

WONCA Global Standards for Postgraduate Family Medicine Education

A guide for program development

WONCA Working Party on Education
2016

Table of Contents

1. Overview

2. Checklist for the WONCA Global Standards for Post Graduate Family Medicine Education

3. Pre-visit or Self-study Questionnaire

The WONCA Global Standards for Postgraduate Family Medicine Education: A guide for program development

1. OVERVIEW

Background

In June 2013, WONCA World Council approved the WONCA Global Standards for Postgraduate Family Medicine Education. The Standards aim to enhance family medicine education globally, facilitate training programs to share expertise and learn from each other, and promote Family Medicine as a discipline. They were developed through an iterative process over 6 years, involving on-line discussions, meetings, workshops and conferences where interested family medicine teachers from across the globe discussed the critical elements in the educating physicians to become family doctors/general practitioners.

This handbook is to be used in conjunction with the Standards themselves, although it may be useful as a preliminary overview in determining how the Standards might be useful for an individual educational program.

The WONCA Standards

In recognition of the global diversity of health care systems, resources, and experience in family medicine education programs, the standards have been developed in two levels: basic and quality development. Basic level represents the fundamental standards that all programs should strive to attain, and quality development standards are those that require more expertise and resources but are highly desirable.

The Standards have been organized into nine *Areas* each with several *Sub-areas,* with descriptions and annotations to provide further explanation. Each standard has both a basic level and a quality improvement level. It may be overly simplistic to consider that the basic level standard is intended for educational programs which are new, developing or have fewer resources, while the quality improvement standards are aspirational for longstanding and well resources programs. It is more than likely that any educational program will fail to achieve standards at the basic level, and will achieve some at the quality improvement level. However, the bi-level standards provide a range of achievement for educational programs to measure themselves against, appropriate for their various contexts and stages.

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, and can be adapted for the local environment.

There are several key themes running throughout these *Areas* and *Sub-areas*, reflecting what WONCA considers to be best practice in postgraduate family medicine education, in addition to traditional aspects of curriculum, assessment, resources etc.

I. **Promotion of program quality improvement**
This includes elements of program evaluation; the examination of outcomes such as graduate performance and work place tracking; feedback from trainees and trainers; engagement in external reviews etc.

II. **Promotion of family medicine as central to the training of family doctors**
Family doctors and settings where family doctors work are essential components in the education of the discipline's future practitioners. While other contexts are useful to provide focused skill development, the majority of training time should be in the hands of family doctors.

III. **Training programs responsive to community needs**
Family physicians practice differently in different parts of the world because the needs of their communities and their patients are very diverse. Elements such as the engagement of stakeholders in the program, adapting the program to the future practice of trainees and program efforts to assess and meet the community needs are included in the standards.

IV. **Learner-centred educational program**
The balance between service and education draws attention, as does the support provided to trainees. Trainee involvement in program development is another aspect of a learner-centred educational program.

Potential Uses of the Standards

a. **New Program Development**
When a program to train family doctors/GPs is being developed, the WONCA Standards provide a useful blueprint to ensuring that all the relevant *Areas* have been considered and planned for. The standards provide desired outcomes for each *Area.* As well, because these are global standards, from a credible organization, program leaders can use the WONCA Standards to advocate for their requirements in implementing the desired program with funders and relevant stakeholders.

b. **Self-Assessment and Program Quality Improvement**
Educational programs already training family doctors should all be engaged in program quality improvement, continually examining their program and striving to improve it. The WONCA standards can be used as a framework for such activities. An educational program may decide to assess its performance on all or several of the Standards, using a quality assurance cycle (example – plan, implement, evaluate, review). By using the Standards as an external guide, blind spots and unrecognized issues may be uncovered leading to program improvements.

c. **Peer Review**
There are great benefits in having external family medicine teachers and program leaders review the educational program to provide fresh perspective and clear evaluations. This can be a powerful tool for change. Peers can use the Standards as a template for such reviews, and the accompanying tools (questionnaire, checklist) may also facilitate this activity. This may be part of a formal accreditation process, or a less formal review.

d. Accreditation of Medical Programs

The accreditation of medical programs is a cyclical quality improvement process, in which an educational program is assessed against predetermined, external standards. The cycle consists of a self-assessment, an external evaluation, planning for improvements, followed by further self-assessment and so on. It is not expected that a program is going to meet each and every standard: for this to be the case, standards would be have to be set too low for this to meet the quality improvement purpose. These standards may be used for external accreditation processes such as this. For guidance, the World Federation for Medical Education has produced an excellent guide to accreditation for basic medical education which can readily be adapted to postgraduate programs.
http://wfme.org/accreditation

e. WONCA Accreditation

It is possible for postgraduate family medicine education programs to apply for official WONCA accreditation. Please see the Guide to WONCA Accreditation for details of this process.

2. CHECKLIST FOR THE WONCA GLOBAL STANDARDS FOR POST GRADUATE FAMILY MEDICINE EDUCATION

This checklist may serve as a quick guide, or reference, to the full Standards. It is important to note that the Standards themselves include many more details and explanations, and this checklist is not a substitute for that document. However, it can be used in preparing a self study or review, as well as in developing new postgraduate programs in family medicine education.

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
MISSION AND OUTCOMES			
1.1 Statement	☐ Describes the post-graduate practice –based learning process that results in family doctors able to practice competently	☐Encourages innovation in training ☐Encourages trainees to become scholars and life-long learners	
1.2 Participation in formulation of statement	☐Statement defined and adopted by principle stakeholders	☐Statement based on input from wider range of stakeholders	
1.3 Professionalism and autonomy	☐Training process based on approved basic medical education ☐Training fosters autonomy		
1.4 Training outcomes	☐Authorities, in consultation with FM and other professional organizations, define competencies which must be achieved by FM trainees	☐Authorities define both broad and specific competencies ☐Measures of competencies used to develop program	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
2. TRAINING PROCESS			
2.1 Learning approaches	☐Follows a systematic program ☐Training is practice based ☐Encompasses reflective observation, theoretical concepts, active participation and practical experiences ☐Trainee guided by supervision, regular appraisal and feedback ☐Ensures increasing independence and responsibility	☐Interfaces with basic medical education and continuing medical education/professional development ☐Trainee has access to educational counseling and support	
2.2 Scientific methods	☐Trainee achieves knowledge of scientific basis and methods of FM ☐Trainee is familiar with evidence based medicine and critical decision making specific to FM	☐Formal teaching about information management, critical literature appraisal, quality improvement, evidenced based medicine and scientific data is provided ☐Trainee is exposed to research	
2.3 Training content	☐Care across continuum of prevention, health promotion, acute and chronic care, rehabilitation and palliative care ☐Care across the spectrum of patients, all ages and genders, with a variety of problems ☐Continuity of care over time ☐Undifferentiated patient care ☐Psychosocial and cultural aspects of heath care ☐Communication skills ☐Understanding of doctor patient relationship issues ☐Use of medical records and communication with other health care workers Knowledge of: ☐bioethics ☐medical –legal issues ☐ quality assurance ☐community medicine ☐health promotion and disease prevention ☐the health care system	Ensures development of FM expert in: ☐health advocacy ☐communication ☐collaboration ☐team-work ☐scholarship ☐administration ☐management ☐professionalism	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
2.4 Training structure, composition, and duration	☐Overall structure composition and duration is clearly stated ☐Compulsory and optional components are clearly stated	☐Integration of practice and theory ensured in training process	
2.5 Relationship between training and service	☐Apprenticeship nature is described and respected ☐Formal agreements assure integration of training and service ☐Supervision guides learning through service activities	☐Capacity of health care system utilized for service based training ☐Training is not subordinated to service demands ☐Permanent FM advisor provides mentorship	
2.6 Management of training	☐Authority and responsibility is clearly defined ☐Coordinated training within FM is ensured	☐Authority is provided with resources for planning, implementation, assessment and innovation ☐FM education experts, trainees and other stakeholders are represented	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
3. ASSESSMENT			
3.1 Assessment methods	☐Method and process is clearly defined ☐Method includes formative and constructive feedback	☐Reliability and validity of methods are documented ☐External FM examiners are included ☐Complementary set of methods are applied ☐Logbook portfolio is used to record stages in acquisition of skills ☐Appeal mechanism is present ☐Supplemental training is supplied if needed	
3.2 Relationship between assessment and training	☐Assessment is compatible with training objectives ☐Promotes learning ☐Documents progress though program ☐Documents readiness to practice FM at the completion	☐Encourages integrated learning ☐Assesses predefined practice requirements ☐Assesses knowledge, skills and attitudes ☐Encourages interaction between clinical practice and assessment	
3.3 Feedback to trainers	☐Constructive feedback and coaching is given on ongoing basis	☐Acceptable performance standards are explicitly specified and conveyed to both trainees and supervisors	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
4. TRAINEES			
4.1 Admission policy and selection	☐Competent authorities and FM professional organizations agree on a policy for criteria and process ☐Policy is published and implemented ☐Procedure includes a mechanism for monitoring and appeal	☐Policy defines cognitive and non-cognitive criteria ☐Procedure is transparent ☐Selection is open to all qualified graduates	
4.2 Number of trainees	☐Number is balanced for resources to ensure training and teaching of adequate quality	☐Number is reviewed with relevant stakeholders ☐Number is changed with attention to community and society needs, and market forces	
4.3 Support and counseling of trainees	☐System of support, counseling and career guidance is ensured	☐Counseling is provided based on monitoring the progress in training and incidents reported ☐Counseling addresses social and personal needs of trainees	
4.4 Working conditions	☐Training is carried out in appropriately remunerated posts/stipendiary positions ☐Posts include all medical activities commonly expected of family physicians which may include on-call duties ☐Conditions and responsibilities are defined and made known to all parties	☐Service components are not be excessive ☐Structure of duty hours considers the needs of patients, continuity of care and educational needs of trainee ☐Part-time training is allowed under special circumstances ☐Total duration and quality of part time training is not less than fulltime ☐Interruption of training is replaced with additional training	
4.5 Trainee representation	☐There is a policy on trainee participation in design of program, working conditions and other matters relevant to trainees	☐Organizations of trainees are involved in decisions about training processes, conditions and regulations	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
5. STAFFING			
5.1 Appointment policy	☐Policy on appointment of trainers, supervisors, and teachers that specifies expertise is required ☐Policy specifies duties and responsibilities of training staff ☐Policy specifically addresses the balance of educational and service functions of training staff ☐Family physicians have a primary role in education of trainees	☐All physicians recognize their professional responsibility to train doctors in practice settings ☐Participation is rewarded ☐Policy ensures trainers are current in relevant fields to the fullest extent ☐Subspecialist trainers are only approved for relevant specific periods during training program	
5.2 Obligations and development of trainers	☐Teachers and trainers are prepared for their educational roles and informed of their responsibilities ☐Teaching activities are included in trainers work schedules ☐The relationship of teaching activities to work schedules of trainees are described	☐Policy includes support of trainers and an organized program for training as teachers ☐Policy includes opportunities for development and advancement of trainers ☐Policy appraises and recognizes meritorious academic activities ☐Ratio of trainers to trainees ensures close personal contact and monitoring of trainee	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
6. TRAINING SETTINGS AND EDUCATIONAL RESOURCES			
6.1 Clinical settings and patients	☐Locations are selected and recognized by competent authorities ☐The supply of sufficient clinical/practical facilities to support training is ensured ☐The supply of sufficient numbers of patients and case mix to meet training objectives is ensured ☐Trainee is exposed to a broad range of experience appropriate to the local context; including office, hospital and on-call activities ☐The number of patients and case mix allows for experience in all aspects of FM, including health promotion and prevention	☐The quality of settings is regularly monitored ☐Trainees follow a group of patients over time and place ☐Trainees see a diversity of problems that represent the full spectrum of FM	
6.2 Physical facilities and equipment	☐Space and opportunity for practical and theoretical study is supplied ☐Access to professional literature is ensured ☐Equipment for training in practical techniques such as procedural skills is available ☐Trainees have access to tools of information management in areas of patient care	☐Physical facilities and equipment are evaluated regularly for appropriateness and quality	
6.3 Clinical teams	☐Trainees have experience working in a team with family physicians and other health professionals	☐Training allows learning in a multi-disciplinary team so that trainee works effectively as member or leader	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
6.4 Information technology	☐Policy addresses effective use of technology with the aim of relevant patient management	☐Trainers and trainees are competent in using technology for self learning, accessing data and working in health care systems	
6.5 Research	☐Policy fosters the application of research into practice in training settings	☐Opportunities for combining clinical training and research are available ☐Trainees are encouraged to engage in health care quality research	
6.6 Educational expertise	☐Policy on use of expertise relevant to the planning, implementation and evaluation of training	☐Access to educational experts is available ☐Use of expertise is documented for use in staff development and research in postgraduate FM	
6.7 Training in other settings and abroad	☐Policy on accessibility of individualized training opportunities at other sites within or outside of the county that fulfill requirements of training ☐Policy for transfer of credits	☐Regional and international exchange of academic staff and trainees are facilitated by resources ☐Authorities establish relations with national or international bodies with the purpose of facilitating exchange and mutual recognition of training	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
7. EVALUATION OF TRAINING PROCESS			
7.1 Mechanism for program evaluation	☐Authorities and profession establish a mechanism for evaluation ☐Training process, facilities and progress of trainees is monitored ☐Process ensures that concerns are identified and addressed	☐The context of the training process, the structure and specific components of the program and other outcomes are assessed	
7.2 Feedback from trainers and trainees	☐Feedback about the program from both trainers and trainees is systematically sought ☐Feedback is analyzed ☐Feedback is acted on	☐Trainers and trainees are actively involved in planning the program evaluation and using results for program development	
7.3 Using trainee performance	☐Performance of trainees is evaluated in relationship to the training program ☐Performance is evaluated in relationship to the mission of post graduate FM education	☐Performance is analyzed in relation to background and entrance qualifications ☐Performance is used to provide feedback to committees responsible for the selection of trainees ☐Performance is used to provide feedback for program planning and counseling	
7.4 Authorization and monitoring of training settings	☐Program is authorized by competent authority based on well defined criteria and program evaluation ☐Authority is able to grant or withdraw recognition of training settings or theoretical courses	☐Authorities establish a system to monitor training settings and other facilities via site visits or other valid and reliable means	
7.5 Involvement of stakeholders	☐Processes and outcomes of evaluation involve managers and administrators of practice settings ☐Evaluation processes and outcomes involve trainers and trainees ☐Evaluation processes and outcomes are transparent to all stakeholders	☐Processes and outcomes of evaluation are credible to all principal stakeholders	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
8. GOVERNANCE AND ADMINISTRATION			
8.1 Governance	☐Training is in accordance with regulations concerning structure, content, process and outcome issued by competent authorities ☐Completion of training is documented by degrees, diplomas, certificates or other evidence of formal qualifications ☐Documentation is conferred as formal recognition as a competent family physician by authorities ☐Authorities continually access training programs, institutions and trainers ☐Authorities are responsible for setting up programs for quality training	☐Procedures are developed to verify documented completion of training for use by both national and international authorities	
8.2 Professional leadership	☐Responsibilities of professional leadership for program are clearly stated	☐Professional leadership is evaluated at defined intervals with respect to achievement of mission and outcome of FM training	
8.3 Funding and resource allocation	☐A clear line of responsibility and authority for budgeting of training resources is defined	☐Budget is managed in a way that supports the mission and outcome objectives of training program	
8.4 Administration	☐Administration staff is appropriate to support implementation of program ☐Good management and deployment of resources is ensured	☐Management includes a program of quality assurance ☐Management submits itself to regular review	
8.5 Requirements and regulations	☐A national body is responsible for defining the numbers and types of recognized specialties within FM ☐National body is responsible for other expert functions for which approved training programs are developed	☐Definition of approved post-graduate medical training programs is made in collaboration with all relevant stakeholders	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
9. CONTINUOUS RENEWAL			
	☐Authorities initiate processes for regular review and updating of the structure, function and quality of training ☐Authorities rectify identified deficiencies	☐Renewal is based on prospective studies and analyses ☐Revisions of the policies and practices of training programs are done in accordance with past experience, present activities and futures perspectives Revisions address the following issues: ☐Adaptation of mission and outcomes to scientific, socio-economic and cultural development of society ☐Modifications of competencies required in accordance with needs of the environment the newly trained doctor will enter ☐Adaptation of learning approaches and methods to assure relevance ☐Adjustment of structure, content and duration of training in keeping with changes in basic biomedical, clinical, behavioral and social sciences; and changes in demographics, health disease patterns, socio-economic and cultural conditions ☐Development of assessment principles and methods according to changes in training objective training and methods	

AREA	BASIC STANDARD ***MUST***	STANDARD FOR QUALITY DEVELOPMENT ***SHOULD***	Notes
9. CONTINUOUS RENEWAL (Continued)			
		☐Adaptation of recruitment of trainees to changing expectations and circumstances, maintaining gender balance, human resource needs, changes in basic medical education and requirements of training program ☐Adaptation of recruitment of trainers, supervisors and teachers according to changing needs of training program ☐Updating trainers qualifications and preparation in medical education to meet needs of trainees ☐Updating training settings and other resources to the changing needs in postgraduate training ☐Refinement of program monitoring and evaluation ☐Development of organizational structure and management principles in order to cope with changing circumstances and accommodation of the different groups of stakeholders ☐Assessment of adequacy of current funding of FM training programs against intended program goals	

4. PRE-VISIT OR SELF-STUDY QUESTIONNAIRE

The completion of this questionnaire provides postgraduate educational programs with an opportunity to assess the various components of their program against the WONCA Global Standards. The actions outlined in the questionnaire are a form of self-study, or can be used for external review. For external reviewers, completion of the questionnaire is an invaluable step both in understanding the educational program and its operation. It also serves to provide external reviewers with needed materials. The materials should be provided well in advance of any visit by an external reviewer to facilitate a focused and productive visit.

WONCA Global Standards for Postgraduate Family Medicine Education
Program Pre-Visit Questionnaire

1. Mission and Outcomes

1.1 Provide copies of the accreditation documents or statements which define the basis for the outcome objectives in family medicine postgraduate education and describe how these are used in by the educational programs in your setting, or under your jurisdiction

1.2 Briefly describe the process by which these have been developed and reviewed.

1.3 Provide a document containing the competencies that trainees are required to achieve as a result of their training programs.

2. Training Process

2.1 Describe the prescribed training program, including the family medicine specific components, and any additional experiences or placements, both clinical and non clinical. A schematic outline may be helpful.

2.2 What is the required degree of involvement of the family medicine training program and family physician teachers/preceptors in each of these experiences?

2.3 What is the expected role of the trainee in delivering patient care?

2.4 How is trainee supervision, feedback and assessment organized during the clinical components of the programs?

2.5 In what ways are programs expected to provide trainees with gradually increasing responsibility over their training?

2.6 Describe the expected balance between clinical service and education in the programs and how programs are required to monitor this.

2.7 How are educational programs organized in your jurisdiction, and what are the requirements for governance and accountability?

2.8 What is the required role of trainees and other stakeholders in the governance of the program?

3. Assessment of Trainees

3.1 Describe the standards that refer to the process of assessing trainees, including the methods required of the training programs as well as any methods or examinations administered by the jurisdiction or College, both in-training or formative and terminal. Indicate the relationship between these methods and the nature of clinical practice.

3.2 What are the requirements for the provision of feedback to trainees and for direct observation of their clinical performance during day-to-day clinical duties?

3.3 Describe the appeal mechanisms that are required at the training program level and at the level of the College or other authority.

4. Trainees

4.1 What are the standards for the conduct of admission to postgraduate training programs?

4.2 How are the numbers of trainees accepted into educational programs determined?

4.3 Describe the requirements for support, counselling and career guidance designed to meet the needs of trainees.

4.4 Describe the nature of trainees' duty hours. What are the requirements for balancing service and education e.g. contracts?

4.5 How are interruptions to training (sickness or parental leave, military duty etc) and part time training positions handled?

4.6 How are trainees represented in the evaluation of the training program and their working conditions?

5. Staffing

5.1 What are the required qualifications and responsibilities for trainers in the training programs?

5.2 What are the requirements for support of staff in their work as trainers, by the educational program and by the larger educational system?

5.3 What are the requirements for teaching of trainees during clinical placements?

6. Training Settings and Clinical Resources

6.1 Describe the expectations for the training sites in the educational programs. How are these monitored for appropriate variety, volume and case mix?

6.2 What is the expected experience for trainees in working with other health care professionals and in in multi-disciplinary teams?

6.3 Describe possible outcomes if a training site is found to no longer be appropriate for family medicine trainees.

6.4 What are the requirements for the physical facilities of training locations, including tools for information management?

6.5 What are the standards for communication and information technology for learning and patient care in the training programs?

6.6 Describe the expectations of trainees with respect to research during their training program

6.7 How are educational experts engaged in the educational programs and what are the requirements for this involvement?

6.8 What is the policy for training experiences outside the trainee's home program, either within or outside the country?

7. Evaluation of Training Process

7.1 What mechanisms are used to evaluate the outcomes of the training program

7.2 What mechanisms are used to evaluate the effectiveness of the training system as a whole?

7.3 Describe the involvement of stakeholders with respect to the results of the evaluation of training programs.

8. Governance and Administration

8.1 What is the required or accepted governance structure of training programs, and under what authority? Highlight in particular the roles of family medicine organizations and family physicians in this governance.

8.2 How is the completion of training recognized, and under what authority?

8.3 In addition to family medicine training, are there defined subspecialties of family medicine with training programs? Please list any, with resulting credentials and the authority under which these are recognized. Examples vary by country, but might include palliative medicine or emergency medicine.

8.4 What are the requirements for management and quality improvement of each training program? How is this implemented? Are there formal outcome measures? If so, please specify.

9. Continuous Renewal

9.1 Describe how the College or authority is involved in reviewing and updating the structure, function and quality of the training programs.

9.2 What studies or data have informed review of postgraduate programs in the last 5 years?

9.3 What standards support each training program in responding to societal needs and to new information and best practices in medical education?

Curriculum

What are the curricular requirements in the following areas?

- 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 healthcare, 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
- 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.