The future of Certificates of Added Competence

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Dear Colleagues,

As we move forward with the recommendations of the Outcomes of Training project (OTP), many have asked how this will affect Certificates of Added Competence (CACs).

We continue to support and be proud of our members who hold CACs. We are finalizing a companion document to the Family Medicine Professional Profile[1] outlining expectations for members with CACs, gleaned from the Residency Training Profile (RTP).[2] A 2020 evaluation of CACs commissioned by the CFPC describes FPs with enhanced skills as "care providers who have both specific expertise in complex areas of care and an important grounding in family medicine that informs the way they practice, their role in the community, and their relationships with patients and other health care providers."[3] The authors described the important contributions of CAC holders and found that "there are some practice arrangements which facilitate comprehensive care through CAC holders and some ... which discourage it."[3] Comprehensiveness works best when FPs with CACs are well integrated in communities of practice, supporting and enhancing the care provided by generalist FPs.

The OTP has been guided by our social accountability mandate. Canadian family doctors are competent with the shortest postgraduate residency program among comparator countries. Our deep dive into current training and scope of practice suggests that, for various reasons, FPs are not practising as comprehensively today as in the past.

Caring for Canadians is complicated and complex; access issues are worsening. Our objective is to elevate and enhance the preparation of all FPs, including those who wish to acquire CACs. This is captured in the RTP, which describes core professional activities for all FPs and those with CACs. A newly created education task force will consider how to create an integrated 3-year family medicine residency, with the intent of supporting the consolidation of skills, training for comprehensive practice, and allowing for some flexibility. The task force will also consider additional training required for CACs for leadership, advocacy, and support of colleagues and communities. The 3-year residency will lead to a CCFP designation, not a CCFP and a CAC. Additional training will be required for added competence in CAC domains. Extending residency training will ideally increase the base level for those pursuing CACs, allowing for further focus on enhanced skills. As we design the new 3-year program, we will assess whether added time and the consolidation of skills in certain clinical areas during core residency will meet some or many of the requirements for CACs, such that a full additional year of CAC training may not be needed.

Currently our members hold a total of 6132 CACs, distributed in the following clinical areas: addiction medicine (289), care of the elderly (418), emergency medicine (3955), enhanced surgical skills (26), family practice anesthesia (424), obstetric surgical skills (53), palliative care (615), and sport and exercise medicine (352).

Another important recommendation of the OTP is to implement a practice-eligible route (PER) for CACs to support advanced family medicine skills and leadership in practice and to develop and advocate for re-entry training opportunities that support practising FPs in obtaining enhanced skills in response to local community needs.

The emergency medicine credential is the oldest, introduced in 1982; it is the only CAC for which an examination is required and the only one for which a PER exists. This will continue to be supported. We plan to expand the PER to other CACs. An advisory group has been created to consider options, including assessing members who can show that they are practising in the domain of care and provide evidence of competence. For procedure-based domains, such as enhanced surgical skills, obstetric surgical skills, and FP anesthesia, options will be developed that allow for the direct observation of competence over time. Our next steps include consulting program directors, medical regulatory authorities, and regional health authorities. We hope to launch the PER expansion over the next 18 months.

We are aiming for comprehensive generalist FPs with a broad scope of practice who have interprofessional work arrangements and are committed to population-based care. We also aim to support those with interest in enhancing their competence in specific areas to better meet community needs. This does not require CACs in all areas, but we will continue to support CACs, reflecting advanced competency and leadership skills acquired through either a residency or a PER. We embark on this work with enthusiasm and with the best interests of learners, practising FPs, and the patients they serve in mind. Stay tuned.

Cet article se trouve aussi en français à la **page 239.**

Acknowledgment
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References
1. *Family medicine professional profile.* Mississauga, ON: CFPC; 2017.
2. *Residency training profile.* Mississauga, ON: CFPC; 2021.
3. Grierson L, Vanstone M, Allice I. *Understanding the impact of the CFPC Certificates of Added Competence.* Hamilton, ON: McMaster University; 2020.

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