Accreditation of Residency Programs

General Standards of Accreditation

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Accreditation Committee Position Paper

Service and Education in Residency Education

The relationship of service and education in postgraduate residency education is a frequent topic of discussion in accreditation of residency programs and often a concern to residents, program directors, program committees, and clinical faculty.[1] The goal of this paper is to address service and education from the point of view of accreditation, but not to give strict "prescriptions" or "recipes" for individual programs.

1. **Dual nature of residents**

   Residents are at the same time learners, or postgraduate trainees registered with universities, and service providers, through their status as employees (ultimately the ministries of health) for which they are paid salaries. Each of these roles is essential to the other. The resident must learn and be taught to achieve the high standards expected in Canadian health care, and must put the knowledge into action, to learn by doing to gain and perfect the essential skills of a specialist. Thus, in postgraduate medical education service and education cannot exist separately but must both be present. Difficulties may arise in the balance between the two.

2. **Primacy of Educational Goals**

   It must always be remembered that the reason the resident is present is to learn.[2] It is expected that all of the activities of residency will relate to a well-developed educational plan. Some goals will best be achieved through clinical activity, others may be better taught through lectures, seminars, skills laboratories, or directed study.

   2.1. Formal learning and didactic sessions should be conducted during protected time away from clinical duties. The use of an academic half-day or equivalent is encouraged. Formal learning activities should not be so extensive as to interfere with the development of clinical skills.

   2.2. Clinical activities should be planned for their educational value and to develop increasing professional responsibility in the resident. Volumes should be adequate to allow each resident to build expertise. There should be a variety of patients or laboratory material to allow residents to develop skill across the full spectrum of the specialty. Optimal use should be made of the clinical setting as a venue for teaching and learning, rather than as just a place where the work must be done.

3. **Inappropriate Service**

   There are two types of inappropriate service work:

3.1. Inappropriate type of work — work that is not appropriate for any physician, but should be done by another employee. Examples are acting as a porter to take patients to tests, arranging taxis and couriers, or cleaning laboratory benches.

3.2. Inappropriate volume of work — There are times when a resident may need to do a task because someone must, it fits in the work of a physician, and it is consistent with the status of employee of the hospital. However, the volume of such work must not be so great as to prevent residents from obtaining other needed experiences, keep them from attending the academic program, or lead to sleep deprivation, exhaustion or loss of well being.

4. **Repetition**

By its nature, the practice of medicine is repetitive. Repetition is essential for the learning of some skills. This is especially true of some technical skills in surgery and other specialties.

Residents should not expect to stop using a skill (doing a procedure, seeing a type of patient) once they have learned it. Each skill should be maintained as new ones are added. Residency should prepare the resident for practice, including in dealing with repetition.

Nevertheless, it is expected that the assignment of duties will be consistent with the educational plan of the program and contribute to the increasing professional skill of the resident. While a reflective physician may be able to learn from any case, something highly repetitive may not be the opportunity of greatest educational value.

5. **Cross Coverage**

Cross coverage, an arrangement to cover the patients on one service by a resident on-call on another service, is not automatically inappropriate. It can be a true teaching and learning opportunity, can extend experience, and provide the opportunity to maintain previous knowledge and skills. This requires acknowledgment of the role and educational needs of the resident on call. There should be careful review of cases with teaching and feedback by the faculty.

Use of cross coverage should be determined by the residency program committee for specific services and experiences, considering teaching and feedback to be mandatory. Residents should not be required to cross cover a clinical service (e.g. ICU) for which they have not received appropriate training, usually through a previous rotation.

6. **Duty of Care; Professional Responsibility**

Residents must recognize that among the skills to be achieved in residency is a sense of professionalism. Inherent in this is the recognition of the concept of Duty of Care. There will be occasions when the care of a patient will take

priority over all other activities, including personal interest and academic events.

Programs should be organized to both emphasize the importance of this concept and minimize disruption of residents' learning by providing alternative coverage for patient care at times of academic events.

1. Mikhael J, et al. *Service to Education Balance*, Council of Ontario Faculties of Medicine, October 2002
2. *General Standards of Accreditation* (February 2002)
   Standard B.3.4: Service responsibilities, including rotation assignments and on-call duties, must be assigned in a manner which ensures that residents are able to attain their educational objectives, recognizing that some objectives can be met only by the direct provision of patient care. Service demands must not interfere with the ability of the residents to follow the academic program.

Approved: May 2003

Accreditation Committee Position Paper (2000)

Ambulatory Care in Specialty Residency Education

Ambulatory care may be defined as the provision of care to individuals who are not hospital in-patients. Changing societal expectations and altered use patterns for in-patient facilities coupled with evolving technology have resulted in the recognition that educational and related research experience can no longer be confined to an acute care hospital setting. Residency programs should evolve to reflect changing patterns of health care delivery and integration of services offered in hospital and community settings.

GOALS

Residency programs should have the following goals related to ambulatory care experience:

1. To encourage concepts of continuity-of-care based on familiarity with the normal evolution of disease entities outside the hospital.
2. To determine the natural history of both treated and non-treated diseases, particularly for those patients who never enter the hospital.
3. To develop the ability to accurately assess the effects of medical and surgical intervention as it relates to outcome, in the patients' community.
4. To foster, whenever appropriate, awareness of the strengths and limitations of clinic or office-based vs. hospital-based practice.
5. To promote understanding of the role played by families, volunteers, other health professionals, and other support services in patient care.
6. To promote recognition of the broad determinants of health, including an appreciation for the importance of social and physical environment.
7. To provide a basis for understanding of population health, including the appropriate potential for disease prevention and health promotion.
8. To improve awareness of health economic issues in ambulatory care:
    - application of evaluative science to diagnostic and treatment modalities,
    - cost benefit analysis of treatment in the ambulatory vs. hospital setting, and
    - decision making re: optimal venues for care.
9. To acquaint residents with the types of investigational and interventional procedures which can appropriately be carried out in ambulatory care settings.
10. To foster research appropriate to the optimal delivery of care in ambulatory settings and to familiarize those in specialty training with the available methodology (e.g., quality of life assessment, outcome analysis, etc.).
11. To encourage interest in the development of practice standards for ambulatory settings, including an awareness of the practitioner's role in the evolution and validation of standards.

OBJECTIVES

Formal written objectives should be developed on a discipline-specific basis at each training site. They should supplement the existing educational objectives for the programs and should reflect the need in most disciplines for a balance between hospital and ambulatory care experiences.

VENUES

The ambulatory care setting will vary depending on the educational objectives of the specialty. Venues which should be considered include:

- primary care offices
- specialist offices
- block-funded health programs
- industry-based clinics
- remote, rural and international clinics
- Department of Health teaching units
- community programs
- community hospitals
- health service research units
- emergency departments
- outpatient facilities in acute care hospitals including medical and surgical day care services
- a community-based clinical teaching unit developed specifically for this educational purpose.

January 1994
Reviewed - May 2000

Accreditation Committee Position Paper

Community Learning Experiences in Residency Education

A community experience may be defined as a learning opportunity occurring outside the conventional teaching service in a teaching hospital. This experience may occur in an environment associated with the teaching hospital, i.e. a clinical teacher's office or an off-site clinic run by clinical teachers, or may be remote from the parent teaching hospital in a community hospital and/or offices and clinics associated with such an institution. It should be emphasized that "community" does not necessarily equate to "ambulatory" but may include a variety of environments where an educational experience can be obtained that would not otherwise be provided to the resident in a teaching hospital. This would include rural or remote sites with adequate qualified supervision.

Health care reforms have significantly changed the practice of medicine, resulting in a continuing expansion of medical care delivery through community-based programs. The classical teaching hospital may deal with a filtered patient population that may not reflect the ultimate practice pattern of the new graduate. The introduction of community experiences to address these needs will require a significant expenditure of time and energy to ensure smooth incorporation within the current teaching system.

PURPOSES AND ADVANTAGES OF COMMUNITY EXPERIENCES

These may be broadly divided into two categories:

i. those that prepare a resident for a specific type of practice (i.e. urban, rural, or remote), to offer residents an opportunity to experience practice in an area where they may subsequently wish to settle and may also enable them to tailor their subsequent training rotations to meet the needs required in a future area of practice; and
ii. those that provide opportunities for learning which are not available in the conventional teaching or urban environment.

Both categories offer the resident the opportunity to meet the following learning objectives:

1. decision-making with limitations of technological resources that are more readily available in tertiary care environments;
2. practice autonomy with independent decision-making with limitation of other medical resource personnel. Self learning for the trainee would be emphasized, and local physicians and mentors can be role-models;
3. natural history of disease, both treated and untreated, with particular regard to outcome evaluation where such evaluation is practical and helpful;
4. evolution of common disease processes;
5. review, diagnosis and management of patients not normally seen in the tertiary care environment;
6. "whole patient" management as opposed to the management of disease; and

7. exposure to a practice environment where the delivery of care is not in a traditional model (e.g. paramedical practitioners).

Community experiences are equally applicable to more than the primary specialties that are practiced in the community. They are not intended to replace but to enhance training in academic centres. However, every program director should have a list of possible and satisfactory community training sites to offer to the residents in the program.

POTENTIAL CHALLENGES OF COMMUNITY EXPERIENCE

1. Suggested community experience sites for residents may cause some dislocation of family life and have some financial implications for the trainee. These types of community experience and service can be reviewed by the resident and program director working within the guidelines of the specific Specialty Committee. Supportive services, financial and travel assistance are becoming more and more available in Canadian community training sites.
2. Concern by trainees that isolation from their peers may diminish their clinical and educational experience may be offset by expanding audio-visual and electronic equipment.
3. The resident may notice different approaches to satisfactory medical/surgical management in the rural/remote rotation in the community sites due to limited technical resources.
4. Although community rotation experience offers smaller libraries and less opportunity for didactic rounds, electronic Internet and E-mail access are now almost universal in any size hospital and/or doctor's office in Canada.

ACCREDITATION OF COMMUNITY EXPERIENCES

Accreditation of community teaching sites will remain one feature of the regular medical school accreditation. However, as several sites may be involved as well as many part-time preceptors, on-site visits by the accreditation team will have to be exchanged for interviews with the community program director and review of relevant data. Resident assessment following their community experience will form an important part of the community assessment.

Internal reviews of community-based programs may include visits to the site, but due to distance, may merely require a review of the usual residency program committee minutes and interview with the community program director, and show evidence that he/she attends at some time the residency program committee meetings or is a corresponding member.

Schools providing community experience may wish to consider the formation of a subcommittee of the Faculty Postgraduate Medical Education Committee to oversee such community experiences. This subcommittee can serve to validate the process, taking into account the needs of residents as well as those of the community, the community faculty, and supportive facilities and available technical equipment.

Individual standards of accreditation may need to be considered in a different context for teaching activities at community sites compared with a conventional teaching program, as outlined below.

STANDARD B.1

It will be necessary to have a program coordinator or supervisor in institutions and/or sites participating in this program. Such individuals should be members of the residency program committee although attendance at meetings of this committee may not be practical if the off-site location is a long distance away from the parent institution. Consideration may be given to the use of conference calls or audiovisual communication to facilitate residency program committee meetings.

STANDARD B.2

Rotation specific goals and objectives developed by the residency program committee outlining the purpose of the educational experience in the community setting **must** be developed and **must** be supplied to residents and teachers at the community site.

STANDARD B.3

The role of the sites participating in community experiences must be defined, taking into account the fact that there may be no other residency programs present in the institution that are relevant to the specialty providing the community experience.

STANDARD B.4

It will be necessary to provide university appointments for key individuals such as the program coordinator in the community setting.

STANDARD B.5

Rotation of residents to a community site implies acceptance by the attending staff at that site of the educational needs of the residents that must be provided by formal and informal educational activities.

STANDARD B.6

Supervisors participating in the community experience must be trained in resident evaluation, both of knowledge as well as skills and especially attitudes, e.g. CanMEDS roles: medical expert, communicator, collaborator, manager, health advocate, scholar, professional.

Approved: May 2002

Quality Assurance/Improvement

Quality Assurance/Improvement is defined as a systematic assessment of the appropriateness and effectiveness of patient care and the quality control of laboratory and other procedures. It includes both the assessment of quality of care and the mechanisms established to improve the quality when necessary. The efficiency of care includes a consideration of the relationship of benefit to cost.

Each residency program committee should develop clear objectives in quality assurance/improvement, and these should be reflected in a defined curriculum. The following general objectives might be used as a basis to design such a curriculum.

1. **Knowledge:** At the end of their training, residents should be able to master:
    a. knowledge of the components of a comprehensive quality assurance/improvement program including those of their own specialty training program,
    b. knowledge of available outcome measurements for quality assurance/improvement programs as well as how to measure them, and
    c. the ability to design outcome measures, to analyse study variables, to interpret results, and to feed them back into the process for further improvement.
2. **Abilities:** At the end of their training, residents should be able to demonstrate:
    a. a capacity to work with a multi-disciplinary team,
    b. an ability to identify a problem in need of improvement, and
    c. an ability to design standards of care.
3. **Skills:** At the end of their training, residents should be able to:
    a. construct algorithms with interlocking steps connected with outcomes,
    b. implement such algorithms,
    c. be able to oversee the program implementation, and
    d. apply, and eventually design, methods of clinical evaluation.

Methods to achieve these goals are diverse. They may include self-study, small group seminars and other didactic sessions, as well as completion of a project from start to finish. The best setting, irrespective of methods used, consists in identifying mentors who are leaders in quality assurance/improvement and who are able to channel all their energies and efforts.

May 2000

Accreditation Committee Position Paper (2001)

Biomedical Ethics

Each residency program should ensure that there are clear objectives in biomedical ethics. These objectives should be reflected in a defined curriculum integrated into the educational program and evaluated by the evaluation system of the Residency Program Committee.

OBJECTIVES

Objectives should include a working knowledge of biomedical ethics as it relates to the specialty or subspecialty, including basic principles and processes which facilitate the development of appropriate ethical attitudes and behaviour in physicians in a variety of different medical settings. In developing appropriate objectives the Residency Program Committee should consider the following:

1. **Knowledge**
    a. awareness of the major ethical theories, perspectives and principles;
    b. knowledge of ethical issues which are commonly encountered in practice including:
        - informed choice (consent or refusal) in competent and incompetent patients (including decision making for and with pediatric patients and assessment of capacity and substitute decision making)
        - confidentiality
        - allocation of resources
        - end-of-life care (including knowledge of concepts such as quality of life, dying with dignity, and brain death)
        - truth-telling
        - dealing with medical error and mishaps
        - professional conduct, including confidentiality, boundary issues, and competence
        - conflict of interest
        - dealing with differences in value systems, e.g. between individuals or institutional vs. personal values;
    c. knowledge of relevant professional codes of ethics;
    d. knowledge of law as it applies to ethical decision-making in medicine, particularly law on consent and confidentiality;
    e. identification of the ethical dimensions of discipline-specific issues as they arise, e.g., new technologies and therapies;
    f. awareness of the ethical issues arising in the teaching and learning environment;
    g. awareness of the ethical components of medical research including experimental design and valid consent.
2. **Attitudes**
    a. an appreciation of the presence of ethical dimensions in all medical decision-making;
    b. respect for diversity and differences including race, national or ethnic origin, religion, sex, age, or mental or physical status;

c. a heightened awareness of the patient's and the resident's religious and cultural beliefs and values that may influence ethical decision making.

3. **Skills**
    a. the ability to identify and analyse ethical issues when making decisions;
    b. the ability to acknowledge uncertainty and the possibility of error in ethical decision making;
    c. the ability to communicate effectively to promote full discussion of ethical issues, including the encouragement and support of patients and families and other health professionals in making ethical decisions. This will include the ability to understand the appropriate mode of communication;
    d. the ability to recognize and deal with conflict;
    e. the ability to develop mature professional relationships with patients and their families, other health care providers and other physicians.

SETTINGS

Settings suitable for biomedical ethics teaching and learning include:

1. Role model relationships and mentoring: faculty-patient-resident in ambulatory settings, e.g., office and outpatient department.
2. Team or group interactions involving multiple health care professionals e.g., CTU, teaching rounds and seminars, small group management sessions.
3. Formal educational sessions: institutional rounds, grand rounds.
4. Participation on institutional ethics committees, research ethics boards.

EVALUATION

1. **Resident Evaluation**

    The Residency Program Committee should identify those areas of the biomedical ethics curriculum to be evaluated and ensure that appropriate evaluation methods are included in the program in-training evaluation system.

    The program should separately assess:

    a. the knowledge, attitudes, and skills the resident has in discussing and dealing with the ethical components of practice and clinical research, and
    b. the personal ethical behaviour of the resident.

2. **Program Evaluation**

    The biomedical ethics component of the program should be reviewed at least once a year by the Residency Program Committee and must be reviewed at the time of an internal review by the University Postgraduate Medical Education Committee and when a survey by the Royal College takes place.

RESOURCES

1. Singer PA, editor. *Bioethics at the Bedside, A Clinician's Guide*, Ottawa: Canadian Medical Association, 1999. This is available on-line at http://www.cma.ca/cmaj/series/bioethic.htm
2. Bioethics for Clinicians, *Annals Royal College of Physicians and Surgeons of Canada*, Volume 32, Supplement, Fall 1999. Further information is also available under Bioethics Curricula.
3. Baylis F, Downie J, Dewhirst K (eds). *Codes of Ethics: Ethics Codes, Standards and Guidelines for Professionals Working in a Health Care Setting in Canada,* Toronto: Department of Bioethics, The Hospital for Sick Children, 2nd ed, 1999.
4. Hébert Philip C. *Doing Right*, Toronto, Oxford University Press, 1996.
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6. Baylis F, Downie J, Freedman B, Hoffmaster B, Sherwin S. *Health Care Ethics in Canada*, Toronto: Harcourt Brace & Company, Canada, 1995.

Revised: January 2001

Accreditation Committee Position Paper (2001)

Teaching and Assessment of Communication Skills in Residency Programs

Communication skills are of vital importance for physicians as they communicate with other physicians on an individual or group basis, work with other health care workers in developing plans for patient care, advocate for the general public, and as they assume roles as physician administrators. Communication takes place in a number of different manners including both written and verbal means. It is well known that most of the complaints brought against physicians to licensing bodies are related to communication skills (1). There is also well-documented evidence that patient outcome can be influenced by the ability of a physician to communicate with patients (2).

CanMEDS 2000 (3) describes the competencies of the communicator as follows. The specialist (resident) must be able to:

- establish a therapeutic relationship with patients/families,
- obtain and synthesize relevant history from patients/families/communities,
- listen effectively, and
- discuss appropriate information with patients/families and the health care team

Good communication is required to impart information, to educate, to solicit opinion, to convey a treatment plan as well as to be a health care advocate and a life long learner.

It is assumed that postgraduate trainees will start their residency with a set of communication skills learned during undergraduate education directed toward obtaining a medical history. These communication skills will need refinement as the trainee gains experience. Communication skills can be taught through a variety of processes including didactic sessions, role-playing, reflection, and evaluation with specific objectives for improvement (4). Communication skills can also be evaluated (5). Assessment may be performed informally by discussion with peers, other health care professionals, students and by the review of written records by the trainee. Formal assessment is also possible through observation (direct or videotaped), use of standardized patients, role playing and other structured programs. Assessment and feedback should be done on a standard marking scale to allow the identification of areas which require improvement or modification. Additionally, such a scale may provide a framework for the reflective physician to modify and refine skills throughout a practice career.

Residents will find themselves in new situations as they enter postgraduate training and the relationship between physician and patients become part of a daily routine. The relationship with colleagues and teachers also changes as new responsibilities are encountered. Areas that may require special emphasis are the delivery of bad

news, obtaining informed consent, helping families make life and death decisions, and being an empathetic listener without compromising truth or principles.

Techniques for interviewing patients with difficult behaviours (e.g. sadness, seductiveness, vagueness, etc.) must be developed and assessed. Areas that residents may need to develop include the ability to communicate with patients where there is a language or physical communication barrier, in a situation where they disagree with a patient, and situations where they are challenged by patients. Residents must be able to understand the principles and practices of obtaining informed consent.

All residency programs should ensure that the principles of appropriate communication skills are taught in a variety of venues and that there is a formal method of assessing communication skills. This should take place in addition to the regular "on the job" feedback given regularly to the residents by consultants. Assessment may take place in a standardized environment, by review of videotaped interviews, by direct observation of interactions and in consultation with other health care professionals. The method of evaluation will differ with the situation and context of the assessment.

REFERENCES

1. Simpson M, Buckman R, Stewart M, Maguire P, Lipkin M, Novack D, Till J. Doctor-patient communication: the Toronto consensus statement. *BMJ* 1991;303:1385-7.
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Accreditation of the Basic Clinical Year

INTRODUCTION

The basic clinical year (BCY) is a component of a broad-based clinical experience required by 18 Royal College specialties: anatomical pathology, anesthesia, community medicine, dermatology, diagnostic radiology, emergency medicine, general pathology, medical biochemistry, medical microbiology, neurology, neuropathology, nuclear medicine, obstetrics and gynecology, occupational medicine, ophthalmology, physical medicine and rehabilitation, psychiatry and radiation oncology.

REQUIREMENTS OF THE BASIC CLINICAL YEAR

It is essential that each specialty program develop the requirements of the BCY for their own residents. This includes development of goals and objectives for the year, the number and type of rotations and the methods of evaluations. The Royal College Specialty Committees are charged with ensuring that the BCY for their specialty is consistent across the country.

In developing the BCY, each program must address the following issues:

1. The requirements of the residents to gain experience while attending a diverse group of patients needs to be ensured. Residents should develop more independence and expertise as they progress though this year. It is important that the residents have more responsibilities and independence than when they were medical students.
2. The program must assume responsibility for selecting and monitoring the experiences of residents throughout the basic clinical year. It is important that each Program Director with BCY residents coordinates the rotations of these residents with all other program directors. Residents should be included in academic and social aspects of their home program.
3. Program Directors and Resident Program Committees with a BCY should devote specific time at meetings to address the needs of BCY residents. It is desirable to have a BCY resident as a member of the Residency Program Committee.
4. Each University must develop a mechanism to ensure that the needs of all programs requiring the basic clinical year are being met.

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