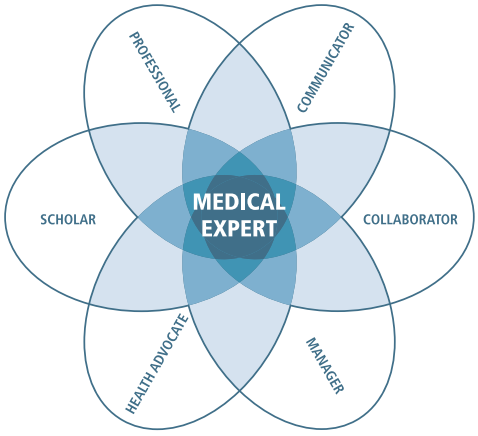
The Draft CanMEDS 2015
Physician Competency Framework

Series I | Series II | Series III

Editors

Jason R. Frank | Linda S. Snell | Jonathan Sherbino

September 2014



Competence by Design

CanMEDS 2015

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

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Medical Expert
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Communicator
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Collaborator
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Leader
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Draft CanMEDS 2015 Physician Competency Framework – Series III

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CanMEDS 2015

Contents

Introduction to the CanMEDS Series III draft

At a glance: What's new in Series III

- The Series III release of the Draft CanMEDS 2015 Physician Competency Framework incorporates more than 2,500 comments submitted by educators and clinicians from at least 14 countries. Thank you!
- For ease of use, the milestones have been moved from the framework to a companion document, the CanMEDS Milestones Guide.
- The Competence Continuum diagram depicting the stages of medical education has been updated on the basis of the feedback we received.
- The editors and the Integration Committee have used the feedback to make some tough choices in compiling Series III. We eliminated redundancy in the key and enabling competencies, reduced the number of enabling competencies by 12, consolidated the milestones by 16%, removed jargon in favour of more accessible language, and streamlined the text wherever possible.
- The Manager / Leader debate continues. We hope that consultations following the Series III release will help us arrive at a final decision.
- The editors and the Integration Committee have reaffirmed that the Communicator Role will house the competencies needed for physician–patient/family encounters. Other communication skills are included within the framework, such as those needed for team communication in the Collaborator Role.
- The CanMEDS 2015 milestones are a "palette," "toolkit," or "guide" for medical educators to use to describe the progression of competence for each discipline. We do not expect that educators will use all of the milestones when they tailor the framework to their discipline.
- The undergraduate (medical school) milestones have been removed from this draft of the framework at the request of the Association of Faculties of Medicine of Canada to make way for their own UGME milestones process. Prerequisite abilities to enter residency have been crafted and are included in the "Requirements for Residency" column of the draft Milestones Guide.
- Please continue to provide us with your feedback. We anticipate that the next version will be the draft sent to committees and organizations for endorsement.

An invitation to participate

The CanMEDS Framework describes the abilities physicians require to effectively meet the needs of the people they serve. Since its launch in 1996, CanMEDS has become the most widely accepted and applied physician competency framework in the world. Renewal is key to ongoing success: the Royal College is committed to updating the framework at regular, and practicable, intervals. The framework was last updated in 2005. With the CanMEDS 2015 project, the framework moves toward its third iteration.

In early 2013, thirteen CanMEDS 2015 Expert Working Groups were assembled to examine how the framework should be updated to meet the demands of contemporary practice. The EWGs examined the seven core CanMEDS Roles and provided advice on

integrating new content related to patient safety and quality improvement and to eHealth into the Roles. Their deliberations, together with input from national and international advisory committees and the Royal College Integration Committee, resulted in the release of the first draft of the CanMEDS 2015 Framework (known as Series I) for public consultation in February 2014. This draft framework was supported by individual reports from the EWGs explaining the rationale for their proposed revisions.

The Series II draft of the CanMEDS Framework included for the first time a series of "milestones" guidelines describing how the revised competencies can be acquired in a progressive fashion across the continuum of training, beginning in medical school. The focus of the Series III draft is residency and continuing professional development. A diagram depicting the continuum of training is presented in draft form as part of this Series III release.

The revisions in the Series III draft have been informed by input and feedback we received from over 1000 stakeholders between February and June 2014. A summary of the feedback has been released concurrently with this report.

This Series III document*—released in September 2014—contains a brief history of CanMEDS, a description of the objectives and methods of the CanMEDS 2015 project, an overview of key changes proposed, and a complete draft of the 2015 Framework. A companion document, the CanMEDS Milestones Guide, contains the revised milestones and has been released concurrently with this report.

Are we on the right track? Have we captured the essence of the medical competencies to meet today's challenges and prepare us to move forward? By sharing your reactions, comments, insights, and suggestions, you will help us to make the CanMEDS 2015 Framework and Milestones Guide better, more useful, and more comprehensive. All of the feedback we receive will be read, analyzed, and integrated into a report that will inform decisions about the milestones' content and design. An online survey will enable you to provide quick responses as well as open-ended comments on the CanMEDS Framework as a whole, on specific Roles, and on the CanMEDS Milestones Guide.

Please participate—and help to shape the world's most influential medical education framework!

September 2014

Jason R. Frank
Linda S. Snell
Jonathan Sherbino

* The Series III release of the framework is available in English and French. The working drafts of the milestone guidelines will be available in French when the milestones are finalized and officially released in 2015.

Acknowledgements

This update to the Royal College CanMEDS Physician Competency Framework could not have been accomplished without the participation of hundreds of dedicated medical educators, clinicians, residents, committee members, and staff who have contributed not only to the working drafts of the 2015 Framework and CanMEDS Milestones Guide, but to all of the earlier versions of the framework as well. This effort is about revision and renewal, not reinvention. We must therefore gratefully acknowledge the work of past contributors, on whose shoulders the CanMEDS 2015 Framework will stand.

We truly appreciate the dedicated work of the members of the Expert Working Groups, the Integration Committee, the National Advisory Committee, and the International Advisory Committee.† The commitment and expertise of the Chairs of the Expert Working Groups deserves special mention. Thank you to Farhan Bhanji, Ming-Ka Chan, Deepak Dath, Leslie Flynn, Bart Harvey, Kendall Ho, Eddy Lang, Alan Neville, Anna Oswald, Denyse Richardson, Jonathan Sherbino, Linda Snell, and Brian Wong. Sincere thanks also to Elaine Van Melle for her scholarly and research support to

† The members of these groups and committees are listed at the end of this document.

the Expert Working Groups and Royal College staff throughout the project.

We also recognize the important contribution of the CanMEDS 2015 Project Advisor, Cynthia Abbott, and we thank her for her leadership in developing a truly collaborative and consultative review process.

Finally, we thank all other participants in the CanMEDS 2015 project: ePanelists, focus group participants, survey respondents, and the 200 participants in "town hall" meetings. Their input will help to ensure the utility and validity of the CanMEDS 2015 Framework and the associated CanMEDS Milestones Guide.

The CanMEDS Framework

Fundamentally, CanMEDS is an initiative to improve patient care by enhancing physician training. From the beginning, its main purpose has been to articulate a comprehensive definition of the competencies needed for all domains of medical practice and thus provide a comprehensive foundation for medical education.

In the early 1990s, Fellows of the Royal College of Physicians and Surgeons of Canada, with support from the charitable institution Associated Medical Services, leveraged the important work of the Educating Future Physicians of Ontario project to develop a competency framework for specialist physicians. The result—the CanMEDS Framework—was formally approved by the Royal College in 1996. Since then, CanMEDS has been adopted by countries on five continents, making it the world's most recognized and most widely applied physician competency framework. The Royal College continues to be the steward and sponsor of the framework, and the current iteration is being prepared with input from major medical institutions around the world.

In Canada, CanMEDS forms the basis for all Royal College educational standards for specialty education. In recent years, it has been modified and formally integrated into the training of all family physicians in Canada through the College of Family Physicians of Canada. CanMEDS has been adopted by the Collège des médecins du Québec, the Medical Council of Canada, the Canadian Medical Association, and Canada's medical schools. This use of a national competency-based framework for medical training is one reason why the Canadian medical education system is regarded as among the best in the world.

The CanMEDS 2015 project: objectives and principles

To help prepare physicians to meet societal expectations in a dynamic and increasingly demanding health care environment, the Royal College is committed to keeping the CanMEDS Framework current and to facilitating its implementation in the real world of medical education and practice. In response to evolving trends and challenges in today's health care, the CanMEDS 2015 project aims to meet the following objectives, while working within the existing CanMEDS Roles:

- to update and add new content, particularly with regard to patient safety and quality improvement, intraprofessionalism, and eHealth
- to address the needs of front-line educators, who have asked for practical changes and updates to make it easier to teach and assess the CanMEDS Roles
- to develop and integrate new competency milestones to provide a guide to the practical application of the framework in residency training programs and throughout a physician's career

To meet these objectives, the participants in the CanMEDS 2015 revision process have adopted the following principles as foundational to their work:

- The process is one of revision and renewal: improvement, not reinvention, is the goal.

- The primary target audience will be the users of the framework: trainees, front-line teachers, program directors of various curricula, and clinician educators who design programs.
- The competency constructs need to be grounded in theory and best practices, while their presentation should be realistic and related to the daily practice of any physician.
- Generic competencies should be articulated for all specialties.
- Concepts that are relevant to multiple Roles should be articulated in the Role where they are the most prominent. Although redundancy and overlap are accepted, and even expected, in practice, the framework itself should avoid repetition while ensuring the appropriate integration of Roles.

CanMEDS 2015 and the Competence by Design initiative

The CanMEDS 2015 update is occurring in a special context. It is part of the Competence by Design initiative of the Royal College, a major, multi-year project to implement an enhanced model for competency-based medical education (CBME) in residency training and specialty practice in Canada.

The aim of the Competence by Design project is to improve the fundamental building-blocks of Canadian medical training. At its core is a move away from the practice of credentialing physicians solely on the basis of time spent on rotations and activities, and toward forms of assessment that examine the learner's achievement of milestones of competence. Therefore, the CanMEDS 2015 Framework will not only update the content of the Roles, but will also provide a set of proposed milestones across the continuum of medical education that can be applied both in curriculum development and in learner assessment. With the input of a consortium of key partners, including participating organizations in the Future of Medical Education in Canada Postgraduate project, the Competence by Design project will position Canadian medical education as the first in the world to integrate CBME across the full continuum of a physician's career.

CanMEDS 2015: a collaborative methodology

Those who use the CanMEDS Framework in education and practice need to be confident that it is a valid and practical foundation for excellence in patient care. Since its beginning in the 1990s, CanMEDS has been the product of an evidence-informed, collaborative process involving hundreds, if not thousands, of Royal College Fellows, family physicians, educators, and other expert volunteers. Its development has involved countless hours of literature reviews, stakeholder surveys, focus groups, interviews, consultations, consensus-building exercises, debate, and work on educational design. Many people in Canada and around the world feel that the strength of the CanMEDS Framework lies in the fact that it was made by physicians for physicians.

For the CanMEDS 2015 project, the Royal College has engaged as many experts and partners as possible to ensure that the next version of the framework is even stronger. As of September 2014, more than 2500* people have contributed directly or indirectly to the development of this working draft of the CanMEDS Framework. In early 2013, the Royal College created a series of committees and working groups, all of whom are contributing to the update process. Participants were recruited for a range of reasons, including their subject matter expertise, their representation of a particular stage of physician development, and their understanding of the health care and medical education systems. These groups and their roles are described below. A list of committee and working group members is given at the end of this document.

* To date, the CanMEDS 2015 project has involved 230 participants in ePanels, 100 Expert Working Group members, 29 National Advisory Committee members, 2000 survey respondents, and 200 participants in "town hall" meetings. The roles of the groups and committees are described below.

Expert Working Groups

With input from key partners, the Royal College assembled thirteen Expert Working Groups (EWGs) to examine the seven core CanMEDS domains. For the Scholar and Professional EWGs, subgroups were formed to focus on the distinct aspects of these Roles. Two additional groups were created to advise the EWGs on integrating new content related to Patient Safety and Quality Improvement and to eHealth across the existing seven CanMEDS Roles.

The thirteen EWGs are therefore as follows:

- Medical Expert
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar:
  - Lifelong Learning
  - Critical Appraisal
  - Teaching
  - Research
- Professional:
  - Professionalism
  - Physician Health
- Patient Safety and Quality Improvement
- eHealth

Each EWG is composed of medical educators and practising physicians from a range of specialties and provinces. They have helped to shape the revised framework, and they contributed their expertise in the development of the first draft of the milestones guide. The EWGs were tasked with

- reviewing the CanMEDS 2005 Framework to identify potential concepts requiring clarification or modification, as well as any gaps or redundancies in the existing CanMEDS competencies
- incorporating new themes such as patient safety and interprofessionalism into the framework
- developing draft milestones within each existing CanMEDS Role
- ensuring that the framework is practical and useful for education across the continuum
- acting on feedback from consultations and integrating relevant content into the revised CanMEDS Framework

CanMEDS 2015 National Advisory Committee

The CanMEDS 2015 National Advisory Committee provides strategic direction and input on the overall CanMEDS 2015 initiative and includes 29 representatives from a range of key stakeholders and partner organizations.

CanMEDS 2015 ePanels

To engage an even broader constituency in the development of the framework, the Royal College convened a series of ePanels open to anyone with an interest in reviewing and commenting on drafts of the framework. The various EWGs have and will continue to engage these panelists at critical junctures in their work. As of January 2014, more than 230 people had participated as CanMEDS 2015 ePanelists.

CanMEDS 2015 International Advisory Committee

The CanMEDS 2015 International Advisory Committee was convened to provide input on the overall CanMEDS initiative from a global perspective, with a view to the potential impact of the revised framework in other countries and jurisdictions. Members include representatives from a range of international stakeholders and partner organizations.

The Royal College Integration Committee

A small team of clinician educators from across Canada was commissioned to edit the framework. The role of the Integration Committee is to synthesize the contributions to the CanMEDS 2015 project into a coherent version of the new framework. These contributions include Expert Working Group reports, direction from the National and International Advisory Committees, survey and focus groups results, and reports from sister institutions worldwide.

Consultations—ensuring we get it right

Changes to the CanMEDS physician competency framework will have an impact on all levels of medical education in Canada. With help from key partners, we have undertaken a comprehensive consultation process to ensure we get it right. The data from these consultations are shaping—and will continue to inform—the iterative work of the CanMEDS 2015 EWGs.

2013 consultations—setting the stage for change. In 2013, consultations included sharing information about the project and gathering feedback regarding the strengths, weaknesses, and gaps of the 2005 Framework. Our tactics ranged from direct personal discussions with key audiences to more structured consultations. A summary report of the results of the 2013 consultations is available on the Royal College website.

2014 consultations—content validation. In 2014, our consultations are focused on gathering feedback on the draft framework and on the draft CanMEDS Milestones Guide. This stakeholder feedback will be key to shaping further revisions to these documents.

A summary report of the results of these consultations is available on the Royal College website.

Launching the CanMEDS 2015 Framework

The CanMEDS 2015 Framework and associated faculty development tools will be officially launched at the 2015 International Conference on Residency Education in Vancouver, British Columbia. The rollout of specialty-specific objectives of training and other associated resources will continue for several years after the launch of the framework, and will include support for faculty development from the Royal College.

What's new in CanMEDS 2015: content changes by Role

The following summary highlights areas where the draft CanMEDS 2015 Framework has changed from its most recent version (2005).

General changes

There is a renewed emphasis on the overall coherence of the framework and on its practical application.

- Role descriptions and definitions are expressed in simpler, more direct, language.
- Overlapping areas between Roles have been minimized; although aspects of a shared plan of care may pertain to more than one Role, the competencies expressed in a given Role should pertain specifically to that Role alone.
- Competencies and milestones describe the *abilities* to be demonstrated in practice, as distinct from the information or content related to aspects of a Role.
- Competencies in safeguarding and enhancing patient safety have been integrated throughout the framework, as recommended by the Patient Safety and Quality Improvement EWG and validated in early consultations.

Medical Expert

- The definition, description, and first key competency of the Medical Expert Role highlights the importance of integrating the six other Roles (the Intrinsic Roles).
- The concepts of complexity, uncertainty, and ambiguity have been included.
- The reference to providing expert legal testimony or advising governments has been presented as an enhanced expertise milestone that may be relevant to some, but not all, specialties.

- The Role has been updated to reflect some of the complexity in decision-making and clinical reasoning that occurs before, during, and after the completion of procedures.
- A key competency has been added to address the evolving recognition of patient safety and continuous quality improvement as important components of medical expertise.

Communicator

- The scope of the Communicator Role is now more explicit: it focuses exclusively on the interaction between physicians and their patients, including patients' family members, partners, and caregivers.
- Patient-centred and therapeutic communication are emphasized.
- Communication with other health care professionals is now covered explicitly in the Collaborator Role.
- The concept of cultural safety is now explicit.

Collaborator

- The concept of intraprofessional collaboration has been given explicit emphasis.
- A relationship-centred model of care is presumed.
- Value is placed on including the patient's perspective in the shared decision-making process.
- Collaboration is reflected more broadly, to extend beyond the context of a formalized health care team.
- A new key competency has been added to address handovers and care transitions.

Leader (formerly Manager)

- A name change for the Role from "Manager" to "Leader" has been proposed to reflect an emphasis on the leadership skills needed by physicians to contribute to the shaping of health care.
- Patient safety and quality improvement processes have been given increased emphasis.
- Emphasis has been placed on the development of skills to achieve a balance between professional practice and personal life.
- Resource allocation has been conceived as a function of good stewardship.
- Competence in health care informatics is viewed as crucial for medical leaders and managers and vital to the delivery of health care.
- Competence in ensuring patient safety and quality improvement, including through the incorporation of patient safety standards such as adverse event reporting, was added.

Health Advocate

- The definition and description of the Role have been expanded and refined.
- The notion of partnership in advocacy has been adopted.
- Competency in communicating with the public at large had been included in this Role as an "enhanced expertise" milestone.

Scholar

- The "life-long learner" component of the Scholar Role has been reorganized into three enabling competencies that reflect (1) both planned and opportunistic learning as well as the need to integrate learning into daily work, (2) the use of data from a variety of sources to guide learning, and (3) continuous learning as an active part of a community of practice.
- The concepts of patient safety and a safe learning environment have been explicitly added to the "teacher" component of the Role.
- A key competency on evidence-informed decision-making has been added; this is separate from

structured critical appraisal and has three enabling competencies of its own.

- There is a new emphasis on skills in structured critical appraisal.
- The concept of research has been broadened, and the contribution and dissemination of skills as a consumer of research are emphasized over those of a participant in research.

Professional

- There is now an increased emphasis on physician health and well-being.
- Key competencies have been reorganized to reflect the commitment of the physician to the patient, to society, and to the profession.
- The notion of commitment to actions or tasks is emphasized as germane to the Professional Role, as distinct from the specific actions or tasks themselves.

What's new in CanMEDS 2015: milestones

Unlike past updates, CanMEDS 2015 is part of the Competence by Design (CBD) project. This major initiative of the Royal College is intended to improve the fundamental building blocks of Canadian medical training. At its core, CBD is a move away from credentialing physicians solely on the basis of time spent on rotations and activities, in favour of assessing achievement on the basis of attained milestones of competence. The addition of these milestones is arguably the biggest change from the 2005 to the 2015 version of the CanMEDS Framework. In the Series III release of the framework, the milestones are presented separately in a companion document, the CanMEDS Milestones Guide. Unlike the framework, which will change infrequently, the Milestones Guide will be treated as a living document and undergo continual revision as educators modify the milestones for their discipline.

The 2005 Framework describes the competencies expected of trainees at the end of their training (i.e., at the point when they are "ready" to enter practice). All trainees and their program directors know from the start what competencies are expected of them by the end of their training, but no standard expectations are articulated for other phases of their career. With the introduction of milestones—descriptions of the abilities expected of a trainee or physician at a defined stage of professional development—all of that will change. Trainees, educators, and practitioners will have specific guidelines to help them determine at every phase whether they are "on track."

Thus, milestones will be used to

- mark the progression of competence throughout a physician's career
- provide clearly defined targets to guide authentic learning and assessment
- enable learners to focus their learning activities more effectively
- enable assessors (and programs) to know when a learner has achieved a given milestone or set of milestones and is truly ready to move to the next stage of training or development

The CanMEDS Milestones Guide

The September 2014 draft of national competency milestones for Canadian medical education is quite different from the first draft, released in May. It contains fewer milestones and uses plainer language, and in response to the feedback we received as part of the comprehensive consultation process, the milestones have been recalibrated to better match each stage of development.

Milestones and the competency-based approach

Traditional stages of medical education. Within the traditional model of physician education, the path to

becoming a specialist is broken down into the stages below. These stages encompass specialty-specific training, and learning throughout practice:

- Junior resident
- Senior resident
- Practising physician

The CBD approach. By introducing a next-generation competency-based medical education (CBME) model into resident training and specialty practice, the CBD initiative will break down specialist education into a series of integrated stages—starting with the transition to discipline and moving through practice. (See diagram on p. 10.)

Each stage incorporates milestones from the new CanMEDS 2015 Framework, which defines the specific abilities expected at certain points within a physician's career. By focusing on learning rather than time, the CBD approach will help align medical education with the realities of today's practice, thus ensuring that physicians have the competencies they need at every stage of their career.

Competency-based medical education: some definitions

Competency-based medical education (CBME): An approach to designing medical training that is focused on outcomes in the form of the abilities of graduates.

Competency: An observable ability of a health professional that develops through stages of expertise from novice to master clinician.

Entrustable professional activity (EPA): A key task of a discipline that can be entrusted to an individual who possesses the appropriate level of competencies.

Milestone: The expected ability of a health professional at a stage of expertise.

See: Frank JR et al. Competency-based medical education: theory to practice. *Med Teacher* 2010; 32(8):638–45.

Medical education phases and stages

Physicians develop competencies at different stages during discipline-specific residency and throughout practice.

Discipline-specific residency. This phase is the period in which a physician trainee builds upon the foundational abilities acquired in medical school to learn the competencies needed for practice (four advancing stages: transition to discipline, foundations of discipline, core of discipline, and transition to practice).

Transition to discipline. In many cases this will be a new addition to the residency phase of medical education. This stage emphasizes the orientation and assessment of new trainees arriving from different medical schools and programs (including outside Canada). Although this stage does exist in some form in many residency programs (for example, residency "boot camps"), the CBD approach will formalize the assessment and orientation process, ensuring a level playing field for residents as they begin their specialist training. This stage may require a day, a month, or two months, depending on the needs of each program and of individual learners.

Foundations of discipline. The second stage in the residency phase of medical education covers broad-based competencies that every trainee must acquire before moving on to more advanced discipline-specific competencies. This may involve rotating through a number of clinical settings so the trainee can acquire a breadth of foundational abilities to prepare for core training.

Core of discipline.* The third stage in the residency phase of medical education covers the core competencies that make up the majority of a discipline.

Transition to practice. In the final stage in the residency phase of medical education, the senior trainee should demonstrate readiness to make the transition to autonomous practice: for example, acting as a chief resident, running an ambulatory clinic, teaching and performing increasingly independent procedures, and teaching others. Within CBD, examination would take place at the end of the "core of discipline" stage, allowing residents to hone their competencies in their last months of training.

* **Royal College examination:** The CBD approach proposes that the Royal College examination be taken at the end of the "core of discipline" stage, rather than the end of the training stage (where it currently sits). Moving the exam will ensure trainees are able to focus on further clinical training in their final year, allowing them to use their final supervised training time to hone competencies. Emphasis will be placed on increasingly independent work and skills—creating physicians who are truly ready for independent practice.

Royal College certification will be granted upon the successful completion of the "transition to practice" stage.

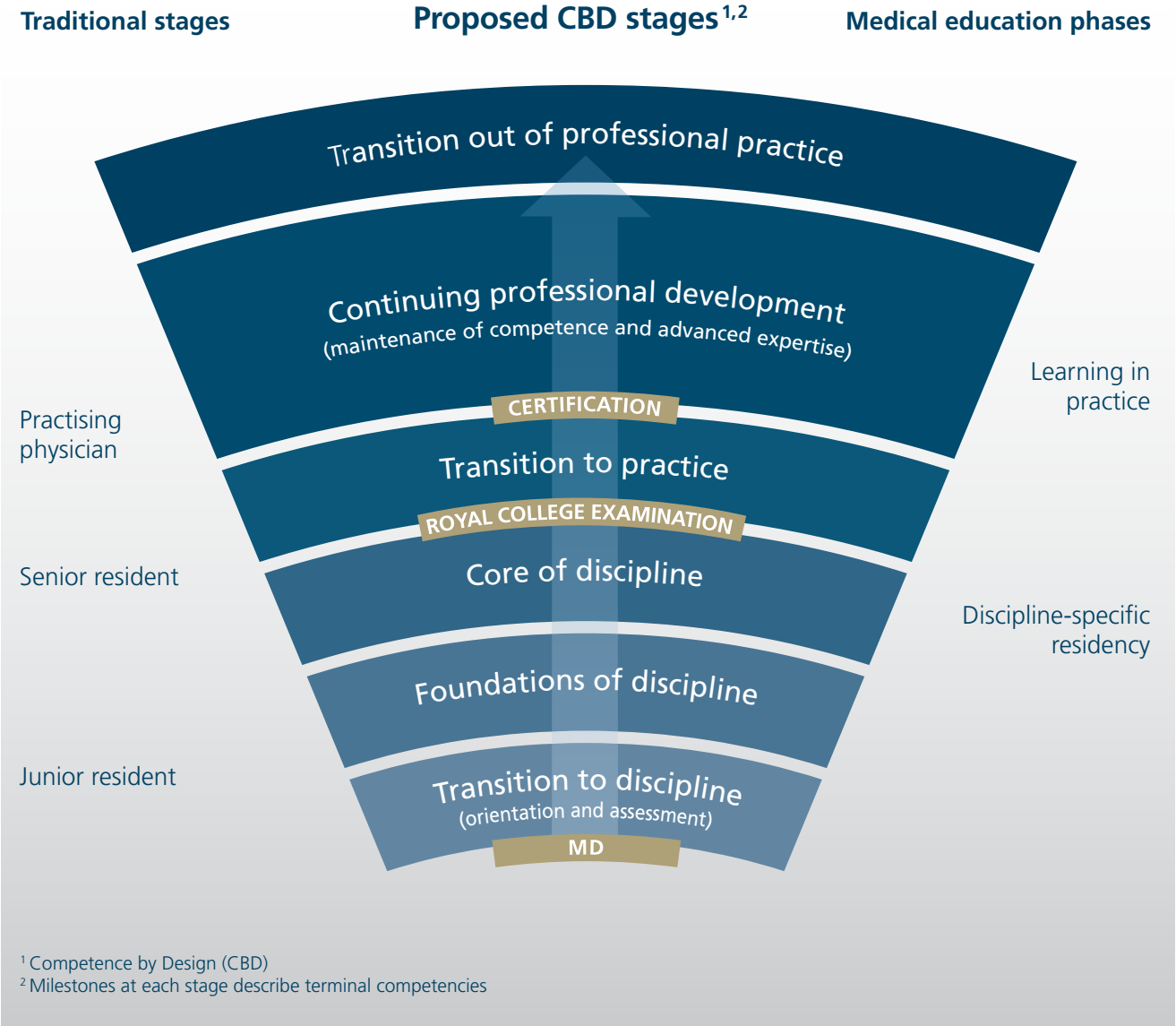
Continuing professional development (CPD). A physician maintains and enhances competence throughout practice in the following ways:

Maintenance of competence. A physician engages in CPD to remain up to date and sustain expertise within his or her scope of practice.

Advanced expertise. The physician acquires new or expanded skills and abilities so that his or her practice can evolve over time in response to practice needs and interests.

Transition out of professional practice. In this last stage, physicians adapt to the final practice period and their changing health care role.

The Competence Continuum



[1] Competence by Design (CBD)
[2] Milestones at each stage describe terminal competencies

MEDICAL EXPERT

Medical Expert Role Expert Working Group

Chair: Farhan Bhanji

Core members: Kathy Lawrence, Mark Goldszmidt, Mark Walton, Kenneth Harris, David Creery, Jonathan Sherbino, Louis-Georges Ste-Marie, Antonia Stang

Advisory members: Ivy Oandasan

For further information about the deliberations of the CanMEDS Medical Expert EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of high-quality and safe patient-centred care. Medical Expert is the central physician Role in the CanMEDS Framework and defines the physician's clinical scope of practice.

Description

As Medical Experts who provide high-quality, safe, patient-centred care, physicians draw upon an evolving body of knowledge, their clinical skills, and their professional attitudes. They collect and interpret information, make clinical decisions, and carry out diagnostic and therapeutic interventions. They do so within their scope of practice and with an understanding of the limits of their expertise. Their decision-making is informed by best practices and research evidence, and takes into account the patient's circumstances and preferences as well as the availability of resources. Their clinical practice is up-to-date, ethical, and resource-efficient, and is conducted in collaboration with patients and their families,* other health care professionals, and the community. The Medical Expert Role is central to the function of physicians and draws on the competencies included in the Intrinsic Roles (Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional).

Key concepts

- Agreed-upon goals of care: 2.1, 2.3, 2.4, 3.2, 4.1
- Application of core clinical and biomedical sciences: 1.3
- Clinical decision-making: 1.4, 1.6, 2.2, 5.4
- Clinical reasoning: 1.3, 1.4, 2.1, 3.1
- Compassion: 1.1
- Complexity, uncertainty, and ambiguity in clinical decision-making: 1.6, 2.2, 2.4, 3.2, 3.3, 3.4
- Consent: 3.2
- Continuity of care: 2.4, 4.1
- Duty of care: 1.1, 1.5, 2.4
- Integration of CanMEDS Intrinsic Roles: 1.2
- Interpreting diagnostic tests: 2.2

* Throughout the Series III draft of the CanMEDS 2015 Framework and Milestone Guide, phrases such as "patients and their families" are intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.

- Medical expertise: all ECs
- Prioritization of professional responsibilities: 1.4, 1.5, 2.1, 3.3, 5.1
- Patient-centred clinical assessment and management: 1.4, 2.2, 2.4, 3.1, 3.3, 3.4, 4.1, 5.1, 5.4, 5.5
- Patient safety: 1.5, 3.4, 5.1, 5.2, 5.3
- Procedural skill proficiency: 3.1, 3.3, 3.4
- Quality improvement: 5.2, 5.3, 5.5
- Self-awareness of limits of expertise: 1.4, 3.4
- Timely follow-up: 1.4, 2.2, 4.1
- Working within the health care team: 1.3, 1.4, 2.1, 2.4, 3.3, 4.1, 5.2

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Practise medicine within their defined scope of practice and expertise	1.1 Demonstrate a commitment to high-quality care of their patients 1.2 Integrate the CanMEDS Intrinsic Roles into their practice of medicine 1.3 Apply knowledge of the clinical and biomedical sciences relevant to their discipline 1.4 Perform appropriately timed clinical assessments with recommendations that are well organized and properly documented in written and/or oral form 1.5 Carry out professional duties in the face of multiple, competing demands 1.6 Recognize and respond to the complexity, uncertainty, and ambiguity inherent in medical practice
2. Perform a patient-centred clinical assessment and establish management plans appropriate for their specialty	2.1 Identify and prioritize issues to be addressed in a patient encounter 2.2 Elicit a history, perform a physical exam, select appropriate investigations, and interpret their results for the purpose of diagnosis and management, disease prevention, and health promotion 2.3 Establish goals of care in collaboration with patients and their families, which may include slowing disease progression, achieving cure, improving function, treating symptoms, and palliation 2.4 Establish a patient-centred management plan

Continued on next page.

3. Plan and perform procedures and interventions for the purpose of assessment and/or management	3.1 Determine the most appropriate procedure(s) for the purpose of assessment and/or management 3.2 Obtain and document informed consent, explaining the risks and benefits of, and the rationale for, the proposed options 3.3 Prioritize procedures, taking into account clinical urgency, potential for deterioration, and available resources 3.4 Perform procedures in a skilful and safe manner, adapting to unanticipated findings or changing clinical circumstances
4. Establish plans for ongoing care and, when appropriate, timely consultation	4.1 Establish the roles of physicians, other health care professionals, and the patient in the provision of a patient-centred care plan that supports ongoing care, including follow-up on investigations, response to treatment, and further consultation
5. Actively participate, as an individual and as a member of a team providing care, in the continuous improvement of health care quality and patient safety	5.1 Recognize and respond to adverse events and near misses 5.2 Contribute to a culture that promotes patient safety 5.3 Adopt strategies that promote patient safety and mitigate negative human and system factors

COMMUNICATOR

Communicator Role Expert Working Group

Chair: Alan Neville

Core members: Wayne Weston, Dawn Martin, Louise Samson, Perle Feldman, Gordon Wallace, Olivier Jamoulle, José François, Marie-Thérèse Lussier, Sue Dojeiji

Advisory members: Judy Brown, Erin Keely, Suzanne Kurtz, Abigail Hain

For further information about the deliberations of the CanMEDS Communicator EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Communicators, physicians form relationships with patients and their families* that facilitate the gathering and sharing of information essential for effective health care.†

Description

Physicians enable patient-centred therapeutic communication by exploring the patient's symptoms, which may be suggestive of disease, and by actively listening to the patient's experience of his or her illness. Physicians explore the patient's perspective, including his or her fears, ideas about the illness, feelings about the impact of the illness, and expectations of health care and health care professionals. The physician integrates this knowledge with an understanding of the patient's context, including socio-economic status, medical history, family history, stage of life, living situation, work or school setting, and other relevant psychological and social issues. Central to a patient-centred approach is shared decision-making: finding common ground with the patient in developing a plan to address his or her medical problems and health goals in a manner that reflects the patient's needs, values, and preferences. This plan should be informed by evidence and guidelines.

Because illness affects not only patients but also their families, physicians must be able to communicate effectively with everyone involved in the patient's care.

Key concepts

- Accuracy: 2.1, 2.4, 3.1, 4.2, 5.1
- Active listening: 1.1,1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 4.1, 4.3
- Appropriate documentation: 2.1, 5.1, 5.2, 5.3
- Attention to the psychosocial aspects of illness: 1.6, 2.1, 2.2, 4.1
- Breaking bad news: 1.5, 3.1, 3.3
- Concordance of goals and expectations: 1.6, 2.2, 3.1, 4.3
- Disclosure of adverse events: 3.2

* Throughout the Series III draft of the CanMEDS 2015 Framework and Milestones Guide, phrases such as "patients and their families" are intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardian, and substitute decision-makers.

† Note that the Communicator Role describes the abilities related to a physician–patient encounter. Other communication skills are found elsewhere in the framework, including health care team communication (Collaborator) and academic presentations (Scholar).

- Effective oral and written information for patient care across different media: 5.1, 5.2
- Efficiency: 2.3, 4.2, 5.2
- Eliciting and synthesizing information for patient care: 2.1, 2.2, 2.3, 2.4
- Empathy: 1.1, 1.2, 1.3
- Ethics in the physician–patient encounter: 3.2, 5.1
- Expert verbal and non-verbal communication: 1.4
- Informed consent: 2.2
- Mutual understanding: 1.6, 3.1, 4.1
- Patient-centred approach to communication: 1.1, 1.6, 2.1, 3.1
- Privacy and confidentiality: 1.2, 5.1
- Rapport: 1.4
- Relational competence in interactions: 1.5
- Respect for diversity: 1.1, 1.6, 2.2, 4.1
- Shared decision-making: 1.6, 4.1, 4.3
- Therapeutic relationships with patients and their families: 1.2, 1.3, 1.4, 1.5, 1.6
- Transition in care: 5.1, 5.2
- Trust in the physician–patient relationship: 1.1, 5.2

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Establish professional therapeutic relationships with patients and their families	1.1 Communicate using a patient-centred approach that encourages patient trust and autonomy and is characterized by empathy, respect, and compassion
	1.2 Optimize the physical environment for patient comfort, dignity, privacy, engagement, and safety
	1.3 Recognize when the values, biases, or perspectives of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly
	1.4 Respond to patients' non-verbal communication and use appropriate non-verbal behaviours to enhance communication with patients
	1.5 Manage disagreements and emotionally charged conversations
	1.6 Adapt to the unique needs and preferences of each patient and to his or her clinical condition and circumstances

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2. Elicit and synthesize accurate and relevant information, incorporating the perspectives of patients and their families	2.1 Use patient-centred interviewing skills to effectively gather relevant biomedical and psychosocial information 2.2 Integrate and synthesize information about the patient's beliefs, values, preferences, context and expectations with biomedical and psychosocial information 2.3 Provide a clear structure for and manage the flow of an entire patient encounter 2.4 Seek and synthesize relevant information from other sources, including the patient's family, with the patient's consent
3. Share health care information and plans with patients and their families	3.1 Skilfully share information and explanations that are clear, accurate, timely, and adapted to patient's and his or her family's level of understanding and need 3.2 Disclose adverse events to patients and their families accurately and appropriately
4. Engage patients and their families in developing plans that reflect the patient's health care needs and goals	4.1 Facilitate discussions with patients and their families in a way that is respectful, non-judgmental, and culturally safe 4.2 Assist patients and their families to identify, access and make use of information and communication technologies to support their care and manage their health 4.3 Use appropriate communication skills and strategies to help patients and their families make informed decisions regarding their health
5. Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy	5.1 Document clinical encounters in an accurate, complete, timely, and accessible manner, in compliance with legal and regulatory requirements 5.2 Communicate effectively using a written health record, electronic medical record, or other digital technology

COLLABORATOR

Collaborator Role Expert Working Group

Chair: Denyse Richardson

Core members: Lisa Calder, Heather Dean, Susan Glover Takahashi, Paule Lebel, Jerry Maniate, Dawn Martin, Louise Nasmith, Christie Newton, Yvonne Steinert

Advisory members: Amir Ginzburg, Ivy Oandasan, Sharon Switzer-McIntyre

For further information about the deliberations of the CanMEDS Collaborator EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Collaborators, physicians work effectively with other health care professionals to provide safe, high-quality patient-centred care.

Description

Collaboration is essential for safe, high-quality, patient-centred care, and involves patients and their families,* physicians and other colleagues in the health care professions, community partners, and health system stakeholders. Collaboration requires relationships based in trust, respect, and shared decision-making among a variety of individuals with complementary skills in multiple settings across the continuum of care. It involves sharing knowledge, perspectives, and responsibilities, and a willingness to learn together. This requires understanding the roles of others, pursuing common goals and outcomes, and managing differences. Collaboration skills are broadly applicable to activities beyond clinical care, such as administration, education, advocacy, and scholarship.

Key concepts

- Collaboration with community providers: 1.2, 1.3
- Communities of practice: 1.3, 3.2
- Conflict resolution, management, and prevention: 2.2
- Constructive negotiation: 2.2
- Effective consultation and referral: 1.2,1.3, 3.1, 3.2
- Effective health care teams: all ECs
- Handover: 3.1, 3.2
- Interprofessional: (i.e., among health care professionals) health care: all ECs
- Intraprofessional: (i.e., among physician colleagues) health care: all ECs
- Recognizing one's own roles and limits: 1.2, 3.1
- Respect for other physicians and members of the health care team: 2.1, 2.2
- Respecting and valuing diversity: 1.2, 2.1, 2.2
- Shared decision-making: 1.3

* Throughout the Series III draft of the CanMEDS 2015 Framework and Milestone Guide, phrases such as "patients and their families" are intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.

- Sharing of knowledge and information: 1.3, 3.1, 3.2
- Situational awareness: 1.1, 1.2, 2.2, 3.1, 3.2
- Team dynamics: 1.1, 2.2, 3.1
- Transitions of care: 3.1, 3.2
- Understanding roles and responsibilities of all members of the health care team: 1.2, 3.1

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Work effectively with physicians and other colleagues in the health care professions	1.1 Establish and maintain healthy relationships with physicians and other colleagues in the health care professions to support relationship-centred collaborative care 1.2 Negotiate overlapping and shared responsibilities with physicians and other colleagues in the health care professions 1.3 Engage in respectful shared decision-making
2. Work with physicians and other colleagues in the health care professions to prevent misunderstandings, manage differences, and resolve conflicts	2.1 Show respect toward collaborators 2.2 Implement strategies to resolve conflicts in a manner that supports a collaborative culture
3. Effectively and safely transfer care to another health care professional	3.1 Assess when care should be transferred to another physician or health care professional 3.2 Demonstrate safe transfer of care, using both verbal and written communication, during a patient transition to a different health care professional, setting, or stage of care

LEADER

Manager Role Expert Working Group

Co-chairs: Deepak Dath and Ming-Ka Chan

Core members: Geoffrey Anderson, Andrew Burke, Saleem Razack, Susan Lieff, Geneviève Moineau, Aaron Chiu, Philip Ellison

Advisory members: David Snadden, Hugh MacLeod, Sherissa Microys, Marie-Josée Bédard, Joshua Tepper, Louis-André Lacasse, Hema Patel

For further information about the deliberations of the CanMEDS Manager EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Leaders, physicians develop a vision of a high-quality health care system and, in collaboration with other health care leaders, take responsibility for effecting change to move the system toward the achievement of that vision.

Description

Society has explicitly identified leadership and management abilities as core requirements for the practice of medicine. Physicians and others exercise collaborative leadership within the complex health care systems that form their specific work environments. At a system level, physicians contribute to the development and delivery of continuously improving health care and engage others to work with them toward this vision. Physicians must balance their personal lives with their responsibilities as leaders and managers in their everyday clinical, administrative, research, and teaching activities. They function as individual care providers, as members of teams or groups, and as participants and leaders in the health care system locally, regionally, nationally, and globally. The CanMEDS Leader Role describes the active engagement of all physicians as leaders and managers in decision-making in the operation and ongoing evolution of the health care system.

Key concepts

- Administration: 4.1, 4.2
- Career development: 4.2
- Collaborative leadership and "followership": 1.1, 3.1, 3.2, 3.3
- Consideration of justice, efficiency, and effectiveness in the allocation of health care resources for optimal patient care: 1.1, 1.2, 1.3, 2.1, 2.2
- Complexity of systems: 1.1
- Effective meetings and committee participation: 1.2
- Health human resources: 2.2, 4.2
- Information technology for health care: 1.3
- Leading change: 1.1, 1.2, 1.3, 2.2, 3.2
- Management of personnel: 4.2
- Negotiation: 1.1, 3.1
- Organizing, structuring, budgeting, and financing: 2.1, 2.2, 4.1, 4.2, 4.3
- Personal leadership skills: 3.1, 4.1, 4.2, 4.3

- Physicians as active participant-architects within the health care system: 1.1, 1.2, 1.3, 2.3, 3.2, 3.3
- Physician remuneration: 4.2
- Physician roles and responsibilities in the health care system: 1.1, 1.2, 1.3, 2.2, 3.1, 3.2
- Practice management to maintain a sustainable practice and physician health: 4.1, 4.2, 4.3
- Priority-setting: 2.1, 3.2, 4.1
- Quality improvement: 1.1, 1.2, 1.3, 2.2, 3.2, 3.3
- Stewardship: 2.1, 2.2
- Supervising others: 4.2
- Systems thinking: 1.1, 1.2, 1.3, 2.1, 2.2
- Time management: 4.1

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Contribute to the improvement of health care delivery in teams, organizations, and systems	1.1 Apply the science of quality improvement to contribute to improving systems of patient care 1.2 Analyse adverse events and near misses to enhance systems of care 1.3 Use health informatics to improve the quality of patient care and optimize patient safety
2. Engage in the stewardship of health care resources	2.1 Allocate health care resources for optimal patient care 2.2 Apply evidence and management processes to achieve cost-appropriate care
3. Demonstrate leadership in professional practice	3.1 Develop their leadership skills 3.2 Design and organize elements of health care delivery 3.3 Facilitate change in health care to enhance services and outcomes
4. Manage their practice and career	4.1 Set priorities and manage time to balance practice and personal life 4.2 Manage career planning, finances, and health human resources in a practice 4.3 Implement processes to ensure personal practice improvement

HEALTH ADVOCATE

Health Advocate Role Expert Working Group

Chair: Jonathan Sherbino

Core members: Deirdre Bonnycastle, Brigitte Côté, Leslie Flynn, Andrea Hunter, Daniel Ince-Cushman, Jill Konkin, Ivy Oandasan, Glenn Regehr, Denyse Richardson, Jean Zigby

Advisory members: Marcia Clark, Sherissa Microys

For further information about the deliberations of the CanMEDS Health Advocate EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when needed, and support the mobilization of resources to effect change.

Description

Physicians recognize their duty to participate in efforts to improve the health and well-being of their patients, their communities, and the broader populations they serve.* Physicians possess medical knowledge and abilities that provide unique perspectives on health. Physicians also have privileged access to patients' accounts of their experience with illness and the health care system. Improving health is not limited to mitigating illness or trauma, but also involves disease prevention, screening, health promotion, surveillance, and health protection. Improving health also includes promoting health equity, whereby individuals and populations reach their full health potential without being disadvantaged by, for example, race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, or level of education.

Physicians leverage their position to support patients in navigating the health care system and to advocate with them to access appropriate resources in a timely manner. Physicians seek to improve the quality of both their clinical practice and associated organizations by addressing the health needs of the patients, communities, or populations they serve. Physicians promote healthy communities and populations by influencing the system (or by supporting others who influence the system), both within and outside of their work environments.

Advocacy requires action. Physicians contribute their knowledge of the determinants of health to positively influence the health of the patients, communities, or populations they serve. Physicians gather information and perceptions about issues, working with patients and their families† to develop an understanding of needs and potential mechanisms to address these needs. Physicians support patients, communities, or populations to call for change, and they speak on behalf of others when needed. Physicians increase awareness about important health issues at the patient, community, or population level. They support or lead the mobilization of resources (e.g., financial, material, or human resources) on small or large scales.

* In the CanMEDS framework, a "community" is a group of people and/or patients connected to one's practice, and a "population" is a group of people and/or patients with a shared issue or characteristic.

† Throughout the Series III draft of the CanMEDS 2015 Framework and Milestones Guide, phrases such as "patients and their families" are intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.

Physician advocacy occurs within complex systems and thus requires the development of partnerships with patients, their families and support networks, or community agencies and organizations to influence health determinants. Advocacy often requires engaging other health care professionals, community agencies, administrators, and policy-makers.

Key concepts

- Adapting practice to respond to the needs of patients, communities, or populations served: 2.1, 2.2
- Advocacy in partnership with patients, communities, and populations served: 1.1, 1.2, 2.1, 2.2, 2.3
- Continuous quality improvement: 2.2, 2.3
- Determinants of health, including psychological, biological, social, cultural, environmental, educational, and economic determinants, as well as health care system factors: 1.1, 1.3, 2.2
- Disease prevention: 1.3, 2.1
- Fiduciary duty: 1.1, 2.2, 2.3
- Health equity: 2.2
- Health promotion: 1.1, 1.2, 1.3, 2.1
- Health protection: 1.3
- Mobilizing resources as needed: 1.1, 1.2, 1.3
- Principles of health policy and its implications: 2.2
- Potential for competing health interests of the individuals, communities, or populations served: 2.3
- Responsible use of position and influence: 2.1, 2.3
- Social accountability of physicians: 2.1, 2.3

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Respond to the individual patient's health needs by advocating with the patient within and beyond the clinical environment	1.1 Work with patients to address determinants of health that affect them and their access to needed health services or resources 1.2 Work with patients and their families to increase their opportunities to adopt healthy behaviours 1.3 Incorporate disease prevention, health promotion, and health surveillance into interactions with individual patients
2. Respond to the needs of the communities or patient populations they serve by advocating with them for system-level change	2.1 Work with a community or population to identify the determinants of health that affect them 2.2 Improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities 2.3 Participate in a process to improve health in the community or population they serve

SCHOLAR

Scholar Role Expert Working Group

Chairs: Denyse Richardson, Anna Oswald

Subgroup chairs: Denyse Richardson (Lifelong Learning); Anna Oswald and Ming-Ka Chan (Teacher); Eddy S Lang (Critical Appraisal); Bart J Harvey (Research)

For further information about the deliberations of the CanMEDS Scholar EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning, the teaching of others, the evaluation of evidence, and contributions to scholarship.

Description

Physicians acquire scholarly abilities to enhance practice and advance health care. Physicians pursue excellence by continually evaluating the processes and outcomes of their daily work, sharing and comparing their work with that of others, and actively seeking feedback in the interest of quality and patient safety. Using multiple ways of learning, they strive to meet the needs of individual patients and their families* and of the health care system.

Physicians strive to master their domains of expertise and to share their knowledge. As lifelong learners, they implement a planned approach to learning in order to improve in each CanMEDS Role. They recognize the need to continually learn and to model the practice of lifelong learning for others. As teachers they facilitate, individually and through teams, the education of students and residents, colleagues, co-workers, the public, and others.

Physicians are able to identify pertinent evidence, evaluate it using specific criteria, and apply it in their scholarly activities and practice. Through their engagement in evidence-informed and shared decision-making, they recognize uncertainty in practice and formulate questions to address knowledge gaps. Using skills in navigating information resources, they identify evidence syntheses that are relevant to these questions and arrive at clinical decisions that are informed by evidence while taking patient values and preferences into account.

Finally, physicians' scholarly abilities allow them to contribute to the application, dissemination, translation, and creation of knowledge and practices applicable to health and health care.

Key concepts

Lifelong learning

- Collaborative learning: 1.3
- Communities of practice: 1.3
- Patient safety: 1.3
- Performance assessment: 1.2
- Personal learning plan: 1.1
- Quality improvement: 1.1, 1.2, 1.3

* Throughout the Series III draft of the CanMEDS 2015 Framework and Milestone Guide, phrases such as "patients and their families" are intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient's circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.

- Reflection on practice: 1.2
- Self-improvement: 1.1, 1.2, 1.3

Teacher

- Faculty, rotation and program evaluation: 2.6, 2.7
- Formal and informal curricula: 2.1
- Hidden curriculum: 2.1
- Learner and faculty assessment: 2.4, 2.5, 2.6, 2.7
- Learning outcomes: 2.4, 2.6
- Mentoring: 2.2, 2.5, 2.6. 5.3
- Needs assessment: 2.4
- Optimization of the learning environment: 2.2
- Principles of assessment: 2.7
- Role-modelling: 2.1, 2.6
- Seeking and providing feedback: 2.6
- Supervision and graded responsibility: 2.3
- Teaching and learning: 2.2, 2.5, 2.6

Evidence-informed decision-making

- Evidence syntheses: 3.2, 3.3, 4.2
- Information literacy: 3.2
- Knowledge gaps: 3.1
- Uncertainty in practice: 3.1

Structured critical appraisal

- Effect size: 4.3, 4.5
- Evidence-based medicine: 3.1, 3.2, 3.3, 4.1, 4.4
- External validity: 4.4, 4.6
- Generalizability: 4.6
- Internal validity: 4.3, 4.3
- Knowledge translation: 4.2, 4.3, 4.7, 5.5
- Risk of bias: 4.3, 4.4
- Quality-appraised evidence-alerting services: 4.8

Research

- Clinical innovation: 5.1, 5.3
- Confidentiality: 5.2
- Conflict of interest: 5.2
- Informed consent: 5.2
- Research: 5.1, 5.2, 5.3, 5.4
- Scholarly inquiry: 5.1, 5.2, 5.3, 5.4
- Scholarship: 5.1, 5.3, 5.4

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Engage in the continuous enhancement of their professional activities through ongoing learning	1.1 Develop, implement, monitor, and revise a personal learning plan to enhance professional practice 1.2 Identify opportunities for learning and improvement by regularly assessing their performance using various internal and external data sources 1.3 Engage in collaborative learning to continuously improve personal practice and contribute to collective improvements in practice
2. Facilitate the learning of students, residents, the public, and other health care professionals	2.1 Recognize the power of role-modelling and the impact of the hidden curriculum on learners 2.2 Promote a safe learning environment 2.3 Ensure patient safety is maintained when learners are involved 2.4 Collaboratively identify the learning needs of others and prioritize learning outcomes 2.5 Demonstrate effective teaching to facilitate learning 2.6 Provide effective feedback to enhance learning and performance 2.7 Use assessment and evaluation tools and practices that are relevant to the teaching and learning context
3. Integrate best available evidence, contextualized to specific situations, into real-time decision-making	3.1 Recognize practice uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that can address them 3.2 Demonstrate proficiency in identifying, selecting, and navigating pre-appraised resources 3.3 Integrate evidence into decision-making in their practice
4. Critically evaluate the integrity, reliability, and applicability of health-related research and literature	4.1 For a given practice scenario, formulate well-structured scholarly questions 4.2 Identify scholarly sources that shed light on a given professional question 4.3 Interpret study findings, including a discussion and critique of their relevance to professional practice 4.4 Determine the validity and risk of bias in a wide range of scholarly sources 4.5 Describe study results in both quantitative and qualitative terms

Continued on next page.

	4.6 Evaluate the applicability (external validity or generalizability) of evidence from a wide range of information resources 4.7 Discuss the barriers to and facilitators of applying study findings to professional practice 4.8 Use quality-appraised evidence-alerting services that highlight new evidence appropriate to their scope of professional practice
5. Contribute to the dissemination and/or creation of knowledge and practices applicable to health	5.1 Demonstrate an understanding of the scientific principles of research and scholarly inquiry and the role of research evidence in contemporary health care 5.2 Identify ethical principles for research and incorporate them into obtaining informed consent, considering potential harms and benefits, and considering vulnerable populations 5.3 Contribute to the work of a research program 5.4 Pose questions amenable to scholarly investigation and select appropriate methods to address them 5.5 Summarize and communicate to professional and lay audiences, including patients and their families, the findings of relevant research and scholarly inquiry

PROFESSIONAL

Professional Role Expert Working Group

Chair—Professionalism: Linda S. Snell

Core members: Leslie Flynn, Merril Pauls, Ramona Kearney, Andrew Warren, Robert Sternszus, Richard Cruess, Sylvia Cruess, Maggy Dupré, Rose Hatala

Advisory members: Shiphra Ginsburg, Sharon Johnston, Yvette Lajeunesse

Chair—Physician Health: Leslie Flynn

Core members: Linda S. Snell, Meri Bukowskyj, Susan Edwards, Jordan Cohen, Anita Chakravarti, Leslie Nickell, Janet Wright

Advisory members: Jonathan DellaVedova, Eva Knell, Derek Puddester, Andrew Warren

For further information about the deliberations of the CanMEDS Professional EWG in revising this Role for CanMEDS 2015, please see their February 2014 Report.

Definition

As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, dedication to the profession, profession-led regulation, and maintenance of personal health.

Description*

Physicians serve an essential role as professionals dedicated to the health and care of others. Their work requires mastery of the art, science, and practice of medicine. The professional identity of physicians has developed over millennia, and the Professional Role reflects contemporary society's expectations of physicians, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, and adherence to ethical standards and values, such as integrity, honesty, altruism, respect for diversity, and transparency with respect to potential conflicts of interest. It is also recognized that, to provide optimal patient care, physicians must take responsibility for their own health and well-being and that of their colleagues. The professionalism of physicians is the basis of the implicit contract between society and the medical profession, by which physicians are granted the privilege of profession-led regulation with the understanding that they are accountable to those served, to society, to their profession, and to themselves.

Key concepts

Commitment to patients

- Altruism: 1.1
- Bioethical principles and theories: 1.3
- Commitment to excellence in clinical practice and mastery of the discipline: 1.2
- Compassion and caring: 1.1
- Confidentiality and its limits: 1.1, 1.5
- Integrity and honesty: 1.1

* The role description draws from Cruess SR, Johnston S, Cruess RL. "Profession": a working definition for medical educators. *Teach Learn Med* 2004;16(1):74–6 and from Cruess SR, Cruess RL. Professionalism and medicine's social contract with society. *Virtual Mentor* 2004 6(4).

- Moral and ethical behaviour: 1.1, 1.3
- Professional boundaries: 1.1
- Respect for diversity: 1.1

Commitment to society

- Commitment to the promotion of the public good in health care: 2.1
- Social accountability: 2.1
- Social contract in health care: 2.1

Commitment to the profession

- Accountability to professional regulatory authorities: 3.1
- Codes of ethics: 3.1
- Commitment to patient safety and quality improvement: 2.1, 4.1
- Commitment to professional standards: 3.1
- Conflicts of interest (personal, financial, administrative, etc.): 1.4
- Medico-legal frameworks governing practice: 3.1, 3.3
- Responsibility to the profession, including obligations of peer assessment, mentorship, collegiality, and support: 3.2, 3.3, 4.3

Commitment to self

- Applied capacity for self-regulation, including the assessment and monitoring of one's thoughts, behaviours, emotions and attention for optimal performance and well-being: 4.1
- Commitment to disclosure of error and/or adverse events and their impact: 4.2, 4.3
- Mindful and reflective approach to practice: 4.2
- Professional identity, career development and transitions: 4.1, 4.2
- Resilience for sustainable practice: 4.2
- Responsibility to self, including personal care, in order to serve others: 4.1

Key competencies	Enabling competencies
Physicians are able to:	Physicians are able to:
1. Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards	1.1 Exhibit appropriate professional behaviours and relationships in all aspects of practice, reflecting honesty, integrity, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality
	1.2 Demonstrate a commitment to excellence in all aspects of practice
	1.3 Recognize and respond to ethical issues encountered in practice
	1.4 Recognize and manage conflicts of interest
	1.5 Exhibit professional behaviours in the use of technology-enabled communication

2. Demonstrate a commitment to society by recognizing and responding to the social contract in health care	2.1 Demonstrate accountability to patients, society, and the profession
3. Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation	3.1 Fulfill and adhere to the professional and ethical codes, standards of practice, and laws governing practice 3.2 Recognize and respond to unprofessional and unethical behaviours in physicians and other colleagues in the health care professions 3.3 Participate in peer assessment and standard-setting
4. Demonstrate a commitment to physician health and well-being to foster optimal patient care	4.1 Exhibit self-awareness and effectively manage influences on personal well-being and professional performance 4.2 Manage personal and professional demands for a sustainable practice throughout the physician life cycle 4.3 Promote a culture that recognizes, supports, and responds effectively to colleagues in need

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