THE FUTURE OF MEDICAL EDUCATION IN CANADA
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L'AVENIR DE L'ÉDUCATION MÉDICALE AU CANADA
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11 Accreditation of Postgraduate Medical Education

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Executive Summary

Accreditation in Canada is a critical element in ensuring quality and accountability of postgraduate medical education. Within the past decade, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, and the Collège des médecins du Québec (CMQ) have collaborated to improve the accreditation standards and processes in the postgraduate medical education system.

Drawing from recent changes in the Canadian accreditation process in postgraduate medical education and existing international models of accreditation, this paper is intended to inform administrators, policy makers and medical educators on how the structure, purpose, design and implementation of accreditation plays an integral role in the future of both the postgraduate medical education program as well as the postgraduate medical trainee.

Accreditation should focus on and promote quality improvement and should provide a means to share best practices. Accreditation can also be a tool for sharing of ideas and promoting sharing of ideas between and among programs.

Key Messages

1. Canadian national education colleges accredit to specific content and educational standards for all disciplines and thus ensure effective standardization of all postgraduate training in Canada. The fact that there is one national college for specialties and one for family medicine ensures that educational standards are maintained across all disciplines. This structure is in stark distinction to other nations that have separate colleges for each discipline and where postgraduate medical education is not necessarily linked to universities.

   The fact that all postgraduate training must be linked to a university that provides a medical school is also a key method of effective control of standards that are reviewed by an accreditation agency.

2. Accreditation has been shown to be highly effective in both identifying problems in programs and universities and then being the lever to successfully solve those identified problems.

3. The Canadian accreditation system is respected internationally, especially as other jurisdictions come to understand our ability to accredit across disciplines, innovate across all programs (such as the CanMEDs initiative), and coordinate nationally. While it is highly regarded however, best practices that could be further explored might include the need for increased public participation; a continuous vs. episodic process and a system that simplifies expectations (example - documentation etc).

Background and Introduction

This paper is one of 24 papers commissioned for the Future of Medical Education in Canada Postgraduate (FMEC PG) Project. This paper describes the key elements in the accreditation of medical education in Canada, focusing on the governance, standard-setting, and review processes of the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC) and the Collège des médecins du Québec (CMQ). We review the limited research literature, critical, comparative and descriptive literature on accreditation, with a particular focus on accreditation in higher education generally and medical education specifically. We then examine the structure and governance of accreditation as well as the design and implementation in Canada. Finally, we focus on key challenges on the near horizon that will affect residency education in Canada: a more inclusive process of standard setting, maintenance of a truly peer-review system, continuous improvement at the program level, faculty development, the ability to incorporate training of other health-care professionals, and common global educational standards.

Methodology

A literature search of MEDLINE, OVID, and PubMED databases with the key terms ‘accreditation’ AND ‘education’ returned approximately 250 references. An initial appraisal of the literature revealed a number of literature reviews and systematic reviews that report on the general principles of accreditation and education; however, the literature pertaining to medical education accreditation process and governance in Canada is limited. An in-depth systematic review of the literature was employed to report on existing accreditation standards as they relate to the accrediting bodies in Canada. There is little published on the trends and emerging issues in peer-reviewed accreditation. Accordingly, a grey literature search was performed to gain further insight in describing the peer-reviewed process, while also identifying the key milestones in the Canadian postgraduate medical education accreditation process in recent decades. A comparative review on international models of accreditation in postgraduate medical education was performed to allow for further questions and analysis on the accreditation system in Canada; in this regard websites for the relevant Canadian, United States, the United Kingdom., Australian, and Irish entities were reviewed. Quality filters were employed to retrieve articles in the MEDLINE, OVID, and PubMED database that were classified as a review, while also limiting the search to English and French within the last ten years.

Given the limited literature, this paper draws substantially on the experience and expertise of the authors.

Discussion

Definitions and Purpose of Accreditation

The purpose of accreditation in higher education is to ensure quality and accountability of professional and academic programs as set out by the higher education community. Accountability has no clear definition, although it is often associated with efficiency, effectiveness, and excellence. Quality differs according to discipline and expertise. For health care in Canada, the definition of quality consists of the following elements: competence, acceptability, effectiveness, appropriateness, efficiency, accessibility, continuity, and safety (1).

The purposes of accreditation in higher education have been described as: fostering quality assurance, facilitating access to federal and state funds, engendering private sector confidence in higher education, and easing transfer of courses and programs among colleges and universities (2).The four pivotal roles for accreditation include a system that: sustains and enhances the quality of higher education; maintains the academic values of higher education; acts as a buffer against the politicizing of higher education; and serves public interest and need.(3) With the exception of the issue of transfer of courses and credits, these purposes apply to medical education in Canada.

An effective accreditation system exists when a program or organization in higher education can demonstrate through a variety of examples that it is meeting the outset purpose of a program; it has defined purposes and standards; it demands a certain organizational structure that has required resources; and it demonstrates that the program will continue to accomplish its purpose by ensuring to stay abreast of the newest and most up-to-date technologies, innovations and best practices in its field (1, 4-6).

Accreditation in Canada

The Canadian approach to accreditation has been influenced by a variety of elements; however, one of the most influential is the relationship of government structure to education (7). In Canada, the federal government plays a limited role in dictating education standards; Canada does not have national higher education policies (8). Canadian higher education is a binary structure where all provincial systems are composed of degree and non-degree-granting sectors that operate in parallel with one another. Given the non-existence of the private degree granting institution in Canada, provinces have generally treated their own higher education institutions as equals, which has ultimately allowed for institutions within the same province to keep similar tuition structures for similar programs. The limited competition within provincial institutions has allowed for a high level of institutional autonomy.

This binary structure exists in medical education to the extent that both federal and provincial processes are involved. National bodies supervise accreditation and certify all physicians in Canada (with the exception of Quebec (9)), while the provincial regulatory colleges' license physicians (10). The colleges accredit to specific content and educational standards for all disciplines and thus ensure effective standardization of all postgraduate training in Canada. The fact that there is one national College for the Family Medicine and one for the other specialties, ensures that educational standards are maintained across all disciplines. This arrangement ensures national standards as set out in the General Standards for Accreditation (11), which address the university, administrative, and program structures that support trainee education, the clinical and academic content of the education, and the evaluation of trainee performance. Presumably, therefore, a resident from a small program within a smaller university will be as well trained as a resident from a large program in an urban centre.

The peer review system, which relies on voluntary surveyors from different institutions, allows for fertilization and diffusion of innovations and best practices across different specializations as well as across the country.

The provincial governments, apart from their role in funding residency positions and programs, have no direct role in accreditation.

Globalization:

In recent years, the notion of internationalization of postgraduate medical training has grown. As a result, there are more opportunities for cross-border education and training. This trend has sparked the attention of the World Health Organization (WHO) and World Federation for Medical Education (WFME). In 2004, the WHO/WFME strategic partnership was formed to improve medical education across borders through reform and evaluation (12).

The idea of setting global standards for accreditation of postgraduate medical education is not a completely new phenomenon. In the last decade, numerous initiatives have been developed worldwide to create consistency of quality assurance standards in higher education. In addition to the Bologna Declaration and Process in Europe, higher education experts in other countries are striving to develop accreditation standards that will make it easier for medical trainees to move between countries. Easier mobility and global accreditation standards for medical trainees would assist in addressing the growing challenges that are arising in health care (12). The globalization process of accreditation would be characterized by a uniformed instructional method, curriculum and education standards that would apply to postgraduate medical education. Advantages and reservations in defining global standards for medical education (5) are described in Table 1 below:

Table 1: Advantages and Disadvantages of Global Standards for Medical Education

Advantages	Reservations
Incentive for Improvement	Interference with autonomy
Basis for national evaluation	Focus on minimum requirements
Formulation of essentials	Risk of conformity
Opportunity for educational research	Sense of control
Facilitation of reforms	Lack of common relevance
Instrument for funding	Disregard for local differences
Facilitation of exchange (students, teachers, programs)	
Basis for accreditation	Increasing brain drain

In Canada, special processes have been developed that apply to the entry of international medical graduates into residency programs[a]. Once in a residency program (and having passed the Assessment Verification Period) international graduates are considered the equivalent of graduates from a Canadian medical school

Structure and Governance of Accreditation in Canada

The current process for accreditation of postgraduate medical residency programs in Canada is determined by the RCPSC and the CFPC.[b] and in the province of Quebec is conjoint with the CMQ. The RCPSC is responsible for all accreditation decisions that

[a] For further information see the websites for HealthForce Ontario at http://www.healthforceontario.ca/ and the Centre for the Evaluation of Health Professionals Educated Abroad http://www.cehpea.ca/

[b] For further information see the College websites at: http://rcpsc.medical.org and http://www.cfpc.ca.

apply to all specialties and subspecialties of medicine and surgery while the CFPC is responsible for accrediting programs in family medicine including enhanced skills

Accreditation is granted only to those residency programs that are under the direction of a Canadian university medical school. The medical school must have affiliated teaching hospitals and other education sites, including community-based clinical offices and practices all of which share a commitment to education and quality of patient care. Finally, there must be appropriate arrangements between the university and all sites participating in postgraduate medical education.

While the two colleges have developed along parallel tracks, their recent history has been characterized by a merging of standards for institutions and programs. Since 2007, the RCPSC and the CFPC have been collaborating on accountability and assurance standards through the creation and use of the 'A' Standard and 'B' Standard manuals, which has unified the accreditation process (11). The most recent collaboration has resulted in the CanMEDS-FM standards for training of family physicians, developed in 2010.

Accreditation milestones of the RCPSC and CFPC are described below in Table 2.

Table 2: Accreditation Milestones of the RCPSC and CFPC

RCPSC		CFPC
• 1944 Recognition of hospitals as training sites for residency education • 1962 Introduction of standards/regulations for approval of hospitals and for individual specialty training programs • 1950-1970 Communication with universities and hospitals regarding university sponsorship of residency programs. • 1970 All residency programs required to be University sponsored • 1982 University mid-cycle internal reviews become mandatory • 1986 First simultaneous/conjoint accreditation visit with CFPC • 1980-1987 Development of General Standards of Accreditation • 2007 Conjoint RCPSC/CFPC/CMQ 'A' Standards adopted • 2009 Conjoint RCPSC/CFPC/CMQ General Standards for all residency programs (B Standards) adopted		• 1966 First family medicine residency program • 1968 First educational objectives for training published • 1970 Development of Red Book Standards for Accreditation • 1971 First CFPC accreditation survey • 1985 Four Principles of Family Medicine published • 1986 First simultaneous/conjoint accreditation visit with RCPSC • 1995 Four Principles revised and updated • 2007 Conjoint RCPSC/CFPC/CMQ 'A' Standards adopted • 2009 Conjoint RCPSC/CFPC/CMQ 'B' Standards adopted

Design and Implementation of accreditation

Both the RCPSC and the CFPC follow the *Guidelines for Good Practice of Academic Accreditation of Professional Programs* as set out by the Association of Accrediting Agencies of Canada (16). The accrediting agencies' process and procedures are also consistent with WHO Guidelines for Accreditation of Basic Medical Education, which state that accreditation bodies must be trustworthy and recognized by all; trust is based on academic competence, efficiency, and fairness of the system, with a high degree of transparency. Transparency is achieved by publishing the accreditation process on the RCPSC and the CFPC websites. All educational standards are displayed publicly; however, final decisions of the review process are not published for public review.

The accreditation process relies on the voluntary participation of individual physicians who function as external surveyors (and may also function as surveyors within their institutions' internal review process). The accreditation process occurs within a defined time cycle (every six years including all elements of internal and external review).

There continues to be little external or public input into the accreditation of postgraduate medical education program in Canada. Direct responsibility for the quality of university postgraduate residency programs rests with the Office of the Dean. The dean then delegates to a faculty postgraduate medical education committee, the postgraduate dean, and the program directors. The internal review, which is considered to be an integral component of the accreditation process, is conducted two years prior to the respective college visit. The objective of the internal review is to assess the strengths and weaknesses of each program, and to consider and evaluate all residency education sites, including elective experiences.

Residents are included in the accreditation process at the policy level as well as through providing opinions regarding their specific programs. Residents have an opportunity to submit input into the review process by completing a Resident Program Evaluation (RPE) form (Fédération des médecins résidents du Québec (FMRQ) for Quebec residents and the Canadian Association of Internes and Residents [CAIR] for residents from all other Canadian provinces). Every medical resident in Canada is given the opportunity to complete this survey prior to the accreditation review process. This process is confidential and regarded as a crucial tool to capture the residents' views. By assessing the feedback from CAIR RPE forms, program directors are given the opportunity to work with their central postgraduate office to improve areas that may be lacking. Residents are also involved directly in specific reviews; all residents in each program are expected to meet as a group with the surveyors for both internal and external reviews. As well, there is resident representation on the Accreditation Committee of the RCPSC.

Research into Accreditation

Limited research is available to inform decisions regarding governance, implementation, and even the value of accreditation. While anecdotal evidence exists, there is little evidence of the negative effects of accreditation. Davis and Ringsted argue that accreditation drives educational practice through content, format and perspective, and note that there are no data linking quality of practice to accreditation status (5). Consequently, there is limited evidence of direct linkages between accreditation of graduate medical education and patient outcomes. Similarly, Bashore et al. argue that the current Accreditation Council for Graduate Medical Education (ACGME) mandate

has, and can have, a negative effect on education practice by describing the time spent on administrative forms, procedures and documentation of detail (13). These questions continue to frame the debate about the complexities of the accreditation process and may merit disciplined inquiry and investigation.

Summary and Key Challenges

This section reviews the key challenges to accreditation – in both standard setting and process – in the future. Certain issues are becoming prominent (and perhaps even urgent), while other issues may arise at an as yet undefined future point. As noted previously, challenges to accreditation may also change in urgency and priority depending on the recommendations arising from the FMEC PG Report.

Challenges in Design and Implementation

Resources

As the system expands (particularly in family medicine with distributed sites), human and financial resources are becoming increasingly strained.

Human Resources

Continuous renewal of the inventory of surveyors is required as physicians retire or opt out of the process, which creates a need for continuous recruitment as well as training and some level of supervision. It is not clear whether the level of volunteerism will remain high enough to ensure an adequate number of surveyors. A significant decline in volunteers threatens the essence of peer review. It is not clear to what extent alternative types of surveyors would undermine the credibility and quality of the accreditation process.

It is no longer possible for surveyors to visit all the family medicine sites, which is a significant shift from a system where face-to-face connection has been considered a strength of the program.

Financial Resources

As accreditation becomes more complex, it requires a higher level of commitment by surveyors and commitment and funding at the institutional level. Universities may require more staff to manage internal and external reviews; more physicians are required to contribute to reviews; program directors may require more protected time to improve their programs. Since accreditation in Canada is a national program, travel expenses may be considerable to move committee members and surveyors across the county. Some of the expenses are borne by the colleges, some by the universities, some by the faculty, and some by the volunteers who function as surveyors. Given that accreditation is an increasingly costly enterprise, a key challenge will be how the system finds an appropriate balance to apportion funding across all participants.

Changing Face of Medicine and Medical Education

Distance and Distributed Education

An increasing number of programs are requesting and maintaining accreditation in locations distant from their home university. These programs may find it challenging to

maintain accreditation standards, where human, physical, and technical resources may be limited. Given that accreditation standards are intended to be consistent across the country, colleges and universities should ensure that these programs obtain sufficient resources to meet all standards.

Intra and Interprofessional Education

As has been discussed in a recent Lancet article (14), physicians are now training side-by-side with colleagues from other disciplines and specialties, which requires higher levels of understanding intra and interprofessional practice. The accreditation standards do not take into account the needs of these other disciplines, for example, to what extent a family medicine program is able to attend to the educational needs of a psychiatry resident rotating through a family medicine site.

Interprofessional education requires bridging gaps across the various colleges (setting standards and processes for their professionals), university faculties (determining the timing and organization of education) and workplaces (ensuring learners have time and opportunity to engage in learning together).

The accreditation system may need to change to reflect these necessary changes in the practice of medicine, both within medicine, and with other health disciplines, including, for example, nursing, physical therapy, occupational therapy, and social work.

Challenges in Structure and Governance

Standard Setting

Standard setting, in addition to employing specialists from across the country, requires liaison between licensing authorities, universities, and colleges. Certain standards relate to clinical and academic content and appropriate evaluation practices (the B5 and B6 Standards). Other standards (B1, B2, and B3) help ensure healthy and safe work environments, learning environments with appropriate balance between work and learning, and a focus on patient safety. Including multiple stakeholders in standard setting is a strength of the system; the logistics of managing expectations remains a challenge.

Public Input

At present, educational standards are set by internal committees without any direct public input. Given the importance of accreditation, a future challenge will be whether, and the extent to which, there will be direct public input into standard setting and processes.

Common International Standards

The increasing movement of physicians around the world raises two issues for accreditation in Canada. The first issue is how accreditation standards and processes can be made more consistent to support greater transparency and greater opportunities for credit transfer between accredited institutions (15). The second issue is the extent to which Canadian accrediting institutions can and should become global assessors – to decide whether a physician from another country is equivalent to a Canadian-trained physician. This second issue raises two sub-issues: whether the accreditation process in

the original country is equivalent, and whether the actual standards for that specific discipline are equivalent.

At present, Canadian accrediting institutions do not accredit institutions outside Canada, but will deem programs as being substantially equivalent to a Canadian program.

Challenges in the postgraduate working and learning environments

Flexibility

The accreditation process may be insufficiently flexible to respond quickly to identified societal needs. As an example, program directors continue to struggle to incorporate all the CanMEDS competencies into their program; most continue to rely on traditional methods of resident assessment, including direct observation. Whether and how accreditation standards and processes can be changed to be more open to and supportive of innovation and diversity, including new types of educational institutions and new approaches for providing educational services such as distance learning, remains a challenge.

Continuous Improvement at the Program Level

Programs should regard the accreditation process as one element in their continuous improvement, rather than a “hoop” that appears every six years. Given that programs change through changes to faculty, resources, patients, and trainees, every program should be engaging in a responsive and reflective process. The internal review process was developed, in part, to respond to programs that attempted to implement all necessary changes just in time for their external review.

It is not clear what can be done within the accreditation process to encourage continuous improvement.

Faculty Development

As accreditation standards change, more is required of the program directors and clinical faculty – for example, the implementation of CanMEDS has required considerable work in curriculum development, instructional design, and resident evaluation. These changes may be different depending on the specialty – for example, surgeons require different simulation experiences than psychiatrists, while psychiatrists require different observational evaluations than surgeon. Universities need additional resources to ensure sufficient support for faculty development initiatives. Smaller universities may have less access to these additional resources. It is unclear how the cost of these additional resources – both human and financial – should be divided equitably between the university, and the accrediting body. Further, it is unclear how smaller institutions can continue to be supported to maintain similar standards to larger institutions. These issues raise the question of whether it is the responsibility of accreditors to ensure sharing of resources, in all forms, across the country.

Conclusions

1. Canadian colleges accredit to specific content and educational standards for all disciplines and thus ensure effective standardization of all postgraduate training in Canada. The fact that there is one national college for specialties and one for the specialty of family medicine ensures that educational standards are maintained across

all disciplines. This structure is in stark distinction to other systems (such as in the United Kingdom, Ireland, Australia, New Zealand, and South America) that have separate colleges for each discipline, and where postgraduate medical education is not necessarily linked to universities.

2. Accreditation has been shown to be highly effective in both identifying problems in programs and universities and then being the lever to successfully solve those problems.

3. The Canadian accreditation system is respected internationally, especially as other jurisdictions come to understand our ability to accredit across disciplines, innovate across all programs (such as the CanMEDs initiative), and coordinate nationally. While it is highly regarded however, best practices that could be further explored might include the need for increased public participation; a continuous vs. episodic process and a system that simplifies expectations (example - documentation etc).

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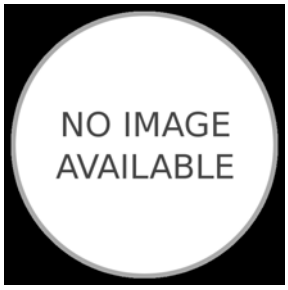
Appendix 1: About the Authors

Margaret Kennedy is the Assistant Director of Accreditation and Liaison at the Royal College of Physicians and Surgeons. Her responsibilities include overseeing the Accreditation process of the College's 60 post graduate medical education residency programs as well as the increasing portfolio of international activities. Her career with the College began in 1986 and in when she accepted a position in the Accreditation Unit of the Office of Training & Evaluation. In 1997 she accepted the position of Manager of the Educational Standards Unit where she remained until she was appointed to the newly created position of Assistant Director, Accreditation and Liaison in 2008.



Paul Rainsberry is the Associate Executive Director for Academic Family Medicine at the CFPC. He holds a Doctorate in Educational Theory from the Ontario Institute for Studies in Education and has worked for over 30 years in medical education at the CFPC. In this capacity he oversees the CFPC Certification Examinations in Family Medicine and Emergency Medicine, postgraduate program accreditation and support for the Section of Teachers of Family Medicine a national association of family medicine educators.

Melissa Kennedy-Hynes, BA, MA Candidate, is the Research Coordinator for the Postgraduate Medical Office, Faculty of Medicine, at the University of Toronto. Melissa's work at PGME involves qualitative and quantitative research, analyzing and interpreting research performance indicators and reporting on outcome measures related to resident evaluation. Melissa's research interests include understanding how residents value of their teaching and learning roles in the postgraduate medical education context.

Erika Abner, LLB LLM PhD, is an Educational Consultant with the Postgraduate Medical Education Office, Faculty of Medicine, University of Toronto. As a legal educator, Dr. Abner has taught at Osgoode Hall Law School, at the Ontario Bar Admission Course, and within law firms as both a consultant and the Director of Continuing Legal Education at a major Canadian law firm. She completed her doctorate from OISE/UT in 2006, researching mentoring in law firms. Her continuing research interests include the transition from school to practice, comparative professions education, and developing expertise in legal writing.

Appendix 2: Annotated Bibliography

Cassie, J., Armbruster, J., Bowmer, M., & Leach, D. (1999). Accreditation of postgraduate medical education in the United States and Canada: a comparison of two systems. *Medical education, 33*(7), 493-498.

This article summarizes the similarities between the systems for accrediting postgraduate medical education in Canada and the United States while also providing a thorough review of the differences. The purpose of both systems is unified in that they work to ensure that resident trainees are being provided with the best quality postgraduate medical education. The article notes that the accreditation system in the United States is more expensive than Canada's and how they are financed comes through membership on varying levels. Additionally, both systems use surveyors; however, each plays a slightly different role. The surveyors in the United States are trained to measure the accuracy of the problem and are not present to consultation conclusions or recommendations. Surveyors in Canada on the other hand are quite active in the process in that they are present to provide consultation and foster learning. The article notes that the two systems continue to make strides to collaborate all the while keeping the best interest of postgraduate medical education at centre of all process and decision.

Karle, H. (2006). Global standards and accreditation in medical education: a view from the WFME. *Academic Medicine, 81*(12), S43.

Physicians are increasingly migrating and moving cross-boarders to gain experience in different countries. The increasing trend of globalization of medicine is also given rise to the development of medical schools worldwide. This situation has recently given rise to the notion that there should be more effective and transparent accreditation standards. This article is based on recommendations from a derived partnership between the World Health Organization (WHO)/World Federation for Medical Education (WFME). Formed in 2004, this partnership had the purpose of providing solutions to the increasing health care delivery needs of the world. Accreditation guidelines are presented in this article, and are noted to be a facilitating driver for providing effective medical education on the continuum through global accreditation standards.

Maniate JM. (2010). Redesigning a resident program evaluation to strengthen the Canadian residency education accreditation system. *Acad Medicine, 85*(7)

This article describes the current picture of accreditation in the postgraduate medical education system in Canada and describes how accreditation in Canada can be improved to foster positive growth in postgraduate medical education training. Through the explanation of how residents currently navigate through the accreditation system in Canada, the author describes a process that was employed to develop, review and disseminate new RPE Feedback was provided at each stage of the process which provided validity in the exercise. These consultations were to ensure both face and content validity of the tools. The notion is that through utilizing this newly developed RPE the perspectives of residents around accreditation will be captured while also allowing opportunity to further educate residents on the importance of accreditation in PGME.