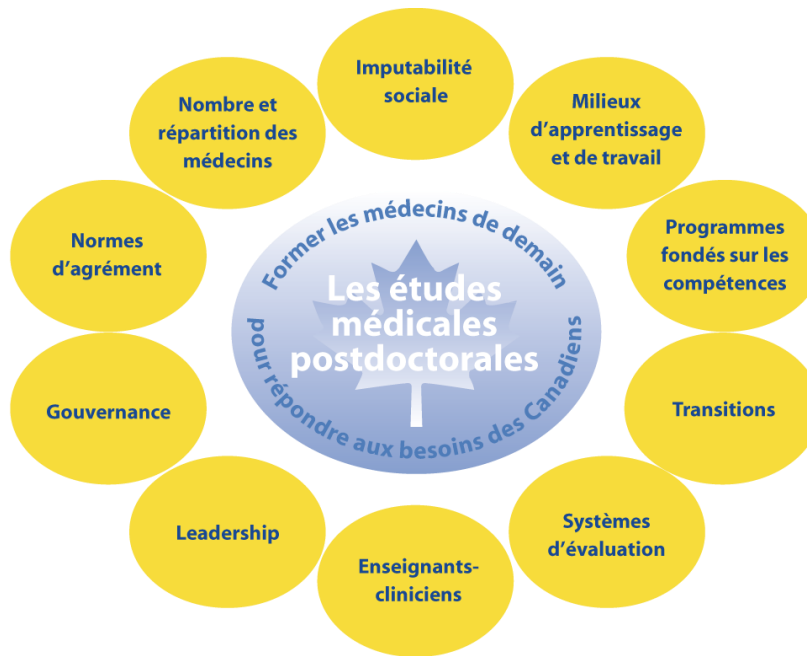


PGME into the Future – A report on FMEC PG Activities



Preamble

Many academic physicians, medical organization representatives, members of the public and learners from across Canada were mobilized to help implement the 10 recommendations in The Future of Medical Education in Canada Postgraduate (FMEC PG) Implementation Project. Implementation was carried out over a period of three years, from 2013 to 2016, funded in part by Health Canada and a consortium of four organizations - the Association of Faculties of Medicine of Canada (AFMC), le Collège des Médecins du Québec (CMQ), the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (Royal College).

The stakeholder groups that have been involved in the project to date, include Accreditation Canada, the Canadian Federation of Medical Students (CFMS), Canadian Medical Association (CMA), the Committee on Accreditation of Canadian Medical Schools (CACMS), the Committee on Accreditation of Continuing Medical Education (CACME), Fédération des médecins résidents du Québec (FMRQ), Fédération médicale étudiante du Québec (FMEQ), Federation of Medical Regulatory Authorities of Canada (FMRAC), HealthCareCAN, the Medical Council of Canada (MCC), Resident Doctors of Canada (RDoC), Postgraduate Deans, Undergraduate Deans, other Deans from CPD, Faculty Affairs, Faculty Development, as well as federal and provincial governments representatives.

A governance structure was set up for the project, with an overarching Strategic Implementation Group (SIG) comprised of representatives from all of the major stakeholder groups and a Management Committee (MC) comprised of representatives from the consortium partners (Dr Geneviève Moineau – AFMC, Dr Anne-Marie MacLellan – CMQ, Drs Pamela Eisener-Parsche and Dr Richard Almond – CFPC & Dr Ken Harris – Royal College), plus a Dean (Dr Jim Rourke), PG Dean (Dr Anurag Saxena), UG Dean (Dr Gary Tithecott) and the Project Lead (Dr Nick Busing). Both of these groups provided strategic leadership for the project and its various implementation committees. Committees and groups were put in place to drive forward implementation of all ten FMEC PG recommendations.

A variety of processes were employed within the committees and working groups. Some groups advanced work in their portfolio using working groups and pilot projects; others conducted extensive environmental scans and literature reviews, while others used expert consultants and conference-type meetings to move forward. The work of the committees and working groups was vetted through the SIG and MC, with the Project Lead providing ongoing strategic leadership for all stakeholders involved in implementation.

Within a socially accountable lens, the FMEC PG Implementation Project strived to keep both societal needs/patient needs and the resident learners at the forefront of its mandate. Collaboration and communication amongst the many stakeholders

involved in postgraduate medical education helped the project reach its intended goals. The support provided by the FMEC PG Project Secretariat was a key facilitating factor throughout the project's implementation. Engagement of experts in specific topic areas helped to ensure the committees and working groups had the right mix of people at the table and the requisite background knowledge and perspectives were involved in the discussions that unfolded. Great advancements have been made in multiple FMEC PG areas, but there is still work to be done to make sure the expectations of FMEC change continue to be embedded into the culture of Canadian medical education. Ongoing collegial collaboration amongst partners and stakeholders, while always keeping the full continuum of medical education in mind, is essential to FMEC PG's long-term success and legacy. Canada already has a world-renowned medical education system - FMEC PG will only add to and enhance the excellence we have built to date.

Recommendation #1 – Ensure the right mix, distribution and number of physicians to meet societal needs

As one of the overarching recommendations of FMEC PG, this recommendation aimed to help the PGME system continually adjust its training programs to respond to the needs of the Canadian population. Forecasting physician resource needs five to ten years into the future is a complex and difficult task, as there are many moving variables involved (changing societal health needs, physician migration both internationally and inter-provincially, meeting the service needs that residents provide in the system, etc.). Implementation of this recommendation has proceeded both within and outside of FMEC PG. To help create a national approach, founded on robust data, to establish and adjust the number and type of specialty positions needed in Canadian residency programs to meet societal needs, the Physician Resource Planning Task Force (PRPTF) was created, supported by the AFMC and the Committee on Health Workforce (CHW). The PRPTF has worked in three main areas to date: developing a collaborative process for addressing physician imbalances across identified specialties, providing accurate information to support decision making by those considering and currently pursuing medical education, both in Canada and abroad,

In June 2012, the Conference of Deputy Ministers of Health directed the Federal/Provincial/Territorial Committee on Health Workforce (CHW) to work with the Association of Faculties of Medicine of Canada (AFMC) to examine ways in which to advance Recommendation One. The resulting Physician Resource Planning Task Force (PRPTF), co-chaired by the province of Ontario (Denise Cole, ADM) and the AFMC (Geneviève Moineau, President and CEO), was established to facilitate the collaboration and coordination of pan-Canadian physician human resources planning in support of Deputy Ministers of Health and Deans of Medicine. Membership includes provincial government representatives from most jurisdictions (many of whom are ADMs), three representatives from AFMC and a representative from CFPC, RC, CMQ, CMA, CFMS, FMEQ, RDoc, FMRO, and CAPER. A Technical Steering Committee, co-chaired by ON and CAPER reports to the PRPTF. Secretariat support is provided by CHW. The specific mandate is focused on three objectives.

Develop a consultative process for collaboration and coordination to address physician imbalances across identified specialties: In November 2015, the PRPTF held a meeting to test the feasibility and requirements of a proposed committee structure. The chosen topic of discussion was the unmatched Canadian medical graduate. The proposed Physician Resource Planning Advisory Committee (PRPAC) was test was successful and was approved by CHW in late February. The committee 2016-17 workplan will address the issue of unmatched Canadian medical graduates through two key foundational principles: 1) there should be adequate undergraduate and postgraduate training capacity to ensure that all graduates of Canadian medical schools have access to post-MD training leading to licensure based on population health need; and, 2) on an individual level, all graduates of Canadian medical schools should be supported on their path to a meaningful clinical or non-clinical career that contributes to the health needs of Canadians.

Lead the development of a pan-Canadian physician planning tool to better inform physician supply and need/demand:

The Conference Board of Canada (CBoC) consulting team is working on continuing development of the pan-Canadian physician supply model and user interface. It will serve as a base model with the ability to generate scenarios for key physician supply variables and project results up to 20 years into the future. The CBOC consulting team will present the supply projection model and prototype outputs to the PRPTF later this spring. The *needs-based* model, however, will provide further information to support workforce planning by projecting the future population health needs and what physician services (i.e. physician mix and distribution) are required to meet those needs. Work on the needs-based tool is expected to begin in November 2016.

Development of products/fact-sheets that provide accurate information to support decision-making by those considering and currently pursuing medical education, both in Canada and abroad:

The AFMC led the development of the Career Counselling Data [Future MD Canada tool](#), in collaboration with the Task Force member organizations. The bilingual tool, aimed at providing accurate information to individuals interested in, or currently in, the medical education system in Canada, is available on the AFMC website. We have received excellent feedback from users particularly pleased with the accuracy of the information and the scope of resources particularly for the medical school aspirant.

Within FMEC PG, a small group of experts, led by Dr Michael Strong, Dean at the Schulich School of Medicine and Dentistry, has worked to establish a national plan to address the training and sustainability of clinician scientists. A consensus conference was held in February 2016, with approximately 50 attendees from across Canada and around the world. A series of recommendations have been developed coming out of the conference, which will state at a high level that we need a national integrated strategy to ensure the robustness of the next generation of health care practitioners who will become clinician scientists. There will be a recommendation about creating an independent federally-sponsored national council to develop a strategy to establish standards and leverage opportunities and partnerships. A national strategy for funding training programs for clinician scientists at all levels will be proposed. The challenge will be how to gain support for the report coming out of the conference, as other reports on this issue have failed to gain traction in the past.

Recommendation #2: Cultivate social accountability through experience in diverse learning and work environments

Social accountability is the major lens through which all of the FMEC PG recommendations must be implemented. Both individual physicians and medical schools must continue to keep the needs of the communities they serve in mind when planning the educational experience of residents. Efforts on this recommendation have focused on developing practical ways to implement social accountability across the country, in which the Deans of Medicine will play a key role. A Committee

chaired by Drs Jim Rourke and Roger Strasser developed A Best Practices guide entitled *FMEC PG Guide to Improved Social Accountability in Medical Schools* based on a survey of Canadian program directors about the extent to which social accountability principles and actions are embedded in their residency programs. The guide has been widely disseminated, and is not meant to be prescriptive in nature, but rather to make helpful suggestions for strategies and specific activities medical schools and residency programs can engage in to increase their social accountability footprint. The social accountability groups of FMEC PG and the AFMC have also joined forces and initiated two significant initiatives. The first is a half-day symposium at CCME 2016 that will be devoted to social accountability. The two groups are also collaborating on having a discussion with the Royal College, CFPC, and CMQ about embedding social accountability into their revised accreditation standards. The AFMC's Social Accountability Group will help keep social accountability moving forward as the FMEC PG project is sunset, and a request has been made to the PGME Governance Council to receive annual updates from the 17 medical schools regarding their progress.

Recommendation #3: Create positive and supportive learning and work environments

Led by Drs Jill Konkin and Chris Watling, the FMEC PG Learning and Work Environments Committee has made significant progress on a number of recommendations in the report—in particular, conversations have been had around the hidden curriculum and a letter has been sent out to the PG Accrediting bodies recommending changes/additions to the standards all programs must meet. Programs are being asked to demonstrate that they are working to identify the positive and negative elements of their hidden curriculum and to support the positive effects and mitigate the negative ones. A second major focus has been on interprofessional education (IPE) as it relates to medical residents. Efforts have focused on identifying who residents' educational counterparts are in hospital and other clinical settings, and how to ensure that they are part of the conversations and decision making about the systems they work in. Experiential learning is crucial and needs to go beyond the clinical knowledge base and patient-care activities to decisions around how the system works. Significant inquiry has been made into the patient-centred care curriculum, and efforts are being made to connect the quality and safety conversation to that piece. Although members of the group have expressed interest in and a willingness to continue their efforts beyond the end of the project, there needs to be leadership beyond that to institute a national initiative around curriculum resources. This particular recommendation has been challenging to tackle at times, as it encompasses such a diverse range of topics and is about culture change. There has been interest expressed by some committee members in continuing their efforts into the future and reporting to the PGME Collaborative Governance Council.

Recommendation #4: Integrate competency-based curricula in postgraduate programs

The FMEC PG process lent support to the initiatives of the College of Family Physicians of Canada and The Royal College as they moved forward with plans to bring in competency based medical education, with leadership from Dr Ken Harris & Dr Pamela Eisener-Parsche and Dr Richard Almond.

CFPC's Triple-C program is at various stages of implementation in all 17 schools, 16 of which are starting to provide results from the longitudinal survey of residents at entry, exit, and three years into practice. This will provide some important information on the impact of the curriculum on their practice. To get a better qualitative understanding of the impact of the competency-based curriculum, a project is also being initiated using focus groups. The Royal College is implementing CBME throughout all speciality programs and medical schools in Canada via an initiative called Competence by Design (CBD). Furthermore, under Fundamental Innovation in Residency Education approval by the Royal College, Queen's University has started the transition to competency-based medical education in all of its residency programs and in postgraduate medical education. To support a staged adoption of CBD, all specialties and subspecialties in Canada have been grouped into Cohorts. Each year (continuing until 2022) the disciplines in a Cohort group will work with the Royal College to develop and adopt CBD practices in all their programs across the country. The original Cohort One disciplines – Medical Oncology and Otolaryngology – Head and Neck Surgery – have already developed their competency documents. In 2016, these two disciplines will focus on field testing aspects of CBD. The Royal College will also establish a national advisory committee composed of key partners and, in collaboration with the PG Deans and others, launch a number of working groups to look at areas requiring more discussion. Work has already begun on creating a management action plan to refine the roadmap, and the co-chairs of the working groups have been determined; plans are to populate the groups and to work through teleconferencing. Work will also be undertaken to support a national collaboration looking at practice-ready assessment and basic competencies for entering into practice, with minimum competencies already developed for family medicine and psychiatry. Developing potential tools for observation in practice is another important part of this work, which may also include the creation of a train-the-trainer material. Along with these activities, the Royal College is continuing to work with various specialties in developing the above mentioned roadmap, a glossary of CBD/CBME terms, messaging and FAQs focused on the CBD rationale and more information about competency-based assessment practices. The need for faculty support is acknowledged and is being developed. They are also continuing to collaborate with the disciplines scheduled in the [remaining cohorts](#) to prepare and fine-tune CBD adoption.

Recommendation #5: Ensure effective integration and transitions along the educational continuum

One of the major recommendations of FMEC PG, the Transitions Implementation Committee advanced implementation of the transition action items with a very engaged set of co-chairs, Drs Jay Rosenfield and Kam Rungta, who created three

working groups and initiated some transformative projects under three main areas of transition: from medical school to residency; career planning and residency matching process, and from residency to practice.

With leadership from Drs Andrew Warren and Bruce Wright, the Transition from Medical School to Residency Working Group moved forward with four specific pilot projects.

The Learner Education Handover Project, led by Dr Leslie Nickell is progressing well and will be piloted later this year. This is an important project that is tackling the critical issue of the transmission of relevant information regarding a learner from one stage of learning to another, in a manner that reflects the privacy concerns of the individual while providing the information that is essential to help learners move forward. There is ongoing support in place for the Learner Education Handover Project from the AFMC.

The AFMC has funded the go-forward for the project on entrustable professional activities (EPAs), which is being managed by Dr Claire Touchie from the Medical Council of Canada and Dr Andrée Boucher from AFMC. The group—which has representation from a broad range of stakeholders, including residents—has already presented its 12 draft AFMC EPAs to both the UG and PG deans and made modifications as a result of their feedback. The document has been sent to the curriculum committees of all of the medical schools for review and has developed good traction. Next steps include presentation and potential adoption of the AFMC EPAs by the Deans at CCME 2016.

Two other pilot projects under the Medical School to Residency Working Group have evolved to be tools that any school will be able to eventually use in their local context. The first is a Post-Match Boot Camp, led by Drs Brock Vair and Andrew Warren, for final year medical students to hone their skills that will be needed at the start of residency. The second is a Simulated Night On-Call program, led by Drs Alison Walzak and Bruce Wright, which will allow final year medical students to work through a variety of scenarios they may encounter their first night on call, to lessen their anxiety and better prepare them for the clinical responsibilities of being a resident.

With leadership from Drs Tony Sanfilippo and Anurag Saxena, the Career Planning and Residency Matching Process Working Group developed two main pilot projects, and began discussions about potential changes to the entry-into-residency system. The Best Practices in Applications and Selection report, prepared by a working group at the University of Toronto chaired by Dr Glen Bandiera, has been validated through a survey of program directors across Canada, three-quarters of whom have endorsed 19 of its 24 recommendations as something they should be doing. Plans are to arrive at a final list of best practices for a national document and then begin work on a strategy to address gaps. Although issues around transparency and documentation record-keeping remain a challenge, there is optimism that national alignment can be achieved. It has been noted that this topic is of high importance to the Deans, who would be very supportive in implementing the recommendations. Dr. Bandiera will be presenting this project to the PG Deans at CCME 2016.

Dr Kelly Howse from Queen's University developed, in consultation with colleagues from across the country, a document on career services standards for medical learners. The document has been disseminated widely and a workshop is being held by Dr Howse at CCME 2016 to further promote the document and increase awareness about the need for standards in this area across the country.

Dr Ken Harris and the Royal College have undertaken to support a small task force of representatives from various constituencies to look at the issue of entry-level disciplines—focusing first on defining the problem and second, on potential solutions. The group had its first meeting at the start of April 2016 and the Resident Doctors of Canada (RDoC) position paper on this topic was a major item of discussion.

Dr Mark Walton and Dr Ivy Oandasan stepped in half-way through the project as co-chairs for the Transition from Residency to Practice Working. The group was reconstituted and broken into two main subgroups—one investigated practice management curriculum components, the other looked at mentorship and resiliency training—to harvest ideas from early-practice physicians, students, and residents on gaps in these areas. Plans have been made to link with initiatives directed by FMEC CPD and by Resident Doctors of Canada to continue to work together to further develop resources for practice management, mentorship and resiliency.

Recommendation #6: Implement Effective Assessment Systems

With leadership from Dr Ian Bowmer (MCC), Dr Ken Harris (Royal College) and Drs Pamela Eisener-Parsche and Richard Almond (CFPC) Initiatives to expand assessment strategies to support the implementation of CBME are being undertaken by CFPC and the Royal College. The Medical Council of Canada is in the early stages of looking at programmatic assessment as a way forward that would also be supportive of CBME.

Recommendation #7: Develop, support and recognize clinical teachers

Clinical teachers are becoming an increasingly important facet of the Canadian medical education community, as more and more residency education moves out of the academic hospitals and into distributed medical education sites and community settings. Ensuring that our clinical teachers are fully supported and integrated into the PGME system will help improve the overall quality of the educational experience for residents. The FMEC PG Clinical Teachers Implementation Committee initially chaired by Dr Geneviève Moineau, and subsequently by Dr Andrée Boucher, has focused on four main areas during its existence.

Led by Drs John Steeves and Nick Busing, suggestions and explicit recommendations relating to clinical teachers were made for inclusion in the new revised and realigned postgraduate accreditation standards currently being developed by the Royal College, CFPC, and CMQ working groups. These recommendations were received by the leads of the Three Colleges working groups and we expect to see our suggestions included in the new PG standards when they are released and rolled out.

Led by Drs Andrée Boucher and Margaret Steele, the Committee began the process of developing a repository of tools and resources for clinical teachers. Only a few items were identified for the repository. The AFMC Faculty Development Committee has expressed an interest in taking over the work on further developing this repository and identifying the platform to house such resources. With the launch of CHEC 2.0 in April 2016, it is hoped that this will be the chosen platform, but leave that decision in the capable hands of our colleagues on this committee. Any information on resources we have been able to collect to date will be transferred over to the Chair of this committee.

Led by Drs Miriam Boillat and Michael Jong, with further consultation from Dr. Ivy Oandasan from the CFPC, The Fundamental Teaching Activities (FTA) framework developed by the CFPC has been endorsed by FMEC PG. The CFPC continues to hold sessions on how to use the FTA framework, focused on Family Medicine faculty developers. The CFPC has invited other medical education organizations to participate in these sessions and hopes to gain the perspectives of these stakeholders on using the FTA Framework. A workshop on implementing the FTA has been submitted to ICRE 2016. The CFPC is open to developing sessions with other groups of medical educators and they feel that these earlier sessions will help working with those outside the CFPC. To this end, the CFPC's new Faculty Development Sub-committee will be happy to look for future opportunities.

FMEC PG has encouraged the Royal College to take this framework into consideration and think about how it could be adapted to Royal College disciplines as well.

Dr Dave Davis is working closely with Dr Boucher to develop a position paper on the topic of governance in Faculty Development/CPD, which will speak to the current state of these two groups, compare and contrast the Canadian and American landscape in this realm, while highlighting research and study findings. Their aim is to complete this paper by summer of 2016.

Recommendation #8: Foster leadership development

Led by AFMC VP – Education Dr Andrée Boucher and Dr David Keegan (University of Calgary), the FMEC PG Leadership Implementation Committee has made great attempts to develop a repository of useful tools and resources for leadership competency training in medical residents. Efforts have not yet resulted in the development of a national, core leadership

curriculum for all residents, but there has been good progress made on this recommendation, including the inclusion of leadership in both the UG and PG accreditation standards and the CanMEDS 2015 Leader framework. The Can Meds leader role has been helpful in addressing some of the issues identified by the FMEC PG project. Although individual schools and programs want to shape things in their own way, the national initiatives will ensure that educational activities support the development of professional and leadership skills in future physicians. Dr. Boucher has recruited Drs. David Keegan and Ming-Ka Chan to be the leads in the development of a repository of leadership tools. An online repository of leadership courses, tools and other resources is being discussed. This work is in its early phase and they are looking at a joint governance structure for the repository's ongoing management.

Recommendation #9: Establish effective collaborative governance in PGME

One of three recommendations (along with the recommendation on Transitions and the recommendation on Accreditation) specifically funded by Health Canada for implementation, Recommendation #9 sought to integrate the multiple bodies (regulatory and certifying colleges, educational and healthcare institutions etc.) that play a role in PGME into a collaborative governance structure in order to achieve efficiency, reduce redundancy, and provide clarity on strategic directions and decisions. The FMEC PG Governance Implementation Committee, chaired by Dr Carol Herbert with co-leadership from Dr Nick Busing, met regularly for face-to-face meetings over the course of the FMEC PG Project, and successfully created Terms of Reference, a Memorandum of Understanding and a Business Case for the proposed structure.

The chosen structure, the Postgraduate Medical Education Collaborative Governance Council (PGME GC), has been formed and had its first "trial" meeting on January 25, 2016, with its official launch on April 1, 2016. The council's membership, terms of reference, and memorandum of understanding between the parties involved have been completed, and its secretariat will be funded on a part-time basis by eight organizations, the majority of which have committed for three years of funding. The first meeting was particularly focused on the application of the consensus model for decision making. While the council is not in a position to make binding decisions on behalf of the organizations around the table, its intent is to seek consensus from those organizations on the recommendations made. These recommendations will then be taken back to the stakeholder organizations involved for ratification. The trial meeting also allowed for a nominating committee to be struck, to create short lists for both a Council Chair and a public member. The council reviewed its membership and decided that its current roster of permanent members and observers should not change for at least two years. Branding issues such as letterhead and web address were discussed. The council will ensure that there are ongoing communications with the CMF and PRPTF to align activities and avoid any duplication of work. Two significant issues were selected for discussion at the trial meeting, based on extensive input and consultation: communication and privacy of learner information, and generalism and the need for

generalists. The meeting was structured around presentations from key players, from which focused discussions took place on how to collectively move the issues forward.

In addition to tackling issues that are difficult and cross-jurisdictional and that need thoughtful input and collective decision, input on the Council's role in the implementation of the FMEC PG recommendations was a key discussion point at the trial meeting. The Council agreed with acting in an advisory capacity for Recommendation #2 (Social Accountability), Recommendation #3 (The learning and work environment), parts of Recommendation #5 (Transitions), and Recommendation #10 (Accreditation Alignment). While one of the Council's principles highlights that PGME is part of a continuum, its position is that it will focus only on issues facing PGME at this time.

Recommendation #10: Align accreditation standards

The FMEC PG Accreditation Implementation Committee (AIC) was another one of the major FMEC PG recommendations, holding regular in-person meetings. Four co-chairs from the Consortium partners led the implementation activities; Dr Geneviève Moineau (AFMC), Dr Anne-Marie MacLellan (CMQ), Dr Louise Nasmith (CFPC) and Dr Jason Frank (Royal College). The activities of this Committee have been taking place while the 3 Colleges that accredit Postgraduate medical education have been aligning their standards, processes and data requirements amongst themselves. The challenge is to further align these PG initiatives with UG and CPD accreditation systems.

The following summary of work provides a snapshot of what has been accomplished to date and areas where the committee will focus their efforts in the future.

Six domains for grouping standards have been agreed upon by all the Canadian accrediting bodies and are currently being used to realign all the existing standards. The domains are:

- 1) Governance: (mission, vision and values)
- 2) Organization (structure, administration)
- 3) Continuous improvement (program evaluation)
- 4) Education Program (learning objectives, academic, assessment of students, outcomes)
- 5) Learners, Teachers and Administrative Personnel ("people" – policies for safety, well-being, faculty development)
- 6) Resources (money, infrastructure)

An extensive mapping exercise was completed of accreditation processes and data elements, with the goal of aligning common processes across organizations/committees and reducing the financial and human resource burden that accreditation poses to the Faculties of Medicine. Potential areas of alignment have been identified in the areas of terminology/language, the length of the accreditation cycle, and accreditation status & appeals. Small working groups have been constituted to investigate many of these areas and plan to bring their recommendations to the last committee meeting

for final decision. The committee has already agreed to adopt the term 'self-study' across the medical education continuum, in lieu of 'pre-survey questionnaire', and there is strong support for all organizations/committees to start using an 8-year accreditation cycle, with regular internal reviews and a focus on continuous quality improvement.

Although data requirements vary across the continuum (UGME, PGME, CPD), similarities and commonalities do exist in the data being requested of medical schools, and there is the potential to streamline certain data and reduce the burden on both medical schools and accrediting bodies. Representatives from various organizations did a systematic review of data collected by the Committee on the Accreditation of Canadian Medical Schools (CACMS) to ensure that PG and CPD were not asking duplicate questions. These common data elements could be accessed via a shared Accreditation Management System (AMS), which is currently being discussed by stakeholders with a vested interest in finding a common platform. Detailed and focused discussions are required amongst the accrediting bodies and their sponsors to properly prepare for a shared accreditation management system (AMS). Cost considerations dictate that all stakeholders should work together to have their precise requirements and aligned processes mapped out before embarking on a shared AMS.

A paradigm shift towards more outcomes-based accreditation, with ongoing but less emphasis on accreditation processes is also in its infancy.

The three colleges have established a consortium called CANRAC (the Canadian Residency Accreditation Consortium). There will be an integration committee meeting at the end of April 2016 where they will be moving ahead with the content of the six domains with a CQI perspective. It is hoped that the spirit of collaboration between all accrediting bodies and their sponsoring organizations will continue beyond the end of the FMEC PG Implementation Project.

There is strong commitment from the invested stakeholders to continue the important work related to alignment of accreditation processes and a shared Accreditation Management System (AMS) beyond the end point of the FMEC PG project. It was noted that, with all of the players working together well, Accreditation related decisions could be referred to the PGME Governance Council only if major roadblocks in moving forward were identified.

Conclusions

The Implementation activities of the FMEC PG project recommendations have truly demonstrated the shared vision for PGME in Canada. Furthermore, the activities have highlighted the impressive benefits of collaboration, working together, seeking common solutions, and the critical importance of always focusing on the social accountability responsibilities of the schools, teachers and learners.