

The last C: centred in family medicine

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The College of Family Physicians of Canada (CFPC) has endorsed the recommendation from the Section of Teachers' Working Group on Postgraduate Curriculum Review that residency training programs develop and implement a competency-based curriculum that is

- comprehensive,
- focused on continuity of education and patient care, and
- centred in family medicine.

Together, these recommendations form the Triple C Competency-based Curriculum (Triple C).¹ This article is the fifth in a series explaining the Triple C initiative²⁻⁴ and highlights the last C: the curriculum must be centred in family medicine.

The term *family medicine-centred* is new; the description and the definition relate to the focus of the experience, the primary setting, the teachers for training, the amount of time spent in individual clinical settings, and the learning processes that are emphasized. If family medicine is to meet the expectations inherent in competency-based education—that is, to graduate physicians who can provide expert care for all Canadians in diverse settings, adapt to dynamic and complex practice environments, and develop the skills for maintaining competence—the curriculum must be centred in family medicine.

Family medicine-centred curriculum

In a family medicine-centred curriculum, family medicine is the focus of and is central to learning. Residents view themselves and function primarily as family physicians continuously taking responsibility for a panel of patients during residency.⁵ The goals and curricular elements are fully planned and controlled by family medicine educators, and education occurs predominantly within a *comprehensive family practice setting*. This is complemented by specialized or focused experiences designed to provide specific competencies, such as more intense exposure to procedural skills or obstetrics. Residents then have opportunities to apply this knowledge and skill within the family medicine context under the supervision of family physician teachers. In a family medicine-centred curriculum the *primary teachers are family physicians*, who serve as role models and demonstrate

not only the learning processes of family medicine but also the integration of knowledge, skills, and attitudes across disciplines and contexts, as well as the application of this learning to individual patients. Family physician teachers are the knowledgeable assessors of the CanMEDS-Family Medicine competencies that residents must demonstrate.⁶ Consulting specialist teachers are also valued educators but they must have a clear understanding of the role of the family physician in the community and a demonstrated respect for the discipline.

To accomplish the goals of Triple C and to provide a family medicine-centred approach, residency training programs will need to complete their evolution away from the traditional rotating internship model with its sequential, discipline-specific "block" experiences. In this block or rotational structure of training, residents attempt to develop expertise in successive disciplines, believing that family physicians need to know "a little bit about everything." This model fails to recognize the unique expertise of our discipline, which must simultaneously manage complexity and uncertainty within multiple dimensions in the context of an ongoing relationship with the patient. From a pedagogical perspective, if residents are to develop this unique expertise, they must have opportunities for deliberate practice (practice plus expert feedback).⁷ Residents must therefore have repeated opportunities to be coached by experienced teachers in the coordinated performance of family medicine skills.⁸

In terms of curricular design, this deliberate practice and promotion of competency integration in family medicine is more easily served by a longitudinal curriculum structure. In such a model, most of the resident's time is spent in the same family practice environment supervised by family medicine faculty.⁹ This structure is ideally suited to the promotion of the second C, *continuity*, which includes continuity of care, supervision, and the learning environment. Continuity of care is essential for the development of ongoing patient-physician relationships; it is the cornerstone of our profession. Continuity of supervision, evaluation, and role modeling are complementary teaching and learning strategies that arise from time spent in a longitudinal placement.⁴ Within a longitudinal family medicine-centred curriculum, some block rotations and specialized or focused learning experiences can be retained and might be required to meet specific competencies depending on the context of training and available local resources.

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Rationale for a family medicine-centred approach

Substantial resource implications are anticipated with the shift to a family medicine-centred approach. A sound rationale must therefore be established for moving to this curricular model.

The recommendation to move toward a curriculum in which most training occurs within the context of family medicine is neither new nor unique. The CFPC initially espoused such an approach in the 1995 report, *The Postgraduate Family Medicine Curriculum: An Integrated Approach*.¹⁰ In addition, position papers from Australia, the United Kingdom, and the United States have all emphasized the importance of this educational focus.^{6,11-13} By comparison, in all other Canadian training programs, residents spend most of their training time in the context of their own specialties.

Evaluations of longitudinal curricula at the undergraduate level suggest improved humanism, patient-centredness, and professionalism.¹⁴⁻¹⁶ Limited literature at the family medicine postgraduate level shows improvement in continuity and opportunities for developing strong patient-physician relationships.^{5,17}


The important role served by residency training in the establishment of a physician's professional identity provides further rationale for a family medicine-centred curriculum. Professionals need a clear sense of their identity and their area of expertise if they are to function effectively.¹⁸ Our goal is to have residents develop an understanding of and identification with the specific profession of family medicine: its expertise, values, cultural aspects (eg, commitment to the community), and rewards. In a family medicine-centred curriculum, where most of the training time is spent with family physicians, there is considerable exposure to role models who demonstrate their beliefs and values, problem-solving processes, and reflective stances.¹⁹ Repeated exposure to these family physician role models will allow the time needed to develop an understanding of our profession, and the development of a positive professional identity.

Issues of educational efficiency also support the family medicine-centred approach of Triple C. If residents are to acquire the expected educational outcomes within a 2-year time frame, they must be primarily engaged in activities with high relevance to overall objectives. Clinical service requirements need to be connected to the educational experience. The resident must be performing tasks consistent with future practice within an authentic environment. Integrated learning in specialized and diverse family medicine settings (office, hospital, home, and rural and urban settings) provides the most appropriate learning in the resident's chosen specialty.

Residents themselves recognize the importance of a training program that is centred in family medicine. In

the CFPC Section of Residents' *Guide for the Improvement of Family Medicine Training*, residents advocate repeatedly for experiences that are pertinent to the issues encountered in primary care.²⁰ The overarching theme of their publication is the development of training experiences with high relevance to their eventual practice that include opportunities to experience continuity of patient care.

The burden of proof for the superiority of one curricular design over another rests with an examination of the quality of graduates and their ability to meet community needs and achieve desired clinical outcomes for their patients. It is anticipated that Triple C, with its emphasis on a family medicine-centred educational approach, will provide the best opportunity to graduate family physicians who have the unique expertise required to provide care for all Canadians in diverse settings; a clear understanding of the centrality of the patient-physician relationship; a well-developed sense of professional identity; and the ability to adapt, maintain, and develop new competencies as required by their practices and communities.

Visit www.cfpc.ca/triple_C or contact triplec@cfpc.ca for more information. 

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Competing interests

None declared

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