



# Impact of Competence by Design (CBD)

Report on semi-structured interviews conducted on the 2017-2018 cohort of R1s in Anesthesiology and Otolaryngology/Head and Neck Surgery in Quebec

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# Abbreviations

EPA	Entrustable Professional Activity
CBD	Competence by Design
RCPSC	Royal College of Physicians and Surgeons of Canada
FMRQ	<i>Fédération des médecins résidents du Québec</i>
OTO/HNS	Otolaryngology/Head and Neck Surgery
R1	Resident 1 (PGY-1)

\* The masculine gender is used in this document purely in the interest of readability.

# Introduction

On July 1, 2017, the Royal College of Physicians and Surgeons of Canada (RCPSC) began implementing a new system for training and assessing medical residents in line with the competency-based approach known as Competence by Design (CBD). The main feature of CBD is that it emphasizes the acquisition of competencies rather than the duration of medical residents' training rotations.

Such a revamping of the teaching and assessment system in postgraduate programs involves numerous changes which will inevitably require adjustments. In this context, the *Fédération des médecins résidents du Québec* (FMRQ) has set itself the mandate of learning as much as possible about the experience and difficulties faced in the field by Quebec's medical residents. In this way, it hopes to contribute to monitoring and tracking CBD in the interest of its members in postgraduate medical education programs.

To this end, the FMRQ decided to conduct follow-up on all medical residents in training in the two programs subject to CBD since July 1, 2017, in order to gather as much information as possible on their experience with CBD. More specifically, the FMRQ in January and February 2018 conducted semi-structured interviews with the residents concerned, to understand and list the specific features of CBD, follow this approach as it evolves, and thus better to defend residents' interests vis-à-vis the authorities responsible for implementing CBD.

The purpose of this report is first to inform the different stakeholders in postgraduate medical education in Quebec and Canada of the challenges experienced by medical residents in the CBD programs. Building on a survey method yielding qualitative information through semi-structured interviews, the FMRQ is reporting here on the main observations made by residents in the field. Subsequent analysis of these observations made it possible to formulate recommendations for facilitating the implementation of CBD for learners and supervisors, and, ultimately, to enhance patient care.

# 1. Methodology

## 1.1. Study tool: semi-structured interviews

Semi-structured interviews are a qualitative study tool based on individual or group interviews where the interviewer dictates solely the different topics to be addressed, without asking any specific questions. Semi-structured interviews are used to gather different types of information: facts and verification of facts, opinions and viewpoints, analyses, proposals, reactions to initial assumptions, and evaluators' conclusions. In addition, this method is conducive to speaking freely within a relatively strict framework. It requires upstream preparation, and downstream analysis.

The interviews were carried out in January and February 2018. The meetings brought together residents from the same specialty and faculty. They were not recorded, and two FMRQ representatives were invited to attend, so one of them could take notes.

## 1.2. Study population

The target population was predetermined by the RCPSC's selection of disciplines for implementation of CBD. It comprised all Quebec medical residents in the first year of residency in 2017-2018 in the following two specialties: Anesthesiology, and Otolaryngology/Head and Neck Surgery (OTO/HNS). Once the general invitation email was sent out, FMRQ representatives called the 32 residents concerned, individually, to set a date for the semi-structured interview. In that regard, we feel the effort expended reflects the desire to conduct a true poll of learners' experiences.

### 1.3. Talking points

A review of the documentation available in August 2017 led to the identification of the main issues with respect to CBD. These elements were then validated for discussion, and grouped together by topic (Table 1).

**TABLE 1 : TOPICS ADDRESSED IN SEMI-STRUCTURED INTERVIEWS**

<b><i>TOPIC 1: Information and training with respect to CBD before July 1, 2017</i></b>
<ul style="list-style-type: none"><li>– Perception of CBD prior to starting residency</li><li>– Specific training or formal information provided prior to starting residency</li></ul>
<b><i>TOPIC 2: Training received and implementation during first six months of CBD</i></b>
<ul style="list-style-type: none"><li>– Training received by residents</li><li>– Implementation process</li></ul>
<b><i>TOPIC 3: Supervising physicians' level of preparedness for CBD</i></b>
<ul style="list-style-type: none"><li>– Preparation of supervisors</li><li>– Supervisors' attitude toward CBD</li></ul>
<b><i>TOPIC 4: Evaluations – milestones, EPAs, and Competence Committee</i></b>
<ul style="list-style-type: none"><li>– Conduct of evaluations and impact of CBD</li><li>– Content of evaluations – milestones</li><li>– Content of evaluations – EPAs – Competency Committee operation</li><li>– Quality of interaction with Competency Committee</li><li>– Resident-supervisor relationship</li></ul>
<b><i>TOPIC 5: Strengths and weaknesses of CBD as seen by residents</i></b>

### 1.4. Data compilation and analysis process

After each of the meetings, the interviewer had to complete an interview evaluation sheet. This required the collection in anonymized, aggregated format of the information gathered on each of the topics addressed, in relation to the objectives pursued. Also, he had to note his first impressions, particularly concerning the distinctions between the conventional curriculum approach and the CBD approach. Subsequently, pooling of the evaluations at a meeting with all the interviewers involved in this process led to highlighting of each interviewer's observations.

The final report was drafted by a previously determined representative, revised and approved by the other members of the FMRQ's Academic Affairs Committee – Specialties, then submitted to the members of the FMRQ Board.

## 2. Findings

### 2.1 Participants

In all, 26 residents (81%) took part in the interviews: 16/21 in Anesthesiology, and 10/11 in OTO/HNS. Broken down by faculty, there were 6/9 residents from the University of Montreal, 9/9 residents from McGill University, 7/7 residents from Laval University, and 4/7 residents from the University of Sherbrooke. Those residents not attending the interviews either could not be reached, had to cancel for other reasons, or said they did not have time.

Generally speaking, the elements reported by Anesthesiology and OTO/HNS residents were similar. The data will therefore be treated together, unless there are observations relevant specifically to one of the specialties.

### 2.2 Topic 1: Information and training with respect to CBD before July 1, 2017

In this regard, the main observation emerging from the semi-structured interviews was candidates' unfamiliarity with CBD before they began a residency program of this type. Most of them had received no information, or only superficial information, by the time of the admission interview. One resident reported that she had unsuccessfully sought additional information on the Internet. Without credible information enabling them to form an opinion concerning CBD, some residents admitted that their perception was negatively impacted by the reservations expressed by senior colleagues.

The only training provided before July 1, 2017 was of varying duration, and considered too theoretical, i.e., insufficient to enable candidates to realize the impact of CBD on their daily lives. This training simply reflected the content of a generic presentation prepared by the RCPSC.

Finally, several residents noted that they had initially had unrealistic expectations concerning a shorter duration of training in the context of CBD-based training.



## 2.3 Topic 2: Training received and implementation during first six months of CBD

Residents were unanimous in saying they felt the need for training on CBD early in their residency. Several of them observed that they had received only emails containing information or attended a presentation based on the generic model prepared by the RCPSC. Three positive examples, though, are worth noting:

- “Pragmatic” training: one program organized an introductory camp for residents, with the collaboration of a number of staff physicians. During the camp, learners had to complete with a supervisor a first EPA evaluation, using a simulated case.
- Frequent, regular group meetings focussing on CBD: one program director met with his residents at the start of the year, then on three other occasions in the first six months, specifically to follow up on the implementation. These meetings served not only to provide information on CBD, but also to gather feedback from residents and follow up on problem elements.
- Nomination of a CBD resource-person in each training site: the only downside was that some residents were unaware of the existence of this resource, which was highly appreciated by their colleagues.

Overall, learners felt a constant need for information on CBD; a single training session at the start of residency was deemed inadequate for enlightening them regarding subsequent details concerning progression in residency.

One major recurrent issue across sites and specialties concerned off-service rotations. Since CBD is being implemented in a limited number of programs, residents encountered numerous difficulties and experienced considerable frustration when they are in these rotations away from their “home” departments. It is related that, while implementation is embryonic in rotations in the home program, residents said they received no faculty support or training outside those rotations. The situation is such a problem that they said they had to guide their supervisors in evaluating their EPAs. In this context, a number of programs had provided for no progression of EPAs in the numerous off-service rotations, preferring to focus the entire evaluation in the few home program rotations scheduled in the first year. There was therefore questioning about the value both of the imperfectly completed EPAs and the rotations with no possibility of progressing in CBD.

Several residents said they were puzzled about implementing CBD while maintaining conventional evaluations. In fact, a good number of programs have added CBD requirements on top of the daily, mid-rotation and summative evaluations of the conventional route. This leads to two problems. On the one hand, learners and supervisors were seen to be tired owing to the additional workload. On the other hand, residents said they did not know exactly which evaluations would be used for their certification. This second part of the problem will be addressed under Topic 4.

Residents appreciated having a schedule for acquisition of the different EPAs through the rotations. Unfortunately, this schedule was in some cases ambiguous, and left to learners’ discretion, while in other cases it was inapplicable. For instance, in one particular program, it was not possible to perform the “wound closure” EPA provided for in the plastic surgery rotation, since residents did not take part in surgery in that rotation.

Residents told of difficulties experienced with electronic platforms that were inadequate, defective or missing, as the case may be. One month's break of service from an IT platform, or loss of their personal evaluation binder, were striking examples which slowed residents' progression in their training.

Finally, note that residents underscored the outstanding work of their program directors, whose dedication greatly encouraged them. In the same breath, concern was expressed that several of these directors appeared inadequately prepared in the face of the major project that implementation of CBD represents.

## 2.4 Topic 3: Supervising physicians' level of preparedness for CBD

Overall, staff physicians' preparation for supervising residents in a CBD system is heterogeneous. Residents' observation as to the total lack of preparation by staff physicians on off-service rotations has already been reported. As to their home program, preparation is variable. Some residents noted that many supervisors are highly motivated and well informed concerning CBD, while others appear to have little interest in or information about this new approach, and this has a negative impact on the completion of evaluations. It was pointed out that those staff physicians were generally less involved in the academic setting. Note also in passing that staff physicians sometimes do not have access to the same explanatory material concerning CBD as residents. Finally, the role of senior residents in CBD is not clear in the field, and they do not appear to have received any training.

While residents are generally proactive in seeking opportunities to complete EPAs, they often have trouble having the supervisor's part completed. It was reported that as many as 30% of EPA evaluation requests remained unanswered. Residents invest energy and time in following up on evaluations not yet completed by supervising physicians. Currently, there is little support for this.

## 2.5 Topic 4: Evaluations – milestones, EPAs, and Competence Committee

### 2.5.1 Number and appropriateness of milestones and EPAs

The number of EPAs required for training by CBD is considered excessive, particularly by residents in Anesthesiology. The high number is detrimental to the quality of feedback, as well as being exhausting for learners and supervisors. At the same time, the number of observations required for a given EPA is considered in many cases to be out of proportion. Overall, learners' and supervisors' attention is currently directed toward attaining EPAs, and not toward learning. The high number of EPAs, combined with the difficulties associated with implementation, prompt serious fears from residents as to their ability to attain all the objectives during their five years of training.

Residents have trouble achieving certain EPAs, for instance, owing to the rarity of certain types of exposure. Along the same lines, the milestones specific to certain EPAs are not applicable to the local clinical reality in some cases. For instance, posterior nasal packing is very rarely performed in Quebec.

Some observations question the operability of EPAs. Generally speaking, technical EPAs and milestones lend themselves more effectively to CBD-type evaluation than those of a non-technical nature. Evaluation of the latter can lead to learning situations that are considered non-authentic by learners, such as: "understanding the patient's perception of his problem."

### 2.5.2 Confidence scale

Residents commented at length on the confidence scale. While many appreciate it specifically for the element of trust it conveys, they all agree that the confidence scale is confusing in the field, and leaves a lot of room for subjectivity. The level of trust required for a successful evaluation is often perceived as unrealistic. For instance, a staff physician should never be confident leaving a first-year resident (R1) to manage an unstable patient on his own. Thus, the level of expertise expected for certain EPAs is considered unreasonable in relation to junior residents' responsibilities and even, in some cases, in relation to their discipline: an R1 in Anesthesiology does not perform a difficult intubation, just as an R1 in OTO/HNS does not evaluate unstable head trauma. In fact, evaluations by supervisors are not homogeneous. For instance, a number of residents reported having been evaluated "non-entrustable" for a foundation EPA, since that is interpreted as being "R5 level." Similarly, a number of cursory evaluations are made. This could be related to the ambiguity of the evaluation criteria for certain EPAs, or staff physicians' and residents' lack of preparedness for CBD.

### 2.5.3 Competence Committee

It is surprising to learn that in February 2018 several residents were still unaware that the Competence Committee existed. In many cases, they did not know whether the Committee had met to evaluate their performance. Residents in only one of the eight programs questioned said they had been informed individually of their promotion by what they believed to be the Program Committee. For all other residents, their promotion to the next stage in the competence continuum (core of discipline) was either unknown to them or delivered in an email or orally in group meetings. Therefore, feedback given to residents concerning their progression through the milestones and EPAs is inadequate. The lack of specific, individualized feedback generates a high level of anxiety among residents, who do not know exactly which criteria will be used to gauge their eligibility for the certification exam.

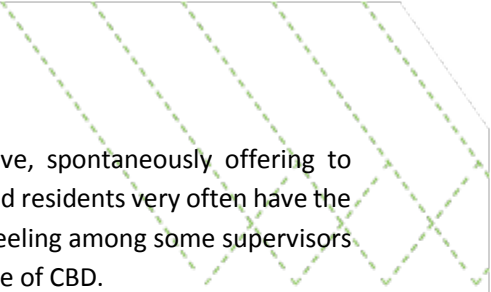
### 2.5.4 Other elements associated with the evaluation process

As previously reported, implementation of CBD while maintaining "conventional" evaluations prompts two questions from residents. First, in this dual-component format, which evaluations will be used to decide on their promotion? Then, is it really desirable to eliminate conventional evaluations completely? On that point, opinion is divided.

Some see duplication as an advantage, since the summative evaluation is used to provide a comprehensive assessment of how they function on a daily basis, and yields a better evaluation of learning not evaluated by EPAs. Elements specifically better evaluated by the conventional format include aptitude for teaching, performance on rounds, teamwork, communication, and quality of oral presentations. None the less, other residents claim that duplicating evaluations simply represents an additional chore.

Moreover, programs that have adapted their rotation grid have made it possible to facilitate the acquisition of EPAs. But it is reported that clinical activities performed on call and during months of night shifts do not lead to progression in EPAs.

It is also important to note that residents consider immediate verbal feedback to be crucial in learning by CBD. They are afraid that an IT platform not geared to this reality will be detrimental to these invaluable learning opportunities.



Staff physicians' attitudes toward CBD are variable. Some are very proactive, spontaneously offering to complete EPA evaluations. Nevertheless, others appear irritated by this task, and residents very often have the impression of being a nuisance when they request evaluation of an EPA. This feeling among some supervisors that this represents an additional chore is no doubt amplified by their ignorance of CBD.

Finally, note that the resident-staff physician relationship generally remains good with the advent of CBD. In fact, most residents do not believe the proliferation of evaluations has altered the relationship they have with their supervisors. But some of them point to being uncomfortable when they have to insist in order to have their evaluations completed.

## 2.6 Topic 5: Strengths and weaknesses of CBD as seen by residents

In general, residents are optimistic concerning CBD, despite their first experiences often leaving them with the feeling of having blazed the trail for those following them. Note here the stress, and even distress, reported by several residents during the interviews.

The strengths most frequently reported are: confidence scale; proliferation of observations; early, objective identification of their strengths and weaknesses; systematizing of the competencies that need to be acquired during their training; and creation of new opportunities for feedback on a day-to-day basis.

The main weakness related by residents is certainly the very significant, even excessive, additional workload generated by CBD. Too many EPAs, too many milestones, too many observations required for the same EPA, evaluations to be explained and re-explained to their supervisors, follow-up on evaluation requests not fulfilled, and all of this sometimes alongside conventional evaluations. Residents claim to have a high level of responsibility compared with their predecessors, without having any more time or resources. Furthermore, they reproach evaluation by CBD with leading to fragmented feedback on their performance, whereas conventional summative evaluations are more conducive to providing a comprehensive view. Finally, residents say they feel programs' lack of preparedness for implementation of CBD. They are also afraid that their efforts will not be sufficient to make up for the backlog caused by this lack of preparedness.

### 3. Discussion

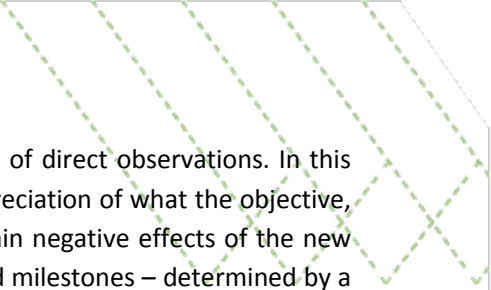
Canada-wide implementation of CBD represents an enormous paradigm shift. Despite the numerous criticisms gathered from residents concerning the changes to CBD, the poll conducted by the FMRQ through semi-structured interviews also led to many constructive comments. Nevertheless, we must emphasize that the residents interviewed expressed themselves while considering not only the quality of their training but also that of their successors. The role of postgraduate medical education bodies such as ours is therefore to hear these observations so as to convert them into a constructive force. First, the goal is to evaluate and compare the hoped-for spinoffs from CBD with the experiences undergone in the field. The recommendations made at the end of this paper attempt to respond to the observations noted down in the semi-structured interviews.

CBD is integrated in a pedagogical system that is living, complex, and well-established in its traditions. One observation must be made following the interviews with residents: training programs are having difficulty offering CBD where that approach coexists with the old system. The problems are particularly troublesome when it comes to off-service rotations, where faculty training is lacking and opportunities for evaluating EPAs are currently rare, if not non-existent in certain rotations. Furthermore, the lack of clear promotion rules in a context where the conventional monthly evaluations continue to be completed is worrisome for medical residents. Insofar as the progressive implementation of CBD will not be completed until 2023, it is inconceivable not to seek solutions to mitigate the impact of the transition between the two medical education systems.

Maintaining the conventional system alongside CBD should not, however, be seen as a problem. Rather, we should be keeping the main positive elements of the conventional formula. Residents observed that the competency-based approach is an enhanced form of silo learning. In fact, while each EPA now encompasses several of the old specialty training objectives, it remains a tangible learning unit. Indeed, several residents commented that monthly evaluations were still helpful to them, since they tell them about their overall performance and their aptitude in aspects not measured by the EPAs completed in the rotation. This aptitude can include teamwork, communication, and oral presentations, among other things. In other words, certain CanMEDS roles are not taken into account when EPA is the sole evaluation method used.

Another aspect of the conventional system raised in the transition to CBD is the defined time frame, which leads to the acquisition of a level of trust over time. Residents told us that a number of rotations where few EPAs could be observed for operational reasons contributed nothing to their progression toward certification. Nevertheless, can we not question the premise that a learner ready for certification is a learner who has correctly performed a predetermined number of actions under supervision? Is it not true that, even if the resident has not been exposed to one of the expected 90 specific situations, we could still conclude that he has acquired, over those five years of training, the necessary tools for confronting an unusual clinical problem in his future practice? In other words, in the CBD era, can we not still agree that experience acquired over the years counts in supervisors' level of trust toward a learner?

These questions arising from fears actually reported by residents in the field, who do not wish to terminate their residency before the time previously required, either—a possibility dangled before them by some people—but who are instead fearful of being incapable of ticking off all the EPAs and milestones required without having to prolong their residency unduly. In that case, would they really be less competent than their predecessors?



One of the strengths of CBD both expected and observed is the proliferation of direct observations. In this regard, the goal is achieved, and even exceeded. Residents stressed their appreciation of what the objective, systematic observation of the competencies brings them, but described certain negative effects of the new system which warrant consideration. First, the number and nature of EPAs and milestones – determined by a national committee – are sometimes unattainable locally, for practical reasons. In this regard, note that the situation is urgent in Anesthesiology, and is generating a great deal of stress among learners. Also, evaluation of CBD and its milestones on a confidence scale is confusing. Learners and supervisors are not trained and equipped to use it effectively. This has a direct impact on the value of the evaluations completed.

Candidates' progression from acquisition of foundations of discipline to transition to practice should take place through a transparent process orchestrated by the Competence Committee. Our observations in Quebec's four universities have unfortunately confirmed to us the existence of numerous shortcomings in this regard. In fact, residents were often unaware of the existence, composition or operation of the Competence Committee, and individual feedback was non-existent. This is without doubt the observation that is the least in line with our expectations.

Finally, it is important to emphasize once again the high level of anxiety experienced by residents following implementation of CBD. They acknowledged the virtues of this new approach, which fosters learners' involvement in their own professional path. But they reported a lack of administrative and educational support in training sites for ensuring the completion of EPAs. In addition, programs' and staff physicians' lack of sensitivity with regard to learners' increased pedagogical responsibilities is hard to go through on a daily basis.

Responsibility for this state of affairs is shared among different stakeholders. Did the Royal College trigger the process too quickly? Did the medical faculties take the prior steps needed to implement CBD in their training sites? Have staff physicians and supervisors taken the true measure of the change? Unfortunately, it is medical residents who are bearing the brunt of this. That is why we are presenting the following recommendations to you.

## 4. FMRQ recommendations concerning implementation of CBD

Recommendations marked with asterisks (\*\*\*) are taken from the *2017 CBME Resident Summit Consensus Statement*. They correspond to what residents said in the semi-structured interviews. Where anything has been added to an original statement, this is identified by square brackets [ ].

### 4.1 Information and preparation prior to starting residency

#### Recommendation #1

Quality information concerning CBD should be provided to medical students before they begin residency. Insofar as the possibility of shortening the duration of a residency program is unlikely, this should no longer be conveyed to candidates as a benefit of CBD.

### 4.2 Training and pedagogical monitoring during residency

#### Recommendation #2

Training for residents concerning CBD should be given before residency begins or at the latest in the first week of residency. Its duration should be sufficient to acquire all the theoretical and practical knowledge necessary for the resident to function well in CBD mode.

The goals of this training should be pragmatic, i.e., acquisition of the concepts and tools residents need on a day-to-day basis to progress in CBD.

The role, operation and composition of the Competence Committee should be explained during the training.

#### Recommendation #3

On transitioning in the competence continuum (acquisition of foundations of discipline, core of discipline, transition to practice), residents should be met with, to present and explain to them the details and anticipated timetable of progression to the next stage. These meetings should also provide for individualized feedback on their progress through CBD, including the Competence Committee's findings.

#### Recommendation #4 \*\*\*

All teaching faculty called upon to provide feedback on EPAs, during both discipline-specific and off-service rotations, should receive prior and ongoing training. Supervisors' participation in such training should be documented and mandatory.

[ADDED: Supervisors should have access to the same explanatory material on CBD as residents. The documents should be available in both English and French.]

### 4.3 Evaluations – milestones, EPAs, and Competence Committee

#### **Recommendation #5**

The RCPSC specialty committees should keep a watch on the list of EPAs and milestones to be attained. Ongoing reassessment of their appropriateness should be carried out during the year in which CBD is implemented, and periodically thereafter.

**5.1\*\*\*** The number of EPAs, milestones, and observations required under CBD must make allowances for practical constraints in the different training sites. In the short term, Anesthesiology would particularly benefit if these requirements were updated.

**5.2** Selected EPAs and milestones should reflect a pan-Canadian practice specific to this specialty. Also, it must be possible to evaluate those of a non-technical nature in genuine learning situations.

#### **Recommendation #6**

The evaluation criteria for EPAs and milestones should be clearly set out. Among other things, it would be helpful to provide a brief description of a first-year resident's "pre-entrustable" and "entrustable" performances for certain foundation EPAs.

#### **Recommendation #7 \*\*\***

Residents are expected to be actively involved in the CBD process. But departments and programs are responsible for ensuring that the evaluation forms forwarded by residents to faculty members are completed within a reasonable timeframe.

#### **Recommendation #8**

Appropriate, regularly updated information systems infrastructure should support EPA evaluation and monitoring. A policy allowing for alternatives should be provided for to enable residents to progress in the event of extended breaks in service.

Regardless of the platform used, oral feedback should be given immediately following the evaluation.

#### **Recommendation #9 \*\*\***

Programs should provide residents with a schedule matching each EPA with a specific rotation conducive to its evaluation.

[ADDED: This schedule should be frequently reassessed during CBD implementation.]



### **Recommendation #10**

In a context of gradual implementation of CBD across the different specialties, mitigation measures should be provided for during the transition.

- 10.1** Progression in EPAs during off-service rotations should be fostered. An example of such a strategy would be using solely evaluation forms from the conventional education system. Consequently, the EPAs specified in this rotation should be credited, provided the resident passes the rotation.
- 10.2** Duplication of evaluation methods (conventional and CBD) should be minimized. Where a hybrid system exists within a given program, a faculty policy should benchmark the use of the different evaluation methods. Among other things, the rules governing decisions concerning resident promotion must be clearly set out.

### **Recommendation #11**

The competency-based approach should be adapted to include certain elements more effectively evaluated by the conventional system. For instance, opportunities for summative evaluations should be retained, and the notion of trust acquired over time should be considered.

### **Recommendation #12 \*\*\***

Academic promotion as directed by Competence Committees should be objective, transparent, comprehensive and flexible. It should not rely solely on the number of clinical observations. Residents should be informed of this relative flexibility.

## **4.4 Other recommendations**

### **Recommendation #13**

The faculties should clearly set out each stakeholder's roles and responsibilities in applying CBD. In particular, the role of senior residents should be clarified, and they should be informed of that role.

### **Recommendation #14 \*\*\***

Continuous improvement measures should be implemented in a long-term perspective.

- 14.1** Programs should foster collaboration by seeking comments from learners and teaching faculty on a continuous basis, and use these comments to improve CBD.
- 14.2** The Royal College should facilitate the sharing of best practices in CBD implementation, in collaboration with departments and programs, and provide increased clarity on the anticipated launch date.

### **Recommendation #15**

The medical faculties and the programs should be aware of the additional workload and stress that CBD brings. To that end, resource persons should be available as required.

## Conclusion

The survey by semi-structured interviews conducted on the first Quebec cohort undergoing CBD – Anesthesiology and OTO/HNS residents – was a time-consuming exercise. Successfully motivating and engaging more than 80% of those residents, who are already very busy, in order to gather their comments concerning this new pedagogical paradigm is an accomplishment in itself. None the less, in light of the observations reported, one thing is clear: the work has only just begun. These observations are sometimes inspiring, sometimes troubling, but they certainly provide food for thought. How can we do better? How can we improve the implementation process for the upcoming 65 programs? How can we limit the impact of such a drastic change and identify pragmatic solutions to the difficulties encountered? The beauty of this type of questioning is that it bears close similarities to the pedagogical process set out in the competency-based approach, the process we are asking our learners to undertake. Without doubt, its main difficulty will be introducing the necessary changes, in order to make our new medical education system an “entrustable” system.

In that regard, the FMRQ is determined to work on the implementation of CBD and to make it a success, insofar as all the stakeholders involved, the Royal College first among them, ensure that the necessary adjustments are made in a timely manner, to resolve the difficulties we have identified. These changes have to be implemented urgently, to avoid their taking place to the detriment of the quality of training. Furthermore, we are all the more concerned at the fact that we are approaching the integration of six new programs in July 2018. We must ensure that the competency-based approach enhances postgraduate education and quality of care in Quebec, and in Canada as a whole.