COMMENTARY

The Evolution of Residency Training in Family Medicine:

A Canadian Perspective

Nancy Fowler MD, CCFP; Francine Lemire, MD, CM, CCFP, CAE, ICD.D; Ivy Oandasan, MD, CCFP, MHSc; Roy Wyman, MD, CCFP

(Fam Med. 2021;53(X):pp-pp.)
doi:
Published Online First May XX, 2021

Both Canada and the United States are in the process of reviewing residency training in family medicine. This commentary examines the College of Family Physicians of Canada's experience with competency-based medical education and length of training decisions as both countries grapple with how best to ensure that training keeps pace with societal needs.

In Canada, we are nearing completion of the College of Family Physicians of Canada's (CFPC) Outcomes of Training Project, a national reflection on residency training that is leading us to pursue a longer training period.[1,2] This will be no small feat to accomplish. Most interesting perhaps is how we got here—our experience with competency-based medical education (CBME) and what we might learn from each other as the United States embarks on a similar process of residency review.

At 2 years in length, Canada has the shortest family medicine residency training in the developed world. We share a commitment with the United States to prepare graduates for a full scope of practice that includes hospital, emergency, and maternal-child (including intrapartum) care. Our family physicians serve a highly diverse population and vast geography where almost 20% of the population lives in a rural or remote environment, including indigenous peoples deeply impacted by colonization and systemic racism.[3,4] This is the broadest training mandate in the developed world, matched only by Australia's rural stream.

What Is Our Story?

In 2010 the CFPC introduced CBME via a reform called the "Triple-C Competency based Curriculum" (Triple C). This reform focused on **C**omprehensiveness, **C**ontinuity, and authentic family medicine learning environments (**C**entered in family medicine), together with transformed workplace-based competency assessment.[5,6] Competence in family medicine was defined by the Canadian Medical Education Directives for Specialists (CanMEDs)-Family Medicine competency framework adapted for family medicine and organized around seven physician roles: expert, communicator, collaborator, leader, professional, advocate, scholar.[7] Assessment benchmarks referred to as the Evaluation Objectives (now Assessment Objectives) were created to guide certification decisions.[8]

Social accountability was the main motivation for introducing Triple C. Originally defined by the World Health Organization in 1995 as "the obligation to direct education, research, and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve," social accountability is a value firmly entrenched in Canadian medical schools and

From the College of Family Physicians of Canada (Drs Fowler, Lemire, Oandasen, and Wyman); Department of Family Medicine, McMaster University (Dr Fowler); and Dept of Family & Community Medicine, University of Toronto (Drs Lemire, Oandasan, and Wyman).

codified in both undergraduate and postgraduate accreditation standards.[9,10]

The CFPC's assertion was that an enhanced commitment to competence would attract and ensure graduates who are fully able (and therefore willing) to take up the task of comprehensive care in our many and diverse environments. A logic model was established with a defined theory of change and anticipated set of outcomes.[5] This was supported by programmatic evaluation, and a national Family Medicine Longitudinal Resident Survey (FMLS) was established to follow learners' educational experiences, career intentions and actual choices at three intervals through training and into practice. This data allows a critical examination of Triple C implementation and its impact.

Where Are We 10 Years Later?

There have been many successes, and residency programs are collectively much stronger as a result. Improved workplace-based assessments focusing on direct observation with feedback and guided reflection has resulted in timelier, more learner-centered educational remediation.[11,12] Triple C transformed residency programs – empowering them to take charge of curricula and elevating the role of family practice teachers. This cultivated a sense of ownership, professional identity, purpose, and enthusiasm within the family medicine teaching community and spawned a generation of educational leaders.[13]

Despite these important accomplishments, CBME does not appear to have moved the needle on our social accountability goals. Rural, indigenous, and inner-city populations are still underserved, with a maldistribution of family physicians and the scopes of practice and practice intentions of our graduates continuing to narrow.[14] Program directors tell us that the "curriculum is full" and so capacity is limited to respond educationally to the many challenges and changes we face as a society.

Lessons Learned?

Based upon Triple C program evaluation, we learned that residency programs did not have a clear understanding of how comprehensive care was being defined and specifically what graduates were expected to be able to do across the broad scope of family medicine by the end of residency. This led to some inconsistencies across programs.[13] As our experience with CBME deepens, we observe that competence, while necessary, may be insufficient on its own to ensure preparedness and uptake of comprehensive practice. What else is required? Family physician colleagues have talked to us about the role that confidence and self-concept play in professional identity formation and career decision-making. We want to better define adaptability for family medicine and to deepen our understanding of the educational conditions that support adaptability and adaptive expertise in our learners.[15] Our rural colleagues have introduced us to the term "clinical courage" pushing us as generalists to think more about what is required to function beyond the comfortable limits of our certainty or competence.[16]

A Theory of Planned Behavior analysis of family medicine residents' career intentions suggests that perceived social norms of practice have a significant influence and so we recognize that the community of practice that surrounds each resident is as important as what we teach in the formal curriculum.[17] There are social and market forces far more powerful than the training experience itself in shaping residents career choices and this forces us to discern how and where we can have an impact. Where do we go from here?

Through the Outcomes of Training Project, we have yet-unpublished data showing that many graduates do not feel prepared for clinical activities outside the office-based primary care setting and this is reactivating our long-standing debate about the length of training. In a CBME paradigm time is considered a resource rather than a metric for learning, a weak proxy for experience.[18] How much resource we require will depend on our goals and this has forced us to reexamine our role(s) as family physicians, and to articulate our intended training outcomes with a clearer link between education and practice. This is the logic behind the CFPC's development of the *Family Medicine Professional Profile* (FMPP) released in 2018.[19] The FMPP is a job description of sorts, defining our collective commitment to a comprehensive scope of practice as well as our care philosophy and interdependent work arrangements such as the Patient Medical Home.[20] The FMPP has been elaborated for training purposes into a Residency Training Profile (RTP) detailing the expectations/scope of training through a set of Core Professional Activities (CPAs) that are brought to life in a series of Practice Narratives assembled from field research done with family physicians.

Both countries face dynamic health care trends with practice and training implications: new technologies and therapeutics, an aging population, complex care needs including an opioid crisis, dehospitalization and shorter stays intensifying community care demands, interprofessional care models, and now, of course a pandemic. These increased demands on education come at a time when, for all good reasons, resident duty hours are reduced. Just prior to the pandemic, the issue of physician burnout was on everybody's lips with various root cause analyses and a sense that narrowing our scope has deskilled us, shrinking our horizons and leading to demoralization and/or a feeling of dislocation.[21]

The CFPC is engaged in an ongoing and iterative attempt to "get to better," defining and using outcomes evaluation as an important tool in the process. Detailing the expected scope of training has made it much easier to identify that we are seriously underresourced. And so, our next educational chapter focuses on the length and scope of training in the larger pursuit of social accountability. Although some decision makers prefer to think of community needs as primary, secondary, or tertiary care, we prefer to position our contribution in terms of proximity care—we commit to a person and to meeting their needs wherever they are, using all means available to us, including collaboration and innovative technologies.[22] Ongoing medical education renewal is a necessary but insufficient ingredient to an improved delivery of community-based care. It must be accompanied by policies and remuneration models that support comprehensiveness and a broad scope of practice, rather than incentivized episodic care. This represents a big task, for which the time has come. The status quo is no longer an option for us.

FINANCIAL SUPPORT: The Outcomes of Training Project cited in this article is fully funded by the College of Family Physicians of Canada.

CONFLICT OF INTEREST STATEMENT: All four authors are paid employees of the College of Family Physicians of Canada. The authors have no other potential professional or personal conflicts of interest to declare.

CORRESPONDING AUTHOR: Address correspondence to Dr Nancy Fowler, College of Family Physicians of Canada, 2630 Skymark Avenue, Mississauga, ON, Canada L4W 5A4. 905-629-0900. nfowler@cfpc.ca.

References

1. Lemire F, Fowler N. Linking education and practice: The Outcomes of Training project. Can Fam Physician. 2018;64(11):866.
2. Sawchuk P. Outcomes of Training: preparing for the future. Can Fam Physician. 2019;65(4):301.
3. Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. The Rural Road Map for Action – Directions. Mississauga, ON: Advancing Rural Family Medicine: The Canadian Collaborative Taskforce; 2017. https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Directories/Committees_List/Rural%20Road%20Map%20Directions%20ENG.pdf. Accessed February 26, 2021.
4. Indigenous Health Working Group of the College of Family Physicians of Canada and Indigenous Physicians Association of Canada. Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada. Mississauga, ON: College of Family Physicians of Canada; 2016. https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf. Accessed February 26, 2021
5. Tannenbaum D, Kerr J, Konkin J, et al. Triple C Competency-based Curriculum. Report of the Working Group on Postgraduate Curriculum Review - Part 1. Mississauga, ON: College of Family Physicians of Canada; 2011, https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Education/_PDFs/WGCR_TripleC_Report_English_Final_18Mar11.pdf. Accessed February 20, 2021.
6. Oandasan I, Saucier D, eds. Triple C Competency-based Curriculum Report—Part 2: advancing implementation. Mississauga, ON: College of Family Physicians of Canada; 2013. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Education/_PDFs/TripleC_Report_pt2.pdf. Accessed February 20, 2021.
7. Shaw E, Oandasan I, Fowler N, eds. CanMEDS-FM 2017: A competency framework for family physicians across the continuum. Mississauga, ON: The College of Family Physicians of Canada; 2017. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Resources/Resource_Items/Health_Professionals/CanMEDS-Family-Medicine-2017-ENG.pdf. Accessed February 20, 2021.
8. Crichton T, Schultz K, Lawrence K, et al. Assessment Objectives for Certification in Family Medicine. Mississauga, ON: College of FamilyPhysicians of Canada; 2020, https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Education/Certification_in_Family_Medicine_Examination/Assessment-Objectives-for-Certification-in-FM-full-document.pdf. Accessed February 20, 2021.
9. Boelen C, Heck JE. Defining and Measuring the Social Accountability of Medical Schools. Geneva, Switzerland: World Health Organization; 2015, http://apps.who.int/iris/bitstream/10665/59441/1/WHO_HRH_95.7.pdf. Accessed February 20, 2021.
10. Rourke J. Social Accountability: A framework for medical schools to improve the health of the populations they serve. Acad Med. 2018;93(8):1120-1124. doi:10.1097/ACM.0000000000002239
11. Ross S, Binczyk NM, Hamza DM, et al. Association of a competency-based assessment system with identification of and support for medical residents in difficulty. JAMA Netw Open. 2018;1(7):e184581. doi:10.1001/jamanetworkopen.2018.4581
12. Lawrence K, Van der Goes T, Crichton T, et al. Continuous Reflective Assessment for Training (CRAFT): A national programmatic assessment model for family medicine. Mississauga, ON: College of Family Physicians of Canada; 2018, https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/About_Us/CRAFT_ENG_Final_Aug27.pdf. Accessed February 20, 2021.

13. Ellaway RH, Palacios Mackay M, Lee S, et al. The impact of a national competency-based medical education initiative in family medicine. Acad Med. 2018;93(12):1850-1857. doi:10.1097/ACM.0000000000002387

14. Weidner AKH, Chen FM. Changes in preparation and practice patterns among new family physicians. Ann Fam Med. 2019;17(1):46-48. doi:10.1370/afm.2337

15. Mylopoulos M, Kulasegaram K, Woods NN. Developing the experts we need: fostering adaptive expertise through education. J Eval Clin Pract. 2018;24(3):674-677. doi:10.1111/jep.12905. Accessed February 23, 2021.

16. College of Family Physicians of Canada. Priority Topics for the Assessment of Competence in Rural and Remote Family Medicine. Mississauga, ON: College of Family Physicians of Canada; 2018. https://portal.cfpc.ca/ResourcesDocs/uploadedfiles/Education/Rural-PT_KF_EN.pdf. Accessed March 24, 2021.

17. Grierson LE, Fowler N, Kwan MY. Family medicine residents' practice intentions: theory of planned behaviour evaluation. Can Fam Physician. 2015;61(11):e524-e531.

18. Holmboe ES, Sherbino J, Englander R, Snell L, Frank JR; ICBME Collaborators. A call to action: The controversy of and rationale for competency-based medical education. Med Teach. 2017 Jun;39(6):574-581. doi:10.1080/0142159X.2017.1315067.

19. College of Family Physicians of Canada. Family Medicine Professional Profile. Mississauga, ON: College of Family Physicians of Canada; 2018. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/About_Us/FM-Professional-Profile.pdf. Acessed March 24, 2021.

20. Weidner AKH, Phillips RL Jr, Fang B, Peterson LE. Burnout and scope of practice in new family physicians. Ann Fam Med. 2018;16(3):200-205. doi:10.1370/afm.2221

21. College of Family Physicians of Canada. A new vision for Canada: Family Practice—The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019. https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf. Accessed March 24, 2021.

22. Beaulieu MD. The perils and the promise of proximity: Dr Ian McWhinney Lecture, 2016. Can Fam Physician. 2016;62(12):964-968.