the Appellant in an updated decision letter within 10 business days of the teleconference.

5.2.3. If the RAC decides to uphold its initial decision on accreditation status, a communication containing the reasons for upholding its decision will be sent to the Appellant within 5 business days of the teleconference. The Appellant will be given 10 business days to decide whether he/she wishes to accept the RAC's reasons to uphold its decision or if he/she wishes to proceed with the appeal.

5.2.4. If the Appellant wishes to accept the RAC's decision to uphold its decision, the initial decision on accreditation status and follow-up will be upheld.

5.2.5. If the Appellant wishes to proceed with the appeal, the appeal is then sent to the Ad Hoc Residency Accreditation Appeals Committee within 10 business days of the Appellant's decision to proceed with the appeal. *See below for the Terms of Reference and Membership of this Committee*

5.3. The Ad Hoc Residency Accreditation Appeals Committee will review the same written materials that were submitted to the CFPC Residency Accreditation Committee. The Appeals Committee will meet with the chair of the accreditation survey visit and the chair of the RAC within 20 business days of the Appellant's decision to proceed with the appeal to ensure that it understands the basis for the RAC's decision and understands what is being presented by the Appellant. The Appellant will also meet with the Appeals Committee within 20 business days of their decision to proceed with the appeal to make oral submissions to support their appeal.

5.4. Within 10 business days, the Ad Hoc Residency Accreditation Appeals Committee will make a final decision on whether or not any change in the accreditation status of the program is required and, if so, which status it will be granted, and will describe the grounds for this decision. This decision will then be promptly communicated in writing to the CFPC Accreditation Department who will promptly notify a) the Chair and voting members of the Residency Accreditation Committee and, b) the Appellant in an updated decision letter.

5.5. The decision by the ad hoc Residency Accreditation Appeals Committee is final and may not be further appealed.

5.6. Any costs associated with conducting an appeal (including but not limited to travel/accommodation/translation, etc.) will be the responsibility of the Appellant.

Ad Hoc Residency Accreditation Appeals' Committee

Terms of Reference

Purpose: The Ad Hoc Residency Accreditation Appeals Committee is established to be the final recourse available to universities to appeal a decision on accreditation status. It will hear and decide on cases of appeal by the Appellant.

Responsibilities

1. To review all materials pertinent to the decision made by the Residency Accreditation Committee (RAC) on the accreditation status of the university contested by the Appellant and to ensure that it understands the basis for the RAC's decision and understands what is being presented by the Appellant.

2. To hear and take into consideration an oral presentation made by the Appellant and the Chair of the RAC.

3. To make a decision on whether or not the accreditation status of a residency program needs to be changed and, if so, to what and why.

Type of Committee

Ad hoc Committee – to be established only when an appeal is received.

Accountability and Authority

The Ad Hoc Residency Accreditation Appeals Committee is accountable to the CFPC Board of Directors.

Committee Membership

Voting members:

- Chair – Chair of the CFPC National Board of Directors

- Three members of the College with significant accreditation experience (i.e. past members of the RAC, program directors or other experienced residency accreditation surveyors), not including the chair of the Residency Accreditation Committee or any individual involved in the original decision

- One resident from the Section of Residents

Term of Office

Ad Hoc

Support Staff

Support is to be provided by the Executive Office

Voting

The Voting Process for the Ad Hoc Residency Accreditation Appeals' Committee will comply with the Bourinot's Rules of Order as outlined in the CFPC By-Laws. Every Motion shall be decided by a majority of the votes cast, assuming – in order to conduct business - more than half the voting members are present (in person or in teleconference). In case of an equality of votes, the Chair of the meeting shall be entitled to a second or tie-breaking vote. If a vote is requested by email, all the members of the Committee who are eligible to vote must approve the motion.

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