Canada's crisis of primary care access: Is expanding residency training to 3 years a solution?

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In 2022, The College of Family Physicians of Canada (CFPC) published its final report of the Outcomes of Training Project, including the recommendation to extend family medicine residency training from 2 to 3 years.[1] Through an expanded training program, the CFPC's goal is to support family physicians to work at the "top of their scope" by enabling residents to meet societal needs, manage complexity and address medical comorbidity through comprehensive primary care practice.[1] While this effort at curricular renewal is welcomed, important concerns should be considered during the transition period.

A CFPC report cited perceived lack of confidence and preparedness in a particular domain of practice, personal time commitments, practice models, practice location, credentialling requirements and remuneration, in addition to lack of interest in a subject area, as important factors in the type of services family physicians provide.[2] Although curricular expansion may support further development of competence and expertise, increasing training length will by no means assure increased provision of comprehensive care. Changes at the level of systems and organizations, and attention to personal factors, in addition to educational enhancements, are essential. These include paying attention to administrative burdens and work–life balance, and spotlighting societal and professional perceptions of the family physician.

Currently, the CFPC requires residency programs to train family medicine residents in the "patient medical home" setting, including team-based collaboration and access to interprofessional colleagues.[3] However, graduates are faced with a scarcity of opportunities to join these practice models. Therefore, to better support primary care, provincial governments must fund and develop these forms of health service delivery to better assist communities and improve patient access. The federal government has already committed to improving primary care funding, and provincial-level reform of primary care payments have been promising.[4] Increasing access to these models of care is critical to help connect more patients to community-based family medicine, as well as to support primary care as a career choice for new medical graduates by ensuring that residents trained to provide comprehensive care can do so after completion of training.

Key points

- The College of Family Physicians of Canada (CFPC) recently recommended extending family medicine residency programs in Canada to 3 years to help graduates better meet societal needs, manage complexity and address medical comorbidity.
- While curricular renewal is welcomed, important concerns should be considered during the transition period, including the potential for extension of training to contribute to declining interest among medical students in pursuing family medicine and its effect on the number of candidates who pursue a focused area of practice.
- This is a critical juncture when administrators at the CFPC and postgraduate training programs will need to be creative around program design to reinvigorate interest in family medicine as a career choice.
- Curricular renewal is important, but insufficient to help strengthen primary care in Canada; addressing system, organizational and personal factors is also crucial to better support the provision of comprehensive and continuous primary care across the country.

Moving to a 3-year residency program may also affect medical student interest in family medicine, especially in the context of declining interest in this specialty as evidenced by a record number of unmatched residency positions in 2023.[5] Published data are lacking from Canadian learners describing the acceptability of or interest in pursuing a 3-year family medicine residency in Canada. However, length of residency training has been shown to influence medical students' career choices.[6] A US comparative case series was unable to determine the ideal training length for family medicine residency programs, but did find that curricular innovation correlated with more medical student applicants and higher rates of graduates practising inpatient care, obstetrics and long-term care.[7] It is unclear if these findings are generalizable to Canada.

Enhanced Skills training and focused practice, such as emergency medicine, palliative care and addiction medicine, are often cited as threats to trainees' choice to provide comprehensive

primary care.[8] Pursuing a focused area of practice has been identified as protective against burnout that can be associated with working in comprehensive primary care in current Canadian health care systems.[9] Moreover, a substantial portion of the Canadian physician workforce includes Certificate of Added Competence (CAC)–trained family physicians practising in focused areas.[10] Currently, the CFPC's position is that the move to a 3-year training program may mean trainees will need to do a fourth year of Enhanced Skills training if they are interested in a CAC, which represents a potential threat if fewer residents choose to pursue a fourth year. The possible downstream effects of a decrease in CAC-trained physicians on the family medicine workforce are unknown and conceivably harmful.

This is a critical juncture when administrators at the CFPC and postgraduate training programs will need to be creative around program design. To address patient needs, avoid burnout and support professional development for family physicians, we recommend designing educational programs that maximize training in comprehensive care, while also allowing trainees the opportunity to weave an area of particular interest into their family medicine residency training. At the University of Toronto, we have piloted an integrated, 3-year family medicine program with Palliative Care and Care of the Elderly Programs and undertaken a parallel program evaluation. The intended outcomes of the program evaluation included feasibility and acceptability of this intervention in its first 2 years. Participants in the qualitative study have included residents, programs directors, family medicine site directors, faculty and administrators. Preliminary results suggest that participants support the potential of the integrated program to augment the development of selected expertise among trainees while providing training in a comprehensive care context. A future goal would be to increase the scale of the intervention and follow resident practice patterns prospectively. We are not suggesting that everyone who completes this Enhanced Skills track will be CAC eligible. Rather, the pilot program design represents an opportunity to gain competence and confidence in an Enhanced Skills area of interest so residents can enter the workforce with a deepened skill set and tool kit of proficiencies. This is but one example of how innovation in program design may attract candidates to family medicine while enabling them to have an expanded scope of practice after graduation. However, it is essential that the design of any pioneering program also support training in comprehensive family medicine and that outcomes be carefully evaluated.

Innovative thinking in educational delivery is essential to generating interest in family medicine and in ensuring graduating physicians are prepared to practise comprehensive primary care. But educational reforms alone are unlikely to achieve the goal of increasing the provision of comprehensive and continuous care. Addressing system, organizational and personal factors, while also creating the curricular conditions that will support a strong family medicine training program, will attract talented physicians to the practice of family medicine.

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