WONCA GLOBAL STANDARDS FOR POSTGRADUATE FAMILY MEDICINE EDUCATION

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The following document is an adaptation of the Postgraduate Medical Education World Federation for Medical Education (WFME) Global Standards for Quality Improvement. It may be helpful to review the original document, available at http://www.wfme.org/. The standards have been modified to fit the requirements of family medicine training specifically, as the World Federation for Medical Education standards deal with postgraduate training in general. Specific content areas and training sites relevant to Family Medicine are therefore included in the WONCA standards. These standards have been developed over several years, and at both world and regional meetings of WONCA.

The term family medicine is used in this document to define the discipline: however, general practice, family practice and primary care are also appropriate terms that are used in some settings for this profession. It is the standards that are important rather than the terms that are being used. The nature of the discipline is one which is based in the community which it serves and fundamentally is relationship based care that endures over place and time, regardless of which of the terms are used to describe it. Family Medicine is a discipline that provides long-term person-centred and comprehensive care and continuing care, from pre-natal to palliative care, across all ages and in all settings**.**

History

In 1998, the World Federation for Medical Education (WFME) launched a program on *International Standards in Medical Education.* The purpose was to provide a mechanism for quality improvement in medical education, in a global context, to be applied by institutions responsible for medical education, and in programs throughout the continuum of medical education. This project, approved by the World

Health Organization (WHO) and the World Medical Association (WMA), has three main intentions:

• to stimulate authorities, organizations and institutions having responsibility for medical education to formulate their own plans for change and for quality improvement in accordance with international recommendations;

• to establish a system of national and/or international evaluation and recognition of medical educational institutions and programs to assure minimum quality standards for the programs;

• to safeguard practice in medicine and medical human resource utilization, under conditions of increasing internationalization, by specifying well defined international standards in medical education.

Medical educationalists from around the globe developed WFME global standards for basic medical education, postgraduate medical education and continuing professional development, all published in 2003. The WFME, conjointly with the World Health Organization has also published conjoint guidelines for accreditation of basic medical education programs. Because these standards were developed through a rigorous process and are global in nature and in development, they provide an excellent framework for the family medicine-specific educational standards developed by the WONCA Working Party on Education (WWPE), beginning in 2006. In May 2012, the WWPE was given permission to adapt the WFME standards as a template for the development of standards in Family Medicine Education. This document represents the standards developed by the WWPE for postgraduate family medicine education, and is based on the WFME global standards.

Use Of The Standards

These global standards may be used in a variety of ways, always with the overall goal of quality improvement in Family Medicine Postgraduate Education. Because these standards are intended to be used globally, and in the very diverse contexts in which family medicine is practiced, they are necessarily quite broad in nature. It is intended that they be adapted for the local environment and to meet community needs. Programs might use these standards for:

- Self assessment and program quality improvement
- New program development
- Peer review
- Recognition and accreditation

Compliance with these standards cannot provide recognition of credentials or reciprocity between jurisdictions, as licensure and credentialing is outside the purview of WONCA.

Definitions

Postgraduate Medical Education may be defined as the phase in which doctors train under supervision towards independent practice after completion of their basic medical qualification. It comprises pre-registration training; vocational/professional training; specialist and sub-specialist training; and other formalized training programs. Upon completion of a formal postgraduate training program a degree, diploma or certificate is usually granted.

Although Postgraduate Medical Education is a time limited phase of medical education it cannot be clearly separated from Continuing Medical Education (CME) or Continuing Professional Development (CPD)[1]. These are carried out during the entire professional life after graduation from the medical school and are characterized by self-directed learning and rarely involve supervised training for extended periods of time.

Many terms are used for physicians receiving postgraduate training. In this document, we use the term “trainee” primarily. In some contexts, this person may be referred to as a registrar, a resident, or a doctor-in-training. Similarly, there are many terms for those who teach or instruct trainees: trainer, supervisor, teacher, instructor, and mentor. This document preferentially uses the term “trainer” to indicate a teacher providing clinical teaching to a trainee and “mentor” for the person guiding and counselling the trainee. It is recognized that these two roles often overlap and are provided by the same individual.

The WFME recommends the following set of global standards in postgraduate medical education structured according to **9 areas** and **38 sub-areas**.[2]

AREAS defined as broad components in the structure, process and outcome of postgraduate medical education and training cover:

1. Mission and Outcomes
2. Training Process
3. Assessment of Trainees
4. Trainees
5. Staffing
6. Training Settings and Educational Resources
7. Evaluation of Training Process
8. Governance and Administration
9. Continuous Renewal

SUB-AREAS are defined as specific aspects of an area, corresponding to performance indicators.

STANDARDS are specified for each sub-area using two levels of attainment:

• **Basic standard**. This means that the standard must be met and fulfilment demonstrated during evaluation of the training program.

*Basic standards are viewed as essential and expressed by a "**must**".*

• **Standard for quality development.** This means that the standard is in accordance with international consensus about best practice for postgraduate medical education. Fulfillment of - or initiatives to fulfill - some or all of such standards should be documented. Fulfillment of these standards will vary with the stage and development of the training program, its resources, the educational policy and other local conditions influencing relevance and priorities. Even the most advanced programs might not comply with all standards.

*Standards for quality development are viewed as desirable and expressed by a "**should**".*

ANNOTATIONS are used to clarify, amplify or exemplify expressions in the standards.

[1] CPD refers to the continuing development of the multi-faceted competencies inherent in medical practice and drawn from various domains of knowledge and skills (e.g. medical, managerial, social, personal) needed for high-quality professional performance. Although often used to designate the period commencing after completion of postgraduate training, it is evident that CPD is a much more far-reaching activity. The shaping, reshaping and development of a professional - responding to changing societal and individual needs within the context of the evolution of medical science and health care delivery – is a life-long continuing process, starting when the student is admitted to medical school and on-going as long as the doctor is engaged in professional activities.

[2] WFME and WWPE are aware of the complex interactions and links between the various areas and sub-areas.

1. Mission And Outcomes

1.1 Statements Of Mission And Outcomes

Basic Standard:

The competent authorities **must** define, in consultation with professional organizations, including one specifically dedicated to family medicine and/or primary care, the mission and outcome objectives for family medicine postgraduate medical training and make them known.

The statements of mission and outcomes **must** describe the practice - based training process resulting in a family doctor competent to undertake comprehensive up-to-date family practice in a professional manner, unsupervised and independently or within a team, in keeping with the needs of the health care system.

Quality development:

The mission and outcome objectives **should** encourage appropriate innovation in the training process and allow for development of broader competencies than minimally required and constantly strive to improve patient care that is appropriate, effective and compassionate in dealing with health problems and promotion of health, in the context of the continuing and comprehensive care of patients. The training **should** encourage family medicine trainees to become scholars within family medicine and **should** prepare them for lifelong, self-directed learning and readiness for continuing medical education and professional development.

Annotations:

• *Statements of mission and outcomes* would include general and specific issues in family medicine relevant to national and regional policy.

• *Competent authorities* would include local and national bodies involved in regulation of postgraduate medical training, and could be a national governmental agency, a national board, a university, a competent professional organization or a combination.

• *Types of postgraduate medical training* would include pre-registration training, systematic vocational training, specialist training and other formalised training for expertise in family medicine, leading to recognition as a specialist in Family Medicine, or equivalent in physician's context.

• *Scholar* refers to deeper and/or broader engagement in the development of the discipline, including responsibility for education, development, research, management, etc.

1.2 Participation In The Formulation Of Mission And Outcomes

Basic standard:

The statement of mission and outcomes of postgraduate training **must** be defined and adopted by its principal stakeholders.

Quality development:

Formulation of mission and outcomes statements **should** be based on input from a wider range of stakeholders.

Annotations:

• *Principal stakeholders* would include family medicine program directors, family physicians' scientific societies, and trainees in family medicine, as well as appropriate governmental authorities, professional associations and other organizations, and patients.

• *A wider range of stakeholders* would include representation of supervisors, trainers, teachers, other health professions, patients, the community, organizations of family physicians and health care authorities.

1.3 Professionalism And Autonomy

Basic standard:

The training process **must**, based on approved basic medical education, further strengthen professionalism of a family physician.

The training **must** foster professional autonomy to enable the doctor to act in the best interests of the patient, bearing in mind the impact any such advice and/or treatment, if followed, might be perceived or received by the community in which the patient lives and/or works.

Annotation:

- *Professionalism* describes the knowledge, skills, attitudes and behaviours expected by patients and society from individuals during the practice of their profession and includes concepts such as skills of lifelong learning and maintenance of competence, information literacy, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice and respect for others.

1.4 Training Outcomes

Basic standard:

The relevant competent authorities **must,** in consultation with the family medicine and other appropriate professional organizations, as defined in 1.1, define the competencies, which must be achieved by family medicine trainees as a result of the training programs.

Quality development:

Both broad and specific competencies to be acquired by trainees **should** be specified and linked with, and build upon, the competencies acquired as a result of basic medical education.

Measures of competencies achieved by trainees **should** be used as feedback for program development.

Annotation:

Competencies can be defined in broad professional terms or as an observable ability integrating such components as knowledge, skills, attitudes and behaviours. Competencies relevant for postgraduate training would, for family medicine, include the following areas:

- Provision of long-term person focused (not disease-oriented) care that is appropriate, safe, effective and compassionate for dealing with a comprehensive range of health problems across the spectrum from health promotion and disease prevention, through acute and chronic disease management, as well as rehabilitation and palliation and end of life care. These problems may represent the entry into

the health care system, and may present in an undifferentiated fashion. Often a single patient has multiple problems requiring simultaneous management over time. A proactive promotion of well being and both systematic and opportunistic prevention and screening approaches are also required.

- Medical knowledge in the basic biomedical, clinical, behavioural sciences, medical ethics and medical jurisprudence, and the application of such knowledge in patient care
- Interpersonal and communication skills that ensure effective information exchange with individual patients and their families and teamwork with other health professions, the scientific community and the public. This should include the acquisition of the competencies of patient centered care, relationship centered care, or similar concepts.
- Life long learning, including the appraisal and utilization of new scientific knowledge to continuously update and improve clinical practice
- Function as supervisor, trainer and teacher in relation to colleagues, medical students and other health professions
- Capability to be a scholar contributing to development and research in the chosen field of medicine
- Professionalism, committed to the health of patients and community, through ethical practice, and high personal standards of behavior. This includes willingness to acknowledge error and deal with its consequences.
- Knowledge of public health and health policy issues and awareness and responsiveness to the larger context of the health care system, including for example the organization and integration of health care, partnership with health care providers and managers, practice of cost-effective health care, health economics, and resource allocations
- Ability to understand health care, and identify and carry out system-based improvement of care.
- Ability to collaborate with other members of the health care team, as well as with patients, both as individuals and as families.
- Interest and ability to act as an advocate for the patient and community
- Being community-based with a sense of social accountability: understanding the health status and needs of the community served in order to develop and provide appropriate services. This includes taking into account the incidence and prevalence of diseases in the community and psychosocial problems including those pertaining to women and children in approaching health care problems

2. Training Process

2.1 Learning Approaches

Basic standard:

Postgraduate medical training **must** follow a systematic family medicine training program. The training **must** be practice – based, in the context within which family medicine is currently delivered, and involve the personal participation of the trainee in the service and responsibility of patient care activities in the training sites. These sites must encompass the variety of patients seen in the local family practice context, based in the community as appropriate, with the family physicians taking the primary role in supervision and teaching. The training program **must** encompass and integrate reflective observation, theoretical concepts, active participation and practical experiences.

The training **must** be directed by an overall program and the trainee guided through supervision and regular appraisal and feedback. The training process **must** ensure an increasing degree of independent responsibility as skills, knowledge and experience grow.

Quality development:

Postgraduate medical training **should** interface with basic medical education and continuing medical education/professional development.

Every trainee **should** have access to educational counselling and support.

Annotations:

• *Educational counselling and support* would include access to designated trainers or mentors.

2.2 Scientific Methods

Basic standard:

The trainee **must** achieve knowledge of the scientific basis and methods of family medicine, and through exposure to a broad range of relevant clinical/practical experience in different settings appropriate to family medicine, become familiar with evidence-based medicine and critical clinical decision-making specific for the care of family medicine patients.

Quality development:

In the training process the trainee **should** have formal teaching about information management skills, including critical appraisal of literature, quality improvement, scientific data and evidence-based medicine, and be exposed to research.

Annotation:

• Training in scientific basis and methods may include the use of elective research projects to be conducted by trainees

2.3 Training Content

Basic standard:

The training process **must** include the practical clinical work and relevant theory of the basic biomedical, clinical, behavioural and social sciences; primary care clinical decision-making individualized to each patient; communication skills, medical ethics, quality improvement processes, public health policy, medical jurisprudence and managerial disciplines required to demonstrate professional practice in family medicine.

For the development of an effective family physician, education in the primary care setting is fundamental, although supplemental experiences in secondary and tertiary settings, particularly where family physicians provide care, or where they refer, may be very useful. At least 50% of postgraduate training time should be in family medicine settings, with family physicians as lead teachers and trainers.

Note:

While it may be necessary to supplement trainee experience with clinical placements outside of family medicine in order to ensure adequate exposure to the full range of experiences required of family physicians, the learning objectives must be those of family medicine.

The following components **must** be included in the program (*see also section 1.4):

- Provision of service to patients across the continuum of health promotion, disease prevention, acute/emergency, chronic, rehabilitative, and palliative care.
- Provision of care across the spectrum of patients (all ages from birth to death, all genders, and with the variety of problems seen in family medicine), with experience in an adequate patient base to experience this diversity in adequate volume for learning and to attain required competencies. This includes assessment, diagnosis, and appropriate management at levels appropriate to the setting, both medical and surgical/procedural.
- The experience of continuity of care – responsibility for a group of patients over time with an appropriate attitude towards the establishment of enduring relationships and ongoing commitment to patients over time, place, and state of health.
- Skills for dealing with undifferentiated patient care problems, such as decision making in the face of uncertainty, and management of the many variables in multisystem disease
- Skill in dealing with the psychosocial and cultural aspects of health care with specific academic programming as well as clinical experiences directed towards learning in this area.
- Communication skills in general, including specific interviewing skills such as dealing with difficult encounters with patients and families, communicating uncertainty to patients, and the ability to engage the patient in decision-making.
- Knowledge and understanding of the doctor patient relationship, including issues of appropriate boundaries and issues of intimacy and power dynamics in that relationship
- The appropriate use of medical records and communication with other health care providers
- Knowledge of bioethics, and understanding of a framework for bioethics, with ability to apply it in the

clinical decision making process.
- Familiarity with medical legal issues relevant to their own setting
- An understanding of quality assurance as applied to family practice, with skills to assess the performance of some aspects of care delivered by the practitioner personally.
- Basic understanding of community medicine/public health, including an understanding of the non-biologic determinants of health and the impact of these on patients seen and the community served.
- An understanding of the concepts of health promotion and disease prevention, with an ability to actively engage in these dimensions of care in the practice setting
- Knowledge of the health care system, including use of community resources in providing care to patients where the family physician functions as the coordinator of such care.

Quality development:

The training process **should** ensure development of knowledge, skills, attitudes and personal attributes in the roles as family medicine expert, health advocate, communicator,

collaborator and team-worker, scholar, administrator and manager, and professional.

2.4 Training Structure, Composition And Duration

Basic standard:

The overall composition, structure and duration of training and professional development **must** be described with clear definition of goals and expected task-based outcomes and explanation of their relationship to basic medical education and health care delivery. Components that are compulsory and optional **must** be clearly stated.

Quality development:

Integration of practice and theory **should** be ensured in the training process.

Annotations:

• *Structure of training* refers to the overall sequence of attachment to the training settings and responsibility of the doctor and not the details of the training experiences.

• *Integration of practice and theory* would include didactic learningsessions and supervised patient care experiences.

2.5 The Relationship Between Training And Service

Basic standard:

The apprenticeship nature of professional development **must** be described and respected and the integration between training and service (on-the-job training) **must** be assured through formal agreements.

Trainees **must** have assigned supervision to guide learning during their service activities.

Quality development:

The capacity of the health care system **should** be effectively utilised for service based training purposes.

The training provided **should** be complementary and not subordinated to service demands.

Trainees **should** have a permanent family physician advisor throughout the training program to provide career guidance and mentorship.

Annotations:

• *Integration between training and service* implies on one hand delivery of proper health care service by the trainees and on the other hand that learning opportunities are embedded in service functions.

• *Effective utilization* refers to optimising the use of different clinical settings, patients and clinical problems for training purposes, and at the same time respecting service functions.

2.6 Management Of Training

Basic standard:

The responsibility and authority for organizing, coordinating, managing and assessing the individual training setting and the training process must be clearly identified.

Coordinated training within family medicine **must** be ensured to gain exposure to different clinical and management areas of the discipline.

Quality development:

The authority responsible for the training program **should** be provided with resources for planning and implementing methods for training, assessment of trainees and innovations of the training program.

There **should** be representation of family medicine education experts, trainees and other relevant stakeholders in the planning of the training program.

Annotation:

• *Other relevant stakeholders* could include other participants in the training process, representatives of other health professions and health authorities

3. Assessment

3.1 Assessment Methods

Basic standard:

Postgraduate medical training **must** include a process of and the competent authorities **must** define and state the methods used for assessment of trainees, including the criteria for passing final examinations and other types of assessment. Assessment **must** emphasize formative in-training methods and constructive feedback.

Quality development:

The reliability and validity of assessment methods **should** be documented and evaluated and the use of external family medicine specialist examiners **should** be encouraged. A complementary set of assessment method **should** be applied. The different stages of training acquisition and formative assessments **should** be recorded in a training log-book/portfolio. An appeal mechanism concerning assessment results **should** be established and, when necessary, second opinion, change of trainer/supervisor or supplementary training **should** be arranged.

Annotations:

• The *definition of methods used for assessment* may include consideration of the balance between formative and summative assessment, the number of examinations and other tests, the balance between different types of examinations, the use of normative and criterion - referenced judgements, and the use of portfolio and special types of examinations, e.g. objective structured clinical examinations (OSCE).

• *Evaluation of assessment methods* may include an evaluation of how they promote training and learning.

• *External examiners* are experts in family medicine not previously involved with the trainee and may provide not only objective assessment but may also bring global perspectives.

3.2 Relation Between Assessment And Training

Basic standard:

Assessment principles, methods and practices **must** be clearly compatible with training objectives and **must** promote learning. Assessment **must** document the trainee's progress through the program, and at completion, readiness for the practice of Family Medicine.

Quality development:

The assessment methods and practices **should** encourage integrated learning and **should** assess predefined practice requirements as well as knowledge, skills and attitudes. The methods used **should** encourage a constructive interaction between clinical practice and assessment.

3.3 Feedback To Trainees

Basic standard:

Constructive feedback and coaching on the performance of the trainee **must** be given on an ongoing basis.

Quality development:

Acceptable standards of performance **should** be explicitly specified and conveyed to both trainees and supervisors.

Annotation:

• *Feedback and coaching* would include assessment results and planned dialogues about clinical performance between trainees and trainers/supervisors with the purpose of ensuring instructions and remedies necessary to enhance competence development.

4. Trainees

4.1 Admission Policy And Selection

Basic standard:

The competent authorities and family medicine professional organizations **must** agree upon a policy on the criteria and process for selection of trainees and **must** publish and implement it.

Quality development:

The selection policy **should** define cognitive and non-cognitive criteria, which considers specific capabilities of potential trainees in order to enhance the result of the training process in family medicine. The selection procedure **should** be transparent and admission open to all qualified graduates from basic medical education. The selection procedure **must** include a mechanism for monitoring and appeal.

Annotations:

- The statement on *process of selection of trainees* would include both rationale and methods of selection and may include description of a mechanism for appeal.
- *Monitoring of admission policies* would include improvement of selection criteria, to reflect the capability of trainees to be competent and to cover the variations in required competencies related to diversity of family medicine.
- *Criteria for selection* may sensitively include, where locally appropriate, gender, ethnicity and other social requirements, including the potential need of a special admission policy for physicians from underserved populations (for example, from rural areas).

4.2 Number Of Trainees

Basic standard:

The number of trainees **must** be balanced for the clinical/practical training opportunities, supervisory capacity and other resources available in order to ensure training and teaching of adequate quality.

Quality development:

The number of trainees **should** be reviewed through consultation with relevant stakeholders. Recognising the inherent unpredictability of physician resource needs in the various fields of medicine, the number of training positions **should** currently be changed with careful attention to existing needs of the community and society and the market forces.

Annotations:

• *Stakeholders* would include those responsible for planning and development of human resources in the local and national health sector.

• Forecasting of the *needs of the community and society* for trained physicians includes estimation of various market and demographic forces as well as the scientific development, migration patterns of physicians, etc.

4.3 Support And Counselling Of Trainees

Basic standard:

The competent authorities **must,** in collaboration with the Family Medicine profession, ensure that a system for support, counselling and career guidance of trainees is available.

Quality development:

Counselling **should** be provided based on monitoring the progress in training and incidents reported and **should** address social and personal needs of trainees.

Annotation:

• *Social and personal needs* would include professional support, health problems, housing problems and financial matters.

4.4 Working Conditions

Basic standard:

Postgraduate training **must** be carried out in appropriately remunerated posts/stipendiary positions in family medicine and **must** involve participation in all medical activities commonly expected of family physicians, which may include on-call duties, thereby devoting professional activities to practical training and theoretical learning throughout standard working time. The service conditions and responsibilities of trainees **must** be defined and made known to all parties.

Quality development:

The service components of trainee positions **should** not be excessive and the structuring of duty hours and on-call schedules **should** consider the needs of the patients, continuity of care and the educational needs of the trainee. Part-time training **should** be allowed under special circumstances, determined by the competent authorities and structured according to an individually tailored program and the service background. The total duration and quality of part-time training **should** not be less than those of full-time trainees. Interruption of training for reasons such as pregnancy (including maternity/paternity leave), sickness, military service or secondment **should** be replaced by additional training.

Annotations:

• *Contractual service positions* would include internship, residency, registrar, senior registrar, etc.

• *The service components of trainee positions* must be subject to definitions and protections embodied in the contract.

4.5 Trainee Representation

Basic standard:

There **must** be a policy on trainee representation and appropriate participation in the design and evaluation of the training program, the working conditions and in other matters relevant to the trainees.

Quality development:

Organizations of trainees **should** be encouraged to be involved in decisions about training processes, conditions and regulations.

Annotation:

• *Trainee representation* would include participation in groups or committees responsible for program planning at the local or national level.

5. Staffing

5.1 Appointment Policy

Basic standard:

The policy on appointment of trainers, supervisors and teachers **must** specify the expertise required and their responsibilities and duties. The policy **must** specify the duties of the training staff and specifically the balance between educational and service functions and other duties. Family physicians **must** have the primary role in educating trainees in the program.

Quality development:

All physicians **should** as part of their professional obligations recognise their responsibility to participate in the practice-based postgraduate training of medical doctors. Participation in postgraduate training of trainees in family medicine **should** be rewarded. The staff policy **should** ensure that trainers generally are current in the relevant field to its full extent and sub-specialised trainers only approved for relevant specific periods during the training.

Annotations:

• *Training staff* would include family physicians, other medical doctors and health

personnel from other professions

• *Other duties* would include administrative functions as well as other educational or research responsibilities.

5.2 Obligations And Development Of Trainers

Basic standard:

Teachers and trainers **must** be prepared for their educational roles with family medicine trainees and must be informed of their teaching responsibilities. Instructional activities **must** be included as responsibilities in the work-schedules of trainers and their relationship to work-schedules of trainees **must** be described.

Quality development:

Staff policy **should** include support of trainers including an organized program for training as teachers and educators, as well as other opportunities for development and advancement in this role. There **should** be policy to appraise and recognise meritorious academic activities, including functions as trainers, supervisors and teachers. The ratio between the number of recognised trainers and the number of trainees **should** ensure close personal interaction and monitoring of the trainee.

Annotation:

- *Preparation for educational roles* would include opportunities to develop an understanding of educational methods and teaching strategies appropriate to the context.
- *An organized program for training as teachers and educators* would provide structured activities, allowing teachers to develop through the stages from novice, competent, proficient, and in some cases expert educators.
- *Recognition of meritorious academic activities* would be by rewards, promotion and/or remuneration.

6. Training Settings And Educational Resources

6.1 Clinical Settings And Patients

Basic standard:

The training locations **must** be selected and recognized by the competent authorities and **must** have sufficient clinical/practical facilities to support the delivery of training. Training locations **must** have a sufficient number of patients and an appropriate case-mix to meet training objectives. The training **must** expose the

trainee to a broad range of experience in family medicine appropriate to the local context for practice, such as office (surgery/outpatient) and inpatient/hospital care and on-duty (on-call) activity. The number of patients and the case-mix **must** allow for clinical experience in all aspects of family medicine, including training in promotion of health and prevention of disease. On-line or electronic means to provide distance education may be useful adjuncts to clinical training experiences.

Quality development:

The quality of training settings **should** be regularly monitored, including ensuring that trainees are each following a group of family practice patients over time and place, and are seeing diverse problems representative of the spectrum of problems in the discipline.

Annotations:

- *Office or outpatient-based settings* would include ambulatory settings where patients receive first-contact care
- Inpatient or hospital care settings would include those where patients are admitted for brief or long terms.
- *The quality of training settings* can be evaluated through site visits, for example.

6.2 Physical Facilities And Equipment

Basic standard:

The trainee **must** have space and opportunities for practical and theoretical study and have ready access to adequate professional literature as well as equipment for training in practical techniques such as procedural skills. There **must** be access to tools of information management in the areas where patient care is provided.

Quality development:

The physical facilities and equipment for training **should** be evaluated regularly for their appropriateness and quality regarding postgraduate training.

Physical facilities of the training

Annotation location would include e.g. lecture halls, tutorial rooms, libraries, and information technology equipment.

- Tools of information management include paper resources such as clinical practice guidelines, recent summaries of research evidence etc, not exclusively electronic tools

6.3 Clinical Teams

Basic standard:

The clinical training **must** include experience in working as a team with family physicians and other health professionals.

Quality development:

The training process **should** allow learning in a multi-disciplinary team resulting in the ability to work effectively with family physicians and other health professions as a member or leader of the health care team.

6.4 Information Technology

Basic standard:

There **must** be a policy addressing the effective use of information and communication technology in the training program with the aim of ensuring relevant patient management.

Quality development:

Trainers and trainees **should** be competent to use information and communication technology for self-learning and in accessing data information and working in health care systems.

Annotations:

• A policy regarding the use of *information and communication technology* which may be print-based as well as computers, internal and external networks and would include coordination with the library services of the relevant institutions.

• The use of *information and communication technology* may be part of education for evidence-based medicine and in preparing the trainees for continuing medical education and professional development.

6.5 Research

Basic standard:

There **must** be a policy that fosters the application of research into practice in training settings.

Quality development:

Opportunities for combining clinical training and research **should** be made available. Trainees **should** be encouraged to engage in health quality development and research, including qualitative research.

6.6 Educational Expertise

Basic standard:

There **must** be a policy on the use of educational expertise relevant to the planning, implementation and evaluation of training.

Quality development:

Access to educational experts **should** be available and evidence demonstrated of the use of such expertise for staff development and for research in the discipline of postgraduate medical education pertinent to family medicine.

Annotations:

• *Educational expertise* would deal with problems, processes and practice of postgraduate medical training and assessment, and would include medical doctors with experience in

medical education, educational psychologists and sociologists, etc. It can be provided by an education unit at the institution or be acquired from another national or international

institution.

• *Medical education research* investigates the effectiveness of training and learning methods, and the wider institutional context.

6.7 Training In Other Settings And Abroad

Basic standard:

There **must** be a policy on accessibility of individualized training opportunities at other sites within or outside the country fulfilling the requirements for the completion of training and for the transfer of training credits.

Quality development:

Regional and international exchange of academic staff and trainees **should** be facilitated by the provision of appropriate resources. The competent authorities **should** establish relations with corresponding national or international bodies with the purpose of facilitating exchange and mutual recognition of training elements.

Annotation:

• Transfer of *training credits* can be facilitated through active program coordination between training institutions.

7. Evaluation Of Training Process

7.1 Mechanism For Program Evaluation

Basic standard:

The relevant authorities and the profession **must** establish a mechanism for evaluation of the training program that monitors the training process, facilities and progress of the trainee, and ensures that concerns are identified and addressed.

Quality development:

Program evaluation **should** address the context of the training process, the structure and specific components of the program and trainee and other outcomes.

Annotations:

• *Mechanisms for program evaluation* would imply the use of valid and reliable methods and require that basic data about the training program are available. Involvement of experts in medical education and assessment would further broaden the base of evidence for quality of postgraduate training.

• *Identified concerns* would include problems presented to program committees, trainers and tutors, etc.

• *The context of the educational process* would include the organization and resources as well as the learning environment

• *Specific components for program evaluation* would include training program description and performance of trainees

• *General outcomes* would be measured e.g. by career choice and performance.

7.2 Feedback From Trainers And Trainees

Basic standard:

Feedback about program quality from both trainers and trainees **must** be systematically sought, analysed and acted upon.

Quality development:

Trainers and trainees **should** be actively involved in planning program evaluation and in using its results for program development.

Annotation:

• *Feedback about program* would include trainee reports about conditions in their program and clinical sites.

7.3 Using Trainee Performance

Basic standard:

The performance of trainees **must** be evaluated in relationship to the training program and the mission of postgraduate family medicine education.

Quality development:

The performance of trainees **should** be analysed in relation to background and entrance qualifications, and **should** be used to provide feedback to the committees responsible for selection of trainees and for program planning and counselling.

Annotation:

• Measures of *trainee performance* would include information about average duration of training, scores, pass and failure rates at examinations, success and dropout rates, as well as time spent by the trainees on areas of special interest. Performance of trainees after graduation, including practice location and scope of practice would also be useful.

7.4 Authorization And Monitoring Of Training Settings

Basic standard:

All training programs **must** be authorised by a competent authority based on well-defined criteria and program evaluation and with the authority able to grant or, if appropriate, withdraw recognition of training settings or theoretical courses.

Quality development:

The competent authorities **should** establish a system to monitor training settings and other educational facilities via site visits or other valid and reliable means.

Annotation:

• *Criteria* for authorization of training settings would include minimal values for number and mix of patients, equipment, library and IT facilities, training staff and training program.

7.5 Involvement Of Stakeholders

Basic standard:

The processes and outcome of evaluation **must** involve the managers and administration of training settings, the trainers and trainees and be transparent to all stakeholders.

Quality development:

The processes and outcome of evaluation **should** be credible to the principal stakeholders

Annotations:

• *Stakeholders* would include the medical professional organizations, other health professions, health authorities and authorities involved in training of doctors and allied health personal, hospital owners and providers of primary care, patients and patient organizations.

• *Principal stakeholders* include trainers, trainees and health authorities.

8. Governance And Administration

8.1 Governance

Basic standard:

Training **must** be conducted in accordance with regulations concerning structure, content, process and outcome issued by competent authorities. Completion of training **must** be documented by degrees, diplomas, certificates or other evidence of formal qualifications conferred as the basis for formal recognition as a competent family physician by the designated authorities. The competent authority **must** continually assess training programs, training institutions and trainers. The competent authority **must** be responsible for setting up a program for quality training.

Quality development:

Procedures **should** be developed that can verify the documented completion of training for use by both national and international authorities.

Annotation:

• *Recognition as a competent family physician* would, depending on the level of training, include doctors with the right to independent practice, specialists in specific areas of family practice, experts, etc.

8.2 Professional Leadership

Basic standard:

The responsibilities of the professional leadership for the postgraduate medical training program **must** be clearly stated.

Quality development:

The professional leadership **should** be evaluated at defined intervals with respect to achievement of the mission and outcomes of postgraduate family medicine training.

8.3 Funding And Resource Allocation

Basic standard:

There **must** be a clear line of responsibility and authority for budgeting of training resources.

Quality development:

The budget **should** be managed in a way that supports the mission and outcome objectives of the training programs and of the service.

Annotation:

• *Budgeting of training resources* would depend on the budgetary practice in each institution and country.

8.4 Administration

Basic standard:

The administrative staff of the postgraduate medical training programs and training institutions **must** be appropriate to support the implementation of the program and to ensure good management and deployment of its resources.

Quality development:

The management **should** include a program of quality assurance and the management **should** submit itself to regular review to achieve quality improvement.

8.5 Requirements And Regulations

Basic standard:

A national body **must** be responsible for defining the number and types of recognised specialties within family medicine and other medical expert functions for which

approved training programs are developed.

Quality development:

Definition of approved postgraduate medical training programs **should** be made in collaboration with all relevant stakeholders.

Annotations:

• *A national body* established according to national laws and regulations would act in the interests of society as a whole.

• *Relevant stakeholders* would include national and local health authorities, universities, medical professional organizations, the public, etc.

9. Continuous Renewal

Basic standard:

In realising the dynamics of postgraduate medical training the relevant authorities **must** initiate procedures for regular review and updating of the structure, function and quality of the training programs and **must** rectify identified deficiencies.

Quality development:

The process of renewal **should** be based on prospective studies and analyses and **should** lead to the revisions of the policies and practices of the postgraduate medical training programs in accordance with past experience, present activities and future perspectives. In so doing it **should** address the following issues:

- Adaptation of the mission and outcome objectives of postgraduate training to the scientific, socio-economic and cultural development of the society.
- Modification of the competencies required on completion of postgraduate training in family medicine in accordance with the needs of the environment the newly trained doctor will enter.
- Adaptation of the learning approaches and training methods to ensure that these are appropriate and relevant.
- Adjustment of the structure, content and duration of training programs in keeping with the developments in the basic biomedical sciences, the clinical sciences, the behavioural and social sciences, and changes in the demographic profile and health/disease pattern of the population, and in socio-economic and cultural conditions.
- Development of assessment principles and methods according to changes in training objectives and methods.
- Adaptation of recruitment policy and methods of selection of trainees to changing expectations and circumstances, maintaining an appropriate gender balance, human resource needs, changes in basic medical education and the requirements of the training program.
- Adaptation of recruitment and policy of appointment of trainers, supervisors and teachers according to changing needs in postgraduate training.
- Updating of trainers' qualification and preparation in medical education to meet the needs of trainees
- Updating of training settings and other educational resources to changing needs in postgraduate training, i.e. the number of trainees, number and profile of trainers, the training program and contemporary training principles.
- Refinement of the process of program monitoring and evaluation.
- Development of the organisational structure and management principles in order to cope with changing circumstances and needs in postgraduate training and, over time, accommodating to the interests of the different groups of stakeholders.
- Assessment of the adequacy of current funding for the family physician training program against intended program goals.

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