



I Ibero American Conference of Experts in Professional Certification and Accreditation Programs in Family Medicine

Wonca-Ibero American Region - ICFM
(Iberoamerican Confederation of Family Medicine)
Pan American Health Organization (PAHO/WHO)

Improving the Professional Quality
of Family Doctors in Iberoamerica

Margarita Island, Venezuela, November 2003

Technical Documents

Working Documents



INTRODUCTION

Adolfo Rubinstein M.D, MSc, PhD

Professor and Director of the Department of Family Medicine

Faculty of Medicine. University of Buenos Aires

Regional President

WONCA-Ibero American Region-ICFM

Charles Godue M.D. (Chief) and Edwina Yen M.D

Human Resources Development Unit

Area of Strategic Health Development

PAHO/WHO

The wealth level of a country, estimated according to certain parameters such as GDP per capita, does not guarantee the existence of the social and economic conditions necessary to result in higher health standards. Even in most industrialized countries systematic differences can be observed regarding the incidence of certain diseases among different populations, with higher concentrations of diseases among the poorest areas. These inequalities are higher in the United States than in any similarly developed country from Northern Europe. In fact, there is plenty of evidence from developed countries but it can also be empirically applied to underdeveloped countries as well, that mortality, especially childhood mortality, tends to have a lower rate in societies where social differences are less important. For example, among those nations with a GDP per capita higher than USD 20,000, variations in life expectancy rates in children younger than 5 years of age is from between 990/1000 in the US to 995/1000 in Sweden. For those nations with a GDP per capita between USD 1,000 and 2,000, the range is from between 99/1000 in Swaziland and 990/1000 in Cuba, which in turn shows life expectancy rates similar or even higher than those of the US, with a GDP per capita 20 times lower.

Ibero America is a diverse region with a wide heterogeneity regarding both, its socio-economic development and its health outcomes, with childhood mortality rates ranging from about 10% in Haiti to less than 1% in Cuba or Chile. Health systems all over this region have experienced several reforms during the last few years. Many of these reforms have been market-oriented regarding the financing, organization and provision of health services. Decentralization during the 90's, followed by privatizations in many cases, was associated with policies especially designed to reduce the role of stewardship of the public sector, as opposed to the paradigm of the 70's when decentralization was considered as a mean to strengthen local involvement following the principles of Primary Health Care. The implementation of such policies resulted in a much deeper institutional fragmentation within these countries. These reforms, aligned with other changes regarding the role of the State, implied great social transformations. One of the most devastating consequences that took place during the last decade was the rise of social inequity levels in spite of the increase of the GDP in many of these countries.

The new generation of reforms, focused on both the health condition and the well-being of the population, has stressed the importance of the reorientation of health systems and services, trying to center the attention on quality improvement so as to foster greater comprehensiveness, continuity of health care systems and a greater ability to respond to patients' demands. Because human resources are an important part of this new agenda, it is mandatory to have a better definition of the desired competencies for health professionals, as well as adequate education and training processes, related to the current health care models of these health care systems.

Family Medicine, as a specialty oriented towards comprehensiveness and continuity, health promotion and disease prevention as well as first contact health care, is increasingly becoming the ideal model to achieve such objectives. However, despite the comprehensive scope of health reforms and the growing importance of Family and Community Medicine in medical education and in the allocation of human resources in Ibero America, a considerable difference throughout the region regarding the stage of development of this specialty not only as a discipline but also as a health care model to families and communities, can still be observed.

Every health care system pursues two main objectives: first of all, optimizing the health of the population by implementing the best and most advanced available knowledge, second, minimizing differences by assuring equal access to all. The 1978 WHO Conference in Alma Alta, "Health for all in the year 2,000" made Primary Health Care a priority for governments and international agencies. This was done as a strategy to achieve higher efficiency and equity of Health Systems. Those services included within this framework had to be essential, practical, scientifically sound, socially acceptable, universally accessible, financially solid, and oriented towards social and economic development. Although these objectives were not fully achieved, Alma Ata brought about the emergence of innovative health reforms all over the world. Almost two decades later, acknowledging the growing social and health differences in almost every country, the WHO adopted a series of principles about ways to set the basis for those services that were part of the Primary Health Care. Known as the Ljubljana Charter on Reforming Health Care, it was suggested that health care systems should be:

- ? Based on human dignity, equity, solidarity and professional ethical values
- ? Oriented towards health protection and promotion
- ? Centered on people, allowing citizens to decisively influence health services and sharing responsibility for their own health
- ? Focused on quality, including cost-effectiveness levels of all interventions
- ? Financially sound in order to offer a universal and egalitarian health care
- ? Primary Health Care-oriented

In a recent study performed by the Pan American Health Organization and the Department of Family and Community Medicine of Baylor University School of Medicine about the situation of Family Medicine in 28 countries in the American Region, responses showed little differences regarding Family health care and Family Medicine. Both models are strictly connected with Primary Health Care strategies, based upon the bio-psycho-social model, prioritizing disease prevention and health promotion, providing coordinated, continuous, and equal care for all, at the family and community level. Family Medicine, recognized as the most adequate medical specialty for the implementation of Primary Health Care, also implies first contact, accessibility, continuity and longitudinality, comprehensiveness and coordination of health care for individuals, family and communities, regardless of age, gender, type of disease or affected organ and with a risk approach to the health care of defined populations. In this study, we can also observe that generalists and family physicians represent the majority of the work force in the primary care setting of most countries. However, it is important to note that, unlike family physicians, generalists are health professionals without formal postgraduate training.

However, as knowledge progresses, physicians are becoming increasingly inclined to choose other specialties –among other reasons- because it is impossible to know everything about every single health-related problem. This tendency towards "super-specialization" has caused the fragmentation of health care by developing health professionals only interested and specialized in certain groups regarding age, gender, organs or systems or diseases. Those specializations focused on the treatment of certain diseases cannot maximize health as a whole because health promotion or disease prevention for individuals and families require a broader perspective than that of the specialist's. Therefore, specialists may be a very appropriate resource for the management of a particular disease at a definite moment in time but generalists are the

most necessary participants for the integration of the multiple health-related problems that either an individual or a family group may face throughout their lives. On the other hand, specialization has not only caused the “decontextualization” of certain problems but also the disintegration or negation of the psychosocial aspects, and, in many cases, the deterioration of doctor-patient relationship. This poses a threat not only to patient satisfaction but also to the efficiency of health care services.

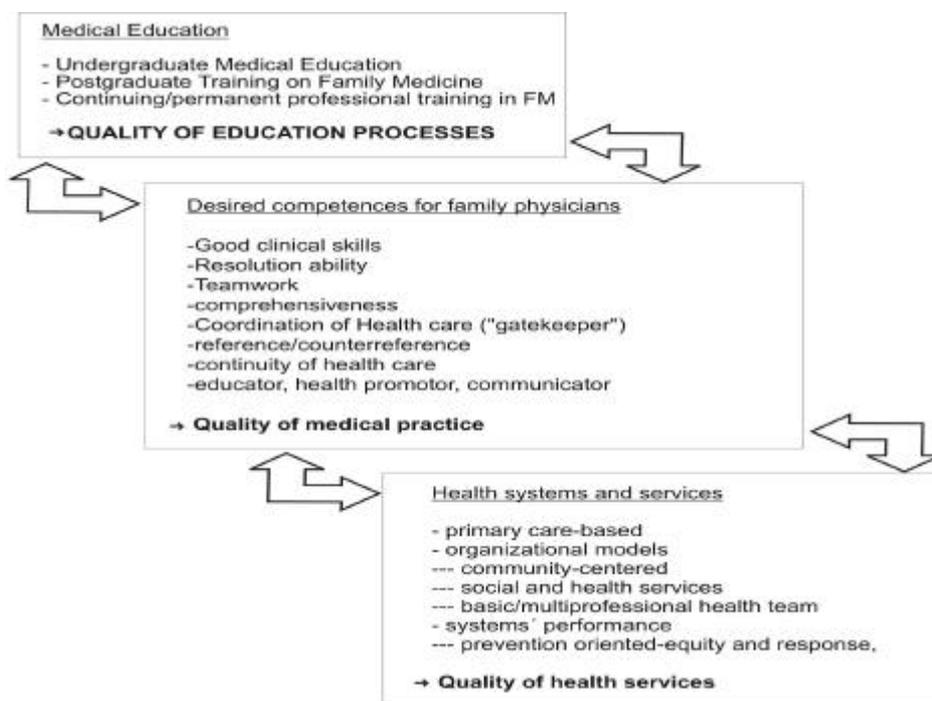
A Health Care System oriented towards specialized care also jeopardizes equity. There is no society in the world with unlimited resources when it comes to the provision of health services, not even in the most developed countries with more health care resources. Specialized care is more expensive than primary care; therefore, they are less accessible for those individuals unable to afford them. Furthermore, resources allocated to disease-oriented high-tech care are in competition with those providing basic and essential services, especially those for the most vulnerable groups with socio-economic, cultural, demographic or epidemiological disadvantages. Unfortunately, the same tendency can be observed in developing countries, especially in Ibero America. In fact, these countries that are now facing the consequences of an institutional fragmentation with an increasingly unregulated private sector, are also becoming less capable of redesigning the objectives of PHC-oriented health systems. As a result, many initiatives and PHC-oriented programs in different Ibero American countries have resulted in frustrating or unsuccessful experiences. The cause of such failures can be attributed to inadequate financing, poorly-trained human resources, insufficient equipment or not enough time committed to solve the problems that needed to be faced. In short, health care quality used to be so poor that could be considered as “primitive” more than primary or “essential”, especially in those cases in which PHC was limited to a more basic and simple care of poorer groups. On the other hand, in developed countries, except the United States and some other countries, PHC has been better integrated within its comprehensive systems because it has been related to the practice of Family Medicine, horizontally integrated within the Family Health Teams together with other health professionals such as nurses, social workers, dentists, psychologists, nutritionists, and so on. There is increasing evidence linking PHC with the improvement of health indicators. B. Starfield conducted several ecological studies in the mid 90’s about the relationship between PHC, and health-related costs and outcomes, including 13 developed countries. Her first finding was that the features that caused the orientation towards PHC of a health system defined the type of professional practice to be performed. Secondly, she found that countries less PHC-oriented (US, Germany, among others), showed higher health-related costs and worse health indicators. Also, similar findings were observed within the US, where States with more PHC professionals showed better outcomes and lower costs. If PHC, considered as a policy favoring more vulnerable and excluded groups, highly depends upon the involvement of the public sector in order to counteract the undesirable effects of pro-market policies, those countries that may strengthen their PHC-oriented policies should also be the ones showing better outcomes in connection with their resources.

According to the Baylor and PAHO study, the health care context in Ibero America at the dawn of the XXI century seems to provide a favorable scenario for the strengthening of Family Medicine as the most adequate specialty to solve those differences still existing in the region. With the growing number of Residency programs and Family Medicine Departments being implemented in many countries, the role of family physicians also increases as well as the awareness of governments and the general public about the high quality services they provide regarding family and community health-related issues. The results of this study confirm the need to intensify efforts in order to implement family-oriented health initiatives in Ibero America. In order to achieve these goals, several critical factors are mentioned such as government support (policy as well as financial support), the promotion of education activities, and community integration within training systems, promoting the use of tools that may facilitate such processes. Such tools include new communication

technologies, distance learning, telemedicine and the ongoing development of medical informatics.

Within the policies that Ibero American countries should develop towards PHC reforms we can find those related to the training and education of professional Human Resources such as those involved in the Family Health Teams, especially Family Physicians. In this regard, Family Health-oriented processes of reform such as those taking place in countries with different health systems such as Argentina, Brazil, Chile, Mexico and Dominican Republic among others, are focusing their attention on the education and training of human resources as their key strategic activities. The search for Quality in the processes of professional development, considering Quality not only as education excellence but also as the application of such academic background to satisfy the needs of the community and health services, begins at undergraduate level, stressing a generalist role model along the career, as an alternative to the specialist role model taught at the traditional schools of Medicine. Such profile should be oriented towards health promotion and disease prevention, and towards interdisciplinary and multi-professional work, not only focused on the patient but also on the community and the context thereof. This curricular framework from the Schools of Medicine should increase the number of students who choose Family Medicine as a graduate specialty. Such model should continue its development after university through Residency training Programs and a continuing professional development. Thus, the Quality of education processes could be measured according to the way medical education programs specify the desired competencies Family Physicians should achieve and how much such competencies influence on the performance and orientation of health services as it can be observed in the following chart:

Figure 1



Family Medicine as a Professional Specialty and Health Care Model:

Relation between education/training process and the practice and performance of health services

As it was initiated at the Summit of Seville, Spain, May 2002 “Committed to improve the health of the population”, WONCA-Ibero American Region”-ICFM) and PAHO/WHO decided to continue and to further develop those aspects related to the quality improvement of Family Doctors by organizing the “First Ibero American Conference of Experts on Certification and Accreditation in Family Medicine” that took place in Margarita Island, Venezuela, November 2003 and finished with the “Declaration of Margarita”. Its mission was to elaborate technical documents and recommendations in three areas that are strategic for the development of Family Medicine, with the acknowledgement that it is a differentiated specialty with its own theoretical frameworks and professional practice bodies. The documents we shall present hereinafter comprise the elaboration of reference frameworks for the Professional Certification and Accreditation processes of Continuing Medical Education and Residency Programs on Family Medicine for Ibero-America. During all this time, over 30 experts from 20 regional countries intensely worked on the elaboration of this material.

Finally, we want to express the desire of the ICFM/ WONCA and PAHO/WHO, that this material may be useful to support and assist in the implementation of these Quality improvement processes in the different countries of our Region with the objective that they may consequently be an instrument to improve the health of our citizens.

REFERENCES

1. Kunst A. Cross-National Comparisons of Socio-economic Differences in Mortality. Rotterdam: Erasmus University. 1997
2. Kennedy BP, Kawachi I, Prothrow-Stith D. Income distribution and mortality: cross sectional ecological study of the Robin Hood index in the United States. *BMJ* 1996;312:1004-7
3. Pan American Health Organization/World Health Organization. The Status of Family Health Care and Family Medicine in the Region of the Americas. Washington, D.C. PAHO. 2001
4. Rosenblatt R, Hart L, Baldwin L, Chan L, Schneeweiss R. The generalist role of specialty physicians: is there a hidden system of PHC?. *JAMA* 1998; 279: 1364-70.
5. Rubinstein A. *Medicina Familiar y Práctica Ambulatoria*. Ed. Médica Panamericana. Buenos Aires. 2001
6. Shi L, Starfield B, Kennedy B, Kawachi I. Income inequality, PHC and Health Indicators. *J Fam Pract*. 1999;48:275-284
7. Shi L. PHC, specialty care, and life chances. *Int J Health Serv* 1994; 24: 431-58.
8. Starfield B. Is PHC essential?. *The Lancet* 1994; 334:1129-1133
9. Starfield B. PHC: balancing health needs, services, and Technology. Oxford University Press. 1998,
10. The Ljubljana Charter on reforming health care. *BMJ* 1996; 312:1664-5
11. Weiner J, Starfield B. Measurement of the PHC roles of office-based physicians. *Am J Public Health* 1983; 73: 666-71.
12. Wilkinson RG. Socioeconomic determinants of health: Health inequalities: relative or absolute material standards? *BMJ* 1997; 314:591)
13. World Development Report. Investing in Health. 1993. World Bank. Oxford University Press. New York
14. World Health Organization. Primary health care. Geneva: WHO. 1978:25

THE IMPORTANCE OF PROFESSIONAL ASSESSMENT IN FAMILY PRACTICE

Carlos A. Brailovsky, MD, MA (Ed.), MCFPC (Hon)

Professor and Chairman

Health Science Evaluation Center (CESSUL)

Faculty of Medicine, Université Laval

One of the problems of professional certification in Ibero America is the lack of well-validated accreditation programs for the Residency training Programs of the different medical specialties. The consequence of this is a wide heterogeneity regarding their quality which varies from country to country, and of course an even wider heterogeneity among the countries that form this Region. On the other hand, this also results in greater variations of clinical competencies of those completing a training program for one medical specialty and, also, in the impossibility of being able to ascertain the proficiency level of those taking part in such programs.

On the other hand, the demands from the public and from health systems require a greater awareness about the social responsibility of academic institutions in charge of the education and training of future doctors. Furthermore, the last quarter of the century has been connected with relevant changes regarding methodology and teaching strategies of educational institutions. This implies the need to create different evaluative interventions that may guarantee to the population that all measures have been taken to provide a responsible and higher quality medical

Evaluation is typical of every educational organization. Thus, there exists, always by fact (or by right in some contexts) the supervision and control of those graduating from different academic institutions. There is no doubt about the need to focus the evaluation of specialists on two conceptually different levels:

1. at the end of the residency training program, i.e., before starting the independent practice of the specialty, in order to ascertain that the professional standards have been met as defined by the medical authorities, and
2. Throughout the professional practice, in order to ascertain that the specialty-related knowledge and skills are maintained so as to continue providing responsible and high-quality professional services.

We could define competence assessment as a qualitative and quantitative appraisal of those professionals at a certain time- appraisal that results from a constructive critical analysis of the data obtained from a set of observation procedures of professionals.

Due to the wide variety of training programs in Ibero America, it is necessary to clearly state the process in which these assessments are performed due to the fact that, at least to a certain extent, it expresses value judgments. Therefore, it is essential to indicate the patterns established in connection with the defined variables. This implies two important aspects: 1) that there are not identical patterns that may be applied to every institution, region or country, 2) that each institution, professional association or official agency should have their own evaluation models with variations characterizing the professional practice.

In the case of an assessment at the end of a residency training program, the process allows (or should allow) not only a prognostic prediction of the quality of the subsequent professional practice but also a diagnostic evaluation of the situation of residency training programs. This would make it possible to redefine those instances tending to solve any detected pitfalls and continuously improve the achievements obtained.

The socio-economic and social changes brought about during the last years have had a fundamental impact on the relationship between medical education institutions,

doctors and the society as a whole. Among others, the access to multiple sources of information, thanks to the internet, has had a greater impact on the expectations and demands of the populations especially regarding their health and the responsibility of doctors when it comes to their care.

On the other hand, a fast-growing evolution could be seen regarding medical practice. Some of the most relevant elements observed relate to:

1. the increase of biomedical knowledge which causes the growing demand not only on professionals and training programs but also on the competence maintaining programs,
2. the technological advent, which requires a constant updating of the most sophisticated aspects of side clinical methods,
3. Cultural and political transformation, partly conditioned by migratory groups that produce changes on the social values and perceptions, due to the ethnic mixture and multiculturalism,
4. changes on health services organization, management and distribution, for example the importance of primary care medicine, local health care centers and ambulatory medicine,
5. the importance of evidence-based medicine that has significantly changed not only the way “medical science” is conceived but also the relationship of doctors with their patients.

The abovementioned elements have caused the awareness of a new dimension which was confided to a secondary role: social responsibility. This is a key and central concept regarding academic institutions in charge of professional training programs. In this sense, such institutions are responsible in front of society for issues concerning

1. Education: programs should be consistent with the needs of the population integrating the health of individuals and the community as a whole,
2. Research: this includes a wide spectrum of interests, for example, population studies and transference action ,
3. Services: these support promotion and participation to original approaches.

Obviously, academic institutions aim at training professionals that belong to an “ideal” professional profile. Such professionals should possess:

- ? Updated knowledge to provide effective and efficient health care for his/her patients,
- ? Sufficient clinical competence to practice medicine according to the expected set standards,
- ? Predisposition to permanently continue his/her training,
- ? Ability to balance both health care and disease prevention interventions
- ? Ability to apply professional values,
- ? Ethical behavior,
- ? Ability to have an excellent use of resources,
- ? Awareness of his/her personal well-being and that of his/her peers,
- ? Professionalism.

Due to the fact that the framework for medical education is a continuum that turns a beginner into an expert, it is necessary to develop, during the training process, assessment and control models in order to assure that professionals are as close as possible from the desired profile and that they are able to maintain such standards during their professional career.

The autonomous practice of family physicians should be monitored by examinations where multiple aspects of the professional’s skills are assessed: technical skills, diagnostic ability, clinical reasoning, and decision-making capability, not only therapeutic but also concerning follow-up of his/her patients. It is evident that we face

the challenge of developing new tools that may allow us to measure and assess the ability of our professionals to use the knowledge, skills, abilities, clinical reasoning and good judgment so as to be able to:

- ? Identify problems
- ? Investigate
- ? Make a diagnosis
- ? Treat, manage and ascertain follow-up of all patients
- ? Interact with patients, peers and the health care system in general.

Such challenge has been satisfactorily solved in Canada, and Quebec in particular, where a complex multidimensional model is used for the assessment of clinical competence of family physicians, just before they start their independent professional practice. It is a model focused on the professional ability to solve standardized clinical problems. This makes it possible to get an overall picture of the competence among different cohorts of residents that practice medicine. This model has been validated through multiple studies though its final validation is represented in its ability to predict the quality of the day-to-day practice of these professionals. In fact, the follow-up of 3 cohorts of residents 3 and 5 years after graduation, showed that the previous appraisal of assessment can be a good predictor not only of the career's profiles but also of the quality of the medical practice of those professionals assessed. This has made it possible to change several aspects of the training programs. Despite high quality terminal or summative standardized examinations, it is essential to further improve and standardize those instruments used to assess clinical skills during the course of their residency programs.

Another important element regarding clinical competence, is the ability to guarantee their maintenance, according to the professional standards. This is a more difficult challenge that confronts several points of view. However, opposing positions can be summarized in two different, and somehow conflicting, models: 1) the implementation of recertification examinations, which professionals must take every 5 or 6 years, 2) a continuing education-based model in order to maintain professional quality.

Because physicians are responsible for maintaining and improving their knowledge and competence, as well as for planning their continuing education programs, the second approach should be favored instead of that of taking periodical examinations. This one only represents an instantaneous picture of a given moment of their professional career and not an ongoing representation of their real professional evolution.

Nowadays, new obligations regarding professional responsibility are being discussed:

- ? The doubtful statement: "Once incorporated –to professional practice – remains for life " is no longer acceptable,
- ? The public has higher expectations regarding quality, safety and responsibility,
- ? The public must be assured that every certified physician is competent at the beginning of and during the entire professional career.

The selection of a model to maintain competence in countries such as Canada represents the result of a long-lasting consideration. Recertification examinations:

- ? Are perceived as invasive and punitive elements,
- ? Are not adapted to the needs of individuals,
- ? Are too expensive, except if they are only formed by multiple choice questions, which is not justifiable enough for this competence assessment
- ? It is difficult to establish minimum criteria which in order to take sound decisions, particularly, how to measure them.

In order to complete the example of the College of Family Physicians of Canada, we should mention that in order to practice family medicine, physicians must be certified and be members of the National Medical Association. To keep their membership, they must fulfill certain requirements. For example, they must get 50 credits per year or 250 in 5 years. The Association states the required continuing medical education activities. Such activities include credits of different significance, such as:

- ? Exercises about evidence based-practice
- ? Small-groups clinical practice-based learning
- ? Rotations for the improvement of clinical practice
- ? Reanimation intensive training programs
- ? Clinical audit
- ? University activities
- ? Self-learning activities
- ? Clinical research activities
- ? Scientific publications

Even when there are many publications and scientific papers on the impact of continuing education activities on day-to-day practice, and its consequences on decisions related to Recertification, little is said about those professionals who fail such recertification exams. What should Associations do in these cases? What are the consequences on the interactions with patients and with the health system? Those countries or institutions which have chosen this last model have not been able to give any satisfactory answer to such questions.

Finally, we must insist upon the fact that no country should import or copy pre-existing certification or recertification models, instead they should develop their own, taking into account their own academic environments and settings of medical practice. Therefore, it is essential to fully understand the expected professional profile of the family physician and to implement or adapt methods that may be valid to include both complex and multidimensional aspects of medical practice

Even when Ibero America has a long way to go in order to achieve its goals, we must admit that a new and shared tendency can be observed among those involved in the decision-making process aiming to explore and apply new ideas for quality assessment in medical education

REFERENCES

1. BRAILOVSKY, CA. "Educación médica, evaluación de las competencias" in "Aportes para un cambio curricular en La Argentina". Buenos Aires University press 2001, 103 – 122.
2. BRAILOVSKY, CA., MILLER, R. "La competencia clínica y su evaluación" in Guía sobre la formación médica y la competencia profesional en atención primaria". Josep M^a Cots (ed). Profarmaco Barcelona 2002, 143 – 156.
3. COLLEGE OF FAMILY PHYCIANS OF CANADA: The Red Book "Standards for Accreditation of Residency Training Programs" 25 pages, 2002
4. CUNNINGTON, J. & SOUTHGATE, L. "Relicensure, Recertification and Practice-Based Assessment", in International Handbook of Research in Medical Education" GR Norman, CPM.van der Vleuten, DI. Newble eds. Kluwer Academic Publishers 2002. p883-912
5. GRAND'MAISON, P., LESCOP, & BRAILOVSKY, CA. "Canadian Experience with Structured Clinical Examinations", *CMAJ*, 1993, 148: 1573-1576.
6. HANDFIELD-JONES, R., BROWN, J.B., RAINSBERRY, P. & BRAILOVSKY, CA. "The Certification Examination of the College of Family Physicians of Canada: II) Conduct and general performance". *Can. Fam. Phy*, 1996, 42: 1188-1195.
7. KLASS, D. "Revalidation: The Ontario Approach" 11th Ottawa Conference in Medical Education. Barcelona July 2002
8. MCKENDRY, R., BUSING, N., DAUPHINEE, W.D., BRAILOVSKY, CA., & BOULAIS, A. "Does the site of postgraduate medical training predict performance on standardized summative examinations? A comparison of medical school and remote site training" *Canadian Medical Association Journal*, 2000, 163:708-711

9. RAINSBERRY, P. (Director of Education, College of Family Physicians of Canada)
"Mutiple internal documents" Association of Family Doctors in Canada
10. TAMBLYN, R., ABRAHAMOWICZ, M., BRAILOVSKY, CA., GRAND'MAISON, P., LESCOP, J., NORCINI, J., GIRARD, N. & HAGGERTY, J.L. "The association between licensing examination scores and medical practice " *JAMA*, 1998, 11 : 989-996.
11. TAMBLYN, R., ABRAHAMOWICZ, M., DAUPHINEE, D., HANLEY, JA., NORCINI, J., GIRARD, N. GRAND'MAISON, P., BRAILOVSKY, CA. "The association between licensure examination scores and practice in primary care" *JAMA*, 2002, 288:3019-3026.

DEFINITION OF CRITERIA FOR THE ACCREDITATION OF RESIDENCY TRAINING PROGRAMS IN FAMILY MEDICINE

PARTICIPANT COUNTRIES:

ARGENTINA, BOLIVIA, CANADA, CHILE, COLOMBIA, CUBA, ECUADOR, SPAIN, UNITED STATES, MEXICO, PERU, DOMINICAN REPUBLIC, URUGUAY AND VENEZUELA.

AUTHORS

COORDINATOR:

- **Dr. Miguel Ángel Fernández Ortega** **Mexico**
Professor and Chairman of the Department of Family Medicine
School of Medicine, Universidad Nacional Autónoma de Mexico.
President of the Mexican Certification Board in Family Medicine, A.C.

MEMBERS OF THE TEAM WORK:

- **Dr. Susana Alvear**
Ecuador
Director of Postgraduate Studies in Family Medicine, Pontificia Universidad Católica del Ecuador, Hospital Vozandes Quito.
- **Dr. Liliana Arias Castillo**
Colombia
Full Professor of the Department of Family Medicine, Universidad del Valle. Vice-president of the Colombian Society of Family Medicine and Coordinator of the Andean Sub-region, ICFM.
- **Dr. Eduardo Durante**
Argentina
Associate Professor in Family Medicine. Faculty of Medicine. University of Buenos Aires
Sub-chief of the Division of Family and Preventive Medicine Hospital Italiano de Buenos Aires.
President of the Certification Committee of the Argentine Federation of Family and General Medicine (FAMyG)
- **Dr. Zulay Giménez de Rojas**
Venezuela
Academic Coordinator of Postgraduate Studies in Family Medicine, IVSS. Sub-director of Medical Care, Ambulatorio "Dr. Rafael Vicente Andrade", IVSS. Professor, Department of Preventive and Social Medicine, Department of Medicine UCLA.
- **Dr. Lilia González Cárdenas** **Cuba**
Full Professor of General Integral Medicine, Institute of Medical Sciences of la Habana.
- **Dr. Ana Lucía Meyer Lorenzo**
Dominican Republic
President of the Dominican Society of Family Medicine.
- **Dr. Zully Isabel Olivera Stupiello**
Uruguay
Specialist in Family and Community Medicine. Family, Physician of the Department of Public Health. Assistant Professor of the Community Education Department. Universidad de la República. Resident Instructor.
- **Dr. María Ángeles Ortiz Camúñez** **Spain**
Instructor of the Education División of Family and Community Medicine, Seville. Coordinator of the Sub-region Spain WONCA Ibero American Region -ICFM.
- **Stephen J. Spann, M.D.** **United States**
Professor and Chairman of the Department of Family and Community Medicine..
Baylor College of Medicine. USA

- **Dr. Miguel Ángel Suárez Cuba**
Bolivia

Family Physician at the Policlínica Central. Vicepresident of the Bolivian Society of Family Medicine. Professor of Family Medicine. I Caja Nacional de Salud, Universidad Mayor de San Andrés.

- **Dr. Edwina Yen**
Canada

Technical Officer. Human Resources Development Unit. Area of Strategic Health Development. PAHO/WHO

- **Dr. Flavio Zepeda López**

Chile

LOGISTIC ACADEMIC SUPPORT

- **Dr. Claudia Teresa Monobe Hernández**

Mexico

Professor of the Department of Family Medicine, School of Medicine, Universidad Nacional Autónoma de México.

INTRODUCTION

After the end of the II World War the entire world experienced an important phenomenon that transformed the practice of Medicine until these days. The emergence of medical specialties and sub-specialties are the result of the knowledge and skills acquired after the dramatic experiences and conditions that doctors faced during the war plus the subsequent technological advent of our time.

Between the post war era and the 60's, the practice of Medicine showed the emergence of specializations, so that, a generalist became neglected as part of a phenomenon that even to this day is still going on in many countries. However, from the 60s on, when some industrialized countries like England, Canada, and the United States created the image of the "specialist in Family Medicine, with the objective that this new Health professional would bring back to like the profile of that doctor of the XIX or the beginning of the XX century, that was capable of solving most of the diseases of individuals and families he assisted, that could either see a child, and elder or a woman, with such a great clinical ability that allow him/her to see patients at his/her office, hospital or even in their own homes with wonderful human qualities. Educator by nature this doctor was also an expert in doctor-patient relationship and in the promotion of health care.

Anyhow, this new specialist had the task of breaking apart the new and fragmented health care model, organ-, system-, and disease-oriented. Furthermore, this doctor had to understand the individual as a whole, increase patient care quality and also decrease the costs of such practice by requiring less participation of specialized resources and less technical support.

After the success achieved in these countries with the new specialist, there is an emergence of residency training programs in Family or General Medicine in other European countries. During the 70s not only United States and Europe had the new trained resource, but also Mexico, Argentina, and Bolivia started in 1971, 1972 and 1976, respectively. The Declaration of Alma-Ata in 1978, was the main trigger for the development of Family Medicine worldwide. Health Primary Care found in Family Medicine a viable instrument for both rich and poor countries, to offer citizens highly qualified professionals not only to keep them healthy or to solve the most common health-related problems, but also to educate, prevent and promote health care, teamwork and to originate community participation, comprehensive, continuous, egalitarian, accessible and human health care.

Gradually, an increasing number of countries incorporated in their National Health Care Systems the role of the family physician, so that, almost every region in the world has Family Medicine Residency training programs, even countries like Japan, that had been reluctant to the implementation of Family Medicine in their university curricula and health institutions, opened the new residency training program in 1997 due to the pressure of such specialists in Family Medicine abroad.

Then, the shift from a curative to a preventive model is underway in many countries in the world, some cases with the aim of broadening health coverage, in others to reduce costs, or to increase quality, etc. However, many international organizations are concerned about the implementation of quality standards for the training and education of specialists in this area. It can be understood that there may be certain differences varying from one country to another regarding the epidemiological, social, economic or political needs but the fact that the same country has such laxity to allow any school, college or health institution to arbitrarily decide the number of years, curricular contents, rotation periods, graduation profiles, etc, without any kind of quality control, cannot be justified. These aspects should be regulated for every academic institution, so as to guarantee that graduates will have a unique and functional professional profile in any region or health institution in the country. This professional training system shall train human resources capable of satisfying the health care needs of the users. Thus, it shall provide an assessment system with similar performance standards, not only of the resident but also of the educators and academic institutions.

The analysis of the situation of Family Medicine specialized training faces many difficulties. First of all, each country is responsible for acknowledging of the specialty. Traditions, needs and policies, make it difficult to establish universal accreditation criteria of residency training programs, especially in Latin America. The characteristics of Local Health Care Systems are so wide that, in many occasions, it is difficult to determine the particularities of the professional profile of a family physician based upon such a varied curriculum. In order to be implemented, accreditation criteria for educators, academic institutions, supervision programs, as well as improvement of residency training programs do not solely depend upon the international accreditation standards, but also on the political and social needs and possibilities of each country. In this sense, we can state that it is important not to set high international standards that may be unapproachable for the reality of each country conditioned by the international context. The bottom line is that, besides the few or many differences that Ibero American countries may have, each one of them shall have a clear perspective of the most appropriate Family Medicine residency accreditation standards. This can be done by *ad hoc* norms and rules, regardless of the academic institution involved. Such institutions shall include regular supervision and assessment activities, and they may not longer be able to continue with their activities if they are not capable of maintaining an optimum academic level.

CONCEPTUAL BASIS

The expression "medical specialty" refers to a certain setting and epistemology of medical practice which is different from the rest. A medical specialty originates or is recognized when a particular object of the medical practice has been identified as lacking special attention from the rest of the already existing medical specialties, when a set of techniques and procedures are determined, and/or when there is a minimum of relevant knowledge about that object in particular. This makes a specialty different from another one, and the specialist who practices it, should do it according to certain universally accepted and perfectly established criteria, not only within the context of his/her own country but also worldwide. The specialty originates when a group of professionals takes in the control of a technique, knowledge or skill in a specific medical field and establishes the criteria to select and train such professionals together with the environment and conditions in which such training shall be completed.

Traditionally, it was possible to become a professional after acquiring a specific set of knowledge on Family Medicine and a set of abilities, skills, attitudes and aptitudes to perform a certain intervention within this field, by using a group of tools and instruments specific of such specialty. Education requirements may be fulfilled by completing a medical residency training program or a specialized formal graduate course in a higher education institution.

The term Resident refers to the medical professional, having a legally-granted University degree, who becomes part of a medical unit in order to complete a specialization training program. Residency training programs require that such medical doctor has full-time involvement and that his/her learning is mainly practice-based with the appropriate supervision and growing responsibility on the decision-making process regarding the health care of his/her patients and his/her academic activities.

Similarly, it is important to define the residency training program in Family Medicine, as the set of activities that a resident must complete during his /her training period. Such period, that in most of the Ibero American countries lasts three years, shall be formed by a set of technical knowledge about the most relevant aspects of Primary Care, such as national morbidity and mortality rates, not only general but also age-disease specific, taking into account not only the main causes of health care demand in first contact health care, but also the risk approach to maintain the health of the population in accordance with their age and phase of the family life cycle.

Training in Family Medicine:

Training at a Family Medicine Residency shall include the assimilation of a responsible attitude regarding the continuous, comprehensive health care of the individual and/or family, taking into account the social, psychological, biological, economic and cultural dimensions of health or sickness. The abilities and skills that such professional must possess are as follows:

- 1. Problem-solving ability of undifferentiated problems:** in the context of a personal, comprehensive and continuous connection with individuals, and families within their social context.
- 2. Risk Approach:** the identification of risks and early detection of diseases in the individuals, families and social setting (violence, poverty, crime, etc) within the population under his/her responsibility.
- 3. Therapeutic Ability:** an adequate doctor-patient-family relationship, professional-client, maximizes the effectiveness of every type of treatment and interventions aiming to health promotion and disease solving.
- 4. Managerial ability for the administration of resources:** the efficient and effective management of available resources in the community and in the health organization.

A training process with such characteristics requires the use of appropriate tools, such as Evidence-Based Medicine, Problem-Based Learning (PBL), Competence-Based learning, etc.

The fundamental contents for every residency training program in Family Medicine shall correspond to the health-related problems or causes for a higher demand on medical care in the general population (85-90 %), as well as those that generate the main causes of deaths in the different age groups; those diseases with high economic and social impact and, overall, all those issues that may provide appropriate interventions for the management of diseases, and that usually correspond to the following medical disciplines or fields:

- ✍ **Specific Contents of Family Medicine** (that should demand most of the training period)
- ✍ Mental Health

- ✍ Public Health
- ✍ Community Oriented Primary Care (COPC)
- ✍ Internal Medicine
- ✍ Cardiology
- ✍ Endocrinology
- ✍ Gastroenterology
- ✍ Rheumatology
- ✍ Pediatrics
- ✍ Obstetrics and Gynecology
- ✍ Surgery
- ✍ ENT
- ✍ Orthopedics
- ✍ Dermatology
- ✍ Radiology
- ✍ Urology
- ✍ Emergency Medicine
- ✍ Geriatrics and Gerontology
- ✍ Psychiatry
- ✍ Health Management and Economy
- ✍ Bioethics
- ✍ Research

Some structural features of the rotation in FM must include home visits, with explicit educational objectives and goals. Furthermore, it must include a schedule for theoretical activities consistent with the clinical practice of patients in the clinical setting of Family Medicine and at the hospital setting.

As it may be logical to think, such a broad academic program regarding its theoretical contents, requires an equally broad clinical practice program, that may allow residents to integrate the acquire knowledge. Because of this, it shall be necessary to assess the most adequate clinical settings for the residents learning, such as Primary Care units and the Hospitals for patient referral.

The Primary Care unit (academic center) is the place where residents shall develop their clinical family medicine-related skills, such as the care of the most common health-related problems in the out-patient setting where patients usually go accompanied by a family member. This unit not only facilitates the diagnosis and management of the health problem but also, sets the basis for a long-term doctor-patient relationship. Furthermore, it encourages disease prevention and detection, health education and promotion even when this is not the main reason for the consultation, not only for the patient but also for the family member. These units facilitate the diagnosis of the health of the population, and, this way, it becomes possible to organize, plan and manage those existing resources so as to be able to address health-related risks within the community, and design strategies for the education, follow-up and recovery of patients and group management. In this medical unit, residents shall acquire not only those skills consistent with the specialty, but also the attitudes and aptitudes typical of such profile. There, it will be possible to find the model of the ideal family physician. This is way it is crucial that both, the selection of the clinical unit and the educator are in accordance with the suitable profile to achieve this objective. Otherwise, we may condemn residents to have an indefinite profile, to feel “all-inclusive”, a mini-internist, mini-emergency specialist, a bad family physician, or even worse, to remain “vaccinated” against Family Medicine due to frustration.

The Family Medicine Unit must also be a patient care center based on the model of primary health care. In those cases in which the specialized education unit cannot be a family medicine health care center or clinic, the existence within the hospital unit of a family medicine department or division will be necessary. Such Department or Division may have a clear functioning within the Health Care system and equal conditions regarding other specialties. The director or head of the program and the

educators must be experienced family doctors, with a valid certification on the specialty. Every family medicine unit must have a stable patient population, quantitatively and qualitatively sufficient to ensure continuity and comprehensiveness in the learning experiences of residents. Most visits must belong to the families that the resident is in charge of. Reference population must precisely represent the general population regarding demographic aspects and, if possible, morbidity and mortality. The health care center must fulfill minimum requirements such as easy accessibility, not only geographically but also regarding other cultural and economic factors. Programs must offer the possibility to train residents in specific skills belonging to other specialties where the concentration of time and experiences could be relatively advantageous (the so-called rotations). During rotations, residents are part of "horizontal" experiences that are embedded in the approach of the specialty itself.

Rotations:

Hospital rotations have the objective of exposing Family Medicine Residents to the contact with patients that suffer from the more frequent diseases according to the general and age-specific morbidity and mortality, as it was mentioned before, and that are also cause of consultation at the first level of health care. One of the advantages of these "disease concentration units", is that residents can learn about patient's disease diagnosis and therapeutic management having the direct feedback of specialists, so that their decision-making ability can be improved. This is so because, many patients that under other circumstances would be referred to the specialist, are now more confidently treated by them. The services for the rotations of family medicine residents are selected according to the specialties that have a higher demand of medical referrals and that, because of their relevance, are included in the theoretical areas already mentioned. This also includes the area of Emergency, because even when most users do not show "real" emergencies, it is necessary that, in case they do, the family physician is able to address them. On the other hand, most of the diseases seen at an Emergency unit are those that are well-known to the family physician, they may have gotten worse or are concomitant with other pathologies or simply because patients did not show up to the primary care unit because of lack of time or comfort. In the first two cases, residents can get specialized advice from their teachers on the diagnosis or treatment of the disease.

In addition, hospital rotations allow residents to get in contact with a more complex, varied and expensive technology and equipment in comparison with those at the Family Medicine units. This makes it possible for the resident to learn to use, interpret its results, learn about the indications and counter indications, or at least to know of their existence.

Another relevant aspect is that residents can measure their own ability in comparison with peers from other specialties. The day-to-day contact with them in the same service or department may allow them to see that many of the competences such specialists have are not so different, that they represents different points of view of a similar phenomenon or case, that they way they see patients and families and address their problems is a characteristic of the specialty itself, etc.

Even when there are so many advantages, two main aspects of hospital rotations must be taken into account. The first one is the right selection of the services where residents will rotate. The program is so wide that it would seem necessary for the Resident to be in every hospital service or Department. However, this is neither possible nor convenient in order to achieve an effective performance. For example, there is no need for a Family Medicine resident to rotate in the Surgery Department, because in clinical practice he/she will not be exposed to surgical procedures, except some minor ones (except when he/she may be completing a rural training program for an isolated population). It is not convenient either for the resident to rotate in a service on a part-time basis, because that may imply a minimal use of the time. Actually, it is not a matter of weeks, hours or even days, it is a limited practice that would not contribute to the training of the resident, considering that it is a 3-year program and that it constitutes the basis for a life-long professional practice. Therefore,

it is recommended that rotations in the selected services may be two months long and have a full-time basis.

The second main aspect is rotation duration. It is advisable that residents do not stay longer than what is necessary. Rotations must be balanced between the hospital and the primary care unit, ideally interchanging and keeping first year residents at least two or four months in the primary care units before getting out the hospital for the first time. This way, they may be able to identify with primary care practices before seeing other specialties.

If residents stay at the hospital for too long, the first consequence will be a resident who finishes his/her residency training program but feels less of a family physician or not family physician at all. If he/she still keeps the identity of a family physician, he/she may not have acquired many of the competences that should have assimilated according to the professional profile.

Finally, educators or those in charge of the residency training program shall be responsible for include all these knowledge, abilities, skills, attitudes and aptitudes to the three pillars that support our discipline. If this is not done, we could hardly refer to a specialist in Family Medicine:

1. Patient and family comprehensive care

It refers to the fact the family medicine resident shall be able to integrate the biological, psychological and social aspects to the diagnosis and management of the patient (biopsychosocial model), in order to have an efficient and effective intervention, as he/she manages a set of knowledge and abilities to do it. Similarly, he/she will be able to observe the individual as an open system that, at the same time, is part of another open system, the family, which at the same time also belongs to another system, society, which affects the individual and other systems and vice versa. One example of this are cancer patients, they are not only biologically affected but also emotionally, economically and maybe even work-affected as well. This disease makes it necessary to readapt family roles, such as father: provider, mother: housewife, or daughter: student, readapt certain home facilities or family nutrition habits, unemployment, capacity to interact in such a family within its own environment and conditions, etc. Similarly, the family physician will consider the family structure and functioning as causes of health and/or disease, and so on.

2. Continuity of Health Care

A family physician is a health professional capable of offering quality health care to patients and their families throughout different stages of their lives, from birth to death, even during the mourning period when the patient is already dead. When we mention that a family physician may see patients and their families at his/her office, emergency unit, hospital or even at the patient's home, we are also talking about continuous care.

3. Risk Approach

Due to the training and education of a family physician, his/her main priority is to maintain healthy individuals by the appropriate evaluation and management of the personal, family and social (including work) risk factors. It deals with disease prevention that we must pursue using every available opportunity, such as health promotion and education, early disease detection, etc. Even when a new disease is detected, there must be an immediate response in order to avoid any major damage, and even if such damage cannot be avoided, a family physician shall focus on the prompt rehabilitation or recovery and a timely referral whenever he/she comes to the conclusion that he/she cannot do anything else for the patient.

In order to develop a curriculum for this specialty, it is essential to have educators specialized in family medicine who fulfill the following three requirements: a) to be an excellent clinician and an role model for his/her residents, b) to have the ability to teach, that is, have a certain teaching background that may allow such educator to pass on his/her knowledge and c) to have the capacity to do scientific research.

Considering the diversity of residency training programs and specialized courses on Family Medicine, it is important to state the minimum criteria for the Accreditation processes that education institutions, residency training programs must possess. Accreditation is the official recognition on the part of a competent authority, based on the ability of the education institutions to develop training processes where the minimum quality standards are met. It is an integral supervision system that higher education and health institutions possess. Its application is done by the use of different mechanisms of regular performance assessment. Variables significant for project development of such institutions are assessed. Such process of Accreditation shall be similar to assess any other specialization program with a Diploma or Certificate of specialist equivalent to that of the Specialist in Family Medicine. This can be done by completing a medical residency training program, o program or equivalence or of accelerated training of specialists. (page 17)

CURRENT SITUATION

The most relevant results of a survey about the Accreditation Criteria for Medical Residencies, performed between August and October 2003 including representatives of the 14 countries participating in this workshop is shown below:

Canada, United States, Argentina, Mexico, Bolivia, Spain, Venezuela, Dominican Republic, Chile, Colombia, Cuba, Ecuador, Uruguay and Peru.

With the aim of gathering reliable and updated information about the abovementioned Accreditation Criteria, a survey was performed to gather information. Such survey contained 34 items, out of which, the first four had the objective of providing a general idea of the condition of residency programs in the countries involved.

The first item referred to the denomination of the specialist who completes a residency training program. We found a total of four names. The most common one was that of specialist in Family Medicine (Bolivia, Canada, United States, Dominican Republic, Colombia, Ecuador and Mexico); followed by Specialist in Family and Community Medicine (Spain, Peru, Uruguay and one institution from Dominican Republic); Integral General Medicine in Cuba and General and Family Medicine in Argentina and Venezuela.

As we all know, Family Medicine began in Ibero America after the experiences of the United States and Canada in 1969, two years later, Mexico started the first residency training program in the Instituto Mexicano del Seguro Social (Mexican Institute of Social Security). In 1972, Argentina, followed by Bolivia in 1976. After the Declaration of Alma-Alta (1978) Spain and Venezuela in 1979 began the training of specialists from Residency programs. Then, it was the turn of the Dominican Republic, Chile, Colombia, Cuba, Ecuador, Uruguay and Peru, that by 1997 finally starts the first official residency training program, although they had already started the unofficial training of family physicians

As regards the number of family physicians, the United States has approximately 69,000, followed by Cuba with over 30,000, Mexico with 22,000, Spain with 16,000 and Canada with 15,000. Argentina and Venezuela have 2,500 and 1,334 respectively. The rest of the countries have less than 500.

Table 1

Country	Year of the beginning of the first generation of Family Medicine residents	Number of family physicians	Number of Residency Training Programs	Number of yearly admitted residents
Argentina	1972	2,500 approx.	100 approx.	300
Bolivia	1976	200 approx.	7	15
Canada	1969	15 000 approx.	16	750-800
Chile	1982	300 approx.	7	35

Colombia	1984	150	5	20
Cuba	1984	30 000	52	3 000
Ecuador	1987	80	3	24
Spain	1979	16,000	98	1 750
United States	1969	69 000	466	3 523
Mexico	1971	22 000	32	914
Peru	1997	120	3	4
Dominican Republic	1981	144	3	13
Uruguay	1996	150	1	25
Venezuela	1979	1334	11	76

The number of Residency Training Programs in each country varies, United States is the country with a highest number (466), followed by Argentina, Spain, Cuba and Mexico Uruguay has the lowest number (1), because the residency training program is centralized in one university. Here, it would be important to make a distinction. In most of the countries interviewed there is recognition of the specialty at the university level, except in the case of Spain, and some institutions in Venezuela.

The number of vacancies corresponding to the residency training programs per year is closely related with the role of the family physician within each one of the National Health Care Systems, being the United States, Cuba, Canada, Spain and Mexico, the countries where more residents are admitted each year.

In twelve of the countries included in the survey, the residency training programs are three-years long, except in the cases of Canada and some institutions in Venezuela where the programs last two years. In all of the cases it is an essential requirement for candidates to have a Degree in Medicine, General Medicine or Surgical Medicine.

In general, it can be said that the selection for admittance to a medical residency training program in each country is done by means of an annual national examination, although Colombia also takes this exam every semester. In the cases of Argentina, Chile, Colombia, Ecuador, Peru and Venezuela, selection is directly made at the academic institution and no through a National Selection Committee. In other cases such as the Dominican Republic and Ecuador, some curricular aspects are also included for the admittance process.

Selection mechanism	Countries
Annual National Examination	Bolivia Cuba Spain Mexico Dominican Republic Uruguay
Examination taken by each higher education or health institution	Argentina Colombia Ecuador Peru Venezuela
Personal interview, merits and national computerized "matching" system	United States Canada

In ten out of the fourteen countries, the Program directly depends upon universities, although, as it has already been mentioned, some programs in Argentina and Venezuela, and Spain, the program depends upon public or private health institutions. In the case of Bolivia, the academic program depends upon the National Committee for the Health Education, Care and Research Integration, formed by education and health care institutions, as well as Medical Associations (non-commercial association). Apart from these differences, all academic programs have a modular design, divided or

structured by academic year, except Ecuador that divides it into semesters, and that includes three basic aspects: mentioned in the Conceptual Bases section:

- a) **Thematic Contents** of the biological, psychological and social areas.
- b) **Clinical Practice**, it generally includes rotations in the key specialties, although they depend on the needs of each country, Physiatry, Sports Medicine, Rehabilitation, Family Therapy and Intensive Care, among others have been added. At the same time, on-call activities at the emergency units are generalized. There is a great divergence about the designated periods for each rotation, in the hospital as well as in the primary care unit. Thus, we can observe that countries such as Bolivia, Ecuador, Peru and Dominican Republic, assign about 85 to 90% of their rotations to hospital activities, with a minimum first level health care activity; Peru and Canada, 25 and 30% respectively in primary care units: Cuba and Uruguay show an inversely distributed length of time in comparison with the above mentioned information, concentrating about 80 to 100% of rotation times in Family Medicine practices. The rest six remaining countries show much more balanced time distribution between both health care activities, as it is recommended at the beginning of this report.
- c) **Research activities**, that are required in every case.

We inquired about the teaching requirements to become a Family Medicine professor or responsible for a residency training program, and it was found a great similarity among all 14 countries. Such similarities can be synthesized in: a) to be a specialist in Family Medicine, except for Uruguay that has another specialty, b) to have a teaching academic background, c) to show interest and ability to generate new knowledge and to communicate through publications, d) In the cases of Canada, the United States and Mexico, the Family Medicine Specialist Certification or Recertification process granted by the specialized Committee (Peer assessment) is required. Without no doubts, the information gathered in this topic is in accordance with what is recommended in the international literature. These requirements are also required for associate professors in Family Medicine, even when this is not always fully done because of availability issues.

Regarding academic institutions of the specialty, there are different levels, but we can say that for the most part, they are a primary care unit, except for Dominican Republic, Peru, Ecuador, some places in Argentina and an institutions in Bolivia (La Paz), where it is a hospital.

A consensus was reached when the requirements of the academic institutions were discussed, which is also associated with what is stated in the international literature, even when a fixed population per health care center allowing continuity was not considered. However, this can be explained taking into account the characteristics of Health Care Services in the different Central and South American countries, that also hinder the process of regionalization or registration of a family to a defined physician.

The requirements mentioned in the survey point out to the fact of having an adequate physical structure, and, also the necessary human and material resources, such as health care team, teaching and research staff. In addition, the importance of having a family oriented clinical chart was also considered, as well as the fact that each unit should cover a wide range of health care problems and demands in the general population according to the profile of the family physician to whom the training is targeted. Countries like United States and Canada also included informatics as well as its technical support.

Even when it seems convenient for each countries to have a unique and distinctive profile of specialists in Family Medicine, that may be functional to any health institution and any working environment, and, therefore, highly competent to practice medicine in any related situation within the scope of the specialization, what we did find in this survey was that Canada, Cuba, Colombia, Spain, Uruguay and Venezuela have a Unified Curriculum designed for all the academic institutions and each one of them applies such curriculum in accordance with its own characteristics. In the cases

of Peru and Mexico each university developed its own curriculum for each one of the academic institutions it recognizes having generally the geographic scope of a State, Province or Department, according to the denomination each country adopt. In the particular case of Mexico, we can observe an almost complete agreement among different programs. The rest of the countries have a Curriculum per academic institution.

Ten out of fourteen countries have set up Academic Committees for the specialty, the responsibility of which is the supervision, assessment and the suggestion of changes for the curricula. However they are not fully empowered to open or close an academic institution, on the grounds or its good or bad performance. It calls our attention that countries like Peru have set up their Academic Committee without the presence of family physicians. This restricts the objectivity and appropriateness in the specialty-related decision-making process; among others because the training of other linear specialties, hinders the understanding of the horizontal training of a family physician.

Another aspect worth of our consideration is that 11 out of 14 countries, (except Argentina, Peru and the Dominican Republic) have formal organizations, responsible for the supervision of the performance of the residency training programs in each country. In many cases, such organizations are formed by an interinstitutional representation which includes health care institutions, universities, even Departments of health or education, and, in a much lesser extent, civil representation, which is fundamental for the specialty-related decision-making process, because who is to know better about the needs and potentialities of specialists than the peers themselves.

To conclude this situational diagnosis of Family Medicine in Ibero America, Canada and the United States, we shall mention the fact that there are certain experiences with some alternative training mechanisms for specialists in Family Medicine different from the medical residency training programs. In the US, Colombia, and Mexico some attempts have been made to strength the National Health Care System, due to the difficulties faced when incrementing the vacancies of the residency training programs because of financial reasons in some cases, and the physical capacity of the academic institutions in others. Therefore these countries have created interesting training models for specialists, where the graduate's profile is fully comparable with those who complete traditional residency training programs.

Accelerated Specialist Training

United States and Colombia

In these countries several experiences about early education of family physicians have been designed (from undergraduate education). In both cases, selection starts from the very first years of the medical university career for those students selected from the fourth or fifth year. The specialty training takes three years and has the objective of dealing with the same standards than those of the residency training program. The experience started in the United States in 1991 at Kentucky University and later on, eleven universities joined in, beginning in Colombia at the end of the decade.

Specialization Program for general doctors with professional experience (reconversión/retraining by means of part-time attendance mode)

Mexico

In this country there is a specialization program in Family Medicine, targeted to general doctors working for health care institutions, initiated in 1994 by the Universidad Nacional Autónoma de México (UNAM). It is a three-year program, similar to that of the residency training program, on a part-time attendance basis; under a well-defined training scheme at a health care service during working hours. The admittance mechanism is made by an interinstitutional agreement (UNAM-Health Institution). Then, selection is made through a general exam, more than 5 years

working experience (at the health institution signing the agreement), being a primary care physician, besides fulfilling the same requirements of the rest of the physicians who are admitted to residency training programs. The requirements for a participant to be able to stay at and graduate from such programs are similar to those of a residency training program. There are usually national or state programs (departments or provinces).

Other Education and Training-based experiences

Argentina and Chile

There are other experiences in Argentina and Chile that aim to increasing the number of family physicians through programs that can be an alternative to Residency Training Programs in Family Medicine which are based on continuing education and short term training activities (courses, clases, seminars, health care hours, etc), the quality of which is accredited by and Academic Committee of specialists so that, when participants accomplished such activities they can get the required credits to be able to take the certification examination and, if passed, have the certificate of specialist in Family Medicine.

PROPOSED CRITERIA AND CHARACTERISTICS

The analysis on the current situation in Ibero America, allows us to appraise with great enthusiasm that, although with different levels of progress, Family Medicine as a specialty is in full development within the Health Care Systems of the region. It is received as a viable alternative for the improvement of the quality of the services in the primary care setting, and it is considered to be very similar among the different countries according to the studied indicators.

At the same time, the important role of the Universities in the development of the specialty in the region should be acknowledged as the promoters of a shift from the curative to the preventive health care model; the Health Care organizations as managers of the change within their specialty units and the Medical Associations as catalysts of the reaction of the university and health care services.

It is irrefutable that the development of Family Medicine in Ibero America during the last 25 years has been greatly driven by the Declaration of Alma-Ata (1978), with the goal of providing "Health For Everyone in the year 2000", being more recently determined by the search of a health care model that allows higher quality and equity of services at a lower cost.

In spite of the similarities in the indicators studied, such as the number of years of Family Medicine Residency training programs, it is advisable to set a 3-year minimum period in accordance with the international average. In some countries, this period is not enough to fully develop the different topics and practices provided in the academic curriculum. In countries such as Israel, Denmark and Greece the length is 4 years, and in Finland, Norway, Sweden and Switzerland, 5 years.

On the other hand, the contents of the academic curriculum, the teachers' profile and the characteristics of the units, the admission, permanence and graduating requirements, are also very similar, so that it would be of great importance to begin by fostering the implementation of a unique Curriculum for each country and that in spite of the differences naturally found in the academic institutions, this curriculum should match with the official residency training program for this specialty as much as possible. It is surprising that although in the questionnaire sent to each country, the speech about the profile of the professional who completes a residency program is very much alike, the truth, in a great number of cases, is far from that idealized view of what should be a family physician, and that is dramatically opposed to the reality of the National Health Care Systems.

Likewise, it is necessary to incorporate other criteria that allow the quality assurance of the programs offered. Here we refer to the Evaluation process that shall have similar standards for the residents of the different academic units, by means of written and oral examinations, with a real patient, through the Objective Structured Clinical

Examination, etc. The point is that if all the academic units have the same curriculum, all students should also have to accredit the same professional competences.

Another important issue on the evaluation issue, is the one referring to the Assessment of the teaching performance of the professor, where he/she should demonstrate the fulfilments not only of the requirements, but also the duties established in his/her working contract; showing that such professional is updated, an excellent clinician and that he/she has the ability to transmit his knowledge to the students, sticking to the curriculum.

It is essential for the legally established governmental organizations work towards the uniformity of such academic entities, since it is inappropriate to have in the same country different kinds of training residencies, with different curricula, different admission and graduation mechanisms and different professional profiles. The residency training programs in Family Medicine shall be qualified to respond to the health care needs of the population regardless his/her field of work, public or private, social security or of Health Departments and Ministries. The government in each country shall assure that the Reforms of the Health Care programs are focused not only on the shift towards higher quality, equity and access health care services, the reallocation of duties and competence for each level of care when incorporating the regionalization of the population. Also, it should make use of the most qualified human resources to provide risk approach health care to prevent disease providing comprehensive and continuous health care to the individual and his/her family, equitable and accessible to the most vulnerable groups. Likewise, it should assure cost-effective health care, repeatedly mentioned in all the documents that deal with that issue.

Independently of these significant aspects for the improvement of the Health Care systems, it is necessary to insist on the importance of establishing the official instances with governmental, academic, health care sector and civil representation, that allow to legitimate the duties of the Family Medicine academic centres, homogenize and update the programs, supervise its development, evaluate as an external audit the quality of their graduates, determine the quantity of the needed resources at a national level in each promotion, etc; and establish the criteria for the accreditation of all and every place for Residency programs in order to limit the existence of low quality academic settings.

It is also important to mention that the Accreditation of the Residency Training Programs in the different countries shall go together with other accreditation processes, such as the **Certification of specialists, Certification of Colleges and Schools of Medicine, and also Health Care centers** It will be difficult for all stakeholders involved in these processes (government, universities, health care institutions and medical associations) to succeed without the participation of the others. That is why it is essential to define the roles, limits and participation mechanisms of each one of them, incorporating the strengths of each party, adding and not minimizing efforts, acknowledging the importance of each of them.

It is difficult to understand a highly effective health care system that can not assure the competence of its professionals once graduated from the Residency Training programs, through the periodic **Certification and Recertification**, carried out by their peers and not by the academic institutions that can have a biased point of view of the training needs in each specialty or the product that graduate from them to the health care sector. It is also hard to measure the academic quality of the universities without the existence of external evaluations (from peers), that allow an appropriate audit of the institution's activities according to perfectly well defined indicators. Finally, a proper quality of the health care services cannot be obtained, without a clear definition of the standards, norms, resources, proceedings and achievements of the units in charge of implementing the institutional programs, and again, without the participation of parties not related to the evaluated institution, that allows a greater objectivity and impartiality in the assessment.

It is important to point out that in every country and region of the world, the unavoidable effects of globalisation can be observed and that in spite of the international borders among nations, the economic, commercial, social, and health effects can be perceived. Although it is true that Latin America has distinct macroeconomic indicators, the morbidity and mortality as well as demographic and epidemiologic transition is similar, this fact compels us to redesign the training programs for generalists and specialists in accordance with the characteristics of the National Health Care systems.

RECOMMENDATIONS

Finally, it is convenient to conclude with two basic recommendations with the aim of contributing to the improvement of the residency training programs in Ibero America:

1. Each country shall be responsible for establishing the minimum requirements concerning the accreditation of Residency training programs in Family Medicine, aiming to guarantee a basic professional competence profile in each and every training unit for the specialists in their countries. To do this, we suggest the consideration of the following aspects: name of the specialty, professional profile, time length, admittance requirements, permanence requirements, graduation requirements, curricular structure, requirements for teachers and professors, characteristics of the Family Medicine academic institutions and characteristics of the academic hospitals which support the education process.

2. The establishment of National Inter-institutional Committees of Medical Residencies is suggested. Such Committees must regulate not only the specialty of Family Medicine but also other medical specialties existing in each country. Its role shall be fundamental for the issuance of accreditation norms and procedures of medical residency programs, it shall allow the complete homogenization of the standards of the minimum necessary competences required by specialties in each country. In this context, it shall set the quality assessment mechanisms of residency training programs approved in accordance with the existing norms regulberog all medical specialties, consistent with the health needs of the population, the performance of health institutions and the organization of under and post graduate education programs at the local universities. Furthermore, it is highly recommended that this Committee may be formed by representatives from education and health institutions in charge of the training of specialists, by the entity responsible for the certification and accreditation processes and by representatives of the corresponding medical associations.

REFERENCES

1. PAHO/WHO. Division of Health Care Systems and Services. Human Resources Development Program. Education quality in the accreditation of specialist training programs and professional certification. 2000.
2. Kitamura K, Fetters M, Ban N. The Experiences of Japanese Generalist Physicians in Overseas Faculty Development Programs. *Fam Med* 2002; 34(10):761-765.
3. Hernández Hernández F, Vargas Negrín F, Cabrera Quintero L. Acceso "Excepcional" al título de especialista en Medicina Familiar y Comunitaria, y ejercicio de la Medicina de Familia en el SNS. Disponible en URL: <http://www.comtf.es/ActaMedica/1998/2/Pag7a9.html>
4. Parchman M, Katerndahl D, Larme A. Family Medicine and Research: From Here to Eternity. *Fam Med* 2003;35(4):291-295.
5. Loewe R. Atención Primaria a la Salud: Revisión Conceptual. *Salud Pública Mex.* 1988; 30: 666-675.
6. PAHO/WHO. Desarrollo de la Práctica y Educación Médicas en América Ibero y el Caribe: Evaluación y Acreditación de Instituciones y Certificación/Recertificación de Profesionales. 1997.
7. Unión Europea (UE). Enciclopedia Micrisoft. Encarta Online 2004. Disponible en URL: <http://es.encarta.msn.com>

8. Weingarten MA, Polliack MR, Tabenkin H, Kahan E. Variations among examiners in family medicine residency board oral examinations. *Medical education*. 2000;34: 13-17.
9. Frenk J. Recursos Humanos para la Salud: cambios y tendencias recientes. En: *Observatorio de la Salud*. Fundación Mexicana para la Salud. México. 1997; 9:221-236.
10. Casson C. The Winston Churchill Memorial Trust. Churchill Fellowship Report 2000. To investigate systems of quality assurance for General Practitioners U.K., Netherlands. Disponible en URL: <http://www.churchilltrust.com.au/Fellows%20Reports/Casson%20Claudia%20report.pdf>
11. Alonso Magdaleno MI. El proceso de convocatorias de plaza MIR en el SNS y su repercusión en la situación del colectivo médico. *El Médico Interactivo*. Diario Electrónico de la Sanidad. El Médico 16-XI-01. Disponible en URL: <http://www.medynet.com/elmedico/informes/gestion/mir.htm>
12. Fabian C. The future general practitioner/family doctor in Europe – a specialist. European Union of General Practitioners. Disponible en URL: http://www.uemo.org/history/a_challenge_for_uemo_2002.htm
13. Colegio Oficial de Médicos de Balears, España. Legislative background available in: <http://www.comib.es/homologacion.PDF>
14. The American Board of Family Practice. Disponible en URL: <http://www.boardcertifieddocs.com/bcd/supplement/fp.pdf>
15. Norris N, Berrington B, McKee A, Hibble A, Johnson, N. Recertification in general practice reconsidered. Norwich: CARE, University of East Anglia. 1998. Disponible en URL: <http://www.uea.ac.uk/care/pubs/recert.pdf>
16. The Accreditation Council for Graduate Medical Education (ACGME). 2000. Disponible en URL: <http://www.acgme.org/GmeDir/sect1info.asp>
17. Brook PJ, Smith SM. Contratación de servicios públicos. La ayuda en función de los resultados y sus aplicaciones. Disponible en URL: <http://worldbank.org/Documents/OBA%20Part2%20Chapt8-S.pdf>
18. Norris TE, Acosta AD. A Fellowship in Rural Family Medicine: Program Development and Outcomes. *Fam Med* 1997; 29(6):414-20.
19. Galazka SS, Zweig S, Young P. Progress Report on Accelerated Residency Programs in Family Practice. *Academic Medicine*. 1996; 11(71).
20. Norma Oficial Mexicana para la Organización y Funcionamiento de Residencias Médicas. NOM-090-SSA1-1994.
21. Ceitlin J, Gómez-Gascón T. *Medicina de Familia: La Clave de un Nuevo Modelo*. SemFyc. Madrid. 1997.
22. Fernández-Ortega MA, Mazón-Ramírez JJ, Ponce-Rosas ER, Torres I, Lizcano-Esperón FJ, Domínguez del Olmo J. Curso Semiescolarizado de Especialización en Medicina Familiar (CuSEMF) en México (1993). *Aten Fam de España*. 2003; 31(2):114-119.
23. Toledo-García JA, Fernández-Ortega MA, Trejo-Mejía JA, Grijalva MG, Gómez-Clavelina, Ponce-Rosas ER. Evaluación de la competencia clínica en el posgrado de Medicina Familiar mediante el examen clínico, objetivo estructurado. *Aten Fam de España*. 2002; 30(7):435-441.

DEFINITION OF CRITERIA FOR THE ACCREDITATION OF CONTINUING MEDICAL EDUCATION ACTIVITIES.

PARTICIPANTS:

ARGENTINA, BOLIVIA, BRAZIL, CANADA, CHILE, COLOMBIA, CUBA, ECUADOR, SPAIN, UNITED STATES, JAMAICA, MEXICO, PARAGUAY, PERU, DOMINICAN REPUBLIC, PUERTO RICO, URUGUAY AND VENEZUELA

AUTHORS

COORDINATOR.

- ? **Antonio Monreal Híjar. Spain.**
Coordinator of the Faculty Unit of Family and Community Medicine, Zona I Zaragoza. Responsible for the Education Division, Spanish Society of Family and Community Medicine (semFYC).

MEMBERS OF THE WORK TEAM.

- ? **Abelardo Saldaña. Panamá.**
President of the Panamenian Society of Family Medicine.
- ? **Ana Antonieta Tassoni Rodríguez de Blain. Venezuela.**
Education and Health Care Sub-director. Centro Ambulatorio "Dr. Luis Guada Lacau". Instituto venezolano de los Seguros Sociales (IVSS) (Venezuelan Institute of Social Security).
- ? **Enrique Abache Salazar. Venezuela.**
Gynecologist and Obstetrician. Service of Fertility at the Maternidad Concepción Palacios. Red de Sociedades Científicas de Venezuela.
- ? **George Velásquez Zúñiga. Cuba.**
President of the Holguin branch of Family and Community Medicine. Universidad "Mariana Grajales Coello". Holguin.
- ? **Nora Díaz Estela. Argentina.**
Vice-president Certification Committee of the Federación Argentina de Medicina Familiar y General-FAMFyG (Argentine Federation of Family and General Medicine). Coordinator of the Residency Training Program in Family Medicine -MSP-Salta-Argentina.
- ? **Norma Ivone Armas Guerra. Ecuador.**
President of the Ecuatorian Society of Family Medicine. Faculty member of the School of Medicine of the Universidad Católica del Ecuador-PUCE.
- ? **Oscar Andrés Fernández Fuentealba. Chile.**
Sub-regional coordinator of Conosur -WONCA- Ibero American Region- ICFM. President of the Chilean Society of Family Medicine.
- ? **Raúl Ramírez Nizza. Paraguay.**
Member of the Accreditation Committee of the Paraguayan Society of Family Medicine.
- ? **Ricardo Escobar. Colombia.**
Executive Director. Colombian Association of the Schools of Medicine. ASCOFAME
- ? **Stephen Spann. EEUU.**
Professor and Chairman of the Department of Family and Community Medicine. Baylor College of Medicine Houston. USA

INTRODUCTION.

The responsible practice of Medicine has always required a commitment with Continuing Medical Education as a main tool for the maintenance and update of Professional Competence.

The *rapid development* of medical-scientific knowledge, the appearance of new alternatives for prevention, diagnosis, and therapeutic approach, as well as the important changes in the physician-patient relationship, based on the introduction of new models of interaction between them, require a commitment on the part of the professionals with their own training.

The World Health Organization defines Continuing Medical Education (CME) as a process aiming to help professionals to adapt and to take an active role in the changes that will be introduced in the systems, as far as they influence their personal and economic progress and their daily clinical practice.

In addition, nowadays there is an evident increase of the social demand of High Quality Health Care Services. It is evident that one of the factors that determine said quality is the level of Health Professionals' Competence. In this respect, Family Physicians play a decisive role.

Recently, the term Continuing Professional Development (CPD) has been coined. It establishes a wider concept, in which not only Continuing Medical Education (CME) is included, but also some other not strictly medical competences, such as personal, social and managerial requirements. Throughout their professional life, Family Physicians, then, have the ethical duty of participating in activities such as CME/CPD. Finally, it is essential to ensure that all the potentially acquired knowledge and competences are put into daily practice, in this respect, Transfer Knowledge [TK]) will be the essential element to practical application of the acquired knowledge during the process of Professional Development.

It is obvious that those chiefly responsible for the maintenance of their professional competences are physicians themselves, this circumstance does not diminishes the enormous responsibility of Health Services or other Healthcare Agencies in their wider conception, for ensuring both the appropriate competence level of their professionals and the easiest access into Continuing Education Systems, with the main goal of ascertain the quality in Healthcare to improve society's health.

We are facing an unquestionable reality in which on one hand, society, in its right, demands the best healthcare in its technical-scientific perspective as well as in other essential aspects such as physician-patient relationship and efficient resource management, among others and on the other hand, healthcare professionals, in their deeply internalized wish, assume the responsibility of putting into practice a Continuing Professional Development as a previous condition to the improvement in the quality of professional assistance and healthcare. Finally, Healthcare Agencies, in their role as competitive professional companies, must ensure the best quality of their product which, in this case, is healthcare, that is why they must assure the best educational context for their professionals.

Therefore, Continuing Medical Education Systems will have to contribute in Knowledge, Skills and Attitudes that Family Physicians need to focus their practice in individuals, families and the community.

Once the decisive importance of Continuing Medical Education and Continuing Professional Development is established, the need to set specific plans and programs, in our case in Family Medicine, that comply with a series of essential characteristics must be defined openly:

Specificity.

Family Medicine, as a Specific and Different Knowledge Area is an academic discipline and a medical specialty. In this way, Family Medicine object of knowledge are individuals in full and families as a social system (as a whole), offering a continuing medical approach, without fragmentation between biological, psychical and social aspects, and increasing health level of individuals through the integration of prevention, promotion, healing, rehabilitation and palliative cares, directed not only to individuals but also to families and communities.

Under this perspective, it is essential to design a Continuing Medical Education Program focused on the aspects previously described and that allows the consolidation of the professional profile as well as Family Physicians' values and Family Medicine.

Accessibility.

The shared responsibility regarding maintenance and improvement in Professional Competence quality must ensure the possibility of an easy access to educational plans and programs of Family Physicians.

To put this into practice, it seems adequate to establish appropriate policies that ascertain not only a wide educational offer including quality criteria within the contents of Family Medicine but also economic and human resources in order to guarantee this.

Scientific-Technical quality guarantee.

Occasionally, professionals can find it difficult to choose Continuing Education activities adequate to their professional improvement areas.

The learning of the Family Doctor's different knowledge, skills and aptitudes has many learning strategies. There are specific pedagogic approaches to transmit and acquire the different contents regarding each competence. The adaptation of the best scientific-technical quality should be granted.

In this respect, it is important that educational institutions/ agencies, such as Continuing Medical Education have a guarantee proving its reliability and suitability for the proposed objectives.

Funding.

Funding of Continuing Medical Education in Family Medicine must be an essential part of the total cost of Healthcare Systems, whether public or private, whether salary earner or self-employed.

As Family Medicine is a professional activity that requires vast knowledge and a constant update, a significant part of the budget should go to Continuing Medical Education to keep and develop the healthcare quality that society demands. In all cases, Continuing Medical Education's funding systems will have to honestly respect the professional integrity of Family Physicians. Consequently, there must exist a complete openness regarding the sources of educational activities funding.

Professional Participation.

It is obvious that professionals, in this case Family Physicians, are the beneficiary of Continuing Medical Education, they should be active participants in the preparation, design and accreditation of the educational offer. Under this perspective, professionals' participation must be ensured through appropriate channels: Professional Associations, Scientific Societies, among others.

Professional Acknowledgement.

Regardless of the Family Physicians' ethic commitment to society respecting the guarantee of their professional competence, the compliance of the said commitment and the added effort that maintenance, constant improvement and adaptation of the professional knowledge presuppose, there should exist a system of motivation, incentive and acknowledgement in a professional as well as institutional and social level.

FAMILY MEDICINE AND CONTINUING MEDICAL EDUCATION.

All the previously described conditions become even more evident when they are tackled from Family Medicine because there exists a set of peculiarities that accurately define Continuing Medical Education's significant value:

Family Medicine as an Entry to Healthcare System

As Family Physicians in many occasions are the first contact of the patient with the healthcare system and given their strategic situation inside it, the exact knowledge of the different alternatives and possibilities make the continuing update of their education something necessary.

Resources Management.

Family Physicians are conscious that the inadequate use of healthcare resources (complementary tests, medication, interventions) apart from producing a iatrogenic effect on the patient, it also presuppose a misuse of a resource, ultimately economic, that could have had a better destination. In this case, once more the deepest scientific-technical knowledge in clinical aspects as well as in healthcare management is essential for the Family Physician.

Bio-psycho-social Perspective of Family Medicine.

It is in Family Medicine, more than ever, that a correct management of the patient's bio-psycho-social determining factors and his/her balance between health and disease is essential. This wide conceptual dimension of Medicine Family, key aspect in the Family Physician's view, is, on the one hand, one of the strengths of the specialty and on the other it turns it into a profession where sociological, psychological and emotional factors become as important as biological ones.

This paradigm demands continuing updating processes in educational areas that traditionally does not belong to conventional Medicine but that are of vital importance to Medicine at the level of Family or Community.

Family Physician's Multidisciplinary Activity.

Regardless that the Family Physicians' professional profile is well defined, nowadays their versatility as a multidisciplinary professional makes different Healthcare Systems include, decisively, Family Physicians in several patient care services such as Emergency Care, Palliative Care Units, Home Care, among others.

On the other hand, Family Physicians' skills in Healthcare Management have a growing importance.

This horizon of multidisciplinary activity heads for the need of a wide and profound educational supply as an essential tool for Family Physicians as a specialty depending on individual professional profile.

Logically, both circumstances require a complete quality assurance to prove the suitability of the scheduled educational actions.

Obviously, the previously described approaches are supported by the perspective of the processes of described Continuing Medical Training will be used, ultimately, for the constant improvement of patients' welfare quality and every educational strategy, whether personal or institutional, must be planned and developed under this premise.

CONCEPTUAL BASIS.

Once the need to implement Continuing Medical Education Individual Programs is clear not only for professionals but also for the Healthcare System and society, it is necessary to establish solid strategies to deal with the operative planning of these educational programs or activities under their own perspectives of Quality Assurance.

Accreditation of Continuing Medical Education's activities supposes one of mainstays of constant professional certification as a backing element to prove that the professional competences are appropriate to the correct practice of Family Medicine.

There are numerous international examples that evidence that the development of activities accreditation structures produces a manifest improvement in their scientific-technical quality and, equally, a final favorable impact on the professional activity. It is set, then, the importance of establishing proposals to define the technical requirements that Continuing Medical Education activities should have to be acknowledged as appropriate to improve professional competence. In that sense, systems of accreditation of activities should contemplate some explicit basic criteria including the following:

A. Appropriateness and Suitability Value Related to Professional Profile.

Family Physician's professional profile in this sense, includes the following competences:

Table 1

✍ Essential Competences	✍ Physician-patient communication.
	✍ Clinical reasoning.
	✍ Healthcare Management.
	✍ Bioethics.
✍ Individual care.	
✍ Family care.	
✍ Community care.	
✍ Education and Research.	

Activity appropriateness: the content of the activity must answer clearly to the specialty profile and to some kind of need or demand justified and specified enough.

B. Concrete and Well Defined Teaching Goals.

Accreditation must ensure that teaching goals are related directly to the educational knowledge of those attending the program, that is to say, to the improvement of professional knowledge, skills or attitudes.

C. Theoretical and Practical Contents.

Appropriate to the desired teaching goals.

D. Appropriate Teaching Methods.

It includes tutorship systems in distance learning activities, ensuring that in all the cases, the method employed is the correct one regarding pedagogic goals. In this sense, it is important to appreciate that there are certain types of educational activities that, due to their methods, encourage the so called "active learning" in which, professionals played a leading role in their own process of acquiring competences.

E. Number of Students.

The number of students should be the adequate to allow the teaching techniques to achieve the greatest efficiency.

F. Qualified Faculty Appropriate to the Type of Activity.

In this sense, the communicative and participatory abilities of the teachers are important. However, it is extremely important that the faculty know perfectly Family Physicians' profiles and values as well as their competences and their professional environment.

G. Appropriate Length.

Regarding activities, they must ensure that, to a certain extent, its length correspond to the desired goals.

H. Bi-directional Activities Evaluation.

The existence of a bi-directional assessment that ascertains the success of the activity is essential in a teaching accreditation context.

There will be two kind of criteria; those legally binding which must be complied in any accredited activity such as clear and adequate goals, adjustment of professional profiles, evaluation of teachers and of those attending the program, appropriate theoretical and practical contents, suitable methods and teaching staff and the other group concerning assessment criteria related to the type of activity: number of students and school hours.

Besides, the systems of activity accreditation will have to have audit or surveillance systems to ensure that what is actually done by the educational agencies correspond to what is evaluated by the accreditation agency.

Once the technical criteria to assess and accredit the activities of Continuing Medical Education are set out, three fundamental approaches must be considered:

1. *Entities capable of accreditation of CME activities.*

States will have to define and justify the delegation of this enormous responsibility once the technical criteria, in which the said accreditation must be supported, are established.

It seems evident that both Public Administrations (Universities, Health and Education Ministries) as ultimate guarantors of professional competence of graduates and Healthcare systems which provide healthcare must take an active part in the accrediting entities.

On the other hand and equally important, professionals represented by their associations (Scientific Societies, Physicians' Association, among others) as direct beneficiaries of the good or poor quality of the activities of Continuing Medical Education must take an active part in the process of evaluation and accreditation of the activities.

2. *Accreditation of Institutions as Educational Product Agencies.*

Accreditation systems, in the interests of sorting out, quantitatively and qualitatively, the enormous educational offer must give their quality guarantee to those agencies that ascertain, through their prestige and widely proved methods, standards of educational products appropriate for the desired needs.

3. *Highest Institutional Acknowledgement of Accredited Educational Activities.*

Accreditation systems must assure to their utmost the acknowledgement of the value bestowed upon accredited activities, nationally as well as internationally.

In this sense, it is important to establish homogeneity and agreement systems of value of educational activities so that the said mutual acknowledgement has a real value. In certain professional areas, **Educational Credit** has been established.

Such figure should not supposed an automatic comparison with school hours of the activities in question, but to count the teaching workload that the development of the mentioned teaching activity implies for those attending these activities, also including hours of attendance of the activity, hours of field activities, the hours of individual studying and the preparation of the evaluation of the teaching activity. Moreover, the value of this measurement unit, which basically pretends to establish a homogenizing element, should acknowledge a higher importance to the educational activities based on scientific evidence and that, therefore, had proved their effectiveness.

The term **Educational Credit** is of special indication in activities that require a major practical component on the part of those attending the training programs and in distance learning and on-line activities.

In this respect, it is evident that the development of professionals' training processes will eventually head to activities in which, customary classes or masterly lessons lose their values as educational referents because nowadays interactive learning systems, based on problem-solving, work and approaches with real patients, directed self-learning, among others are predominant. This new educational scene evidently escapes from hours' quantification to approach to concepts of teaching hours or Educational Credit.

Likewise, it is important to clarify that Educational Credit concept and other credit models dealing with equally important aspects in Continuing Professional Development (CPD) are compatible.

Finally, it can be concluded in this section that although there is no scientific evidence which ascertains irrefutably that Continuing Medical Education activities improve clinical and professional effectiveness, it is evident that the regulation of the intrinsic value of educational activities favor individual professional growth regarding the evident educational needs.

In conclusion, it is necessary to verify that Continuing Medical Education Systems ideally must represent **Integrated Educational Programs** with clearly defined aims of constituting "a whole" with internal and external logic and coherence where the components or some of them interact between them under an educational planning previously defined. It is important to emphasize this because sometimes educational activities seem to pursue, as a priority, to occupy a certain share on the market's offer more than the ultimate aim to which they should have been defined.

CURRENT SITUATION OF ACREDITATION PROCESSES OF CONTINUING MEDICAL EDUCATION ACTIVITIES IN IBERO AMERICA.

According to what has been stated before, it could be inferred that the Continuing Medical Education activities constitute an essential element for the maintenance of the Professional competence and to the final extent for the improvement of the quality of the Health care systems.

On the other hand, it is clear that there is a shared responsibility among the Family physician, the Health Care Service and the academic entities and Scientific associations of the specialty in the maintenance of the Professional Competence, seeming logical to encourage the professionals to evaluate their areas of competence in order to demonstrate the situations of improvement, motivating those professionals who show a greater commitment with their education.

Under these previous premises, the situation of the Ibero-American countries regarding every aspect of the Continuing Medical Education must be analyzed, looking for the points of confluence on which to propose policies and strategies that facilitate the technical homogenization of the countries involved, as an element of quality assurance of the Family Physician's professional education.

Agencies or institutions that provides Continuing Medical Education activities.

In the analysis of the ownership of educational supplies of eighteen Latin-American countries, an ample training portfolio is shown, being the Scientific Societies, Universities, Medical Associations and Health Care Services the main providers of said offer. This leadership takes place in most of the countries. In a second level there are other more diversified and apparently less consolidated suppliers: Hospitals, Institutes, pharmaceutical companies, etc.

From this, it could be inferred that a great homogenization in the offer of activities in the selected countries is produced, and that the offering agencies are mainly of public ownership or depend on professional associations. (Exhibit 2).

EXHIBIT 2: INSTITUTIONS OR ENTITIES LEADING THE SUPPLY OF CONTINUING MEDICAL EDUCATION

COUNTRY	SCIENTIFIC ASOCIATIONS	SCHOOLS OF MEDICINE	MEDICAL COLLEGES	HEALTH SERVICES	PRIVATE ENTITIES
Argentina	+	+			+
Bolivia	+	+	+	+	
Brazil	+	+		+	
Chile	+	+		+	
Canada	+	+		+	+
Colombia	+	+		+	+
Cuba	+	+		+	+
Ecuador	+			+	+
United States of America		+	+		+
Spain	+		+	+	+
Mexico	+	+		+	+
Panama	+	+		+	+
Paraguay	+	+		+	+
Peru	+	+		+	
Puerto Rico	+	+	+	+	
Dominican Republic	+		+		
Uruguay	+	+		+	
Venezuela	+			+	+

Financing of Continuing Medical Education activities.

In contrast to what takes place in the offer of activities, in which the pharmaceutical industry is in financial resources used by the professionals while facing the economic cost of said activities, the brands is clear and evident.

In a second analysis, the same professionals would be the ones to assume the cost of the education in countries the Public Administration directly finances the continuing education.

The role of the Scientific Societies in this aspect is limited, granting in certain circumstances members. (Exhibit 3).

Role of the Continuing Medical Education activities in the professional development.

Having clarified the importance granted by professionals in associated countries to the education offer not only Public but also private and its financing resources, it is necessary to show the importance of Medical Education activities concerning the Professional Career.

It seems evident that the appraisal of said activities when having access to vacancies to fill teaching positions, improvement of the working conditions, etc., could constitute a very interesting additional value which is important in itself for the Family Physician.

From the analysis of the information gathered in the different countries it is inferred that even with an evident tendency to grant curriculum value to every kind of education activity: courses, workshops, conferences, etc. In this sense, the necessity to take a certain amount of teaching hours or credits to be consolidating, as a system of maintenance and improvement of competence. (Exhibit 4).

Apart from the curriculum value, that is slowly consolidating the program and educational activities in systems of medical recertification, it is becoming more and more essential to certify having carried out a certain number of hours or credits, in order to have access to certain Health care and educational positions. In some cases, there is an economic motivation for such activities.

In a generic way, it seems that the exclusive private practice of health care does not provide a contribution in the public function, where in certain cases, it is compulsory to carry out a minimum amount of continuing education implicit in the post being developed.

In the countries in which the systems of recertification are not applicable, there is not at present a requirement of Continuing Medical Education activities as a requirement to maintain the medical license, as it occurs in countries where such systems are applicable.

EXHIBIT 3: FINANCING SYSTEMS OF CONTINUING MEDICAL EDUCATION

COUNTRY	THE INTERESTED PARTY	PHARMACEUTICAL INDUSTRY	SCIENTIFIC ASSOCIATION	INSTITUTIONS	OTHERS
Argentina	+	+	+		
Bolivia	+	+	+		
Brazil	+	+	+	+	
Canada	+	+	+	+	+
Chile	+	+	+	+	
Colombia		+			Employee
Cuba				+	
Ecuador	+	+			
Unite States of America	+	+			
Spain	+	+		+	
Mexico	+	+		+	
Panama	+	+		+	
Paraguay	+	+			
Peru	+	+			
Puerto Rico	+	+	+	+	Hospitals
Dominican Republic.			+		+
Uruguay	+	+	+		
Venezuela	+	+			

Accreditation Systems of Continuing Medical Education activities.

In most of the associated countries, the providers of educational activities request with relative frequency the instituti mainly from the Schools of Medicine, Scientific societies or Medical Academies granting support to the scientific-techni Basically, the above mentioned activities, take place in the traditional educational way: courses, workshop, sem programs.

There is less consolidation in the acknowledgement and support to other kind of activities as for example the scientific Finally, a scarce impact of these mechanisms is noticed on the Education through Internet, and it coincides with distance learning activities.

Technical components of the certification of the systems of Continuing Medical Education activities.

As it is clear that the tendency to carry out solid education activities that possess in its majority a support from insti prestige, the existence of standards and goals of scientific-technical nature that grant an acceptable and acknowledge professional sector, are not at present adequately developed.

In spite of the fact that the above detailed situation corresponds to the general observed scene, it is highly promisi already elaborated objective quantifiable systems to evaluate the activities.

EXHIBIT 4: VALUE OF THE CONTINUING MEDICAL EDUCATION ACTIVITY

COUNTRY	CERTIFICATION/ RECERTIFICATION	VALUE	WORK VALUE	
Argentina	YES	Credits	Relative.	
Bolivia	YES	Credits/points	Access to posts	
Brazil	YES		Access to posts	
Canada	YES	Credits	Access and Maintenance	
Chile			Access to posts	C
Colombia				
Cuba	YES	Credits	Access to posts	
Ecuador		Credits	Access to posts	V
EEUU	YES	Credits	Access and maintenance	
Spain			Access to posts	
Mexico	YES		Compulsory for officials	At
Panama			University teaching hours	Teaching
Paraguay	YES	Credits		
Peru	YES		Access to posts. Promotion	6-8 C
Puerto Rico	YES	Credits	Access to educational posts	60 I
Dominican				
Uruguay				
Venezuela		Credits	Access to posts. Promotion	V

These more or less consolidated systems have the following quality components under consideration (chart 5):

Scientific-technical components frequently used
☞ Clear goals
☞ Relevance and ability
☞ Teaching methodology
☞ Organization and logistics
☞ Assessment
☞ Duration

A clear tendency to appraise the activities in relation to their duration is observed. The rest of the components, if not properly fulfilled will constitute a restriction in the evaluation of the educational activity. Once these components are fulfilled, in some circumstances they enrich the credit value conferred basically by the learning hours.

In every case, a positive tendency is shown in relation to the necessity to propose objective and tangible appraisal systems.

System of acknowledgement of Institutions or other kind of entities as supplying agencies of Continuing Medical Educational activities.

Although in a discrete way, systems of acknowledgment of institutions or entities that by its rigorous trajectory deserve to be recognized as prestigious when offering activities, are being developed.

Said acknowledgements are basically given among Universities, Medical Schools or Professional Schools of the national sector. It is essential that acknowledgement systems not only ensure the scientific-technical quality of the activities at the moment of their planning and proposal, but also to guarantee the correct implementation of said activities measuring if possible, its real impact over the professional competences of the participants.

In brief it can be concluded that once the current situation in the associated countries is examined, a great variety of Medical Education offers can be found with different entities providing activities backed in general by an important solvency as educational agencies.

It is equally observed certain homogeneity in the tendency to the normalization of the acknowledgement processes. Different countries find themselves in the best condition for the creation of policies that are in accordance with the appraisal/acknowledgement systems of the activities.

In the current situation, said policies, should emphasize the unification of technical criteria and credit models that will appraise in a balanced way the workloads with the quality components of the educational acts.

According to the preexistent situation it seems suitable to create proposals directed to achieve the compatibility and the credit and curricular validation of the educational professional knowledge, as an instrument of cohesion and consolidation of the Health Care systems and in particular of the Family Medicine as a cornerstone of Health Care policies.

**EXHIBIT 5: SYSTEMS OF ACCREDITATION /
ACKNOWLEDGEMENT/SUPPORT OF CME ACTIVITIES**

COUNTRY	YES NO	TECHNICAL CRITERIA	SCIENTIFIC SOCIETIES	SCHOOLS OF MEDICINE	MEDICAL COLLEGES	HEALTH SERVICES	OTHERS	OBSERVACIONES
Argentina	YES	YES	YES					There exists an Accreditation Regulatic
Bolivia	YES	YES ?	YES		YES			
Brazil	YES			YES	YES			Universities apply technical methods.
Canada	YES	YES	YES	YES	YES			CMFC, CRMCC
Chile	YES	+ / -		YES		YES		ASOFAMECH. Quality Criteria.
Colombia	NO	NO						
Cuba	YES	NO						Value according to duration of the activ
Ecuador	YES	NO		YES				0.5 point per each 32 hours.
United States of America	YES	YES						AAFP, AMA.
Spain	YES	YES	YES					State Mixed Organism.
Mexico	YES	NO ?		YES				INSTITUTION AKNOWLEDGEMEN
Panama	YES	NO		YES				The teacher is required to participate.
Paraguay	NO	NO						
Peru	YES	NO		YES	YES			It is not currently carried out
Puerto Rico	YES	YES		YES	YES		Hospital	Support from the Med. Examination Co
Dominican Republic	YES	NO	YES		YES			
Uruguay	YES	NO		YES			Syndicates	Institution acknowledgement.
Venezuela	YES	NO	YES		YES			

APPROACHES AND PROPOSED CHARACTERISTICS.

From the detailed analysis of the current situation in the different Ibero-American countries regarding the organization , financing, accreditation and curricular value of the continuing Medical Education activities, it is evident that although with different pace and levels of implementation, practically all the countries have as a target, the consolidation of this kind of educational offering as an essential element in the maintenance and improvement of the Professional competence of the Family Physician process.

On the other hand, the institutes and supranational organisms interested in the development of Health Care policies that guarantee the best health levels of the population, should be in charge of proposing convergence strategies in the different aspects related, in this case, to the Permanent Professional Development of the Family Physicians.

Under these approaches and assuming the scientific-technical arguments previously exposed, it is highly important for the different countries to carry out the necessary efforts in order to develop steady, structured, updated, relevant and assessable Educational Programs that correspond to the areas of competence regarding the Professional Profile of the Family Physician. These Programs, potentially developed either by public or private institutions, as

well as by the different professional associations, shall be submitted to mechanisms oriented to quality assurance that support their capacity to achieve the proposed aims, in relation to its contents, and in the aspects related to the knowledge transmission.

The activity assessment criteria should be objective, reliable and with the maximum homogeneity with the ones proposed by the International recommendation on the subject, and should grant in this way the principle of equity in the access to quality Continuing Medical Education among the professionals, simplifying the mechanisms of mutual acknowledgement of educational credits of the different countries in order to respect the curriculum merits concerning the developed education and not hinder the free circulation of the professionals.

For the proper implementation of the process of Continuing Medical Education accreditation, prestigious agencies of accreditation, technical solvency and scientific independence should be created. In said Agencies, as well as in the internal mechanism of the accreditation, the professional participation shall be fundamental as a referent of the group to which said activities are destined.

RECOMMENDATIONS.

In conclusion to all of the above mentioned and with the aim of establishing common guidelines in the Ibero-American countries regarding the accreditation of Continuing Medical Education activities that consolidate the policies of Permanent Professional Development in the practice of Family Medicine as an essential part of the Health Care systems, the following **Recommendations** are established:

- 1.- Taking Continuing Medical Education activities (CME) constitutes a fundamental and essential element for maintaining and improving the Professional competence of the Family Physicians. The Health Care Services shall facilitate to the maximum extent the accessibility to the programs of Continuing Medical Education as quality guarantee element in the rendering of the Health Care services.
- 2.- The countries shall constitute appropriate instances, that gather the entities involved in the accreditation of activities (scientific societies, Universities, Health Services, Medical associations, etc.), which guarantee by means of objective processes, the relevance, capacity and scientific-technical quality of the programs of Continuing Medical Education.
- 3.- These Programs shall specifically deal with aspects related to the competence and values of the Family Physician professional profile and should constitute an important element in the systems of Professional Recertification and maintenance of the capacity and qualification of the Family Medicine.
- 4.- The corresponding encouragement measures on the professionals should be developed in order to foster the carrying out of the Continuing Medical Education activities. Likewise, it is recommended to implement systems of acknowledgment for those professionals that implement said educational activities.

REFERENCES

1. Barón M. La formación médica continuada en Canadá como modelo de intervención profesional. *Educación Médica* 2001; 4: 52-65.
2. Brailovsky C, Miller F. Reflexiones sobre la investigación en Educación Médica. En: *Guía de formación médica y competencia profesional en Atención Primaria*. Barcelona. Ediciones Profármaco.2. 2002.
3. Cantillon P, Jones R. Does continuing medical education in general practice make a difference? *BMJ*. 1999; 318: 1276-1279.
4. Cots J. *Guía de formación médica y competencia profesional en Atención Primaria*. Barcelona. Ediciones Profármaco.2. 2002.
5. Davis D, O'Brien MA, Freemantle N, Wolf FM, Manmanian P, Taylor-Vaisey A. Impact of formal continuing medical education: do conferences, workshPAHO rounds and other traditional continuing education change physicians behavior or health care outcomes? *JAMA* 1999; 282: 867-874.

6. Davis D, ThWHOon MA, Freemantle N, Wolf FM, Mazmian P, Taylor-Vaisey A. Impacto de la formación médica continuada. JAMA (ed esp) 2000; 9.
7. Davis D. Continuing medical education: Global health, global learning. BMJ 1998; 316: 385-389.
8. EACCME (European Accreditation Council for Continuing Medical Education). In: European Union of Medical Specialist. UEMS Compendium of Medical Specialist 2001. London. KPL Group. 2001.
9. EQUIP. (European Association for Quality in General Practice/Family Medicine). WONCA Region Europe. Continuing Professional Development in Primary Health Care. 2003; [http:// www.equip.ch](http://www.equip.ch).
10. Fox RD, Bennett NL. Continuing medical education: learning and change: implications for continuing medical education. BMJ 1998; 316: 466-468
11. Gayoso P, de la Cal A. Criterios de acreditación de actividades de formación continuada: ¿se sigue algún protocolo? Formación Médica Continuada. 1999; 6 (3): 141-143.
12. Gayoso P. Acreditación de Formación Continuada. ¿Sirve realmente para algo?. Tribuna Docente. 2000; 1 (3): 21-27.
13. Grant J. Learning needs assessment: assessing the need. BMJ 2002; 324: 156-9
14. Miller F, Jacques A, Brailovsky C, Simdon A, Bordage G. When to recommend compulsory versus optional CME programs? A study to establish criteria. Acad Med 1997; 72(9): 760-4.
15. Pardell H. ¿qué podemos esperar de la formación médica continuada? Mitos y realidades. Med clin (Barc) 2000; 114: 419-430.
16. Peck C, McCall M, Mclearen B, Rotem T. Continuing medical education and continuing professional development: international comparisons. BMJ 2000; 320: 432-435.
17. Prieto A. Experiencias preliminares de acreditación de la formación médica continuada en España. Acreditación de las actividades de formación continuada en Atención primaria. JANO 1999; LVII (1.309): 584-585.
18. Programa de la Especialidad de Medicina Familiar y Comunitaria. Comisión Nacional de Medicina Familiar Y Comunitaria. Ministerio de Sanidad y Consumo. Ministerio de Educación Cultura y Deporte. Madrid. 2002.
19. Quiros C. ¿debe ser obligatoria la formación continuada? Tribuna Docente. 2000; 1 (4): 25-33.
20. Sistema de Acreditación de Actividades de Formación Médica Continuada en Atención Primaria. SaAP. (semFYC-SEMERGEN). <http://www.semfyces/Nueva/Acreditacion/marco.htm>
21. U.E.M.S. (European Union of Medical Specialist). Criteria for international accreditation of CME. Bruselas. 1999. <http://www.uems.be/eaccme-3.htm>

GLOSSARY OF TERMS USED IN THE DOCUMENT ABOUT THE ACCREDITATION OF CONTINUING MEDICAL EDUCATION ACTIVITIES FOR SPECIALISTS IN FAMILY MEDICINE.

Accreditation of Continuing Medical Education Activities. The Accreditation of Continuing Medical Education Activities consists of the formal acknowledgement on the part of a competent authority in the subject, that an education activity fulfills the minimum previously accepted and set quality standards.

Pertinent Teaching Activity. Teaching Activity that clearly responds to the profile of the specialty and to certain type of sufficiently stated and justified need or demand.

Formative Credit. Reference Formative Unit that is the basis for the structure and organization of education curricula in most countries. Its value has traditionally been defined by the number of hours (workload) of the training activity in question. There is currently a tendency towards the recognition of the Formative Credit regarding the workload required for the student/resident to complete a determined education activity including, besides the theoretical-practical workload, the individual, field work, literature search, and evaluation... .

Permanent Professional Development (PPD). It constitutes a broader concept than that of Continuing Medical Education which includes the integration of professional competencies in management, personal and social interactions that contribute to high quality standards.

Continuing Medical Training (CMT)/Continuing Medical Education (CME). Any of the ways by which medical professionals continue their education and training after the basic education period has been completed or as is the case of all physicians, after completing any additional training program in order to practice the profession of General Physician or Specialist including the acquisition of knowledge, skills, attitudes that may allow maintenance and improvement of Professional Competence.

Professional Profile. Set of specific functions and activities of a professional, in this case a Family Physician that make possible to differentiate him/her from other professionals.

Knowledge Transference (applied to learning or transference of learning). Mechanism by which it is possible to guarantee the process of translating the contents of learning processes into practical competencies that directly result in a higher quality professional performance. The transference of previous knowledge represents the activation and application of that knowledge when facing new situations" (Gagné). It also implies the use of prior knowledge in order to activate conceptual networks that may allow the decision-making process when facing patient diagnosis, treatment and follow-up. (Brailovsky)

DEFINITION OF CRITERIA FOR CERTIFICATION OF SPECIALISTS IN FAMILY MEDICINE

PARTICIPANT COUNTRIES:

ARGENTINA, BOLIVIA, BRAZIL, CANADA, CHILE, COLOMBIA, CUBA, ECUADOR, SPAIN, UNITED STATES, JAMAICA, MEXICO, PARAGUAY, PERU, DOMINICAN REPUBLIC, PUERTO RICO, URUGUAY AND VENEZUELA.

AUTHORS

COORDINATOR:

- **Dr. Eduardo Durante** **Argentina**
Associate Professor in Family Medicine. Faculty of Medicine. University of Buenos Aires
Deputy-Chief of the Division of Family and Preventive Medicine, Hospital Italiano de Bs As
President of the Certification Committee, Argentine Federation of Family and General Medicine (FAMFYG)

MEMBERS OF THE WORK TEAM:

- **Carlos A. Brailovsky, MD, MA (Ed.), MCFPC (Hon)** **Canada**
Professor and Chairman
Health Science Evaluation Center (CESSUL)
Faculty of Medicine, Université Laval
- **Charles Godue M.D.** **Canada**
Human Resources Development Unit
Area of Strategic Health Development
PAHO/WHO
- **Irma Monique Bourget** **Brazil**
Coordinator of the Certification Board - SBMF
- **Isabel Segovia** **Chile**
President, National Certification Committee - SCMFC
- **Epifanio de Serdio Romero** **Spain**
Education- SEMFYC
- **Susana Alvear** **Ecuador**
Director of the Graduate Division of Family Medicine,
Pontificia Universidad Católica del Ecuador, Hospital Vozandes Quito.
- **Víctor Castillo Claire** **Bolivia**
Family Physician. Policlínica Central
President of the Bolivian Society of Family Medicine.
- **Liliana Arias Castillo** **Colombia**
Full Professor of the Department of Family, Universidad del Valle, Vicepresidenta Sociedad Colombiana de Medicina Familiar y Coordinadora Subregión Andina, ICFM.
- **Miguel Ángel Fernández Ortega.** **México**
Professor and Chierman. Department of Family Medicine
School of Medicine, Universidad Nacional Autónoma de Mexico.
President of the Mexican Certification Board in Family Medicine, A.C.
- **Aníbal Marín** **EEUU- Puerto Rico**
Professor of Family Medicine

- **Elda Gianzante**

Network of Scientific Societies of Venezuela

Venezuela

- **Ada Vedilei**

President, SOVEMEFA

Venezuela

- **César Brandt Toro**

WONCA- ICFM

Venezuela

- **Ana Lucia Meyer Lorenzo**

President of the Dominican Society of Family Medicine.

República Dominicana

- **Zully Isabel Olivera Stupiello**

Specialist in Family and Community Medicine. Family, Physician of the Department of Public Health. Assistant Professor of the Community Education Department. Universidad de la República. Resident Instructor

Uruguay

INTRODUCTION

According to the technical documents produced at the Ist Ibero American Summit on Family Medicine held in Seville (Spain) in 2002, importance is given to the role played by the Family Doctor as the “Orchestra Director in Health Care”. A Family Doctor (FD) is the physician devoted to the health maintenance and the solution of frequent health problems in individuals, families or communities, regardless of sex, age, or the affected organ or system. The FD integrates biological, clinical and behavioral sciences, being always closely related to the needs of the community served by him/her.

In order to clearly establish the position of this role within the health systems, it is important to develop the specific competencies that differentiate it from the other medical specialties: medical specialties are lineal, while Family Medicine is horizontal. The FD, due to his/her competencies, is not only a specialist in people but also the coordinating nexus of the whole health system, the one who orders, integrates and combines the attention of the system for the benefit of people.

When it comes to assessing the quality of the FD’s and the family health teams, the Declaration of Seville (2002) points out four fundamental issues: services structure, delivery of services, clinical performance, and health care system’s outcomes. The core aspect is the set of criteria that a FD must have as a specialist with respect to specific responsibilities and competencies, both in his/her horizontal relationship with Family Health Teams and his/her vertical integration with lineal specialists. In order to assess such quality, the referred document strongly recommends the use of an indicator showing the number of FD’s that are certified as specialists.

As a quality improvement strategy, the document also recommends the development of professional certification systems, as well as of FD unit accreditation systems and FD educational activities (postgraduate courses and residency training programs).

Regarding the particular case of certification, the design and implementation of certification systems for specialists in Family Medicine (FM) implies not only recognizing and strengthening this “specialization” in certain countries within the region where FM has just started to be developed, but also guaranteeing patients that the care provided by these specialists complies with quality standards.

In order for Family Medicine Specialist certification to guarantee such results, certain conditions must be fulfilled, which are described below.

CONCEPTUAL BASIS

Usually, medical practice guarantees that professionals have the required basic competencies by way of passing a certification exam. Generally speaking, certification is the recognition that a certain individual has completed an educational experience. Certification may be of two types: certification of attendance to an educational course or program, or certification of competence. The former is related to the “process,” while the latter is related to the “product” of the training (whether the professional is competent or not). In the medical field, a pre- or postgraduate training certificate is usually of the second type. In the case of pre-graduate education, a competence certificate implies that the individual has satisfactorily completed a formal education period; in the postgraduate education, on the other hand, certification not always involves it, since there may be certification without having completed formal training. In such a case, learning is assessed through the evaluation of educational experiences (credits, points), which allow for the individual to be certified.

Specialist Certification is the process by which an entity, applying pre-established and publicly known criteria, guarantees –through a valid, reliable and transparent evaluation process– that a professional duly registered has the minimum knowledge, abilities, skills and attitudes required for patient care. Certification may be final or temporary. In most Latin American countries, certification is a voluntary process. In other countries, such as Canada, certification is mandatory.

A fundamental issue in the certification exam is for the professionals that pass it to show a quality care practice towards their patients. Fortunately, research has been carried out that provides now sufficient evidence so as to recommend certification exams (or competence assessment exams) having certain characteristics in order to predict the future practice of Family Doctors (see below).

COMPETENCE AS A “MULTIDIMENSIONAL” CONSTRUCT

Competence is the level of knowledge, skills and good sense used in relation to the profession, in all situations faced by the professionals in the medical practice. The core of this definition relies on the

fact that it relates competence with the application of knowledge, skills and clinical judgment in real clinical situations faced by the professional, in this case, the Family Doctor. In other words, clinical competence must always be assessed within the context of relevant and specific clinical problems, and not in an isolated way.

From this viewpoint, competence is a construct that emphasizes “multidimensionality” (see **Figure 1**). As any construct, access to reality is only partial, through different measuring parameters that reflect partial aspects of its complexity: knowledge, psychomotor skills, attitudes, clinical reasoning, communication skills, ability to work in an interdisciplinary environment, etc. It is evident, however, that even measuring all these aspects we cannot have access to the full construct of “clinical competence”. In other words, and paraphrasing family medicine language, clinical medicine is not only the sum of all these partialities but a complex and systematized whole.

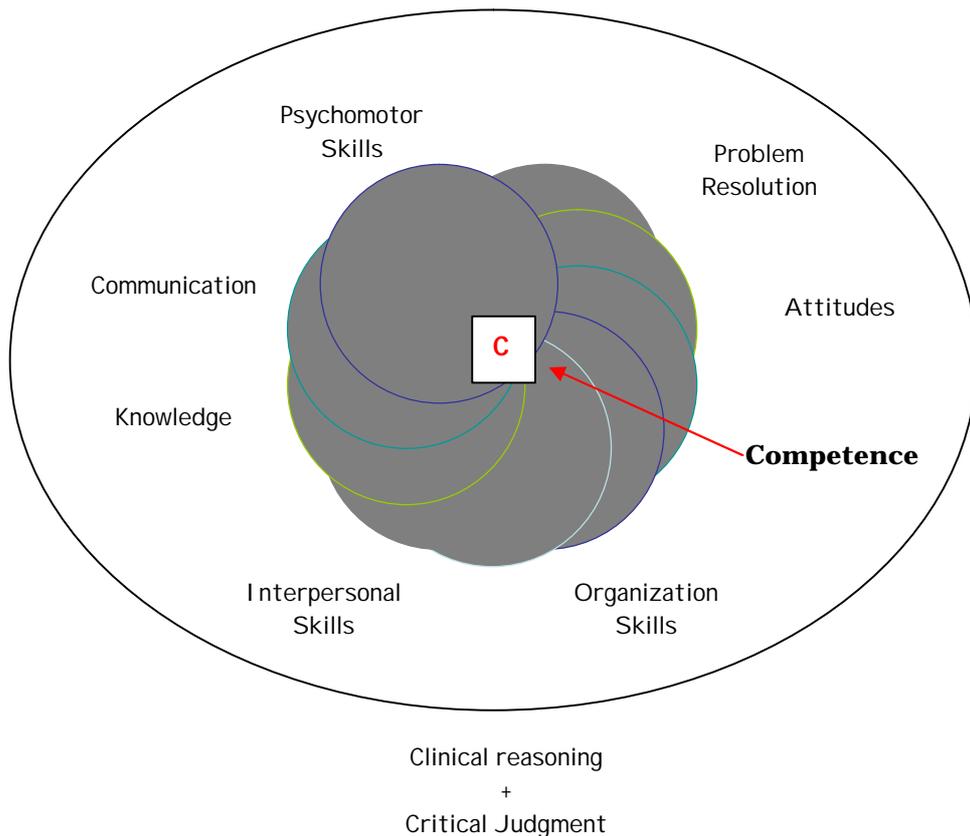


Figure 1. Multidimensional Perspective of Clinical Competence (modified from Brailovsky C, 2001).

Currently, and taking into account **Figure 1** above, the evaluation of competencies may be illustrated as shown in **Figure 2** below, where this complex multidimensional system is taken to the utmost simplicity. This example perfectly points to the fact that simplification of complex models practically eliminates the sense of the construct at issue.

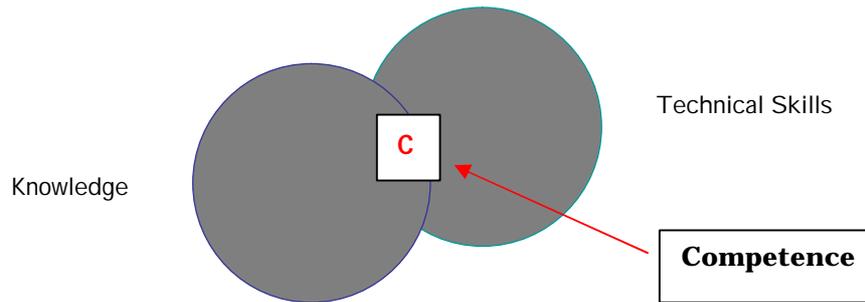


Figure 2. “Simplified” Multidimensional Perspective of Clinical Competence (modified from Brailovsky C, 2001).

Taking into account these limitations, Miller's knowledge model may be useful to establish the current state of the art of clinical competence evaluation.

Educator George Miller (1990) defined a model to evaluate professional competence, consisting in a four-level pyramid (see **Figure 3**). The bottom and second levels show knowledge (“knows”) and telling how to apply such knowledge to concrete cases (“knows how”). The third level (“shows how”) shows competence as measured in “in vitro” –or simulated– environments, where the professional must demonstrate all he/she is able to do. The top level shows professional **performance** (“does”), i.e., what the professional actually does in real practice, regardless of what he/she has demonstrated is able to do (**competence**).

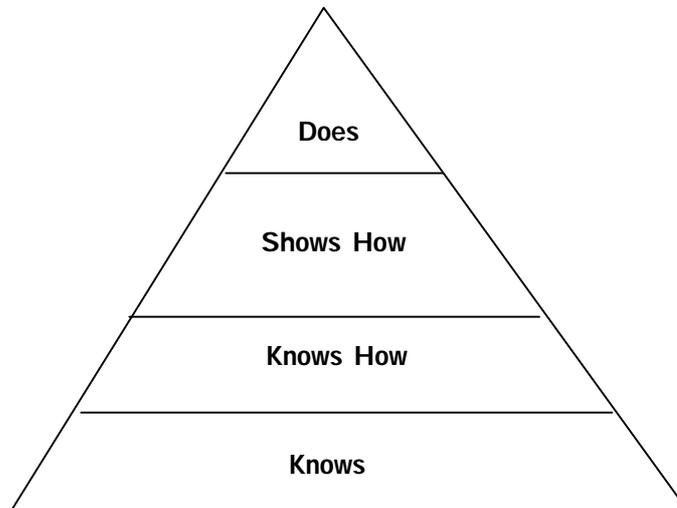


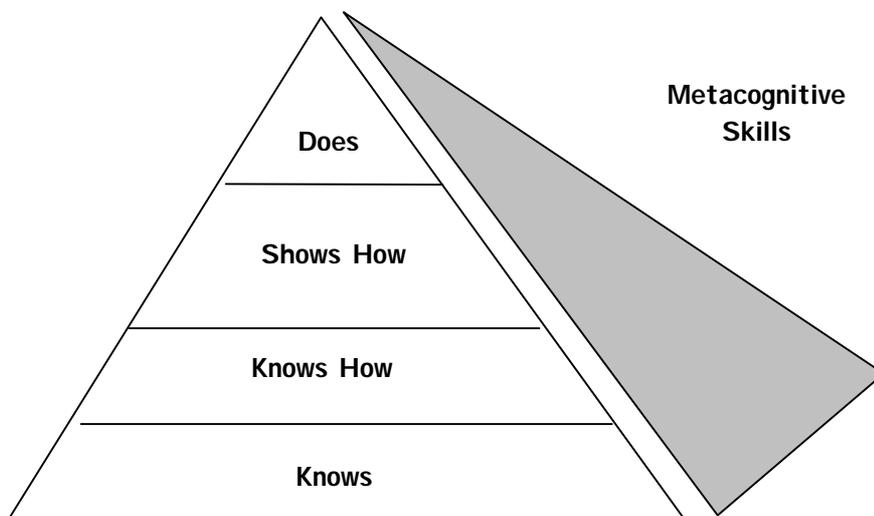
Figure 3. Miller’s Pyramid, Miller G, 1990.

When the term “competence” appears within the definition of certification, what is in fact of interest from the viewpoint of health systems and quality is the professional's performance or real practice (what he/she "does" in real life, taking care of patients). Unfortunately, there is evidence showing that what the doctor is able to do in the **shows how** level (assessment of clinical skills in “simulated” real-life environments) does not predict his/her **performance** in the "does" level (what the doctor actually does in real life, i.e., competence). In other words, it is possible that such doctor be an excellent specialist in the “lab”, but with a poor performance in real life. This is due to the fact that acts and decisions taken on a day-to-day basis in real practice are influenced by many factors that are “controlled” at the pure competence evaluation level. Such factors may be categorized as: those related to the individual (professional’s physical and mental health, his/her cognitive condition upon

the patient's consultation, relationship with other people, including family) and those related to the system where the professional carries out his/her activities (mandatory government's programs to be applied to patients' care, health care system organization features, payment forms, patient care setting conditions, etc.). Therefore, we may conclude that there is a complex interaction between competence, performance, and individual and systemic factors regarding patients' care. However, as mentioned above, recent publications (Tamblyn 1998 and 2002) show that well-elaborated multidimensional models for measuring "in vitro" competence satisfactorily predict not only the quality of medical practice up to 5 years after finishing residency in family medicine, but also the practice profile. In fact, it has been demonstrated that choosing the type and scope of professional practice is closely related to the scores obtained in certification exams.

Based on the above, the certification process should ideally be able to measure all these components in order to predict as accurately as possible the future performance of the certified specialist. In other words, this process should not only measure knowledge at the bottom levels of the pyramid but also assess the doctor's performance in real life (competence).

On the other hand, the certification process should be able to "measure" the so-called "**metacognitive**" skills, which define the individual's perception on why he/she knows what he/she knows (**Graphic 2**). This term refers to the knowledge structures that allow for "diagnosing" and "prescribing" treatments faced when there are caveats in certain portions of knowledge. This is a system that monitors knowledge and the style each individual has to acquire it. When such skills are not developed –i.e. when this monitoring system is not fully developed– continuing learning becomes difficult, i.e. continuing professional education becomes dependent on course availability (teacher-focused learning, or rather learning focused on continuing education providers) rather than on the specialists' demand for knowledge for the purpose of solving problems arising from medical care (student-focused learning). Some countries have started to include tests to evaluate these competencies in the certification exam (e.g., Canada).



Graphic 2. Metacognitive Skills (modified from Van Der Vleuten K, 2001).

The following important conclusions may be inferred from the above:

1. Mere assessment at the bottom levels does not guarantee competence in the highest levels.
2. Ideally, certification should evaluate the professional's performance along the four levels, as well as his/her metacognitive skills.
3. However, this model is partially useful to measure competencies at the level of real-life performance, which is, on the other hand, difficult to implement.

Based on the above definitions, the certification process should guarantee competence in at least the knowledge areas of **knows**, **knows how** and **shows how**. It would be very important to include tests that may assess the performance area (**does**) and the metacognitive skills.

Certification should be achieved after passing a summative assessment, including different tests in relation to all these areas. In certain countries, such as in Spain, certification is achieved as a product of the formative assessment. **Chart 1** shows advantages and disadvantages of each method.

Chart 1. Advantages and Disadvantages of Certification by means of summative or formative Assessment (modified from Newble D, Jolly B & Wakeford R. 1994. *The Certification and Recertification of Doctors: Issues in the Assessment of Clinical Competence*. Cambridge University Press).

Certification through summative Assessment	Certification through formative Assessment
<p><u>Advantages</u></p> <ul style="list-style-type: none"> - Measures what the candidate <i>knows</i>. - High reliability. - Equivalent to all participants. - Allows for a wide sample of contents. - Efficient to administrate. - Efficient to grant scores. - Promotes low-biased scoring. - Methods to establish passing criteria. 	<p><u>Advantages</u></p> <ul style="list-style-type: none"> - Measures what the candidate <i>does</i>. - High face validity. - Allows for assessing multiple characteristics. - Allows for assessing performance throughout time. - Makes use of many observers with different experiences. - Allows for constructive feedback. - Not time-limited. - Reports to the participants about their performance. - "Non-invasive" assessment
<p><u>Disadvantages</u></p> <ul style="list-style-type: none"> - May assess limited characteristics. - May excessively influence the participants' activities. - Costly regarding time, work and money. 	<p><u>Disadvantages</u></p> <ul style="list-style-type: none"> - Not reliable. - Not standardized through institutions. - Not standardized through participants. - Biased assessments. - Few instruments available. - Training is necessary to carry out the assessment. - Requires an excellent record. - The roles of teacher and evaluator are mixed.

THE CERTIFICATION EXAM

In the countries that require the certification process to include a summative evaluation, certain conditions must be met in order for the conclusions and decisions taken with regard to a given candidate to be based on accurate and valid information.

In order to define the certification exam, we must firstly identify the competencies expected from Family Medicine specialists. Fortunately, many documents –especially those issued by the Ist Ibero American Summit on Family Medicine, held in Seville (Spain) in 2002– define the expected profile and competencies for Family Doctors, which could be summarized in the following areas:

1. A Family Doctor is an expert in health care for individuals and families, regardless of age, sex, organ or system affected, and setting.
2. The Family Doctor practice is based on the Community, which is considered by the FD as a risk population; therefore, the FD must be able to know and/or determine which the most frequent problems are and how to work at a community level for their solution.
3. The doctor-patient-family relationship is core to the FD's work. Communication skills are essential for this purpose, as well as for the communication with other specialists and health professionals.

Table 1 below summarizes the Family Doctor's competencies:

✍ Essential Competencies	✍ Doctor-patient communication
	✍ Clinical reasoning
	✍ Health care management
	✍ Bioethics
✍ Care to the individual	
✍ Care to the family	
✍ Care to the community	
✍ Training and research	

Table 1. Competencies of the Family Doctor (Monreal A; Accreditation of Continuing Medical Education Activities in Family and Community Medicine, 2003).

Anyway, each country should define its respective Family Doctor's local profile, as well as the required competencies to fulfill such profile. In order to reach such definitions, it is very important that many stakeholders be involved, including scientific associations, universities, health care authorities, and the patients themselves. These final competencies are the ones to be considered as "final" or end points to be assessed. From an operating perspective, it is simpler to define the clinical problems to be faced by the Family Doctor and then identify the necessary competencies to handle them. This is rather complex and requires a participative thinking on the expected Family Doctor's profile definition in each country. Although hard and time-consuming, this step is a practical and integrating approach to identify the contents to be evaluated. Competencies must be defined in terms of "excellence", i.e., the performance that a Family Doctor with an excellent level should achieve, and not in terms of "minimum criteria".

The second step is to establish which of these competencies are to be evaluated. It is important here to identify a "representative" sample of such competencies, which will be included in the exam. The preparation of a table of specifications ("blueprint method") guarantees that all competencies are included and that the sample is representative. The use of this method also guarantees that each competence will be evaluated within a clinical context and not in an isolated way.

Both the above-mentioned steps are essential. If the contents of the exam are not defined, even the use of the most sophisticated assessment instruments will not make up for the lack of representation of the clinical tasks to be evaluated.

The third step consists in the definition of the competence assessment methods according to the contents already identified. In order to select the assessment methods, the following criteria may be used:

✍ **Validity:** it means that the method should be able to measure what is expected. If communicational skills are to be assessed, then multiple choice tests are not valid for that competence. There are different types of validity, the discussion of which exceeds the scope of this paper. Graphic 2 shows different tests applicable to the different levels of Miller's pyramid.

✍ **Reliability:** it refers to the accuracy or reproducibility of the method when measuring what it is expected. For example, if the same scale shows different values for a 1 kg. weight in different occasions, such scale is not reliable (since it may sometimes weight 0.900 kg. and sometimes 1.110 kg.). A particular characteristic of reliability is "**content specificity**". This condition, widely described in literature, refers to the fact that the score obtained in a given task of a test (e.g., a stage in a test of the Objective Structured Clinical Exam –OSCE– type) does not predict the student's performance in the other tests. This has to do with the fact that the acquisition of competencies is specific for different contents although they may seem similar (e.g., competence in the physical exam of a patient suffering from a heart condition does not predict competence in the physical exam of a patient suffering from asthma). As a consequence, in order to reach reliable results in the assessment tests, a relatively high number of samples is needed regarding the different clinical competencies (interview, physical examination, interpretation of diagnostic tests), which considerably increases evaluation time (e.g., for the results of an OSCE to be reliable, approximately 13 stages are required, varying from 10 to 15 minutes each, resulting in a total exam time of 4 to 5 hours).

✍ **Educational Impact:** "Evaluation guides students' learning". This statement has become a new paradigm in education. This means that students (in this case, certification candidates) want to "pass" the exams, rather than striving for "learning". The integration of knowledge and the

acquisition of certain competencies are stimulated according to the type of exam being applied. Tests requiring the candidate to **shows how** will stimulate the acquisition of competencies related to this field. If the test consists in multiple choice, learning will be oriented to the **knows** field –or, at the most, the **knows how** field– rather than the **shows how** and **does** levels.

⚡ Acceptability: it means that both candidates and evaluators may accept the evaluation methods proposed for the certification exam. There may be resistance towards new initiatives, which may be related to the culture of a given country, the educational model (teacher-focused vs. student-focused), postgraduate training systems, etc.

⚡ Cost: the new competence assessment methods (such as OSCEs, portfolios, observation of real-life interviews, etc.) are valid to evaluate competence at the **shows how** and **does** levels. However, their implementation is costly due to the logistic and economic requirements they involve, which may limit their application, although they may comply with all the other characteristics.

Summing up, a Family Medicine Specialist certification exam should be: valid in relation to the set of excellence competencies to be evaluated; reliable (i.e., those differences in score correspond to each candidate's performance); have an educational impact on the competence learning process; be accepted by both the candidates and the certification institutions; and have an affordable cost.

In order to achieve these goals, sometimes a combination of methods is required to evaluate the different levels of the pyramid (sequential tests).

Another important aspect is the method used to determine the **standard setting**. Certification represents the recognition that the minimum criterion (standard) has been fulfilled. In general, in summative certification exams, the standard is absolute, i.e., the exam is passed if a certain minimum score is obtained, which would reflect a minimum level of competence. Definition of such standard is complex and must be established on a methodological basis rather than on a simple mathematical basis (e.g., the classic 60% of the multiple choice exams), which does not represent a minimum level of competencies. Well-validated methods are currently available, which allow for establishing pass criteria based on the candidate's performance observed.

CURRENT SITUATION OF THE CERTIFICATION PROCESSES IN LATIN AMERICAN COUNTRIES

Most Ibero-American countries have been surveyed. The information gathered from each of them has been summarized and organized for easy reading in this section.

The analysis has been developed based on the information provided by the following **18** countries: Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Cuba, Ecuador, Spain, USA, Jamaica and CARICOM, Mexico, Paraguay, Peru, Dominican Republic, Puerto Rico, Uruguay and Venezuela.

As a result of the information gathered from the questionnaires carried out in the different countries, certain important conclusions arise:

All Latin American countries, together with USA and Canada, acknowledge the Family Medicine specialty. Names and responsibilities vary in each country depending on their health system organization, although there is a basic set of professional competencies which are common to all of them.

The curricular experiences to acquire such competencies are varied, although the following two basic modalities are recognized:

- 1- Family Medicine residency, varying from two years (Canada) to three or four years (the remaining countries).
- 2- Attendance to a Family Medicine Center or Primary Health Care Center, as well as to specialty courses organized by scientific associations, universities, medical associations, etc. (Argentina, Brazil, Chile, Jamaica, Mexico, among others).

Family Doctor certification is available in all countries (except for Ecuador), ranging from long standing certification processes –such as those in force in Canada (1969) or the USA (1968)– to recent certification processes –such as that in force in Brazil (2004). Certification is voluntary, except for Canada, where it is mandatory. Recognition as a specialist is also variable, and is known by different names in the referred countries. In Bolivia, Spain and Jamaica, a doctor that has finished his/her Family Medicine residency is recognized as a specialist, even though such doctor has not passed a summative assessment. In the other countries, passing a summative evaluation is generally required to be certified. However, the certifying institutions are as varied as the health systems they reflect.

Adopting one method or the other –or else other options– depends on the stage reached by this specialty in each country, as well as on the feasibility to organize credible, valid and reliable evaluations.

In certain countries within the region (Argentina, Chile), different institutions grant Family Medicine Specialist certifications, which qualify the professional to act as such. Although these prestigious and reliable institutions usually understand and share the Family Medicine paradigm, it is not strange to see that other specialists (the renowned “many lineal specialists make up for one generalist doctor” statement) participate in the Family Doctor certification. Lack of unified criteria through which certification is achieved may result in poor certification results. In most countries, however, there is a centralization of the certification process, which guarantees equality in relation to the other specialties.

Except for the above-mentioned cases of Bolivia, Spain and Jamaica, a final competence evaluation is carried out in all countries (the “certification exam”). Except for Canada, which uses the OSCE method to assess higher levels in Miller's pyramid, the other countries make use of different methodologies to evaluate the **knows** and **knows how** levels of the pyramid (mostly multiple choice tests, and other types such as a variant of the OSCE in Argentina, or a family health study in Mexico and Bolivia). In other cases, performance is evaluated through observation of the doctor's behavior towards his/her patients, although these instruments are biased due to their low reliability and validity levels (Chile, Cuba). However, more countries in the region (Spain, USA, Argentina) currently show a trend towards including, on the medium or long term, tests of the OSCE type. In most countries, the definition of pass criteria is absolute.

Certification exams are carried out twice a year in most countries, and a fee is usually paid.

In six of the countries having specialist certification (Canada, Cuba, Spain, USA, Puerto Rico and Venezuela) access to the certification exam is available only after passing a residency in such specialization. The other countries (and those considering residency as an exclusive criterion –such as USA, Puerto Rico and Spain) have credit or point systems which allow for taking the certification exam even if a Family Medicine residency has not been completed.

Most of the countries that have certification exams (except for Chile, Cuba, Spain, Jamaica and Venezuela) also have recertification processes. The specialist certification is generally valid for 5 years.

Specific Criteria that define the Certification Processes in the countries of the Region

Based on the study of the different documents on certification and recertification analyzed in this paper, we may conclude that there are different interpretations of both concepts. In order to clarify this, we will consider the following definitions:

- ? **Family Medicine Specialist Certification:** Certification is the process by which an entity, applying pre-established and publicly known criteria, guarantees –through a valid, reliable and transparent evaluation process– that a professional duly registered has the minimum knowledge, abilities, skills and attitude required for patient care (definition prepared based on the different definitions included in the associations' documents). Certification may be final or temporary, voluntary or mandatory. This is an aggregate evaluation towards a final assessment of the curricular experience, generally including a residency. In certain countries of the region, a professional that has passed a Family Medicine residency is usually considered *certified*, although he/she may not have passed a summative assessment.
- ? **Recertification:** This is the process by which the specialist is assessed so as to guarantee that he/she keeps the acquired competencies in patients' care. When certification is temporary, recertification is then necessary. No recertification is possible without prior certification.

Having clarified the above, a brief description of the characteristics pertaining to the certification processes for Family and General Medicine Specialists in the CIMF member-countries will be shown below. As a reference to allow for comparison between countries, the following aspects are included in the analysis:

1. **Process** by which degree is achieved (Table 2).
2. **Ways** used for the training of the Family Doctor (Table 3).

3. **Existence** of a regulated certification process on Family Medicine, which means that the Family Medicine specialty is recognized and that the candidate must pass an **evaluation process** (Table 4):
 - a. **Exclusive Summative Assessment**: it refers to the fact that certification is not available if the candidate has not passed the summative evaluation.
 - b. **Start Year** of the process: it refers to the year in which the Family Medicine certification process started to be implemented.
 - c. **Number of specialists** that are certified by means of this process as from its implementation.
4. **Entity** granting the specialist certification, also stating whether such certification **qualifies** the professional to carry out his/her practice as Family or General Medicine specialist (Table 5).
5. **Existence** of a certification exam and type of such exam: whether there is a summative assessment of the competencies expected from a Family Medicine specialist, what type of knowledge is assessed, and which instruments are used for such assessment (Table 6):
 - a. Criteria to define competencies.
 - b. Knowledge assessment: it refers to the **know** and **know how** levels of Miller's classification.
 - c. Assessment of cognitive, psychomotor and/or affective skills: it refers to the **shows how** level and, exceptionally, to the **does** level in real life.
 - d. Standard setting: it refers to the definition of criteria to be applied in order to establish if a candidate has passed a summative assessment or not. Standards may be relative (when such pass level is established based on each participant's performance in such particular assessment, i.e., pass criteria change with each evaluation) or absolute (the standard is established beforehand, according to the minimum expected competencies, regardless of the participant's performance in each particular assessment).
6. **How** the summative assessment is administered (Table 7):
 - a. Fee.
 - b. Annual frequency.
 - c. External Audit: when supervision is carried out by officers pertaining to entities other than the institution carrying out the certification process.
7. How to **access** to a certification exam (Table 8):
 - a. Residency as exclusive criterion: it refers to the fact that the only way to have access to the summative assessment is to have completed a Family Medicine residency.
 - b. Credit or score system that allows for taking the certification exam although the participant may not have completed a Family Medicine residency.
 - c. Other.
8. **Term** of validity of the certificate, and whether the certified professional must afterwards be recertified and, in such a case, if there is a recertification process. These processes are described with more detail in the document dealing with CME (Table 9).

Table 2. Process by which degree is achieved

Country	Pre-Graduate Course Duration	Medical Qualification
Argentina	7 years (1-year internship)	Automatic
Bolivia	6 years (1-year internship)	Mandatory rural service or purchase of registration
Brazil	6 years	Automatic
Canada	4 years	Only if choosing to be specialist: 2year residency in FM or any other specialization, plus certification exam
Chile	7 years (2-year internship)	Automatic
Colombia	No data available	
Cuba	No data available	
Ecuador	No data available	
USA	4 years	Multiple choice questionnaire (MCQ) and interview with patients; or exclusive qualification for residency
Spain*	6 years	Automatic (for private sector)
Jamaica and CARICOM	5 years	One-year internship grants qualification in each country, plus CARICOM's exam (in all member countries)
Mexico	6 years	The last year consists in rural social service. The candidate must take a final exam of general knowledge and another practical exam attending a patient
Paraguay	No data available	
Peru	No data available	
Puerto Rico	4 years	MCQ and interview with patients; or exclusive qualification for residency
Venezuela	6 or 7 years	Automatic (after a 1-year rotating rural internship or 2-year internship)
Uruguay	8 years	The last year is a "mandatory internship" after a competitive examination

* In **Spain**, qualification is only for the private sector. Otherwise, the professional must compete for residency by taking a national selection exam called MIR.

Table 3. Ways used for the formation of the Family Doctor

Country	Ways used for the formation of FM Specialists
Argentina*	- University residency (3 or 4 years) - Non-university residencies - Courses plus APS practice
Bolivia	- Residency (3 years)
Brazil	- Residency (2 years) - Courses plus practice
Canada	- Residency (2 years)
Chile	- University residency (3 years)
	- For CONACEM: Courses plus practice in accredited center (5 years)
Colombia	No data available
Cuba	No data available
Ecuador	- Residency (3 years)
Spain	- Residency (3 years)
USA	- Residency (3 years)
	- Distance education course (3 years)
Jamaica and CARICOM	- Residency (3 years)
	- Distance learning course (3 years)
Mexico	- Residency (3 years)
	- Part-time attendance specialization course (3 years) with the same residency program for practicing general doctors hired by public institutions
Paraguay	No data available
Peru **	
Puerto Rico	- Residency (3 years)
Uruguay	- Residency (3 years)
Venezuela	- Residency (3 years) or postgraduate course

Table 4. Existence of a regulated certification process for Family Medicine

Country	Existence of FM Specialist Certification	Exclusive Summative Assessment	Start Year	Number of Specialists Certified by this Process
Argentina	Yes	Yes	AAMF 1997 FAMFYG 2003	400
Bolivia	No	No	1976	200
Brazil*	Yes	Yes	2004	271
Canada	Yes	Yes	1969	12,500
Chile	Yes (Universities)	No	1982 - Residency	250 (without exam)
	Yes (CONACEM)	Yes	2001- CONACEM	50 (with exam)
Colombia	Yes	Yes	2002?	?
Cuba	Yes	Yes	No data available	
Ecuador	No			
USA	Yes	Yes	1968	64,448
Spain**	Yes	No	1978	18,000
Jamaica and CARICOM	Yes	No	1980	35
Mexico	Yes	Yes	1988	7,800 out of 22,000
Paraguay	Yes	Yes	2002	
Peru	Yes	Yes	1999	10
Puerto Rico	Yes (idem USA)	Yes	1969	180
Uruguay	Yes	Yes	2003	30 officially appointed without exam 100 with exam
Venezuela	Yes	No	1982	1,200

Exclusive Summative Assessment: it means that the candidate cannot be certified if he/she does not pass a summative assessment.

Start Year of the process: it means the year in which the Family Medicine certification process was implemented.

Number of Specialists certified by this process since its implementation:

** In the case of **Brazil**, the situation of 91 candidates that had passed residency without certification exam was regularized. The rest (190) had to take the summative assessment.

***In the case of **Spain**, the Family and Community Medicine Specialist degree is obtained by passing a 3-year residency, but no certification exam is available. In addition to residency, professionals that obtained their degree in Medicine before 1995 can achieve FM

specialization by way of another process that includes a final summative assessment through an OSCE-type test. This alternate process will end in 2008.

Table 5. Entity granting the specialist certification, also stating whether such certification qualifies the professional to carry out his/her practice as Family or General Medicine Specialist

Country	Certifying Entity	Qualifying Degree
Argentina*	FAMFYG	No
	Universities	Yes
	Medical Associations	Yes
	National Health Ministry	Yes
Bolivia	Medical Association of Bolivia (Bolivian association of family medicine)	No (it is only a diploma that qualifies for FM practice)
Brazil	<i>Associacao Médica Brasileira</i> together with <i>Sociedade Brasileira de Medicina de Família e Comunidade</i>	No
Canada	Family Doctors Association of Canada	Yes
Chile	Universities (without exam)	No
	CONACEM (with exam)	No
Colombia	?	?
Cuba	Health system	Yes
Ecuador	-	
Spain	Ministry of Education	Yes
USA	American Board of Family Physicians	No
Jamaica and CARICOM	The University of West Indies	Yes
Mexico	Mexican Board of Family Medicine Certification AC	Yes
Paraguay	Paraguayan Family Medicine Association	No data available
Peru **	Universities	Yes
Puerto Rico	Idem USA	Yes
Uruguay***	University of the Republic	Yes
Venezuela	SOVEMEFA	No
	Universities	No
	Regional Medical Associations	Yes
	National Health Ministry	No
	Social Security Institute	No

* In the case of **Argentina**, the analysis is made on the FAMFYG's certification process, since the other entities have different processes which are difficult to categorize. Anyway, FAMFYG is striving towards the recognition of its certificate as a qualifying degree.

** In the case of **Peru**, having obtained the degree at the university where residency was carried out, the FD can request the Medical Association (without any prior requirements, except for the payment of the respective fee) to be registered as Specialist on a national basis, equivalent to any other specialties. However, such "qualifying" degree might be questionable, since a professional that has passed residency may start practice as specialist even without the respective degree.

*** In the case of **Uruguay**, the situation of the FDs formed outside the Residency Program (from 1989 to 1994) was regularized in 2003 by means of a competence test.

Table 6. Existence of a certification exam and type of such exam

Country	Definition of Competencies	Knowledge Test	Competence Assessment Test	Standard
Argentina	Yes	150-item MCQ	Only if passing knowledge test: Modified OSCE consisting in 15:20 stages	Absolute
Bolivia****		MCQ, submission and defense of a bio-psycho-social case, a research work, and a study on community-oriented primary care		
Brazil	Yes	100-item MCQ	No	Absolute
Canada	Yes	Written test consisting in 40-45 questions to be answered as brief essays	Only if passing knowledge test:: OSCE consisting in 5 stages of 15 minutes each	Absolute
Chile	CONACEM: Yes (with exam)	Yes (2004) Non-specified Case study	Only if passing knowledge test: Observation of patients during one week	Absolute (under study)
	Universities: No exam			
Colombia				
Cuba	Yes	National Theoretical Exam	a) On-site evaluation during 12 weeks b) Submission of thesis	No data available
Ecuador	No			
USA	Yes	MCQ	Interpretation of supplementary studies	Absolute
Spain**	Yes		OSCE	Absolute
Mexico	Yes	MCQ	Family health study	Absolute
Paraguay	Yes	No data available	No data available	No data available
Peru ***	Yes	50-item MCQ	No	Absolute
Puerto Rico	Idem USA			
Uruguay*****	Yes	90-item MCQ	Research work on Family and Community Health	Absolute
Venezuela	No			

** In the case of **Spain**, the Family and Community Specialist degree is obtained after passing a 3-year residency, but no certification exam is available. In addition to residency, professionals that obtained their degree in Medicine before **1995** can achieve FM specialization if they give evidence of a 5-year experience in APS and 300-hour training, which includes a final aggregate evaluation through an OSCE-type test. This alternate process will end in **2008**.

*** In the case of **Peru**, all residents, upon finishing their specialty, must take a certification exam, which is prepared for all specialties by an ad-hoc commission appointed by the Postgraduate School, whose members are all lineal specialists.

***** In the case of **Bolivia**, there is a final exam, which is administered by a Commission consisting in a representative of the local public university, an instructing teacher, a representative of the educational institution and a representative of the Health Service (SEDES).

***** In the case of **Uruguay**: for Residents (2004) the test is under study; submission of the Monographic Work is mandatory for all Medical Residencies.

Table 7. How the summative evaluation is carried out

Country	Fee	Frequency	External Supervisors
Argentina	Yes	Twice a year	Yes
Bolivia		Once a year	Yes
Brazil	Yes	Twice a year	
Canada	Yes	Twice a year	
Chile	Yes (CONACEM)	Twice a year	Yes
Colombia			
Cuba	No data available	No data available	
Ecuador	-	-	-
Spain	-	Once a year	?
USA	Yes	Once a year	Yes
Mexico	Yes	Twice a year?	?
Paraguay	No data available		
Peru *	Yes	Once a year	Yes
Puerto Rico	Idem USA	Once a year	Yes
Uruguay	-	Once a year	
Venezuela	-	-	-

Table 8. How to access to a certification exam

Country	Exclusive Residency	Credits	Other
Argentina	No	Yes	
Bolivia	No (yes)	Yes (no)	
Brazil	No	Yes	
Canada	Yes	Yes *	
Chile	No (CONACEM)	Yes (training hours)	
Cuba	Yes		
Ecuador	-		
USA	Yes		
Spain**	Yes		
Paraguay	No	Yes	
Mexico	No	No	University Family Medicine Specialization Course (3 years)
Peru ***	Yes	No	
Puerto Rico	Idem USA		
Uruguay****	Yes		Yes
Venezuela	-	-	-

* In the case of **Canada**, there is a possibility to take the certification exam without having completed residency, by giving evidence of practical attendance and training in continuing bibliographic search skills.

** In the case of **Spain**, the Family and Community Medicine Specialist degree is obtained after passing a 3-year residency, but **no** certification exam is available. In addition to residency, professionals that obtained their degree in Medicine before **1995** can achieve FM specialization by way of another process that includes a final aggregate evaluation through an OSCE-type test. This alternate process will end in **2008**.

*** In the case of **Peru**, a Non-Attendance Residency in Integrated General Medicine through competence assessment is under elaboration, which will start in 2004-2005.

**** In the case of **Uruguay**, the first generation of Certified Family Doctors did not complete residency; they were subject to a one-time evaluation after giving evidence of their competence through Documented Practice or Evident

Competence, pursuant to the University's regulations on Specialist's Degree, in order to regularize the situation of the professionals practicing such specialty for more than 5 years.

Table 9. Term of validity of the certificate, and whether recertification is mandatory

Country	Certificate's Term of Validity	Recertification
Argentina	5 years	Yes (voluntary)
Bolivia	5 years	Yes (voluntary)
Brazil	5 years	No
Canada	5 years	Yes (voluntary)
Chile	-	No
Colombia		
Cuba	-	No
Ecuador	-	-
Spain	-	No
USA	7 years	Yes (voluntary)
Jamaica and CARICOM		No
Mexico	5 years	Yes (every 5 years)
Paraguay	5 years	Yes
Peru *	Permanent	Yes
Puerto Rico	Idem USA	
Uruguay	Permanent	No
Venezuela	Permanent	No

* In the case of **Peru**, there is a voluntary recertification system fostered by the Medical Association, which is based on the attendance to a certain number of courses per year. However, there is no guaranteed quality assurance regarding such courses and, consequently, regarding the acquisition of competencies.

REFERENCES

1. Brailovsky C. *Educación Médica, Evaluación de las competencias* en Aportes para un Cambio Curricular en Argentina 2001. PAHO y Facultad de Medicina, UBA: 2001.
2. Kane MT. The assessment of clinical competence. *Evaluation and the Health Professions*. 1992; 15: 163- 182.
3. Freidzon E. 1994. *How dominant are the professions?* en Professionalism Reborn: Theory, Prophecy and Policy. Cambridge, Polity Press.
4. (Tamblyn R, Abrahamowicz, Brailovsky CA, Grand'Maison P, Lescop J., Norcini J., Girard N, Haggerty JL. "The association between licensing examination scores and medical practice " *JAMA*, 1998, 11:989-996
5. Tamblyn R, Abrahamowicz, M, Dauphinee DW, Hanley JA, Norcini J, Girard N, Grand'Maison P, Brailovsky CA. "Association between licensure examination scores and practice in primary care" *JAMA*, 2002, 23:3019-3026
6. Harden R, Gleeson F (1979). Assessment of clinical competence using an objective structured clinical examination (OSCE). *Medical Education* 13: 41- 54.
7. Martín Zurro A (2002). Evaluación de la formación posgraduada, certificación y recertificación profesional de los médicos de familia en diferentes países (Reino Unido, Estados Unidos, Canadá, Holanda, Australia y España). *Aten Primaria* 30 (1): 46- 56.
8. Miller G (1990). The assessment of clinical skills/ competence/ performance. *Academic Medicine* 65: S63 – S67.
9. Muijtjens AMM, van Vollenhoven HM, van Luijt S, van der Vleuten CPM (2000). Sequential testing in the assessment of clinical Skills. *Academic Medicine* 75: 369- 373.
10. Newble D, Jeager K (1983). The effect of assessments and examinations on the learning of medical students. *Medical Education* 17: 165- 171.
11. Newble D et al (1994). Guidelines for assessing clinical Competence. *Teaching and Learning in Medicine* 6: 213- 220,
12. Newble D, Jolly B, Wakeford R (Ed) (1995). *The Certification and Recertification of Doctors: Issues in the assessment of clinical competence*. Cambridge University Press, UK.
13. Rethans JJ et al (2002). The relationship between competence and performance: implications for assessing practice performance. *Medical Education* 36: 901- 909.

14. Streiner DL, Norman GR (1995). *Health Measurement Scales: A Practical Guide to their development and use*, 2nd Edition. New York: Oxford University Press.
15. Van der Vleuten CPM (1996). The assessment of professional competence: development, research and practical implications. *Advances in Health Sciences Education* 1: 41- 67.
16. Van der Vleuten CPM (2000). Validity of final examinations in undergraduate medical training. *BMJ* 321: 1217- 1219.
17. Venturelli J (1997). *Medical Education, New approaches, goals and methods*: Washington DC, USA. (Freidzon E. 1994. How dominant are the professions? in *Professionalism Reborn: Theory, Prophecy and Policy*. Cambridge, Polity Press).

GLOSSARY OF TERMS USED IN THE DOCUMENT ABOUT THE CERTIFICATION OF SPECIALISTS IN FAMILY MEDICINE

- ? **Certification of specialists in Family Medicine:** Certification is the process by which an entity, by the application of certain pre-established criteria and public knowledge, guarantees, through a valid, reliable and transparent evaluation process that a dully registered professional has knowledge, skills, and attitudes that assure the minimum competencies for patient health care (taken from the different definitions found in the documents of medical associations). It can be definite or temporary. In general, it is a voluntary process,
- ? **Recertification:** It is the process by which the specialist is assessed in order to guarantee the maintenance of the competence regarding patient care. When certification is temporary, it is necessary to obtain a recertification. It is not possible to have a recertification process without a previous certification process. In some countries, it is possible to obtain certification when completing a postgraduate training program (for example, a residency training program), **without a certification examination**. Considering this point of view, in these countries certification is obtained through a summative assessment together with a *recertification process* of the specialist certification already granted. In our definitions, this would imply certification.
- ? **Authorizing Degree/Certification:** it refers to whether the certificate obtained through the certification and/or recertification processes are legally valid or not in order to be able to be as a dully certified Family Physician. To do so, it is necessary for the specialty to be previously recognized.
- ? **Competence:** it is the level of utilization of the profession-related knowledge, skills and good judgment, in all situations that may be faced during the clinical practice (Kane MT. 1992).
- ? **Certification Examination:** it refers to whether a summative assessment of the competences required of a Family Medicine specialist exists. Such summative assessment should measure different aspects of knowledge:
 1. The **knows** and **knows-how** levels from the Miller classification: instruments such as multiple choice tests, essay-questions tests are appropriate to measure such aspects.
 2. Cognitive psychomotor and/or emotional skills: it refers to the levels of **shows-how** and exceptionally, **does** in the reality of the Miller classification itself. Instruments such as objective and structured clinical examination (OSCE) is the most commonly used to measure this aspect.
 3. **Metacognitive skills:** it refers to the cognitive structures that are capable of identifying knowledge “gaps” as well as the planning and implementation of a plan so solve such gaps without the assistance of the educator. To be assessed, it is possible to use instruments such as the self-evaluation, peer evaluation type, logs where daily activities can be written down, the simulation of learning and assessment processes, etc. These are rarely assessed in the certification processes.
- ? **Miller Pyramid:** The educator George Miller designed a model of professional knowledge as a pyramid with several levels. In the two levels on the bottom part of the pyramid we find knowledge (*know*) and the way to apply such knowledge in specific cases (*know how*). In the level following these ones (*show how*), we find competence when measured in contextualized “in vitro” environments (simulated) where the professional must show everything he/she is capable of doing. At the top we find the *does* or what the professional really does in the actual practice independently from what he demonstrates to be capable of doing
- ? **OSCE (Objective and Structured Clinical Examination):** it is a form of assessment in which a variety of methods are used in order to objectively evaluate the knowledge, skills and attitudes that form clinical competence. During the assessment, participants go around a circuit of different stations in each one of which they must perform a specific activity. Such activities or tasks include: to interview and/or examine a simulated patient, to make a diagnosis, to interpret complementary tests, prescribe a therapeutic plan, among others. Different assessment methods may be used, from multiple choice tests to essay questions, though simulated patients are the most commonly used. The performance of participants is objectively observed and assessed by the use of a checklist or previously defined scale system. A typical exam includes about 20 stations, which take between 5 to 15 minutes each.

DECLARATION OF MARGARITA

FIRST IBERO AMERICAN CONFERENCE OF EXPERTS IN PROFESSIONAL CERTIFICATION AND ACCREDITATION PROGRAMS IN FAMILY MEDICINE

WONCA-IBERO AMERICAN REGION - ICFM (IBEROAMERICAN CONFEDERATION OF FAMILY MEDICINE)

PAN AMERICAN HEALTH ORGANIZATION (PAHO/WHO)

INTRODUCTION

Organized by ICFM, PAHO/WHO and semFYC, the First Ibero American Summit of Family Medicine took place in May 2002 in Seville, Spain, the motto of which was "Committed to improve the health of the population". This relevant event had 116 participants representing the Departments of Health, Social Security Agencies, Universities and other academic institutions, international organizations and Scientific Associations in Family Medicine from 17 Ibero American countries. There, proposals were elaborated and discussed concerning fundamental aspects for the development and institutional insertion of Family Medicine in the countries of the Region. The results of this work teams resulted in the publication of four technical documents focused on thematic areas which were synthesized in the "Declaration of Seville", where its most important recommendations are summarized as follows:

1. "About health care systems and the needs and demands of citizens"- Family physicians, who are responsible for the health care of people not only in their individual dimension but also in their family and community context, are the ideal "agents" to transform the biomedical into a biPAHOychosocial model in the context of Primary Care and within a multi-professional and interdisciplinary approach. This model should be promoted as a strategy of the countries of the Region to improve efficiency equity, quality and sustainability of their health care systems.
2. "About the contributions of Family Medicine to quality improvement of Health Care Systems"- It is critical to promote a culture of quality improvement of our specialty in the region through formal certification and accreditation processes. The objective of such processes is to guarantee minimum standards of competence in the education, training and performance of family physicians.
3. "About undergraduate education and Family Medicine"-it is essential that our discipline becomes part of the undergraduate curriculum of the schools of medicine supporting innovative curricular experiences with an early connection with health services"
4. "About postgraduate training and education programs for primary care physicians"- It is necessary to state minimum requirements for the training of family physicians, Residency training programs and continuing education activities, taking into consideration the contents and length of such programs, the teaching processes and the training of professors

In the trend initiated at the Summit of Seville, WONCA-Ibero American Region -ICFM and PAHO/WHO decided to continue and improve quality improvement aspects for family doctors, by organizing the "First Ibero American Conference of Experts on the Certification and Accreditation in Family Medicine". Its mission was to elaborate technical documents and recommendations in three thematic areas strategic for the development of Family Medicine, with the acknowledgement that it is a differentiated specialty with its own theoretical frameworks and professional practice bodies. The documents dealt with the elaboration of reference frameworks for the Professional Certification and Accreditation processes regarding continuing education activities and residency training programs in Family Medicine for Ibero America. From July 2003 to the end of October, over 30 experts from 20 countries of the Region, intensely worked on the elaboration of these technical documents to subsequently discuss them and elaborate the proposals and recommendations at the Conference that during that period took place in Margarita Island, Venezuela.

This declaration and its three sections according to the issues addressed, from now on referred to as "Declaration of Margarita", is summarized in 10 recommendations that we hope will become a guide for those countries that are trying to embark on the processes of Certification and Accreditation of

Family Medicine in Ibero-America. It is the determination of the ICFM/ WONCA, together with PAHO/WHO, to provide advice, support and to facilitate the implementation of such processes in the countries of the Region that may so desire.

RECOMMENDATIONS

Accreditation of Residency Training Programs in Family Medicine

1. Each country shall be responsible for establishing the minimum requirements concerning the accreditation of Residency training programs in Family Medicine, aiming to guarantee a basic professional competence profile in each and every training unit for the specialists in their countries. To do this, we suggest the consideration of the following aspects: name of the specialty, professional profile, time length, admittance requirements, permanence requirements, graduation requirements, curricular structure, requirements for teachers and professors, characteristics of the Family Medicine academic institutions and characteristics of the academic hospitals which support the education process.
2. The establishment of National Inter-institutional Committees of Medical Residencies is suggested. Such Committees must regulate not only the specialty of Family Medicine but also other medical specialties existing in each country. Its role shall be fundamental for the issuance of accreditation norms and procedures of medical residency programs, it shall allow the complete homogenization of the standards of the minimum necessary competences required by specialties in each country. In this context, it shall set the quality assessment mechanisms of residency training programs approved in accordance with the existing norms regulberog all medical specialties, consistent with the health needs of the population, the performance of health institutions and the organization of under and post graduate education programs at the local universities. Furthermore, it is highly recommended that this Committee may be formed by representatives from education and health institutions in charge of the training of specialists, by the entity responsible for the certification and accreditation processes and by representatives of the corresponding medical associations.

Professional Certification in Family Medicine

3. Professional Certification is a process that guarantees technically and socially accepted health care quality standards for the users of health services. Thus, it is extremely important to have certification processes for specialists in Family Medicine in all Ibero American countries. Family Doctors must be responsible for the definition, implementation and administration of certification processes in those institutions where professionals obtained such certifications.
4. Each country shall define its own certification system in accordance with its own reality. This process shall conclude with a formal evaluation by which the expected competences regarding not only formal knowledge but also abilities and aptitudes can be measured and assessed for a good professional performance. It is important for the evaluation of said competences to be contextualized and adapted to the individuality of the doctor, the patient, the family, the community values and characteristics, and the organization of health care services. In order to define the "contextualized" competence criteria, it would be useful to have as many stakeholder perspectives as possible. Such actors are those who play an important role in these situations: representatives of the specialty of Family Medicine, scientific associations, users, etc.
5. The fulfillment of validity, educational impact and feasibility in the application of the evaluation method should be guaranteed because the conclusions of such criteria should be as precise as possible considering the serious consequences of certification on the life of professionals and patients in general.
6. Recertification shall be periodic and shall guarantee not only the maintenance but also the acquisition of new competences that emerge due to the continuing education and the growing complexity of the tasks of a Family Physician within health care systems.

Accreditation of Continuing Medical Education Activities

7. The performance of Continuing Medical Education (CME)-related activities is a key element to maintain and improve the Professional Competence of Family Physicians. Health Care Services should maximize the access of such professionals to Continuing Education Programs as a way to guarantee the quality when providing health-related services.
8. Countries should create adequate environments gathering those institutions involved in the accreditation process (Scientific Societies, Universities, Health Care Services, etc.), that may guarantee through objective processes, the scientific-technical appropriateness, suitability, and quality of Continuing Medical Education programs.
9. Continuing Medical Education programs must specifically deal with aspects related to the competences and values of the professional profile of Family Physicians and should become an important element in the Professional Recertification systems and those systems tending to maintain the abilities and skills in Family Medicine.
10. The appropriate motivation mechanisms shall be established in order to promote Continuing Medical Education activities in Family Medicine professionals. Thus, the implementation of incentives is recommended for those professionals who accomplish these activities.

Margarita Island, Venezuela. November 2003

