THE FUTURE OF MEDICAL EDUCATION IN CANADA
POSTGRADUATE PROJECT

L'AVENIR DE L'ÉDUCATION MÉDICALE AU CANADA
PROJET POSTDOCTORAL

FMEC PG Project
Draft Recommendations

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA
COLLÈGE DES MÉDECINS DU QUÉBEC
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL DES MÉDECINS ET CHIRURGIENS DU CANADA

A Health Canada-funded project

Recommendations with Rationale and Actions

1: Ensure the Right Mix of Physicians to meet Societal Needs

RECOMMENDATION
Both individually and collectively, physicians working in healthcare teams must address the diverse health and wellness needs of individuals and communities throughout Canada. The Postgraduate Medical Education (PGME) system must adjust its training programs to produce the right mix, distribution and number of generalist and specialist physicians, including clinician scientists, educators, and leaders to serve the public need and be accountable to the Canadian population.

Rationale:

Medical education and the delivery of healthcare must be conducted within the context of a social accountability framework, in which the medical education system is accountable to and operates in the service of the public to meet the broad and varied needs of Canadians. Social accountability also requires good stewardship, which includes responsible allocation of precious human and financial resources. Within the context of PGME, good stewardship requires consideration of the health needs and outcomes of the young and the old, the poor and the wealthy, those living in urban, rural and remote locations, Aboriginal communities, new immigrants, those who are able-bodied as well as those who are differently-abled. Responding to such diverse societal needs of Canadians requires that we not only match the necessary *qualities* of knowledge, skills and behaviours, but that we also provide the requisite *number* of physicians to meet identified needs, and further facilitate the integration of health care into communities.

Aligning our resources to deliver the right number and constellation of qualified physicians requires coordinated planning among leaders and stakeholders across the PGME system. Yet, the complexity of the PGME system presents a challenge in and of itself – comprised of a web of stakeholders, including e.g., federal, provincial/territorial and Aboriginal governments; health authorities; individual hospitals and other clinical teaching sites; faculties of medicine and their host universities; medical professional associations, including resident associations; unions; student organizations; licensing bodies and individual faculty members. The PGME system, perched at the confluence of education and health care, reflects multiple levels of responsibilities and accountabilities. To navigate these complexities and deliver the social benefit promised, collaborative stewardship is a must.

Launching a dialogue among stakeholders will prove to be the critical first step to effectively navigate*, and* negotiate this complex web of the PGME system. Leaders within the PGME system will need to build connections across geographical, governmental, and functional silos, and invite participation in creating a pan-Canadian

educational agenda. Through this strategic engagement process, stakeholder leaders can together develop a national agenda to guide the necessary assessment, forecasting, and planning to support socially accountable resident training and health care services.

While we advocate for the development of a pan-Canadian agenda in facilitating socially accountable health care, we also recognize the inherent need for flexible adaptation and implementation of such an agenda in various jurisdictions across Canada. Whereas national consensus may be reached on principles, application of these principles will necessarily hinge on local needs and interests. That said, we expect that through a national dialogue, shared interests for postgraduate medical education will be articulated to address such topics as movement of physicians across provincial boundaries; remuneration structures; the differing needs of rural and urban health care; job security; and changing scopes of practice (subspecialties and diploma programs) juxtaposed against geography and demographic changes.

Medicine is fundamentally about individual wellness, and this includes the well being of residents, whose professional fulfillment merits attention. While societal needs provide a target, finding the “right” mix also requires attention to the individual interests and aspirations of residents. For example, some residents will find themselves in the midst of a tension created by the stated support for greater generalism and the actual trend towards greater specialization. Practicing good stewardship of our human resources means that PGME must find new ways to support physicians in training as they make career choices along the lifelong learning continuum maintaining competencies to meet the needs of the communities they serve.

Actions:

1. Develop a pan-Canadian strategy in conjunction with Federal, Territorial and Provincial authorities for assessing and adjusting training programs to respond to societal health and wellness needs, factoring in health disparities related to geographic locations, ageing, socio-economic status and historical marginalization of Aboriginal communities, as well as other marginalized populations.

2. Establish a national process for determining the number and types of specialties and focused training programs within Canadian residency programs that are required to meet societal needs.

3. Deliver effective and efficient approaches to integrate IMGs into the Canadian system.

2: Align Physicians' Learning, Service and Work Around the Health and Wellbeing of Patients and Communities

RECOMMENDATION
Residents, as developing medical professionals, must orient their work, service and learning around the health of patients and communities within the context of a broader social accountability to all Canadians. To this end, PGME must foster a culture that values, encourages and rewards competency in, and integration of, *all* CanMEDS and CanMEDS-FM roles (medical expert, communicator, collaborator, manager, health advocate, scholar, and professional), emphasizing quality care, patient safety, and accountability.

Rationale:

Social accountability provides a framework of obligations and expectations to direct medical education, research and service in meeting the health care needs of patients and their communities. To play an effective leadership role, PGME stakeholders, through public consultation and community engagement, must articulate a shared understanding of expectations. Clearly, Canadians expect caring and medically competent care from their physicians. Patients also expect an ethical and trusting relationship with their doctor, which ensures responsive health care. The RCPSC and the CFPC, through CanMEDS and the CanMEDS-FM frameworks, respectively, have created a useful rubric through which to consider and evaluate physician competency, which includes technical and non-technical knowledge, skills and behaviour. To be accountable to Canadians, PGME must ensure that each resident enters into independent practice with the full range of competencies to meet the public's needs for health and wellness.

To promote the health and wellbeing of patients and communities, PGME must lead systemic changes that shift the educational culture in which patient safety and quality care are focal points. This shift can be achieved through a variety of ways, such as embedding patient safety into accreditation standards, curriculum, and assessment. Specific faculty development on pedagogy and role modeling would facilitate this shift to ensure greater accountability to patients' wellbeing.

Curriculum and assessment work in tandem to develop residents as competent physicians and professionals. PGME curriculum and assessment must align its focus to ensure that residents are taught and develop core medical knowledge, technical proficiency, clinical skills and judgment required of them as a Medical Expert. At the same time, residents must be encouraged and supported to develop and integrate their "non-medical expert" roles. For example, the trend towards team-based health care delivery requires that residents are fluent in collaboration and communication skills. To foster the development of skills required for working effectively in teams, resident training should incorporate assessment tools that promote team skills and cultivate an appreciation for and incorporation of interprofessionalism and intraprofessionalism.

Health education scholarship has demonstrated that explicit role modeling, a social aspect of medical training, has a potent effect on resident learning. The transfer of learning through this so called “hidden” or “unofficial” curriculum has been demonstrated as especially robust in regards to teaching the non-medical expert roles in the CanMEDS and CanMEDS-FM frameworks. Responsible role modeling by faculty (and residents when performing in a teaching capacity) is, therefore, critical in demonstrating appropriate behaviours and skills in working with patients and their families, peers and team members, hospital administration, and the community. To develop broadly competent physicians requires that the curriculum – official and “hidden” – incorporate elements of respectful communication, collaborative practices, and the centrality of the patient across all topics and teaching venues. In preparing residents for independent practice, faculty must be supported and developed to demonstrate the competencies in knowledge, skills and behaviors that lead to safe and quality care to patients.

Actions:

1. Provide resident training that role models and reflects patient-centred care that ensures quality, safety and accountability.

2. Provide residents with adequate opportunities to work as part of a health care team, in which residents are exposed to the competencies and roles of other allied health professionals, and the environments in which they will work in the future.

3. Integrate all CanMEDS and CanMEDS-FM roles into residency training curricula, connecting the development of knowledge, skills and behavior to responsible, safe, and quality patient care, particularly in the context of interprofessional delivery of health care services.

4. Provide learning experiences and service opportunities for all residents with underserved and disadvantaged populations to develop the understanding of variations in health, wellbeing and needs of differing patients and communities and service delivery models.

5. Support resident-led projects to improve the health and health care of underserved and disadvantaged patients and populations.

3: Implement Competency-Based Curricula to meet Evolving Health Care Needs

RECOMMENDATION
Focus on competency-based, innovative, learner-centred methods that enable educators to be flexible in adapting curricula content and training models to meet the diverse learning needs of residents and, the evolving health care needs of Canadians and the best interest of society.

Rationale:

The content and delivery of the postgraduate curriculum must be aimed to meet Canadians' continually evolving needs for health and wellness. In basic terms, the content of *what* we teach residents unfolds in the curriculum, whereas *how* we teach residents can be examined through the structure of training models. Society's needs for health and wellness must inform both the curriculum and training models used to adequately prepare residents for independent practice in providing health care to patients and communities.

PGME curriculum should be reviewed and redesigned to meet the competencies required for residents' readiness to practice. In keeping with the implementation of competency-based curricula, the use of new technologies supports resident learning of all required competencies. New technologies, such as virtual patient simulations, web-based training modules, videoconferencing, and the use of hand-held devices for tracking cases should be incorporated alongside other structured learning opportunities to enable the development of residents' competencies across all CanMEDS and CanMEDS-FM roles. Innovative curriculum tools aimed at developing non-medical expert roles, e.g., interprofessional and intraprofessional collaboration deserve continued attention.

With respect to how curriculum is delivered, PGME should dedicate efforts to assess time-based versus competency-based models in terms of their effectiveness in training residents who are ready to practice, measured by health outcomes. A national-level review, which measures the relative impact of time-based versus competency-based curriculum, within various disciplines, would yield valuable data for educational planning. In addition to enhancing educational responses to society's health needs, such a pan-Canadian approach could also support faculty development in areas of curriculum design, planning, assessment, and teaching. A national forum in which to share best practices in medical education would support knowledge translation of innovative pedagogy and new learning technologies. Finally, through greater collaboration, the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons (RCPSC) might align their efforts in order to streamline services to patients and communities by reviewing commonalities and distinctions in competencies across specialties.

According to the latest Canadian census data, nearly 80% of Canadians live in urban areas. Serving the health care needs of all Canadians, however, means that we must

adapt our training of doctors to meet the unique health care interests of the minority as well as the majority of the population. To adequately meet the needs of rural and remote communities, curriculum must be adapted to provide residents with exposure to different populations and different service delivery models outside urban and large tertiary care centres.

Throughout this report, we highlight the benefits of collaborating across inherent silos in PGME. Here too, in the area of curriculum and training models, benefits flow from a national coordinated approach. During an age when innovation and efficiency are critical to success, a plan for national collaboration among university program directors, which are responsible for the design and implementation of residency education, is vital. Given that the competencies related to CanMEDS and CanMEDS-FM roles are similar in content yet different in context, creating a national forum and a repository of best practices would support wide dissemination of information for effective uptake for change.

Actions:

1. Provide residency training across diverse sites with greater emphasis on ambulatory, community-based, and geographically distributed sites, exposing residents to the evolving healthcare needs of Canadians.

2. The College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons (RCPSC) should demonstrate evidence that program standards and competencies achieved during training, across the spectrum of comprehensive care providers to focused subspecialists, align with the needs of society.

3. Require the CFPC and RCPSC to establish a process to define competencies of practitioners in specific areas that avoids duplication of residency programs, and that supports access to health care without negatively impacting the balance of generalist and specialist care required to meet society's needs.

4. Create innovative training models, encouraging new ways of teaching within and across specialties and health care professionals, which reflect patient expectations for interprofessional, patient-centred collaborative care.

5. Conduct a thorough, evidence-based review of training model options, rooted in competency assessment, that most effectively measure readiness to practice by specialties.

6. Review and amend content of training programs, especially those with reduced work schedules, to ensure that residents are learning the competencies required for practice.

7. Support and implement residency training models based on demonstrated acquisition of competencies required for readiness to practice - which may differ from strict time-based measures that have been traditionally used to determine completion of residency.

8. Develop a system and a process to share curricular innovations and best practices among faculties and residency training programs.

4: Create and Implement Effective Assessment Tools and Systems that Support Residents as Learners

RECOMMENDATION
Competence and readiness to practice must be assessed favouring longitudinal formative feedback and assessment tools that are valid, fair, and reliable over final summative examinations. Multiple observations using multiple modalities and input from self, supervisors, peers and other health professionals, patients, and families should be used. Faculty must be appropriately trained and supported to provide honest and accurate feedback.

Rationale:

We pay attention to what we measure. Assessment provides mechanisms for focusing our attention to stay on track and on target in educating residents. While assessment instruments inform educators whether they have delivered on an established objective, e.g., residents' demonstration of competencies, assessment is more than a collection of value-laden scores. Assessment is also about a process, and the process must be unequivocally fair.

Assessments must also produce valid and reliable data. Educational scholarship has shown that multiple, independent observations enhance validity, and that direct observation is the best means of assessing residents' skills in patient care. Yet, there remains room for improving assessment practices and tools, particularly in a competency-based curriculum environment. Because of the inherent subjectivity in determining whether behaviours demonstrate "effective" leadership in teams or "respectful" collaboration, assessing the non-medical expert roles identified in the CanMEDS and CanMEDS-FM frameworks presents a specific challenge. Whether assessing medical knowledge or professional behaviour, an opportunity exists to improve the effectiveness of assessment tools and systems for residents.

Assessing International Medical Graduates (IMGs) requires a more nuanced approach. To fairly and accurately assess IMGs, we must factor in differences in culture and previous learning practices. The same flexibility in assessment could also be applied to Aboriginal residents, who, as a group, have been historically marginalized. Flexibility in assessment does not amount to lowering standards, but rather finding innovative means for measuring competencies.

On a day-to-day basis, we assess trainees to improve their ability to care for patients. In a broader sense, we assess learners and faculty as a means to ensure the best quality health care to meet the needs of Canadians. As a self-regulating profession, we have made a commitment to the Canadian public to be expert, professional, and patient-centered. With social accountability as a driver, PGME must shift the culture of medical education to value assessment as a tool for continual quality improvement – of individual learners and faculty, as well as the learning environment – in the service of the health and wellness of Canadians.

Actions:

1. With patient safety and quality care as guiding interests, ensure that residents are provided with adequate feedback, including identification of difficulties, to support progressive development along the learning continuum.

2. Develop summative assessment methodologies and tools for providing evidence of readiness for independent practice that reflects integration of all CanMEDS and CanMEDS-FM roles.

3. Together, the CFPC, RCPSC and PGME educators should develop a framework of assessment tools methods, and implementation processes that support the development and mastery of required physician competencies.

4. Strengthen the linkages between in training evaluation methods, which demonstrate competency within residency, and national examinations, which determine readiness for independent practice.

5. Reexamine the timing of examinations in order to ensure that appropriate time is spent in the last year of residency, honing clinical competencies needed for practice.

6. Commit resources to develop assessment tools and methodologies that can be applied to supporting effective integration of IMGs into the Canadian health care system.

7. Ensure adequate funding and flexibility are available for residents who require remediation.

5: Support Clinician-Teachers through Professional Development

RECOMMENDATION
All physicians, in their roles as learners, teachers and care providers, should possess and exhibit the competencies outlined in the CanMEDS and CanMEDS-FM roles. In order to foster quality postgraduate medical education, clinician-teachers must be supported – through targeted professional development, including performance feedback – to provide excellent teaching, responsible role modeling and effective assessment and feedback.

Rationale:

Physicians who teach must also embrace their role as learners. By embracing the role of learner, faculty are best able to stay current in the medical knowledge they are expected to translate to residents under their tutelage. Beyond maintaining medical expertise in their discipline, Clinician-teachers must also possess and demonstrate fluency in the entire range of CanMEDS and CanMEDS-FM roles. In other words, clinician-teachers should be skilled communicators, collaborators, managers, health advocates, as well as scholars and exemplars of ethical and professional practice. We learn by watching, and so those who teach must be ever mindful of the impact of their actions on the learner.

Teaching and learning of residents involves a dynamic exchange of information occurring through multiple channels and in a variety of experiential situations. Residents are in a continuous state of learning and development. And, faculty, across all domains of postgraduate medical education – from clinician-teachers to clinician-scientists – play a vital role in delivering the official and hidden curriculum. Some teach more than others, yet regardless of the contact hours faculty have with residents, there is an expectation that all faculty will lead by example.

Faculty from across the PGME spectrum should be supported, developed and encouraged (by their institutions) to provide excellent teaching and responsible role modeling. For example, faculty must be supported to incorporate the latest technologies, such as simulation and web-based media, alongside more traditional teaching practices, that together enhance resident learning. Clinical teachers outside the academic tertiary care environment must also be supported to deliver the official and hidden curriculum. There appears to be a particular need for faculty development to improve teaching competencies and assessment of the non-medical expert roles, e.g., collaborator, communicator, and manager. From a broader perspective, the CanMEDS and CanMEDS-FM framework offers a useful structure and a range of resources that can be adapted and implemented by teaching sites and universities for targeted faculty development. Through further partnership with the RCPSC and the CFPC a national competency-based curriculum and assessment for teaching faculty might be developed, leveraging the tools built through CanMEDS and CanMEDS-FM.

Assessment provides a valuable method to encourage excellence in teaching. To fully

embrace this dual role of teacher and learner, faculty (like the residents they teach) must be evaluated on their competencies in teaching and role modeling. Faculty assessment should be conducted in the spirit of continuous quality improvement, aimed at the professional development of the individual faculty member as well as supporting improvement of the learning environment as a whole. As is the case with assessing residents, assessment of faculty must be valid, fair and reliable, affording both formative and summative feedback to clinician-teachers.

Faculty must be supported to provide valid, fair and reliable assessments of residents through a variety of means. Similarly, residents – who are also expected to teach – must be supported and developed to provide effective assessments. All teachers across all ranks and learning sites should be trained to give and receive constructive and honest feedback. Furthermore, PGME must ensure that summative assessment tools and methods are directly linked to measuring CanMEDS and CanMEDS-FM competencies. Such tools and methods should also align with national examinations that, together, with a program's summative assessments determine readiness to practice.

To excel at teaching goes beyond natural talent and intellect; it also requires a dedication of time and effort, patience, self-awareness, empathy, and leadership, to name a few. Excellence in teaching is a rare achievement and should be acknowledged. To provide recognition for teaching is especially important in light of the volunteerism of many clinical teachers who teach because they are committed to developing the next generation of doctors and clinical educators. Recognition of faculty contributions should be further explored, locally and nationally, as a means of encouraging teaching excellence.

Actions:

1. Develop a comprehensive, national, continuing professional development strategy that supports physicians to learn, teach, and assess each of the CanMEDS roles.

2. Identify effective incentives to encourage continuous professional development of physicians through systemic mechanisms such as licensing, certification, granting of hospital privileges and funding models

3. Develop valid, fair and reliable assessment tools with which residents can safely provide formative performance feedback to clinician-teachers to support ongoing professional development of faculty.

6: Promote Continuous Learning and Effective Transitions

RECOMMENDATION
Medical education occurs along a continuum, beginning with the MD program, progressing through to residency and into practice. PGME must prepare physicians for independent practice. The promotion of continuously graded, increasing responsibility and life-long learning is required throughout the medical education continuum with effective transitions from UG to PG and from PG to independent practice.

Rationale:

PGME's mandate is to prepare physicians – intellectually, technically, and emotionally – for independent and interdependent practice, i.e., as members of interprofessional teams. Residents' development, however, begins before and continues beyond postgraduate education, and is progressive throughout one's career. PGME plays an integral role in supporting residents' progress along this developmental path, a role that involves collaborative planning with other leaders in medical education to facilitate more effective and smoother transitions. To improve transitions there are a number of focal areas – at the systemic and programmatic levels - that deserve attention.

Collaborative planning among medical education stakeholders is a prerequisite to more effective transitioning to and from residency. Length of training and timing of national examinations are critical factors to discuss with Faculties of Medicine, Medical Council of Canada, CFPC, RCPSC, among others. Timing, as a structural consideration, must be reviewed in relation to competency acquisition in determining length of training; Resident competency remains the guiding objective. National examinations, which are but one tool for assessing competence, must be considered in the entire context of an assessment process, giving rise to an opportunity for timing to be revisited

The number of discipline streams and entry positions for first year residents also deserves specific attention. More importantly, PGME must find a way to ensure greater flexibility for residents to explore options through career counseling or mentoring once they have entered a particular stream. Supporting continuous learning for residents means that PGME must create elasticity in the system, e.g., to afford greater choice and mobility for residents wanting to explore new disciplines or streams.

Additionally, PGME can facilitate improved transitions into and out of residency through specific curricular and programmatic adjustments to prepare and assess residents for transitions. Specifically, UGME and PGME might augment the curriculum for the final year of the MD program that better prepares residents for increasing responsibilities and independent practice. Assessment tools, to measure the graduating MD's level of competencies, would provide further guidance and structure for the transition into first year residency. Preparation for residency could be further improved by creating a national orientation program for PGY1 residents that includes a special track for first year IMGs, PGME must also improve its sign-off process indicating residents are ready to practice, such that the exit ramp for graduating trainees ensures competency and

accountability. Residency training must prepare trainees to independently practice all CanMEDS competencies and offer an opportunity to demonstrate and assess their abilities in a protected and supported environment.

While PGME must examine and revise the systems and programs for improved transitions, it must also consider the individual resident, who will have unique learning goals and career aspirations. Ultimately, these aspirations must align with society's healthcare. That said, supporting each resident to navigate his or her own learning path requires that PGME find new means for providing timely and useful guidance to residents. This may include more structured coaching and mentoring. PGME must also factor in the unique needs that International Medical Graduates (IMGs) may have as they transition along the path of progressive competencies and life-long learning.

Actions:

1. Review current practices and systems, e.g., timing of national examinations, to develop smoother and more effective transitions from undergraduate education to postgraduate training, and from postgraduate training to independent practice and throughout practice.

2. PGME and UGME must collaborate to ensure that MD programs appropriately prepare students for entry into residency by including a rigorous and flexible use of the final year of medical school.

3. Align entry positions to meet societal needs, such that foundational disciplines are filled, while enabling flexible, efficient progression into other specialties and sub-specialties.

4. Develop a pan-Canadian approach to resident orientation, including assessment and supplemental learning modules for IMGs, to ensure readiness to begin postgraduate medical education.

5. Review and determine the length and content of training, based on competencies required for readiness to practice, rather than traditional time-based models.

6. In order to provide a period of monitored independence, reassess the timing of national examinations, linking readiness to practice with demonstrated competencies.

7: Align Governance, Standards of Training and Accreditation

RECOMMENDATION
Governance and accreditation should be aligned across the learning continuum - beginning with the MD program through residency and continuing into professional practice - designed within a social accountability framework and focused on meeting the health care needs of Canadians. This requires collaborative action among the credentialing colleges, CACMS, the Medical Council of Canada, CACME, medical regulatory authorities, hospitals, teaching sites, universities, health authorities, federal, territorial and provincial governments, resident and student associations, specialty and sub-specialty societies, and other stakeholders.

Rationale:

Effective governance is an essential cornerstone to administering the PGME system in which standards of training and accreditation are foundational structures. “Governance” in the context of PGME includes the institutions, policies and processes that support the administration and delivery of resident training. To ensure *effective* governance within PGME, clarity of roles and responsibilities among the many stakeholders *and* a practice of collaborative dialogue must be in place. And yet, the PGME system is a complex array of players (from education, government, health authorities, etc.) with accountabilities pointing in various directions. Up to this point, this complexity has presented a challenge in finding the clarity and collaboration required for effective governance, resulting in a lack alignment towards a common vision for resident training.

PGME should assume a leadership role in beginning a dialogue with other medical education stakeholders to articulate a common vision, interests, responsibilities and various accountabilities in meeting Canadians’ identified health and wellness needs. If sustainable health care in Canada is to be achieved, effective governance must be put into practice to enable careful forecasting of numbers and types of physicians required in our system in order to make effective health and human resources decisions. With forecasting data as targets, PGME partners can then implement standards and accreditation that align to a common vision.

Actions:

1. Develop a process to set out commitments and defined responsibilities among stakeholders that address the health and human resource needs of Canadians.

2. Align accreditation processes over the continuum of UGME, PGME and CPD, in order to facilitate and enable a more integrated medical education system and to support life long learning.

3. Refocus accreditation and training standards within CACMS, the three certifying Colleges and, CACME to align with delivering health outcomes to meet societal needs

4. Develop competency milestones for residents, which are based on targets set by PGME partners to measure success in meeting the health and human resource needs of Canadians.

5. Create a national forum with relevant stakeholders to make the PGME system more flexible and responsive to societal needs, by defining specific responsibilities and accountabilities along the medical education continuum (UG, PG, CPD).

8: Foster Residents' Leadership and Teamwork

RECOMMENDATION
Foster the development of leadership and teamwork skills in future physicians so they may work efficiently with other health care professionals and help shape our complex health care system to better serve our society.

Rationale:

Physicians are perceived by society as leaders. Understanding that leadership is an enabling component for all CanMEDS and CanMEDS-FM roles and relevant to career paths focused on patient care, education, research, and administration, leadership curriculum must be a part of core learning for every resident. Today's leadership training must be focused on the current environment in which physicians are working as inter-professional team members who at times are facilitators, followers or leaders. Residents must have the opportunity to receive feedback regarding their performance on teams to permit their teamwork development. All residents should become engaged in improving the health care of our patients and populations and the health care system in general. To this end, residents must be supported to develop their leadership focus during training and have the opportunity to experience how to become an agent of positive change in our complex health care system.

Actions:

1. Develop a national core leadership curriculum for all residents over 2 years with a focus on self-awareness, providing and receiving feedback, conflict resolution and working on a team as leader, facilitator or follower.

2. Provide residents with multi-source feedback (from patients, students, peers, other health care professionals, and preceptors) regarding their performance as team members.

3. Establish the requirement for residents to complete a leadership project during their training. The project could have a basis in (but not be limited to) advocacy, quality improvement, health systems, health policy, public health, or professional organizational work.

4. Residents would all participate in one administrative task during training, such as taking role as a committee member, accepting a leadership role, representing a group at a meeting/conference. Resident participation would be supported by programs/faculties.

9: Ensure Patient Safety and Quality Patient Care

RECOMMENDATION
Teaching and learning must be provided to residents in environments that are nurturing and founded on principles of patient centredness, safety and quality care.

Editorial Note: *A recommendation relating to patient safety and quality of care is currently being developed and will be circulated to key stakeholder groups - Steering Committee, Advisory Committee of PGME Deans, Strategic Implementation Group and Public Panel - in early December for review and comment.*