

ROYAL COLLEGE RESIDENCY ACCREDITATION COMMITTEE

POLICIES AND PROCEDURES – CANADIAN RESIDENCY EDUCATION

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The policies and procedures contained herein supersede all policies and procedures previously approved and/or operationalized by the Royal College in the course of residency education accreditation.

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1. GENERAL

The Royal College of Physicians and Surgeons of Canada (Royal College) is the national organization that certifies specialists in all disciplines of medicine and surgery in Canada, with the exception of Family Medicine. The Royal College, in its mandate articulated by a Royal Charter in 1929, plays a key role in the oversight of the system of specialty medicine in Canada. One of the Royal College's responsibilities with respect to this mandate is to accredit residency programs sponsored by Canadian medical schools to evaluate these programs to ensure residents acquire the knowledge and expertise necessary for specialty or subspecialty practice.

The accreditation process is carried out conjointly among the Royal College, the College of Family Physicians of Canada (CFPC), the national college for Family Medicine, and the Collège des médecins du Québec (CMQ), the Quebec college and medical regulatory authority for all specialties including Family Medicine. The Royal College, CFPC, and CMQ have developed national conjoint standards for evaluation and accreditation of residency programs sponsored by Canadian universities.

The objectives of the conjoint system of residency education accreditation are to:

- ensure that all accredited programs adhere to a set of high and uniform minimum standards within a flexible framework that accommodates innovation,
- objectively evaluate residency programs,
- provide guidance in the development of new residency programs, and
- facilitate continuous quality improvement by providing formative feedback to a program's leaders about where the program excels and where improvements can be made.

2. DEFINITIONS/TERMINOLOGY

Accreditation

A form of program evaluation, whereby information on the structure, process and outcomes of an educational program and its educational environment are evaluated against pre-defined educational standards by an independent organization.

Accreditation Report

A report prepared by the accreditation team or individual surveyor, following the onsite evaluation of a program or institution, which summarizes the survey findings, including identified strengths and weaknesses, and which informs the accreditation decision. It is provided to the postgraduate medical education office (PGME) which is invited to share the accreditation report with those who are necessary to make the required changes to improve any cited weaknesses. Decision-making regarding distribution lies within the PGME; however, the Royal College does not support public postings of this report. Also referred to as a “Survey Report”, “Report” or “Final Report”.

Accreditation Standards

Formal written requirements or expectations against which a residency program or Faculty/School of Medicine is evaluated (See section 4).

Accreditation Status – see Category of Accreditation

Accreditation Visit

An onsite visit of a residency program/Faculty of Medicine by an external team, to conduct an evaluation against the accreditation standards.

Accredited Program

An accreditation status accorded by the three colleges, signifying acceptable compliance with the accreditation standards (See subsection 5.1).

Active Program

An accredited residency program that has at least one resident enrolled (see “resident (current)”).

Appeal

A formal, documented application requesting reconsideration of the accreditation decision made by the Residency Accreditation Committee (See subsection 5.6 and General Policy 7.4).

Application for Accreditation

A completed application and accompanying documentation requesting an accredited program in a specific discipline at a Canadian medical school (See subsection 5.2).

Assessment

A process of gathering and analyzing information on competencies from multiple and diverse sources in order to measure a physician’s competence or performance and compare it to pre-defined criteria (Royal College Medical Education Glossary) Link to [Link to Glossary](#).

Category of Accreditation

An official accreditation status awarded to a residency program, in accordance with evaluation against the general and specific standards for the discipline.

Code of Conduct

A written set of guidelines to help staff and volunteers conduct their actions in accordance with its primary values and ethical standards of the Royal College.

Competency

A behaviour (or set of behaviours) that demonstrates knowledge, skills or attitudes required by a learner to perform a given task.

Conflict of Interest

A set of conditions in which judgment or decisions concerning a primary interest is unduly influenced (or perceived to be influenced) by a secondary interest (personal or organizational benefit including financial gain, academic or career advancement, or other benefits to family, friends, or colleagues).

Decision Letter

A letter that provides the final status awarded by the Residency Accreditation Committee to the postgraduate dean of the relevant Canadian medical school, regarding an accredited residency program or application for a residency program, following an accreditation review (onsite/external/internal/progress report/application). The decision letter includes identified strengths (if applicable) and identified weaknesses (if applicable) of the program or application, which will be expected to be addressed by the follow-up date determined by the accreditation status. The decision letter identifies the date of the next follow-up review which is dependent on the status awarded (onsite/external/internal/progress report/application). The decision letter is sent via email to the postgraduate dean and copied to the dean, program director, chair of the Specialty Committee and the chair of the Residency Accreditation Committee.

Deferral

The act of deferring the award of an accreditation status for an application for accreditation, until specified requirements (e.g., additional information, clarification) have been met.

Educational Sites

An institution or health care site where residents or trainees complete some or all of their educational program.

Educational Objectives

The learning goals for the resident or trainee for the duration of the rotation, educational experience, year, stage, or program.

Evaluation

A process of employing a set of procedures and tools to provide useful information about medical education programs and their components to decision-makers. This term is often used interchangeably with Assessment (see above) when applied to individual physicians, but is not the preferred term used by the Royal College.

Faculty/School of Medicine

The organizational function within a university devoted to medical education.

Inactive Program

An accredited residency program that does not have a resident (see “resident (current)”) enrolled in the program for longer than six months. A program with an accreditation category of Notice of Intent to Withdraw Accreditation cannot become inactive.

Inter-Institution Affiliation (IIA) Agreement

A formal, written agreement between two or more Faculties/Schools of Medicine, to collaborate and/or provide residents with certain educational experiences, ensuring a complete residency program that complies with the general and specialty-specific standards of accreditation, and the policies and procedures governing residency education accreditation. There are several different kinds of IIA agreements (see Section 6).

Intimidation and Harassment

Behaviour that induces fear or involves aggressive pressure on an individual in effort to affect his/her actions.

Learner Experience

Perception of the learner of his/her experience in an educational program.

Policy

An organization’s position, plan, guideline or course of action with respect to a specified issue.

Postgraduate Medical Education (PGME)

A period of formal structured education physicians receive after finishing medical school in preparation for practice and leading to certification or attestation of higher clinical competence, also known as “Residency education” or “Graduate Medical Education” (Royal College Medical Education Glossary). [Link to Glossary](#).

Pre-survey Questionnaire (PSQ)

A form and accompanying documentation required of medical schools (institutions), affiliated teaching sites, and programs in preparation for onsite accreditation reviews (See section 5).

Procedure

A documented series of steps for completing a task, often connected to a policy.

Process

A series of steps for completing a task, which is not necessarily documented.

Program Director

The physician designated with authority and accountability for the operation of the residency/fellowship program. The program director must have qualifications that are acceptable to either the Royal College, the CFPC or the CMQ for the Québec residency programs.

Resident (Current)

Any trainee enrolled in a Royal College accredited residency program on the date of the accreditation review (onsite, external or internal review), who is following the academic curriculum and specialty-specific standards set out by the discipline. Current residents include those on authorized leaves of absence from the program of less than six months (provided they maintain a contract with the university and full or educational license to practice).

Residency Program Committee (RPC)

A committee whose function is to support the program director in the planning, organization and supervision of the program. It includes at least one resident representative selected by residents in the program.

Rotation

A structured period of time (typically one to four months in duration) that a resident spends in a particular clinical environment to acquire certain experiences or competencies or to achieve certain educational objectives. May also be referred to as “block”.

Specialty

A specialty is an area of medicine with a broad-based body of knowledge that is relevant in both community and tertiary care.

Subspecialty

An area of medicine with a more focused or advanced scope that builds upon the broad-based knowledge defined in a parent specialty.

Supporting Documentation

Documentation that accompanies an application for accreditation or pre-survey questionnaire that provides additional information, typically in the form of a required appendix.

Surveyor

Volunteer peer reviewers who are trained to evaluate the medical education program or Faculty/School of Medicine against the accreditation standards.

3. ROLES AND RESPONSIBILITIES

3.1 Accreditation Committee

The Accreditation Committee (AC) is a subcommittee that reports to the Committee on Specialty Education. The AC provides oversight for the decisions regarding all institutions, programs, and providers that are accredited by the Royal College, as well as oversees the quality of the Royal College's accreditation systems, including policies, standards and processes. See Appendix E for the Terms of Reference for the Accreditation Committee.

3.2 Other Subcommittees of the Accreditation Committee

Residency Accreditation Committee (Res-AC)

A subcommittee of the Accreditation Committee. Responsibility for the accreditation of Canadian residency programs is delegated by the Council of the Royal College to the Res-AC. Its major role is to ensure that Canadian residency programs accredited by the Royal College meet the requirements and guidelines for accreditation of residency programs and are conducted in a manner that permits graduates of the programs to achieve a level of competence compatible with Royal College certification. Decisions of the Res-AC are final, pending any appeal process to the Accreditation Committee. See Appendix E for the Terms of Reference of the Res-AC.

Areas of Focused Competence – Accreditation Committee

A subcommittee of the Accreditation Committee, the Areas of Focused Competence – Accreditation Committee (AFC-AC), has responsibility for the accreditation of all AFC (diploma) programs, which is based on the *General Standards for Areas of Focused Competence (AFC) Programs*. Please refer to the AFC-AC policy documents for more information.

International Program Review - Accreditation Committee

A subcommittee of the Accreditation Committee, the International Program Review Committee (IPRC) has responsibility for the accreditation of international programs, which is based on the *International Institutional Standards* and the *International Program Standards*. Decisions of the IPRC are final, pending any appeal process to the Accreditation Committee. See Appendix E for the Terms of Reference of the IPR-AC.

3.3 Specialty Committees

Specialty Committees, with voting representation from each region of Canada, act as stewards for their discipline. The role of Specialty Committees in the accreditation process is to develop discipline-specific standard requirements and associated accreditation documentation, and to provide consultative input to the surveyors and the Res-AC, based on a review of applications and the documentation for program reviews, including both pre-survey questionnaires and accreditation reports. Specialty Committees are specifically asked to:

- a. develop and review periodically the *Specific Standards of Accreditation for Residency Programs*, the *Specialty Training Requirements* and the *Objectives of Training* in the specialty or subspecialty;

- b. develop and review periodically the specialty-specific portions of the application form and pre-survey questionnaire, which are used to obtain information on programs applying for accreditation and on programs to be surveyed or otherwise reviewed;
- c. review all applications for accreditation of new programs and advise the Res-AC on the category of accreditation to be granted (Specialty Committee chair does not have a vote on the final Res-AC decision);
- d. review pre-survey documents and provide comments and suggestions to assist the onsite surveyor(s);
- e. review progress reports, reports of mandated internal and external reviews, and reports from regular onsite accreditation reviews, and recommend to the Res-AC the category of accreditation to be granted;
- f. nominate individuals from the specialty or subspecialty to be members of the survey team for external reviews of specific programs and for regular onsite accreditation reviews; and
- g. regularly review the accreditation status, as well as the summary of strengths and weaknesses, of all accredited programs in the discipline, with the aim of identifying systemic issues in the discipline, maintaining national standards, and providing support to programs in continuous quality improvement.¹

Input provided by the Specialty Committee is of particular importance in evaluating the structure and organization of the program as well as the adequacy of clinical and other resources, the program's academic content and its specialty-specific teaching and assessment of the CanMEDS competencies.

3.4 Faculty/School of Medicine

The Faculty/School of Medicine provides the framework to support residency education programs within the University(ies). The PGME function within the Faculty/School of Medicine, commonly referred to as "PGME office", is the single point of contact for the Royal College's Office of Specialty Education with respect to the accreditation of residency education. Accordingly, the Faculty/School of Medicine, via the PGME office, and specifically the postgraduate (PG) dean, is responsible for submission of all accreditation-related documentation, including applications, and pre-survey questionnaires as well as all communication with the Office of Specialty Education related to accredited programs.

The Office of Specialty Education (OSE) communicates only with deans of medicine, PG deans and the PGME office, unless otherwise instructed by the PGME office, or as specified in the *Policies and Procedures – Canadian Residency Education* (e.g., decision letters are copied to program directors). A key function of the PGME Office, therefore, is to disseminate information within the Faculty/School of Medicine and to individual relevant programs.

3.5 Residents

Input from residents is an integral component of the accreditation process. Accordingly, programs without enrolled residents (see definitions of "resident (current)", and "inactive program"). Furthermore, residents play an important role in several key steps in the accreditation of residency education in Canada, including in the deployment and review of the survey of residents to inform the resident surveyors' participation in the regular onsite

¹ This review is an important part of Specialty Committees' reports to the Committee on Specialties in the discipline review process.

accreditation process, during reviews of institutions and programs, and as voting members and observers of the Res-AC (see section 5 for more detailed description of the process).

Resident input and representation is coordinated with Resident Doctors of Canada (RDoC) and the Fédération des médecins résidents du Québec (FMRO).

3.6 Educational Standards Unit, Office of Specialty Education

The Educational Standards Unit (ESU) of the Royal College's OSE facilitates and supports the accreditation process for residency education. Its role includes:

- Development and maintenance of a surveyor pipeline, including deployment/assignment to accreditation reviews as well as training and assessment;
- Logistical coordination of regular onsite accreditation reviews and external reviews;
- Provision of guidance to Faculties/Schools of Medicine regarding policy and process issues such as interpretation of accreditation standards, preparation of applications for accreditation, and preparation for regular onsite accreditation reviews, external reviews, internal reviews and progress reports;
- Facilitation of the involvement of Specialty Committees in the accreditation process;
- Coordination and administration of the Accreditation Committee (AC) and its subcommittee the Res-AC;
- Policy and program development and maintenance related to the accreditation of residency education;
- Receipt of all applications for accreditation, PSQs, progress reports and internal reviews and corresponding review of these submissions to determine completeness and readiness for review by the Specialty Committee, Res-AC, and/or surveyors; and
- Communication with the Faculty/School of Medicine, specifically with the dean, PG dean and PGME office (unless otherwise requested by the PG dean), regarding applications for accreditation and accredited residency programs.

3.7 College of Family Physicians of Canada

The CFPC accredits Family Medicine and Enhanced Skills residency training programs in departments of family medicine at Canadian university faculties of medicine. The purpose of the accreditation of residency programs by the CFPC Accreditation Committee is to attest to the educational quality of accredited programs and to ensure sufficient uniformity and portability to allow residents from across Canada to qualify for the CFPC examinations as residency eligible candidates.

The document entitled *Specific Standards for Family Medicine Residency Training Programs Accredited by the College of Family Physicians of Canada*, commonly known as the "Red Book", outlines the standards used by the CFPC to accredit Family Medicine and Enhanced Skills residency programs. These discipline-specific standards are complementary to the Royal College, CFPC and CMQ conjoint *General Standards Applicable to all Residency Programs* and are intended to clarify or expand on the general standards as they relate to the education of family physicians.

For the reviews of all Canadian Faculties/Schools of Medicine, the Royal College survey team and the CFPC survey team conduct the onsite accreditation reviews simultaneously; the institutional

review is conducted by a conjoint survey team and the program reviews are conducted independently. The precise dates and overall logistics for onsite accreditation reviews, conducted as part of the regular accreditation cycle are determined conjointly by the Royal College and the CFPC in consultation with the implicated Faculty/School of Medicine. For Faculties/Schools of medicine in Quebec, this process is conducted conjointly with all three colleges.

Residency training programs in Palliative Medicine are conjointly accredited by the CFPC and the Royal College (see Appendix A). It should be noted that decisions to proceed with Certificates of Added Competence by the CFPC and to develop a subspecialty in Palliative Medicine by the Royal College have resulted in the need to create different and separate programs replacing the conjoint program currently in existence. Family Medicine residents completing the conjoint program in 2016-17 will be eligible for a Certificate of Added Competence in Palliative Care.

3.8 Collège des médecins du Québec

In the province of Québec, the CMQ has the legal responsibility for the accreditation of all residency programs for disciplines recognized by the CMQ. In practice, the CMQ and the Royal College have a formal agreement to collaborate on the accreditation of specialty residency programs in Québec.

The precise dates and overall logistics for onsite accreditation reviews conducted in the province of Québec as part of the regular accreditation cycle are determined conjointly by the Royal College, the CFPC and the CMQ in consultation with the implicated Faculty/School of Medicine. The CMQ and the Royal College collaborate in the appointment of surveyors to the survey team and have a cost-sharing agreement in place with respect to onsite accreditation reviews. In addition, representatives of the CMQ participate on the survey team for Québec universities.

The CMQ is represented by voting members on the Royal College's Res-AC; likewise, Royal College staff attend the meetings of the CMQ's *Comité d'éducation médicale et agrément* (CEMA) to facilitate communication and collaboration between these entities. In addition, correspondence related to the accreditation of specialty residency programs in Québec, for disciplines recognized by the CMQ, is conducted conjointly between the Royal College and CMQ.

4. ACCREDITATION STANDARDS

General Standards Applicable to all Residency Programs

The Royal College, the CFPC, and the CMQ maintain national standards for evaluation and accreditation of residency programs sponsored by Canadian universities, namely the *General Standards Applicable to all Residency Programs*, commonly referred to as the “B” Standards or the “Blue Book”. The standards are organized under six general topics: Administrative Structure; Goals and Objectives; Structure and Organization of the Program; Resources; Clinical, Academic and Scholarly Content of the Program; and, Assessment of Resident Performance. In addition to the *General Standards Applicable to all Residency Programs*, Royal College specialty programs must comply with the relevant *Specialty-Specific Standards of Accreditation (SSAs)*, which are developed and maintained by each Specialty Committee.

To improve consistency in interpreting and evaluating compliance with the General Standards of Accreditation, “descriptors” have been developed for each of the standards. The descriptors are intended to assist program directors, faculty and residents in understanding what needs to be in place to demonstrate compliance with each standard. They are also intended to help surveyors, Specialty Committees, and Res-AC members with the interpretation of the standards and their evaluation of programs against the standards.

General Standards Applicable to the University and Affiliated Sites

While no category of accreditation is awarded at the institutional level, the Royal College, CFPC and CMQ also maintain a set of standards on which the institutional review is based. These standards, namely the *General Standards Applicable to the University and Affiliated Sites*, are commonly referred to as the “A” Standards or the “Purple Book”, and are evaluated by a conjoint survey team (Royal College and CFPC, with CMQ in Quebec) at the time of the onsite accreditation review in the regular accreditation cycle. The standards are organized under three general topics: University Structure; Sites for Postgraduate Medical Education; and, Liaison between the University and Participating Sites.

5. ACCREDITATION PROCESS

5.1 Categories of Accreditation

Each program application and program review considered by the Residency Accreditation Committee (Res-AC) results in an accreditation status (category of accreditation), which corresponds to a particular requirement regarding follow-up (i.e., the next accreditation review of that program). The categories of accreditation were revised and approved by the Royal College, the CMO, and the CFPC in 2012 and came into effect in January 2013. The categories of accreditation and related follow-ups are summarized below.

CATEGORIES OF ACCREDITATION		
Categories	Follow-up	Definition
Program Reviews	Next Regular Onsite Accreditation Review	Program demonstrates acceptable compliance with standards
	External Review	Major issues identified in more than one Standard AND concerns <ul style="list-style-type: none"> are specialty-specific and best evaluated by a reviewer from the discipline, OR have been persistent, OR are strongly influenced by non-educational issues and can best be evaluated by a reviewer from outside the University External Review conducted within 24 months
	Mandated Internal Review	Major issues identified in more than one Standard Internal Review due within 24 months
	Progress Report*	Program has more than one issue across more than one standard, which would typically require follow-up by internal review; however, the issues identified are amenable to a written response highlighting the actions taken (as opposed to full mandated Internal Review of the program) Progress Report review due within 12 months (unless 18 months specified by Res-AC)
	Accredited Program on Notice of Intent to Withdraw Accreditation*	External Review Major and/or continuing non-compliance with one or more Standards which calls into question the educational environment and/or integrity of the program External Review conducted within 24 months
	Withdrawal of Accreditation	New Application Effective immediately (active residents complete current year of training) New application must be submitted following a waiting period of 12 months
Applications	Accredited New Program	Internal Review Program demonstrates acceptable compliance with standards. Internal Review of program is conducted after enrollment of first resident.**
	Defer*	Response Program requires clarification in several areas before the Res-AC can be assured that all components of the program are in place. If no response is received from the program within one year of the Res-AC decision, a new application for accreditation must be submitted.
	No Approval	New Application Program application did not demonstrate acceptable compliance with the standards and a new application is required.
IUAs	N/A	Addition The Res-AC agreed the addition of the requested IUA would provide the residents the opportunity to meet all of the educational requirements of the specialty or subspecialty.
		Removal The Res-AC agreed the accredited program has sufficient resources to provide a full program and allow residents the opportunity to meet all educational requirements of the specialty or subspecialty.

*Programs cannot receive this status consecutively.

**Follow-up of the Internal Review is based on the length of the residency program according to the following timelines:

- **Nine months** following activation for **one-year** residency programs. This deadline may also apply for two year subspecialty programs that allow up to one year of double counting with training in the primary discipline..
- **18 months** following activation for **two-year** residency programs.
- **24 months** following activation of programs longer than **two-years**. In cases where there is one or more foundational training year(s) in the program, the deadline may be extended to allow for the residents to enter the specialty-specific portion of their training. For example, the follow-up will be **30 months** following activation for residency programs that include two years of training in Surgical Foundations.

5.2 Applications for Accreditation of New Programs

a. Eligibility

Applications for accreditation of new residency programs must be sponsored by one of the seventeen Canadian Faculties/Schools of Medicine recognized by the Royal College.¹

It should be noted that in order to maintain the integrity of the program, the Res-AC does not separately accredit individual components of a program; rather the category of accreditation applies to the program as a whole.

b. Documentation

The Faculty/School of Medicine applying for accreditation of a new residency program must submit an application form² as well as supporting documentation requested in that form, to the Office of Specialty Education.

c. Review Process

The OSE determines the completeness of each submitted application, coordinates any revisions or additions needed on the part of the applicant, and then circulates the application to the voting members of the relevant Specialty Committee for their comments. The chair of the Specialty Committee consolidates the input from voting members into the committee's final recommendation, with comments. The Res-AC then reviews the application at an upcoming meeting, along with the input from the Specialty Committee. Following the meeting, the applicant, via the postgraduate dean of the Faculty/School of Medicine, is informed in writing of the decision ("decision letter").

¹ Any university wishing to establish a Faculty/School of Medicine beyond those 17 currently recognized by the Royal College should contact the Office of Specialty Education by email at accredadmin@royalcollege.ca.

² Application forms are circulated by the Office of Specialty Education (OSE) for all new disciplines to all postgraduate offices. They can also be obtained from the OSE via email at accredadmin@royalcollege.ca.

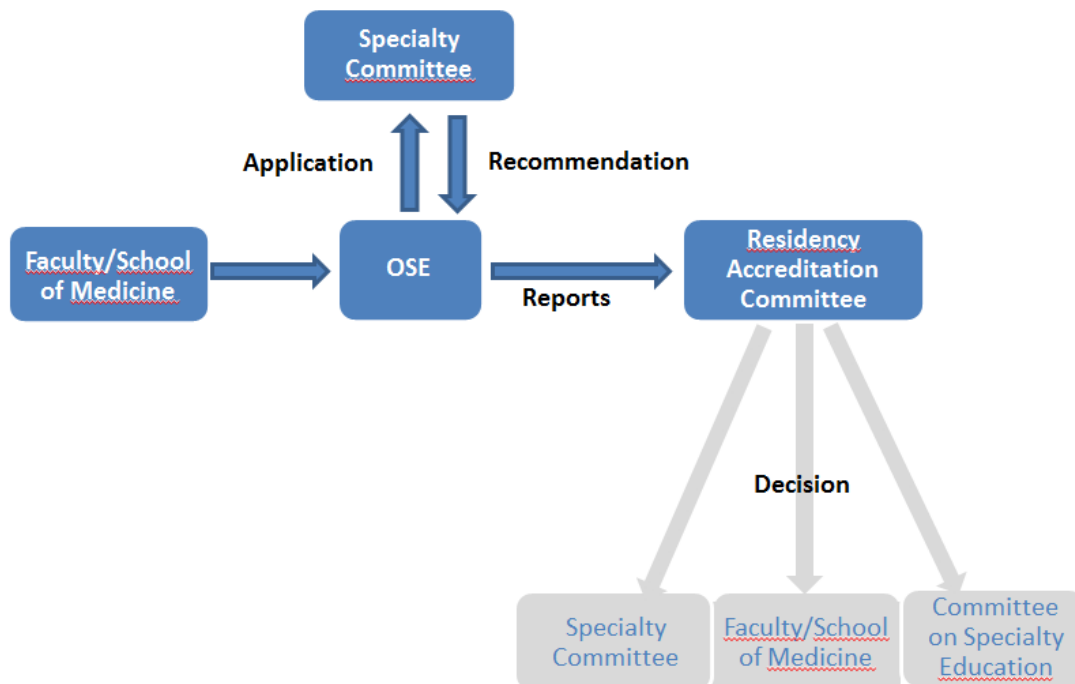


Figure 1: Overview of the Application Process

d. Categories of Accreditation & Follow-up

The categories of accreditation for new program applications (see subsection 5.1) are interpreted and operationalized as follows:

Accredited New Program - The application has demonstrated acceptable compliance with the *General Standards Applicable to all Residency Programs* (B Standards) and the specialty-specific standards for the discipline. The OSE will send the decision letter to the postgraduate dean, informing them of the accreditation decision and the status of the program.

Activation: The Faculty/School of Medicine must notify the Office of Specialty Education in writing within two months from when the first resident(s) has been enrolled in the program, and specify the date that training commenced. Upon receipt of this notification, the OSE will confirm the deadline for submission of the mandated Internal Review.

Follow-up: Following activation of the program (i.e., commencement of training of the first resident(s)), a mandated Internal Review (see subsection 5.4b for process) must be conducted by the faculty postgraduate medical education committee and submitted, along with required supporting documentation,³ to the Office of Specialty of Education⁴ for consideration by the Res-AC. The deadline for submission of the Internal Review is based on the length of the residency program, according to the following timelines:

- **Nine months** following activation for **one-year** residency programs.

³ The submission must include the prescribed documentation in the correspondence from the Royal College, which is sent to the PGME office 12 months in advance of the deadline (see subsection 5.4.b),

⁴ The internal review and supporting documentation (as prescribed in the requirements for mandated internal reviews) be submitted to the OSE via email at accredadmin@royalcollege.ca.

- **18 months** following activation for **two-year** residency programs.
- **24 months** following activation for residency programs **longer than two years**. In cases where there is one or more foundational training year(s) in the program, the deadline may be extended to allow for the residents to enter the specialty-specific portion of their training. For example, the follow-up will be **30 months** following activation for residency programs that include two years of training in Surgical Foundations.

The follow-up timelines are designed to ensure the participation of current residents in the program in the internal review process (i.e., before completion of training) and to facilitate the evaluation of the unique aspects of residency programs, including specialty-specific content.

Expiration: Accreditation will be withdrawn for newly accredited programs which are continuously inactive (i.e., not yet activated) for two consecutive regular surveys. A complete new application for accreditation must be submitted.

Retroactivity: The **Accredited New Program** category of accreditation is retroactive to the beginning of the academic year in which it was awarded. For example, a program receiving the status of **Accredited New Program** anytime between July 1, 2016 and June 30, 2017 would be considered accredited for the entire 2016-17 academic year, and its residents would therefore be eligible for credit for training completed during that period.

Defer – The application demonstrates acceptable compliance with most of the *General Standards Applicable to all Residency Programs* (B Standards) and specialty-specific standards for the discipline, but clarification is required in several areas before the Res-AC can be assured that all components of the program are in place, and before **Accredited New Program** status can be granted. When the Res-AC renders a decision of **Defer** with respect to an application, the Royal College sends a decision letter to the applicant, via the PG dean, requesting clarification of specific areas of the application.

Follow-up: Applicants are asked to submit, via their PG dean, to the Office of Specialty Education, a response specific to the areas identified for clarification as soon as possible. The submission must contain only the information required for the requested clarification; a complete new application is not required.

Expiration: If no response to the deferred application is received within one year of the date of the decision letter, a complete new application for accreditation must be submitted.

Review of responses to deferred applications: Once the submission has been received by the OSE, the process for review depends on the original specialty committee recommendation prior to the Res-AC decision of **Defer**. There are three possible scenarios:

- 1) The original Specialty Committee recommendation was **No Approval**
- 2) The original Specialty Committee recommendation was **Defer**
- 3) The original Specialty Committee recommendation was **Accredited New Program**

In the case of scenarios 1) and 2) above, the process for review will be the same:

- The deferred application submission is reviewed by the appropriate Specialty Committee. The original application is not included.

- The Specialty Committee chair provides a written recommendation to the Res-AC. The Specialty Committee chair may consult with the voting members of his/her specialty committee.
- Although the specialty committee chair provides input to the Res-AC, s/he does not have a vote on the final accreditation decision.

In the case of scenario 3) above, the process for review will be:

- No additional feedback is required from the Specialty Committee chair to the Res-AC.

The Res-AC will consider the response submission at its next meeting and, in doing so, will take into account the recommendation of the Specialty Committee, if applicable (i.e., in the case of scenarios 1) and 2) as outlined above). An effort will be made to assign the review of the response submission to Res-AC members who reviewed the original application, if possible.

The Res-AC cannot defer its decision with respect to an application for accreditation more than once. At the time of the consideration of the response to the deferred application, the committee will have the option of granting **Accredited New Program** status or **No Approval**. The OSE will send the decision letter to the postgraduate dean, informing him/her of the accreditation decision, including the status of the program and timeline for follow-up, if applicable.

No Approval – The application does not demonstrate acceptable compliance with the *General Standards Applicable to all Residency Programs* (B Standards) and/or specialty-specific standards for the discipline. The OSE will send the decision letter to the postgraduate dean, informing them of the accreditation decision and the status of the program.

Follow-up: A complete new application for accreditation must be submitted.

5.3 Regular Accreditation Cycle

The accreditation process is based on a system of regular onsite accreditation review of the residency programs of each Canadian Faculty/School of Medicine on a six-year cycle, with a mid-cycle internal review of each program conducted by the Faculty/School of Medicine. Regular onsite accreditation reviews include an institutional review of the Faculty/School of Medicine, which is done conjointly with the CFPC (and the CMQ, in Québec), as well as reviews of individual residency programs, which are conducted conjointly with the CMQ in Québec and, concurrently, although not conjointly, with the CFPC.⁵

The primary purpose of regular onsite accreditation reviews is to provide the Res-AC, the Specialty Committees of the Royal College, the postgraduate dean and PGME office, as well as the program's leadership and faculty, with an onsite, peer evaluation of each accredited program and the extent to which it meets the general and specialty-specific standards of accreditation. The interaction among experienced medical educators from different universities also provides the opportunity for an exchange of ideas and best practices.

⁵ With the exception of the Palliative Medicine program, which is reviewed conjointly with surveyors from both the Royal College and the CFPC (see Appendix A, special programs).

a. Programs to be reviewed at the Onsite Accreditation Review

All residency programs sponsored by the Faculty/School of Medicine which are active⁶ at the time of the regular onsite accreditation review must be reviewed; exceptions are listed below.

At any one Faculty/School of Medicine, one or more programs may not be on the regular accreditation cycle (see subsection 5.4); leading up to and at the time of planning for the upcoming regular onsite accreditation review, every effort is made, where appropriate and in discussion with the postgraduate dean, to include programs not on the regular accreditation cycle in the schedule for review during the regular onsite accreditation review. The below stipulations, where applicable, will be outlined in the program's decision letter.

For accredited programs with follow-up by External Review, the External Review will be conducted at the time of the regular onsite accreditation review, according to the format prescribed for external reviews (see subsection 5.4), provided the deadline for the External Review is within the six months immediately prior to or following the date of commencement of the regular onsite accreditation review. If the deadline for the External Review is more than six months before or following the date of the regular onsite accreditation review, the program may be reviewed at the time of the regular onsite accreditation review, at the discretion of the postgraduate dean and based on consultation with the program. If not reviewed at the time of the regular onsite accreditation review, the program will retain its follow-up by the specified deadline.

For accredited programs with follow-up by mandated Internal Review, the Internal Review will be replaced by a regular onsite accreditation review of the program, provided the deadline for the mandated Internal Review is within the six months immediately prior to or following the date of commencement of the regular onsite accreditation review. If the deadline for the mandated internal review is more than six months before or following the date of the regular onsite accreditation review, the program may be reviewed at the time of the regular onsite accreditation review, at the discretion of the postgraduate dean and based on consultation with the program. If not reviewed at the time of the regular onsite accreditation review, the program will retain its follow-up by the specified deadline.

For accredited programs with follow-up by Progress Report, the Progress Report will be replaced by a regular onsite accreditation review of the program, provided the deadline for the Progress Report is within 12 months of the date of commencement of the onsite accreditation review; this stipulation is to ensure that the program does not go without a comprehensive review over two consecutive cycles.

b. Regular Onsite Accreditation Review Process

Institutional Review

The onsite institutional accreditation review is based on the General A Standards of Accreditation, which are applicable to the Faculty/School of Medicine, the postgraduate dean, and PGME office.

In preparation for the regular onsite accreditation review, the faculty and hospital pre-survey questionnaires (PSQs) and associated documentation must be completed by the Faculty/School of Medicine and submitted to the Royal College to inform the onsite institutional review. The chair and, as required according to the size of the Faculty/School of Medicine, deputy chair of the survey team are appointed by the Royal College and, together with a reviewer from the CFPC, the Federation of Medical Regulatory Authorities (FMRAC),

⁶ Please refer to the definitions of "active program", "resident (current)" and "inactive program".

and, for Québec universities, a staff member from the CMQ, are responsible for the review of the operation of the PGME office, including the faculty postgraduate medical education committee and any subcommittees, the process for mid-cycle internal reviews, and the relationship and communication with the clinical teaching sites involved in education.

The institutional review process includes interviews with the chief executive officer and other members of the administration of each affiliated site. The institutional review also evaluates the relationship between the postgraduate dean and office and the residency programs, including identifying strengths or areas for improvement at the institutional level that affect the delivery of education at the program level. The faculty postgraduate medical education committee and the residency program committees are responsible for all sites used for residency education and are required to maintain a current list of all educational sites involved in the delivery of residency education.

It is important to note that there is no category of accreditation awarded to the postgraduate office or the Faculty/School of Medicine writ large as a result of the institutional review. The chair, along with the institutional review survey team, prepares a summary of the results of the institutional review, which is presented to the Faculty/School of Medicine orally. The final written report is sent to the PGME office and is also shared with the Res-AC in conjunction with the results of the program reviews.

Program Reviews

The onsite accreditation reviews of individual residency programs are based on the General B Standards of Accreditation and are applicable to each residency program. In addition, each program is evaluated according to the specialty-specific standards for the discipline.

The team of surveyors is appointed by the Office of Specialty Education (with CMQ, for Québec) on behalf of the Res-AC, with each surveyor having the responsibility of reviewing the pre-survey documentation (including the PSQs plus additional documentation and the Specialty Committee comments and questions), of typically three or four programs and conducting the onsite review of these programs. It is important to note that surveyor assignments are not driven by a need for specialty-specific expertise onsite except in the case of mandated external reviews (see subsection 5.4); rather, specialty-specific input is sought from the relevant Specialty Committee prior to and following the survey. Assignment of surveyors to programs is made in consideration of any potential or perceived conflicts of interest and to ensure that surgeons are assigned to review surgical programs. As a general rule, surveyors are not invited to participate in two consecutive accreditation reviews at the same Faculty/School of Medicine; in the event that a surveyor is required to participate in consecutive accreditation reviews (due to specialty requirements or insufficient skilled surveyors being available), a request will be sent to the PGME office for consideration, and ensuring that the surveyor will not be reviewing the previously assigned programs. The surveyors who participated in a previous accreditation review are however eligible to participate as chair or deputy chair of the onsite review.

In addition, one resident surveyor per 20 active programs scheduled to be reviewed and appointed by RDoC or the FMRQ (for Québec universities) are members of the survey team and participate as surveyors for a selection of programs at their discretion. The resident organizations send a survey to all residents four to six months prior to the regular onsite survey. The survey results are not made available to the Royal College or the survey team; rather, they are used to inform the resident representative(s) on the accreditation review team.

In preparation for the regular onsite accreditation review, a PSQ must be completed for each residency program by the program director, with support from the Residency Program Committee (RPC), the program coordinator or additional administrative support. The PSQ provides an opportunity for the program's self-evaluation against the general and specific

standards as well as in reference to previously identified weaknesses, and serves as a foundation of information regarding each residency program for reference during subsequent steps of the accreditation review process. All PSQs must be signed by the postgraduate dean as well as the program director and submitted to the OSE by the PGME office. Once received, the PSQs are sent to the appropriate Specialty Committees for review, including, in particular, an evaluation of the resources available to the program and questions to be clarified during the onsite review. The Specialty Committee's comments and questions are provided to the onsite surveyors approximately one to two weeks before the survey to inform their review; they are also provided to the program director, via the PGME office, to help prepare for the review.

Onsite, the surveyor evaluates each residency program through interviews with the program director, department head or equivalent, core teaching faculty, all current residents (see definition of "resident – current"), and the RPC. Program reviews are most often one day in duration, except for atypically large or small programs.

Surveyors also review resident files to evaluate the quality of the program's assessment processes and to determine the program's compliance with the general and specialty-specific standards of accreditation. The selection of resident files must include a sample from the program, including a representative sample across resident year (PGY), as well as a sample of residents who have or are experiencing performance difficulty and/or are on remediation, if applicable (Please see Appendix D for a Review resident files-accreditation review).

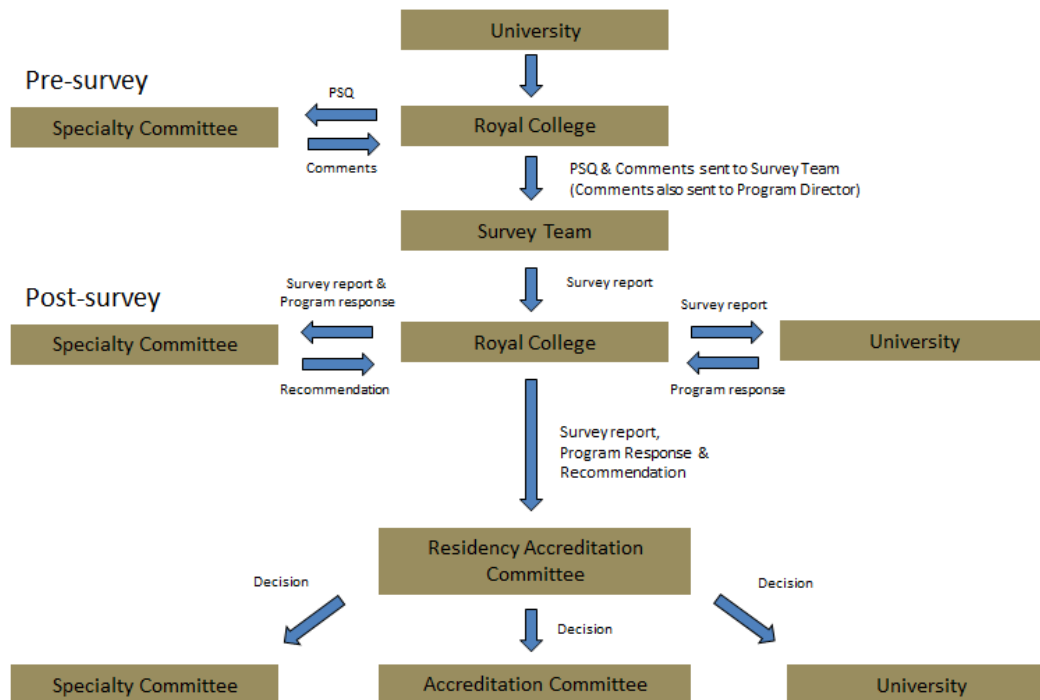
Each evening of the regular onsite accreditation review, all members of the survey team meet to consider the program reviews that were conducted that day. Each surveyor makes an initial recommendation to the onsite accreditation review team regarding the accreditation status (category of accreditation) for the program as well as a summary of strengths and weaknesses based on the general and specialty-specific standards of accreditation. The survey team discusses the results of each program and agrees by majority vote to a recommended accreditation status, strengths and weaknesses. The following morning, the surveyor meets with the program director to verbally relay the survey team's recommended accreditation status, with the understanding that final decisions in terms of accreditation status, strengths and weaknesses are the purview of the Res-AC.

Following the conclusion of the onsite survey, all surveyors submit a written report for each program reviewed, which is sent to the OSE for review for completeness and editing. The finalized report is then sent to the postgraduate dean for distribution to the program director, who is asked to review the report and respond in writing to errors of fact. The relevant Specialty Committee is sent the survey report and program response, if applicable, for an evaluation of the survey findings, and to make a recommendation of accreditation status, strengths and weaknesses, all of which may or may not be the same as those of the survey team.

All information related to the regular onsite accreditation review of each program, including the pre-survey documentation, the survey report, the response from the program, and the Specialty Committee comments and recommendation, is sent to the Res-AC for review. The dean and postgraduate dean are invited to attend the meeting at which the survey reports, the program responses, and the recommendations of the respective Specialty Committees are considered. Following the meeting, decisions regarding each program's accreditation status, strengths and weaknesses are communicated to the principal, dean, postgraduate dean, program director, the chair of the Specialty Committee, and surveyors via a decision letter.

The decision of the Res-AC regarding the category of accreditation, strengths and weaknesses to be accorded to each program is final. The decision may be appealed via a formal request for reconsideration, on the grounds that the decision was unduly harsh, or information missed or misinterpreted (see subsection 7.4). In addition, if it is felt the “B Standards” for accreditation were misinterpreted by the Res-AC (e.g. cited as a weakness), there is a mechanism in place for consideration by the Res-AC. In either case, a letter from the PG dean office must be sent to the OSE⁷ within 60 days of the issue of the original decision letter.

Overview of Residency Accreditation Process



¹ **Figure 2: Overview of the Regular Survey Process**

Risk Management: Onsite Accreditation Reviews and Unexpected Events, Emergencies, or Disruptions

In the event of an unexpected issue or circumstance that affects the ability for the onsite accreditation review (or external review, refer to subsection 5.4) to be completed as previously scheduled, the Royal College staff, conjointly with the CFPC and CMQ, as appropriate, the affected PG dean and PGME office, and survey chairs will organize an alternate plan. The alternate plan document will be prepared conjointly and distributed to all affected parties including the entire survey team. Criteria for the plan will take into account potential risks to surveyors, faculty, residents and Royal College staff if onsite accreditation review will be proceeding as well as a plan for cancelling the onsite accreditation review altogether.

⁷ Appeals may be submitted to the OSE by email at accreditation@royalcollege.ca

c. Mid-cycle Internal Reviews of Residency Programs

The PG dean, the Faculty/School of Medicine's postgraduate medical education committee and program directors have collective and direct responsibility for the quality of university residency programs. The mid-cycle internal review, which is considered to be an integral component of the accreditation process, should be conducted near the mid-point in time between regular surveys, and at least two years prior to the regular survey.

The purpose of the mid-cycle internal review is to assist the Faculty/School of Medicine in the ongoing quality improvement of its residency programs, including all residency education sites and elective experiences, by providing the postgraduate dean, postgraduate medical education committee and program directors with an evaluation of the strengths and weaknesses of residency programs. This process in turn enables the Faculty/School of Medicine to take action to further develop areas of strength and address areas for improvement in between regular surveys, resulting in higher quality residency programs. While the mid-cycle programs reviews are required, additional internal reviews may be conducted by the Faculty/School of Medicine at any time, depending on the issues in or needs of the particular program. For example, Faculties/Schools of Medicine may wish to consider a series of internal reviews for programs with significant and persistent weaknesses.

The internal review team for each program typically includes:

- a. a member of the postgraduate medical education committee, preferably a program director from another program;
- b. a faculty member from another discipline who is experienced in postgraduate medical education; and
- c. a resident from another discipline who is chosen by the resident group at the university.

The internal review team should have available all documentation regarding the program, including the previous survey report(s) and the basic factual information that would typically be included in the Royal College PSQ, which should be updated and maintained in each program office. As for a regular survey program review, the mid-cycle internal review should provide an evaluation of the quality of residency programs, based on the general and specific standards of accreditation. A series of interviews must take place with the program director, core teaching faculty, all residents, and with the RPC. All residency education sites and elective experiences should be reviewed by the internal review team; visits to educational sites should take place as appropriate.

The written report of the internal review should include the strengths and weaknesses of the program and specific recommendations for continued development and improvements. This report should be submitted to the postgraduate dean, the chair of the department, the program director, and members of the RPC. The report should then be circulated to the members of the faculty postgraduate medical education committee (and/or one of its subcommittees) and discussed at a meeting of that committee that is attended by appropriate representatives of the program under review.

Internal review reports are deemed to be internal documents of the university. However, the internal review reports for all programs, including Family Medicine, are provided to the Royal College survey team chair prior to the regular survey, to enable the chair to evaluate the efficacy of the internal review process as part of the institutional review. The mid-cycle internal review reports are not made available for review by the surveyors at the time of a regular survey and are not considered by the Residency Accreditation Committee in making decisions regarding the accreditation status of individual programs.

5.4 Programs not on the Regular Accreditation Cycle

Each program review considered by the Res-AC results in an accreditation status (category of accreditation), which corresponds to a particular follow-up (i.e., the next accreditation review of that program). Programs with a category of accreditation associated with a follow-up review other than the next regular survey are termed programs not on the regular accreditation cycle (sometimes referred to as off-cycle programs). The parameters related to the follow-up reviews that do not correspond to the regular accreditation cycle are outlined below.

a. Accredited Programs with Follow-up by Progress Report

Definition: Accredited programs with a status of “Accredited Program with follow-up by Progress Report” are defined (see subsection 5.1) as those programs with significant weaknesses identified in more than one standard, which would typically require an internal review of the program, but where the weaknesses requiring additional follow-up¹ are amenable to response through a written report. The follow-up by progress report is meant to provide programs with weaknesses amenable to response through a written report as a means to address these without undertaking a comprehensive internal review of the program. This category of accreditation may only be awarded at the stage of the Res-AC’s review (i.e., not by the survey team or Specialty Committee) and is available only to programs that are initially recommended by the Res-AC to receive the status of “Accredited Program with follow-up by Internal Review” (See Appendix G, Process for Implementation of the “Accredited Program with follow-up by Progress Report” Category of Accreditation).

Follow-up: The progress report must be produced by the program director, with support from the RPC, the program coordinator or additional administrative support, as required, and submitted to the OSE² by the postgraduate dean, within 12 months³ of the decision letter.

Process: The progress report must consist of a narrative description (and any associated additional documentation) to demonstrate evidence of how the weaknesses identified in the decision letter as requiring follow-up by Progress Report have been addressed.

The completed progress report and accompanying documentation is sent to the Specialty Committee to obtain its recommendation.

The decision letter from the Res-AC outlining the category of accreditation,⁴ and strengths and weaknesses,⁵ is communicated to the dean, PG dean, program director, the chair of the

¹ It is not necessary that the progress report address all weaknesses identified in the program. Rather, the Res-AC may highlight in the decision letter those weaknesses that require additional follow-up which must be addressed in the progress report. If a subset of weaknesses cited in the decision letter is not specifically identified as requiring follow-up by Progress Report, all weaknesses cited in the decision letter must be addressed.

² Progress reports and any supporting documentation may be submitted to the OSE by email at accredadmin@royalcollege.ca.

³ The conjoint categories of accreditation state that “the written progress report is produced by the program director and is due within 12-18 months”; however, the default follow-up is 12 months to ensure consistency among Royal College programs and with the CFPC. In cases where the Res-AC feels that more than 12 months is required, it may specify in its motion that the follow-up by progress report should be within 18 months (versus 12). In addition, extensions may be considered on a case-by-case basis (see subsection 5.5b).

⁴ In reviewing progress reports, the Res-AC may confer a new status of Accredited Program with follow-up at Next Regular Onsite Accreditation Review, if the issues prompting the Progress Report have been adequately addressed, or Accredited Program with follow-up by Internal Review, if the issues prompting the Progress Report have not been adequately addressed. The status of Accredited Program with follow-up by Progress Report cannot be awarded twice consecutively.

⁵ The decision letter following review of a Progress Report will include the category of accreditation, strengths (as identified in the previous accreditation review and cited in the decision letter) and weaknesses identified in the previous review (those cited for follow-up by Progress Report that were not fully addressed, and those cited for follow-up by Next Regular Onsite Accreditation Review – i.e., not cited for follow-up by Progress Report).

Specialty Committee, and surveyors. The decision of the Res-AC regarding the category of accreditation, strengths and weaknesses accorded is final. The decision regarding the category of accreditation may be appealed via a formal request for reconsideration (see subsection 5.6).

b. Accredited Programs with Follow-up by Internal Review

Definition: Accredited programs with a status of “Accredited Program with follow-up by Internal Review” are defined (see subsection 5.1) as those programs with significant weaknesses identified in more than one standard.

Follow-up: This Internal Review must be conducted by the Faculty/School of Medicine and its report submitted to the OSE within 24 months of the Res-AC’s decision.

Process: When an Internal Review of a program is mandated by the Res-AC, the internal review process (as for the mid-cycle internal review process) conducted by the Faculty/School of Medicine should mirror that of a Royal College regular onsite accreditation review for a program in terms of meetings with the program director, core teaching faculty, current residents, and RPC. Like the process for mid-cycle reviews, the internal review team for each program typically includes:

- a. a member of the postgraduate medical education committee, preferably a program director from another program;
- b. a faculty member from another discipline who is experienced in postgraduate medical education; and
- c. a resident from another discipline who is chosen by the resident group at the university.

The postgraduate dean should provide the review team with a copy of the report from the residents (as described below) in advance of the review.

Internal review reports must be submitted to the OSE⁶ by the postgraduate dean for the consideration of the Res-AC. The submission must include:

- i. A letter or email from PG Dean confirming that the documents have been reviewed by the faculty postgraduate medical education committee;
- ii. An internal review report that addresses each of the “General Standards of Accreditation”. The format must follow that used in regular surveys, including a summary identifying the strengths and weaknesses of the program, but must not recommend a status of accreditation for the program;
- iii. A completed PSQ including accompanying appendices; and
- iv. A report from the residents in the program, prepared by the resident representative(s) on the RPC, and commenting on:
 - a. strengths of the program,
 - b. weaknesses previously identified in the program and the residents’ perception of how well these have been addressed, and
 - c. any other significant changes in the program since the last review.

The internal review documentation is sent to the Specialty Committee to obtain its recommendation to the Res-AC. The decision of the committee regarding the category of accreditation, strengths and weaknesses is communicated to the dean, postgraduate dean, program director, the chair of the Specialty Committee, and surveyors.

⁶ Internal review reports and supporting documentation may be submitted to the OSE by email at accredadmin@royalcollege.ca.

The decision of the Res-AC regarding the category of accreditation, strengths and weaknesses awarded is final. The decision regarding the category of accreditation may be appealed via a formal request for reconsideration (see subsection 5.6).

c. Accredited Programs with Follow-up by External Review

Definition: Accredited programs with a status of “Accredited Program with follow-up by External Review” are defined (see subsection 5.1) as those programs with significant weaknesses identified related to more than one standard, with some or all of those weaknesses being:

- specialty-specific, and therefore best evaluated by a reviewer from the discipline,
- persistent, i.e., were also identified at previous accreditation review(s), and/or
- related to non-educational issues, and therefore best evaluated by a reviewer from outside the university.

Follow-up: For Royal College programs, this follow-up entails a complete review of the program, which must take place onsite within 24 months of the Res-AC’s decision and is organized by the OSE in consultation with the PGME office.

Process: Two experienced surveyors are appointed by the OSE (with CMQ, for Quebec) on behalf of the Res-AC, to evaluate whether the program has addressed the weaknesses cited in the decision letter and is meeting the general and specialty-specific standards of accreditation. Unlike the process for regular accreditation program reviews, and depending on the nature of the identified weaknesses, one of the surveyors may be a specialist in the discipline concerned. In addition, a resident representative will be included on the survey team.

As required for programs reviewed during a regular survey, a PSQ must be completed by the program director, with support from the RPC, the program coordinator or additional administrative support. The PSQ is sent to the Specialty Committee for its review and input, which informs the onsite surveyors and is also sent to the program director, via the PGME office, to help prepare for the review.

Onsite, akin to the regular survey process, the surveyors evaluate the residency program through interviews with the program director, department head or equivalent, core teaching faculty, all residents, and the RPC. Surveyors also conduct a review of resident files (see Appendix D for this process). The length of the external review is typically one day in duration, except for atypically large or small programs. Following the formal interviews, the survey team meets to discuss the findings and determine the strengths and weaknesses of the program and the recommended category of accreditation. The survey team then meets with the program director to relay the survey team’s recommendation.

Following the onsite review, the surveyors prepare an external review report, which is edited and finalized by the OSE, then sent to the PG dean and PGME office for review and correction of any errors of fact. The survey report and the program’s response are sent to the Specialty Committee to obtain its recommendation to the Res-AC. The decision of the Res-AC regarding the category of accreditation, strengths and weaknesses is communicated to the dean, postgraduate dean, program director, the chair of the Specialty Committee, and surveyors.

The decision of the Res-AC regarding the category of accreditation, strengths and weaknesses to be accorded to each program is final. The decision regarding the category of accreditation may be appealed via a formal request for reconsideration (see subsection 5.6).

d. Accredited Programs on Notice of Intent to Withdraw Accreditation

Definition: Accredited programs with a status of “Accredited Program on Notice of Intent to Withdraw Accreditation”⁷ are defined (see subsection 5.1) as those programs with significant and/or persistent non-compliance with one or more standards, to the extent that the educational environment and/or integrity of the program is called into question.

Residents actively enrolled in the program and learners already contracted to enter the program, as well as all applicants to the program, must be advised immediately of the status of the program. At the time of the review, the onus is on the program to demonstrate why accreditation should not be withdrawn.

It is important to note that accreditation will be immediately withdrawn from a program with a status of “Accredited Program on Notice of Intent to Withdraw Accreditation” that becomes inactive (see section 5.4f, Inactive Programs).

Follow-up: For Royal College programs, this follow-up entails a complete review of the program, which must take place onsite within 24 months of the Res-AC’s decision and is organized by the OSE in consultation with the PGME Office.

Process: The external review of the program is conducted according to the process described in subsection 5.4c. In addition, a Royal College staff member (or a CMQ staff member for Quebec universities) will also be included on the survey team in an observer capacity.

e. Withdrawal of Accreditation

There are several reasons for which accreditation may be withdrawn, as follows:

Withdrawal due to Non-Compliance: Withdrawal of accreditation will only be done after a program has received the “Notice of Intent” category of accreditation. Programs with this status that do not demonstrate acceptable compliance with the standards of accreditation will have accreditation withdrawn.

Voluntary Withdrawal: A Faculty/School of Medicine may voluntarily withdraw a program at any time, with notification to the OSE.

Withdrawal due to Inactivity:

- a) Notice of Intent to Withdraw Accreditation status: Accreditation will be withdrawn from a program with the accreditation status of “Accredited Program on Notice of Intent to Withdraw Accreditation” that becomes inactive (see section 5.4d).
- b) Programs inactive across two regular accreditation cycles: Accreditation is withdrawn from programs which are continuously inactive across two consecutive regular surveys (see section 5.4f).

Process: The decision to withdraw accreditation of a program becomes effective immediately, unless there are residents enrolled in the program, in which case withdrawal becomes effective at the end of the academic year in which the decision is taken. No credit will be given by the Royal College to any residents for training completed in a program once the accreditation of the program has been withdrawn.

In the case of withdrawal of accreditation, a new application for accreditation is required. This application will not be considered by the Res-AC for at least one year following the date of the decision letter.

⁷ Programs cannot receive this status consecutively.

f. Inactive Programs

Definition: Resident input is an integral component of a thorough evaluation of a residency program. Accordingly, when a program is scheduled for an accreditation follow-up (i.e., Regular Onsite Accreditation Review, an External Review, a mandated Internal Review, or Progress Report) and there will be no residents (see definition, “resident – current”) enrolled in the program at the time the review is scheduled to take place, the program will be designated as inactive (see definition, “inactive program”) and will not be reviewed.

De-activation: The Faculty/School of Medicine must notify the OSE in writing⁸ within two months when there is no current resident enrolled in a residency program. The program will be designated as inactive.

Re-activation: The Faculty of Medicine must notify the OSE in writing⁹ within two months when a resident(s) enrolls in an inactive program, specifying the date that training commenced. Upon receipt of this notification, the OSE will confirm the format and deadline for the required follow-up accreditation review.

Follow-up: The required follow-up for a re-activated program is dependent on the length of the program and the program’s accreditation history.

- i. For programs with the accreditation status of Accredited Program with Follow-up at the next Regular Onsite Accreditation Review, and which were inactive (and therefore not reviewed) at the time of the university’s regular onsite accreditation review, a mandated Internal Review must be conducted by the faculty postgraduate medical education committee and submitted to the OSE for consideration by the Res-AC.
- ii. For programs that became inactive and were then re-activated between regular surveys, the required follow-up depends on the accreditation status of the program. Upon reactivation:
 - o Programs with a status of “Accredited Program with follow-up by Regular Onsite Accreditation Review” do not require follow-up review until the next regular onsite accreditation review.
 - o Programs with a status of “Accredited Program with follow-up by External Review” require follow-up by external review.
 - o Programs with a status of “Accredited Program with follow-up by Internal Review” require follow-up by mandated internal review.
 - o Programs with a status of “Accredited Program with follow-up by Progress Report” require follow-up by Internal Review; this proviso is in place to ensure a complete review of the program following inactivity.
 - o Programs with a status of “Accredited New Program” require follow-up by mandated internal review.
- iii. The reviews outlined in sections i and ii must be conducted according to the following timelines:
 - o **Nine months** following re-activation for **one-year** residency programs.¹⁰
 - o **18 months** following re-activation for **two-year** residency programs.
 - o **24 months** following re-activation for programs **longer than two years**. In cases where there is one or more foundational training year(s) in the program, the deadline may be extended to allow for the residents to enter the specialty-specific portion of their training. For example, the follow-up will be **30 months** following activation of residency programs that include two years of training in Surgical Foundations.

⁸ The OSE may be notified by email at accredadmin@royalcollege.ca.

⁹ The OSE may be notified by email at accredadmin@royalcollege.ca.

¹⁰ This timeline may also apply to two year subspecialty programs that allow up to one year of double counting with training within the primary discipline.

- iv. Inclusion in the Regular Accreditation Survey: Reactivated programs with a follow-up by internal review or external review may be included in the next regular survey if the regular survey is scheduled to take place close to the applicable deadline. For example, programs with deadlines within six months of the regularly scheduled onsite review will be included in the onsite review; programs with deadlines between six and twelve months may be included in the onsite review, at the discretion of the postgraduate dean in consultation with the program director. Refer to section 5.3a for additional details.
- v. Withdrawal due to Inactivity: Accreditation is immediately withdrawn from a program that becomes inactive with a status of “Accredited Program on Notice of Intent to Withdraw Accreditation”. In addition, accreditation is immediately withdrawn from programs which are continuously inactive across two consecutive regular surveys. See section 5.4e (Withdrawal of Accreditation).

5.5 Deadlines

Upon receipt of an application or accreditation review, the OSE commits to completing the processing of documentation in a timely fashion such that the application or accreditation review can be considered by the Res-AC at the next possible opportunity.

a. Missed Deadlines

Decision letters are sent to postgraduate deans, care of their PGME office, following the review of each application and program by the Res-AC, specifying the accreditation status and required follow-up. These letters indicate the due date for completion of the follow-up review, for consideration at the relevant upcoming Res-AC meeting.

For programs requiring follow-up by External Review, the discussion of scheduling and logistics is typically initiated months in advance of the deadline by the OSE staff and/or the relevant PGME office. As a result, there is less opportunity for a deadline to be missed, although requests for extension of deadlines do occur (see subsection 5.5b).

For programs requiring follow-up by Internal Review or Progress Report, the OSE sends reminders to postgraduate offices regarding upcoming or late submissions. To ensure consistency and clarity in the process, an operational policy was developed that articulates the roles and responsibilities of the OSE and PGME offices and, ultimately, the consequences of failure to submit a progress report or an internal review by the deadline (see appendix H, Policy: Missed Deadlines). This policy does not apply in cases where a Faculty/School of Medicine has requested and been granted an extension for the submission of a progress report or internal review; such requests will continue to be considered by the Royal College on a case-by-case basis (see subsection 5.5b).

In rare instances when the submission of documentation (PSQs, other supporting documentation) for an External Review is not received by the deadline, the policy and procedure outlined in Appendix H will be operationalized by the OSE and the Res-AC.

b. Extensions

Recognizing that circumstances do occur that are outside of the normal course of business and beyond what can be reasonably anticipated, the OSE considers requests for extension of deadlines for accreditation reviews on a case-by-case basis. Such requests must be submitted in writing to the OSE¹¹ by the postgraduate dean, and must state the program, the follow-up review, and the rationale for the request for extension.

¹¹ The OSE may be notified by email at accredadmin@royalcollege.ca.

The OSE will make every effort to accommodate requests for extension where the date of consideration by the Res-AC does not change (i.e., where the accreditation review will be considered by the Res-AC at the same meeting). For requests for extension where the date of consideration by the Res-AC (and hence, consideration of the program's accreditation status) would be delayed, the OSE will consider the rationale provided and any potential risks to the residency program or its residents, based on the program's accreditation status and accreditation history.

5.6 Appeals and Requests for Reconsideration

Despite the checks and balances in the accreditation process, there may be occasions when the Faculty/School of Medicine feels that a decision taken by the Res-AC is unfair or in error.

Reconsideration of an Accreditation Decision

A request for reconsideration of an accreditation decision may relate to a concern that facts were not obtained or were misinterpreted by the survey team, that inordinate weight was placed on some areas of weakness in a program by the survey team or the Res-AC, or that the Res-AC was unusually harsh in its decision. Section 7.4 includes details of appeal and request for reconsideration of Res-AC decisions.

Review of a Cited Standard on the Grounds of Standards Interpretation

A request for clarification regarding the interpretation of one or more general standards within an official decision letter can be made by the postgraduate office if they feel the cited standard may have been interpreted incorrectly. Section 7.5 outlines the process a postgraduate office is to follow should they wish to request the review of a cited standard on the grounds of standards interpretation.

5.7 Program Changes

a. Program Directors

The Royal College recognizes **one** program director per accredited residency program. This program director is ultimately accountable for the quality of the residency program, and is accountable to the Faculty/School of Medicine overseeing the residency program. How the program is operationalized in practice is at the discretion of the Faculty/School of Medicine. For example, it is acceptable to have associate or co-program directors; however, the Royal College will only recognize one individual as the program director.

The Royal College maintains a public list, posted on the Royal College website, of all residency programs that are accredited by the Royal College, including the name and contact information of the program director. Accordingly, the Faculty/School of Medicine must notify the OSE in writing by completing a standard form when there is a change in program director. The form must be submitted to the Royal College by the postgraduate dean's office.

Process for Review of Program Director Appointment Changes

The OSE reviews all requests for changes and new appointments of program directors of accredited residency programs. For cases where new program directors are not Royal College certified in the relevant discipline and the specialty-specific standards of accreditation (SSA) for the discipline specify that Royal College certification or *equivalent qualifications* are acceptable to satisfy Standard B1.1, input from the specialty committee is needed to ensure the change in program director meets the SSA requirement. In these

cases, the OSE will request information regarding the program director's qualifications from the postgraduate dean; this information is then sent to the Specialty Committee for consideration. The Specialty Committee is asked to provide a written decision as to whether the qualifications may be considered equivalent to Royal College certification in the discipline. This decision is conveyed to the university, the onsite accreditation survey team and the Res-AC to inform the review of the program. Universities may initiate this process at any time as part of the consideration of candidates for program director roles by contacting the OSE.¹²

b. Other Program Changes

In addition to changes in program directors, Faculty/School of Medicine offices must inform the Royal College¹³ if there are major changes in an accredited program, or if major changes in the circumstances of an accredited program threaten the educational quality of the program. Such changes could include;¹⁴

- significant turnover in teaching faculty impacting education;
- a significant increase or decrease in program enrolment numbers affecting the clinical resources available to the program;
- concerns about the learning environment, including intimidation and harassment, affecting education; or
- addition/removal of one or more clinical teaching sites impacting education.

Process for Review of Other Program Changes

Upon receipt of a notification of a program change, the OSE will bring forward that information to the Res-AC at its next meeting; the Res-AC will review the situation and may request additional information and/or require an accreditation review, as appropriate.

¹² The OSE may be notified by email at accreditation@royalcollege.ca.

¹³ The OSE may be notified by email at accreditation@royalcollege.ca.

¹⁴ Determination of any further program changes and whether or not a notice to the Royal College is appropriate is the purview of the PGME office.

6. INTER-INSTITUTION RESIDENCY PROGRAMS & AFFILIATION AGREEMENTS

The Royal College accredits only those programs that provide opportunities for residents to meet all of the educational requirements of the relevant discipline and does not accredit components of a program (see section 5.2a).

Nevertheless, the Royal College recognizes that, while a Faculty/School of Medicine may have the resources required to support a partial, but not complete, residency program, there may be compelling reasons for that medical school to be involved in residency education in a particular discipline (e.g., regional need for physicians). In addition, faculties/medical schools with adequate resources to support a complete residency program may have compelling reasons for residents in that program to complete a portion of their training at another educational site affiliated with a different university. Accordingly, the accreditation process accommodates several forms of inter-institution residency programs, provided the following requirements (subsection 6.1) are met.¹

General guidelines that apply to all types of inter-institution agreements:

- All inter-institution affiliation agreements (IIAs) must be up-to-date and in writing, signed by both/all postgraduate deans involved in the program, when provided to the Office of Specialty Education (OSE) prior to either a regular onsite accreditation review or an external review; and,
- All inter-institution affiliations must be initiated and kept up-to-date by the sponsoring or home institution.

6.1 Types of Inter-Institution Residency Programs: Accreditation Requirements

a. Program Completion Agreements

Definition: This type of inter-institution affiliation is required when a medical school has sufficient resources to provide most of the required components of a residency program, but lacks the resources to provide one or more essential elements as defined by the discipline's specialty-specific standards.²

Requirements:

- The program at the home school **must** be accredited by the Royal College. The program at the receiving school must also be accredited by the Royal College.
- The home school must enter into a written IIA with an accredited program ("receiving" school).
- The IIA must specify that the receiving program will receive residents and provide them with those program components that are not available in the sponsoring program.
- In accordance with the general standards, the home school **must** have a program director and Residency Program Committee (RPC). This RPC must include representation from the receiving school as a mandatory component of training. There must be clear and effective communication between the RPC and the receiving university.

¹ The exchange of residents between two accredited programs does not require special permission from the Royal College.

² Note that this type of affiliation does not apply to medical schools or programs that can offer all mandatory components of a program but wish to send residents to another medical school for an elective component of the program. This type of affiliation must be less than 50% of the total requirements for the residency programs and usually applies when 1 or 2 rotations are completed at the "receiving" school.

- The agreement must include the details of the program components to be provided to the home program's residents, including the length of the rotation(s), if applicable.
- Administrative arrangements for the resident rotations/educational experiences and assessment must be arranged by the home program (regardless of funding arrangements). Assessments conducted at the receiving school for the given program component(s) must be provided to the home school as part of the residents' file.
- The home school remains responsible for the endorsement of the residents' certificates of completion of training (i.e. Final In-Training Evaluation Form, FITER).
- With respect to accreditation, the Faculty/School of Medicine with the home program has ultimate responsibility for demonstrating that all aspects of the program comply with the standards of accreditation. The component(s) of the program taken at the receiving school will be considered within the context of the home program.

Implications: Accreditation of the home program **is contingent** upon maintenance of the IIA unless, at the time of review, the program can demonstrate that it can offer all required aspects of the discipline as required by specialty-specific standards.

b. Satellite Program Agreements

Definition: This type of IIA is required for programs with a home/satellite relationship, where residents complete a significant portion³ of residency training in one Faculty/School of Medicine without an accredited program in the discipline (known as the **satellite school**); however, residents complete/fulfill their training objectives at a second Faculty/School of Medicine, with a complete accredited program (known as the **home school**).

Requirements:

- The institutions of **both** the home and satellite school programs **must** be recognized by the Royal College. Recognized institutions include the 17 currently recognized Faculties/Schools of Medicine in Canada and those international institutions that have undergone a successful Royal College institutional review (i.e. with "Recognized Institution" status).
- The program at the home school **must** be accredited by the Royal College and **must** be in good standing.⁴ The program located at the satellite school is not independently accredited by the Royal College, but is rather considered part of the accredited program at the home location.
- The Faculties/Schools of Medicine of the home and satellite schools **must** enter into an IIA, specifying the terms of the program, including the relationship between the two faculties/schools for integrated processes such as resident selection, teaching and assessment, and remediation.
- The home school **must** be responsible for the endorsement of the residents' certificates of completion of training (i.e. Final In-Training Evaluation Form, FITER).
- In accordance with the general standards, the home school **must** have a program director and Residency Program Committee (RPC). In addition, the satellite school's portion of the program **must** be overseen by an associate program director and a RPC or subcommittee. This RPC must include representation from the home school.
- With respect to accreditation, the Faculty/School of Medicine with the home program has ultimate responsibility for demonstrating that all aspects of the program comply

³ No more than 60% of the residency training requirements.

⁴ Programs in good standing are considered to be those with the accreditation status of "Accredited Program", regardless of follow-up. Programs with the accreditation status of "Accredited Program on Notice of Intent to Withdraw Accreditation" are not considered to be in good standing.

with the standards of accreditation. As such, the accreditation status of the home program is dependent on the quality of all components of the residency program, including those at the satellite school.

- o During the onsite accreditation review of the home program, all satellite components of the program will be reviewed; travel and expenses for surveyors to visit the satellite component(s) of the program will be borne by the two Faculties/Schools of Medicine and not by the Royal College.
- o The satellite faculty/school **must** collaborate with the home faculty/school in the accreditation process, and also in the follow-up of the accreditation decision.
- o For the mid-cycle internal review, the satellite school's institution **must** conduct its own internal review of the satellite school's component of the program that includes all aspects of the program at that school. This internal review must include representation from the home school(s) and the final report must also be shared with the home school(s).

Implications: Recognition of a satellite school's component of the program as credit for training towards the Royal College examination and certification **is contingent** upon maintenance of the IIA with the home school. Accreditation of the program at the home school is **not** contingent upon maintenance of the agreement.

c. Offsite Location Agreements

Definition: This type of IIA is required when a Faculty/School of Medicine has a complete accredited residency program in a particular discipline, but wishes to have its residents rotate to another educational site, for a mandatory core component of the program, affiliated with a different university⁵ that does not have an accredited program in that discipline, for a portion of their training.⁶

Requirements:

- The program at the home school **must** be accredited by the Royal College. There is no program located at the receiving educational site that is independently accredited by the Royal College; rather, the educational site is considered part of the accredited program at the home location.
- The program at the home university must enter into an IIA agreement, specifying the offsite location at the receiving university that will receive residents and provide them with the desired training.
- In accordance with the general standards, the home school **must** have a program director and Residency Program Committee (RPC). This RPC should include representation from the receiving educational site. There must be clear and effective communication between the RPC and the receiving university.
- Administrative arrangements for the resident rotations and assessments must be made by the sponsoring program (regardless of funding arrangements).
- Administrative arrangements for the resident rotations/educational experiences and assessment must be arranged by the home program (regardless of funding arrangements). Assessments conducted at the receiving school for the given program component(s) must be provided to the home school as part of the residents' file.
- The home school remains responsible for the endorsement of the residents' certificates of completion of training (i.e. Final In-Training Evaluation Form, FITER).

⁵ This university does not have to be an institution recognized by the Royal College, but must be an academic institution. Educational sites not affiliated with a university may still be used as an educational site, but must be addressed by an institutional affiliation agreement via the home university.

⁶ The maximum amount allowable under this type of IIA is 20% of the program components at one offsite location and is required for a mandatory rotation not an elective.

- With respect to accreditation, the home school has ultimate responsibility for demonstrating that the rotation(s) or educational experience(s) at the offsite location complies with the standards of accreditation.

Implications: Accreditation of the program at the initiating university is not contingent upon maintenance of this type of inter-institution affiliation, provided residents no longer rotate to the offsite location for the rotation(s) or experience(s). Recognition of the rotation(s) or experience(s) at the offsite location as credit for training towards the Royal College examination and certification **is contingent** upon maintenance of the IIA.

d. Conjoint/Network Residency Program Agreements (programme réseau)

Definition: This type of IIA is required when two or more Faculties/Schools of Medicine collaborate to offer a single residency program in a particular discipline. Accreditation of a conjoint program implies that a complete program in the discipline is not available at any of the sponsoring universities, or that it makes most sense from the perspective of exposure to clinical and educational experiences for the universities to collaborate to offer a complete learning experience to the residents. The integration of two (or more) medical schools in the delivery of a residency program must have positive advantages for residents and must not be for the purpose of redistributing services.

Requirements:

- The two (or more) Faculties/Schools of Medicine must enter into a written IIA agreement, specifying the terms of the conjoint program.⁷
- The conjoint/network program is considered a single program and **must** be accredited by the Royal College.
- There **must** be a single RPC for the conjoint program, with representation from each of the universities involved in the conjoint program.
For the purposes of the Royal College, the conjoint program **must** be overseen by a single residency program director who is accountable for the residency program; the **home** Faculty/School of Medicine is considered to be that where the single program director is affiliated.
 - How the program is operationalized in practice is at the discretion of the Faculties/Schools of Medicine involved in the program. For example, it is acceptable to have associate or co-program directors and residency program committees (and subcommittees) at each of the sites. There must be clear and effective communication between the RPC and each of the networked sites.
- The RPC, via the **home** school, is responsible all aspects of the program, including resident assessment, and the endorsement of the residents' certificates of completion of training (i.e. Final In-Training Evaluation Form, FITER).
- With respect to accreditation, the **home** school has ultimate responsibility for demonstrating that all aspects of the program comply with the standards of accreditation. As such, the accreditation status of the network program is dependent on the quality of all components of the residency program. As such, the educational components at all sites participating in the conjoint or network program will be reviewed.
 - During the onsite accreditation review of the program, all components of the program will be reviewed; travel and expenses for surveyors to visit the necessary component(s) of the program will be borne by the Faculties/Schools of Medicine and not by the Royal College.
 - For the mid-cycle internal review, an internal review of the conjoint/network program **must** be conducted that includes all aspects of the program.

⁷ Both faculties/schools of medicine must be recognized by the Royal College.

Implications: Accreditation of the conjoint program **is contingent** upon maintenance of the IIA.

6.2. Review Process

All IIA agreements at a **home** university are reviewed and updated at the time of the university's regular onsite accreditation review. In addition, all aspects of the review of any program with an IIA agreement, including meetings with residents, faculty and the RPC, must reflect the IIA, to ensure a complete evaluation of the program.

Between regular onsite accreditation reviews, any additions, removals or amendments to IIAs must be approved by the Residency Accreditation Committee (Res-AC).⁸ Requests are reviewed according to the following process:

1. Receipt of the Request by the Office of Specialty Education (OSE)

Applications for the amendment, removal or addition of an IIA agreement must be submitted using the appropriate form, to the OSE, through the postgraduate dean at the university. Upon receipt of an application, the Royal College will send an acknowledgement letter to the requesting postgraduate office.

2. Review of the Request by the Specialty Committee

Once the submission has been received and acknowledged by OSE, the documentation is circulated to the voting members of the relevant Specialty Committee for their comments and recommendation. These recommendations are collated by the chair of the Specialty Committee and provided to the OSE.

3. Final Decision by the Residency Accreditation Committee

The Res-AC will consider the request for addition, removal or amendment of the IIA agreement at its next meeting and, in doing so, will take into account the recommendation of the Specialty Committee. Following the meeting, the OSE will send a decision letter to the postgraduate dean of the university, informing them of the Res-AC's decision regarding the IIA agreement and any implications for the accreditation of the program.

⁸ Inter-institution affiliation agreement forms are available from the Educational Standards Unit of the Royal College at accredadmin@royalcollege.ca.

7. GENERAL POLICIES

7.1 Code of Conduct

The Office of Specialty Education requires that everyone involved in its activities, including staff and volunteers, conduct themselves responsibly and honestly when representing the Royal College. To this end, it maintains a Code of Professional Conduct, which addresses confidentiality and privacy as well as issues of competing or conflicting interests.

a. Conflict of Interest

For volunteers involved in the Royal College residency education accreditation process, a conflict of interest arises whenever their past and/or current professional, personal, and/or academic experiences impair, potentially impair, or could be perceived to impair, their ability to perform their accreditation duties with integrity, fairness, objectivity, and honesty.

Volunteers should declare any potential conflict that may be perceived to positively or negatively influence them in their role, by signing a declaration of potential conflict of interest statement. The final decision as to the actual effect of the declared potential conflict of interest – and therefore appropriate mitigating action, if any – is at the discretion of the Royal College.

There is potential for actual or perceived conflict of interest in accreditation where, in relation to the faculty of medicine or program undergoing an accreditation activity:

1. A volunteer or his/her immediate family members (defined as a spouse, life partner, child, parent, or sibling) have been connected as a student, graduate, faculty member, administrative officer, staff member, employee, or contracted agent within the past five years;
2. A volunteer or his/her immediate family members have interviewed for employment within the past five years or have immediate plans to apply for employment;
3. A volunteer has ever been denied promotion or dismissed;
4. A volunteer's associated faculty of medicine is located in the same province or territory, or in such close geographic proximity, that there can reasonably be considered competition for resources or financial or other advantage with the faculty or program undergoing accreditation;
5. A volunteer is engaged in substantial cooperative or contractual arrangements with the program, faculty of medicine, or the university;
6. A volunteer or his/her immediate family members have any financial, political, professional, or other interest that may conflict with the interests of the Royal College;
7. A volunteer has participated in more than one role (e.g., surveyor and Specialty Committee member) with respect to an accreditation activity for a particular faculty of medicine and/or program (including mid-cycle internal reviews); and
8. A volunteer is engaged in active collaboration with a current faculty member or resident in the residency program undergoing accreditation.

7.2 Complaints

While the Royal College has a regular cycle of accreditation visits in which it surveys each residency program at least every six years, with more frequent follow-up if there are problems, there are nevertheless cases where complaints against a residency program should arise outside the regular or follow-up accreditation processes required by the college.

It is important to note that the Royal College, in its role of reviewing the quality of residency programs and their compliance with the accreditation standards, does not adjudicate disputes between parties, nor does it serve as an investigatory agent or appeal mechanism for issues such as resident selection, promotion or dismissal; harassment and intimidation; or contract disputes. Such matters must be addressed via the appropriate mechanisms of the faculty of medicine sponsoring the residency program. Residents may also choose to seek advice from the appropriate provincial residents' association.

Failure of the faculty of medicine within the university to address such an issue in a manner prescribed by the *General or Specific Standards of Accreditation* may be cause for involvement of the Royal College. In such cases, where there is change in circumstances of a program or demonstrated non-compliance with the accreditation standards, the Residency Accreditation Committee will monitor the situation and may require a reevaluation of the accreditation status of the program.

Procedure for Complaints

The following procedure will be followed when complaints are received by the Royal College.

1. A signed letter clearly outlining the complaint must be sent to the Director, Specialty Education, Strategy, and Standards of the Royal College. Anonymous complaints will not be considered.
2. Letters of complaint will be treated as public documents and copied to the university. Confidentiality will be maintained only if requested; however, in some cases it may not be possible to fully evaluate some complaints under such conditions. In such cases where, based on judgement of the Director of Education, it is necessary to disclose the name of the complainant(s), written permission will be sought.
3. Further information will be sought from the postgraduate dean of the faculty of medicine. In cases where the allegations include the postgraduate dean, information will be sought from the dean.
4. If, in the judgement of the Director, Specialty Education, Strategy, and Standards, the allegations made against the program might, if proven, constitute grounds for re-evaluating the accreditation status of the program, all of the information gathered will be considered at the next meeting of the Residency Accreditation Committee, at which the committee may decide that:
 - i. there are no grounds for re-evaluating the accreditation status of the program (i.e. no further action is needed and the program will maintain its current accreditation status);
 - ii. the situation will be monitored by the Residency Accreditation Committee while handled by the university;

- iii. a revision of the accreditation status may be required after further evaluation, through a mandated internal review conducted by the faculty of medicine or a special external survey conducted by the Royal College;¹ or
 - iv. while there are concerns, they may best be evaluated at the next regularly scheduled accreditation survey, in which case the survey team will be made aware of the concerns.
5. The complainant(s) and the postgraduate dean will be informed in writing of the decision of the Residency Accreditation Committee, including any required follow-up resulting from that decision.

7.3 Intimidation & Harassment

The Royal College, CFPC and CMQ developed a conjoint position paper regarding accreditation and the issue of intimidation and harassment in residency education, which includes guidelines for surveyors and programs (see Appendix J).

7.4 Appeal Policy: Request for Reconsideration of Residency Accreditation Committee Decisions

1. Introduction

This policy dictates the procedures that will be followed to ensure a standardized mechanism in the event of an appeal for reconsideration of a Residency Accreditation Committee decision.

2. Scope

Based on a set of criteria and as per the procedure noted below, postgraduate (PG) deans, on behalf of their residency programs, are granted the opportunity to make a single appeal for reconsideration of an accreditation decision.

3. Policy

An appeal for reconsideration must be based on the same information available at the time of the program review; changes or improvements in the program following the completion of the program review will not be considered in the appeal.

Therefore, appeals will only be considered valid on the following grounds:

- A lack of due process during the review; or
- A factual error in the interpretation of the information provided to the survey team for the purposes of the onsite review; or
- Concerns that the decisions made by the Residency Accreditation Committee reflect a misapplication of the criteria for the award of an accreditation status.

The procedures noted below have been written in reference to the decision-making body to which the appeal is directed; the Accreditation Committee. Should the Accreditation Committee uphold the appeal, the implication is that the decision regarding the

¹ Note ii (i.e. continued monitoring) may evolve to iii.

accreditation status of the program is final. Appellants only have a single opportunity to appeal: that is, if the appeal is not upheld (i.e. it is rejected), it cannot be further appealed to the next committee within the governance structure.

4. Procedures

- 4.1. A written request to appeal a decision of the Residency Accreditation Committee must be submitted by the PG dean to the Office of Specialty Education (OSE) within 60 days of the date of the letter transmitting the Residency Accreditation Committee's decision (i.e., decision letter). Requests received after the 60 days will not be considered.
 - 4.1.1. To be considered complete, the request must refer to the appeal criteria (due process, misinterpretation of information, decision-making unduly harsh), stating the reasons why the Residency Accreditation Committee's decision should be reevaluated.
- 4.2. The OSE will review the appeal to ensure the request is complete.
 - 4.2.1. If it is not, the OSE will confer with the appellant to complete the appeal request.
 - 4.2.2. If complete, the OSE will then notify the Chair of the Residency Accreditation Committee that the decision is being appealed.
- 4.3. The appeal for reconsideration is sent to the Chair of the Accreditation Committee² for initial review and consideration. The OSE will provide the Chair of Accreditation Committee with the information which was available to the Residency Accreditation Committee at the time of its decision as well as the transcript from the meeting and the request from the postgraduate dean, including the rationale for the appeal.³
- 4.4. The Chair of the Accreditation Committee will appoint the appeal panel consisting of three members from the Accreditation Committee, not including the chair of the Residency Accreditation Committee or any individual involved in the original decision. Once the panel has been appointed, one of the appeal panel members is designated as its chair.
- 4.5. After reviewing the material provided, the appeal panel will rule on whether or not there are grounds for reconsideration by the Accreditation Committee, and what those grounds are, and will communicate this decision in writing to the Royal College.
 - 4.5.1. If the appeal panel rules that there are not grounds for reconsideration by the Accreditation Committee, the PG dean office will be informed of this decision in writing.
 - 4.5.2. If the appeal panel rules that there are grounds for reconsideration, the program will be reviewed by the Accreditation Committee at its next meeting. This review will be based on the information available to the Residency Accreditation Committee at the time of the original consideration; no new information will be considered. Following the meeting, the Accreditation Committee's decision will be communicated in writing to the PG Dean's office via a decision letter.
- 4.6. The decision by the Accreditation Committee is final and may not be further appealed.

² Where the Chair of the Accreditation Committee has a conflict of interest (refer to the conflict of interest policy), the Chair of the Committee on Specialty Education will appoint the appeal panel

³ In this case, a conflict for the Chair of the Accreditation Committee would include but not be limited to if they were a faculty member in the university requesting the reconsideration, a member of the survey team.

7.5 Process for considering requests to clarify the interpretation of a general standard

The process to request a review of a cited standard, within an official decision letter, based on the grounds of standards interpretation is:

1. Postgraduate deans and offices, on behalf of the accredited program, may at any time since the program's last accreditation review request a review of a cited weakness in a decision letter, to clarify the interpretation of the relevant standard(s).⁴
2. The request will be brought to the next meeting of the Res-AC for consideration. In reviewing the request, the Res-AC will discuss the committee's interpretation of the standard(s), including the application to the particular program(s) in question.
3. A letter will be provided back to the postgraduate dean on behalf of the program, outlining the interpretation of the relevant standard(s). This letter may include clarity on how the weaknesses could be addressed at the next onsite accreditation review of that program, as applicable.
4. If the Res-AC deems that the interpretation provided may be beneficial to all universities, a general memo clarifying the interpretation of the relevant standard(s) will be issued to all postgraduate deans and their offices to assist them in the preparation for future program reviews.

⁴ Like the request for a reconsideration or appeal of an accreditation decision, any such request must be received from the relevant postgraduate dean and/or office. Requests for reconsideration from individual programs will not be considered.



Accreditation of Special Programs

In the context of Royal College discipline recognition, a small subset of disciplines have been labeled “special programs”, in that they do not meet any of the other categories of discipline recognition set out by the Royal College’s Committee on Specialties. As a result, most of these “special programs” have unique features that necessitate adjustments to the model of accreditation generally applied to residency education. These programs include Surgical Foundations, Palliative Medicine, and the Clinician Investigator Program.

Surgical Foundations (SF)

Eight primary surgical specialties require Surgical Foundations, namely Cardiac Surgery, General Surgery, Neurosurgery, Orthopedic Surgery, Otolaryngology – Head and Neck Surgery, Plastic Surgery, Urology, and Vascular Surgery.¹ A Faculty/School of Medicine wishing to have an accredited program in one of these primary specialties must also sponsor a Surgical Foundations program that complies with the Objectives of Training (OTR) or Specialty Training Requirements (STR) documents for Surgical Foundations. [OTR, SSF & STR link RC website](#)

As of 2013, the *Standards for Surgical Foundations (SSF)* [Standards for Surgical Foundations \(SSF\) link RC website](#) apply to accreditation of all Surgical Foundations programs in Canada. Responsibility for demonstrating that surgical programs comply with the *SSF* in addition to the general and specialty-specific standards of the surgical discipline is shared between the Surgical Foundations program and the primary surgical specialty program(s).

The review of Surgical Foundations programs for the purpose of accreditation is conducted according to the regular accreditation cycle, and integrated into the onsite accreditation survey process for surgical programs. Specifically, all surveyors assigned to the review of one or more surgical programs that require Surgical Foundations participate in a two-hour review of Surgical Foundations, which takes place the morning of the first day of the survey. This Surgical Foundations review includes:

- Review of documents (e.g., learning objectives, curriculum, resident assessments),
- Meeting with SF Director, and
- Meeting with SF Committee (including resident representatives, if applicable).

No category of accreditation is awarded to Surgical Foundations; a decision letter, however, is provided to the Faculty/School of Medicine which includes any cited strengths or weaknesses. A copy of these strengths and weaknesses is also attached to the other surgical specialty programs that were reviewed during the onsite accreditation review.

For surgical programs that are off the regular cycle of accreditation reviews, the Surgical Foundations Advisory Committee (described below) plays an active role in the accreditation review process.

Surgical Foundations Advisory Committee

Surgical Foundations Advisory Committee (SFAC), with voting representation from each region of Canada, acts as stewards for the foundational, horizontal curriculum known as Surgical Foundations. The role of the SFAC in the accreditation process is to develop discipline-specific standard requirements (STR, OTR, SSFs) and associated accreditation documentation, and to provide consultative input to the surveyors and the Residency Accreditation Committee, based on

¹. As of July 1, 2016, Obstetrics and Gynecology will also include Surgical Foundations in its training.

a review of the documentation for program reviews, including pre-survey questionnaires, accreditation reports, and applications, as appropriate. Input provided by the SFAC is of particular importance in evaluating the structure and organization of the SF program, the relationship between SF and the primary surgical programs that incorporate SF, as well as the program's academic content and its teaching and assessment of the CanMEDS competencies.

The SFAC is specifically asked to:

- a. develop and review periodically the *Objectives of Training (OTR)*, *Specialty Training Requirements (STR)*, and SSF documents for Surgical Foundations;
- b. develop and review periodically the SF specific portions of the pre-survey questionnaire, which is used to obtain information on programs to be surveyed or otherwise reviewed;
- c. review applications for accreditation of a new surgical program at a Faculty/School of Medicine, if no surgical programs currently exist;
- d. review pre-survey documents and provide comments and suggestions to assist the onsite surveyor(s);
- e. review progress reports, reports of mandated internal and external reviews, and reports from regular accreditation surveys (in cases where surgical foundations is cited as a weakness in a surgical program);
- f. nominate individuals from the specialty or subspecialty to be members of the survey team for external reviews of specific programs and for regular surveys; and
- g. regularly review the summary of strengths and weaknesses of all SF programs, with the aim of identifying systemic issues, maintaining national standards, and providing support to programs in continuous quality improvement.²

Palliative Medicine

Residency training programs in Palliative Medicine are currently³ conjointly accredited by the CFPC and the Royal College, according to a framework developed collaboratively by the two colleges, which includes:

- 1) Conjoint Specific Standards of Accreditation (SSA) [Conjoint Specific Standards of Accreditation \(SSA\) link RC website](#).
- 2) Procedures for the Review of a Conjoint CFPC/RCPSC Palliative Medicine Program. (Attached)
- 3) Conjoint RCPSC/CFPC Guidelines for Appeals of Palliative Medicine Residency Programs. (Attached)

Clinician Investigator Program (CIP)

The Clinical Investigator Program is considered a special program according to its category of discipline recognition, with implications for its specialty-specific standards. CIP's standards, which include Specialty-specific Standards of Accreditation (SSA), Objectives of Training (OTR) and Specialty Training Requirements (STR) documents, can be accessed using this [link](#). From an accreditation perspective, however, CIP programs are accredited according to the regular accreditation process (see section 5).

² This review is an important part of Specialty Committees' reports to the Committee on Specialties in the discipline review process.

³ It is anticipated that the current conjoint program for Palliative Medicine will be sunset as of July 1, 2017, after which time the Royal College will recognize only the two-year subspecialty in Palliative Medicine, and the CFPC will maintain its own one-year program of added competence.



Operational Policy & Procedure: Residency Accreditation Committee Meeting Procedures

The following operational policy guides the process of review of both programs and applications by the Residency Accreditation Committee (Res-AC).

Program Reviews

1. The chair of the Res-AC states the name of the program and the reviewers.
2. The first reviewer¹ presents:
 - a. the recommendation of the survey team, if applicable (i.e., regular survey, external review), the recommendation of the Specialty Committee, and his/her own recommendation regarding the status of accreditation;
 - b. a brief summary of the program's history, including the accreditation status and follow-ups, if any, and the associated timeline;
 - c. whether the program has an inter-institution affiliation agreement in place and, if so, whether this agreement is still required (and up-to-date); and
 - d. the weaknesses cited following the preceding program review, if applicable, and whether these weaknesses have been adequately addressed.
3. The first reviewer discusses the program's level of compliance with each of the general and specialty-specific standards and then makes a motion regarding the category of accreditation to be awarded, as well as the list of strengths and weaknesses to be included in the decision letter.
4. The second reviewer¹ indicates whether or not s/he supports the first reviewer's motion. If s/he concurs with the comments provided by the first reviewer, it is not necessary to make additional remarks. If s/he disagrees with any of the first reviewer's comments or wishes to make additional comments, the reasons should be stated and these comments must be linked to an accreditation standard and/or criteria for the accreditation status/category of accreditation.
5. For regular onsite accreditation reviews of programs and external reviews, the dean and/or the postgraduate dean, as available, are provided with an opportunity to comment on the program and the comments made by the reviewers.
6. Committee members are asked for any comments, questions, and discussion. Issues over which there is a need for clarification or disagreement are discussed.
7. Voting members of the Res-AC vote anonymously on the motion.
9. The Chair states the decision of the Committee, which is recorded by the Office of Specialty Education (OSE).
10. The first reviewer electronically submits a comment sheet, which includes a summary of the Res-AC's decision and any strengths and weaknesses to be cited in the decision letter (all of which must be associated with an accreditation standard) to the OSE. For progress reports, the reviewer is asked to stipulate which weaknesses in particular require a response in the progress report.

¹ The first and second reviewers are identified for each program and application on the reviewer assignments sheet, circulated prior to the meeting. Reviewer assignments are allocated by the staff of the OSE, based on a number of business rules to ensure even distribution of workload and to prevent conflict of interest (see section 7.1). Residency Accreditation Committee members are responsible for notifying the staff of the OSE of any conflicts of interest that might affect their review of a program or application and which thus requires reassignment.

Application Reviews

The Res-AC conducts application reviews according to the same process as that for program reviews, with the exception that applications are also assigned a third reviewer, who is responsible for reviewing only the goals and objectives of the application under review (as well as the goals and objectives for one or more additional applications), which are evaluated against Standard B2. The purpose of this review of goals and objectives is to improve the consistency of the threshold applied by the Res-AC, specifically with respect to this section of the applications. The first and second reviewers do not comment on the goals and objectives.

Process for Consent Agenda programs

1. Only programs that have a previous status of Accredited Program with follow-up by Regular Survey **AND** have uniformly received a recommendation of **Accredited Program with follow-up by Regular Survey** from the survey team and the Specialty Committee will have the possibility of being exempted from discussion during the Res-AC meeting.
 - a. Consistent with the current process, these programs will still be assigned to two Res-AC reviewers. The standard pre-meeting review will continue to be done by these two reviewers.
 - b. Should both reviewers agree with the recommendations of the survey team and specialty committee, the program will be exempted from discussion during the Res-AC meeting. The strengths and weaknesses of the program noted by the reviewers will be compared to ensure cohesion. In the circumstance that the recommendation of the two reviewers differs, the program will be discussed at the Res-AC meeting in a manner akin to the current process.
 - c. A list of programs that will not be discussed at the Res-AC meeting will be circulated in advance of the meeting. If a Res-AC member has concerns with a program not being discussed, he or she may request in advance of the meeting that the program be discussed at the meeting.
 - d. At the Res-AC meeting, the Chair will highlight the programs that were exempted from discussion. The strengths and weaknesses of the programs will still be presented by the Chair, and unless a Res-AC member requests that a particular program be discussed, no discussion will occur. Instead, a vote will be taken by the Res-AC for a recommendation for Accredited Program with follow-up by Regular Survey. Consistent with the current process, the programs will receive a decision letter with their strengths and weaknesses, as well as an explanation on their exemption from discussion at the meeting.
2. Any program recommended for Accredited Program with follow-up by Internal Review or External Review, or for Notice of Intent to Withdraw Accreditation to the Res-AC, will automatically be discussed at the meeting in a manner akin to the current process, i.e. presented by two reviewers followed by discussion.
3. Any program that has a previous status of Accredited Program with Follow-up by Progress Report, Internal Review, External Review, or Notice of Intent to Withdraw Accreditation, regardless of whether the program is now recommended for Regular Survey, will automatically be discussed at the Res-AC meeting, in a manner akin to the current process, i.e. presented by two reviewers.
4. Any program where the survey team and the Specialty Committee do not agree on the category of accreditation to be recommended, or where the Specialty Committee recommendation has a split vote or is not received, will automatically be discussed at the Res-AC meeting in a manner akin to the current process, i.e. presented by two reviewers followed by discussion.

Summary of approach to survey team members present at the Residency Accreditation Committee²

Principles

1. Survey team members will be recused for programs that they reviewed as a surveyor/co-surveyor. Res-AC member will be excused for discussions of only that program at a university in which s/he was the Royal College surveyor for that program at the most recent review and is the author or co-author of the current survey report on the program. Therefore, these individuals will be provided with a list of programs that they reviewed and will be asked to leave the room during the discussion and vote.
 - a. This approach would not apply to the **consent agenda** summary and programs (as there is no discussion, etc.), but perhaps we could ask that they could be asked to vote "abstain" for the consent agenda vote.
2. Survey team members will be allowed to remain in the room for programs that they did not review. These members will be allowed to remain in the room but their participation in reviews, discussion and voting will depend on whether or not they were present for the discussion of the program at the onsite review.
 - a. For programs where they **were** present, they will not be involved in reviewing the programs as an assignment, and will not participate in the discussion. They will be allowed to vote (to count towards quorum) but will be asked to vote "abstain" for these programs³. We will provide them with a list.
 - b. For programs where they **were not** present, they may be involved in reviewing the programs as an assignment, but only as a second reviewer. They may participate in the discussion, and vote.

² See also Conflict of Interest policy.

³ This same condition will apply to Specialty Committee Chairs who provided a recommendation for a program being reviewed at the Res-AC meeting.

Principles

To ensure equity in the review of English and French programs, reviewers must have a clear picture of the programs under review and the information necessary to make a sound recommendation. The objective of the translation policy and procedure is to facilitate consistency of accreditation processes at the Royal College in both official languages, while also increasing efficiency and reducing the workload for Specialty Committee and Residency Accreditation Committee (Res-AC) members in conducting program and application reviews.

The cost of translation associated with the accreditation of residency programs in Québec, in disciplines recognized by the Collège des médecins du Québec (CMQ), is shared equally between the Royal College and the CMQ.

Translation Procedures

Regular Surveys, External Reviews, Internal Reviews and Progress Reports

For the review of regular surveys, external reviews, internal reviews and progress reports, appendices submitted in French will not be translated. One individual from the relevant Specialty Committee will be assigned by the Specialty Committee chair to review the appendices on behalf of the Specialty Committee and provide recommendations to the Specialty Committee. The Res-AC will focus on the content of the main documents (i.e., the PSQ, survey report and/or progress report) rather than the content of the appendices.

As mentioned above, for the review of progress reports, the appendices will not be translated unless it is required to explain the evidence presented (as deemed by the Office of Specialty Education), in consultation with the Faculty/School of Medicine to ensure the Specialty Committee and Res-AC can evaluate whether the weaknesses have been addressed.

Applications

The process for review of appendices for applications differs from that for regular onsite accreditation reviews, external reviews, internal reviews and progress reports, based on the feedback received from the members of the Specialty Committees and several Res-AC members emphasizing the importance of the appendices for new program applications.

For the review of English applications the voting members of the Specialty Committee will receive and review the appendices along with the application and provide their feedback directly to the chair of the Specialty Committee. That recommendation will be available in the reviewer package for the Res-AC.

For the review of French applications, the following documents will be translated:

- Appendix C (assessment forms),
- Appendix D (program policy on resident safety),
- Appendix G (goals and objectives),
- Appendix H (overall goals of the programs),
- Appendix I (inter-institution affiliation agreements, if any), and
- Appendix J (formal academic curriculum).

The following appendices will not be translated:

- Appendix A (PGME letter of support),
- Appendix B (letters of support),
- Appendix E (research grants), and
- Appendix F (faculty publications).



Review of Resident Files – Accreditation Review

Review of Resident Files – Accreditation Review

Purpose

During the accreditation process and the review of university residency programs, Royal College surveyors review a selection of resident files. These files are selected and reviewed to allow surveyors to evaluate the quality of the program's assessment processes, to determine the program's compliance with the general and specialty-specific standards of accreditation, and most notably, the Standard B6, Assessment of Resident Performance. The purpose is not to review in detail the circumstances surrounding an individual resident's performance, or to investigate or serve as an arbitration body for issues such as remediation, appeals, or dismissals.

Selection of Resident Files

Only those files of residents who have consented to the review of their file may be provided to the surveyors during the accreditation review. In addition, the selection of resident files must include a sample from the program, including a representative sample across resident year (PGY).

In addition, to allow surveyors to evaluate the quality of the assessment process, particularly surrounding Standards B1.3.4.1 and B6.4, the selected resident files must include a sample of residents in the program who are experiencing performance difficulty and/or are on remediation, if applicable. This sample of residents in performance difficulty/on remediation must include a cross-section of outcomes, as applicable, including but not limited to those processes that:

- a) have resulted in acceptable performance/progression in the program;
- b) have resulted in temporary suspension and/or leave from the program;
- c) have led to a formal appeal within the program and/or university; and,
- d) have resulted in dismissal from the program.

Accessibility of Resident Files during the Accreditation Review

Resident files selected for the review by surveyor(s) during the accreditation review, as per the guidelines above, must be made accessible to the surveyor(s) while onsite during the review. It is the program's responsibility to ensure the protection of the residents' privacy by limiting access to the files during the review. If the files are provided in hard copy, those files may be provided in the interview room accessible by the surveyor(s). If they are automated, it is suggested to arrange access to a computer, ensure that it is easy to navigate and retrieve the relevant files, and provide assistance or a demonstration, as required.

Accreditation Committee

Role

The Accreditation Committee (AC) is a subcommittee that reports to the Committee on Specialty Education. The AC provides oversight for the decisions regarding all institutions, programs, and providers that are accredited by the Royal College, as well as oversees the quality of the Royal College's accreditation systems, including policies, standards and processes.

Responsibility and Authority

The Accreditation Committee's core responsibilities are to:

- Make recommendations to the Committee on Specialty Education regarding policies, standards, and criteria relating to the accreditation of Canadian and international residency programs and institutions, Continuous Professional Development (CPD) providers and activities, simulation centres, and Areas of Focused Competence (AFC) programs, as appropriate; and
- Offer an appeal mechanism for any accreditation decisions made by any of its subcommittees.

The Accreditation Committee also delegates authority regarding specific accreditation decisions (e.g., for particular programs or centres, etc.) to five subcommittees—Residency Accreditation Committee, Continuing Professional Development Accreditation Committee, Simulation Accreditation Committee, International Program Review Accreditation Committee, and AFC Accreditation Committee—as outlined in their respective Terms of Reference.

Composition

The Accreditation Committee has 14 voting members, including the chair and a vice-chair. The chair is a member of the Committee on Specialty Education. The composition of the committee also includes:

- Chair, Areas of Focused Competence Accreditation Committee (ex-officio);
- Chair, International Program Review Accreditation Committee (ex-officio);
- Chair, Residency Accreditation Committee (ex-officio);
- Chair, Continuing Professional Development Accreditation Committee (ex-officio);
- Chair, Simulation Accreditation Committee (ex-officio);
- Three (3) Fellows-at-large with experience in accreditation and/or experience in medical education across the continuum;
- One (1) Collège des médecins du Québec (CMQ) representative (ex-officio);
- One (1) Federation of Medical Regulatory Authorities (FMRAC) representative (ex-officio);
- One (1) Specialty Resident representative, as selected from two nominees from Resident Doctors of Canada (RDoC); and
- One (1) Specialty Resident representative, as selected from two nominees from the Fédération des médecins résidents du Québec (FMRQ).

The Accreditation Committee also has eight (8) non-voting members. This includes: an

individual from the Accreditation Council for Graduate Medical Education (ACGME), Accreditation Council for Continuing Medical Education (ACCME), Association of Faculties of Medicine of Canada (AFMC), Canadian Resident Matching Service (CaRMS), College of Family Physicians of Canada (CFPC), Secretary to the Committee on Accreditation of Canadian Medical Schools (CACMS), Secretary to the Committee on Accreditation of Continuing Medical Education (CACME) and the Federation of Medical Regulatory Authorities (FMRAC) are also invited to attend meetings as observers and as such shall not be counted for the purposes of establishing quorum.

Key Competencies and Characteristics

Committee members should possess the following key competencies and characteristics: experience and expertise in standard setting and/or program evaluation; demonstrated knowledge of the policies, processes, and standards related to accreditation; general knowledge about the principles and practices of the accreditation subcommittees; and an ability to integrate strategic thinking and risk management in the formulation of accreditation policies and standards.

Members should have previous senior experience in medical education, preferably serving in such roles as program director, divisional/departmental head, CME/CPD Dean (or equivalent), postgraduate dean or specialty committee member, CME/Education Chair (or equivalent) of an accredited national specialty society, or senior level university faculty.

Term of Office

The usual term of office of the chair is two years, renewable once (maximum of four years). The term of the vice-chair is one year, renewable three times (maximum of four years). The usual term of office for members is two years, renewable twice (maximum of six years). The terms of office take effect as stipulated so long as the member's total years of service on the committee do not extend beyond 10 years.

All terms shall begin and end at the time of the Annual Meeting of the Members when vacancies need to be filled.

The chair and all voting members of the committee require appointment by the Executive Committee of Council (or the CEO if it is a midterm appointment). Non-voting members do not require approval of the ECC or the CEO.

Meetings

The Accreditation Committee usually meets twice per year. Business may be conducted electronically at the discretion of the committee coordinator.

Quorum consists of a majority of the voting members of the committee (i.e., 50% plus one). The chair is counted as a voting member in constituting quorum. However, as the presiding official of the committee, the chair does not move motions. Furthermore, the chair shall only vote when the vote is conducted by secret ballot or when it is necessary to break a tie.

Appointment to a Royal College committee carries significant responsibilities and requires



absolute discretion. Committee members shall not divulge, re-produce, or release any confidential information except when authorized by the Royal College.

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Residency Accreditation Committee

Role

The Residency Accreditation Committee is a subcommittee that reports to the Accreditation Committee. Its major role is to ensure that Canadian residency programs accredited by the Royal College meet the requirements and guidelines for accreditation of residency programs and are conducted in a manner that permits graduates of the programs to achieve a level of competence compatible with Royal College certification.

Responsibility and Authority

The Residency Accreditation Committee has the following responsibilities and authority:

- Develops, maintains, and recommends to the Accreditation Committee policies, standards, and criteria relating to the accreditation of Canadian residency programs;
- Assesses applications for accreditation of new residency programs or for modifications of accredited programs;
- Reviews the reports of periodic evaluations of accredited residency programs through on-site surveys and other means; and
- Determines the level of accreditation to be granted to each residency program, within Royal College regulations and policies.

Composition

The Residency Accreditation Committee has 24 voting members, including the chair and a vice-chair. Seven (7) of the voting members are ex-officio, as listed below. The chair is a member of the Accreditation Committee. The chair or a designate is also a member of the International Program Review Accreditation Committee (IPRC) to ensure consistency between domestic and international accreditation of residency programs. The Residency Accreditation Committee's composition is determined as appropriate and includes Fellows, residents and others.

- Two (2) members from the Association of Faculties of Medicine of Canada (AFMC);
- One (1) representative from the Collège de Médecins du Québec (CMQ);
- One (1) representative from the Federation of Medical Regulatory Authorities of Canada (FMRAC);
- One (1) Specialty Resident representative, as selected from two nominees from Resident Doctors of Canada (RDoCs);
- One (1) Specialty Resident representative, as selected from two nominees from the Fédération des médecins résidents du Québec (FMRQ);
- One (1) Chair or designate from the IPRC, to ensure consistency between the domestic and international accreditation of residency programs; and
- Seventeen (17) Fellows at large.

There are 10 non-voting member positions. These include: individuals from the Association of Canadian Academic Healthcare Organizations (ACAHO), Accreditation Council for Graduate Medical Education (ACGME), AFMC, Canadian Resident Matching Service (CaRMS), College of



Family Physicians of Canada (CFPC), Collège des médecins du Québec (CMQ), Secretary to the Committee on Accreditation of Canadian Medical Schools (CACMS) and resident organizations of RDoCS and FMRQ are also invited to attend meetings as non-voting observers and as such shall not be counted for purposes of establishing quorum.

Key Competencies and Characteristics

Generally, committee members should possess the following key competencies and characteristics: experience and expertise in postgraduate medical education; knowledge of all facets of the postgraduate medical education system in Canada; demonstrated knowledge of the policies, processes, and standards related to accreditation; and ability to integrate strategic thinking and risk management in the formulation of accreditation policies and standards.

Members should have previous senior experience in medical education, preferably serving in such roles as program director, divisional/departmental head, postgraduate deans or specialty committee member, or senior level university faculty.

Term of Office

The usual term of office of the chair is two years, renewable once (maximum of four years). The term of the vice-chair is one year, renewable three times (maximum of four years). The usual term of office for members is two years, renewable twice (maximum of six years).

The terms of office take effect as stipulated so long as the member's total years of service on the committee do not extend beyond 10 years. All terms shall begin and end at the time of the Annual Meeting of the Members when vacancies need to be filled.

Meetings

The Residency Accreditation Committee usually meets face-to-face three times per year and additionally via teleconference or web-based meeting, as needed.

Quorum consists of a majority of the voting members of the committee (i.e., 50% plus one). The chair is counted as a voting member in constituting quorum. However, as the presiding official of the committee, the chair does not move motions. Furthermore, the chair shall only vote when the vote is conducted by secret ballot or when it is necessary to break a tie.

Appointment to a Royal College committee carries significant responsibilities and requires absolute discretion. Committee members shall not divulge, re-produce, or release any confidential information except when authorized by the Royal College.



International Residency Program Review and Accreditation Committee

Role

The International residency Program Review Accreditation Committee (IPR-AC) is a subcommittee that reports to the Accreditation Committee. The Accreditation Committee has delegated responsibility to the IPR-AC for the development and oversight of the international accreditation process, including international program review for residency programs.

The primary role of the IPR-AC is to support a process for international program accreditation for residency education. The committee accomplishes this role through the development of international standards and an objective process to determine what level of program review is appropriate for each jurisdiction requesting such a review. In addition, the IPR-AC will ensure that international residency programs accredited by the Royal College meet the requirements and guidelines for accreditation and are conducted in a manner that permits graduates of the programs to achieve a level of competence comparable to the graduates of Canadian residency programs.

Responsibility and Authority

The IPR-AC is responsible to the Accreditation Committee for the processes related to international program review and international accreditation. All standards will be equivalent to current accreditation standards and policies. Criteria will be aligned as much as possible with existing accreditation policies and criteria relating to Canadian programs.

The IPR-AC has the following responsibilities and authority:

- Develops, maintains, and recommends to the Accreditation Committee the policies, standards, and criteria for recognition of international programs, International Accreditation Standards, and the categories of accreditation for international accreditation;
- Reviews the reports of international programs which have been reviewed; and
- Determines the level of accreditation to be granted to each international residency program, consistent with Royal College standards, regulations, policies, and guideline.

Composition

The IPR-AC will have 10 voting members, including the chair and a vice-chair. The committee will also include the chair or designate of the Residency Accreditation Committee to ensure consistency between domestic and international accreditation of residency programs, and a representative from the Board of Royal College Canada International. The chair of the IPR-AC will also be an ex-officio voting member of the Accreditation Committee. The composition of the IPR-AC is determined as appropriate and includes Fellows and others.



Key Competencies and Characteristics

Generally, committee members should possess the following key competencies and characteristics:

- Demonstrated knowledge of Royal College accreditation standards;
- Experience in postgraduate medical education gained by participation in Royal College accreditation reviews or as demonstrated by experience as a Postgraduate Dean or Chair of a Specialty Committee;
- Knowledge of policies and procedures relating to accreditation of postgraduate training programs;
- An ability to integrate strategic thinking and risk management in the formulation of accreditation policies and standards; and
- Ability to strategize on new directions and processes for international accreditation.

It is preferable that members also have the following experience: participation in at least one international program review; and have been a member of the Royal College Residency Accreditation Committee.

Term of Office

The usual term of office of the chair is two years, renewable once (maximum of four years). The usual term of office for members is two years, renewable twice (maximum of six years). The terms of office take effect as stipulated so long as the member's total years of service on the committee do not extend beyond 10 years.

All terms shall begin and end at the time of the Annual Meeting of the Members when vacancies need to be filled.



Meetings

The IPR-AC meetings will be conducted face to face and via teleconference, two to four times per year.

Quorum consists of a majority of the voting members of the committee (i.e., 50% plus one). The chair is counted as a voting member in constituting quorum. However, as the presiding official of the committee, the chair does not move motions. Furthermore, the chair shall only vote when the vote is conducted by secret ballot or when it is necessary to break a tie. Appointment to a Royal College committee carries significant responsibilities and requires absolute discretion. Committee members shall not divulge, re-produce, or release any confidential information except when authorized by the Royal College.

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New Terminology for the CATEGORIES OF ACCREDITATION

Each program considered by the Accreditation Committee is granted an accreditation status or category of accreditation as outlined below. In order to maintain the integrity of the program, the Accreditation Committee does not separately accredit individual components of a program; rather the category of accreditation applies to the program as a whole.

Accredited New Program

Definition:

- An acceptable application for a residency program.
- Within 24 months¹ of a resident being enrolled, a College-mandated Internal Review of the program must be conducted.
- This review may be delayed until the first resident(s) enrolled in the program reaches the specialty-specific portion of the program, i.e. beyond a basic clinical year or surgical foundations years, to allow assessment of the educational aspects unique to the program.

Accredited Program

- 1) Accredited Program with Follow-up at the Next Regular Onsite Accreditation Review

Definition:

- Program demonstrates acceptable compliance with standards.
- Follow-up of the program will be by the following:
 - Regular Onsite Accreditation Review (in 6 years); and,
 - Normal University-governed internal review required at mid-cycle.

In addition to the Regular Onsite Accreditation Review and normal University-governed internal reviews, follow-up may also be required by one of the following:

- 2) Accredited Program with Follow-up by Progress Report

Definition:

- Specific issue(s) are identified and require follow-up only on the identified issue(s). A complete review of the whole program is not required.
- The written Progress Report is produced by the program director and is due within 12-18 months.

- 3) Accredited Program with Follow-up by College-mandated Internal Review

Definition:

- Major issues are identified in more than one standard.
- An Internal Review of the program is required and is conducted by the University.

¹ For Royal College programs, follow-up of the Internal Review is based on the length of the residency program according to the following timelines:

- **Nine months** following activation for **one-year** residency programs.
- **18 months** following activation for **two-year** residency programs.
- **24 months** following activation of programs longer than **two-years**. In cases where there is one or more foundational training year(s) in the program, the deadline may be extended to allow for the residents to enter the specialty-specific portion of their training. For example, the follow-up will be **30 months** following activation for residency programs that include two years of training in Surgical Foundations

- The Internal Review is due within 24 months.
- 4) External Review

Definition:

- Major issues are identified in more than one standard, with concerns that:
 - Are specialty-specific and therefore best evaluated by a reviewer from the discipline;
 - Have been persistent, i.e. present since the previous review(s); or,
 - Are strongly influenced by non-educational issues and therefore best be evaluated by a reviewer from outside the University.
- A focused (CFPC) or complete (Royal College) review of the program is required.
- The review is organized by the respective College.
- The External Review is conducted within 24 months.

Accredited Program on Notice of Intent to Withdraw Accreditation

Definition:

- Major and/or continuing non-compliance with one or more standards which calls into question the educational environment and/or integrity of the program.
- Follow-up will be an External Review that is conducted within 24 months by 3 people (2 specialists + 1 resident).
- Residents in the program or already contracted to enter the program, as well as all applicants to the program, *must* be advised immediately by the program director of the status of the program.
- At the time of the review, the program will be required to show why accreditation should not be withdrawn.

Withdrawal of Accreditation

Definition:

- Decision to withdraw accreditation of a program becomes effective immediately unless there are residents enrolled in the program in which case it becomes effective at the end of the academic year in which the decision is taken.
- No credit will be given by the respective College to any residents for training taken in a program once the accreditation of the program has been withdrawn.
- A request to reinstate the accreditation of such a program will not be considered by the Accreditation Committee for at least one year following the date of the decision of the Accreditation Committee.
- In those cases where accreditation has been withdrawn from a program because the program has been inactive, the one-year waiting period may be waived.

Accreditation will be immediately withdrawn from a program that becomes inactive following a notice of intent to withdraw accreditation.

A school may voluntarily withdraw a program but may not reapply for accreditation for at least one year from the date of withdrawal.

Approved by the RC Education Committee - April 2012
 Approved by the CFPC - June 2012
 Approved by the CMQ - May 2012
 Editorial revisions – January 2016



Process for Implementation of the "Accredited Program with follow-up by Progress Report" Category of Accreditation

1. Introduction

This document outlines the process for use of the "Accredited Program with follow-up by Progress Report" Category of Accreditation.

2. Eligibility

The category of "Accredited Program with follow-up by Progress Report" may only be used by the Residency Accreditation Committee (Res-AC); it may not be recommended by the survey team or the specialty committee.

Only programs with a recommendation by Res-AC reviewers of "Accredited Program with follow-up by Internal Review" are eligible for a final decision by the Res-AC of "Accredited Program with follow-up by Progress Report".

3. Residency Accreditation Committee Decision of "Accredited Program with follow-up by Progress Report"

The decision to award an accreditation status of "Accredited Program with follow-up by Progress Report" can be taken by the Res-AC according to the following process:

1. Motion to award "Accredited Program with follow-up by Internal Review" is moved and seconded.
2. Res-AC chair asks the Res-AC reviewers whether the program's identified weaknesses are "amenable to response through a written report as opposed to an internal review."
 - a. If the Res-AC reviewers' response is affirmative, a new motion to award an accreditation status of "Accredited Program with follow-up by Progress Report" is moved and may be seconded. The Res-AC reviewers outline the weaknesses which require follow-up on evidence being addressed in the progress report. The AC then votes on the motion.
 - b. If the Res-AC reviewers' response is negative, the Res-AC votes on the existing motion to award an accreditation status of "Accredited Program with follow-up by Internal Review."
3. The decision letter issued by the Royal College stipulates those weaknesses that require additional follow-up which must be addressed in the progress report as well as the documentation and evidence required to demonstrate the weaknesses have been addressed.

4. Submission of Progress Reports

Progress reports must be submitted by the program director and the postgraduate dean (both signatures are required) to the Educational Standards Unit of the Royal College within 12 months of the date of the decision letter.¹

5. Accreditation Committee Review of Progress Reports

Progress reports will be reviewed by the Res-AC at the next regularly scheduled meeting following submission to the Royal College. In reviewing progress reports, the Res-AC will

¹ The conjoint categories of accreditation state that "the written progress report is produced by the program director and is due within 12-18 months"; however, it is proposed that the default follow-up be 12 months to ensure consistency across Royal College programs as well as with the College of Family Physicians of Canada (CFPC). In cases where the Residency Accreditation Committee feels that more than 12 months is required it may specify in its motion that the follow-up by progress report should be within 18 months (versus 12).

consider the criteria for the categories of accreditation and the overall weaknesses of the program, including those previously listed which did not require follow-up by progress report² as well as those listed for follow-up by progress report and were not fully corrected. The Res-AC may confer a new status of accreditation of either:

- Accredited Program with follow-up at Next Regular Survey, if the concerns prompting the Progress Report have been adequately addressed, or,
- Accredited Program with follow-up by Internal Review, if the concerns prompting the Progress Report have not been adequately addressed.
- The status of Accredited Program with follow up by Progress Report cannot be awarded twice in succession.

The Faculty/School of Medicine will be notified of the decision of the Res-AC Committee via decision letter.

² Those weaknesses listed previously which were not deemed by the Residency Accreditation Committee to require follow-up by progress report are not considered recurrent weaknesses for the purposes of reviewing the progress report and awarding a new category of accreditation.



Procedure: Missed Deadlines for Royal College Program Reviews

1. Introduction

This document dictates the procedures that will be followed in the event of missed deadlines for Royal College program reviews, including regular reviews, external reviews, internal reviews and progress reports.

2. Scope

This procedure applies to any program review follow-up, including regular reviews, external reviews, internal reviews and progress reports mandated by the Royal College. This procedure does not apply in cases where a university has requested and been granted a deferral of a submission; such requests will continue to be assessed by the Royal College on a case-by-case basis.

3. Procedures for Internal Review or Progress Report

3.1 Decision Letter

- 3.1.1 In conveying an accreditation decision of "Accredited Program with follow-up by Internal Review" , "Accredited New Program" or "Accredited Program with follow-up by Progress report" via a decision letter, the Royal College will provide the university with a due date by which they must submit an internal review report and supporting documents.

3.2 Submission of Internal Reviews and Progress Reports: Follow-up and Due Date Extensions

- 3.2.1 The Educational Standards Unit (ESU) will provide a letter to all postgraduate medical education (PGME) offices annually outlining all upcoming accreditation reviews, including internal reviews and progress reports and the corresponding due dates for submission to the Royal College.
- 3.2.2 If the Royal College has not received the internal review submission or progress report one week prior to the deadline, the ESU will follow-up with the PGME office to provide a reminder of the upcoming deadline and to receive an update on the status of the submission.
- 3.2.3 If the Royal College does not receive the internal review submission or progress report by the due date, within two business days the ESU will follow-up with the PGME office in writing¹, requesting the internal review report or progress report and supporting documents by an extended due date of two - weeks from the date of the follow-up.
- 3.2.4 If the Royal College does not receive the internal review submission or progress report by the extended due date, within two business days the ESU will follow-up with the university in writing² a second time, requesting the internal review report or progress report and supporting documents by a due

¹ Follow-up by telephone or in person will be subsequently confirmed in writing.

² Follow-up by telephone or in person will be subsequently confirmed in writing.

date of two - weeks from the date of this second follow-up (an additional two - weeks from the first extended due date, for a total of four -weeks from the original deadline). The written request will be copied to the Associate Director, Education Strategy & Accreditation of the Royal College and the postgraduate dean (PG Dean) of the university.

- 3.2.5 If the Royal College does not receive the internal review submission or progress report by the second extended due date (four - weeks from the original deadline), within two business days the ESU will send a final correspondence to the PG Dean, copying the Dean of Medicine of the university, on behalf of the Associate, Director. The letter will outline the final deadline for submission (an additional two weeks from the second extended deadline, for a total of six weeks from the original deadline). It will also outline that should the internal review or progress report not be received by the final deadline, the internal review or progress report will not be reviewed at the upcoming Residency Accreditation Committee. The program's accreditation status will automatically change as per the procedure outlined below. This final written request will be copied to the Dean of Medicine of the university.

4. Procedures for Regular and External Reviews³

4.1. Decision Letter

- 4.1.1. In conveying an accreditation decision of "Accredited program with follow-up at the next Regular survey", "Accredited program with follow-up by External review" and "Accredited program on notice of intent to withdraw accreditation" via a decision letter, the Royal College will provide a deadline by which the external review must be conducted.
- 4.1.2. At least twelve months prior to the deadline, the ESU will contact the PGME office to schedule the external review.
- 4.1.3. Once the date for the external review has been confirmed by the Royal College, a deadline for the submission of the pre-survey questionnaire and supporting documents will be set.

4.2. Submission of pre-survey documentation

- 4.2.1. If the Royal College has not received the pre-survey documentation one week prior to the deadline, the ESU will follow-up with the PGME office to provide a reminder of the upcoming deadline and to receive an update on the status of the submission.
- 4.2.2. If the Royal College does not receive the pre-survey documentation by the due date, within two business days, the ESU will follow-up with the PGME office in writing (copying the PG dean), requesting submission by an extended due date of one week from the date of the original deadline.
- 4.2.3. If the Royal College does not receive the pre-survey documentation by the extended due date, within two business days, the ESU will send correspondence to the PG dean, copying the Dean of Medicine of the University, on behalf of the Associate Director, which will outline the final

³ External reviews include External Review and Notice of Intent for an onsite accreditation review.

deadline for submission (two weeks from the original deadline). This letter will also outline that should the pre-survey documentation not be received by this final deadline, the external review will be cancelled; the program will not be reviewed at the upcoming Residency Accreditation Committee, and the program's accreditation status will automatically change as per the procedure outlined below.

5. Implications for Programs' Accreditation Status

5.1. *If the Royal College does not receive the report or pre-survey documentation by the final extended due date (as outlined in 3.2.5 and 4.2.3, respectively), the program's accreditation status will be changed immediately. This change will be brought to the Residency Accreditation Committee, for information and final ratification.*

5.1.1. In cases where the program's pre-existing accreditation status was "Accredited program",⁴ the program's accreditation status will change to "Accredited program on notice of intent to withdraw accreditation" with a follow-up by external review. The external review will be arranged by the Royal College at the university's expense. The program will be formally notified of the due date for the external review which will be conducted by two external surveyors within six months of the final missed deadline date.

5.1.2. In cases where the program's pre-existing accreditation status was "Accredited program on notice of intent to withdraw accreditation", the program's accreditation will be withdrawn.

Summary Table of Decisions and Follow-ups for Missed Deadlines:

Accreditation Status	Accreditation Status Change	Follow-up (to be ratified by the Res-AC at their next meeting)
Regular survey	Notice of intent to withdraw accreditation	External review at the university's expense within six months of the missed deadline
Progress report	Notice of intent to withdraw accreditation	External review at the university's expense within six months of the missed deadline
Internal review	Notice of intent to withdraw accreditation	External review at the university's expense within six months of the missed deadline
External review	Notice of intent to withdraw accreditation	External review at the university's expense within six months of the missed deadline
Notice of intent to withdraw accreditation	Withdrawal of accreditation	Withdrawal of accreditation

⁴ This status includes all possible associated follow-ups: Regular Survey, Progress Report, Internal Review, or External Review.



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**The Royal College of Physicians and Surgeons of Canada
Office of Specialty Education: Code of Professional Conduct**

Please note: The Office of Specialty Education Code of Professional Conduct was first issued in August 2006. The RCPSC reserves the right to amend these policies at any time and without prior notification.

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1. PREAMBLE

The Office of Specialty Education of the Royal College of Physicians and Surgeons of Canada (RCPSC) sets the highest standards for its accreditation, certification and examination processes. As a result, the RCPSC is recognized globally for the quality and integrity of its activities. To implement its standards, the Office of Specialty Education requires that everyone involved in its activities conduct themselves responsibly and honestly when representing the RCPSC.

The Office of Specialty Education is responsible for a wide range of functions including program accreditation, candidate credentialing and certification examinations. At any given time, there are hundreds of people supporting these core business activities. To help promote consistency, clarity and transparency in its core activities, the Office of Specialty Education has created this *Code of Professional Conduct* to provide direction on the management of private and confidential information to describe appropriate measures to identify and manage competing interests.

The Office of Specialty Education's *Code of Professional Conduct* is further supported by a series of detailed policies and procedures that are targeted specifically to key user groups within the Office of Specialty Education. In particular, members of Examination Boards are provided with in-depth policies outlining the Office of Specialty Education's expectations for conduct before, during and following the examination process.

1.1 Scope

This *Code of Professional Conduct* is applicable to all RCPSC staff ¹and individuals acting on behalf² of the RCPSC.

The expected conduct, as outlined in this document is not exhaustive and should be considered as a supplement to good judgment. The fundamental principle is personal responsibility for professional conduct at all times based on the professional ethic long espoused by the RCPSC.

1.2 Expectations

Individuals are expected to know and comply with the policies in the Office of Specialty Education's *Code of Professional Conduct*. Individuals who violate, attempt to violate, or aid others in violating its provisions may face sanctions for their actions.

¹ Includes all permanent and contract employees.

² Includes, for example, surveyors, examination board members, standardized patients, members of Specialty Committees, standing committee and sub-committee members, guests and observers.

1.3 Misconduct

The Office of Specialty Education has a responsibility to its Fellows, future Fellows and the Canadian public to promote professionalism and ethical standards in its activities. For this reason, any alleged infraction of the Code of Professional Conduct will be investigated and managed appropriately.

Any individual witnessing or suspecting an infraction is honour bound to report the event to the Director of Education (or his/her delegate).

1.4 Key Terms

Confidential information – includes, but is not limited to, examination questions and model answers, scoring methods for examinations, statistics for pass / fail rates sorted by specialty and / or university, credentialing documents such as Preliminary Assessment of Training, questionnaires and Final In-Training Evaluation Reports.

Personal Information – includes, but is not limited to, an individual's name, age, residential address and phone number, e-mail address, examination scores and identification number. Personal information does not include job titles, business addresses and business phone/fax numbers.

Competing Interests – exist when an individual has personal, professional or financial relationships that could reasonably be perceived to inappropriately influence his/her actions or judgment. These relationships vary from those with negligible potential to those with significant potential to influence judgment. Not all relationships represent true competing interest and the potential for conflict can exist whether or not an individual believes that the relationship affects his or her judgment.

2. CODE OF CONDUCT

2.1 Confidentiality and Privacy

In an effort to maintain and improve its high standards for professional conduct, the Office of Specialty Education requires that everyone involved in its activities will abide by the following requirements when handling confidential information and data:

- a. Review the RCPSC General Privacy Statement regularly;
- b. Limit the collection, use and disclosure of personal information to the minimum required to conduct the activities;
- c. Be mindful that you are dealing with sensitive information and act accordingly;

- d. Use private and/or confidential information exclusively for the purpose that it was intended. When it is unclear whether it is appropriate to disclose the information to another person, seek the advice of the Director of Education (or his/her delegate);
- e. Avoid public discussions or comments about specific cases that relate to the activities of the Office of Specialty Education;
- f. Clearly label all confidential material as such;
- g. When transmitting confidential information attach a standardized disclaimer indicating that the material is i) intended for the use of the individual or entity to which it is addressed, and ii) may contain information that is privileged, confidential and exempt from disclosure; and
- h. Take all necessary precautions to dispose of personal and confidential information that is no longer required for operational purposes in a responsible and timely fashion.

2.2 Competing Interests

The Office of Specialty Education acknowledges that the people involved in its activities are persons of honesty and integrity. It also understands that these people have numerous relationships, interests and memberships within the national and international medical community.

Within each person's complex spheres of activities, there exist the potential for real or perceived conflict between their personal, professional, and business interests and the interests of the RCPSC and those that it serves. The Office of Specialty Education wishes to protect its representatives from sensitive or uncomfortable situations, and also to protect the RCPSC itself from situations that may undermine the integrity of the College's reputation and standing in the medical community. Therefore the Office of Specialty Education requires anyone involved in its activities to adhere to the standards of behavior set forth below.

- a. Recognize, avoid and disclose competing interests that arise prior to or in the course of your involvement in RCPSC activities;
- b. Once a potential conflict has been disclosed, abstain from participating in any further activities until such time that the Director of Education (or his/her delegate) determines whether it is, or is not, appropriate/advisable to continue to act in that particular capacity; and
- c. Do not request or accept any compensation or gift while representing the RCPSC.



ACCREDITATION AND THE ISSUE OF INTIMIDATION AND HARASSMENT IN POSTGRADUATE MEDICAL EDUCATION GUIDELINES FOR SURVEYORS AND PROGRAMS

BACKGROUND:

At the request of the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada (CFPC) and the Collège des médecins du Québec (CMQ) the current working group reviewed work done on this topic from 1996 to 2003. This includes the document by the previous working group and also the Ethics and Equity Committee. The goals were to develop further definitions and to clarify an approach to the problem that could advise programs, Universities and survey teams. We also have the CanMEDS competencies and Principles of Family Medicine, which govern attributes that are to be taught, evaluated and modelled.

“Intimidation is a form of abuse and, as with other forms of abuse, any is too much.” (Ref.1). It is clear that when behaviours of this nature are recognized in a program, there must be a response. This can be at the level of the program director, hospital unit, department or university. If there needs to be a formal review, this occurs via the postgraduate office or the office that deals with complaints of this nature. During a survey, the Chair’s team must review the office within the University that has the formal role of support and investigation. This will include the scope, numbers, decisions and resolutions. The survey team and surveyors will listen for comments on the educational environment. When there are allegations during a survey, they must be understood as fully as possible and even more important the university and program response must be clarified. The survey team will document comments during a survey, but ultimately the resolution is within the program, department and university.

A fair question to ask is whether this is a substantive problem that requires further clarification and action. The Royal College carried out a major survey of all Royal College residents graduating between 1995 and 1999 to assess aspects of intimidation and harassment experienced during their training. The preliminary findings were presented at the Royal College Educational Meeting in September 2001. This work clearly outlines that there is an on-going and substantial problem across a variety of Canadian training programs. The report indicated problems involving men and women in almost equal numbers although there were more male trainees overall. Although the dyads involved in abusive situations can be varied, the overwhelming majority of instances involve staff people towards residents. Given the inherent power differential between faculty and residents, this is not surprising. However, there are instances when a resident can exhibit inappropriate behaviour towards faculty. The same mechanisms can be used to investigate a complaint in either direction. Occasionally the situations involve more than one individual, but again, the vast majority are dyadic.

It is imperative that we strive towards supportive respectful learning environments in all of our training programs. At some universities there is a formal Code of Conduct governing behaviour and professionalism. Royal College standards require: “ensuring a proper educational environment free of intimidation and harassment with mechanisms in place to deal with such issues as they arise” (Blue Book A1:3.7). There is a detailed section in the

CFPC book that defines the learning environment (Red Book). The CanMEDS competencies of "professionalism", "collaboration" and "communication" are particularly relevant in helping to define this learning environment. The Four Principles of Family Medicine also emphasize these attributes. These are concepts of major importance that need to be understood and incorporated into training. There should be opportunities within the university for trainees and teachers in all disciplines to be involved in seminars and discussion sessions. These aspects of behaviour also need to be both modelled and evaluated as they are integrated into daily fundamental attitudes.

However, in reality, there will continue to be instances where problems occur and need attention. There must be mechanisms within each university that can both identify problems in the learning environment as they unfold and develop a response. One difficulty is that residents might suffer reprisals for complaints. Thus, there needs to be an identified individual or office within the university for safe and confidential reporting. This office must have the capacity to receive complaints, assess the information and start an internal process to review and resolve the problem.

DEFINITIONS:

As one attempts to give the universities and survey teams some mechanisms for review and an approach to identifying and resolving issues of intimidation and harassment it is useful to have some clarity about the actual definitions.

The terms intimidation, harassment and abuse tend to be used interchangeably. It is useful to review the technical Oxford and Webster Dictionary definitions:

1. Intimidate: terrify, overawe, cow, especially as to influence conduct. Force to do or deter from some action by threats or violence. Inspire with fear. To daunt or make afraid.
2. Intimidation: the act of intimidating someone in order to interfere with the free exercise of political or social rights. The fact or condition of being intimidated. The use of authority to influence someone to do or refrain from an action or to do something they would not do or should not do otherwise.

e.g. asked to do extra work; refraining from reporting patient events; falsely positive faculty evaluations. It can also include 'flattering' intimidation such as "you are different than the others so I wonder if you can."; "you're great, you never complain and I wonder if you could take on this task for me..."

3. Harassment: trouble by repeated attacks. Subject to constant molesting or persecution. Repeated, often public, critical remarks or ridicule. Singling out for grilling or interrogation. Unjustified negative remarks or inappropriately positive remarks about appearance or dress. Unjust assignment of duties.
4. Abuse: exploitation of trust and exploitation of authority. Improper use, perversion, reviling abusive language, injury, maltreatment. Types can include verbal, mental, psychological, physical and sexual.

It should be recognized that intimidation and harassment does not always have to be repetitive to be significant. A single incident can have an impact.

These terms are on a continuum with some overlap representing increasing severity to full abuse. One factor in confronting these issues is that as these problems have been identified and discussed over several years, there has been a shift away from using these words. They

are too laden with ominous meaning. Instead there is a tendency to shy away to euphemisms such as "unfortunate moment", "he/she was a bit off..." "that tendency popped up again". We need to help the learners and teachers address these issues with courage to clarify and hopefully to resolve. This remains a challenge, as the identification and exploration of these types of situations can often provoke defensive reactions.

It is important to emphasize that there are people whose personality style can be perceived as intimidating but they are not actually practising intimidation. They may be "austere, remote, demanding and have high standards." This is not intimidation, harassment or abuse providing that their requests for high performance are not injected with sarcasm or ridicule. Also, the process of training demands that feedback and constructive criticism be made regularly. This is not intimidation, again provided it is not done with ridicule. The inherent power differential between trainees and supervisors may invoke a degree of feeling intimidated or anxiety to perform well. This is not unique to medical training but is common in many situations of training and job performance. The distinction between being intimidated and feeling pressure to function well needs to be clarified for residents, programs, universities and survey teams.

PRINCIPLES

1. Timely identification of a concern about intimidation and harassment should be the goal of all programs.
2. Trainees should be encouraged to inform their program director or university administration of problems.
3. The initial discussion must occur in a confidential setting.
4. There should be a process to clarify the facts concerning the allegation.
5. The process of clarification must occur in an atmosphere free of retribution.
6. There should be a process to address and resolve allegations in a timely manner.

INVESTIGATING A COMPLAINT

UNIVERSITY

Concerns of this nature will continue to occur across our broad and complex teaching systems. Many instances of problems occur and are solved at a local level. Individuals that face a problem will choose a confidant with whom they are comfortable. This could be a Chief Resident, another staff or mentor, a site director or even another peer. Often resolution can occur without the problem being referred to the more formal university mechanisms. There is no way of knowing the frequency of such events and resolution nor is there any real need to know. If an immediate and local approach can solve matters, this is to everyone's advantage.

However, for the more difficult or persistent situations, it is essential to have an approach within the university that is thorough and can produce significant results and resolution.

Internal Reviews

All universities conduct their own Internal Reviews through the Postgraduate Medical Education office. These occur in at least the last two years in the six-year cycle between external full College accreditation visits. Some universities may find it advantageous to use Internal Reviews as an on-going mechanism for continuous improvement throughout the six years. This provides an organized opportunity to train the internal review surveyors to understand these questions and to help programs improve continually. This helps mitigate against surprise allegations at an external review.

Investigating Office

Each university must have a mechanism for investigation of their internal problems. There must be a person or office that is identified to receive this information, for example, an Associate Dean of Equity, the Associate Dean Postgraduate, or an Ombudsman. Each university must have a Code of Conduct or Standards of Professionalism that is foundational in defining the behaviour that is required throughout the institution and training programs.

This formal mechanism for support and investigation should be widely known. The authority for investigation should not be broad, but should reside primarily within this one office. This minimizes the opportunities for lack of confidentiality. This is of critical importance to everyone involved. Concerns are often not brought forward in an environment where confidentiality is uncertain. When concerns are discussed in a safe environment, this action alone often allows some strategies and resolution.

The reality of the sensitivity of many of these issues is such that most details never need be known even within the University, outside of the investigating office. However, a well-functioning office will be well known and accessible within the university. In some instances, this office must come to some conclusions and recommendations that need to be acted on. At this point of action, a Program Director, Associate Dean Postgraduate, Department Head or the Dean may need to be involved to carry out the recommendations. The courage and clarity with which a university has acted when necessary becomes part of the evaluation at an external full accreditation. In some rare instances, the problem may need intervention from outside the university. This can always be done as a review from the appropriate College at the request of the University.

CLARIFICATION DURING A SURVEY

Ideally, allegations should not surface de novo at external surveys. However, there will remain times when this is the mechanism of discovery or the opportunity for the raising of the issues.

First, a survey team must understand the university mechanism that exists for the clarification of complaints. This should be done as part of the review by the chairs team of the Standards. This review includes the function of the Postgraduate Office and should encompass a review of the office dedicated to this purpose, if one exists. If there is an Office of Equity or Officer that fulfills this role, that office should present to the team the process they use and the scope and number of instances that they deal with on a yearly basis. The scope and the types of recommendations and actions that resulted should also be reviewed. This will give the survey team clarity about the function of the university in monitoring and dealing with these issues. A university should be given recognition for a well functioning and tenacious process.

There are particular challenges when identification of intimidation is made at a survey during program reviews. Surveyors need a repertoire of questions to guide their approach. It is not enough to just document an allegation of intimidation. There must be follow-up questions. It is important to differentiate as much as possible between significant problems and allegations that are unfounded. It is possible to have complaints made by a disenfranchised individual. The mechanism of clarification must stay balanced and alert in the collection and assessment of the information.

Information that should be obtained by the surveyor when confronted during the visit with an allegation of intimidation or harassment include: clarification that the person making the allegation knows of a process to be followed in such cases; Was that process followed. If not,

why not? Was the incident reported to the program director? Another person? Was the outcome satisfactory?

It is important that the surveyor ask how the concepts of professionalism, collaboration and communication are taught and supported in the learning environment.

Another challenge is that there may be ambivalence and outright disagreement within a resident cohort as to whether issues of intimidation and harassment should be discussed. We have seen surveyors receive information that initially seems reliable but on wider discussion the residents recant and deny the concerns. This leads to confusion and frustration on all sides.

In the process of clarification by a survey team that is internal or external, it is important that the resident or person making the allegation not be left with the impression that the accreditation team will resolve the specific incident or pattern of behaviour. Rather, the team must ensure that the university is informed that an allegation has been made and has in place the means to identify and deal with such situations effectively. The goal is to determine an accurate understanding of how the system works to address the concerns and if it is an effective approach.

Allegations of these types of problems must be discussed during the survey teams meetings. Further clarification can occur between the Chair and the Postgraduate Dean.

The attempt to clarify the response to problems is critical. The individual survey reports should document the response that occurred within the program and university. Universities need to be given recognition for substantial processes that are in place and are carried out in a rigorous manner to address these problems. This should be reflected in the Chairs' report to the University and Accreditation Committees.

RESPONSE AT ACCREDITATION

First, if there is mention of intimidation or harassment in a program, the survey report should contain the answers to the types of questions previously outlined. This allows the program reviewer to understand the depth and severity of the problem and also the steps that have been taken to improve and provide solutions.

There is no standard response for all reports of intimidation and harassment in a program. However, it is important to underline that there must be some response. The issue cannot be ignored.

At times an incident may be isolated and it may be clear that the program and university have completely dealt with the problem. There can be instances of substantial problems that have been dealt with thoroughly. If there is sufficient awareness, a recognized office and mechanism and progress to address the problem, the accreditation status can stay at full approval.

If there is substantial doubt about the effectiveness of the process, the accreditation team may recommend a Provisional Accreditation status to be followed by an internal review or a special survey. This is a mechanism for the university and program to have the clout and awareness to deal with the problem. Rarely, problems may be so widespread and entrenched that consideration is given to using the category of Intent to Withdraw. Usually, if there are problems of this magnitude in a program, they will occur in many other areas. Thus the accreditation status does not rest on the issue of intimidation or harassment alone.

Overall, there is clear recognition and endorsement in all our universities and programs of standards of professional behaviour that are conducive to learning. The vast majority of teacher and learner interactions are positive and fruitful. These are some of the mechanisms to recognize and remediate those instances that remain problematic.

LITERATURE

1. Report of the working Group on Intimidation in Postgraduate Medical Education March 1996 and addendum 1998
2. 2000 Royal College Survey on Harassment and Intimidation. Preliminary findings presented at Royal College Annual Conference September 2001
3. UWO Code of Conduct
4. CanMEDS Competencies
5. CAIR pre-survey questionnaire
6. Royal College Workshop Education Meeting September 2002
7. Royal College General Information Concerning Accreditation of Residency Programs (Grey Book)
8. CFPC Standards for Accreditation of Residency Training Programs (Red Book)
9. UBC Professionalism Standards

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Approved October 2004
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