

The Evolution of Residency Training in Family Medicine: A Canadian Perspective

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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 **a**uthentic 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

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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.

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