A Pan-Canadian PRA Process Design

Internal Medicine PRA Standards
## Document Version Control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description</th>
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<tr>
<td>0.1</td>
<td>May 10, 2013</td>
<td>Using pan-Canadian Family Medicine standards, highlight information that may be different for Internal Medicine under consideration and reflect the Standard for the Issuance of a Provisional Licensure (Appendix B)</td>
</tr>
<tr>
<td>0.2</td>
<td>May 20, 2013</td>
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<td>Review with NAC PRA Steering Committee clarifying standards</td>
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<td>Feb. 10, 2014</td>
<td>General edits and clarifications based on the NAC PRA Psychiatry standards discussions</td>
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<td>0.5</td>
<td>April 4, 2014</td>
<td>Review with Internal Medicine subject matter experts focusing on draft competencies and assessment characteristics</td>
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<tr>
<td>0.6</td>
<td>Oct. 28, 2014</td>
<td>Review with Internal Medicine subject matter experts focusing on competencies and over-time assessment tools</td>
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<td>0.7</td>
<td>Feb. 18, 2015</td>
<td>Final review with Internal Medicine subject matter experts</td>
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<tr>
<td>0.8</td>
<td>Mar. 23, 2015</td>
<td>Review with NAC PRA Steering Committee and recommendation for approval</td>
</tr>
<tr>
<td>1.0</td>
<td>May 15, 2015</td>
<td>Review and approval by the NAC³</td>
</tr>
<tr>
<td>1.1</td>
<td>June 30, 2016</td>
<td>Incorporation of the revised FMRAC Model Standards for Provisional Licensure in Canada</td>
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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), 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.

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)
- RCPSC and the Internal Medicine Specialty Committee subject experts for leading the definition of Internal Medicine competencies that ensure alignment of PRA for initial licensure with final specialty-specific evaluations (under the leadership of Dr. Bill Coke, Dr. Jeffrey Schaefer, Dr. Bonnie Richardson, and Dr. Brian O'Brien)
- Broader specialty groups including the RCPSC Specialty Committee on Internal Medicine and the Canadian Society of Internal Medicine (CSIM)
- IMG PRA programs who actively contributed and reflected with a view to adjust respective programs to meet the defined standards

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1 In Quebec, the restrictive permit allows independent practice but only in specific establishments.
This collaboration and these relationships have been instrumental in defining pan-Canadian standards for practice ready assessment and developing approaches for implementation.
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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 Internal Medicine in Canada. This document is one part of the continuum towards specialty certification. Successful PRA enables an individual to demonstrate the ability to practice under a provisional licence from a provincial/territorial medical regulatory authority. It is aligned with, but separate from, the activities leading to specialty certification by the RCPSC (e.g., practice eligibility route). 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
• Appendix C: Objectives of Training in Internal Medicine
**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)
• Royal College of Physicians and Surgeons (RCPSC) Objectives of Training in Internal Medicine
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 is contained in Appendix B – FMRAC Standards for Provisional Licensure - Expectations and/or Requirements for Entry into PRA.

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

2 The FMRAC standards are as defined at the point of finalization of this standards document. The primary source is accessible through FMRAC.
1.3. Information about screening and basic eligibility requirements must be publically available

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 evolution of common or comparable selection and ranking activities is desirable.

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\(^3\) 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 Internal Medicine context and competencies have been defined and inform the regional variations in assessment that will exist within a pan-Canadian process. This section outlines the competencies expected from a specialist in Internal Medicine (i.e. primary specialty).

**Background**

The *CanMEDS 2015 Physician Competency Framework* describes the abilities that physicians are required to meet the needs of the population they serve. The concepts have resonated with the wider medical education community and it has become the most widely adopted physician competency framework worldwide. From the outset, the primary purpose has been to articulate a definition of the competencies needed for all domains of medical practice, providing a comprehensive foundation for education and assessment.

The framework consists of seven roles that all physicians need to develop to optimize patient care: Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional.

*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.*

In addition to the overarching CanMEDS framework, the following competencies have been defined by subject matter experts to identify the practice-ready competencies all Internal Medicine physicians must demonstrate. These competencies were defined through an iterative process of consultation and align with the CanMEDS competencies as outlined in the Objectives of Training (Appendix C) developed by the RCPSC Specialty Committee on Internal Medicine.

The CanMEDS 2015 Framework also features milestones that physicians in training are expected to achieve at specific stages throughout training. Entrustable professional activities (EPAs) serve as the practical markers of performance relevant to clinical practice that can demonstrate achievement of competence; EPAs represent what physicians do in daily practice. The EPAs typically cover multiple milestones from multiple CanMEDS Roles.

**A. Generic Competencies**

**Main statement:** This candidate is competent to be licensed as an Internal Medicine physician on a provisional register as a most responsible physician (MRP) with supervision, because:

*“He has demonstrated that he has acquired and use, in a habitual and judicious manner, the core knowledge, skills and attitudes that are found in good Internal Medicine physicians, to deal successfully with problems throughout the clinical domains of care.”*
In describing competency and context for Internal Medicine, the focus is on specific Internal Medicine competencies that any practice-ready physician must demonstrate. The following two tables describe these competencies from an entrustable professional activities (EPA) perspective and specific Internal Medicine competency statements expected to be demonstrated through the over-time assessment period.

**Table 1: Entrustable Professional Activities**

<table>
<thead>
<tr>
<th>EPA Code</th>
<th>Entrustable Professional Activity</th>
<th>Concise EPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assess, diagnose and manage patients with acute, common and complex diseases across inpatient settings</td>
<td>Inpatients</td>
</tr>
<tr>
<td>2</td>
<td>Assess, diagnose and manage patients with acute, common and complex diseases across outpatient settings</td>
<td>Outpatients</td>
</tr>
<tr>
<td>3</td>
<td>Assess, diagnose and manage patients with chronic diseases across multiple care settings</td>
<td>Chronic Disease</td>
</tr>
<tr>
<td>4</td>
<td>Recognize and implement appropriate disease-prevention and health-promotion</td>
<td>Prevention &amp; Promotion</td>
</tr>
<tr>
<td>5</td>
<td>Assess, diagnose and manage unstable or critically ill patients</td>
<td>Critically Ill</td>
</tr>
<tr>
<td>6</td>
<td>Provide Internal Medicine consultation to referring sources across multiple care settings</td>
<td>Consultation</td>
</tr>
<tr>
<td>7</td>
<td>Manage transitions of care</td>
<td>Transition of Care</td>
</tr>
<tr>
<td>8</td>
<td>Lead and work within interprofessional health care teams</td>
<td>Team Leader</td>
</tr>
<tr>
<td>9</td>
<td>Collaborate with patients, families and members of the interdisciplinary team</td>
<td>Collaborator</td>
</tr>
<tr>
<td>10</td>
<td>Improve patient safety and the quality of health care at both the individual and systems level</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>11</td>
<td>Demonstrate habits that support lifelong learning</td>
<td>Lifelong Learning</td>
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**Table 2: List of Critical Competencies**

<table>
<thead>
<tr>
<th>Competency</th>
<th>EPAs</th>
<th>CanMEDS Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Function effectively as an MRP and Internal Medicine consultant, integrating all of the CanMEDS roles to provide optimal, ethical, safe and patient-centered medical care</td>
<td>1, 2, 3, 5, 6, 7</td>
<td>MED EXPERT</td>
</tr>
<tr>
<td>2. Establishes and maintains proficiency in clinical knowledge, skills and attitudes appropriate to Internal Medicine</td>
<td>10, 11</td>
<td>MED EXPERT</td>
</tr>
<tr>
<td>3. Perform a complete and appropriate assessment of a patient, including a complete history, organized hypothesis-driven physical examination, and the ability to synthesize information to form an appropriate treatment plan and follow up including: a. Recognize, effectively assess unstable patients and initiate appropriate resuscitation b. Be able to assess patients with one or more chronic conditions, develop a comprehensive plan of investigation and management</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11</td>
<td>MED EXPERT</td>
</tr>
<tr>
<td>4. Uses preventive and therapeutic interventions proficiently</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11</td>
<td>MED EXPERT</td>
</tr>
<tr>
<td>5. Seeks appropriate consultation from other health professionals, recognizing the limits of one’s own expertise</td>
<td>1, 2, 3, 4, 5, 7, 10</td>
<td>MED EXPERT</td>
</tr>
<tr>
<td>Competency</td>
<td>EPAs</td>
<td>CanMEDS Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>------------------</td>
</tr>
<tr>
<td>6. Minimizes risks and discomforts to the patient</td>
<td>1, 2, 3, 4, 5, 6, 9, 10</td>
<td>MED EXPERT</td>
</tr>
<tr>
<td>7. Overall, is proficient in clinical and procedural skills relevant to Internal Medicine, including identification of indications and contraindications, interpretation of results, discussion of potential risks and benefits, obtaining consent, and handling samples as needed. These skills can include performing cardiopulmonary resuscitation, electrocardiograms, lumbar puncture, central line placement in elective and emergency situations, invasive and non-invasive mechanical ventilation, insertion and care of peripheral arterial catheters, knee arthrocentesis, and diagnosing and treating abdominal paracentesis.</td>
<td>1, 2, 3, 5, 6, 10</td>
<td>MED EXPERT PROCEDURAL</td>
</tr>
<tr>
<td>8. Develops rapport, trust and ethical therapeutic relationships with patients and families</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>COMM</td>
</tr>
<tr>
<td>9. Accurately elicits and synthesizes relevant information and perspectives of patients and families, colleagues and other professionals accurately</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>COMM</td>
</tr>
<tr>
<td>10. Conveys relevant information and explanations accurately to patients and families, colleagues and other professionals</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>COMM</td>
</tr>
<tr>
<td>11. Conveys oral and written information about a medical encounter effectively</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>COMM</td>
</tr>
<tr>
<td>12. Develops a common understanding on issues, problems and plans with patients, families and other professionals to develop a shared plan of care</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>COMM</td>
</tr>
<tr>
<td>13. Participates effectively and appropriately in an interprofessional health-care team</td>
<td>8, 9, 10</td>
<td>COLLAB</td>
</tr>
<tr>
<td>14. Works with other health professionals effectively to prevent, negotiate and resolve interprofessional conflict</td>
<td>8, 9</td>
<td>COLLAB</td>
</tr>
<tr>
<td>15. Demonstrates appropriate use of health-care resources in their interaction and treatment management of patients</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11</td>
<td>LEADER</td>
</tr>
<tr>
<td>16. Critically evaluates medical information, its sources and applies this appropriately to practice decisions</td>
<td>11</td>
<td>SCHOLAR</td>
</tr>
<tr>
<td>17. Maintains and enhances professional activities through ongoing learning</td>
<td>11</td>
<td>SCHOLAR</td>
</tr>
<tr>
<td>18. Facilitates the learning of patients, families and other health-care providers</td>
<td>6, 7, 9, 10</td>
<td>SCHOLAR</td>
</tr>
<tr>
<td>19. Demonstrates a commitment to their patients, profession and society through ethical practice</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>PROF</td>
</tr>
<tr>
<td>Competency</td>
<td>EPAs</td>
<td>CanMEDS Role</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>20. Meets deadlines, is punctual, monitors patients and provides follow up</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>PROF</td>
</tr>
<tr>
<td>21. Demonstrates knowledge of and applies the professional, legal and ethical codes for physicians</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11</td>
<td>PROF</td>
</tr>
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</table>
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 the 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 the assessment, in preferably a university (postgraduate training) and community setting, etc.). Overall,
Internal Medicine practices that provide suitable environments and exposure to care of adults including end-of-life care must provide:

4.1. Sufficient numbers of patients with new or acute recurring problems that require resolution
4.2. Sufficient range and variety of the cases and diagnoses found in an Internal Medicine practice setting
4.3. Environments that are suited to cover the context may include
   4.3.1. In-patient services
   4.3.2. Emergency departments
   4.3.3. Ambulatory care
   4.3.4. Intensive care
   4.3.5. Critical care

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 Internal Medicine 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 and 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])
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 observation of cumulative interactions with patients and therefore require time
      5.1.1.1. The decision to end an over-time assessment period early because a candidate’s performance is at either extreme of the decision spectrum has been deemed

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
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

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 Internal Medicine 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 license to practice medicine and be in good standing with their MRA
      1.2.2. The lead assessor must have at least five years of practice in Canada within a similar scope of practice in Internal Medicine to the proposed PRA placement
      1.2.3. The lead Assessor should hold RCPSC certification in Internal Medicine
   1.3. It is preferred that assessors have prior experience in assessment (e.g., assessment of residents)

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

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 observed 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
3. Assessment tools must facilitate documentation of observed competence in a natural setting
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 3 provides the standards and guidelines that have been established for each data source.

Recommendation:
• Candidates should maintain a log of their clinical interactions throughout the assessment period as a mechanism for assessor and candidate discussions
### Table 3: Standards and Guidelines for Over-Time Assessment Tools

<table>
<thead>
<tr>
<th>CHARACTERISTICS/DATA SOURCES</th>
<th>Multi-Source Data</th>
<th>Chart-Based Components</th>
<th>Observed Assessment (Clinical Observation Over-Time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                             | • Data focuses on communicator, collaborator & professional roles | • Chart review/audit  
|                             |                    | • Chart stimulated recall (CSR)  
|                             |                    |   Including the review of referral letters, charts, notes and discharge summaries for clarity and clinical reasoning | • Field notes  
|                             |                    |                        | • Mini-CEX  
|                             |                    |                        | • Educational prescriptions |
| STANDARD                    |                   |                        |                                                      |
|                             | • Data comes from patients and allied health professionals (non-MD)  
|                             | • Input is documented | • Candidates demonstrate ability to meet jurisdictional regulatory standards for charting activities  
|                             |                    | • Chart-based observations are reported | • Observations cover all competencies  
|                             |                    |                        | • Observations occur across time and patient problems |
| GUIDELINE5                  | Normally, multi-source data comes from:  
|                             | • No fewer than 15 patients/family/caregivers sampled as broadly as possible across patient demographics and problems  
|                             | • 8 allied health professionals (non-MD)  
|                             | • MD colleagues where possible | Normally, data comes from:  
|                             |                    | • 8-12 chart reviews/audits  
|                             |                    | AND  
|                             |                    | • 8-12 CSRs | More than one clinical setting may be required to ensure appropriate sampling of a minimum of:  
|                             |                    |                        | • 40-80 field notes OR  
|                             |                    |                        | • 12 mini-CEX AND  
|                             |                    |                        | • Educational prescriptions |

5 Note: the guidelines are proposed in context of standard Section 3, Part A.2 item 5.1.1.1.
4. DECISION-MAKING

A successful, standardized, pan-Canadian PRA process for Internal 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 view of the assessment.

It is generally agreed 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

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
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 candidates with targeted continuing professional development during 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 healthcare 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., consent guidelines, consultation process, controlled substances, etc.)

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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBD</td>
<td>Case-based discussion</td>
</tr>
<tr>
<td>CMPA</td>
<td>Canadian Medical Protective Association</td>
</tr>
<tr>
<td>DOPS</td>
<td>Direct Observation of Procedural Skills</td>
</tr>
<tr>
<td>FMRAC</td>
<td>Federation of Medical Regulatory Authorities of Canada</td>
</tr>
<tr>
<td>HHR</td>
<td>Health human resource</td>
</tr>
<tr>
<td>IELTS</td>
<td>International English Language Testing System</td>
</tr>
<tr>
<td>IMG</td>
<td>International medical graduate</td>
</tr>
<tr>
<td>MCC</td>
<td>Medical Council of Canada</td>
</tr>
<tr>
<td>MCCEE</td>
<td>Medical Council of Canada Evaluating Examination</td>
</tr>
<tr>
<td>MCCQE</td>
<td>Medical Council of Canada Qualifying Examination</td>
</tr>
<tr>
<td>MEAAC</td>
<td>Medical Education Assessment Advisory Committee</td>
</tr>
<tr>
<td>Mini-CEX</td>
<td>Mini-clinical evaluation exercise</td>
</tr>
<tr>
<td>MRA</td>
<td>Medical Regulatory Authority</td>
</tr>
<tr>
<td>MRP</td>
<td>Most Responsible Physician</td>
</tr>
<tr>
<td>NAC</td>
<td>National Assessment Collaboration</td>
</tr>
<tr>
<td>PRA</td>
<td>Practice ready assessment</td>
</tr>
<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
</tr>
<tr>
<td>TOEFL</td>
<td>Test of English as a Foreign Language</td>
</tr>
<tr>
<td>WGAS</td>
<td>Working Group on Assessment and Supervision</td>
</tr>
</tbody>
</table>
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.
A. Standard for the Issuance of a Provisional License

<table>
<thead>
<tr>
<th>Other specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MD Degree (WDMS 2000 or IMED) or Doctor of Osteopathic Medicine (U.S.); and</td>
</tr>
<tr>
<td>2. MCC Evaluating Exam or MCC Qualifying Exam Part I⁶</td>
</tr>
<tr>
<td>N.B.: this does not apply to physicians with academic appointments (see Exemptions); and</td>
</tr>
<tr>
<td>3. (a) Satisfactory completion of discipline-specific postgraduate training in Internal Medicine (candidates with less than four years of discipline-specific postgraduate training will likely have restrictions/conditions on their licence); and (b) A verifiable document of completion of specialist training in Internal Medicine; or</td>
</tr>
<tr>
<td>If a verifiable document is not issued or available, then has been recognized as a specialist authorized to practice independently in Internal Medicine in the country where the postgraduate training was completed; and</td>
</tr>
<tr>
<td>4. A competency-based, pre-practice assessment in Canada⁷.</td>
</tr>
</tbody>
</table>

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⁶ For the MCC Evaluating Examination and the MCC Qualifying Examination Part I, the standard is to record success only.
⁷ 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 C – OBJECTIVES OF TRAINING IN INTERNAL MEDICINE

2011
VERSION 1.0

This document applies to those who begin training on or after July 1st, 2011.

(Please see also the “Policies and Procedures.”)

DEFINITION

An Internist is a specialist trained in the diagnosis and treatment of a broad range of diseases in adults involving all organ systems, and is proficient in the medical management of patients who have undifferentiated or multi-system disease processes. An Internist cares for hospitalized and ambulatory patients and may play a role in teaching or research.

GOALS

Upon completion of training, a resident will be a competent specialist in Internal Medicine and will be able to fulfill a consultant’s role in the specialty. The resident must acquire proficiency in the theoretical basis of the specialty, including its foundations in basic medical sciences and research. The overall aim of this physician training is to instill knowledge and understanding, skills and attitudes, from which are formed the competencies for lifetime practice as a physician in adult Internal Medicine.

Residents must demonstrate the requisite knowledge, skills, and attitudes for effective patient-centered care and service to a diverse population. In all aspects of specialist practice, the graduate must be able to address issues of gender, sexual orientation, age, culture, ethnicity and ethics in a professional manner.

These Objectives of Training have three purposes:

• To provide a template for trainees in acquiring relevant knowledge, skills and attitudes in Internal Medicine
• To provide guidance for programs regarding required areas of training
• To provide a template for assessment of trainees
INTERNAL MEDICINE COMPETENCIES

Upon completion of residency training, Internists will show proficiency in the field by demonstrating:

- Interviewing, problem formulation and treatment
- A developmental, cultural and lifespan perspective
- The ability to teach
- Consultation, assessment and management referrals
- The ability to review and interpret the scientific literature

This is the minimum competency level required to achieve successful preparation for practice in Internal Medicine.

At the completion of this training, the resident will have acquired the following competencies and would be able to function effectively as a:

Medical Expert

Definition:

As Medical Experts, Internal Medicine physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care. Medical Expert is the central physician Role in the CanMEDS framework.

Key and Enabling Competencies: Internists are able to...

1. Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical, safe and patient-centered medical care
   1.1. Perform a consultation effectively, including the presentation of well-documented assessments and recommendations in written and/or verbal form in response to a request from another health care professional
   1.2. Synthesize and prioritize effectively problems that are complex and/or undifferentiated
   1.3. Describe the CanMEDS framework of competencies relevant to Internal Medicine
   1.4. Demonstrate effective use of all CanMEDS competencies relevant to Internal Medicine
   1.5. Identify and appropriately respond to relevant ethical issues arising in patient care
   1.6. Apply lifelong learning skills of the Scholar Role to implement a personal program to keep up-to-date, and enhance areas of professional competence
   1.7. Contribute to the enhancement of quality care and patient safety in Internal Medicine, integrating the available best evidence and best practices
   1.8. Demonstrate the ability to prioritize professional duties effectively and appropriately when faced with multiple patients and problems
   1.9. Demonstrate compassionate and patient-centered care
1.10. Recognize and respond to the ethical dimensions in medical decision-making
1.11. Demonstrate medical expertise in situations other than patient care, such as providing expert legal testimony or advising governments, as needed

2. Establish and maintain proficiency in clinical knowledge, skills and attitudes appropriate to Internal Medicine

2.1. Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to the following clinical scenarios and conditions applicable to Internal Medicine including an understanding of the manifestations, investigation and management:

2.1.1. Acute medicine
   2.1.1.1. Immediately life-threatening metabolic, cardiac, pulmonary, neurological gastrointestinal and other organ system dysfunction and abnormalities
   2.1.1.2. Hyperthermia / hypothermia
   2.1.1.3. Shock, including knowledge and identification of the different etiologies
   2.1.1.4. Cardio-respiratory arrest
   2.1.1.5. Poisoning
   2.1.1.6. Severe drug reactions including but not limited to anaphylaxis and toxic epidermal necrolysis
   2.1.1.7. Complications of chemotherapy
      2.1.1.7.1. Febrile neutropenia
      2.1.1.7.2. Tumour lysis syndrome
      2.1.1.7.3. Acute spinal cord compression

2.1.2. Cardiac disease
   2.1.2.1. Chest pain
   2.1.2.2. Dyspnea
   2.1.2.3. Syncope
   2.1.2.4. Palpitations
   2.1.2.5. Cardiac murmurs
   2.1.2.6. Abnormal cardiac enzymes
   2.1.2.7. Congestive heart failure
   2.1.2.8. Coronary heart disease
   2.1.2.9. Acute coronary syndromes and their complications
   2.1.2.10. Valvular heart disease
   2.1.2.11. Cardiomyopathies
2.1.2.12. Pericarditis and pericardial effusion and tamponade
2.1.2.13. Pulmonary hypertension

2.1.3. Vascular disease
   2.1.3.1. Hypertension
   2.1.3.2. Claudication
   2.1.3.3. Edema
   2.1.3.4. Aortic aneurysm
   2.1.3.5. Venous thrombo-embolic disease and prophylaxis
   2.1.3.6. Peripheral arterial disease
   2.1.3.7. Peripheral venous insufficiency
   2.1.3.8. Venous and arterial ulcers

2.1.4. Pulmonary disease
   2.1.4.1. Acute dyspnea
   2.1.4.2. Chronic dyspnea
   2.1.4.3. Cough
   2.1.4.4. Wheeze
   2.1.4.5. Hemoptysis
   2.1.4.6. Superior vena cava syndrome
   2.1.4.7. Interpretation of Pulmonary Function Testing
   2.1.4.8. Pneumonia
   2.1.4.9. Chronic obstructive lung disease
   2.1.4.10. Bronchial asthma
   2.1.4.11. Interstitial lung disease
   2.1.4.12. Pulmonary embolism
   2.1.4.13. Pneumothorax
   2.1.4.14. Pleural effusion
   2.1.4.15. Sarcoidosis
   2.1.4.16. Lung cancer: primary and metastatic including paraneoplastic syndromes

2.1.5. Gastrointestinal disease
   2.1.5.1. Upper and lower gastrointestinal hemorrhage
   2.1.5.2. Dysphagia
   2.1.5.3. Nausea and vomiting
2.1.5.4. Chest pain
2.1.5.5. Regurgitation
2.1.5.6. Acute and chronic abdominal pain
2.1.5.7. Malabsorption syndromes
2.1.5.8. Acute and chronic diarrhea
2.1.5.9. Acute and chronic constipation
2.1.5.10. Abnormal liver enzymes
2.1.5.11. Jaundice
2.1.5.12. Ascites
2.1.5.13. Encephalopathy
2.1.5.14. Bacterial peritonitis
2.1.5.15. Intestinal obstruction
2.1.5.16. Esophageal disease
   2.1.5.16.1. Gastro-esophageal reflux and its complications
   2.1.5.16.2. Esophageal motility disorders
   2.1.5.16.3. Esophageal cancer
   2.1.5.16.4. Hiatus hernia
   2.1.5.16.5. Esophageal varices

2.1.5.17. Gastro-duodenal disease
   2.1.5.17.1. Peptic ulcers
   2.1.5.17.2. Gastritis
   2.1.5.17.3. Gastric motility disorders
   2.1.5.17.4. Gastric cancer

2.1.5.18. Pancreatic disease
   2.1.5.18.1. Acute and chronic pancreatitis
   2.1.5.18.2. Pancreatic cancer

2.1.5.19. Biliary tract disease
   2.1.5.19.1. Cholelithiasis and its complications
   2.1.5.19.2. Sclerosing cholangitis
   2.1.5.19.3. Biliary cancers

2.1.5.20. Small and large bowel disease
2.1.5.20.1. Celiac disease and other diseases causing malabsorption
2.1.5.20.2. Inflammatory bowel disease
2.1.5.20.3. Infectious diseases
2.1.5.20.4. Small bowel neoplasia
2.1.5.20.5. Colorectal Cancer
2.1.5.20.6. Diverticular disease
2.1.5.20.7. Irritable bowel syndrome

2.1.5.21. Liver disease
2.1.5.21.1. Acute and chronic hepatitis
2.1.5.21.2. Biliary tract diseases
2.1.5.21.3. Cirrhosis and its complications
2.1.5.21.4. Cancer: primary and metastatic

2.1.6. Kidney Disease
2.1.6.1. Fluid and electrolyte abnormalities
2.1.6.2. Acid-base disturbances
2.1.6.3. Acute renal failure and oliguria
2.1.6.4. Hematuria
2.1.6.5. Proteinuria
2.1.6.6. Complications of chronic renal disease
2.1.6.7. Renal replacement therapy and transplantation
2.1.6.8. Nephritic and Nephrotic syndromes
2.1.6.9. Glomerulonephritis
2.1.6.10. Acute tubular necrosis
2.1.6.11. Interstitial nephritis
2.1.6.12. Renovascular hypertension
2.1.6.13. Renal tubular acidosis
2.1.6.14. Renal calculi
2.1.6.15. Renal complications of diabetes, hypertension and rhabdomyolysis

2.1.7. Endocrine and Metabolic Disorders
2.1.7.1. Weight gain and loss
2.1.7.2. Obesity
2.1.7.3. Fatigue and malaise
2.1.7.4. Amenorrhea and loss of libido
2.1.7.5. Hirsutism
2.1.7.6. Galactorrhea and gynecomastia
2.1.7.7. Lipid disorders
2.1.7.8. Pituitary masses
2.1.7.9. Hyper- and hypoglycemia
2.1.7.10. Hyper- and hypocalcemia
2.1.7.11. Thyroid enlargement and nodules
2.1.7.12. Hyper – and hypothyroidism
2.1.7.13. Hyper – and hypoparathyroidism
2.1.7.14. Diabetes mellitus: type I and type 2
2.1.7.15. Complications of diabetes including diabetic foot and neuropathy
2.1.7.16. Adrenal masses
2.1.7.17. Hyper – and hypoadrenalism
2.1.7.18. Porphyrias
2.1.7.19. Hyper - and hypogonadism
2.1.7.20. Pancreatic endocrine tumours
2.1.7.21. Neural crest tumours

2.1.8. Diseases of the Nervous System
2.1.8.1. Altered mental status and disorders of consciousness
2.1.8.2. Dementia and delirium
2.1.8.3. Syncope
2.1.8.4. Dizziness and vertigo
2.1.8.5. Tremors
2.1.8.6. Acute and chronic headache
2.1.8.7. Localized and generalized weakness
2.1.8.8. Alcohol abuse and withdrawal
2.1.8.9. Movement disorders including Parkinson’s syndrome
2.1.8.10. Seizure disorders and status epilepticus
2.1.8.11. Meningitis and encephalitis
2.1.8.12. Multiple sclerosis
2.1.8.13. Brain tumours
2.1.8.14. Increased intracranial pressure
2.1.8.15. Determination of brain death
2.1.8.16. Abnormal cranial nerve function
2.1.8.17. Cerebral vascular disease: stroke and transient ischemic attack (TIA)
2.1.8.18. Guillian-Barré syndrome
2.1.8.19. Amyotrophic lateral sclerosis
2.1.8.20. Acute spinal cord compression
2.1.8.21. Peripheral neuropathy
2.1.8.22. Myasthenia gravis

2.1.9. Diseases of blood and blood-forming organs
   2.1.9.1. Anemia
   2.1.9.2. Myelodysplastic disorders
   2.1.9.3. Myeloproliferative disorders
   2.1.9.4. Leukemia
   2.1.9.5. Eosinophilia
   2.1.9.6. Congenital and acquired bleeding disorders including, but not limited to hemophilia, diffuse intravascular coagulation and thrombocytopenic purpura
   2.1.9.7. Anticoagulant therapy
   2.1.9.8. Hypercoaguable states
   2.1.9.9. Thrombosis and thrombophilia
   2.1.9.10. Lymphadenopathy
   2.1.9.11. Lymphoma
   2.1.9.12. Splenomegaly
   2.1.9.13. Complications of systemic chemotherapy
   2.1.9.14. Transfusion of blood products
   2.1.9.15. Multiple myeloma and other dysproteinemias

2.1.10. Diseases of the musculo-skeletal system
   2.1.10.1. Acute monoarthritis
   2.1.10.2. Acute and chronic polyarthritis
   2.1.10.3. Low back pain
   2.1.10.4. Proximal muscle weakness
   2.1.10.5. Muscular pain
   2.1.10.6. Raynaud’s phenomenon

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2.1.10.7. Gout and pseudogout
2.1.10.8. Septic arthritis
2.1.10.9. Osteomyelitis
2.1.10.10. Osteoarthritis
2.1.10.11. Rheumatoid arthritis
2.1.10.12. Sero-negative arthropathies
2.1.10.13. Sjögren’s syndrome
2.1.10.14. Systemic lupus erythematosus
2.1.10.15. Scleroderma
2.1.10.16. Temporal arteritis and polymyalgia rheumatica
2.1.10.17. Ankylosing spondylitis
2.1.10.18. Fibromyalgia
2.1.10.19. Paget’s disease of bone
2.1.10.20. Primary and secondary tumours

2.1.11. Diseases of the immune system
2.1.11.1. Prevention of opportunistic infections
2.1.11.2. Immunocompromise in the patient with cancer
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2.1.11.4. Immunoglobulin deficiencies
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2.1.12. Diseases of the skin and appendages
2.1.12.1. Hyperpigmented lesions
2.1.12.2. Petechiae, purpura, ecchymoses
2.1.12.3. Bullous skin disease
2.1.12.4. Urticaria
2.1.12.5. Maculopapular eruptions
2.1.12.6. Pruritis
2.1.12.7. Abnormalities of nails
2.1.12.8. Clubbing
2.1.12.9. Arterial and venous insufficiency
2.1.12.10. Systemic disease with skin and nail manifestations
   2.1.12.10.1. Nutritional deficiencies
   2.1.12.10.2. Inflammatory bowel disease
2.1.12.10.3. Celiac disease
2.1.12.10.4. Malignancy
2.1.12.10.5. Connective tissue disease
2.1.12.10.6. Endocrine and metabolic disease
2.1.12.10.7. Systemic immunosuppression

2.1.12.11. Eczema
2.1.12.12. Stasis dermatitis
2.1.12.13. Psoriasis
2.1.12.15. Herpes zoster
2.1.12.16. Stevens-Johnson syndrome
2.1.12.17. Toxic epidermal necrolysis
2.1.12.18. Disseminated Herpes simplex
2.1.12.19. Skin cancer and premalignant conditions

2.1.13. Diseases associated with infectious agents

2.1.13.1. Pneumonia
2.1.13.2. Urosepsis
2.1.13.3. Infective endocarditis
2.1.13.4. Meningitis and encephalitis
2.1.13.5. Cellulitis and other skin infections
2.1.13.6. Bone and joint infections
2.1.13.7. Intra-abdominal infections
2.1.13.8. Necrotizing soft tissue infections
2.1.13.9. Infectious diarrhea
2.1.13.10. Fever of unknown origin
2.1.13.11. Fever in the immuno-compromised host
2.1.13.12. Fever in the hospitalized patient
2.1.13.13. Fever, skin diseases and diarrhea in the returning traveler
2.1.13.14. Sexually transmitted infections
2.1.13.15. Malaria
2.1.13.16. Tuberculosis including intradermal testing and interpretation
2.1.13.17. Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and its treatment and complications, including but not limited to:
### OBJECTIVES OF TRAINING IN INTERNAL MEDICINE (2011)

2.1.13.17.1. Fever
2.1.13.17.2. Weight loss
2.1.13.17.3. Dyspnea, cough, hemoptysis
2.1.13.17.4. Dysphagia, diarrhea
2.1.13.17.5. Anemia, neutropenia, thrombocytopenia
2.1.13.17.6. Metabolic derangements
2.1.13.17.7. Opportunistic infections

2.1.13.18. *Clostridium difficile* colitis
2.1.13.19. Spectrum of activity, adverse effects and dose adjustments for antibiotics
2.1.13.20. Infection control in the hospital setting

#### 2.1.14. Medical aspects of specific situations

2.1.14.1. Surgery

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2.1.14.6. Abnormal liver tests
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2.1.14.8. Venous thromboembolic disease
2.1.14.9. Cardiomyopathy
2.1.14.10. Endocarditis prophylaxis
2.1.14.11. Asthma
2.1.14.12. Liver diseases of pregnancy
2.1.14.13. Infectious diseases including but not limited to HIV and hepatitis
2.1.14.15. Drug prescribing in pregnancy and post-partum period

2.1.14.5. The elderly
2.1.14.5.1. Atypical presentations of common diseases
2.1.14.5.2. Delirium
2.1.14.5.3. Dementia including, but not limited to Alzheimer’s disease, Lewy-body, vascular and frontal lobe dementias
2.1.14.5.4. Depression
2.1.14.5.5. Urinary and fecal incontinence
2.1.14.5.6. Constipation
2.1.14.5.7. Gait instability
2.1.14.5.8. Falls
2.1.14.5.9. Neglect/abuse
2.1.14.5.10. Rational drug prescribing

2.1.14.6. End of life
2.1.14.6.1. Pain
2.1.14.6.2. Dyspnea
2.1.14.6.3. Delirium
2.1.14.6.4. Constipation
2.1.14.6.5. Use of opioids and other medications
2.1.14.6.6. Nausea and vomiting
2.1.14.6.7. Nutritional deficiencies
2.1.14.6.8. Terminal phase of malignant and non-malignant illness

2.1.14.7. Malignancy
2.1.14.7.1. Oncologic emergencies including, but not limited to:
   2.1.14.7.1.1. Hypercalcemia
   2.1.14.7.1.2. Spinal cord compression
   2.1.14.7.1.3. Superior vena cava syndrome
   2.1.14.7.1.4. Pleural and pericardial effusion
   2.1.14.7.1.5. Tumour lysis syndrome

2.1.14.7.2. Screening and prevention
2.1.14.7.3. Chemotherapy induced symptoms, such as Myelosuppression and Hyperemesis

2.1.14.7.4. Most cancers are included with the relevant systems. The resident must be familiar with the principles of diagnosis, and treatment. Cancers not previously discussed including, but not limited to:
   2.1.14.7.4.1. Breast cancer
   2.1.14.7.4.2. Ovarian cancer
   2.1.14.7.4.3. Endometrial and cervical cancer
   2.1.14.7.4.4. Transitional cell cancer
   2.1.14.7.4.5. Prostate cancer
   2.1.14.7.4.6. Head and neck cancers

2.1.14.7.5. Para-neoplastic syndromes

3. Perform a complete and appropriate assessment of a patient

3.1. Identify and explore issues to be addressed in a patient encounter, including the patient’s context and preferences, and the impact of illness on the patient’s life

3.2. Elicit a history that is relevant, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis and/or management
   3.2.1. Elicit information relevant to a risk profile for disease
   3.2.2. Obtain relevant information from the family history
   3.2.3. Elicit an accurate occupational history, as appropriate, with documentation of the patient’s exposure to occupational health hazards, safety risks and job demands for commonly encountered occupations
3.3. Perform a focused physical examination that is relevant and accurate for the purposes of prevention and health promotion, diagnosis and/or management, including:

3.3.1. Perform a functional assessment of basic and instrumental activities of daily living, mental status examination, assessment of competency and capacity for decision-making and assessment of gait and balance for elderly patients

3.3.2. Perform a quantitative measure of performance status for patients with malignancy

3.4. Select medically appropriate investigative methods in a resource-effective and ethical manner

3.5. Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnoses and management plans

4. Use preventive and therapeutic interventions proficiently

4.1. Implement an effective management plan in collaboration with a patient and family

4.2. Demonstrate effective, appropriate, and timely application of preventive and therapeutic interventions relevant to Internal Medicine. These include, but are not limited to:

4.2.1. Use of medications

4.2.2. Life-style changes

4.2.3. Modification of addictive behaviors

4.2.4. Physical therapies

4.2.5. Nutrition

4.2.6. Complementary medicine

4.3. Ensure appropriate informed consent is obtained for therapies

4.4. Ensure patients receive appropriate end-of-life care

5. Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic

5.1. Demonstrate effective, appropriate, and timely performance of the following diagnostic and therapeutic procedures relevant to Internal Medicine including indications benefits, risks and interpretation of results.

5.1.1. Establishing an airway, bag and mask ventilation, mouth-to-mask ventilation, and use of hand-held resuscitators

5.1.2. Invasive and non-invasive mechanical ventilation

5.1.3. Insertion and care of peripheral arterial catheters

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5.1.4. Venous access including central line placement in elective and emergency situations
5.1.5. Cardiopulmonary resuscitation
   5.1.5.1. Combined assisted ventilation and external cardiac compression in one-person and two-person rescue
   5.1.5.2. External cardiac defibrillation
   5.1.5.3. Endotracheal intubation
   5.1.5.4. Emergency trans-cutaneous pacing
   5.1.5.5. Diagnosing and managing life threatening cardiac arrhythmias

5.1.6. Electrocardiograms
5.1.7. Diagnostic and therapeutic thoracentesis
5.1.8. Diagnostic and therapeutic abdominal paracentesis
5.1.9. Lumbar puncture
5.1.10. Knee arthrocentesis

5.2. Ensure appropriate informed consent is obtained for procedures
5.3. Document and disseminate information related to procedures performed and their outcomes
5.4. Ensure adequate follow-up is arranged for procedures performed

6. Seek appropriate consultation from other health professionals, recognizing the limits of one’s own expertise
   6.1. Demonstrate insight into their own limitations of expertise
   6.2. Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care
   6.3. Arrange appropriate follow-up care services for a patient and their family

Communicator

Definition:

As Communicators, Internists effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.
Key and Enabling Competencies: Internists are able to proficiently...

1. Develop rapport, trust, and ethical therapeutic relationships with patients and families
   1.1. Recognize that being a good communicator is a core clinical skill for physicians, and that effective physician-patient communication can foster patient satisfaction, physician satisfaction, adherence and improved clinical outcomes
   1.2. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
   1.3. Respect patient confidentiality, privacy and autonomy
   1.4. Listen effectively
   1.5. Be aware of and responsive to nonverbal cues
   1.6. Facilitate a structured clinical encounter effectively

2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals
   2.1. Gather information about a disease and about a patient’s beliefs, concerns, expectations and illness experience
   2.2. Seek out and synthesize relevant information from other sources, such as a patient’s family, caregivers and other professionals

3. Convey relevant information and explanations accurately to patients and families, colleagues and other professionals
   3.1. Deliver information to a patient and family, colleagues and other professionals in a humane manner and in such a way that it is understandable, encourages discussion and participation in decision-making
      3.1.1. Demonstrate proficiency at counseling for HIV antibody testing
      3.1.2. Promote patient safety through effective health care communication
   3.2. Communicate effectively with patients and their caregivers about terminal illness and bereavement, including:
      3.2.1. Care of the dying
      3.2.2. Decision making concerning resuscitation
      3.2.3. Immediate aftermath of bereavement
      3.2.4. Organ donation requests
      3.2.5. Demonstrating sensitivity to the emotional and psychological impact of acute emergency situations on patients, families and staff, together with the capability of providing appropriate counseling
4. **Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care**

4.1. Identify and explore problems to be addressed from a patient encounter effectively, including the patient’s context, responses, concerns, and preferences

4.1.1. Identify and respect important ethical and legal issues in caring for elderly people.

4.2. Respect diversity and difference, including but not limited to the impact of gender, religion and cultural beliefs on decision-making

4.3. Encourage discussion, questions, and interaction in the encounter

4.4. Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care

4.5. Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

5. **Convey effective oral and written information about a medical encounter**

5.1. Maintain clear, concise, accurate and appropriate records (written and electronic) of clinical encounters and plans

5.2. Present verbal reports of clinical encounters and plans

5.3. Present medical information to the public or media about a medical issue

**Collaborator**

**Definition:**

As Collaborators, Internists effectively work within a health care team to achieve optimal patient care.

**Key and Enabling Competencies: Internists are able to proficiently...**

1. **Participate effectively and appropriately in an inter-professional health care team**

1.1. Describe the Internist’s roles and responsibilities to other professionals

1.2. Describe the roles and responsibilities of other professionals within the health care team

1.3. Recognize and respect the diversity of roles, responsibilities and competences of other professionals in relation to their own.

1.4. Work with others to assess, plan, provide and integrate care for individual patients (or groups of patients)
1.4.1. Incorporate understanding of the interactions of diseases involving multiple organ systems in the creation of multidisciplinary diagnostic and management strategies

1.4.2. Work with interprofessional teams to provide palliative care

1.5. Work with others to assess, plan, provide and review other tasks, such as research problems, educational work, program review or administrative responsibilities

1.6. Participate effectively in inter-professional team meetings

1.7. Enter into interdependent relationships with other professions for the provision of quality care

1.8. Describe the principles of team dynamics

1.9. Respect team ethics, including confidentiality, resource allocation and professionalism

1.10. Demonstrate leadership in a health care team, as appropriate

1.11. Respond to an emergency in a positive, organized and effective manner, including demonstrating the ability to direct an emergency team, and to prioritize tasks in the resuscitation

1.12. Work within inter-professional teams to optimize both patient safety and quality of care

2. Work with other health professionals effectively to prevent, negotiate, and resolve interprofessional conflict

2.1. Demonstrate a respectful attitude towards other colleagues and members of an interprofessional team

2.2. Work with other professionals to prevent conflicts

2.3. Employ collaborative negotiation to resolve conflicts

2.4. Respect differences and address misunderstandings and limitations in other professionals

2.5. Recognize one’s own differences, misunderstanding and limitations that may contribute to interprofessional tension

2.6. Reflect on interprofessional team function

Manager

Definition:

As Managers, Internists are integral participants in health care organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the health care system.
Key and Enabling Competencies: At the end of the program, residents are able to proficiently...

1. Participate in activities that contribute to the effectiveness of their health care organizations and systems
   1.1. Work collaboratively with others in their organizations
   1.2. Participate in systemic quality process evaluation and improvement, such as patient safety initiatives
       1.2.1. Anticipate, recognize and manage situations that place patients at risk
       1.2.2. Recognize the occurrence of an adverse event or close call and respond effectively to mitigate harm to the patient, ensure disclosure and prevent recurrence
   1.3. Describe the structure and function of the health care system as it relates to Internal Medicine, including the roles of physicians
   1.4. Describe principles of health care financing, including physician remuneration, budgeting and organizational funding

2. Manage their practice and career effectively
   2.1. Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
   2.2. Manage a practice including finances and human resources
   2.3. Implement processes to ensure personal practice improvement
   2.4. Employ information technology appropriately for patient care

3. Allocate finite health care resources appropriately
   3.1. Recognize the importance of just allocation of health care resources, balancing effectiveness, efficiency and access with optimal patient care
   3.2. Apply evidence and management processes for cost-appropriate care

4. Serve in administration and leadership roles
   4.1. Chair or participate effectively in committees and meetings
   4.2. Lead or implement change in health care
   4.3. Plan relevant elements of health care delivery (e.g., work schedules)
Health Advocate

Definition:
As Health Advocates, Internists responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.

Key and Enabling Competencies: Internists are able to proficiently...

1. Respond to individual patient health needs and issues as part of patient care
   1.1. Identify the health needs of an individual patient
   1.2. Identify opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care

2. Respond to the health needs of the communities that they serve
   2.1. Describe the practice communities that they serve
   2.2. Identify opportunities for advocacy, health promotion and disease prevention in the communities that they serve, and respond appropriately
   2.3. Appreciate the possibility of competing interests between the communities served and other populations

3. Identify the determinants of health for the populations that they serve
   3.1. Identify the determinants of health of the populations, including barriers to access to care and resources
   3.2. Identify vulnerable or marginalized populations within those served and respond appropriately

4. Promote the health of individual patients, communities, and populations
   4.1. Describe an approach to implementing a change in a determinant of health of the populations they serve
   4.2. Describe how public policy impacts on the health of the populations served
   4.3. Identify points of influence in the health care system and its structure
   4.4. Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism
   4.5. Appreciate the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper
   4.6. Describe the role of the medical profession in advocating collectively for health and patient safety
Scholar

Definition:

As Scholars, Internists demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge.

Key and Enabling Competencies: Internists are able to...

1. Maintain and enhance professional activities through ongoing learning
   1.1. Describe the principles of maintenance of competence
   1.2. Describe the principles and strategies for implementing a personal knowledge management system
   1.3. Recognize and reflect on learning issues in practice
   1.4. Conduct a personal practice audit
   1.5. Pose an appropriate learning question
   1.6. Access and interpret the relevant evidence
   1.7. Integrate new learning into practice
   1.8. Evaluate the impact of any change in practice
   1.9. Document the learning process

2. Critically evaluate medical information and its sources, and apply this appropriately to practice decisions
   2.1. Describe the principles of critical appraisal
   2.2. Critically appraise retrieved evidence in order to address a clinical question
   2.3. Integrate critical appraisal conclusions into clinical care

3. Facilitate the learning of patients, families, students, residents, other health professionals, the public and others
   3.1. Describe principles of learning relevant to medical education
   3.2. Identify collaboratively the learning needs and desired learning outcomes of others
   3.3. Select effective teaching strategies and content to facilitate others’ learning
   3.4. Demonstrate an effective lecture or presentation
   3.5. Assess and reflect on a teaching encounter
   3.6. Provide effective feedback
   3.7. Describe the principles of ethics with respect to teaching
4. **Contribute to the development, dissemination, and translation of new knowledge and practices**
   4.1. Describe the principles of research and scholarly inquiry
   4.2. Describe the principles of research ethics
   4.3. Pose a scholarly question
   4.4. Conduct a systematic search for evidence
   4.5. Select and apply appropriate methods to address the question
   4.6. Disseminate the findings of a study
   4.7. Participate in a scholarly project/activity in Internal Medicine

**Professional**

**Definition:**

As Professionals, Internists are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior.

**Key and Enabling Competencies: Internists are able to...**

1. **Demonstrate a commitment to their patients, profession, and society through ethical practice**
   1.1. Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism
   1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence
   1.3. Recognize and appropriately respond to ethical issues encountered in practice
   1.4. Manage conflicts of interest
   1.5. Incorporate an ethical framework for appropriate interventions in patients with life threatening disease, including truth telling, consent, treatment choice, the question of euthanasia, advanced directives and boundaries of palliative care.
   1.6. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law
   1.7. Maintain appropriate relations with patients

2. **Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation**
   2.1. Demonstrate knowledge and an understanding of the professional, legal and ethical codes of practice
   2.2. Fulfill the regulatory and legal obligations required of current practice
2.3. Demonstrate accountability to professional regulatory bodies
2.4. Recognize and respond to others’ unprofessional behaviours in practice
2.5. Participate in peer review

3. **Demonstrate a commitment to physician health and sustainable practice**

3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
3.2. Strive to heighten personal and professional awareness and insight
3.3. Recognize other professionals in need and respond appropriately