Triple C: a new vocabulary for a changing reality

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Family medicine as a discipline in Canada has come of age; we are now 58 years old. We have grown and reached maturity, and can stand tall articulating what we do, what our specialty is, and how we uniquely contribute to patient care. Governments have taken notice with commitments to primary care reform. National research agencies have stepped up to the plate issuing calls for programmatic research focused on primary care. And the public continues to advocate for increasing access to family physicians. Given the changing landscape in Canada, with increased attention to quality, accountability, and access; new interprofessional models of health care delivery; and the never-ending introduction of new technologies, evidence, and knowledge into our discipline, it was time for the College of Family Physicians of Canada (CFPC) to reflect upon how we educate future family physicians.

For years, education committees in the College have been actively developing innovative ways to enhance what and how to teach family medicine residents, but 2012 marked the official launch of the CFPC's renewed approach to family medicine residency education. The Triple C Competency-based Curriculum builds on our internationally recognized training model offered by the 17 university-based family medicine residency programs in Canada.[1] It highlights the College's vision of developing sufficient numbers of family physicians who can provide *comprehensive* and *continuing care* through education within *family medicine–centred* learning environments.

Learning the language

As with any new innovation, it takes time to fully understand new terminologies and concepts. There is often a period when people wade through uncertainty until clarity emerges. For educators and practitioners teaching family medicine in Canada, this period is upon us. Numerous terms are being introduced, helping to articulate what we do as family physicians, how we teach family medicine, and how we assess family medicine residents. The following terms will help you better understand Triple C.

Competency-based education requires thinking about learning based on outcomes. Outcomes are defined for what learners are expected to learn. These outcomes or competencies vary by the stage of the learner within the physician's continuum of learning. For example, what medical students need to know about intrapartum care at the time of graduation from medical school varies from the competencies expected of them upon completing residency. This reflects the notion of understanding competence at a point in time.[2] Competence also varies by context.[2] Physicians who practise in remote settings and who are the only physicians providing intrapartum care might require even more specific competencies.

Medical education has been delivered according to a time-based, "tea steeping" model of learning.[3] In the time-based approach, learners are immersed in a learning context for a period of time (eg, pediatrics for 4 weeks); what is learned is based on what learners are exposed to, often by happenstance. This is in contrast to an outcomes-based approach, in which intentional learning opportunities are provided, maximizing opportunities for learners to gain competencies expected to be acquired within the learning environment and within a specified time. If family medicine residents are expected to learn specific competencies, they need the opportunities to learn these competencies within contexts relevant to family medicine. Educators need to shape learning opportunities for residents that are *centred on the specific needs of family physicians.* Learning from specialty colleagues outside of family medicine remains critical, and we are asking our colleagues for ongoing partnership to help our family medicine residents demonstrate competence to the level of a physician who is beginning the practice of the specialty of family medicine.

The International Competency-based Medical Education Collaborative defined *competence* as an "array of abilities across multiple domains or aspects of physician performance in a certain context."[2] Our context is family medicine. We practise with patients across the life cycle, from babies to the elderly, with individuals who present for acute care, for rehabilitation, and with other levels of acuity and chronicity. We practise in clinics, emergency departments, long-term care, patients' homes, and other settings. Our educational programs must provide these contexts, or *domains of clinical care,* within which family medicine trainees can learn how to become family physicians.

The *continuum of learning* is an underlying concept for competency-based education. Society expects physicians, as members of a self-regulated profession, to embark upon lifelong learning to ensure maintenance of ongoing competence. Our educational journey as family physicians begins as medical students, continues through our residency training, and is maintained while we are in practice.

The *CanMEDS–Family Medicine (CanMEDS-FM) roles*[4] describe the professional roles played by family physicians in their work with patients, colleagues, other health

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professionals, and the health system. Each family physician integrates these roles into practice. Derived from the Educating Future Physicians of Ontario project of the late 1980s, roles were developed to help undergraduate and postgraduate programs be more responsive to the evolving needs of society.[5] The CanMEDS-FM roles (family medicine expert, communicator, collaborator, manager, health advocate, scholar, and professional) are based on those used by the Royal College of Physicians and Surgeons of Canada[6] and have been made more specific to family medicine.

The 4 principles of family medicine have served us well, providing us with the foundational values of our discipline. The CanMEDS-FM roles help to describe the different facets of what we do as family physicians, based on the 4 principles. What distinguishes us as family medicine experts relates to specific knowledge, skills, attitudes, values, and behaviour that we incorporate across all the CanMEDS-FM roles and in our daily practice.

Our residency programs need to incorporate learning opportunities for family medicine residents to discover how the CanMEDS-FM roles are applied to patients across the domains of clinical care. Ensuring that the learning experiences offered to learners span these domains is critical so that residents understand the breadth of the discipline. How we teach these roles within the domains must reflect critical themes of our discipline, including *comprehensive care* and *continuity of care*—the first 2 *C*s of Triple C. The third *C—centred in family medicine*—reflects the belief that future family physicians need to develop their identity and their competence in environments that centre learning on the needs of family medicine learners. *Canadian Family Physician* has been publishing articles that help distinguish each of the components of Triple C.[7-13] These detailed articles help us understand what needs to be taught, who can best provide the teaching, where and with whom learning should be situated, and how we should approach our teaching and assessment of learners.

Role of the universities

University programs are responsible for providing family medicine residents with accredited training that readies them for independent practice. Program directors are charged with providing a judgment related to a learner's readiness for independent practice. This judgment, together with passing the CFPC's Certification examination, is the rite of passage for family medicine residents to the next stage of their career as CFPC-Certified family physicians—beginning specialists in family medicine.

In the true spirit of competency-based education, judging a learner's readiness for independent practice requires a process of inquiry that accurately ascertains a learner's acquisition of the required *competencies* or abilities necessary to practise independently. To become a family physician, and hence to be *competent* to practise our specialty, residents must demonstrate that they have developed the identity and abilities that define our discipline. The successful family medicine graduate, in demonstrating this, has demonstrated that he or she has the necessary foundation to continue mastering the abilities required of a specialist in family medicine. To make this judgment, the CFPC has adopted the use of the *evaluation objectives.*[14] The evaluation objectives provide us with one tool that can assist in assessing resident competence at the point of graduation. The framework is useful for the purposes of assessment.

Continuing the conversation

Triple C is intended to enhance our already excellent residency programs in Canada. Triple C reaffirms our belief in the family physician's lifelong learning journey, aligning well with the paradigm of competency-based education advocated by the CFPC. Incorporating and mastering competencies related to the CanMEDS-FM roles in our work as family physicians is our lifelong task. The evaluation objectives help to define the competencies expected by the end of residency. These competencies are foundational to our ongoing acquisition of contextually specific competencies over time.

As we muddle through understanding and applying this enhanced educational approach to family medicine education in Canada, let us recognize the impressive steps we are making in Canada as we lead the advancement of family medicine worldwide. We can celebrate a new language that helps to distinguish our uniqueness as family physicians and our discipline's coming of age.

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Competing interests
Dr Oandasan is Associate Director, Academic Family Medicine for the CFPC.

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