



The College of  
Family Physicians  
of Canada

Le Collège des  
médecins de famille  
du Canada

**Standards for the Assessment of Non-  
Canadian Postgraduate Family Medicine  
Education Programs**

## Preamble

As jurisdictions from other countries have approached the College of Family Physicians of Canada, seeking reciprocity of credentials, or recognition of training, it has become increasingly important that our College develop a rigorous and fair system for doing so. This system must also take into account the inevitable differences of context that exist in different countries and health care systems, and yet still ensure that physicians who have trained as family physicians elsewhere have been provided with all that is necessary for independent practice in Canada. It was clear that simply using the accreditation guidelines to which our own training programs adhere would not be appropriate based as they are in the Canadian context. There have not, as yet, been any global standards developed for family medicine training. However, there is an excellent model for postgraduate education in general.

The World Federation for Medical Education (WFME) has as its mission the improved health of all peoples. In keeping with its constitution, as the international body representing all medical teachers and medical teaching institutions, WFME undertakes to promote the highest scientific and ethical standards in medical education, initiating new learning methods, new instructional tools, and innovative management of medical education.

In accordance with this mandate, WFME in its 1998 position paper, launched the program on ***International Standards in Medical Education***. The purpose was to provide a mechanism for quality improvement in medical education, in a global context, to be applied by institutions responsible for medical education, and in programs throughout the continuum of medical education. (WFME 2003) The WFME ***Global Standards*** have been developed to cover the spectrum of medical education: **basic medical education; postgraduate medical education; and continuing professional development**. In addition, the WFME in partnership with the WHO developed guidelines for accreditation of medical training programs. These standards were each developed by an international task force of experts in medical education, and are presently recognized around the world and have been used by many countries in developing their own standards. As such, the Postgraduate Medical Education WFME Standards for Quality Improvement can be an extremely useful tool for countries to have a common framework and language to better understand each other's training programs.

The following document is an adaptation of the Postgraduate Medical Education WFME Standards for Quality Improvement for Family Medicine education. It may be helpful to review the original document, available at <http://www.wfme.org/>. Modifications generally fall into two categories. The standards have been modified to fit the requirements of family medicine training specifically, unlike the original which deals with postgraduate training in general. Specific content areas and training sites are therefore included in these standards. Secondly, the original WFME standards are designed at two levels: basic and quality improvement. The latter represents what is considered internationally as “best practice” in medical education. We believe that, in general, that is a requirement for educational reciprocity with the College of Family Physicians of Canada. Hence, we have modified the standards to eliminate any distinction between the basic standards and quality improvement standard. All programs need to be working in the quality improvement level. In some situations, the word “should” is used, rather than “must”. This represents a standard in which there is some flexibility in how the standard is met.

**The term family medicine is used in this document to define the discipline: however, general practice, family practice and primary care are also appropriate terms which are used in some settings. It is the standards which are important rather than the terms which are being used. The nature of the discipline is one which is based in the community which it serves and fundamentally is relationship based care that endures over place and time, regardless of which of the terms are used to describe it. Family Medicine is a discipline that provides continuous and comprehensive care, from pre-natal to palliative care, across all ages and in all settings.**

## FUNDAMENTALS OF POSTGRADUATE MEDICAL EDUCATION

Postgraduate medical education is the phase of medical education in which doctors develop discipline specific competencies after completion of their basic medical qualification.

This phase of training is usually conducted according to specified regulations and rules. The training has developed from a setting similar to apprenticeship, meaning that the young doctors work in e.g. clinical settings with more experienced colleagues who take the responsibility for their instruction and supervision. Postgraduate medical education comprises pre-registration training, vocational/professional training, specialist and sub specialist training and other formalized training programs for defined expert Functions. In addition to the practical clinical aspects, further theoretical education is required. This can be organized in various ways, either closely connected with the clinical training or through regional, national or international theoretical courses. Such programs may be managed by universities, specialist boards, medical societies and colleges or institutes for postgraduate medical education. Postgraduate medical education is part of the continuum of learning in medicine, which also includes Continuing Medical Education (CME) or Continuing Professional Development (CPD). However, over the last decades there has been an increasing convergence in training methods with emphasis on both practical training and theory. Modern principles of medical education have exerted increasing influence in all countries. In postgraduate medical education highly sophisticated learning programs have developed, the components of which are planned clinical/practical placements, expert supervision, theoretical teaching, research experience, systematic assessments and evaluation of the training programs.

### DEFINITIONS

Postgraduate Medical Education may be defined as the phase in which doctors train under supervision towards independent practice after completion of their basic medical qualification. It comprises pre-registration training, vocational/professional training, specialist and sub-specialist training and other formalized training programs. Upon completion of a formal postgraduate training program a degree, diploma or certificate is usually granted. Although Postgraduate Medical Education is a time limited phase of medical education it cannot be clearly separated from Continuing Medical Education (CME) or Continuing Professional Development (CPD)<sup>1</sup>. These are carried out during the entire professional life after graduation from the medical school and are characterized by self-directed learning and rarely involve supervised training for extended periods of time.

WFME recommends the following set of global standards in postgraduate medical education structured according to **9 areas** and **38 sub-areas**.

**AREAS** defined as broad components in the structure, process and outcome of postgraduate medical education and training cover:

1. Mission and Outcomes
2. Training Process
3. Assessment of Trainees
4. Trainees
5. Staffing
6. Training Settings and Educational Resources
7. Evaluation of Training Process
8. Governance and Administration
9. Continuous Renewal

**SUB-AREAS** are defined as specific aspects of an area, corresponding to performance indicators.

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## 1. MISSION AND OUTCOMES

### 1.1 STATEMENTS OF MISSION AND OUTCOMES

The competent authorities **must** define, in consultation with professional organizations, including one specifically dedicated to family medicine and/or primary care, the mission and outcome objectives for family medicine postgraduate medical training and make them known.

The statements of mission and outcomes **must** describe the practice - based training process resulting in a family doctor competent to undertake comprehensive up-to-date family practice in a professional manner, unsupervised and independently or within a team, in keeping with the needs of the health care system.

The mission and outcome objectives **must** encourage appropriate innovation in the training process and allow for development of broader competencies than minimally required and constantly strive to improve patient care that is appropriate, effective and compassionate in dealing with health problems and promotion of health. The training **must** encourage doctors to become scholars within family medicine and **must** prepare them for lifelong, self-directed learning and readiness for continuing

medical education and professional development.

**Annotations:**

- *Statements of mission and outcomes* would include general and specific issues relevant to national and regional policy.
- *Competent authorities* would include local and national bodies involved in regulation of postgraduate medical training, and could be a national governmental agency, a national board, a university, a competent professional organization or a combination.
- *Types of postgraduate medical training* would include pre-registration training, systematic vocational training, and specialist training in family medicine.
- *Scholar* refers to deeper and/or broader engagement in the development of the discipline, including responsibility for education, development, research, management, etc.

## 1.2 PARTICIPATION IN THE FORMULATION OF MISSION AND OUTCOMES

The statement of mission and outcomes of postgraduate training **must** be defined by its principal stakeholders.

Formulation of mission and outcomes statements **should** also include input from a wider range of stakeholders.

**Annotations:**

- *Principal stakeholders* would include trainees, program directors, scientific societies, hospital administrations, governmental authorities and professional associations or organizations.
- *A wider range of stakeholders* would include representation of supervisors, trainers, teachers, other health professions, patients, the community, organizations and health care authorities.

## 1.3 PROFESSIONALISM AND AUTONOMY

The training process **must**, based on approved basic medical education, further strengthen professionalism of the doctor.

The training **must** foster professional autonomy to enable the doctor to act in the best interests of the patient and the public.

**Annotation:**

- *Professionalism* describes the knowledge, skills, attitudes and behaviours expected by patients and society from individuals during the practice of their profession and includes concepts such as skills of lifelong learning and maintenance of competence, information literacy, ethical

behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice and respect for others.

## 1.4 TRAINING OUTCOMES

The relevant competent authorities **must**, in consultation with the professional organizations, as defined in 1.1, define the competencies, which must be achieved by trainees as a result of the training programs.

Both broad and specific competencies to be acquired by trainees **must** be specified and linked with the competencies acquired as a result of basic medical education. Measures of competencies achieved by trainees **should** be used as feedback for program development.

### ***Annotation:***

*Competencies* can be defined in broad professional terms or as specific knowledge, skills, attitudes and behaviours. Competencies relevant for postgraduate training (see references 9-12) would, for family medicine, include the following areas:

- Patient care that is appropriate, effective and compassionate for dealing with health problems and health promotion and disease prevention.
- Medical knowledge in the basic biomedical, clinical, behavioural and clinical sciences, medical ethics and medical jurisprudence and application of such knowledge in patient care
- Interpersonal and communication skills that ensure effective information exchange with individual patients and their families and teamwork with other health professions, the scientific community and the public. This should include the teaching of patient centred care, relationship centred care, or similar concepts.
- Appraisal and utilization of new scientific knowledge to continuously update and improve clinical practice
- Function as supervisor, trainer and teacher in relation to colleagues, medical students and other health professions
- Capability to be a scholar contributing to development and research in the chosen field of medicine
- Professionalism ability and willingness to acknowledge error
- Interest and ability to act as an advocate for the patient
- Knowledge of public health and health policy issues and awareness and responsiveness to the larger context of the health care system, including e.g. the organization of health care, partnership with health care providers and managers, practice of cost-effective health care, health economics, and resource allocations
- Being community-based: understanding the health status and needs of the community served in order to develop and provide appropriate services
- Ability to understand health care, and identify and carry out system-based improvement of care.

- Ability to collaborate with other members of the health care team, as well as with patients and families

## 2. TRAINING PROCESS

### 2.1 LEARNING APPROACHES

Postgraduate medical training **must** follow a systematic training program, which describes generic and family medicine-specific components of training. The training **must** be practice - based involving the personal participation of the trainee in the services and responsibilities of patient care activities in the training sites. These sites must encompass the variety seen in family practice, based in the community, with the family physicians taking the primary role in supervision and teaching. The training program **must** encompass integrated practical and theoretical instruction.

Postgraduate medical training **must** interface with basic medical education (undergraduate medical education) and continuing medical education/professional development. The training **must** be directed and the trainee guided through supervision and regular appraisal and feedback. The training process **must** ensure an increasing degree of independent responsibility as skills, knowledge and experience grow. Every trainee **must** have access to educational counseling.

#### ***Annotations:***

- *Educational counseling* would include access to designated tutors or mentors.

### 2.2 SCIENTIFIC METHODS

The trainee **must** achieve knowledge of the scientific basis and methods of family medicine, and through exposure to a broad range of relevant clinical/practical experience in different settings appropriate to family medicine, become familiar with evidence-based medicine and critical clinical decision-making.

In the training process the trainee **must** have formal teaching about critical appraisal of literature, scientific data and evidence-based medicine, and be exposed to research.

#### ***Annotation:***

- Training in scientific basis and methods may include the use of elective research projects to be conducted by trainees (cf.6.5).



## 2.3 TRAINING CONTENT

The training process **must** include the practical clinical work and relevant theory of the basic biomedical, clinical, behavioural and social sciences; clinical decision-making; communication skills, medical ethics, public health policy, medical jurisprudence and managerial disciplines required to demonstrate professional practice in family medicine.

The training process **must** ensure development of knowledge, skills, attitudes and personal attributes in the roles as medical expert, health advocate, communicator, collaborator and team-worker, scholar, administrator and manager.

For the development of an effective family physician, education in the primary care setting is fundamental, although supplemental experiences in secondary and tertiary settings, particularly where family physicians provide care, may be very useful. The following components **must** be included in the program:

- Provision of service to patients across the continuum of acute/emergency, chronic, rehabilitative, and palliative care.
- Provision of care across the spectrum of patients (all ages from birth to death, all genders, and with the variety of problems seen in family medicine), with experience in an adequate patient base to experience this diversity in adequate volume for learning. This includes assessment, diagnosis, and appropriate management at levels appropriate to the setting, both medical and surgical/procedural.
- The experience of continuity of care – responsibility for a group of patients over time with an appropriate attitude towards the establishment of enduring relationships and ongoing commitment to patients over time, place, and state of health.
- Skills for dealing with undifferentiated patient care problems, such as decision making in the face of uncertainty, and management of the many variables in multisystem disease
- Skill in dealing with the psychosocial and cultural aspects of health care with specific academic programming as well as clinical experiences directed towards learning in this area.
- Communication skills in general, including specific interviewing skills such as dealing with difficult encounters with patients and families and ability to engage the patient in decision making.
- Knowledge and understanding of the doctor patient relationship, including issues of appropriate boundaries and issues of intimacy and power dynamics in that relationship
- The appropriate use of medical records and communication with other health care providers
- Knowledge of bioethics, and understanding of a framework for bioethics, with ability to apply it in the clinical decision making process.
- Familiarity with medical legal issues relevant to their own setting
- An understanding of quality assurance as applied to family practice, with skills to assess the performance of some aspects of care delivered by the practitioner personally.
- Basic understanding of community medicine/public health, including an understanding of the non-biologic determinants of health and the impact of these on patients seen and the community

served.

- An understanding of the concepts of health promotion and disease prevention, with an ability to actively engage in these dimensions of care in the practice setting
- Knowledge of the health care system, including use of community resources in providing care to patients

**Note:**

While it may be necessary to supplement trainee experience with clinical placements outside of family medicine in order to ensure adequate exposure to the full range of experiences required, the learning objectives must be those of family medicine.

## **2.4 TRAINING STRUCTURE, COMPOSITION AND DURATION**

The overall composition, structure and duration of training and professional development **must** be described with clear definition of goals and expected task-based outcomes and explanation of their relationship to basic medical education and health care delivery. Components which are compulsory and optional **must** be clearly stated.

Integration of practice and theory **must** be ensured in the training process.

**Annotations:**

- *Structure of training* refers to the overall sequence of attachment to the training settings and responsibility of the doctor and not the details of the training experiences.
- *Integration of practice and theory* would include didactic learning sessions and supervised patient care experiences.

## **2.5 THE RELATIONSHIP BETWEEN TRAINING AND SERVICE**

The apprenticeship nature of professional development **must** be described and respected and the integration between training and service (on-the-job training) **must** be assured.

The capacity of the health care system **must** be effectively utilized for service based training purposes. The training provided **must** be complementary and not subordinated to service demands.

**Annotations:**

- *Integration between training and service* implies, on one hand, delivery of proper health care service by the trainees and, on the other hand, that learning opportunities are embedded in service functions.
- *Effective utilization* refers to optimizing the use of different clinical settings, patients and clinical

problems for training purposes, and at the same time respecting service functions.

## **2.6 MANAGEMENT OF TRAINING**

The responsibility and authority for organizing, coordinating, managing and assessing the individual training setting and the training process **must** be clearly identified.

Coordinated training within family medicine **must** be ensured to gain exposure to different areas and management of the discipline.

The authority responsible for the training must be provided with resources for planning and implementing methods for training, assessment of trainees and innovations of the training program. There **must** be representation of staff, trainees and other relevant stakeholders in the planning of the training program.

### ***Annotation:***

- *Other relevant stakeholders* would include other participants in the training process, representatives of other health professions and health authorities.

## 3. ASSESSMENT OF TRAINEES

### 3.1 ASSESSMENT METHODS

Postgraduate medical training **must** include a process of assessment, and the competent authorities **must** define and state the methods used for assessment of trainees, including the criteria for passing examinations or other types of assessment. Assessment **must** emphasize formative in-training methods and constructive feedback.

The reliability and validity of assessment methods **must** be documented and evaluated and the use of external examiners **must** be encouraged. A complementary set of assessment methods **must** be applied, using multiple sources of feedback, including direct observation of trainee performance. The different stages of training **must** be recorded. An appeal mechanism concerning assessment results **must** be established and, when necessary, second opinion, change of trainer/supervisor or supplementary training **must** be arranged. Promotion criteria must be clear, and available to trainees and trainers.

#### **Annotations:**

- The *definition of methods used for assessment* may include consideration of the balance between formative and summative assessment, the number of examinations and other tests, the balance between different types of examinations, the use of normative and criterion-referenced judgments, and the use of portfolio and special types of examinations, e.g. objective structured clinical examinations (OSCE). *Evaluation of assessment methods* may include an evaluation of how they promote training and learning.
- *External examiners* or auditors may increasingly represent global perspectives.

### 3.2 RELATION BETWEEN ASSESSMENT AND TRAINING

Assessment principles, methods and practices **must** be clearly compatible with training objectives and **must** promote learning. Assessment **must** document adequacy of training.

The assessment methods and practices **must** encourage integrated learning and **must** assess predefined practice requirements as well as knowledge, skills and attitudes. The methods used **must** encourage a constructive interaction between clinical practice and assessment.

### 3.3 FEEDBACK TO TRAINEES

Constructive feedback on the performance of the trainee **must** be given on an ongoing basis.

Acceptable standards of performance **must** be explicitly specified and conveyed to both trainees and supervisors.

**Annotation:**

- *Feedback* would include assessment results and planned dialogues about clinical performance between trainees and trainers/supervisors with the purpose of ensuring instructions and remedies necessary to enhance competence development.

## 4. TRAINEES

### 4.1 ADMISSION POLICY AND SELECTION

The competent authorities and professional organizations **must** agree upon a policy on the criteria and process for selection of trainees and **must** publish and implement it.

The selection policy **must** define cognitive and non-cognitive criteria, which considers specific capabilities of potential trainees in order to enhance the result of the training process in family medicine. The selection procedure **must** be transparent and admission open to all qualified graduates from basic medical education. The selection procedure **must** include a mechanism for monitoring and appeal.

**Annotations:**

- The statement on *process of selection of trainees* would include both rationale and methods of selection and may include description of a mechanism for appeal.
- *Monitoring of admission policies* would include improvement of selection criteria, to reflect the capability of trainees to be competent and to cover the variations in required competencies related to diversity of family medicine.
- *Criteria for selection* may include consideration of balanced intake according to gender, ethnicity and other social requirements, including the potential need of a special admission policy for underprivileged groups of doctors.

## 4.2 NUMBER OF TRAINEES

The number of trainees **must** be proportionate to the clinical/practical training opportunities, supervisory capacity and other resources available in order to ensure training and teaching of adequate quality.

The number of trainees **must** be reviewed through consultation with relevant stakeholders. Recognizing the inherent unpredictability of physician manpower needs in the various fields of medicine, the number of training positions **must** currently be changed with careful attention to existing needs of the community and society and the market forces.

### ***Annotations:***

- *Stakeholders* would include those responsible for planning and development of human resources in the local and national health sector.
- Forecasting of the *needs of the community and society* for trained physicians includes estimation of various market and demographic forces as well as the scientific development, migration patterns of physicians, etc.

## 4.3 SUPPORT AND COUNSELLING OF TRAINEES

The competent authorities **must**, in collaboration with the profession, ensure that a system for support, counseling and career guidance of trainees is available.

Counseling **must** be provided based on monitoring the progress in training and incidents reported and **must** address social and personal needs of trainees.

### ***Annotation:***

- *Social and personal needs* would include professional support, health problems, housing problems and financial matters.

#### 4.4 WORKING CONDITIONS

Postgraduate training **must** be carried out in appropriately remunerated posts/stipendiary positions in family medicine and **must** involve participation in all medical activities - including on-call duties - relevant for family medicine training, thereby devoting professional activities to practical training and theoretical learning throughout standard working time. The service conditions and responsibilities of trainees **must** be defined and made known to all parties.

The service components of trainee positions **must** not be excessive and the structuring of duty hours and on-call schedules **must** consider the needs of the patients, continuity of care and the educational needs of the trainee. Policies designed to protect trainee safety must be in place, as must policy and procedures to deal with intimidation and harassment. Part-time training **should** be allowed under special circumstances, determined by the competent authorities and structured according to an individually tailored program and the service background. The total duration and quality of part-time training **must not** be less than those of full-time trainees. Interruption of training for reasons such as pregnancy (including maternity/paternity leave), sickness, military service or secondment **must be** replaced by additional training.

##### **Annotations:**

- *Contractual service positions* would include internship, residency, registrar, senior registrar, etc.
- *he service components of trainee positions* must be subject to definitions and protections embodied in the contract.

#### 4.5 TRAINEE REPRESENTATION

There **must** be a policy on trainee representation and appropriate participation in the design and evaluation of the training program, the working conditions and in other matters relevant to the trainees.

Organizations of trainees **should** be encouraged to be involved in decisions about training processes, conditions and regulations.

##### **Annotation:**

- *Trainee representation* would include participation in groups or committees responsible for program planning at the local or national level.

## 5. STAFFING

### 5.1 APPOINTMENT POLICY

The policy on appointment of trainers, supervisors and teachers **must** specify the expertise required and their responsibilities and duties. The policy **must** specify the duties of the training staff and specifically the balance between educational and service functions and other duties. Family physicians **must** have the primary role in educating trainees in the program.

All physicians **should** as part of their professional obligations recognize their responsibility to participate in the practice-based postgraduate training of medical doctors. Participation in postgraduate training **must** be awarded. The staff policy must ensure that trainers generally are current in the relevant field to its full extent and sub-specialized trainers only approved for relevant specific periods during the training.

#### ***Annotations:***

- *Expertise* would include recognition as a specialist in the relevant field of medicine
- *Training staff* would include medical doctors and other health personnel
- *Other duties* would include administrative functions as well as other educational or research responsibilities.

### 5.2 OBLIGATIONS AND DEVELOPMENT OF TRAINERS

Instructional activities **must** be included as responsibilities in the work-schedules of trainers and their relationship to work-schedules of trainees **must** be described.

Staff policy **must** include support of trainers including training and further development, if appropriate, and **must** appraise and recognize meritorious academic activities, including functions as trainers, supervisors and teachers. The ratio between the number of recognized trainers and the number of trainees **must** ensure close personal interaction and monitoring of the trainee.

#### ***Annotation:***

- *Recognition of meritorious academic activities* would be by rewards, promotion and/or remuneration.



## 6. TRAINING SETTINGS AND EDUCATIONAL RESOURCES

### 6.1 CLINICAL SETTINGS AND PATIENTS

The training locations **must** be selected and recognized by the competent authorities and **must** have sufficient clinical/practical facilities to support the delivery of training. Training locations **must** have a sufficient number of patients and an appropriate case-mix to meet training objectives. The training **must** expose the trainee to a broad range of experience in family medicine and include both office (surgery/outpatient) and inpatient care and on-duty (on-call) activity.

The number of patients and the case-mix **must** allow for clinical experience in all aspects of family medicine, including training in promotion of health and prevention of disease. In addition to office based settings, the training **must** include relevant hospitals/institutions and community based settings/facilities such as assisted living facilities. The opportunity to provide intrapartum maternity care **must** form a part of training. The quality of training settings **must** be regularly monitored, including ensuring that trainees are each following a group of family practice patients over time and place, and are seeing diverse problems representative of the spectrum of problems in the discipline.

#### **Annotations:**

- *Community-based settings* would include home visits, specialty clinics, nursing homes, primary health care stations.
- *The quality of training settings* can be evaluated e.g. through site visits.

### 6.2 PHYSICAL FACILITIES AND EQUIPMENT

The trainee **must** have space and opportunities for practical and theoretical study and have access to adequate professional literature as well as equipment for training in practical techniques such as procedural skills. There **must** be access to tools of information management in the areas where patient care is provided.

The physical facilities and equipment for training **must** be evaluated regularly for their appropriateness and quality regarding postgraduate training.

### **Annotation**

- *Physical facilities* of the training location would include e.g. lecture halls, tutorial rooms, libraries, and information technology equipment.
- Tools of information management include paper resources such as clinical practice guidelines, recent summaries of research evidence etc, not exclusively electronic tools

## **6.3 CLINICAL TEAMS**

The clinical training **must** include experience in working as a team with colleagues and other health professionals.

The training process **must** allow learning in a multi-disciplinary team resulting in the ability to work effectively with colleagues and other health professions as a member or leader of the health care team.

## **6.4 INFORMATION TECHNOLOGY**

There **must** be a policy which addresses the effective use of information and communication technology in the training program with the aim of ensuring relevant patient management.

Trainers and trainees **must** be competent to use information and communication technology for self-learning and in accessing data information and working in health care systems.

### **Annotations:**

- A policy regarding the use of computers, internal and external networks and other means of *information and communication technology* would include coordination with the library services of a health institution.
- The use of *information and communication technology* may be part of education for evidence-based medicine and in preparing the trainees for continuing medical education and professional development.

## 6.5 RESEARCH

There **must** be a policy that fosters the integration of practice and research in training settings. Description of the training setting **must** include research facilities and research activities and priorities.

Opportunities for combining clinical training and research **should** be made available. Trainees **should** be encouraged to engage in health quality development and research.

## 6.6 EDUCATIONAL EXPERTISE

There **must** be a policy on the use of educational expertise relevant to the planning, implementation and evaluation of training.

Access to educational experts **must** be available and evidence demonstrated of the use of such expertise for staff development and for research in the discipline of postgraduate medical education.

### ***Annotations:***

- *Educational expertise* would deal with problems, processes and practice of postgraduate medical training and assessment, and would include medical doctors with experience in medical education, educational psychologists and sociologists, etc. It can be provided by an education unit at the institution or be acquired from another national or international institution.
- *Medical education research* investigates the effectiveness of training and learning methods, and the wider institutional context.

## 6.7 TRAINING IN OTHER SETTINGS AND ABROAD

There **must** be a policy on accessibility of individualized training opportunities at other sites within or outside the country fulfilling the requirements for the completion of training and for the transfer of training credits.

Regional and international exchange of academic staff and trainees **should** be facilitated by the provision of appropriate resources. The competent authorities **should** establish relations with corresponding national or international bodies with the purpose of facilitating exchange and mutual recognition of training elements.

### ***Annotation:***

- Transfer of *training credits* can be facilitated through active program coordination between training institutions.

## 7. EVALUATION OF TRAINING PROCESS

### 7.1 MECHANISM FOR PROGRAM EVALUATION

The relevant authorities and the profession **must** establish a mechanism for evaluation of the training program that monitors the training process, facilities and progress of the trainee, and ensures that concerns are identified and addressed.

Program evaluation **must** address the context of the training process, the structure and specific components of the program and the general outcomes.

#### **Annotations:**

- *Mechanisms for program evaluation* would imply the use of valid and reliable methods and require that basic data about the training program are available. Involvement of experts in medical education and assessment would further broaden the base of evidence for quality of postgraduate training.
- *Identified concerns* would include problems presented to program committees, trainers and tutors, etc.
- *The context of the educational process* would include the organization and resources as well as the learning environment
- *Specific components for program evaluation* would include training program description and performance of trainees
- *General outcomes* would be measured e.g. by career choice and performance.

### 7.2 FEEDBACK FROM TRAINERS AND TRAINEES

Feedback about program quality from both trainers and trainees **must** be systematically sought, analyzed and acted upon.

Trainers and trainees **must** be actively involved in planning program evaluation and in using its results for program development.

#### **Annotation:**

- *Feedback about program* would include trainee reports about conditions in their courses.

### 7.3 USING TRAINEE PERFORMANCE

The performance of trainees **must** be evaluated in relationship to the training program and the mission of postgraduate medical education.

The performance of trainees **should** be analyzed in relation to background and entrance qualifications, and **should** be used to provide feedback to the committees responsible for selection of trainees and for program planning and counseling.

***Annotation:***

- Measures of *trainee performance* would include information about average duration of training, scores, pass and failure rates at examinations, success and dropout rates, requirements for remediation, as well as time spent by the trainees on areas of special interest.

### 7.4 AUTHORISATION AND MONITORING OF TRAINING SETTINGS

All training programs **must** be authorized by a competent authority based on well-defined criteria and program evaluation and with the authority able to grant or, if appropriate, withdraw recognition of training settings or theoretical courses.

The competent authorities **must** establish a system to monitor training settings and other educational facilities via site visits or other relevant means.

***Annotation:***

- *Criteria* for authorization of training settings would include minimal values for number and mix of patients, equipment, library and IT facilities, training staff and training program.

## 7.5 INVOLVEMENT OF STAKEHOLDERS

The processes and outcome of evaluation **must** involve the managers and administration of training settings, the trainers and trainees and be transparent to all stakeholders.

The processes and outcome of evaluation **must** be credible to the principal stakeholders

### **Annotations:**

- *Stakeholders* would include the medical professional organizations, other health professions, health authorities and authorities involved in training of doctors and allied health personal, hospital owners and providers of primary care, patients and patient organizations.
- *Principal stakeholders* include trainers, trainees and health authorities.

## 8. GOVERNANCE AND ADMINISTRATION

### 8.1 GOVERNANCE

Training **must** be conducted in accordance with regulations concerning structure, content, process and outcome issued by competent authorities. Completion of training **must** be documented by degrees, diplomas, certificates or other evidence of formal qualifications conferred as the basis for formal recognition as a competent medical doctor in family medicine by the designated authorities. The competent authority **must** continually assess training programs, training institutions and trainers. The competent authority **must** be responsible for setting up a program for quality training. This authority **must** be family medicine directed.

Procedures **must** be developed that can verify the documented completion of training for use by both national and international authorities.

### **Annotation:**

- *Recognition as a competent medical doctor* would, depending on the level of training, include doctors with the right to independent practice in family medicine. There may be **additional** training in the subspecialties of family medicine (e.g. emergency medicine, palliative medicine); however the basis of training must be in family medicine.

## 8.2 PROFESSIONAL LEADERSHIP

The responsibilities of the professional leadership for the postgraduate medical training program **must** be clearly stated.

The professional leadership **must** be evaluated at defined intervals with respect to achievement of the mission and outcomes of postgraduate medical training.

## 8.3 FUNDING AND RESOURCE ALLOCATION

There **must** be a clear line of responsibility and authority for budgeting of training resources.

The budget **must** be managed in a way that supports the mission and outcome objectives of the training programs and of the service.

### ***Annotation:***

- *Budgeting of training resources* would depend on the budgetary practice in each institution and country.

## 8.4 ADMINISTRATION

The administrative staff of the postgraduate medical training programs and training institutions **must** be appropriate to support the implementation of the program and to ensure good management and deployment of its resources.

The management **must** include a program of quality assurance and the management **should** submit itself to regular review to achieve quality improvement.

## 8.5 REQUIREMENTS AND REGULATIONS

A national body **must** be responsible for defining the number and types of recognized specialties within family medicine, and other medical expert functions for which approved training programs are developed.

Definition of approved postgraduate medical training programs **must** be made in collaboration with all relevant stakeholders.

**Annotations:**

- *A national body* established according to national laws and regulations would act in the interests of society as a whole.
- *Relevant stakeholders* would include national and local health authorities, universities, medical professional organizations, the public, etc.

## 9. CONTINUOUS RENEWAL

In realizing the dynamics of postgraduate medical training the relevant authorities **must** initiate procedures for regular review and updating of the structure, function and quality of the training programs and **must** rectify identified deficiencies.

The process of renewal **must** be based on prospective studies and analyses and **should** lead to the revisions of the policies and practices of the postgraduate medical training programs in accordance with past experience, present activities and future perspectives. In so doing, it **should** address the following issues:

- *Adaptation of the mission and outcome objectives of postgraduate training to the scientific, socio-economic and cultural development of the society.*
- *Modification of the competencies required on completion of postgraduate training in family medicine in accordance with the needs of the environment the newly trained doctor will enter.*
- *Adaptation of the learning approaches and training methods to ensure that these are appropriate and relevant.*
- *Adjustment of the structure, content and duration of training programs in keeping with the developments in the basic biomedical sciences, the clinical sciences, the behavioural and social sciences, and changes in the demographic profile and health/disease pattern of the population, and in socio-economic and cultural conditions.*
- *Development of assessment principles and methods according to changes in training objectives and methods.*
- *Adaptation of recruitment policy and methods of selection of trainees to changing expectations and circumstances, human resource needs, changes in basic medical education and the requirements of the training program.*
- *Adaptation of recruitment and policy of appointment of trainers, supervisors and teachers according to changing needs in postgraduate training.*
- *Updating of training settings and other educational resources to changing needs in postgraduate training, i.e. the number of trainees, number and profile of trainers, the training program and contemporary training principles.*
- *Refinement of the process of program monitoring and evaluation.*



- *Development of the organizational structure and management principles in order to cope with changing circumstances and needs in postgraduate training and, over time, accommodating to the interests of the different groups of stakeholders.*

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It should be emphasized that the development of the Trilogy of documents also benefited from other important contributions. These consisted of a great number of verbal and written commentaries as well as discussions at national and international meetings and conferences.

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