A PAN-CANADIAN PRA PROCESS DESIGN

FAMILY MEDICINE PRA STANDARDS

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Document Version Control

Version	Date	Description
0.1	Sept. 18, 2012	Incorporation of NAC PRA Steering Committee input
0.2	Sept. 26-27, 2012	Incorporation of Chair & CFPC representative into the document
0.3	Oct. 16, 2012	Incorporation of extended stakeholder working group input
0.4	Jan. 18, 2013	Review and formalization of standards vs. recommendations and revisions to content; separation of standards and sustainable business model components
0.5	Feb. 21, 2013	Walkthrough and substantive changes to competencies and assessment section from PRA programs, MRAs and CFPC
0.6	March 18, 2013	Review by MCC's Medical Education Assessment Advisory Committee (MEAAC)
0.7	March 27-28, 2013	Modifications and revisions based on extended stakeholder working group input from PRA programs, MRAs, CFPC, RCPSC and MoH
1.0	May 10, 2013	Incorporation of NAC[3] input & final approval
1.1	June 16, 2014	Incorporation of clarifications approved by the NAC PRA Steering Committee
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2.0	May 15, 2015	Incorporation of revisions suggested by the NAC PRA working groups, NAC PRA Steering Committee and approved by the NAC[3]
2.1	June 30, 2016	Incorporation of the revised FMRAC Model Standards for Provisional Licensure in Canada

Acknowledgement

The National Assessment Collaboration (NAC) comprises a number of Canadian organizations including:

- Health Canada
- The Medical Council of Canada (MCC)
- Provincial and territorial governments
- Regional IMG assessment programs
- Provincial and territorial medical regulatory authorities
- The Federation of Medical Regulatory Authorities of Canada (FMRAC)
- The Association of Faculties of Medicine of Canada (AFMC)
- The Royal College of Physicians and Surgeons of Canada (RCPSC)
- The College of Family Physicians of Canada (CFPC)
- Le Collège des médecins du Québec (CMQ)

Representatives from these organizations form the governance body, the National Assessment Central Coordinating Committee (NAC[3]), with the goal of developing pan-Canadian assessment processes for international medical graduates (IMGs) that include a common practice ready assessment (PRA) process.

Several provinces already offer a PRA locally. To enhance transferability across provincial and territorial boundaries and reduce duplication, the NAC is working to create a pan-Canadian PRA process that will be consistent and comparable across Canadian jurisdictions. This route would be available to IMGs seeking a provisional licence to enter independent practice.[1]

The NAC PRA project has been funded by Health Canada to develop a sustainable, pan-Canadian process to evaluate IMGs' readiness for practice. The development and agreement on standards for such a process has been possible through engaging and working with representatives from the medical regulatory authorities (MRAs), existing and planned IMG PRA programs and/or processes, certification colleges, provincial and territorial Ministries of Health and other subject experts.

Of particular note, these standards would not have been achievable without the efforts and dedication of critical stakeholder support from:

- MRAs and FMRAC for their work on defining the *Standards for the Issuance of a Provisional Licence*, developed through the FMRAC Registration Working Group and the work completed under the FMRAC Working Group on Assessment and Supervision (in addition to its role as an active steering committee for the pan-Canadian PRA work)
- CFPC for leading the definition of family medicine competencies through the outstanding leadership of Dr. Tim Allen working with our expert panels
- IMG PRA programs who actively contributed and reflected with a view to adjust respective programs to meet the defined standards

This collaboration and these relationships have been instrumental in defining pan-Canadian standards for practice ready assessment and developing approaches for implementation.

[1] In Quebec, the restrictive permit allows independent practice but only in specific establishments.

Contents

Document Overview

Document Purpose

This document presents acceptable standards for a pan-Canadian practice ready assessment (PRA) process for international medical graduates (IMGs) wishing to practice family medicine in Canada. It has been developed under the aegis of the National Assessment Collaboration (NAC) and focuses on the "what" of a pan-Canadian process.

Document Structure

The document is organized according to the PRA focus areas outlined below and provides an overview of the following:

Main Body:

- **Process component description:** the intention of the process component is given in context of pan-Canadian PRA
- **Future pan-Canadian state:** proposal for the future state of PRA
  - *Standards*
  - *Recommendations or guidelines*

Appendices:

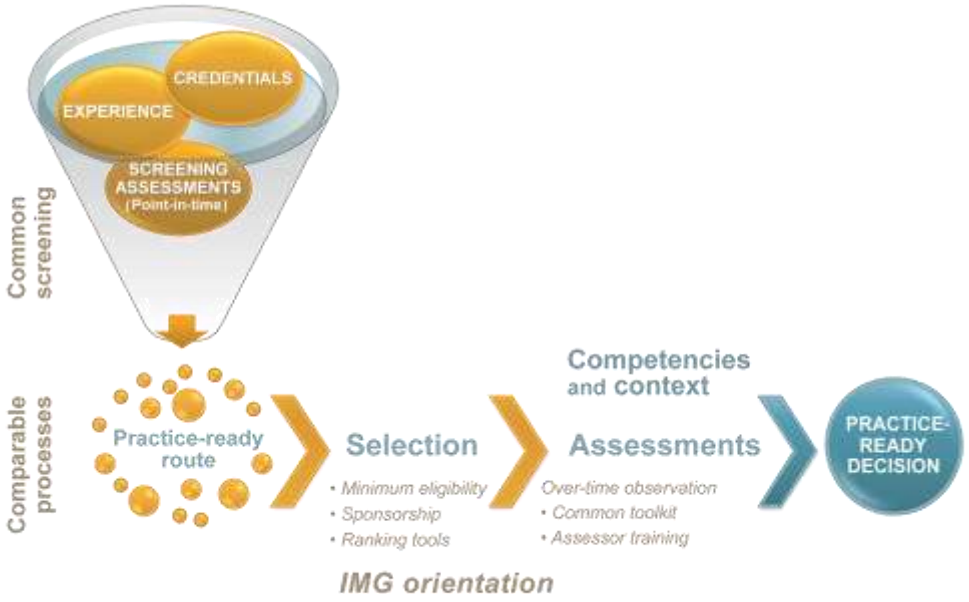
- **Appendix A:** Acronyms used within the document
- **Appendix B:** Federation of Medical Regulatory Authorities of Canada (FMRAC) Standards for Provisional Licensure

Pan-Canadian PRA Standard Overview

The National Assessment Collaboration (NAC) Practice Ready Assessment (PRA) objectives are:

1. Design and propose a pan-Canadian process for the evaluation of a physician's readiness for practice (i.e., to be issued a provisional licence as a most responsible physician [MRP]).
2. Develop or adopt common standards across jurisdictions.

Through the NAC PRA Environmental Scan finalized in April 2012, an overall process was explored and is depicted in the diagram below. The proposed PRA process includes common screening elements and comparable processes across jurisdictions.



As part of the design, activities will focus on establishing acceptable standards across various process areas including:

- Initial screening and PRA selection (Section 1)
- Context and competencies (Section 2)
- Assessment process, assessor criteria and tools used (Section 3)
- Decision-making about an IMG physician's readiness to practise (Section 4)
- IMG orientation (Section 5)

In addition to the various meetings and workshops, information sources for this document include:

- NAC PRA Environmental Scan final report
- FMRAC Working Group on Assessment and Supervision (WGAS)

1. Initial Screening & PRA Selection

A relatively standardized initial screening and selection process is envisioned for selecting those IMGs who have the highest likelihood of success into the PRA process of any given jurisdiction. The specific resources used for screening and selection may vary by region and may include:

- Nationally required screening assessments, credentials and experience (i.e., Medical Council of Canada [MCC] Evaluating Examination [MCCEE], MCC Qualifying Examination [MCCQE] Part I and language proficiency results)
- Minimum eligibility criteria that may be required by the individual Medical Regulatory Authorities (MRAs) for provisional licensure
- Ranking practices
- Application/registration-related policies (i.e., number of attempts, evidence of remediation/learning activities following prior PRA attempts, etc.)

A. Initial Screening

To qualify for a PRA process, a physician applicant must meet the minimum eligibility requirements for registration in Canada as per FMRAC's agreement on standards for medical registration in Canada. For ease of reference, the elements required for provisional licensure that inform this initial screening are listed in Appendix B – *FMRAC Standards for Provisional Licensure - Expectations and/or Requirements for Entry into PRA*[2].

To note, additional tools are being considered and may be recommended (e.g., MCCQE Part I when available internationally or more frequently, the assessment of language skills required for the practice of medicine) if evidence supports the predictive validity of the tools for language testing.

Where possible, initial screening point-in-time assessments should be accessible outside of Canada.

B. Application/Registration

General application and registration standards are required within the pan-Canadian PRA process to facilitate consistent and clear communications for IMGs and to enable information sharing across jurisdictions.

1. Program

1.1. Capacity for an assessment ("an assessment spot") must be available prior to a candidate being accepted into the PRA program

1.2. IMG physicians must be sponsored for a future potential job prior to an over-time assessment occurring; however, it is highly recommended that sponsorship be determined at point of application to a PRA program

1.3. Information about screening and basic eligibility requirements must be publically available

[2] The FMRAC standards are as defined at the point of finalization of this standards document. The primary source is accessible through FMRAC.

2. Candidate-Related Items

2.1. The candidate will have a maximum of two over-time assessment attempts in total in Canada (regardless of the provincial or territorial jurisdictions where the attempts take place)[3]

2.1.1. Attempts must take place within a five-year period

2.1.2. An over-time assessment attempt is defined as the start of the over-time assessment period

2.1.2.1. In the event of a withdrawal, the PRA program may elect to not count the over-time assessment as an attempt with the acceptance of a candidate's valid petition of extenuating circumstances

2.2. PRA programs must acquire candidates' consent for the disclosure and use of information including:

2.2.1. PRA attempts

2.2.2. Appeal outcomes

2.2.3. PRA results (pass/fail/incomplete/withdrawal)[4]

2.2.4. De-identified information for research purposes

2.3. Candidate consent must include informed consent regarding the stakeholders who will have access to their information

C. PRA Selection/Ranking

In some jurisdictions, there are further requirements for entry into a PRA process. Typically, these include ranking activities and/or assessment tools to further filter IMG physicians who are applying for a PRA where capacity is constrained by cost, resources, timelines, etc. (i.e., where there are more candidates than assessment spots). These ranking and selection activities occur prior to the assessment described in Section 3.

No standards are described for this activity; however, the development of common or comparable selection and ranking activities is desirable.

[3] A jurisdictional PRA program determines how many point-in-time selection attempts a candidate may have.

[4] At the request of the MRAs, two versions of standardized language to obtain the appropriate consent from candidates undergoing PRA were approved and will be referenced in future policy-related documentation.

2. CONTEXT & COMPETENCIES

As part of the assessment process, standard requirements for context and competencies will be agreed upon and will inform the regional variations in assessment that will exist within a pan-Canadian process.

Background

Competence is not solely doing the "right thing"; it is doing the right thing, at the right time, in the right way, for the right reasons and to do this habitually in daily practice for the benefit of those being served. The recommended reference document for defining competence in these terms for the practice of family medicine is the College of Family Physicians of Canada (CFPC) Evaluation Objectives (EO). These are competency-based objectives developed and refined by the CFPC through an iterative process of consultation with practicing family physicians from across the country. The EO were developed from this expanded concept of competence and are currently the basis for designing in-training assessment during residency and for setting certifying examinations.

The EO have a four-layered structure and any particular individual competency is usually described by all four layers:

1. **Essential Skill Dimensions of Competence**[5]
    - Clinical reasoning skills – concentration on phases that require higher cognitive levels of thinking (e.g., diagnostic or problem solving phases, hypotheses and differential diagnosis, dynamic data gathering and decision-making *[refer to phases, priority topics and key features]*)
    - Selectivity – recognition that competence is characterized more by selective and adaptive approaches to problems than by routine or stereotypical approaches *(refer to priority topics and key features)*
    - Communication skills *(refer to themes and observable behaviours)*
    - Professionalism *(refer to themes and observable behaviours)*
    - Procedure skills – emphasis on the general skills necessary to perform any procedure in a competent fashion and not on the technical skills themselves *(refer to core procedures and key features)*
2. **Phases of Clinical Encounter**
3. **Priority Topics, Core Procedures and Themes**
4. **Key Features and the Observable Behaviours**

5 A sixth essential skill, the patient-centered approach or the patient-centered clinical method, is more properly at the level of certification in family medicine and is not required for PRA. While candidates should be expected to be patient-centered in their care, they do not need be assessed on their methodology for achieving this goal.

The four layers cover all dimensions of competence, provide a clear guide for clinical learning and assessment and help set a reasonable and transparent standard for determining success in the PRA process. The layers are built around common clinical tasks and problems, which will likely be easy to apply and use; they lend themselves to final reporting in almost any framework that might be chosen.

The reference document for this section, *Defining competence for the purposes of certification by the College of Family Physicians of Canada: the evaluation objectives in family medicine*, is available at http://www.cfpc.ca/EvaluationObjectives.

A. Competencies

Main statement: These candidates are competent to be licensed as family physicians on a provisional register as a most responsible physician (MRP) with supervision, because:

> *"they have demonstrated that they have acquired and use, in a habitual and judicious manner, the eight Sentinel Habits that are found in good family physicians, to deal successfully with problems throughout the Clinical Domains of Care in Family Medicine, and as described by the Evaluation Objectives in Family Medicine of the College of Family Physicians of Canada."* [6]

Table 1: List of Sentinel Habits and Clinical Domains of Care

Sentinel Habits	Clinical Domains of Care
Incorporates the patient's experience and context into problem identification and management	Behavioural medicine Mental health
Generates relevant hypotheses resulting in a safe and prioritized differential diagnosis	Care of adults
Selects and attends to the appropriate focus and priority in a situation	Care of children and adolescents
Manages patients using available best practices	Care of the elderly
Demonstrates respect and/or responsibility	Care of vulnerable and underserviced
Verbal or written communication is clear and timely	Maternity/newborn care
Uses generic key features when performing a procedure	Palliative care
Seeks out and responds appropriately to feedback	Procedure skills

[6] **Defining competence for the purposes of certification by the College of Family Physicians of Canada:** *the evaluation objectives in family medicine.* The CFPC Working Group for the Certification Process (http://www.cfpc.ca/EvaluationObjectives)

A.1 Sentinel Habits and Clinical Domains of Care

The essential skills in family medicine are most often used in an integrated fashion in the daily clinical practice setting. The key integrated clinical skills that are found in a good family physician become a set of habitual behaviours indicative of overall competence, and so they have been labeled "sentinel habits". The sentinel habits have consistently proved useful and useable by clinicians providing assessment and feedback of colleagues in the clinical workplace, and so provide a solid foundation for any workplace-based assessment of competence.[7] Workplace-based assessment, even when it is primarily summative, must provide and document the feedback that justifies the final decisions.

The clinical domains of care are a convenient way to describe the breadth of practice of family medicine and a framework for ensuring that an assessment of competence takes place across the breadth of this practice. The priority topics and procedures from the CFPC EO all pertain to one or several of the clinical domains of care.

A.2 Range of Topics and Skills

The precise topics and problems that successful PRA candidates should be able to handle, the care that they should be able to offer and the clinical skills they should use are those described in the CFPC's EO (essential skills, phases, priority topics, key features and observable behaviours) with the following additional qualifying comments:

1. **Intra-partum care and obstetrical procedures:** there is no requirement to be competent in this area of care for PRA
2. **Physical examination:** the candidate must be competent in all the common elements of the physical examination
3. **Level or context of care:** the candidate must be competent[8] to provide care in the following practice environments:
   - The community
   - Long-term care institutions
   - Community hospitals providing in-hospital care and acute or urgent care
4. **Specific practice environments:** for candidates going to a practice environment that requires specific procedural skills or the capacity to deal with certain types of patients and problems that are not included in the above:
   - Additional competency requirements must be clearly identified
   - Additional competencies are just that, they do not obviate the need to demonstrate all the general competencies, as specified above

[7] **Competency-Based Achievement System**: *Using formative feedback to teach and assess family medicine residents' skills.* Ross S, Poth CN, Donoff M, Humphries P, Steiner I, Schipper S, Janke F, Nichols D. **Canadian Family Physician** 2011; 57:e323-30

[8] This competency requirement does not imply that assessment must or should take place in these settings.

3. Over-Time Assessments

Assessment is the critical component of a pan-Canadian PRA process and encompasses acceptable standards for the required over-time assessment of clinical competence in the workplace. The scope of assessment is broad and includes the assessment environment, competence expectations as defined in Section 2 (*Context & Competencies*), the protocols and tools for conducting the assessments, assessor specifications and the reporting tools necessary to facilitate comparability of practice-ready decision-making across jurisdictions. The main objective is to assess the attitudes, skills and behaviours of PRA candidates over a reasonable sample of relevant clinical domains to ensure quality and comparability of assessments across jurisdictions.

A balance should be found between:

- General competency and the specific skills required for a specific jurisdictional practice context
- Minimum and maximum assessment documentation recommendations for legal defensibility
- The number of documented observations, assessors, locations, domain recommendations and regional parameters related to cost and logistics
- Providing for regional variation and ensuring quality and comparability of assessment decisions across jurisdictions

A. Over-Time-Assessment in a Supervised Environment

A.1 Environment

Supervision and assessment must occur in practice environments that reflect the anticipated practice environment for the PRA candidate:

1. Over-time assessment should be independent of the sponsoring person or organization
   1.1. Where an independent over-time assessment is not feasible for resource reasons; such as no alternate practice is available and/or assessor capacity limits, then the assessment process must ensure that there are safeguards in place to avoid real or perceived assessor bias and/or conflict of interest
2. The assessment must occur in a supervised practice setting with:
   2.1. Ongoing, closely supervised clinical practice with regular assessment and daily feedback
   2.2. Sufficient time and structure for the PRA candidate to become integrated into the practice environment and to demonstrate performance that allows for a valid assessment of their clinical competence
3. If at any time during the assessment period a PRA candidate represents a significant safety risk to the public, the assessor will report to the PRA program which will in turn report this to the MRA; the MRA will consider its options, including termination of the candidate's licence (see A.2, item 5.1.1.1)
4. The assessment must occur in an environment conducive to performing the assessment (e.g., appropriate space, commitment of assessors and practice partners who are not assessors to host

Recommendations:

- PRA candidates must be issued a license in order to participate in an assessment, where required
- PRA candidates must qualify for Canadian Medical Protective Association (CMPA) coverage (i.e., be registered), where required

the assessment, etc.). Family practices that respond to most phases of community needs or community emergency departments would likely provide suitable environments, meaning:

4.1. Sufficient numbers of patients with undifferentiated new problems that require resolution

4.2. Sufficient range and variety of the topics and situations found on the priority topics and key features lists (CFPC)

A.2 Assessment Period Standards

A program plan must be established that allows sufficient time for the candidate to experience the broad range of patient presentations that are common to family practice, to be exposed to life-threatening emergencies and to demonstrate the required competencies outlined in Section 2. More specifically, this means:

1. Clear objectives are set for the assessment period
2. Multiple independent observations are made across multiple situations by multiple observers
3. Patient presentations chosen for assessment, documentation and feedback are understood to be primarily opportunistic in nature, determined by the patient availability within a given setting; it is also understood that patient presentations must have the potential to significantly inform the assessment to support a valid decision regarding the PRA candidate's clinical competence
   3.1. As necessary, observations during work may be complemented by structured or semi-structured assessments for specific purposes (e.g., charting, a few procedures, case-based discussion [CBD])
   3.2. Assessments may occur in time blocks organized by competency in the same or different locations; ideally, each block would be supervised by a different assessor
4. Any assessment period must provide:
   4.1. Time for situational acclimatization/adaptation for the candidate to the assessment environment
   4.2. Adequate time to provide feedback and assess if the feedback has been incorporated
5. Any assessment period must provide sufficient time to document the observations required for valid decision-making against the competencies as defined in Section 2
   5.1. Specifying the exact time period for the assessment is less important than completing and documenting sufficient observations of the required competencies; however, the rationale for exceptions to the jurisdictionally-established time periods should be documented and legally defensible
      5.1.1. Practice-ready decisions are based on the cumulative observation of interactions with patients and therefore require time
         5.1.1.1. The decision to end an over-time assessment early because a candidate's performance is at either extreme of the decision spectrum has been deemed acceptable across programs with the caveat that the emphasis is on "extreme ends of the decision spectrum" (i.e., dangerous or clearly outstanding); this understanding was reached with the agreement that such decisions should be rare and should not subvert the inherent principles of over-time assessment

Recommendation:
While the standard requires multiple observations over multiple situations, an over-time assessment should:

- Follow the guidelines related to Assessment Tools (Table 2)
- Take no longer than 12 weeks

B. Assessors

Assessors across jurisdictions should reach similar conclusions regarding the practice-readiness of PRA candidates. To this end, the following standards and guidelines are articulated:

1. Assessor Recruitment Criteria

1.1. Assessors should be experienced, competent family physicians who practise in areas that are compatible with PRA placements

1.2. Common assessor recruitment criteria across PRA programs are:

1.2.1. Assessors must hold a licence to practise medicine and be in good standing with their MRA

1.2.2. Assessors must have at least three years of practice in Canada within a similar scope of practice to the proposed PRA placement

1.3. Assessors are not required to have prior formal experience in assessment so long as assessor supports are in place

Recommendation:

- It is preferable that assessors have CFPC certification; however, this is not mandatory

2. Assessor Supports

2.1. Assessors must be provided with specific assessor training, the length of which will depend on their experience

2.2. Support and feedback for the assessor must be in place throughout the assessment period

2.3. Assessor orientation and training must include:

2.3.1. Assessment goals and the assessment requirements

2.3.2. Information on the IMG physician context; e.g., cultural diversity and acculturation challenges

2.3.3. Updates on specific clinical situations as needed and required by the proposed practice placement for the PRA candidate

2.3.4. Assessment methodology:

2.3.4.1. Clinical competencies and domains being assessed

2.3.4.2. Contra-indicators of practice-readiness

2.3.4.3. Providing valid feedback

2.3.4.4. Assessment tools (i.e., how to document observations)

2.3.4.5. Fairness principles

2.3.4.6. Reporting requirements

2.3.5. Guidelines and support for addressing challenging situations and candidates in a timely manner

C. Candidates

Any assessment program must provide the candidate with:

- A safe and impartial assessment
- Support and/or mechanisms to raise and discuss issues and/or concerns with the assessment process

Recommendation:
- PRA programs should ensure that PRA candidates are familiar with the tools that will be used during the assessment

D. Assessment Tools

Over-time assessment data to support decision-making for practice-readiness must come from three sources: multi-source data, chart-based assessment and continuous clinical assessment. General principles have been articulated:

1. Tools used within individual PRA programs must be *comparable* to those tools used by other PRA programs
2. Assessment tools must support documentation of patient/PRA candidate interactions and assessor/PRA candidate interactions
   2.1. Documentation must include, but is not limited to, narrative comment on competencies (e.g., field notes)
3. Assessment tools must facilitate documentation of observed competence in a natural setting (e.g., field notes or mini-clinical evaluation exercise [mini-CEX])
4. Assessment tool(s) each have a specified purpose and their use must be appropriate to the competencies being assessed
5. The combination of assessment tools must support formative feedback in the workplace and summative decisions
6. Examinations used to complement the over-time assessment must not duplicate any of the screening assessments; such examinations should assess competencies that have been identified for the PRA that are not readily assessed in the workplace, commonly for logistical or cost reasons

More specifically, Table 2 provides the standards and guidelines that have been established for each data source.

Table 2: Standards and Guidelines for Over-Time Assessement Tools

	CHARACTERISTICS/DATA SOURCES		
	Multi-Source Data	**Chart-Based Components**	**Continuous Clinical Assessment (Observation Over-Time)**
DESCRIPTION	• Not specified (data focuses on communicator, collaborator & professional roles)	• Chart stimulated recall Chart audits • Case-based discussions	• Mini-CEX • DOPS • CBAS • Field notes
STANDARD	• Data comes from patients and professional colleagues (MD & non-MD) • Input is documented	• Candidates demonstrate ability to meet jurisdictional regulatory standards for charting activities • Chart-based observations are reported	• Observations cover all sentinel habits across all clinical domains (may omit palliative care) • Observations occur across time and patient problems
GUIDELINE	Ideally, multi-source data comes from: • No fewer than 15 patients sampled as broadly as possible across patient demographics and problems • 5-8 professional colleagues (MD & non-MD)	• Assessor decision regarding number of charts for review	More than one clinical setting may be required to ensure appropriate sampling, if only using • field notes, one/day totaling 40-80 or • mini-CEX (or equivalent), one/week totaling 8-12

4. Decision-Making

A successful, standardized, pan-Canadian PRA process for family medicine is one that allows for some regional flexibility and allows all jurisdictions to have confidence in the end result regardless of which jurisdiction administered the assessment. In short, the same pass/fail decision should be made for similarly-competent PRA candidates.

Regardless of differences in screening requirements, processes, tools and length of assessment time:

- Jurisdictions (provinces/territories and health-care authorities) need to be confident that the appropriate practice-ready decision has been made
- MRAs need to be confident that a physician who has successfully completed a PRA program is acceptably competent

Reporting of PRA decisions needs to inform licensing decisions and meet the information needs of PRA candidates and other jurisdictional stakeholders.

A. Characteristics

A formal decision-making process must be documented and transparent to the PRA candidate and all PRA programs, meaning:

1. To be able to infer that overall competence is likely, decisions must be based on competence that is demonstrated repeatedly over a sufficient variety of situations in an appropriate practice environment
2. Decisions must be based on all the assessment data from all locations and experiences and must reflect having demonstrated a significant level of competence in all requirements
3. The final decision as to a PRA candidate's practice readiness must be made by the PRA program based on the recommendations of the lead assessor and an overall review of the assessment.

Recommendation: Very strong performance in some areas does not compensate for less than adequate performance in other areas; an "average score" approach is *not* recommended

It is generally agreed that the practice-ready decision should be made by the PRA program (regardless of where the program is "housed") based on the recommendation/observations of the lead assessor. It is clear that MRA licensure decisions are not in scope of this activity.

B. Reporting

Common information should be reported to the PRA candidate and other stakeholders.

1. Candidates should receive detailed feedback supporting the final practice-ready decision
2. Reporting should be organized under common headings and language (e.g., "Competencies have been demonstrated in…") and should include:
   - 2.1. Description or summary of the assessment process used
   - 2.2. Description of the competencies assessed (scope)
   - 2.3. Candidate assessment information (evidence upon which the decision was based)
   - 2.4. Formative feedback

2.5. Practice-ready decision
2.6. Evidence that the findings have been reviewed by the candidate

3. Candidates must consent to the sharing of their information
4. PRA program information must be shared with other stakeholders upon request and should include:
   4.1. Examples of practice-ready competencies demonstrated by the PRA candidate
   4.2. Useful detail for the sponsor that enables the sponsor to assist the candidate with targeted continuing professional development during the provisional licensure period and to inform the post-provisional licensure supervision period
   4.3. Useful aggregate data for the provincial/territorial government and/or the NAC
5. MRAs
   5.1. Record of the result (pass/fail/incomplete/withdrawal/appeal outcome)

C. Appeals

PRA programs must ensure candidate access to a jurisdictional appeals process, meaning:

1. The appeals process must be legally defensible in each jurisdiction and comply with jurisdictional legislation
2. The appeals process must be clearly documented and PRA candidates must be informed of the policy before entering a PRA program
3. Appeals must be handled in a timely manner

5. IMG Orientation

Orientation must be available for IMGs either before or during the PRA. The ultimate goal is to select the IMG physician with the required skill sets to serve the public. An underlying principle is that there should be a level playing field for IMG physicians attempting PRA.

The content, length, duration and sequencing of an orientation program are to be determined by jurisdiction; however, to ensure a level playing field for the comparability of assessments and to meet health human resource needs, common topics must be covered. The guiding principle is for common content and regional flavour.

Given the understanding that minimum acceptable orientation standards should be set, the following guidelines are presented:

- Other organizations may administer, facilitate, fund or deliver the orientation provided the required content is covered
- PRA orientation should offset the inherent disadvantages of an IMG candidate, based on limitations that may exist to their understanding of health-care delivery in Canada due to cultural background and different underlying assumptions about health care

A. Content

1. PRA candidates must be offered orientation
2. Content covered includes:
    - 2.1. PRA program information
        - 2.1.1. Policies for the assessment
        - 2.1.2. Assessment logistics and schedule
        - 2.1.3. Competencies to be assessed
    - 2.2. Jurisdictional information such as the role of jurisdictional stakeholders and legal obligations
    - 2.3. Canadian context information:
        - 2.3.1. Overview of the Canadian health-care system
        - 2.3.2. Physician expectations
            - 2.3.2.1. Patient-centered care
            - 2.3.2.2. Effective physician communication
            - 2.3.2.3. Boundary issues
            - 2.3.2.4. Electronic health records
            - 2.3.2.5. Prescribing in practice
            - 2.3.2.6. Medical/legal issues
            - 2.3.2.7. Ethics
            - 2.3.2.8. Multi-disciplinary teams
        - 2.3.3. Key learning activities (i.e., Assessment, Learning and Technology Solutions [ALTS])

Note: These standards were proposed in context of the FMRAC document entitled Integrating International Medical Graduates into the Medical Community authored by Ms. Gwen MacPherson (October 2011).

APPENDIX A – LIST OF ACRONYMS

Acronym	Description
ALTS	Assessment, Learning and Technology Solutions
CBAS	Competency-Based Achievement System
CBD	Case-based discussion
CCA	Continuous Clinical Assessment
CFPC	College of Family Physicians of Canada
CMPA	Canadian Medical Protective Association
DOPS	Direct Observation of Procedural Skills
EO	Evaluation Objectives (in Family Medicine)
FMRAC	Federation of Medical Regulatory Authorities of Canada
IELTS	International English Language Testing System
IMG	International medical graduate
MCC	Medical Council of Canada
MCCEE	Medical Council of Canada Evaluating Examination
MCCQE	Medical Council of Canada Qualifying Examination
MEAAC	Medical Education Assessment Advisory Committee
Mini-CEX	Mini-clinical evaluation exercise
MoH	Ministry of Health
MRA	Medical Regulatory Authority
MRP	Most Responsible Physician
NAC	National Assessment Collaboration
PRA	Practice ready assessment
RCPSC	Royal College of Physicians and Surgeons of Canada
TOEFL	Test of English as a Foreign Language
WGAS	Working Group on Assessment and Supervision

APPENDIX B – FMRAC STANDARDS FOR PROVISIONAL LICENSURE - EXPECTATIONS AND/OR REQUIREMENTS FOR ENTRY INTO PRA

Appendix B.1 – Model Standards for Medical Registration in Canada

The following is sourced from the FMRAC Model Standards for Medical Registration in Canada, (Section 2; Provisional Licensure) and are applicable in the context of PRA. Please refer to FMRAC for the most current version; http://fmrac.ca/model-standards-for-medical-registration-in-canada-2/ .

The PRA application should include a statement in the beginning that instructs the candidate of the need to adhere to strict honesty in answering all the questions.

Model Standards for Provisional Licensure in Canada

A. Pre-screening Requirements

The pre-screening requirements for physicians who may qualify for a provisional license include the following seven components and are grouped into when the element must be confirmed:

A.1 To be completed before a candidate is offered a practice-ready assessment

1) Language proficiency - basic language skills:

a) French language testing in accordance with the laws in Québec.
b) English language testing:
   a. Candidates are exempted from English language proficiency testing if:
      i. their undergraduate medical education was taken in English in one of the countries that have English as a first and native language (see list below); or
      ii. they are currently in practice or in a postgraduate medical education program in a country or jurisdiction where English is a first and native language (see list below) and they met the FMRAC Language Proficiency Testing model standard in order to enter postgraduate training or practice in that country jurisdiction.
   b. All other candidates must have taken IELTS academic version within the last 24 months at the time of application, and achieved a minimum score of 7.0 in each of the four components in the same sitting.

List of countries that have English as a first and native language

- Countries: Australia, Bahamas, Bermuda, British Virgin Islands, Canada, Ireland, New Zealand, Singapore, South Africa, United Kingdom, United States of America, US Virgin Islands
- Caribbean Islands: Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Grenadines, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent, Trinidad and Tobago

2) Currency of practice: Upon submission of the completed application, the candidate must provide documented evidence of having been in discipline-specific formal training or discipline-specific independent practice within the last three years.
3) Length of time away from practice:
   a) For non-medical reasons
      The candidate must provide an explanation for any and all periods of three months or more that were spent away from discipline-specific training or practice, for the entire professional lifetime.
   b) For medical reasons
      The candidate must report any absence from training or practice (clinical, teaching, research or administration) that resulted from a medical condition that could have (a) a risk of harm to patients, (b) a negative impact on practice, or (c) both. If in doubt about the obligation to report an absence of this nature, the candidate is requested to contact the relevant medical regulatory authority.
4) Credentials: In recognition of the varying amount of time required for source verification of credentials, the candidate's application will be considered once all the relevant documents have been received for verification by the Physician Credentials Repository. The medical regulatory authority has the right to reverse its decision if verification is not possible, if adverse information is uncovered, or if the candidate withdraws consent to view the document or documents.
5) Medical Council of Canada Evaluating Examination (MCCEE).

A.2 To be completed after a candidate is offered a practice-ready assessment but before beginning over-time assessment

1) Good standing/character: The candidate must provide evidence of good character through several processes, for example: self-disclosure (best achieved through the application process), certificates of professional conduct from each and every jurisdiction in which they held a license, letters of reference, criminal record checks and any other information as required by the medical regulatory authority.
2) Fitness to practise (physician health): The candidate must provide evidence of fitness to practise (physician health) through several processes, for example: self-disclosure (best achieved through the application process), certificates of professional conduct from each and every jurisdiction in which they held a license, letters of reference, criminal record checks and any other information as required by the medical regulatory authority.
   - N.B.: For A.2 (1 and 2), criteria on who should provide letters of reference and a standard form for these letters have been developed and approved, and are available upon request.
3) Medical Council of Canada Examinations: At minimum, the Medical Council of Canada Evaluating Examination; preferably, the MCC Qualifying Examination Part I.

B. Standard for the Issuance of Provisional Licensure Applicable to PRA

General Practitioners/Family Physicians
1. MD Degree (WDMS 2000 or IMED) or Doctor of Osteopathic Medicine (U.S.); ***and***
2. At minimum the MCC Evaluating Examination; preferably the MCC Qualifying Examination Part I [9] N.B.: this does not apply to physicians with academic appointments (see Exemptions); ***and***
3. a) Satisfactory completion of a nationally approved two-year discipline-appropriate postgraduate training program in general practice or family medicine, with certification of satisfactory completion of training and of registration/recognition as a general practitioner/family physician within the jurisdiction; **or** b) Satisfactory completion of at least one year of discipline-specific postgraduate training in general practice or family medicine, and three years of discipline-specific time in independent practice as a general practitioner or family physician outside of Canada (see B.2 for questionnaire on recent practice experience); ***and***
4. A competency-based, pre-practice assessment in Canada[10]

[9] For the MCC Evaluating Examination and the MCC Qualifying Examination Part I, the standard is to record success only.

[10] For the pre-assessment (filter) components and the competency-based, pre-practice assessment, the standard is to record the result (pass / fail / incomplete / withdrawal) from all Canadian jurisdictions and consent to do so will be obtained from the candidates.

Appendix B.2 – Practice Experience

IMPORTANT: All questions in this section refer to the candidate's three years of practice immediately prior to this application.

ATTESTATION TO INDEPENDENT GENERAL PRACTICE

I attest that my most recent practice in the discipline of general practice/ family medicine (within the last 3 years of my reported practice experience) has been independent, meaning that I have practised without supervision or oversight by another physician.

- ☐ Yes
- ☐ No. Briefly explain: _____

I attest that my most recent practice as described above was exclusively in primary care general practice, I was not acting as a consultant to other physicians and not seeing patients referred by other physicians

- ☐ Yes
- ☐ No. Briefly explain: _____

CLINICAL PRACTICE SETTING

Please indicate all the clinical practice settings that apply to your most recent practice and the average % of the time you spend in each setting in a typical month (please note that the total amount of time must add up to 100%).

Clinical practice setting		Average % of time spent in this setting in any month
1	Ambulatory / office practice	
2	Hospital	
3	Emergency	
4	Long-term care	
5	Other (please specify):	
	Total time	**100%**

SCOPE OF PRACTICE AND PATIENT POPULATIONS

Please indicate all categories of care that apply within your most recent practice. For each category, you will be required to provide a brief description and indicate the volume (number of patients).

(A) Obstetrical care: provide a summary description in the chart below of the type of obstetrical patients/cases you routinely encounter in your most recent practice. Where applicable, include numbers of cases in each of the areas.

Pre-natal	Intra-partum (attendance at delivery)	Post-natal

(B) All others (please complete the table): provide a summary description in the chart below of the type of patients/cases you routinely encounter in your most recent practice.

→ PATIENT POPULATION ↓ PATIENTS PRESENTING	OBSTETRICAL	PEDIATRIC			ADULT		
		Neonate	Child	Adolescent	Young adults	Other adults	Geriatric
With medical conditions							
With surgical conditions							
With psychiatric conditions							
At the end of life							
Percentage of Most Recent Practice (must add up to 100%)	%	%	%	%	%	%	%