Federation of National Specialty Societies of Canada (FNSSC)

Guide to Continuing Professional Learning
For Specialists in Canada

Appendices

1. Acronyms/Definitions

2. Selected References for Further Reading


4. What is Maintenance of Certification and Framework for Sections within MainCert

5. What is CanMEDS?


7. Association of Faculties of Medicine of Canada (AFMC)

8. Society for Academic Continuing Medical Education (SACME)

9. Alliance for Continuing Medical Education (ACME)

10. Le Collège des médecins du Québec

11. College of Family Physicians of Canada

12. RCPSC Standards for Accreditation

13. RCPSC Accredited Providers

14. RCPSC Definitions of Physician and Non-physician Organizations

15. RCPSC Interpretation of 2007 revised CMA Guidelines
## Appendix 1 Acronyms & Definitions

### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCME</td>
<td>Accreditation Council for Continuing Medical Education (US based)</td>
</tr>
<tr>
<td>AFMC</td>
<td>Association of Faculties of Medicine of Canada</td>
</tr>
<tr>
<td>AMLFC</td>
<td>Association des médecines de langue française du Canada</td>
</tr>
<tr>
<td>ACME</td>
<td>Alliance for Continuing Health Education</td>
</tr>
<tr>
<td>AMEE</td>
<td>Association for Medical Education in Europe</td>
</tr>
<tr>
<td>CACHE</td>
<td>Canadian Association of Continuing Health Education</td>
</tr>
<tr>
<td>CACMS</td>
<td>Committee on Accreditation of Canadian Medical Schools</td>
</tr>
<tr>
<td>CADTH</td>
<td>Canadian Agency for Drugs and Technologies in Health</td>
</tr>
<tr>
<td>CEMCQ</td>
<td>Conseil de L’Education Médicale Continue du Québec</td>
</tr>
<tr>
<td>CIHR</td>
<td>Canadian Institutes for Health Research</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CFPC</td>
<td>College of Family Physicians of Canada</td>
</tr>
<tr>
<td>CHE</td>
<td>Continuing Health Education</td>
</tr>
<tr>
<td>CMA</td>
<td>Canadian Medical Association</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>FCFPC</td>
<td>Fellow of the College of Family Physicians of Canada</td>
</tr>
<tr>
<td>FMRAC</td>
<td>Federation of Medical Regulatory Agencies of Canada</td>
</tr>
<tr>
<td>FMOQ</td>
<td>Fédération des médecins omnipraticiens du Québec</td>
</tr>
<tr>
<td>FMSQ</td>
<td>Fédération des médecins spécialistes du Québec</td>
</tr>
<tr>
<td>FRCPC</td>
<td>Fellow of the Royal College of Physicians and Surgeons of Canada</td>
</tr>
<tr>
<td>GAC</td>
<td>Guideline Advisory Committee for Ontario</td>
</tr>
<tr>
<td>IPRC</td>
<td>Industry Practices Review Committee – within Rx and D</td>
</tr>
<tr>
<td>JCEHP</td>
<td>Journal of Continuing Education in the Health Professions</td>
</tr>
<tr>
<td>KT</td>
<td>Knowledge Translation</td>
</tr>
<tr>
<td>MAINCERT</td>
<td>Maintenance of Certification</td>
</tr>
<tr>
<td>MAINPRO</td>
<td>Maintenance of Proficiency</td>
</tr>
<tr>
<td>PAAB</td>
<td>Pharmaceutical Advertising Advisory Board</td>
</tr>
<tr>
<td>PDA</td>
<td>Personal data accessory/assistant</td>
</tr>
<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
</tr>
<tr>
<td>Rx and D</td>
<td>Canada’s research-based pharmaceutical companies</td>
</tr>
<tr>
<td>SCCME</td>
<td>Standing Committee on CME - US</td>
</tr>
<tr>
<td>SACME</td>
<td>Society for Academic Continuing Medical Education</td>
</tr>
</tbody>
</table>
### Definitions

<p>| <strong>Accreditation</strong> | A process that recognizes organizations that provide education to physicians as accredited providers and thereby able to apply standards to programs leading to a designation of being “accredited” for a specific type of credits with the Main Pro and MainCert programs. Accreditation is granted by three organizations in Canada see p6. |
| <strong>Accredited Group Learning Activities</strong> | These include workshops, meetings, educational sessions within conferences, courses and other group learning activities that are reviewed and approved by a Royal College accredited provider or Canadian College of Family Physicians. Any group learning activity developed exclusively by a pharmaceutical or medical communications company can only be included for MainCert credits under Section 2. within the RCPSC framework. |
| <strong>ACCME</strong> | Accreditation Council for Continuing Medical Education (US). The ACCME’s Mission is the identification, development, and promotion of standards for quality CME utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities. |
| <strong>AFMC</strong> | Association of Faculties of Medicine of Canada – the national voice of Canada’s 17 Faculties of Medicine |
| <strong>AGREE Tool</strong> | A guide to internationally recognized standards for the process of writing, disseminating and implementing clinical practice guidelines |
| <strong>ACME</strong> | Alliance for Continuing Medical Education. A US-based organization for all stakeholders in CME/CPD. A membership organization that provides professional development opportunities for CME/CPD professionals&amp; advocates and strives to improve health care outcomes |
| <strong>AMEE</strong> | Association for Medical Education in Europe Teachers and organizations or national bodies committed to high standards of education in medicine and the health care professions |
| <strong>CACHE</strong> | Canadian Association of Continuing Health Education An association that promotes inter-sectoral collaboration in CME and CPD in Canada |
| <strong>CACMS</strong> | Committee on Accreditation of Canadian Medical Schools A standing committee of the Association of Faculties of Medicine in Canada(AFMC) |
| <strong>CACME</strong> | Committee on Accreditation of Continuing Medical Education, committee of the Association of Faculties of Medicine in Canada(AFMC) |</p>
<table>
<thead>
<tr>
<th><strong>CADTH</strong></th>
<th>Canadian Agency for Drugs and Technologies in Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CanMEDS</strong></td>
<td>The list of essential competencies that specialist physicians are expected to retain as certified specialists. There are seven roles: Medical Expert; Communicator; Collaborator; Health Advocate; Manager; Scholar; and Professional (See Appendix 5)</td>
</tr>
<tr>
<td><strong>Centre for Effective Practice</strong></td>
<td>Division at the University of Toronto focusing on tools to improve knowledge transfer</td>
</tr>
<tr>
<td><strong>Certification</strong></td>
<td>Physicians are “certified” to practice following examinations. This is granted by the RCPSC or the CFPC or Le Collège des médecins du Québec.</td>
</tr>
<tr>
<td><strong>CMA Infobase</strong></td>
<td>A searchable database of clinical practice guidelines that have either been developed by or approved by a Canadian organization</td>
</tr>
<tr>
<td><strong>EMR</strong></td>
<td>Electronic Medical Record: usually referring to systems in physicians offices or hospitals that enable patient records to be stored, linked and accessed through a computer</td>
</tr>
<tr>
<td><strong>GAC</strong></td>
<td>Guideline Advisory Committee for Ontario: a joint venture of the Ontario Medical Association and the Ontario Ministry of Health. GAC reviews and assigns ratings to selected guidelines in terms of the process by which the guideline was developed (application of AGREE Tool)</td>
</tr>
<tr>
<td><strong>Guidelines, Clinical Practice</strong></td>
<td>Synthesis of evidence through a panel of experts and systematic process that provides guidance to clinical practice</td>
</tr>
<tr>
<td><strong>IPRC</strong></td>
<td>Industry Practices Review Committee, a committee within Rx and D– that reviews complaints regarding industry practices</td>
</tr>
<tr>
<td><strong>Knowledge Translation (CIHR)</strong></td>
<td>Knowledge translation is a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. <a href="http://www.cihr-irsc.gc.ca/e/29418.html">www.cihr-irsc.gc.ca/e/29418.html</a></td>
</tr>
<tr>
<td><strong>Licensure</strong></td>
<td>Qualification to practice medicine in Canada granted by Provincial Colleges of Physicians and Surgeons</td>
</tr>
<tr>
<td><strong>MAINCERT</strong></td>
<td>Maintenance of Certification: program of the RCPSC to support Canadian specialists in maintaining their specialty certification</td>
</tr>
<tr>
<td><strong>MainPort</strong></td>
<td>The portal at the RCPSC website that enables Fellows to track and plan their CPD activities</td>
</tr>
<tr>
<td><strong>MAINPRO</strong></td>
<td>Maintenance of Proficiency: program for maintenance of fellowship with the College of Family Physicians of Canada</td>
</tr>
<tr>
<td><strong>PAAB</strong></td>
<td>Pharmaceutical Advertising Advisory Board. It must approve all material presented to a physician by a representative of a company that is not deemed to be “accredited education”</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PDA</strong></td>
<td>Handheld data accessory. Used to store and access information</td>
</tr>
<tr>
<td><strong>Preceptored courses</strong></td>
<td>Courses, fellowships and higher education programs developed and offered by a university, college or institute. Each course must have clear objectives and a defined beginning and end date</td>
</tr>
<tr>
<td><strong>Rx &amp; D</strong></td>
<td>Canada’s research-based pharmaceutical companies. An organization which self-regulates and guides policies for participating companies</td>
</tr>
<tr>
<td><strong>SCCME</strong></td>
<td>Standing Committee on CME for the Academic Federation of Medical Colleges (AFMC): primarily includes assistant and associated deans of medical school CME/CPD divisions</td>
</tr>
<tr>
<td><strong>SACME</strong></td>
<td>Society for Academic Continuing Medical Education. US-based association of leaders in CME/CPD. Has usually included strong representation from the Canadian Medical Schools</td>
</tr>
<tr>
<td><strong>Section 1 or Section 3</strong></td>
<td>Elements of the Royal College Maintenance of Certification Program</td>
</tr>
<tr>
<td><strong>Traineeship</strong></td>
<td>Structured educational activities planned by an individual in collaboration with a mentor or supervisor to meet defined professional needs</td>
</tr>
<tr>
<td><strong>Web-casting</strong></td>
<td>A popular form of administering educational programs or conducting meetings. Participants can hear each other and view material sent via internet.</td>
</tr>
</tbody>
</table>

Appendix 2
Appendix 2

Selected References for Further Reading


Davis D. Continuing education, guideline implementation and the emerging transdisciplinary field of knowledge translation. JCEHP 2006; 26:5-12.


Davis DA, Lindsay E, Mazmanian PE. The effectiveness of CME interventions, In: Davis DA, Fox RD, editors. The physician as learner. Chicago: American Medical Association; 1994:245-80


The Research and Development Resource Base in CME, www.rdrb.utoronto.ca


Sklar BM. Online continuing medical education. http://www.cmelist.com/list.htm#M

GUIDELINES FOR PHYSICIANS IN INTERACTIONS WITH INDUSTRY

The history of health care delivery in Canada has included interaction between physicians and the pharmaceutical and health supply industries; this interaction has extended to research as well as to education. Physicians understand that they have a responsibility to ensure that their participation in such collaborative efforts is in keeping with their primary obligation to their patients and duties to society, and to avoid situations of conflict of interest where possible and appropriately manage these situations when necessary. They understand as well the need for the profession to lead by example by promoting physician-developed guidelines.

The following guidelines have been developed by the CMA to serve as a resource tool for physicians in helping them to determine what type of relationship with industry is appropriate. They are not intended to prohibit or dissuade appropriate interactions of this type, which have the potential to benefit both patients and physicians.

Although directed primarily to individual physicians, including residents, and medical students, the guidelines also apply to relationships between industry and medical organizations.

General Principles

1. The primary objective of professional interactions between physicians and industry should be the advancement of the health of Canadians.
2. Relationships between physicians and industry are guided by the CMA’s Code of Ethics and by this document.
3. The practising physician’s primary obligation is to the patient. Relationships with industry are inappropriate if they negatively affect the fiduciary nature of the patient-physician relationship.
4. Physicians should resolve any conflict of interest between themselves and their patients resulting from interactions with industry in favour of their patients. In particular, they must avoid any self-interest in their prescribing and referral practices.
5. Except for physicians who are employees of industry, in relations with industry the physician should always maintain professional autonomy and independence. All physicians should remain committed to scientific methodology.
6. Those physicians with ties to industry have an obligation to disclose those ties in any...
situation where they could reasonably be perceived as having the potential to influence their judgment.

Industry-Sponsored Research

7. A prerequisite for physician participation in all research activities is that these activities are ethically defensible, socially responsible and scientifically valid. The physician’s primary responsibility is the well-being of the patient. 8. The participation of physicians in industry sponsored research activities must always be preceded by formal approval of the project by an appropriate ethics review body. Such research must be conducted according to the appropriate current standards and procedures.

9. Patient enrolment and participation in research studies must occur only with the full, informed, competent and voluntary consent of the patient or his or her proxy, unless the research ethics board authorizes an exemption to the requirement for consent. In particular, the enrolling physician must inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of the physician’s participation and must advise prospective subjects that they have the right to decline to participate or to withdraw from the study at any time, without prejudice to their ongoing care.

10. The physician who enrolls a patient in a research study has an obligation to ensure the protection of the patient’s privacy, in accordance with the provisions of applicable national or provincial legislation and CMA’s Health Information Privacy Code. If this protection cannot be guaranteed, the physician must disclose this as part of the informed consent process.

11. Practising physicians should not participate in clinical trials unless the study will be registered prior to its commencement in a publicly accessible research registry.

12. Because of the potential to influence judgment, remuneration to physicians for participating in research studies should not constitute enticement. It may cover reasonable time and expenses and should be approved by the relevant research ethics board. Research subjects must be informed if their physician will receive a fee for their participation and by whom the fee will be paid.

13. Finder’s fees, whereby the sole activity performed by the physician is to submit the names of potential research subjects, should not be paid. Submission of patient information without their consent would be a breach of confidentiality. Physicians who meet with patients, discuss the study and obtain informed consent for submission of patient information may be remunerated for this activity.

14. Incremental costs (additional costs that are directly related to the research study) must not be paid by health care institutions or provincial or other insurance agencies regardless of whether these costs involve diagnostic procedures or patient services. Instead, they must be assumed by the industry sponsor or its agent.

15. When submitting articles to medical journals, physicians must state any relationship they have to companies providing funding for the studies or that make the products that are the subject of the study whether or not the journals require such disclosure. Funding sources for the study should also be disclosed.

16. Physicians should only be included as an author of a published article reporting the results of an industry sponsored trial if they have contributed substantively to the study or the composition of the article.

17. Physicians should not enter into agreements that limit their right to publish or disclose results of the study or report adverse events which occur during the course of the study. Reasonable limitations which do not endanger patient health or safety may be permissible.

Industry-Sponsored Surveillance Studies

18. Physicians should participate only in post-marketing surveillance studies that are
scientifically appropriate for drugs or devices relevant to their area of practice and where the study may contribute substantially to knowledge about the drug or device. Studies that are clearly intended for marketing or other purposes should be avoided.

19. Such studies must be reviewed and approved by an appropriate research ethics board. The National Council on Ethics in Human Research is an additional source of advice.

20. The physician still has an obligation to report adverse events to the appropriate body or authority while participating in such a study.

Continuing Medical Education / Continuing Professional Development (CME/CPD)

21. This section of the Guidelines is understood to address primarily medical education initiatives designed for practicing physicians. However, the same principles will also apply for educational events (such as noon-hour rounds and journal clubs) which are held as part of medical or residency training.

22. The primary purpose of CME/CPD activities is to address the educational needs of physicians and other health care providers in order to improve the health care of patients. Activities that are primarily promotional in nature, such as satellite symposia, should be identified as such to faculty and attendees and should not be considered as CME/CPD.

23. The ultimate decision on the organization, content and choice of CME/CPD activities for physicians shall be made by the physician-organizers.

24. CME/CPD organizers and individual physician presenters are responsible for ensuring the scientific validity, objectivity and completeness of CME/CPD activities. Organizers and individual presenters must disclose to the participants at their CME/CPD events any financial affiliations with manufacturers of products mentioned at the event or with manufacturers of competing products. There should be a procedure available to manage conflicts once they are disclosed.

25. The ultimate decision on funding arrangements for CME/CPD activities is the responsibility of the physician-organizers. Although the CME/CPD publicity and written materials may acknowledge the financial or other aid received, they must not identify the products of the company(ies) that fund the activities.

26. All funds from a commercial source should be in the form of an unrestricted educational grant payable to the institution or organization sponsoring the CME/CPD activity.

27. Industry representatives should not be members of CME content planning committees. They may be involved in providing logistical support.

28. Generic names should be used in addition to trade names in the course of CME/CPD activities.

29. Physicians should not engage in peer selling. Peer selling occurs when a pharmaceutical or medical device manufacturer or service provider engages a physician to conduct a seminar or similar event that focuses on its own products and is designed to enhance the sale of those products. This also applies to third party contracting on behalf of industry. This form of participation would reasonably be seen as being in contravention of the CMA’s Code of Ethics, which prohibits endorsement of a specific product.

30. If specific products or services are mentioned, there should be a balanced presentation of the prevailing body of scientific information on the product or service and of reasonable, alternative treatment options. If unapproved uses of a product or service are discussed, presenters must inform the audience of this fact.

31. Negotiations for promotional displays at CME/CPD functions should not be influenced by industry sponsorship of the activity. Promotional displays should not be in the same room as the educational activity.

32. Travel and accommodation arrangements, social events and venues for industry sponsored
CME/CPD activities should be in keeping with the arrangements that would normally be made without industry sponsorship. For example, the industry sponsor should not pay for travel or lodging costs or for other personal expenses of physicians attending a CME/CPD event. Subsidies for hospitality should not be accepted outside of modest meals or social events that are held as part of a conference or meeting. Hospitality and other arrangements should not be subsidized by sponsors for personal guests of attendees or faculty, including spouses or family members.

33. Faculty at CME/CPD events may accept reasonable honoraria and reimbursement for travel, lodging and meal expenses. All attendees at an event cannot be designated faculty. Faculty indicates a presenter who prepares and presents a substantive educational session in an area where they are a recognized expert or authority.

Electronic Continuing Professional Development (eCPD)

34. The same general principles which apply to “live, in person” CPD events, as outlined above, also apply to eCPD (or any other written curriculum-based CPD) modules. The term “eCPD” generally refers to accredited on-line or internet-based CPD content or modules. However, the following principles can also apply to any type of written curriculum-based CPD.

35. Authors of eCPD modules are ultimately responsible for ensuring the content and validity of these modules and should ensure that they are both designed and delivered at arms’-length of any industry sponsors.

36. Authors of eCPD modules should be physicians with a special expertise in the relevant clinical area and must declare any relationships with the sponsors of the module or any competing companies.

37. There should be no direct links to an industry or product website on any web page which contains eCPD material.

38. Information related to any activity carried out by the eCPD participant should only be collected, used, displayed or disseminated with the express informed consent of that participant.

39. The methodologies of studies cited in the eCPD module should be available to participants to allow them to evaluate the quality of the evidence discussed. Simply presenting abstracts that preclude the participant from evaluating the quality of evidence should be avoided. When the methods of cited studies are not available in the abstracts, they should be described in the body of the eCPD module.

40. If the content of eCPD modules is changed, re-accreditation is required.

Advisory/Consultation Boards

41. Physicians may be approached by industry representatives and asked to become members of advisory or consultation boards, or to serve as individual advisors or consultants. Physicians should be mindful of the potential for this relationship to influence their clinical decision making. While there is a legitimate role for physicians to play in these capacities, the following principles should be observed:

A. The exact deliverables of the arrangement should be clearly set out and put in writing in the form of a contractual agreement. The purpose of the arrangement should be exclusively for the physician to impart specialized medical knowledge that could not otherwise be acquired by the hiring company, and should not include any promotional or educational activities on the part of the company itself.

B. Remuneration of the physician should be reasonable and take into account the extent and complexity of the physician’s involvement.

C. Whenever possible, meetings should be held in the geographic locale of the physician or as part of a meeting which he/she would normally attend. When these arrangements are not feasible, basic travel and accommodation
expenses may be reimbursed to the physician advisor or consultant. Meetings should not be held outside of Canada, with the exception of international boards.

Clinical Evaluation Packages (Samples)

42. The distribution of samples should not involve any form of material gain for the physician or for the practice with which he or she is associated.
43. Physicians who accept samples or other health care products are responsible for recording the type and amount of medication or product dispensed. They are also responsible for ensuring their age-related quality and security and their proper disposal.

Gifts

44. Practising physicians should not accept personal gifts of any significant monetary or other value from industry. Physicians should be aware that acceptance of gifts of any value has been shown to have the potential to influence clinical decision making.

Other Considerations

45. These guidelines apply to relationships between physicians and all commercial organizations, including but not limited to manufacturers of medical devices, nutritional products and health care products as well as service suppliers.
46. Physicians should not dispense pharmaceuticals or other products unless they can demonstrate that these cannot be provided by an appropriate other party, and then only on a cost-recovery basis.
47. Physicians should not invest in industries or related undertakings if this might inappropriately affect the manner of their practice or their prescribing behaviour.
48. Practising physicians affiliated with pharmaceutical companies should not allow their affiliation to influence their medical practice inappropriately.
49. Practising physicians should not accept a fee or equivalent consideration from pharmaceutical manufacturers or distributors in exchange for seeing them in a promotional or similar capacity.
50. Practising physicians may accept patient teaching aids appropriate to their area of practice provided these aids carry at most the logo of the donor company and do not refer to specific therapeutic agents, services or other products.

Medical Students and Residents

51. The principles in these guidelines apply to physicians-in training as well as to practising physicians.
52. Medical curricula should deal explicitly with the guidelines by including educational sessions on conflict of interest and physician-industry interactions.
What is Maintenance of Certification?

The MOC program, initially introduced in 2000, is a Royal College educational initiative designed to support, enhance and promote the continuing professional development activities of its Fellows. The MOC program is distinct from processes and programs designed to confirm competence or continuing fitness to practice. Working in partnership with the faculties of medicine, the national specialty societies and the Federation of Medical Specialists of Quebec, the goals of the MOC program are to ensure:

- Fellows engage in a planned continuing professional development program based on their identified practice needs, allowing them to build evidence-based practices that enhance the quality of specialty care; and
- learning outcomes and practice enhancements are documented and validated for purposes such as licensure or privileges to practice.

The MOC program will continue to evolve and adapt to reflect the highest standards for continuing professional development and ensure that the program promotes the following vision, mission and educational principles.

**MOC Program Vision**

Pursuing the highest quality specialty care through lifelong learning processes.

**MOC Program Mission**

To establish, promote and implement educational standards, strategies and tools that enable Fellows to develop a continuing professional development plan that is effective, efficient and integrated within their practice context.

**MOC Educational Principles**

The following educational principles provide the philosophical foundation of the MOC program in achieving its vision, mission and goals.

**Principle 1: Personal**

Fellows are encouraged to design and implement individual continuing professional development plans tailored to their scope of practice, identified professional needs and competencies. As a professional priority, continuing professional development requires an investment of time and effort to ensure that expertise is sustained over a lifetime of practice.

**Principle 2: Needs Based**

Fellows select learning activities that address the needs they are aware they have (perceived needs), as well as those needs only identifiable through assessments of professional practice (non-perceived needs).

**Principle 3: Scope of Practice**

Learning activities must be relevant to the evolving knowledge and skills of a Fellow’s specialty, professional roles and responsibilities, and areas of expertise.

**Principle 4: Reflection**

Reflection enables Fellows to critically think about current practices to identify areas for future learning. Through the use of questions, Fellows can review their current assumptions, knowledge and actions, and consider how to translate this information into knowledge for practice.
Principle 5: Continuous Improvement
The commitment to professionalism requires that Fellows continuously engage in learning activities promoting excellence in specialty care.

Principle 6: Choice
Fellows are responsible for choosing appropriate learning methods or resources and evaluating the learning outcomes for their practice. The principle of choice is central to promoting flexibility, personal growth and lifelong learning.

Principle 7: Inter-Professional
Fellows are encouraged to integrate their learning within inter-professional health care teams, groups or communities. The program encourages strategies that promote inter-professional sharing of individual knowledge (evidence-based and tacit), experiences and expertise that contribute to improved performance and health outcomes. Collectively these principles reflect our commitment to learner-centred professional education. There is no set curriculum to follow and no mandated learning activities. Fellows are responsible for their own continuing professional development plan linked to their professional practice. The primary role for the Royal College is to establish the educational, ethical and documentation standards for all activities included within the program. The College also provides guidance to Fellows on the integration of lifelong learning tools and strategies within their practices. How the program is used to enhance personal continuing professional development is dependent on a Fellow’s practice needs, professional responsibilities and learning preferences.

Development in the MOC Program
Continuing professional development is any learning activity that enhances the knowledge, skills and competencies required for professional practice. Although continuing medical education (CME) plays a significant role in a Fellow’s ongoing medical expert role, continuing professional development encompasses a more holistic approach to learning. Spanning a wide range of areas, continuing professional development includes clinical education, practice management, ethical decision-making, evidence-based care, managed care principles and others. Unlike traditional CME, continuing professional development facilitates a variety of learning formats such as small-group and self-directed learning, and focuses on the outcomes relevant and applicable to practice.

Linking Learning to Your Professional Practice
In the MOC program, a Fellow’s professional practice provides both the driving force and practical situations that make lifelong learning possible. Learning can occur in the setting of an office or operating room, during a teaching session or administrative meeting, or when attending formal courses or rounds. Daily work routines provide opportunities to update skills, gain new information and improve abilities related to communicating with patients or collaborating with other members of inter-professional health teams. Because continuing professional development is shaped by career goals, immediate practical needs and current or ongoing projects, learning is both important and relevant when linked to the practical problems or challenges Fellows face every day. From this perspective, learning is no longer an obstacle or interruption to practice but a strategy that enhances the effectiveness and efficiency of practice by expanding expertise. In linking learning with practice, we are embracing a commitment to improve the quality of care we provide and to pursue practice-based improvement as a professional goal.

The Framework Supporting MOC
The MOC program is built on a framework of learning activities that reflects three types of continuing professional development activities.

- Group learning activities designed to meet defined educational criteria and ethical standards. All conferences held in Canada must be reviewed and approved by a Royal College accredited provider.
- Self-learning activities planned and developed individually or in collaboration with others to address a question, issue or need relevant to practice.
- Practice assessment activities focused on assessing one’s current knowledge or performance in order to identify areas of potential improvement.
Planning your Continuing Professional Development

An effective continuing professional development plan addresses questions, issues or problems identified in practice. Any continuing professional development plan should be relevant to your
• current professional roles and responsibilities (scope of practice),
• professional needs (those currently recognized and those identifiable only through assessment), and
• ability to sustain the competencies required for exemplary specialty medicine.

Developing an effective plan begins by answering the following questions:
1. What are my current professional roles and responsibilities?
2. What areas of expertise are essential to my practice and what new areas of expertise would I like to acquire?
3. How will I scan my environment to identify new developments or skills that are applicable to my practice?
4. What questions or issues do I need answered?
5. What areas of practice should I assess? How am I going to compare my practice with an ideal practice?
6. How can I evaluate the degree to which my practice reflects the CanMEDS competencies?

When these questions have been answered, the learning activities included within the MOC program can be used to address specific questions, needs, competencies and areas of expertise. For assistance with creating an effective continuing professional development plan, contact the Educational Support Centre.

Participation in MOC

When Fellows join the Royal College, they are automatically registered in the MOC program. The program is based on a five-year cycle, with the first cycle beginning on January 1 of the year following admission to Fellowship. The time between a Fellow joining the College and starting a cycle is considered a bonus period. Fellows are not required to partake in the program during this period; however, learning activities completed during the bonus period can be included in the first MOC cycle. For example, if a Fellow is admitted to Fellowship on July 1, the six months between July 1 and December 31 will be considered a bonus period. Once a cycle is completed, the Fellow is automatically registered in a new cycle. Participation in the MOC program is mandatory for admission to and renewal of Fellowship in the College, for use of the designations FRCPC. Website: http://rcpsc.medical.org

Professional Development Activities:
Definitions and Documentation Requirements

SECTION 1: ACCREDITED GROUP LEARNING ACTIVITIES

One credit per hour: No Maximum

Activities within Section 1 include large- or small-group learning activities that meet defined educational criteria and ethical standards. Hospital-based rounds or journal club programs, as well as non-hospital based small-group activities, are approved if they meet established criteria. In Canada, for conferences to be included under Section 1 they must be approved by an accredited provider recognized by the Royal College. All conferences or courses outside of Canada are included if they are developed by a university, academy, college, academic institution or physician organization.

Self-Approved Group Learning Activities

Self-approved group learning activities means a planning committee has determined that the criteria required for these activities have been met. All self-approved rounds, journal clubs and small-group learning sessions must be registered with the Royal College’s Office of Professional Development. For details, please visit http://rcpsc.medical.org.
a. Hospital-sponsored rounds and journal clubs

**Definition:** Hospital-based rounds or journal clubs are regularly scheduled events (at least once per month) developed by a planning committee accountable to a department, hospital or regional health authority.

**Documentation Required for Credit Validation:**
Written confirmation from the chair of the planning committee specifying the
- number of hours the Fellow attended the rounds or journal club program, and
- round/journal club has met the criteria established for these self-approved group learning activities.

b. Small-group learning sessions

**Definition:** Small-group learning sessions are planned by the members of a cohesive group (typically 12 or less) that meets regularly (at least once per month) outside a hospital setting to discuss issues of common interest.

Provider Approved Group Learning Activities

c. Accredited group learning activities held in Canada

**Definition:** These include workshops, meetings, educational sessions within conferences, courses and other group learning activities held in Canada that are reviewed and approved by a Royal College accredited provider ([see http://rcpsc.medical.org](http://rcpsc.medical.org)). Any group learning activity developed exclusively by a pharmaceutical or medical communication company can only be included under Section 2.

d. Accredited group learning activities held outside of Canada

**Definition:** These include workshops, meetings, educational sessions within conferences, courses and other group learning activities developed or sponsored by an academic institution, academy, college, specialty society OR those activities recognized, affiliated or approved by an accredited organization. Any group learning activity outside of Canada developed by a pharmaceutical or medical communication company can only be included under Section 2.

e. Web-based continuing medical education (CME) events

**Definition:** These include synchronous or asynchronous group learning activities delivered online. All web-based group learning activities must be reviewed and approved by a Royal College accredited provider in Canada to meet the same criteria defined for face-to-face accredited group CME activities.

**SECTION 2: OTHER LEARNING ACTIVITIES**

**One credit per hour: Maximum 100 CREDITS per cycle**

Other learning activities include group learning or self-learning activities that do not meet the standards for learning activities included within other sections of this framework.

**Definition:** Included in this section are group activities developed by either a pharmaceutical or medical communication company that do not meet the educational or ethical criteria for accredited group learning activities (Section 1). Self-learning activities include reading or reviewing various enduring materials such as medical journals, CD-ROMs, audiotapes, videotapes or other online material.

Fellows can submit a maximum of 100 credits for each cycle in this section. However, this section can be an important stimulus for developing other learning activities (e.g., personal learning projects in Section 4) that lead to additional credits within the MOC program.
SECTION 3: ACCREDITED SELF-ASSESSMENT PROGRAMS

Two credits per hour: no Maximum

These programs are designed to assist Fellows to identify their educational needs or gaps in knowledge (written self-assessment programs) or skills (medical simulations).

Definition: Self-assessment programs (SAPs) must be developed, cosponsored or approved by a Royal College accredited provider based on the program’s ability to meet established criteria.

SECTION 4: STRUCTURED LEARNING PROJECTS

One credit per hour: no Maximum

Structured learning projects are learning activities planned and developed individually or in collaboration with other members of a group or community to address a question, issue or need relevant to professional practice. The individual is responsible for identifying and recording the outcome or impact on practice for each project.

a. Personal Learning Project (PLP)

Definition: A PLP is any learning activity that meets the following criteria:

1. a question, idea or issue that describes the learning focus that initiated the project is identified;
2. a learning strategy that includes a description of what stimulated the development of the question, idea or issue; which resources were selected for learning (e.g., a literature search, discussion with colleagues, attending group learning events, etc.); and what aspect of expertise the project relates to or supports; and
3. a conclusion identifying what was learned and/or the impact of this learning for practice.

Two variations of PLPs are also available for use.

Point of care learning projects are PLPs initiated by a patient interaction where all learning is completed and applied to a patient at the point of care. The learning resources for point of care learning are likely to be limited to evidence-based resources available through the Internet, a PDA and/or collegial discussions. These projects are by design shorter in duration than most PLPs. The documentation required for credit validation is the same as that for PLPs.

b. Traineeship

Definition: Traineeships are structured educational activities planned by an individual in collaboration with a mentor or supervisor to meet defined professional needs (e.g., learning a skill, surgical procedure or expanding an area of competence).

c. Preceptored courses, fellowships, master or PhD programs

Definition: These are courses, fellowships and higher education programs developed and offered by a university, college or institute. Each course must have clear objectives and a defined beginning and end date. For the purposes of documentation, only include the hours spent participating in formal classes or seminars for each course. Additional credits for learning stimulated by the development of papers or other course requirements can be earned by creating one or more personal learning projects under Section 4a.
SECTION 5: PERSONAL PRACTICE REVIEW

Two credits per hour: no Maximum

Personal practice review activities focus on a particular aspect of a Fellow’s professional practice. The purpose of these activities is to assess one’s current performance in practice against an ideal practice to identify areas for potential improvement. These reviews may be developed and implemented by the individual or others.

Definition: Practice review activities can focus on any aspect of a Fellow’s professional practice—clinical, education, administration or research—or competency included within the CanMEDS 2005 framework. A Fellow, hospital, regional health authority, specialty society or provincial/territorial regulatory authority can initiate these reviews. Each activity must review your actual performance in practice (e.g., with your own patients).

Since the focus of Section 5 is a personal review of one’s practice, activities such as assessing another physician’s practice or sitting on hospital quality assurance committees are not included under Section 5. Activities such as these can be an important stimulus for developing other learning activities (e.g., personal learning projects in Section 4) that lead to additional credits within the MOC program.

SECTION 6: PERSONAL EDUCATIONAL DEVELOPMENT

One credit per hour: no Maximum

Personal educational development activities expand a Fellow’s expertise or the ability to practice that expertise within defined scholarly activities (teaching, research or standard setting).

a. Teaching sessions and presentations

Definition: Activities include the preparation or delivery of teaching sessions or presentations that facilitate the teaching of others. The focus of this section is on how your expertise as an educator was enhanced through the process of preparing for or evaluating the impact of your teaching. Examples of relevant teaching activities and how to calculate hours are available on http://rcpsc.medical.org.

b. Publications and grant proposals

Definition: The focus of this section is on how your expertise as a researcher was enhanced through the development and submission of manuscripts for publication or grant proposals for peer review. Fellows should only submit specific activities that expanded their expertise or their ability to practice their expertise.

c. Standard setting activities

Definition: The focus of this section is on how your expertise in setting standards was enhanced by participating in activities that establish standards for clinical practice (e.g., development of a clinical practice guideline or care map), educational practice (e.g., examinations) or administrative practice (e.g., hospital policies or procedures). Fellows should only submit specific activities that expanded their expertise or their ability to practice their expertise.

Note: This section does not provide credits for simply participating in teaching, research or standard setting activities. The credits are meant to reflect the learning acquired from participating in each of these types of activities or how this learning has contributed to a Fellow’s expertise as an educator, researcher, standard setter or other dimensions of specialty practice.
Appendix 5
What is CanMEDS?

The CanMEDS Physician Competency Framework

Better standards, better physicians, better care

In 1996, the Royal College adopted an innovative framework for medical education called the CanMEDS framework of essential physician competencies. Fundamentally, CanMEDS is an initiative to improve patient care. The focus of CanMEDS is on articulating a comprehensive definition of the competencies needed for medical education and practice. Today, the CanMEDS model for physician competence is being adapted around the world as well as in other professions.

The CanMEDS framework is organized around seven Roles: Medical Expert (central Role), Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional. The CanMEDS competencies have been integrated into the Royal College's accreditation standards, objectives of training, final in-training evaluations, exam blueprints, and the Maintenance of Certification program.

CanMEDS makes explicit the abilities that have long been recognized in highly skilled physicians, and constantly updates them for today's—and tomorrow's—medicine. As such, the CanMEDS framework was extensively reviewed, updated and launched in September 2005.

CanMEDS Diagram

A diagram was created in 2001 to illustrate the elements and the interconnections of the CanMEDS Roles embodied by competent physicians: Medical Expert (the central Role), Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional. This diagram, also known as the CanMEDS "cloverleaf," "daisy," "flower" and "illustration" was officially trademarked in 2005 and was revised to more accurately reflect the fluidity and overlap amongst the CanMEDS Roles.
For more information, please read the CanMEDS Overview or contact us at canmeds@rcpsc.edu.

Web page updated: 20 February 2007
Appendix 6
Chairman’s Summary of the Conference

Continuing Education in the Health Professions: Improving Healthcare Through Lifelong Learning

In November 2007 the Josiah Macy, Jr. Foundation convened a conference to address complex issues concerning continuing education in the health professions. Participants developed the set of conclusions and recommendations found at the end of this Executive Summary.

A more detailed account of the proceedings, along with the background papers, will be included in a monograph to be published by the Macy Foundation late in 2008.

Continuing education (CE) of health professionals is essential to the health of all Americans. With accelerating advances in health information and technology, physicians, nurses and other health professionals must maintain and improve their knowledge and skills throughout their careers in order to provide safe, effective and high quality health care for their patients.

Yet continuing education in the health professions is in disarray. Over the past decade, both professional and lay reports have identified multiple problems. CE, as currently practiced, does not focus adequately on improving clinician performance and patient health. There is too much emphasis on lectures and too little emphasis on helping health professionals enhance their competence and performance in their daily practice. With Internet technology, health professionals can find answers to clinical questions even as they care for patients, but CE does not encourage its use or emphasize its importance. And, while studies show that inter-professional collaboration, teamwork and improved systems are key to high quality care, accrediting organizations have not found ways to promote teamwork or align CE with efforts to improve the quality of health systems.

Another significant problem is the growing link between continuing education and commercial interests. In 2006, the total income for accredited CE activities in medicine was $2.4 billion. Commercial support from pharmaceutical and medical device manufacturers accounted for more than 60 percent, about $1.45 billion, of the total. Over the past two years, the Senate Finance Committee has investigated pharmaceutical company support for continuing education in medicine. Despite efforts to control improper influences, the committee concluded that the organizations providing continuing education could still accommodate commercial interests of sponsors and sponsors could still target their funding for educational programs likely to support sales of their products.

To address concerns about CE, the Josiah Macy, Jr. Foundation convened a conference on “Continuing Education in the Health Professions.” Suzanne W. Fletcher, M.D., M.Sc., Professor of Ambulatory Care and Prevention, Emeritus, at Harvard Medical School, served as chair. The two-and-one-half-day conference, which was held in Bermuda in November of 2007, included 36 leaders in medicine, nursing and education. Commissioned background papers covered a range of CE-related topics, including a review
of how physicians and other health professionals learn, the role of information technology, financing and certification.

Although much of the conference discussion was relevant to the continuing education of all health professionals, participants focused on accredited CE for medicine and nursing. They acknowledged that much professional learning takes place informally and outside accredited formats.

Conference themes were inter-related, for the methods used for continuing education are influenced both by the means of financial support and by mechanisms for accreditation. Unfortunately, participants found, current systems of CE do not meet the needs of health professionals as well as they should:

— Too much CE relies on a lecture format and counts hours of learning rather than improved knowledge, competence and performance.

— Too little attention is given to helping individual clinicians examine and improve their own practices.

— Insufficient emphasis is placed on individual learning driven by the need to answer the questions that arise during patient care.

— CE does not promote inter-professional collaboration, feedback from colleagues and patients, teamwork, or efforts to improve systems of care, activities that are key to improved performance by health professionals.

— CE does not make adequate or creative use of Internet technology, which can help clinicians examine their own practice patterns, bring medical information to them during patient care, and aid them in learning new skills.

— There is too little high-quality scientific study of CE.

Participants warned that the health professions, especially medicine, threaten the ethical underpinnings of professionalism by participating in a multi-billion dollar CE enterprise so heavily financed by commercial interests. This arrangement, which evolved over the years, distorts continuing education. It places physicians and nurses who teach CE activities in the untenable position of being paid, directly or indirectly, by the manufacturers of health care products about which they teach. At the same time, commercial support of CE places learners in an obligatory position because they are often given free meals and small gifts. Independent judgment of how best to care for patients is compromised. Bias, either by appearance or reality, has become woven into the very fabric of continuing education. The professions, themselves, must right this wrong.

In a free-market system, commercial entities, such as drug and device manufacturers, have a clear responsibility to shareholders to gain market advantage and generate a profit, while health professionals have a moral responsibility to provide safe, high quality care for their patients, based on valid scientific findings. The two responsibilities are fundamentally incompatible. Even if bias could be avoided, the potential, and the perception, are ever-present. Companies with billions of dollars at stake cannot be expected to be neutral or objective when assessing the benefits, harms and cost-effectiveness of their products, for they are in the legitimate business of gaining market advantage and want clinicians to use and prescribe their products.

Yet, an objective and neutral assessment of clinical management options is precisely what is needed in continuing education. Participants emphasized that, regardless of the financial impact on for-profit companies, patient care must be based on scientific evidence and commercial interests should not determine the topics or content of CE. Because of these underlying ethical issues, participants concluded that the commercial entities that manufacture and sell health care products should not provide financial support for the continuing education of health professionals.

Participants acknowledged that many major advances in health care, especially in the development of new drugs and devices, have come from careful collaboration between medical and
commercial investigators. Too, corporations have made valuable donations to academic health centers to support professorships, scholarships, programs and buildings, all of which contribute to the public good.

Despite recent changes in CE accreditation to reduce commercial influence, the problem persists and organizations with little professional expertise in health care, and supported almost entirely by commercial interests, provide accredited continuing education. At the same time, accrediting groups require all organizations providing CE to go through laborious, bureaucratic procedures to document that no inappropriate influence has occurred.

Participants pinpointed another serious failure with current accreditation mechanisms. At a time when inter-professional collaboration, teamwork, and improvement of systems are key to high quality health care, accrediting organizations for the various health professions still work in silos. Rather than promoting inter-professional collaboration and education, regulations and procedures for accreditation make inter-professional collaboration difficult. And, while systems of care have a major impact on the quality of health care delivered by clinicians, accrediting organizations have been slow to align their CE activities with quality improvement efforts by systems of care.

Participants identified a set of principles they believe should underlie and guide continuing education of the health professions:

— Integrate continuing education into daily clinical practice.
— Base continuing education on the strongest available evidence for practice.
— Minimize, to the greatest extent possible, both the reality and the appearance of bias.
— Emphasize flexibility and easy accessibility for clinicians.
— Stress innovation and evaluation of new educational methods.
— Address needs of clinicians across a wide spectrum, from specialists in academic health centers to rural solo practitioners.
— Support inter-professional collaboration.
— Align continuing education efforts with quality improvement initiatives at the level of health systems.

After two and a half days of discussion, participants agreed to the following conclusions and recommendations:

CONCLUSIONS

Continuing Education and the Public

The quality of patient care is profoundly affected by the performance of individual health professionals.

The fundamental purposes of continuing health professional education (CE) are:

— To improve the quality of patient care by promoting improved clinical knowledge, skills and attitudes, and by enhancing practitioner performance.
— To assure the continued competency of clinicians and the effectiveness and safety of patient care.
— To provide accountability to the public.

CE fulfills a critically important, indeed essential, public purpose. Given the accelerating pace of change in clinical information and technology, CE has never been more important.

Responsibilities of individual professionals, professional teams and health systems

Maintaining professional competence is a core responsibility of each health professional, regardless of discipline, specialty or type of practice.

The individual clinician has been the principal
unit of accountability for performance in the healthcare delivery system. Given that the performance of health systems also profoundly affects patient care, CE fails to take into account systems of care.

Effective patient care increasingly depends on well-functioning teams of healthcare professionals. Therefore, CE must address the special learning needs of collaborating teams.

Quality improvement efforts and CE activities overlap and ideally are mutually reinforcing.

**CE Methods**

Traditional lecture-based CE has proven to be largely ineffective in changing health professional performance and in improving patient care. Lecture formats are employed excessively relative to their demonstrated value.

Professional conferences play an important role in CE by promoting socialization and collegiality among health professionals. Health professionals have the responsibility to help one another practice the best possible care. Meeting together provides opportunities for cross-disciplinary and cross-generational learning and teaching.

Practice-based learning and improvement is a promising CE approach for improving the quality of patient care. Maintenance of certification programs (in which clinicians review the care they actually deliver in their own practices, compare the results with standards of excellence and create a plan for improvement) and maintenance of licensure programs are moving CE in this direction. Currently, most CE faculty are insufficiently prepared to teach practice-based learning.

Information technology is essential for practice-based learning by:

— Providing access to information and answers to questions at the time and place of clinical decision-making (point-of-care learning).

— Providing a database of clinician performance at the individual and/or group practice level, which can be compared to best practices and used to make plans for improvement.

— Providing automated reminder systems.

Interactive scenarios and simulations are promising approaches to CE, particularly for skills development, whether the skill is a highly technical procedure, history taking, or a physical examination technique.

Insufficient research is currently directed at improving and evaluating CE. There is no national entity dedicated to advancing the science of CE as there is for biomedical and clinical research.

**Financing CE**

The majority of financial support for accredited CME, and increasingly for CNE, derives directly or indirectly from commercial entities.

Pharmaceutical and medical device companies and health care professionals have inherently conflicting interests in CE. Commercial entities have a legitimate obligation to enhance shareholder value by promoting sales of their products, whereas healthcare professionals have a moral obligation to improve patient/public health without concern for the sale of products.

Commercial support for CE:

— Risks distorting the educational content and invites bias.

— Raises concerns about the vows of health professionals to place patient interest uppermost.

— Endangers professional commitment to evidence-based decision making.

— Validates and reinforces an entitlement mindset among health professionals that CE should be paid for by others.

— Impedes the adoption of more effective modes of learning.

No amount of strengthening of the “firewall”
between commercial entities and the content and processes of CE can eliminate the potential for bias.

Academic health centers and other healthcare delivery systems are not sufficiently attentive, either to their roles in planning, providing, and assessing CE or to their responsibilities in managing their own conflicts of interest and those of individual faculty and administrators when paid by commercial interests for CE teaching.

Accrediting CE

Current accreditation mechanisms for CE are unnecessarily complex yet insufficiently rigorous. Compared to earlier, formal stages of health professions education, the CE enterprise is fragmented, poorly regulated, and uncoordinated; as a result, CE is highly variable in quality and poorly aligned with efforts to improve quality and enhance health outcomes.

With the increasing need for inter-professional collaboration, accrediting bodies of the various health professionals need closer working relationships.

RECOMMENDATIONS

CE Methods

The CE enterprise should shift as rapidly as possible from excessive reliance on presentation/lecture-based formats to an emphasis on practice-based learning.

New metrics are needed:

— To assess the quality of CE. These metrics should be based on assessment of process improvement and enhanced patient outcomes.

— To identify high-performing healthcare organizations. The possibility of awarding CE credit to individual health professionals who practice in such organizations should be explored.

— To automate credit procedures for point-of-care learning.

Federal and state policymakers should provide financial support for the further development of information technology tools that facilitate practice-based learning and should strongly encourage all clinicians to use these tools.

The responsibility for lifelong learning should be emphasized throughout the early, formal stages of education in all health professions. Students should be taught the attitudes and skills to accomplish CE throughout their professional lifetimes.

A national inter-professional CE Institute should be created to advance the science of CE. The Institute should:

— Promote the discovery and dissemination of more effective methods of educating health professionals over their professional lifetimes and foster the most effective and efficient ways to improve knowledge, skills, attitudes, practice and teamwork.

— Be independent and composed of individuals from the various health professions.

— Develop and run a research enterprise that encourages increased and improved scientific study of CE.

— Promote and fund evaluation of policies and standards for CE.

— Identify gaps in the content and processes of CE activities.

— Develop mechanisms needed to assess and fund research applications from health professional groups and individuals.

— Stimulate development and evaluation of new approaches to both intra- and inter-professional CE, and determine how best to disseminate those found to be effective and efficient.

— Direct attention to the wide diversity and scope of practices with special CE needs, ranging from highly technical specialties on the one hand to solo and small group practices in remote locations, on the other.
— Acquire financial resources to support its work and provide funding for research. Possible funding sources include the Federal government, foundations, professional groups, and corporations.

A concerted effort is needed to make the concept of a Continuing Education Institute a reality. To achieve this, The Institute of Medicine should convene a group to bring together interested parties to propose detailed steps for developing a Continuing Education Institute.

**CE Financing**

Accredited organizations that provide CE should not accept any commercial support from pharmaceutical or medical device companies, whether such support is provided directly or indirectly through subsidiary agencies. Because many professional organizations and institutions have become heavily dependent on commercial support for current operations, an abrupt cessation of all such support would impose unacceptable hardship. A five-year “phase out” period should be allowed to meet this recommendation.

The financial resources to support CE should derive entirely from individual health professionals, their employers (including academic health centers, health care organizations, and group practices), and/or non-commercial sources.

Faculty of academic health centers should not serve on speakers’ bureaus or as paid spokespersons for pharmaceutical or device manufacturers. They should be prohibited from publishing articles, reviews and editorials that have been ghostwritten by industry employees.

**CE Accreditation and Providers**

Organizations authorized to provide CE should be limited to professional schools with programs accredited by national bodies, not-for-profit professional societies, health care organizations accredited by the Joint Commission, multi-disciplinary practice groups, point-of-care resources, and print and electronic professional journals.

Existing accrediting organizations for continuing education for medicine (the Accreditation Council for Continuing Medical Education) and nursing (the American Nurses Credentialing Center) should meet and within two years develop a vision and plan for a single accreditation organization for both nursing and medicine. The new organization should incorporate the guiding principles for CE and the recommendations laid out in this report where relevant. The American Academy of Nursing and the Association of American Medical Colleges should convene the two accrediting bodies for this purpose.

Academic health centers should examine their missions to determine how to strengthen their commitment to CE. They should help their faculty gain expertise in teaching practice-based learning and incorporate information technology, simulations and interactive scenarios into their CE activities.
## Conference Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suzanne W. Fletcher, M.D., M.Sc.*</td>
<td>Harvard Medical School</td>
</tr>
<tr>
<td>Barbara F. Atkinson, M.D.</td>
<td>University of Kansas Medical Center</td>
</tr>
<tr>
<td>Denise Basow, M.D.*</td>
<td>UpToDate</td>
</tr>
<tr>
<td>Regina Benjamin, M.D., M.B.A.</td>
<td>Bayou Clinic, Inc.</td>
</tr>
<tr>
<td>David Blumenthal, M.D., M.P.P.</td>
<td>MGH/Partners Health Care System</td>
</tr>
<tr>
<td>James A. Clever, M.D.</td>
<td>Marin County, CA</td>
</tr>
<tr>
<td>Jordan J. Cohen, M.D.*</td>
<td>Association of American Medical Colleges</td>
</tr>
<tr>
<td>Ellen M. Cosgrove, M.D.*</td>
<td>University of New Mexico School of Medicine</td>
</tr>
<tr>
<td>Linda Cronenwett, Ph.D., R.N.</td>
<td>University of North Carolina at Chapel Hill</td>
</tr>
<tr>
<td>David A. Davis, M.D.</td>
<td>Association of American Medical Colleges</td>
</tr>
<tr>
<td>Catherine D. DeAngelis, M.D., M.P.H.</td>
<td>JAMA and Archives John Hopkins University</td>
</tr>
<tr>
<td>Lyn DeSilets, Ed.D., R.N.-B.C.</td>
<td>Villanova University</td>
</tr>
<tr>
<td>F. Daniel Duffy, M.D.*</td>
<td>American Board of Internal Medicine</td>
</tr>
<tr>
<td>Harvey Fineberg, M.D., Ph.D.</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>Grant S. Fletcher, M.D., M.P.H.</td>
<td>University of Washington School of Medicine</td>
</tr>
<tr>
<td>Melvin I. Freeman, M.D.</td>
<td>Virginia Mason Medical Center</td>
</tr>
<tr>
<td>Michael Green, M.D., M.Sc.</td>
<td>Yale University School of Medicine</td>
</tr>
<tr>
<td>Carol Havens, M.D.</td>
<td>Kaiser Permanente Medical Center, Sacramento, CA</td>
</tr>
<tr>
<td>Paul C. Hébert, M.D., M.H.Sc.</td>
<td>Canadian Medical Association Journal</td>
</tr>
<tr>
<td>Maryjoan Ladden, Ph.D., R.N.*</td>
<td>Harvard Medical School</td>
</tr>
<tr>
<td>David Leach, M.D.*</td>
<td>Accreditation Council for Graduate Medical Education</td>
</tr>
<tr>
<td>Donald A. B. Lindberg, M.D.*</td>
<td>National Library of Medicine</td>
</tr>
<tr>
<td>Phil Manning, M.D.</td>
<td>Keck School of Medicine of the University of Southern California</td>
</tr>
<tr>
<td>Paul Mazmanian, Ph.D.</td>
<td>Virginia Commonwealth University</td>
</tr>
<tr>
<td>Pamela Mitchell, Ph.D., M.S., B.S.</td>
<td>University of Washington</td>
</tr>
<tr>
<td>Donald E. Moore Jr., Ph.D.</td>
<td>Vanderbilt School of Medicine</td>
</tr>
<tr>
<td>Ajit Sachdeva, M.D.</td>
<td>American College of Surgeons</td>
</tr>
<tr>
<td>Marla E. Salmon Sc.D., R.N.</td>
<td>Emory University</td>
</tr>
<tr>
<td>David Slawson, M.D.</td>
<td>University of Virginia</td>
</tr>
</tbody>
</table>

Macy Conference participants are invited for their individual perspectives and do not necessarily represent the views of any organization.

---

*Planning Committee*
Appendix 7
About AFMC

The Association of Faculties of Medicine of Canada (AFMC) is the national voice of Canada’s 17 faculties of medicine.

Our core campuses and teaching communities are comprised of more than 8,000 undergraduate medical students in training, more than 10,000 postgraduate trainees and almost 30,000 full and part-time faculty members. These figures reflect a growth of more than 25% in both the number of students and faculty since 2000.

As part of its mandate, AFMC is continually engaged in advocacy activities related to all facets of academic medicine.

AFMC Standing Committees provide guidance on continuing, postgraduate and undergraduate medical education as well as research and graduate studies. The AFMC Special Resource Committees and Resource Groups also address a variety of issues relevant to medical education.

AFMC manages a rigorous system of accreditation at the undergraduate levels for all 17 faculties of medicine in Canada. Accreditation of undergraduate medical education is undertaken jointly between the Committee on Accreditation of Canadian Medical Schools (CACMS) in Canada and the Liaison Committee on Medical Education (LCME) in the U.S.

AFMC, through the Committee on Accreditation of Continuing Medical Education (CACME), also accredits the offices of Continuing Medical Education at all Canadian faculties of medicine.

The Canadian Post-M.D. Education Registry (CAPER) is the active data-gathering and research arm of AFMC with an interest in the post-M.D. clinical education of physicians in Canada.

Since 2002, AFMC’s Social Accountability Initiative (SAI) has acknowledged and promoted the role of faculties of medicine in Canada in ensuring access to and quality of the system in order to meet the health needs of the population by addressing issues of professionalism and engaging with other key stakeholders in the areas of public health, Aboriginal health and end-of-life palliative care issues and with young leaders to look at what the health care system will be like in the future. Through the SAI, AFMC is looking at inter-professional models of education and care delivery. AFMC recently received funding to conduct a project on the future of medical education in Canada.

Since 2005, the AFMC is the secretariat of the premier Canadian Conference on Medical Education. AFMC works together with the Canadian Association for Medical Education, College of Family Physicians of Canada, Medical Council of Canada and Royal College of Physicians and Surgeons of Canada to organize the conference. It has become an exceptional venue for those involved in medication education to come together to share their experiences and plan new ways to better meet the needs of their constituencies.
Contact Us

Phone: +1 613-730-0687 [+ three-digit extension number]
E-mail: username@afmc.ca
Fax: +1 613-730-1196
Mail: 265 Carling Avenue, Suite 800 Ottawa, ON K1S 2E1

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Extension</th>
<th>Username</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busing, Nick (MD)</td>
<td>President &amp; Chief Executive Officer</td>
<td>222</td>
<td>nbusing</td>
</tr>
<tr>
<td>Crabbe, Kathryn</td>
<td>Project Associate (CAPER)</td>
<td>(613) 730-1204 Ext. 247</td>
<td>kcrabbe</td>
</tr>
<tr>
<td>Elliott, Tracy</td>
<td>Manager, Human Resources and Administration</td>
<td>244</td>
<td>telliott</td>
</tr>
<tr>
<td>Flanagan, Nicole</td>
<td>Executive Assistant to the President &amp; Chief Executive Officer</td>
<td>222</td>
<td>nflanagan</td>
</tr>
<tr>
<td>Fortin, Yannick</td>
<td>Data &amp; Analysis Manager</td>
<td>232</td>
<td>yfortin</td>
</tr>
<tr>
<td>Forward, Les</td>
<td>Database Manager (CAPER)</td>
<td>(613) 730 - 1204 Ext. 230</td>
<td>lforward</td>
</tr>
<tr>
<td>Frassine, Lidia (BCom)</td>
<td>Manager, Financial Services</td>
<td>233</td>
<td>lfrassine</td>
</tr>
<tr>
<td>Gilchrist, Angelie</td>
<td>Conference Assistant, Canadian Conference on Medical Education</td>
<td>265</td>
<td>agilchrist</td>
</tr>
<tr>
<td>Gold, Irving (MA, MCA)</td>
<td>Vice President, Government Relations and External Affairs</td>
<td>236</td>
<td>igold</td>
</tr>
<tr>
<td>Gushue, Colleen</td>
<td>Project Associate</td>
<td>243</td>
<td>cferris</td>
</tr>
<tr>
<td>Holloway, Christine</td>
<td>Conference Manager, Canadian Conference on Medical Education</td>
<td>240</td>
<td>cholloway</td>
</tr>
<tr>
<td>Kealey, Liane</td>
<td>Research Associate</td>
<td>227</td>
<td>ikealey</td>
</tr>
<tr>
<td>Le Quellec, Claudine</td>
<td>Accreditation Manager</td>
<td>225</td>
<td>claudine</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Extension</td>
<td>Username</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>LeBlanc, Hélène</td>
<td>Executive Assistant to the Vice President, Research and Analysis (CAPER)</td>
<td>(613) 730 - 1204 Ext. 231</td>
<td>hleblanc</td>
</tr>
<tr>
<td>Looker, Margaret E</td>
<td>Executive Assistant to the Vice President, Education and Special Projects</td>
<td>234</td>
<td>mlooker</td>
</tr>
<tr>
<td>de Lucovich, Claire</td>
<td>Project Assistant</td>
<td>241</td>
<td>cdelucovich</td>
</tr>
<tr>
<td>Maskill, Susan (BSc)</td>
<td>Vice President, Education and Special Projects</td>
<td>224</td>
<td>smaskill</td>
</tr>
<tr>
<td>Moffatt, Catherine</td>
<td>Project Manager</td>
<td>237</td>
<td>cmoffatt</td>
</tr>
<tr>
<td>Mutschler, Stéphanie</td>
<td>CAME/Meeting Planner</td>
<td>238</td>
<td>smutschler</td>
</tr>
<tr>
<td>Peirce, Catherine (MA)</td>
<td>Project Manager, e-Learning</td>
<td>239</td>
<td>cpeirce</td>
</tr>
<tr>
<td>Russ, Natalie</td>
<td>Executive Assistant to the Vice President, Government Relations and External Affairs</td>
<td>228</td>
<td>nruss</td>
</tr>
<tr>
<td>Shore, Barbie</td>
<td>Project Manager</td>
<td>235</td>
<td>bshore</td>
</tr>
<tr>
<td>Slade, Steve (BA)</td>
<td>Vice President, Research and Analysis (CAPER/ORIS)</td>
<td>(613) 730 - 1204 Ext. 229</td>
<td>sslade</td>
</tr>
<tr>
<td>Trinity, Schallah</td>
<td>Receptionist/Administrative Assistant</td>
<td>100</td>
<td>strinity</td>
</tr>
<tr>
<td>Yeatman, Dale</td>
<td>Research Assistant</td>
<td>226</td>
<td>yeatman</td>
</tr>
</tbody>
</table>

Copyright © The Association of Faculties of Medicine of Canada
265 Carling Avenue, Suite 800 Ottawa, ON K1S 2E1
Tel: (613) 730-0687    Fax: (613) 730-1196
The AFMC Standing Committee on Continuing Medical Education

Physicians spend up to 40 years pursuing continuing medical education and professional development (CME/CPD). This is the longest and possibly most influential education a doctor will receive. To ensure this education and development is of the highest quality, the AFMC Standing Committee on Continuing Medical Education (SCCME) advises on and guides the education of medical professionals and their continuing professional development.

In addition to representatives from all 17 faculties of medicine in Canada, there are members from a number of partner organizations: the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons, the Canadian Medical Association, the Canadian Association of Continuing Health Education, the Foundation for Medical Practice Education, the Federation of Medical Regulatory Authorities of Canada, and the Conseil Québécois de développement professionnel continue des médecins. The large number of partners is indicative of the complexity of the CME/CPD enterprise in Canada.

The committee works in a number of areas to foster professional development within the faculties. For example, it examines the alignment of university programs with the standards of the College of Family Physicians and the Royal College and also helps develop and accredit online CME programs. The committee works with university CME offices to enhance research programs in CME/CPD; to support the assessment and education of international medical graduates; to enhance the university CME web portal as a source of excellent, non-biased CME/CPD for Canadian physicians; and to develop common projects for social accountability in CME/CPD.

Most CME/CPD offices are self-financing through program fees and external support. They usually run with a small staff and faculty, even though they must fill the two complementary roles of offering CME programs and fulfilling an academic mandate. As well, the CME/CPD offices, unlike most other organizations in the field, are subject to a five-year accreditation review by the Committee on Accreditation on Continuing Medical Education. As part of that review, they must explicitly outline how they have met their academic mandate by contributing to scholarship in this important area.

The SCCME meets monthly via teleconference. It also has an annual retreat, business meeting, and two research meetings at the annual conference on medical education.
Appendix 8
SACME was established on April 2, 1976 as the Society of Medical College Directors of Continuing Medical Education (SMCDCME). On July 20, 1998, SMCDCME was renamed the Society for Academic Continuing Medical Education (SACME).

See also SACME History

Our Mission

The mission of the Society for Academic Continuing Medical Education is to promote the research, scholarship, evaluation and development of CME/CPD (continuing medical education/continuing professional development) that helps to enhance the performance of physicians and other healthcare professionals practicing in the United States, Canada, and elsewhere for purposes of improving individual and population health.

Our Objectives

This mission statement embraces the following objectives for the Society:

- Establish a forum and structure within which academic CME/CPD professionals in the U.S., Canada, and elsewhere are enabled to enhance academic CME/CPD;
- Represent academic CME/CPD in national forums and with policy and decision makers on issues relevant and pertinent to CME/CPD and in collaborations with other societies and organizations, consistent with objectives of the Society to enhance the effectiveness of CME/CPD in improving healthcare;
- Promote life-long learning skills of its membership and physicians and healthcare professionals at large;
- Advocate academic scholarship which promotes the generation, translation and dissemination of knowledge, skills, attitudes, and competencies related to CME/CPD;
- Promote, disseminate and fund research in CME/CPD, adult and continuing education, professional development, and any other fields related to how physicians and other members of the healthcare team learn and change clinical behaviors;
- Provide leadership in the design and implementation of efficient and cost-effective CME/CPD activities that address how physicians and other members of the healthcare team learn and change their professional and clinical behaviors to improve healthcare outcomes;
Foster continuous improvement in the skills of those working in academic CME/CPD; and

Foster learning and career development of students, trainees, faculty, professionals and other individuals interested in careers in academic CME/CPD.

Our Goals

promote, disseminate, and fund research in CME, adult and continuing education and other fields related to how physicians learn and change clinical behaviors;

design and implement educational activities that address not only how physicians learn but ways in which physicians change their professional behaviors;

establish a forum for leaders of academic continuing medical education.
CME Best Practices

There are many ways to discover how other CE providers are conducting business: consulting survey data or colleagues, subscribing to listservs and mailing lists, attending meetings, viewing the Web sites of professional associations for FAQs and toolkits ... Besides the links to resources on this page, SACME members have access to two valuable sources of information:

- Best Practices abstracts and presentations from past SACME meetings
- SACME listserv discussions, searchable through the SACME listserv archives

See also News & Events, News Sources, Journals, Blogs & Listservs, Evidence-Based Medicine Resources, Conversations in CME; Current [SACME] Board & Officers

- Survey Data
- FAQs, Guides & Toolkits
- Media Resources
- Granting Sources
  See also RFPs & Calls for Grant Applications
  SACME members see also SACME Research Grants
- Quality Improvement/Assurance

Survey Data

SACME Biennial Surveys

Since 1982 SACME’s Research Committee has surveyed CME units at medical schools in the United States and Canada. To view all the reports see Biennial Survey


ACCME Annual Report Data

Each year, ACCME accredited providers submit an Annual Report form that contains information about their CME program, including the number and type of activities provided, hours of instruction presented, numbers of physician and non-physician participants, as well as some financial information.

FAQs, Guides & Toolkits

- The National Task Force on Continuing Medical Education Provider/Industry Collaboration. Get the Facts! Campaign Toolkit
  The Get the Facts! Campaign is a national effort to disseminate factual information on issues that are important and relevant to the CME community. Participants include the Alliance for Continuing Medical Education (Alliance for CME), Society for Academic Continuing Medical Education (SACME), Association for Hospital Medical Education (AHME) and the Coalition for Healthcare Communications. Link to a podcast of Maureen Doyle-Scharff discussing the Get the Facts campaign. Call to Action

  Vol. 1, Issue 1: Continuing Medical Education: Providing Valid and Independent Evidence for Clinical Decisions
  Vol. 1, Issue 2: Continuing Medical Education: Addressing Conflict of Interest (COI)

- Ask ACCME [Search ACCME’s frequently asked questions by category]
- Documents And Forms Library [ACCME] See also Accreditation & Maintenance of Certification
- Meeting Planner Survival Guide [MeetingsNet]
- Tools to Support Implementation of a Monitoring System Regularly Scheduled Series [ACCME; updated January 2008]
- TOOLBOX OF ASSESSMENT METHODS® [ACGME Outcomes Project & Accreditation Council for Graduate Medical Education]
- Teaching From a Competency Perspective: An Instructional Toolbox for Graduate Medical Education [ACGME]
- Planning Accredited Rounds [CE resources from the University of Toronto Faculty of Medicine Department of Medicine]
- Event & Course Directors: 10 Steps in Designing a Course [University of Toronto Faculty of Medicine Continuing Education & Professional Development (CEPD)]
- HEAL: health education assets library [free, high-quality digital materials for health sciences education]
- MedEdPORTAL : Providing Online Resources to Advanced Learning in Medical Education [AAMC]
- FMDRL: Family Medicine Digital Resources Library [Society of Teachers of Family Medicine]
- Explorations in Learning & Instruction: The Theory into Practice [TIP] Database "contains brief summaries of 50 major theories of learning and instruction. These theories can also be accessed by learning domains and concepts."
- Learning-Theories.com: Knowledge Base and Webliography [Index of Learning Theories and Models]


Mission Statement and Values

Vision of Continuing Medical Education (CME)
Physicians will use CME more effectively in their strategies to deliver the best possible patient care. CME professionals will support these efforts by working with physicians to plan, implement, and support educational activities that focus on prevention, health care, and improved outcomes.

Vision of the Alliance for CME
The Alliance for CME will be the recognized leader and advocate for CME and the development of CME professionals.

Mission of the Alliance for CME
The Alliance for CME is a membership organization that provides professional development opportunities for CME professionals, advocates for CME and the profession, and strives to improve health care outcomes.

Goals of the Alliance for CME

- To deliver valuable and relevant member services, resources and assistance to enhance the practice of the CME professional.
- To provide for members professional development opportunities that exemplify best practices.
- To provide a forum to discuss issues that impact the profession and practice of CME.
- To advocate proactively for CME and the CME profession.
- To demonstrate organizational effectiveness by employing best practices in association governance and management.
Values of the Alliance for CME

Responsiveness: We will meet and exceed the needs and expectations of our members.

Innovation: We will encourage new ideas and methods in the planning, implementation and administration of educational activities and programs.

Collaboration: We will partner with organizations and individuals involved in all areas of health care.

Respect: We will embrace individual and organizational diversity.

Integrity: We will perform at the highest level of ethical behavior in all of our activities.

Purpose
The Alliance provides educational opportunities, professional development, information exchange, and supportive services. These assist members in adapting to the changing health care environment, improving the CME activities offered for physicians, and shaping the future of the CME field.

Accredited Provider of CME
The Alliance for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
Appendix 10
APPENDIX 10

Collège des médecins du Québec www.cmq.org

Our Organization

The mission of the Collège des médecins du Québec is to promote quality medicine so as to protect the public and help improve the health of Quebecers.

To accomplish its mission, the Collège des médecins du Québec:

- verifies the competence of future physicians and their fitness to practise medicine;
- ensures and promotes the maintenance of competence of physicians;
- evaluates and controls the professional practice of physicians;
- receives and deals with complaints from the public;
- controls the illegal practice of medicine;
- takes a position in debates of public concern in matters of health

To fulfil its functions, the Collège des médecins has permanent committees and divisions. For each statutory committee of the Collège des médecins there is a corresponding division, composed of physicians employed full-time in most cases and responsible for implementing the decisions taken by the corresponding committee and the Board of Directors of the Collège des médecins. The Executive Committee coordinates the activities of all divisions.

Administrative Structure

To know more about it, consult the list of divisions available in the right-hand menu.
À propos de l'ordre

Bienvenue

Je vous souhaitez la bienvenue dans le nouveau site Web du Collège, entièrement revu afin de mieux répondre à vos besoins.

Avec ce site, le Collège souhaite vous offrir un portail dynamique, contemporain, accueillant et professionnel. Plus spécifiquement, il souhaite faciliter vos recherches et refléter les valeurs de transparence et d'humanisme qu'il prône.

Conçue de manière à regrouper l'information en cinq micro-sites, cette interface vous permet d'accéder rapidement aux pages qui vous intéressent. De plus, l’onglet À propos de l'ordre vous permet d'avoir une idée d'ensemble des activités du Collège à partir de n'importe quelle page du site.

Je vous invite à vous familiariser avec les nouveautés : les grands thèmes sont disponibles à l'horizontale, dans le menu en rouge, et les éléments secondaires à droite, à la verticale. Vous pouvez aussi constater que certains outils de navigation sont maintenant positionnés à droite, de manière ergonomique et près de la souris. La Foire aux questions, qui a bénéficié d'une restructuration, regroupe les questions les plus fréquemment posées sur de nombreux sujets. La section des nouvelles est également bonifiée et accessible en tout temps à partir de la barre bleue, tout en haut de la page.

Ce site, nous y travaillons depuis plusieurs mois dans le but de mieux vous servir. N'hésitez pas à nous faire parvenir vos commentaires, soit en répondant au mini-sondage en page d'accueil, ou encore en nous écrivant à l'adresse suivante : info@cmq.org.

Cordialement,

Yves Lamontagne, M.D.
Président-directeur général
Appendix 11
Mainpro® (Maintenance of Proficiency / Maintien de la compétence professionnelle) is The College of Family Physicians of Canada (CFPC) program that governs the continuing medical education (CME) requirements of its members.

History

The CFPC was founded in 1954 to promote the highest possible standards of care provided by Canadian family physicians through education and research. In 1969, the CFPC introduced certification in family medicine to recognize those members who could demonstrate acquisition of the knowledge and skills integral to the practice of family medicine. From the beginning, it was intended that those physicians who were successful in attaining this standard would make a commitment to maintain it throughout their careers. The first Maintenance of Certification program was introduced in 1977.

Certification in family medicine is a Special Designation of CFPC membership. Eligibility for Certification in family medicine is granted by the CFPC to those individuals who have either completed approved residency training in family medicine or become eligible for certification through a combination of training and practice experience. Once eligible, these individuals must also successfully complete the Certification Examination in Family Medicine. Certificants may use the designation CCFP (Certificant of the College of Family Physicians).

The CFPC developed the four principles of family medicine in 1985 to provide a definition of Family Medicine as a distinct discipline within the broader practice of medicine. They help to steer many of the activities of the CFPC.

- The patient-doctor relationship is central to family medicine.
- The family physician is a skilled clinician.
- Family medicine is community based.
- The family physician is a resource to a defined practice population.

Mainpro® was introduced as an integrated program in 1995 at a time when the CFPC made some important changes to its CME requirements.

Organization and decision-making

Policies and changes are developed by the CFPC National Committee on Continuing Professional Development / Continuing Medical Education (NCCME). This committee has a representative from each of the ten CFPC provincial chapters and a chair. The NCCPD/CME reports to the CFPC Board of Directors.

Each CFPC provincial chapter has a CPD/CME committee. In most cases, the chair of this committee serves as the chapter representative on the NCCPD/CME. The chapter appoints this person and the local Mainpro accreditation reviewers.
Guiding educational principles

Mainpro is based on the following guiding principles:

- The maintenance of effective, patient-oriented family practice depends on the ongoing responsibility of physicians both individually and collectively to maintain and enhance their knowledge and skills.
- Members of the CFPC continuously maintain and improve the quality of care they offer to their patients as defined by the four principles of family medicine.
- Mainpro should reinforce family medicine as a distinct medical discipline.
- Physicians should plan their own programs of self-directed, practice-based lifelong learning.
- Family physicians should be at the centre of education for themselves and their colleagues.
- All aspects of Mainpro should be developed and managed by practising family physicians.
- Effective CME for family physicians requires active planning.
  - CME should be planned according to sound educational and adult learning principles.
  - CME providers, family physicians, and the CFPC and its chapters should follow appropriate ethical standards at all times.

Research has shown that traditional CME in the form of didactic lectures and informal reading, while helpful in reinforcing knowledge, does not generally lead to significant changes in practice patterns. Approaches that link learning directly to practice and which emphasize active physician involvement tend to be more effective.

Effective learning involves the following concepts:

- Learning is both emotional and intellectual. It is also personal and subjective.
- Learning occurs within the context of life-long learning. It is not a one-time event.
- Planning of education and learning should be based on evidence of the effectiveness of various learning formats.
- The learning process should be directed by physicians involved actively at all stages from conceptualization to evaluation.
- Effective learning emanates from a sense of a need arising from the individual physician. It is linked to critical questioning of one’s practice.
- Information sought is accurate and appropriate.
- Information is only one part of learning. More important is the process employed to identify it, to reflect on it, and to change behaviour accordingly.
- Self evaluation is built into the process. Physicians assess how their current knowledge and skills meet the changing needs of their patients.
- Physicians should be self-critical in assessing how integrating new information impacts on their practices.
- Providers of CME should neither direct nor prescribe CME. To enhance learning opportunities for physicians, they should facilitate, manage, consult and arrange.
One way to express these principles is as a reflective learning cycle. The process begins when a physician formulates a specific question about his or her practice. This is followed by a search for appropriate information, which is then interpreted as it applies to his or her specific practice. In other words, the question comes before the information. Physicians reflect on their current practice in developing questions, on how to integrate new information into practice, and later, on what kind of impact the process ultimately had on their practice. The reflective learning cycle can be illustrated as follows:

These ideas provide the essential framework that the CFPC uses to determine the eligibility of CME activities for Mainpro-M1 and Mainpro-C credits.

Mainpro has the flexibility to meet members’ different needs and situations, and provides guidelines to ensure that selected CME activities are useful and meaningful. A well defined CME accreditation process encourages providers to improve the overall quality of CME available to family physicians.

Outcome-based research continues to identify the characteristics of CME which help physicians both reinforce what they do and introduce new knowledge into their practices. The CFPC will participate in the research process by evaluating the effectiveness of its own CME activities and programs and by seeking feedback about Mainpro both from members and CME providers. The CFPC will continue to modify Mainpro accordingly.

**Continuing medical education and continuing professional development**

Strictly speaking, CME refers to the process of acquiring new clinical knowledge and skills by practising physicians. Continuing professional development (CPD) is a broader concept. It incorporates not only the development of clinical knowledge and skills, but also of all other professional roles of family physicians including consultant, expert, academic, administrator, communicator, and community leader. The four principles of family medicine and Mainpro embrace all of these. In this document, the terms “continuing medical education” and “CME” will be used in this broader context.
Accreditation of Mainpro M-1 Programs to be run Nationally

Effective September 01, 2007, accreditation for all Mainpro M-1 programs, to be run nationally, will be administered through the CFPC National office, as part of a shared process, in which final accreditation will be granted by the CFPC Chapters.

Accreditation Process for Mainpro M-1 Programs, to be run nationally:

- All applications for these programs must be sent to the CFPC National office.
- All applications must be accompanied by a national ‘Needs Assessment’, representing each of the 5 CFPC-defined regions within Canada.
- The planning committee for each program must include CFPC Family Physicians from each of the 5 CFPC regions across Canada (British Columbia/Alberta; Saskatchewan/Manitoba; Ontario; Quebec; and Atlantic Canada).
- Where French-speaking Physicians are included in the target audience, the CPD Provider will submit French translations of the program to the CFPC National office. This material may be submitted once the English version has been deemed acceptable – i.e. no further changes or revisions.
- All English reviews will be conducted by two English-speaking CFPC reviewers.
- When the audience will include French-speaking Physicians, the final French materials will be sent to a third French-speaking Quebec reviewer, through the CFPC National office.
- All program content must be provided with the application, including all slides. These will be reviewed for ‘balance and bias’.
- The Department of Continuing Professional Development of the CFPC will notify the CPD provider, along with all (relevant) provincial CFPC Chapter offices when a program review has been completed, and deemed acceptable.
- Applicants must provide all materials at least 8 weeks in advance of their program; failure to provide complete materials will delay process.
- The fee for this review will be $700.00, paid by the CPD provider to the CFPC National office.
- Turn-around Time - CME Providers have a 30-day time period in which to respond to reviewers’ or Chapters’ requests for additional information, material, or revisions. If the provider does not respond within this time frame, reapplication will be required, including a new application fee.
- When an activity based on the reviewed program is to be run within a given province, the CPD provider will apply to the corresponding provincial CFPC Chapter for an ‘ethical review’, and by paying $100.00
- For purposes of this ethical review, the CPD provider will provide the CFPC provincial Chapter Office with all program promotional materials, invitations, correspondence to potential attendees, and all other published announcements /publicity in print or electronic media, websites, etc.
- The above-mentioned materials will be provided in the language(s) appropriate to the intended audience.
Specifically, the Chapter ‘ethics review’ will address the logistical components of the program – meals, entertainment or other social events associated with the program, location, cost for attendees, speakers, – and each will be screened for suitability, in keeping with the CFPC’s accreditation standards and ethical guidelines, along with those of Rx&D and the CMA.

Ultimately each CFPC provincial Chapter will be responsible for granting or denying the final accreditation of the National Mainpro M-1 program.

Applicants must wait up to 5 business days for a CFPC provincial Chapter’s final accreditation.

Once the CFPC National Office has deemed a program acceptable, but prior to receiving final accreditation from the Chapter Offices, the applying CPD Provider may state the following on all correspondence, invitations, and promotional materials: “This program has been reviewed by the College of Family Physicians of Canada, and is awaiting final accreditation by the College’s ____Chapter”.

Final accreditation will provide for the statement “This program has been accredited by the College of Family Physicians of Canada, and the ____Chapter, for up to ____ Mainpro-M1 credits.”

Mainpro M1 Provincial Accreditation

This section describes all the information necessary to apply for accreditation for Mainpro-M1 credits for conferences, courses, and workshops. Mainpro-M1 accreditation is administered through the CFPC's provincial chapters. Copies of all application materials are submitted to the chapter in any province where the activity is to be held.

Conferences, courses and workshops must meet the Mainpro-M1 accreditation criteria.

The following documentation must be submitted for any conference, course or workshop. All of this information is required to assess how well the activity meets the Mainpro-M1 accreditation criteria. If accreditation is granted, the application form will be signed and a copy returned to the applicant. If not accredited, reasons will be provided. In case of uncertainty, conflict, or unusual circumstances, the chapter reviewer can consult with another program reviewer (even in another province), the chapter’s representative on the National Committee on Continuing Professional Development / Continuing Medical Education (NCCPD/CME), the chair of the NCCPD/CME, or the CFPC Director of CPD/CME.

1. Accreditation application form

The program coordinator must submit a completed Mainpro-M1 Accreditation Application Form. These are available from the CFPC national office and from all provincial chapter offices. The CFPC member must complete and sign the section on the form certifying his or her involvement.

2. Information

The following information must be provided in a letter or other format. It relates to the accreditation criteria and will provide the information necessary for the reviewer to make an informed decision.

1. What was the involvement of the CFPC member in planning the program?
The member must describe his/her involvement to the CFPC. This should consist of one of the following:

- A detailed statement written directly in the space provided on the accreditation application form.
- A letter from the member.
- A CME program worksheet, used to facilitate the planning of the program, which the member could complete.
- A copy of the minutes of the planning committee meeting(s) that indicates involvement in discussions.

2. How were the topics selected?

3a. How were the learning needs of the participants considered?

3b. How were the learning needs used to develop the learning objectives?

4. How did you communicate with the speakers regarding the format and learning objectives they were to address? What kind of instruction were they given?

5a. What is the format of the sessions? How will the participants be able to interact with each other and the speakers? What time is built in for questions and answers?

5b. Describe the venue (location, rooms, environment).

5c. How are the learning sessions scheduled in relation to any social activities?

6. Describe the process to be used to evaluate the program.

- If an evaluation form is to be used, please attach a copy.
- If the evaluation of the sessions involves a discussion rather than the use of forms, how will this be done and how will the feedback be used?

7a. What are the costs to the participants, including registration fees, education materials, and social events?

7b. Fully describe any outside funding sources.

7c. Describe how potential conflicts of interest (including relevant financial affiliations) will be disclosed to the participants.

3. **Copy of the printed program**

The printed program must include the following information. A draft version is acceptable as long as there will be no substantial changes.

- Content/sessions

(The sessions for which accreditation is being requested should be clearly indicated. Only educational sessions are eligible. Refreshment, exhibit, meal, other social breaks, and written tests are not.)

- Learning objectives.
- Duration of program or sessions.
- Speakers.
- Funding sources.
4. **Administration fee**

An administration fee of $300.00 is payable to the CFPC chapter in the province where the program is to be held or to the national office for any application that should be submitted there. This fee does not guarantee accreditation and is non-refundable.

**Other important information**

**Reviewer**

The application will be assessed by a reviewer designated by the chapter. If a provincial reviewer is him/herself involved in the planning or implementation of a program, he/she will not be involved in its accreditation review. An alternate accreditor from the same or a different province (preferably within the same region) will review it.

**Jurisdiction**

Mainpro-M1 accreditation is program and site specific. Mainpro-M1 credits are not transferable by providers or participants from an accredited program to one which is not. Further, program reviewers cannot assign Mainpro-M1 credits outside their area of jurisdiction. This applies to both CFPC chapter reviewers and to university CME office personnel.

**Deadlines**

Applications should be received at least 8 weeks prior to the date of the course to be guaranteed an accreditation decision on time. The CFPC reserves the right to deny accreditation to any program because of a late application. The CFPC will not consider accrediting programs that have already occurred.

**Turn-around Time**

CME Providers have a 30-day time period in which to respond to reviewers’ or Chapters’ requests for additional information, material, or revisions. If the provider does not respond within this time frame, reapplication will be required, including a new application fee.

**Notice of accreditation**

No reference may be made to the CFPC or its accreditation system prior to the actual notification that credit has been awarded. Do not state "CFPC credit applied for" or similar wording. Upon written confirmation from the CFPC that a program has been accredited, program providers may indicate this on program materials. This notice must be presented exactly as follows:

*This program meets the accreditation criteria of The College of Family Physicians of Canada and has been accredited for up to ______ Mainpro-M1 credits.*
5. **Partial accreditation**

The CFPC is prepared to accredit individual sessions within a larger CME activity. The accreditation criteria need only apply to the relevant sessions. This applies also to hospital rounds. Organizers are required to inform participants which sessions have been accredited.

**Certificate of participation**

It is the responsibility of the CME provider to provide participants with a record of participation, which could be in the form of a certificate or letter. It is recommended to include the member’s name, the program’s name, date and location, and the number of approved Mainpro-M1 credits. Members should maintain these records in the event that the CFPC requests them.

**Programs held in the United States**

See the section below on the American Academy of Family Physicians for information on the accreditation of CME held in the United States.

**Programs held outside Canada or the United States**

Any CME program being planned by a Canadian organization that is to be held anywhere outside Canada or the U.S. must be submitted to the national office of the CFPC for review.

Canadian university CME offices are exempt from this. They can assign Mainpro-M1 credits to programs they organize themselves outside Canada or the U.S. They must inform the national office of the CFPC of all such programs (preferably by completing and submitting the top part of the accreditation application form).

**Program audit**

All programs are subject to audit by the NCCPD/CME, the CFPC Department of CME, or by a provincial chapter CME committee. Failure to comply with any of the Mainpro accreditation criteria or process requirements will result in denial or withdrawal of accreditation. In the case of withdrawal of accreditation, it is the responsibility of the CME provider to inform all participants that they cannot claim Mainpro-M1 credits, even if the accreditation is withdrawn after the activity has been held.

**Appeal process**

Any decision to deny accreditation to a CME program can be appealed by activity providers. The request must be made in writing to the appropriate CFPC chapter or national office. A full justification of why accreditation should be granted should be provided with any helpful additional documents. In case of disagreement, the decision of the NCCPD/CME will be final.
Accreditation by other organizations

As a means of streamlining the accreditation of programs, the CFPC has accreditation agreements with other CME organizations. **These accreditation agreements apply only to Mainpro-M1 credits, not to Mainpro-C credits.**

**Canadian university CME offices**

Canadian university CME offices have the authority to assign Mainpro-M1 credits to activities in which they have had significant input into the planning, organization, development and implementation as long as they meet the criteria for Mainpro-M1 accreditation. In order to have this authority, a university CME office must be accredited by the Committee on Accreditation of CME (CACME). This is an independent national accrediting body with representation from multiple national Canadian medical organizations whose sole mandate is to evaluate the university CME offices.

**The Fédération des médecins omnipraticiens du Québec**

The Collège des médecins du Québec (CMQ) has given the authority to the Fédération des médecins omnipraticiens du Québec (FMOQ), the Quebec Chapter of The College of Family Physicians of Canada, the four Quebec universities CME offices and the AMLFC to grant Category 1 credits. The College of Family Physicians of Canada accepts these credits as equivalent to Mainpro-M1 for events held within that province.

**The Royal College of Physicians and Surgeons of Canada**

The Royal College of Physicians and Surgeons of Canada (RCPSC) has a Maintenance of Certification program for Canadian specialists. Canadian national specialty societies are accredited by the RCPSC to put on accredited CME activities which can be claimed in Section 1 of the RCPSC program. Members may request individual consideration for Mainpro-M1 credits for these.

**The American Academy of Family Physicians**

The American Academy of Family Physicians (AAFP) is the accrediting body for CME in family medicine in the U.S. The CFPC and the AAFP have a bilateral reciprocal accreditation agreement.

CME activities held across the Canada-U.S. border are accredited according to the nationality of the primary target audiences regardless of where the providers are located. The programs will be reviewed according to the criteria of the accrediting organization.

A CME activity is to be accredited by the CFPC if the primary target audience is Canadian. If it is to be held in Canada by an American provider, this is done through the appropriate CFPC Chapter office. If it is to be held in the U.S., it is done through the CFPC national office. The CFPC will inform the AAFP of all such programs.
The Canadian university CME offices are exempt from this. They can assign Mainpro-M1 credits to programs they organize themselves in the U.S. as long as the primary target audience is Canadian. They must inform the CFPC national office of all such program. The CFPC will then inform the AAFP.

A CME activity is to be accredited by the AAFP if the primary target audience is American. This is true if it is to be held in the U.S. by a Canadian provider or if it is to be held in Canada by an American provider. The AAFP will inform the CFPC of all such programs held in Canada.

AAFP members who attend any CME program accredited by the CFPC for Mainpro-M1 or Mainpro-C credits can claim AAFP Prescribed credit. Providers who would like to promote their programs to AAFP members can remind them of this. Upon written confirmation from the CFPC that a program has been accredited, the following notice can be used in program materials but must be presented exactly as indicated:

Members of the American Academy of Family Physicians are eligible to receive up to_____ Prescribed credit hours for attendance at this meeting due to reciprocal agreement with The College of Family Physicians of Canada.

CFPC members who attend any CME program accredited by the AAFP for Prescribed credit can claim Mainpro-M1 credits. Providers who would like to promote their programs to CFPC members can remind them of this. Upon written confirmation from the AAFP that a program has been accredited, the following notice can be used in program materials but must be presented exactly as indicated:

Members of The College of Family Physicians of Canada are eligible to receive up to_____ Mainpro-M1 credits for attendance at this meeting due to reciprocal agreement with the American Academy of Family Physicians.

Mainpro-M1 re-accreditation policy

If a Provider wishes to have a program reaccredited for Mainpro-M1 credits the following must be provided:

1. A new application with appropriate fee.
2. A needs assessment or current literature review showing that the previous program still addresses the needs of the target audience and its content is current.
3. A summary of evaluations and comments from previously run programs.

The program content does not need to be resubmitted for peer review unless substantial changes have been made, added, or requested by the reviewer.
Letter to potential members of CME/CPD Planning Committees

Dear CFPC Member,

The College of Family Physicians of Canada (CFPC) values your contribution to the development, planning and approval of the CME programs that we accredit. As a CFPC member with substantial input into the planning/development of a CME program seeking Mainpro® accreditation, you play an integral role in ensuring program compliance with CFPC standards for quality educational offerings. You become the intermediary between CME providers and the College, helping to ensure that Mainpro® accredited CME offerings:

- Address at least one of the four principles of family medicine;
- Foster improved patient care by family physicians;
- Include only content that is grounded in scientific evidence and/or is generally accepted by the medical community at large;
- Provide balanced, unbiased information;

As the CFPC member included on the application for a CME program seeking Mainpro® accreditation, it is implied that you have been actively involved in the planning and design of that program; you are asked to certify that you have had substantial input into program planning and development, and to vouch for the programs appropriateness and relevancy to family physicians. At this time, we encourage you to review the requirements and responsibilities assumed when serving as a CFPC member in this capacity.

To facilitate the review process, we have included a series of frequently asked questions, and answers, on the following page. As well, there are several active web-based links included throughout that will direct you to additional information on Mainpro® and the Mainpro® accreditation process. If you have any questions or concerns, please contact Lori Hill, CPD Manager.

The College values your commitment and contribution to the ongoing professional development of family physicians. Your involvement helps to ensure that Canadians continue to access to the best primary health care services available.

Sincerely,

Bernard Marlow MD, CCFP, FCFP
Lori Hill, MEd
Director, Continuing Professional Development Manager, Continuing Professional Development

For further information on the specific requirements for Mainpro-M1, National Mainpro-M1 and/or Mainpro-C accreditation, visit the College’s website at www.cfpc.ca (click on ‘Mainpro’ under the tab marked “CME”) or click here for a direct link to the appropriate section of the College website. CFPC Members – CME Program Planning Page 2 of 2 Last Revised: July 23, 2008
What does the CFPC consider to constitute “substantial input” into CME development/planning?

The role of the CFPC member involved in CME program planning is to ensure that CME programs are appropriate and relevant to Canadian family physicians. Given this, the CFPC member must:

- Be an active member of the CME program planning committee (and, where it exists, the program scientific committee);
- Actively contribute to the consideration of learning needs, the determination of learning objectives, the choice of speakers and/or presenters, selection of appropriate venues, etc.;
- Participate in and/or be privy to all issues and decisions related to the CME program budget, including sponsorship, costs to participants, honorariums, etc.;
- Have a sound understanding of what constitutes ethical standards for CME programs/events;
- Be a resident of the province (and ideally from the region) where the CME program is to be held.

Is it permissible to review a finalized CME program application to determine its appropriateness/relevancy to family medicine if I have not actively participated in the program development/planning phase?

No. The guidelines for CME providers seeking Mainpro® program accreditation clearly state that there must be appropriate CFPC representation (see table below). It is considered a violation of the College’s CME regulations to ask an individual to act as a CFPC member with substantial input without that individual having actively participated in the planning and development phase of the CME program.

<table>
<thead>
<tr>
<th>Program Type:</th>
<th>CFPC Member Involvement Requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Mainpro-M1</td>
<td>A total of five (5) CFPC members, one (1) from each of the five CFPC regions of Canada (British Columbia/Alberta; Saskatchewan/Manitoba; Ontario; Quebec; and Atlantic Canada), must be included in the development/planning phase of the CME program and provide verification of their participation.</td>
</tr>
</tbody>
</table>
| Mainpro-M1                | **One (1) CFPC member** must be included in the development/planning phase and provide verification of their participation.  
  *Note: The CFPC member must be a resident of the province in which the program/session is being offered.* |
| Mainpro-C                 | A minimum of one (1) CFPC Certificant member must be involved at all stages of development and implementation of the program. This includes the needs assessment and the follow-up/post-program reflective activity. Further, planning committees must consist of at least 50% family physicians. |
Appendix 12
APPENDIX 12
Royal College
Standards Accreditation
June 2007

STANDARD 1 – Goals and Objectives of the Overall CPD Program

1-a / CPD has been integrated into the mission statement of the organization, which also describes the intended target audience.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>There is no organizational mission statement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>There is an organizational mission statement, however it does not contain any reference to CPD or make reference to a defined target audience.</td>
</tr>
<tr>
<td>Adherence</td>
<td>There is an organizational mission statement that includes a reference to CPD and to the organization’s defined target audience.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to meeting the criteria for adherence above, the organization is able to demonstrate how it has consistently reviewed, evaluated and revised its mission statement to meet the measured needs of the organization and the CPD needs of its target audience. This should be reviewed at least once per accreditation period (or every 3 - 5 years for previously unaccredited organizations).</td>
</tr>
</tbody>
</table>

1-b / The organization has defined CPD goals and objectives that are relevant to a defined target audience and are reflected in the scope of CPD events planned by the organization.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The organization’s CPD goals and objectives are not related to a defined target audience, nor are they reflected in the scope of its CPD events.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization has CPD goals and objectives that are related to a defined target audience, but these goals are not reflected, or are only partially reflected, in the scope of its CPD events.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The organization has defined CPD goals and objectives that are related to a defined target audience and are reflected in the scope of CPD events planned by the organization.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to meeting the criteria for adherence above, the organization is able to demonstrate how it has evaluated the effectiveness of the scope its CPD events in meeting the organization’s CPD goals and objectives.</td>
</tr>
</tbody>
</table>
### STANDARD 2 – Resources

#### 2-a / The organization has adequate financial resources to meet its CPD goals and objectives.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The organization has not allocated any resources for CPD in its annual budget.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization has developed, but not implemented, a plan to allocate resources to CPD in its annual budget.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The organization has prospectively allocated sufficient funds within its annual budget to meet the goals and objectives of CPD.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the organization has acquired external funds to support CPD innovation and development.</td>
</tr>
</tbody>
</table>

#### 2-b / The organization has established an educational structure (for example, a CPD committee) representative of the identified target audience with responsibilities to plan and implement the goals and objectives relating to CPD for the organization.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The educational structure does not include individuals who are representative of the identified target audience.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The educational structure is only partially representative of the identified target audience.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The educational structure is fully representative of the identified target audience.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the organization has a systematic way to assess the effectiveness of the educational structure in implementing its overall CPD program.</td>
</tr>
</tbody>
</table>

#### 2-c / The organization’s educational structure, as discussed in 2-b, should also include individuals with adult education expertise.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The organization has no access to individuals with expertise in educational program planning for the adult learner.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization has limited access to individuals with expertise in educational program planning for the adult learner.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The organization has consistent access to individuals who have expertise in educational program planning for the adult learner.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the organization has implemented a strategy to enhance and ensure the continuity of the level of knowledge and expertise.</td>
</tr>
</tbody>
</table>
**2-d** / The organization has an administrative structure (for example, a secretariat) to help plan educational events, as well as administer the collection, storage and retrieval of accreditation documents and records of participation in CPD events.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>There is no separate administrative structure established by the organization to plan its CPD events.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization has established an informal administrative structure that assists in the planning of CPD events. The system in place to collect, store and retrieve accreditation documents and records of participation in CPD events is decentralized.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The organization has a well functioning administrative structure to help with the planning of CPD events, as well as a centralized system for the collection, storage and retrieval of accreditation documents and records of participation.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, there is a strategy to evaluate the effectiveness of the administrative structure in meeting the CPD needs of the organization, as well as a computerized system to facilitate timely access/retrieval of collected and stored accreditation documents and records of participation.</td>
</tr>
</tbody>
</table>

**STANDARD 3 – Relationship with Sponsors**

**3-a** / The organization must have written policies and procedures that define the relationship with sponsors related to the funding of CPD events.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The organization has no written policy that defines the relationship with sponsors of CPD events.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization has adopted in principle the CMA guidelines governing the relationship between physicians and the pharmaceutical industry, but has no system to implement these guidelines in planning individual CPD events.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The organization has adopted and integrated the CMA guidelines governing the relationship between physicians and the pharmaceutical industry, including written policies and procedures that govern funding arrangements, educational planning and ethical aspects of CPD events.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the organization has been able to demonstrate how it has reviewed and refined its policies to ensure its continued adherence with the CMA guidelines.</td>
</tr>
</tbody>
</table>

**3-b** / The organization must have written policies and procedures that define co-development relationships that guide the planning of CPD events, or potential future relationships with other physician organizations and non-physician organizations.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The organization has no written policies or procedures governing co-development relationships with physician and non-physician organizations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization has developed draft policies to govern co-development relationships with both physician organizations and non-physician organizations, but has no system to operationalize these policies.</td>
</tr>
</tbody>
</table>
### Adherence

| The organization has developed and implemented (where applicable) written policies and procedures to govern co-development relationships with both physician and non-physician organizations. |

### Exemplary Adherence

| In addition to achieving the criteria for adherence above, the organization regularly evaluates its written policies and procedures governing co-development relationships with other physician and non-physician organizations. |

#### STANDARD 4 – Review of CPD Events

### 4-a / The organization must have written policies and documented procedures for reviewing events submitted for approval under Section 1 (Accredited Group Learning Activities).

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>The organization does not have written policies and procedures for reviewing events.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>The organization is developing written policies and procedures for reviewing events.</td>
</tr>
<tr>
<td>Adherence</td>
<td>The organization has developed and implemented written policies and procedures for reviewing events.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the organization has evaluated its policies and procedures for reviewing events and has implemented quality control mechanisms.</td>
</tr>
</tbody>
</table>

### 4-b / The organization has written policies and documented procedures for reviewing events submitted for approval under Section 3 (Accredited Self-Assessment Programs).

<p>| Non-adherence | The organization does not have written policies and procedures for reviewing SAPs. |</p>
<table>
<thead>
<tr>
<th>Partial Adherence</th>
<th>The organization is developing written policies and procedures for reviewing SAPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adherence</strong></td>
<td>The organization has developed and implemented written policies and procedures for reviewing SAPs.</td>
</tr>
<tr>
<td><strong>Exemplary Adherence</strong></td>
<td>In addition to achieving the criteria for adherence above, the organization has evaluated its policies and procedures for reviewing SAPs and has implemented quality control mechanisms.</td>
</tr>
</tbody>
</table>

**STANDARD 5 – Assessment of Needs**

| **5-a** / There is a system established to identify the perceived professional development needs of the target audience. |
| Non-adherence                     | There is no system established to identify the perceived professional development needs of members of the target audience. |
| Partial Adherence                 | The system to identify the perceived professional development needs of members of the target audience is limited. |
| Adherence                          | The system to identify the professional development needs of the target audience includes sound methods to establish perceived needs. |
| Exemplary Adherence               | In addition to achieving the criteria for adherence above, the organization has included needs assessment strategies that explore areas of professional practice beyond the medical expert role. |

| **5-b** / There is a system established to identify the unperceived professional development needs of the target audience. |
| Non-adherence                     | There is no system established to identify the unperceived professional development needs of members of the target audience. |
| Partial Adherence                 | The system to identify the unperceived professional development needs of members of the target audience is limited. |
| Adherence                          | The system to identify the professional needs of the target audience includes sound methods to establish unperceived needs. |
| Exemplary Adherence               | In addition to achieving the criteria for adherence above, the organization has included needs assessment strategies that explore areas of professional practice beyond the medical expert role. |

| **5-c** / The organization has demonstrated how identified needs have been integrated into individual CPD events. |
| Non-adherence                     | There is no established link between the identified needs and the planned CPD events. |
| Partial Adherence                 | There is a partial link between identified needs and the planned CPD events. |
Adherence | Identified needs have been fully incorporated in the planning of CPD events.
---|---
Exemplary Adherence | In addition to achieving the criteria for adherence above, the organization has planned CPD events focused on areas of professional practice beyond the medical expert role.

**STANDARD 6 – Learning Objectives**

**6-a** / The organization has formulated overall and session specific learning objectives derived from needs assessment strategies for each planned CPD event. The planning committee is responsible for ensuring a clear link between needs assessment and objectives.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>There is no link between the learning objectives and the identified learning needs of the target audience.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>There is a partial link between the learning objectives and the identified learning needs of the target audience.</td>
</tr>
<tr>
<td>Adherence</td>
<td>There is a clear link between the identified needs of the target audience and the learning objectives created for the event and its sessions.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the learning objectives promote innovation or additional learning.</td>
</tr>
</tbody>
</table>

**6-b** / The organization has formulated overall and session specific learning objectives that indicate what a learner will be able to know or do as a result of engaging in the event or session.

<table>
<thead>
<tr>
<th>Non-adherence</th>
<th>There are no learning objectives listed for educational events planned by the organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Adherence</td>
<td>There are learning objectives, but they do not describe the specific knowledge, behavior, skill, attitude or learning outcomes that participants can anticipate from attending a CPD event or session.</td>
</tr>
<tr>
<td>Adherence</td>
<td>For the CPD event and most sessions there are learning objectives that describe the specific knowledge, behavior, skill, attitude or learning outcomes that participants can gain from attending individual CPD events or sessions.</td>
</tr>
<tr>
<td>Exemplary Adherence</td>
<td>In addition to achieving the criteria for adherence above, the organization provides guidelines/tools to assist in the creation of learning objectives.</td>
</tr>
</tbody>
</table>

**STANDARD 7 – Educational Methods and Delivery**

**7-a** / The organization has selected and implemented learning formats consistent with the identified needs and established learning objectives.

<p>| Non-adherence | The learning formats selected are not linked to the identified educational needs or established learning objectives. |</p>
<table>
<thead>
<tr>
<th><strong>Partial Adherence</strong></th>
<th>The learning formats selected are limited in scope and are linked to only a portion of the identified educational needs or established learning objectives.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adherence</strong></td>
<td>There are a variety of learning formats selected that are linked to the identified educational needs and established learning objectives.</td>
</tr>
<tr>
<td><strong>Exemplary Adherence</strong></td>
<td>In addition to achieving the criteria for adherence above, the organization is applying its established learning formats to meet learning objectives related to professional roles and responsibilities beyond that of the medical expert role.</td>
</tr>
</tbody>
</table>

**7-b /** The organization has devoted at least 25% of either session or event time to interactive learning.

<table>
<thead>
<tr>
<th><strong>Non-adherence</strong></th>
<th>The organization has not devoted any session or event time to interactive learning.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partial Adherence</strong></td>
<td>The organization has devoted time to interactive learning, but it is less than 25% of the session or event time.</td>
</tr>
<tr>
<td><strong>Adherence</strong></td>
<td>The organization has devoted a minimum of 25% of session or event time to interactive learning.</td>
</tr>
<tr>
<td><strong>Exemplary Adherence</strong></td>
<td>In addition to achieving the criteria for adherence above, the organization has found innovative ways to encourage interactive learning.</td>
</tr>
</tbody>
</table>

**STANDARD 8 – Evaluation**

**8-a /** There is an evaluation strategy to measure the effectiveness of the overall CPD program in meeting its CPD aims and goals and the educational needs of the organization’s membership.

<table>
<thead>
<tr>
<th><strong>Non-adherence</strong></th>
<th>There is no strategy to measure the effectiveness of the organization’s overall CPD program.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partial Adherence</strong></td>
<td>The evaluation strategies to measure the effectiveness of the overall CPD program are limited to assessing the perceptions of the planning committee derived from the surveys completed by participants at individual events.</td>
</tr>
<tr>
<td><strong>Adherence</strong></td>
<td>The evaluation strategies to measure the effectiveness of the overall CPD program are based on establishing the degree to which the CPD program met its educational goals and objectives relating to CPD.</td>
</tr>
<tr>
<td><strong>Exemplary Adherence</strong></td>
<td>In addition to achieving the criteria for adherence above, the evaluation strategy to evaluate the effectiveness of the overall CPD program is extended to how participation in CPD events has enhanced physician performance and health care outcomes.</td>
</tr>
</tbody>
</table>

**8-b /** There is an evaluation system established to evaluate the outcomes of individual CPD events and sessions, including the level to which the identified learning needs and objectives were met.

| **Non-adherence** | There is no evaluation system established to measure the outcomes of individual CPD events and sessions. |
Partial Adherence | There is an evaluation system to measure the outcomes of individual CPD events and sessions, but it is primarily focused on participant satisfaction with the event and providing feedback to speakers.

Adherence | There is an evaluation system that is focused on the degree to which the identified needs and learning objectives of the event were achieved, as well as the learning outcomes identified by participants.

Exemplary Adherence | In addition to achieving the criteria for adherence above, the organization has established strategies to measure the impact of the learning objectives or learning outcomes identified by participants on their future performance (ex. PLPs, practice audits, patient surveys).

**Self-Assessment Programs (SAPs)**

Self-Assessment Programs are tools that enable physicians to assess aspects of their knowledge or practice and to identify opportunities to enhance their competence through further learning activities. Self-Assessment Programs are not tests but assessment strategies to assist physicians to develop an effective continuing professional development plan linked to their professional roles and responsibilities.

All Self-Assessment Programs must meet 4 standards for approval within the RCPSC Maintenance of Certification (MOC) program. Credits can only be claimed under Section 3 of the MOC program if the SAP has been reviewed and approved by a Royal College accredited provider. The following documents have been created to:

a. Outline the [New Standards for Accredited Self-Assessment Programs](#)
b. Provide a [New SAP Application Form](#)
c. Facilitate an accredited provider’s review through the use of an [SAP Assessment Checklist](#)
d. Facilitate [The Renewal of Previously Approved SAP Application Form](#)
e. Provide an [SAP Development Template](#)

*Web page updated: 4 November 2008*
Appendix 13
APPENDIX 13

Accredited Providers of CPD Activities for Specialists

Please contact an Accredited Provider for information on how to receive approval for Section 1 or Section 3 programs. Please see the guidelines for more information on how to seek program approval.

National Specialty Societies
University CME Offices

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact person</th>
</tr>
</thead>
</table>
| Association of Medical Microbiology and Infectious Disease Canada | Dr. Gary Victor  
Telephone: 613-737-8592  
E-mail: gvictor@ottawahospital.on.ca |
| Canadian Anesthesiologists' Society               | Ms. Joy Brickell  
Telephone: 416-480-0602, ext. 20  
Fax: 416-480-0320  
E-mail: adminservices@cas.ca |
| Canadian Association of Emergency Physicians       | Ms. Vera Klein  
Telephone: 613-523-3343, ext. 12  
Fax: 613-523-0190  
E-mail: cme@caep.ca |
| Canadian Association of Gastroenterology           | Mr. Paul Sinclair  
Telephone: 905-829-2504  
Fax: 905-829-0242  
E-mail: cagoffice@cag-acg.org |
| Canadian Association of General Surgeons           | Ms. Jasmin Lidington  
Telephone: 613-730-6280  
Fax: 613-730-1116  
E-mail: cags@rcpsc.edu |
| Canadian Association of Medical Biochemists         | Dr. Elizabeth Mac Namara  
Telephone: 514-340-8222, ext. 5091  
Fax: 514-340-7524  
E-mail: elizabeth.macnamara@mcgill.ca |
| Canadian Association of Nuclear Medicine            | Dr. Jonathan Romsa  
Telephone: 519-663-3426  
Fax: 519-663-3860  
E-mail: Jonathan.Romsa@lhsc.on.ca |
| Canadian Association of Pathologists                | Dr. Joan Sweet  
Telephone: 416-340-4563  
Fax: 416-340-5517  
E-mail: joan.sweet@uhn.on.ca |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
<th>Telephone</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Association of Physical Medicine and Rehabilitation</td>
<td>Ms. Rita Assabgui</td>
<td>613-730-6245</td>
<td>613-730-1116</td>
<td><a href="mailto:capmr@rcpsc.edu">capmr@rcpsc.edu</a></td>
</tr>
<tr>
<td>Canadian Association of Radiation Oncology</td>
<td>Dr. Juhu Kamra</td>
<td>705-728-9090, ext. 43386</td>
<td>705-728-1122</td>
<td><a href="mailto:KamraJ@rhv.on.ca">KamraJ@rhv.on.ca</a></td>
</tr>
<tr>
<td>Canadian Association of Radiologists</td>
<td>CAR Office</td>
<td>613-860-3111</td>
<td>613-860-3112</td>
<td><a href="mailto:info@car.ca">info@car.ca</a></td>
</tr>
<tr>
<td>Canadian Cardiovascular Society</td>
<td>Ms. Kimberley Ross</td>
<td>613-569-3407, ext. 404</td>
<td>613-569-6574</td>
<td><a href="mailto:ross@ccs.ca">ross@ccs.ca</a></td>
</tr>
<tr>
<td>Canadian Dermatology Association</td>
<td>Ms. Michelle Albagli</td>
<td>613-738-1748</td>
<td>613-738-4695</td>
<td><a href="mailto:malbagli@dermatology.ca">malbagli@dermatology.ca</a></td>
</tr>
<tr>
<td>Canadian Fertility and Andrology Society</td>
<td>Ms. Agneta Holländer</td>
<td>514-524-9009</td>
<td>514-524-2163</td>
<td><a href="mailto:CFASoffice@cfas.ca">CFASoffice@cfas.ca</a></td>
</tr>
<tr>
<td>Canadian Geriatrics Society</td>
<td>Ms. Tena How</td>
<td>613-592-7111</td>
<td>613-599-7027</td>
<td><a href="mailto:info@cgs-scg.ca">info@cgs-scg.ca</a></td>
</tr>
<tr>
<td>Canadian Neurological Society</td>
<td>Ms. Marika Fitzgerald</td>
<td>403-229-9544</td>
<td>403-229-1661</td>
<td><a href="mailto:marika-fitzgerald@cnsfederation.org">marika-fitzgerald@cnsfederation.org</a></td>
</tr>
<tr>
<td>Canadian Neurosurgical Society</td>
<td>Ms. Marika Fitzgerald</td>
<td>403-229-9544</td>
<td>403-229-1661</td>
<td><a href="mailto:marika-fitzgerald@cnsfederation.org">marika-fitzgerald@cnsfederation.org</a></td>
</tr>
<tr>
<td>Canadian Ophthalmological Society</td>
<td>Mr. Hubert Drouin</td>
<td>613-729-6779, ext. 225</td>
<td>613-729-7209</td>
<td><a href="mailto:hdrouin@eyesite.ca">hdrouin@eyesite.ca</a></td>
</tr>
<tr>
<td>Canadian Orthopaedic Association</td>
<td>Mr. Douglas C. Thomson</td>
<td>514-874-9003, ext. 5</td>
<td>514-874-0464</td>
<td><a href="mailto:doug@canorth.org">doug@canorth.org</a></td>
</tr>
</tbody>
</table>
Canadian Paediatric Society  Ms. Andrea Roscoe-Lacasse  
Telephone: 613-526-9397, ext. 248  
Fax: 613-526-3332  
E-mail: andrear@cps.ca

Canadian Psychiatric Association  Ms. Katie Hardy  
Telephone: 613-234-2815, ext. 223  
Fax: 613-234-9857  
E-mail: cpd@cpa-apc.org

Canadian Society of Allergy and Clinical Immunology  Ms. Louise Tremblay  
Telephone: 613-730-6208  
Fax: 613-730-1116  
E-mail: ltremblay@rcpsc.edu

Canadian Society of Endocrinology and Metabolism  Dr. Heather Lochnan  
Telephone: 613-738-8400, ext. 81941  
Fax: 613-761-5358  
E-mail: hlochnan@ottawahospital.on.ca

Canadian Society of Internal Medicine  CSIM Office  
Telephone: 613-730-6244  
Fax: 613-730-1116  
E-mail: csim@rcpsc.edu

Canadian Society of Nephrology  Dr. Ellen Burgess  
Telephone: 403-944-1598  
Fax: 403-283-2494  
E-mail: ellen.burgess@calgaryhealthregion.ca

Canadian Society of Otolaryngology - Head and Neck Surgery  Dr. Sam J. Daniel  
Tel: 514-412-4304  
Fax: 514-412-4342  
E-mail: sam.daniel@mcgill.ca

Canadian Society of Plastic Surgeons  Ms. Karyn Wagner  
Telephone: 514-843-5415  
Fax: 514-843-7005  
E-mail: csps_sccp@bellnet.ca

Canadian Society of Vascular Surgery  Dr. Jerry Chen  
Telephone: 604-708-5679  
Fax: 604-876-2268  
E-mail: jec@interchange.ubc.ca

Canadian Thoracic Society  Ms. Suzanne Desmarais  
Telephone: 613-569-6411, ext. 229  
Fax: 613-569-8860  
E-mail: sdesmarais@lung.ca

Canadian Urological Association  Dr. Peter Anderson  
Telephone: 902-470-8861  
Fax: 902-470-8267  
E-mail: Peter.Anderson@iwk.nshealth.ca
| **Society of Obstetricians and Gynaecologists of Canada** | **Telephone:** 613-730-4192, ext. 345  
**Fax:** 613-730-4314  
**E-mail:** vsenikas@sogc.com |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universities</strong></td>
<td><strong>Contact person</strong></td>
</tr>
</tbody>
</table>
| **University** | **Telephone:** 604-875-5075  
**Fax:** 604-875-5078  
**E-mail:** credits@cpdkt.ubc.ca |
| University of British Columbia | Ms. Sabine Cruickshank  
**Telephone:** 604-875-5075  
**Fax:** 604-875-5078  
**E-mail:** credits@cpdkt.ubc.ca |
| University of Calgary | Ms. Glenda Wong  
**Telephone:** 403-220-7761  
**Fax:** 403-270-2330  
**E-mail:** gfwong@ucalgary.ca |
| University of Alberta | Dr. Chris de Gara  
**Telephone:** 780-407-6346  
**Fax:** 780-407-1442 |
| University of Saskatchewan | Ms. Mavis Procyshyn  
**Telephone:** 306-966-7794  
**Fax:** 306-966-7673  
**E-mail:** mavis.procyshyn@usask.ca  
Ms. Heather Stenerson  
**Telephone:** 306-766-4018  
**Fax:** 306-766-4019  
**E-mail:** heather.stenerson@rqhealth.ca |
| University of Manitoba | Dr. José Franco  
**Telephone:** 204-789-3660  
**Fax:** 204-789-3911  
**E-mail:** francois@cc.umanitoba.ca |
| University of Western Ontario | Mr. Jason Eadie  
**Telephone:** 519-850-2936  
**Fax:** 519-661-3797  
**E-mail:** Jason.Eadie@schulich.uwo.ca |
| McMaster University | Ms. Sheila Laffan  
**Telephone:** 905-525-9140, ext. 22120  
**Fax:** 905-572-7099  
**E-mail:** laffans@mcmaster.ca |
| University of Toronto | Ms. Susan Rock  
**Telephone:** 416-978-8337  
**Fax:** 416-971-2200  
**E-mail:** s.rock@utoronto.ca |
Queen's University
Ms. Patricia Payne
Telephone: 613-533-2540
Fax: 613-533-6642
E-mail: pp9@post.queensu.ca

University of Ottawa
Ms. Nadine Booth
Telephone: 613-798-5555, ext. 12733
Fax: 613-761-5262
E-mail: nabooth@ottawahospital.on.ca

McGill University
Dr. Michael D. Rosengarten
Telephone: 514-398-3500
Fax: 514-398-2231
E-mail: michael.rosengarten@mcgill.ca

Université de Montréal
Dr. Martin Labelle
Telephone: 514-343-6367
Fax: 514-343-6913
E-mail: martin.labelle.2@umontreal.ca

Université de Sherbrooke
Dr. Gilles Voyer
Telephone: 819-564-5350
Fax: 819-820-6815
E-mail: louise.corriveau@USherbrooke.ca

Université Laval
Dr. Michel Rouleau
Telephone: 418-656-5958
Fax: 418-656-2465
E-mail: michel.rouleau@fmc.ulaval.ca

Dalhousie University
Dr. Michael Fleming
Telephone: 902-494-2106
Fax: 902-494-1479
E-mail: michael.fleming@dal.ca

Dr. Dana Farina
Telephone: 902-473-7781
Fax: 902-473-4406
E-mail: dfarina@dal.ca

Memorial University of Newfoundland
Dr. Ford Bursey
Telephone: 709-777-6960
Fax: 709-777-8044
E-mail: fbursey@morgan.ucs.mun.ca

Dr. Sharon Peters
Telephone: 709-777-7090
Fax: 709-777-7569
E-mail: speters@mun.ca

Web page updated 3 February 2009
Appendix 14
RCPSC Definition of Physician and Non-physician Organizations

Physician organization
A physicians organization is a not-for-profit group of health professionals with a formal governance structure, accountable to and serving, among others, specialist physicians through:

- Continuing professional development;
- Provision of health care; and/or
- Research

This definition includes (but is not limited to) the following groups:

- Faculties of medicine
- Hospital departments or divisions;
- Medical societies
- Medical associations;
- Medical academies and
- Health branch of the Canadian forces.

The definition excludes pharmaceutical companies or their advisory groups, medical supply and surgical companies, communication companies or other for-profit organizations and ventures/activities.

Non-physician organization
Non-physician organizations are disease-oriented organizations, pharmaceutical companies or their advisors, medical supply companies, communication companies or other for profit organizations.
Appendix 15
## CMA Guidelines Comparison

### Continuing medical education/ Continuing professional development (CME/CPD)

<table>
<thead>
<tr>
<th>2001 Guidelines</th>
<th>2007 Guidelines</th>
<th>R.C. Interpretations and Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. The primary purpose of CME/CPD activities is to address the educational needs of physicians and other health care providers in order to improve the health care of patients. Activities that are primarily promotional in nature should be identified as such to faculty and attendees and should not be considered as CME/CPD.</td>
<td>21. This section of the Guidelines is understood to address primarily medical education initiatives designed for practicing physicians. However, the same principles will also apply for educational events (such as noon-hour rounds and journal clubs) which are held as part of medical or residency training. Activities that are primarily promotional in nature should be identified as such to faculty and attendees and should not be considered as CME/CPD.</td>
<td>The extension of the CMA guidelines to include rounds, journal clubs and small group learning events supports our decision to promote one standard (educational and ethical) for all types of accredited group learning activities included within Section 1. The educational needs of physicians are determined through a formal needs assessment process to include, where appropriate, perceived and unperceived needs. The identification of needs must describe gaps in knowledge, skills, performance/clinical care or health outcomes. Needs assessment must be translated into learning objectives, influence the selection of learning formats and set the ceiling on what a CME event can evaluate.</td>
</tr>
<tr>
<td>22. The primary purpose of CME/CPD activities is to address the educational needs of physicians and other health care providers in order to improve the health care of patients. Activities that are primarily promotional in nature, such as satellite symposia, should be identified as such to faculty and attendees and should not be considered as CME/CPD.</td>
<td></td>
<td>In our current context, the term satellite symposium is used to describe both accredited and unaccredited group learning activities. The Royal College is planning to create a definition and criteria to facilitate the identification of unaccredited (goal is promotional) from accredited (educational events based on needs) satellite symposium. Only accredited satellite symposium can be included under Section 1.</td>
</tr>
<tr>
<td>18. The ultimate decision on the organization, content and choice of CME/CPD activities for physicians shall be made by the physician-organizers.</td>
<td>23. The ultimate decision on the organization, content and choice of CME/CPD activities for physicians shall be made by the physician-organizers.</td>
<td>CME conferences and courses are valued resources used by physicians to plan and implement practice specific CPD strategies. Accredited group CME therefore must be developed or co-developed by a physician organization who assumes responsibility for ensuring the educational and ethical standards for individual programs have been met.</td>
</tr>
</tbody>
</table>

APPENDIX 15
| **19.** | CME/CPD organizers are responsible for ensuring the scientific validity, objectivity and completeness of CME/CPD activities. Organizers must disclose to the participants at their CME/CPD events any financial affiliations with manufacturers of products mentioned at the event or with manufacturers of competing products. |
| **24.** | CME/CPD organizers and individual physician presenters are responsible for ensuring the scientific validity, objectivity and completeness of CME/CPD activities. Organizers and individual presenters must disclose to the participants at their CME/CPD events any financial affiliations with manufacturers of products mentioned at the event or with manufacturers of competing products. There should be a procedure available to manage conflicts once they are disclosed. |
| **20.** | The ultimate decision on funding arrangements for CME/CPD activities is the responsibility of the physician-organizers. Although the CME/CPD publicity and written materials should acknowledge the financial or other aid received, they must not identify the products of the company (ies) that fund the activities. |
| **25.** | The ultimate decision on funding arrangements for CME/CPD activities is the responsibility of the physician-organizers. Although the CME/CPD publicity and written materials may acknowledge the financial or other aid received, they must not identify the products of the company (ies) that fund the activities. Funding provided by commercial interests or organizations in support of accredited group learning events must be provided directly to the physician organization. Physician organizations are responsible to develop a budget, pay all conference expenses including the travel, accommodation, and honoraria (where applicable) for faculty presenters. The names of companies providing financial sponsorship for a CME/CPD event can be included on conference materials. The inclusion of product specific materials on preliminary or final conference brochures or materials or any other material distributed to participants is strictly prohibited. |
| **21.** | All funds from a commercial source should be in the form of an unrestricted educational grant payable to the institution or organization sponsoring the CME/CPD activity. Upon conclusion of the activity, the physician-organizers should be prepared to present a statement of account for the activity to the funding organizations and other relevant parties. |
| **26.** | All funds from a commercial source should be in the form of an unrestricted educational grant payable to the institution or organization sponsoring the CME/CPD activity. The term “unrestricted” educational grant is becoming increasingly difficult to as commercial sponsors are under legal obligations to ensure any financial support provided is directed to a specific event or activity. Therefore the Royal College is recommending the use of the term “educational grant” with appropriate criteria that explains the need to ensure the independence of accredited group learning events from any commercial interest. The Royal College is recommending that physician organizations should provide a statement of account to sponsoring organizations of how funding was allocated or spent. |
| No equivalent | 22. Whenever possible, generic names should be used rather than trade names in the course of CME/CPD activities. In particular, physicians should not engage in peer selling.* If specific products or services are mentioned, there should be a balanced presentation of the prevailing body of scientific information on the product or service and of reasonable, alternative treatment options. If unapproved uses of a product or service are discussed, presenters must inform the audience of this fact. Faculty must disclose to the participants at CME/CPD events any financial affiliations with manufacturers of products or service providers mentioned at the event or with manufacturers of competing products or providers of competing services. |
| 27. **Industry representatives should not be members of CME content planning committees. They may be involved in providing logistical support.** |
| Membership of a scientific (content) planning committee for an accredited CPD activity must reflect the intended target audience. The integrity of the educational planning process therefore would prohibit the inclusion of industry representatives as members of scientific planning committees. Industry representatives could assist or contribute to overall steering or logistical planning groups. |
| 28. **Generic names should be used in addition to trade names in the course of CME/CPD activities.** |
| Faculty who present at accredited group events must develop presentations and recommendations that are balanced and objective. The Royal College requires faculty presentations to be consistent in their use of either generic names, trade names or both generic and trade names during their presentation. The monitoring of faculty compliance to be consistent throughout their presentation should be monitored by the physician organization responsible for the CME/CPD event. |
| 29. **Physicians should not engage in peer selling. Peer selling occurs when a pharmaceutical or medical device manufacturer or service provider engages a physician to conduct a seminar or similar event that focuses on its own products and is designed to enhance the sale of those products. This also applies to third party contracting on behalf of industry. This form of participation would reasonably be seen as being in contravention of the CMA’s Code of Ethics, which prohibits endorsement of a specific product.** |
| Peer selling is primarily judged on the basis of other standards and bias assessments. Faculty at CME/CPD events may intentionally or unintentionally engage in peer selling of products, tools or devices if their presentations are not balanced and evidence informed. Peer selling in this respect cannot be included within accredited group learning activities included under Section 1 of the MOC program. |
| 30. If specific products or services are mentioned, there should be a balanced presentation of the prevailing body of scientific information on the product or service and of reasonable, alternative treatment options. If unapproved uses of a product or service are discussed, presenters must inform the audience of this fact. |
| Physician organizations are required to instruct faculty of their responsibility to ensure their presentations (and any recommendations) are balanced and reflect the current scientific literature. Unapproved use of products or services must be declared by faculty presenters. The only caveat to this guideline is where there is only one treatment or management strategy. Where appropriate, physician organizations should conduct content reviews of presentations where the likelihood of commercial bias is assessed to be high. |
| 31. **Negotiations for promotional displays at CME/CPD functions should not be influenced by industry sponsorship of the activity. It is preferable that promotional displays not be in the same room as the educational activity.** |
| Promotional displays must not be placed in rooms, outside the rooms or in areas where educational activities are being conducted. Promotional displays should include only published materials. |
| 24. | Travel and accommodation arrangements, social events and venues for industry-sponsored CME/CPD activities should be in keeping with the arrangements that would normally be made without industry sponsorship. For example, the industry sponsor should not pay for travel or lodging costs or for other personal expenses of physicians attending a CME/CPD event. Subsidies for hospitality should not be accepted outside of modest meals or social events that are held as part of a conference or meeting. However, faculty at CME/CPD events may accept reasonable honoraria and reimbursement for travel, lodging and meal expenses. Scholarships or other special funds to permit medical students, residents and Fellows to attend educational events are permissible as long as the selection of recipients of these funds is made by their academic institution. |
| 32. | Travel and accommodation arrangements, social events and venues for industry sponsored CME/CPD activities should be in keeping with the arrangements that would normally be made without industry sponsorship. For example, the industry sponsor should not pay for travel or lodging costs or for other personal expenses of physicians attending a CME/CPD event. Subsidies for hospitality should not be accepted outside of modest meals or social events that are held as part of a conference or meeting. **Hospitality and other arrangements should not be subsidized by sponsors for personal guests of attendees or faculty, including spouses or family members.** |
| 33. | Faculty at CME/CPD events may accept reasonable honoraria and reimbursement for travel, lodging and meal expenses. **All attendees at an event cannot be designated faculty. Faculty indicates a presenter who prepares and presents a substantive educational session in an area where they are a recognized expert or authority.** |

<table>
<thead>
<tr>
<th><strong>Electronic Continuing Professional Development (eCPD)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No equivalent</td>
</tr>
<tr>
<td>No equivalent</td>
</tr>
<tr>
<td>No equivalent</td>
</tr>
</tbody>
</table>

| All accredited group CME/CPD events cannot provide funding for physicians to travel to attend events or to pay for their lodging or other related costs. Faculty who present at accredited CME/CPD events can receive financial support for travel, lodging and honoraria (where appropriate). Physician organizations are accountable and responsible to ensure that all hospitality and other arrangements are modest and do not compete in any way with planned educational activities. |
| The payment of honoraria, travel, lodging and meal expenses for faculty presenting at an accredited group CME/CPD event is the responsibility of the physician organization. The Royal College agrees with the definition of faculty provided in the 2007 CMA guidelines |
| Authors of e-CPD modules are equivalent to faculty presenters at face to face CME/CPD events. Authors of e-CPD modules are accountable for the scientific validity and content of their modules. Physician organizations are responsible and accountable to ensure adherence to the standards governing commercial support of face to face group CME/CPD including disclosure of all conflicts of interest |
| Authors of e-CPD modules should be selected for their expertise in the subject area (clinical or non-clinical) being discussed. All authors must declare all conflicts of interest similar to face to face CME events at the beginning of the on-line event. |
| No equivalent | 37. There should be no direct links to an industry or product website on any web page which contains eCPD material. | We agree that all eCPD must be free of any promotional displays or infomercials. If a link to a sponsor’s web site is provided then physician participants must be informed that if they click on such a link they will leave the e-CPD host site completely and must log back in. e-CPD that is accredited under Section 1 should include a link to MAINPORT to facilitate documentation of participation or for the development of personal learning projects stimulated by their participation in these modules. |
| No equivalent | 38. Information related to any activity carried out by the eCPD participant should only be collected, used, displayed or disseminated with the express informed consent of that participant. | We agree that participants must be informed and consent (through the use of a consent form) for programs to use any participant information for the purposes other than collecting and storing participation in and completion of the online event. Use of personal information must comply with privacy legislation reflected by PIPEDA. |
| No equivalent | 39. The methodologies of studies cited in the eCPD module should be available to participants to allow them to evaluate the quality of the evidence discussed. Simply presenting abstracts that preclude the participant from evaluating the quality of evidence should be avoided. When the methods of cited studies are not available in the abstracts, they should be described in the body of the eCPD module. | We agree that eCPD modules should provide participants with links to review studies that are presented or referred to during the presentation. In making this recommendation we recognize that it is not the responsibility of the CPD provider to pay for access to references that require a fee or subscription. |
| No equivalent | 40. If the content of eCPD modules is changed, re-accreditation is required. | The accreditation of eCPD modules based on the Medical Expert role can only be approved for one year and require review and updating before they can be submitted for approval. eCPD modules based on other CanMEDS Roles can be approved for durations of up to 3 years assuming that the content of the module is not changed. Changes to the module would require a separate review and/or approval by an accredited CPD provider recognized by the Royal College. |