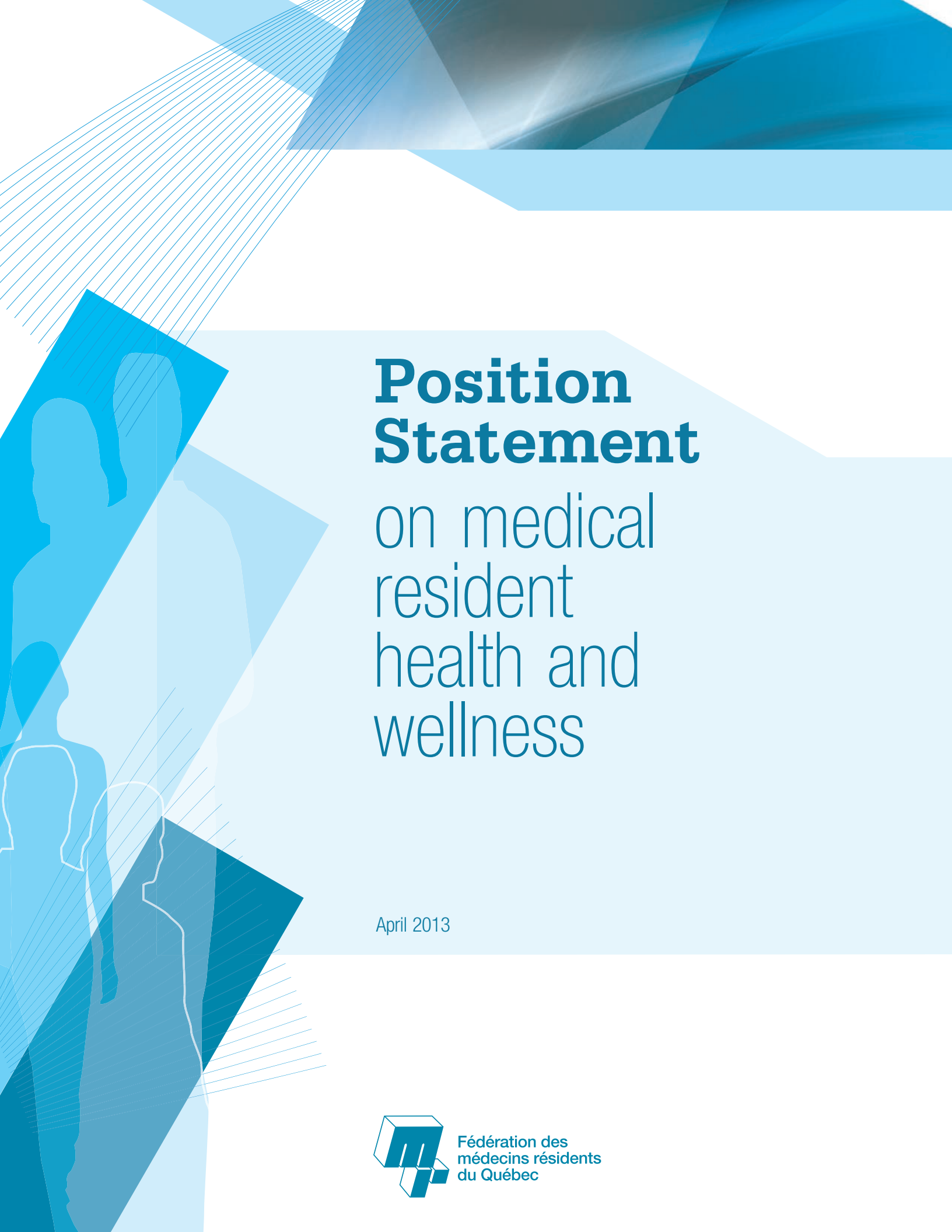

Position Statement

on medical resident health and wellness

April 2013

Fédération des médecins résidents du Québec

Fédération des médecins résidents du Québec

Introduction

The *Fédération des médecins résidents du Québec* (FMRQ) has for several years observed the impact of psychological distress and psychological harassment in training settings. Indeed, medical residents are increasingly consulting the various resources placed at their disposal, in particular when they encounter difficulties on the academic, medical or personal fronts. Over the years, the scale of this distress and the problems from which medical residents suffer have increased. Is this because there are more residents in difficulty, or because it is easier and faster for them to consult? Hard to say, particularly since each individual consults the organization that best suits him, depending on his situation.

Psychological harassment or intimidation regrettably remain present in our postgraduate training sites. Psychological harassment is defined on the one hand by the instigator's actions (insults, threats, blackmail, restrictions, stigmatization, violence, etc.) and on the other hand by the effect on the victim (stress, isolation, distress, etc.). These behaviours can have a negative impact on the resident's psychological stability and mental health, influence his career choice and whether he continues his studies, diminish his work satisfaction and, ultimately, jeopardize the quality of patient care. The Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC) have made psychological harassment an accreditation criterion, i.e., all training sites must implement measures to intervene rapidly and effectively in such situations. For its part, the FMRQ has made it a priority. For medical residents, there is zero tolerance of psychological harassment.

The FMRQ has been working for several years already to raise awareness in training sites and identify lasting solutions to these problems. In that regard, the Federation set up a Resident Wellness Committee (RWC) in December 2001, to ensure its members' health and wellness within their training sites. The FMRQ's action is taken directly with the medical residents themselves, but also vis-à-vis the different stakeholders: aid offices, faculties, universities, medical federations and associations, government, etc.

Our goal

To raise awareness and inform medical residents and teaching physicians.

The **Postdoctoral Training program tour**, initiated in 2003, helps us establish dialogue on the question of the health and wellness of physicians-in-training. Various other tools have been put in place over the years. But difficulties persist.

The following **FMRQ position statement on medical resident health and wellness** is intended to raise issues and work with all health system stakeholders to bring solutions to them and thus improve the work conditions of physicians-in-training.

We invite you to read it, and to get in touch with the FMRQ with any comments concerning this position statement.

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The **FMRQ position statement on medical resident health and wellness** was produced through the collaboration of the members of the *Fédération des médecins résidents du Québec* Resident Wellness Committee (RWC). We wish to thank the authors of these texts: Dr Étienne Désilets, RWC chairperson; Dr Cynthia Kadoch, vice-president for resident wellness, *Association des médecins résidents de Montréal*; Dr Leon Tourian, vice-president for resident wellness, Association of Residents of McGill; Dr Paul Trân, vice-president for resident wellness, *Association des médecins résidents de Sherbrooke*; Dr Émilie Desrosiers, vice-president for resident wellness, *Association des médecins résidents de Québec*; RWC members for 2011-2012; and Johanne Carrier, FMRQ advisor.

Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Psychological distress, burnout and mental health

RECOMMENDATIONS

 # 1 Incorporate awareness activities with respect to mental health, suicide and burnout into medical residents' curriculum, in conjunction with faculties and program directors, in line with the CanMEDS health promoter role.

 # 2 Conduct systematic screening for psychological distress in medical residents during the annual or semi-annual meeting with the program director.

 # 3 Allow the introduction of accommodations to facilitate the integration of medical residents with physical or mental health disorders.

 # 4 Allow greater flexibility in progressive returns following sick leave.

 # 5 Inform medical residents of the procedure to be followed in case of medical error, and support them in that regard.

SITUATION SUMMARY

Medical residents' state of mind has been evaluated on many occasions in the past decade. Approximately one-third of them describe their lives as being moderately or highly stressful[1], mostly owing to lack of time to fulfill their obligations[2]. Prolonged occupational stress can lead to burnout, which is reported in proportions as high as 25% to 75%[3,4].

The debt burden[5] and certain personality traits are associated with burnout. Moreover, this appears more prevalent at the start of training[6]. Perceived medical errors[7] are also an important factor involved in medical residents' psychological instability, with an impact on occupational stress, fatigue and empathy[8]. As many as 18% of residents described their mental health as poor or borderline[2]. Their sectional rates of depression are higher compared with the population strata of the same age, and relative suicide risks are higher among doctors (1.1 to 3.4 for a man, and 2.5 to 5.7 for a woman)[9]. It is also shown that psychological distress and the associated physical symptoms have a negative impact on medical residents' professional and academic performance and the safety of patient care[4]. Finally, a number of medical residents present physical or mental health problems requiring extended leave. In such cases, it is still very difficult to convince the faculty authorities to permit a progressive return to residency when the medical resident has recovered from his health problems.

ACTION TAKEN

The FMRQ has been working for several years to try to identify the problems along with lasting solutions with respect to psychological distress, in conjunction with the medical faculties and health professionals. In December 2001, owing to the growing number of requests and to ensure an optimum learning climate for medical residents, the Federation set up the Resident Wellness Committee (RWC). This committee's mandate is to inform residents and raise awareness in postgraduate education settings concerning the psychological distress found in training sites, and to identify tools and measures for improving residents' health and wellness.

Among action taken by the RWC since its creation were the staging of the Postgraduate training programs tour, an awareness activity targeting program directors and teaching physicians, but also reaching medical residents in those programs; Medical Resident Day; talks on wellness; and the Medical resident's survival kit, given to residents at the start of training. The RWC also keeps an updated directory of resources available with respect to psychological assistance through each medical faculty's assistance services, and leads mutual assistance group and sponsorship projects in different sites. Finally, the FMRQ raises members' awareness of the difficulties and resources at their disposal through its *Bulletin* (Winter 2012 edition), the *FMRQ Express* (monthly wellness capsule), and editorials and articles in medical publications.

The Quebec Physicians' Health Program (QPHP) is also a major player in the help provided to medical residents in distress, and the Federation is one of the founding members of that organization. Similarly, each faculty is involved in the assistance provided to residents through assistance or services to student life offices.

NEEDS IDENTIFIED

Awareness activities concerning psychological distress with respect to residents are organized voluntarily by the programs, and most often stem from initiatives from outside the faculties. The problem training programs are only rarely involved in these activities. Residents should be met at least twice a year by their program director to provide updates, and they should be asked questions concerning their psychological wellness.

Additional support should be offered to those facing a medical error, in particular through talks or workshops offered by, among others, the Canadian Medical Protective Association. Medical training must become more flexible, particularly with regard to accommodations with respect to call duty performed by medical residents with mental health problems and to progressive returns in case of sickness. Finally, the medical community should show greater openness and empathy toward any colleague whose mental health is shaken, in order to put an end to stigmatization and isolation, particularly with regard to mental illness.

CONCLUSION

Psychological distress is a prevalent problem affecting medical residents, and the preventive and support measures in place must be reinforced.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
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Psychological harassment

RECOMMENDATIONS

 # 1 Draft and implement of a policy or regulation concerning psychological harassment specific to each faculty, including in particular the withdrawal of the medical resident from the training site or the supervision of the person concerned.

 # 2 Implement a code of conduct signed by medical residents and teaching physicians confirming that everyone subscribes to the principal of zero tolerance with respect to psychological harassment.

 # 3 Make available a variety of tiered, independent resources for victims of psychological harassment, particularly through a specialized, independent intervention centre or office.

 # 4 Implement mandatory training with respect to psychological harassment, in particular for medical residents and faculty members in all postgraduate education programs.

 # 5 Offer assistance resources for individuals with disruptive behaviour.

 # 6 Continuously raise doctors' and residents' awareness in order to change medical culture with regard to intimidation.

SITUATION SUMMARY

Intimidation and harassment occur in all organizations, although the proportion appears higher in health care establishments. Indeed, these behaviours can be more common in medical faculties than in other areas of higher education[1]. It is reported that in their years at medical school, 42% of students say they were victims of harassment, and 84% of intimidation[2]. Heterogeneous studies report a similar trend among residents: from 45% to 50% of Canadian medical residents say they have been victims of harassment, intimidation or maltreatment in various forms during residency, compared with 18% of British residents and 91% of Japanese residents.

The sources of these abuses are numerous: supervising physicians, clinical fellows, nurses, residents and patients are most often cited. Certain rotations, such as general surgery (28%), internal medicine (21%), emergency medicine (12%) and anesthesiology (11%) are among the sites most frequently mentioned[6].

Only 12%[7] to 33%[3] of victims report these acts, and some even see in them a certain acceptability[4] which has unfortunately long been rooted in the medical culture. The impact on the psychological wellness of the individuals targeted is not in doubt. It is felt on the choice of specialty, level of stress, risk of depression and suicidal thoughts, alcohol consumption, the feeling of trust toward faculty members and professional satisfaction[2].

ACTION TAKEN

Awareness activities have been organized for more than 10 years by the FMRQ, which has a zero tolerance policy concerning psychological harassment. Indeed, this position is expressed in the Federation's collective agreement, which provides for recourse for any manifestation of psychological harassment: "No form of psychological harassment shall be tolerated" (Art. 3.03), from anyone working in the establishment or being located there for professional reasons (Art. 3.04). Each training program is solicited yearly as part of the program tour organized by the RWC. The FMRQ's academic aid service has existed for many years, and enables medical residents to consult in the event of detrimental behaviour. Quebec's four universities with medical faculties have also adopted policies or regulations defining psychological harassment and setting out students' rights. There is also a student ombudsman in most cases. As to the accreditation bodies, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the *Collège des médecins du Québec*, manage the program accreditation process and monitor, among other things, the prevalence of harassment by meeting with residents on training site visits.

NEEDS IDENTIFIED

First of all, greater openness from program directors is desirable, so as to allow periodic training and awareness activities concerning psychological harassment. Contact with certain programs has been sought for a number of years by the FMRQ, but they have never been met with. Also, faculty members' training in this area is inadequate. University harassment policies should also reflect the reality of the medical world, and each medical faculty would gain from adapting these regulations and offering intervention services through a specialized, independent intervention centre or office.

CONCLUSION

Despite some progress, psychological harassment is still present in training sites, and has a negative impact on the psychological wellness of its victims. The culture has to be changed in training sites and within the medical profession and the stigmatization of victims of psychological harassment has to be eliminated, so that situations of harassment are reported and dealt with properly and in a timely manner.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Parenthood

RECOMMENDATIONS

 # 1 **Foster the establishment of policies on parenthood in Quebec's four medical faculties, in conjunction with the authorities concerned.**

 # 2 **Support residents who are parents in problem situations, and foster accommodations with programs, including the following:**

- **Avoid penalizing a resident who chooses to use the leave provided for in the collective agreement to lighten his weekly load;**
- **Allow maternity leave and return to work to begin in the middle of a rotation, and not necessarily at the start of a rotation.**

 # 3 **Apply a "zero-tolerance" policy toward discrimination with respect to pregnancy or parenthood.**

SITUATION SUMMARY

The desire to be a parent frequently occurs alongside completion of a medical residency program. But many obstacles can face resident-parents during pregnancy and after the birth of the child. The literature on the subject and a survey conducted in 2012 by the *Association des médecins résidents de Québec* (AMReQ) report many problem situations, in particular the difficulty of reconciling work and family (lack of time, irregular schedules, rotations away from home, impossibility of a lighter schedule). Added to this are the impact on the duration of residency, financial aspects, the opportunity or impossibility of performing a fellowship, the impact on studying for exams and the consequences within the work team. Currently, in a review of policies associated with parenthood in all Canadian medical schools[1], Quebec's four medical faculties received an unsatisfactory rating, at 12 or 13 on a scale of 21.

Moreover, the rate of pregnancy complications, particularly during the third trimester, appears higher among women residents than in the general population. Indeed, the risk of preeclampsia, of enforced rest for complications[6], the child's failure to thrive[5] and preterm labour[4] are higher among residents. The explanations put forward for these phenomena are work-related stress, hours spent standing and the intense level of physical activity in certain specialties. These complications are comparable, in fact, to those experienced by other women whose work is physically demanding. But certain stress factors are strictly associated with postgraduate training, in particular the unrealistic work requirements of residency and the desire not to have her colleagues suffer the consequences of her absence.

On the other hand, other factors have been identified as facilitators for pregnant residents, including:

- the flexibility of the program;
- the presence of role models;
- the ability to choose when to become pregnant;
- the support of the program director; and
- the possibility of returning to work part-time.

Having a pregnant colleague seems to be well received in training sites. A U.S. study conducted at the University of Pittsburgh showed that virtually all residents of either sex saw no negative impact from a colleague's pregnancy, and that some even saw a positive impact, whether through working alongside colleagues who were more fulfilled as parents or through the increased exposure and

resulting autonomy that their colleagues' absence entailed[2]. Of the respondents to the AMReQ poll, 39% said they had to compensate for the absence of resident-parents, but most considered that to be normal and wished staff physicians and programs to be more flexible toward the residents who remain, particularly in small programs where medical residents are often asked to double up the number of presentations or call duty periods.

The duration of maternity leave varies considerably: the Canadian experience appears to differ from the American experience, which has been more extensively reported in the literature. Whereas in the United States, maternity leave is generally of six weeks' duration[7], a Toronto study conducted in the 1980s already showed that maternity leave lasted an average of 16 weeks in the psychiatry program[8]. According to the findings of the AMReQ survey, the average duration of maternity or paternity leave was four months (ranging from one week to more than 12 months).

Nevertheless, residents tend to work longer during pregnancy, often to term[2] or on the days preceding delivery, with a schedule that is generally not at all or not much lighter[4]. The return to work is also a potential source of stress, particularly among women residents, and problems associated with looking after the baby appear to accentuate this stress.

Medical residents' satisfaction with their parental role has not been recently evaluated in Canada, but a 2000 study conducted in Saskatchewan revealed that the level of dissatisfaction with work was the highest among female residents with children[3]. The AMReQ survey revealed that 56% of parent-residents felt their work did not allow them to spend sufficient time with those close to them, compared with 35.1% of non-parent residents ($p<0.05$).

ACTION TAKEN

Over the past few years, the *Fédération des médecins résidents du Québec* has looked at the difficulties reported by pregnant residents and new parents. In March 2010, the FMRQ published a *Bulletin* on pregnancy and parenthood which included interviews, along with tips for parents. Note also that, during pregnancy and after the birth of the child, or in case of an adoption, medical residents who are parents enjoy enviable conditions which have been negotiated and are included in their collective agreement.

NEEDS IDENTIFIED

These data therefore allow us to identify many situations that require special attention. A large part of the work lies in raising training sites' awareness of the importance of the phenomenon of parenthood and the difficulties of reconciling work and family for medical residents. Moreover, pregnant residents being more exposed to a higher risk of miscarriage, it is important to offer solutions to maximize their learning, while minimizing the impact on their progression and the demands made on their colleagues, particularly through a rearrangement of rotations.

Solutions which could be envisaged include allowing days of leave to be split into half days, while treating those half days as time worked, so as to comply with the 75% of rotation time carried out in order for the rotation to be validated, or allowing pregnant residents to postpone demanding rotations or exchange rotations from different levels of residency, in order to alleviate the requirements during pregnancy or in the event of health problems in the child.

CONCLUSION

Parenthood during residency involves major challenges, most of which can be met through better work to raise the awareness of all stakeholders involved in medical education. Dialogue among the Federation, program directors and those responsible for rotations is one of the best ways of ironing out the difficulties associated with pregnancy and parenthood. This dialogue should, moreover, lead to the drafting and implementation of policies, particularly on parenthood, thus laying the foundation for better support for residents who are or wish to become parents.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Resident presenteeism

RECOMMENDATIONS

 # 1 Educate medical faculties, training programs, resident preceptors and residents in the phenomenon of presenteeism.

 # 2 Bring medical faculties, training programs and resident preceptors assess the presence of presenteeism in residents by using questions derived from validated screening tools to help prevent further decreases in resident wellbeing.

 # 3 Solicit faculties' collaboration to address presenteeism in resident preceptors. Doing so will enable a positive mirroring in residents.

 # 4 Prevent presenteeism by ensuring that training programs support a healthy work/life balance in their residents.

 # 5 Avoid presenteeism by ensuring that training hospitals provide a healthy working environment including fitness installations, healthy meals and the promotion of healthy lifestyle habits.

SITUATION SUMMARY

Presenteeism is defined as working while ill[1*]. Coming into work while sick more than 10 days per year is an indication of presenteeism. The cardinal symptom of presenteeism is the loss of efficacy at work. For residents this translates into the possibility of poor patient care[2,4*] and, more certainly, poor self-care. Resident presenteeism is a taboo subject amongst peers, training programs and medical faculties. Presenteeism is often perceived as extreme devotion to work and, as such, is praised by preceptors and viewed as a rite of passage to physicianship. A recent survey amongst residents shows rates of presenteeism close to 60 per cent [5, 6]. Risk factors for resident presenteeism include a consistently heavy work load or personnel related demands, impression of lack or little control over one's work environment and schedule, lack of feeling appreciated, conflicts with other members of the care team, work related dissatisfaction, demotivation and disengagement, and uncertainty of future job prospects[7*].

ACTION TAKEN

To date, not much action has been taken to address the issue of presenteeism among residents. However, improved work schedules have been considered as a means of addressing this issue. In fact, the *Fédération des médecins residents du Québec* (FMRQ) recently signed a new collective agreement abolishing 24-hour call based on the fact that overwork is detrimental to patient care, resident training and resident wellbeing. An article was recently published in the Québec medical publication *L'Actualité médicale* on the subject of presenteeism[8*].

NEEDS IDENTIFIED

Resident training programs should include official and clear guidelines to support work/life balance. Wellbeing is being considered by the Royal College as a potential CanMEDS core competency; confirmation of this change will invariably contribute to continued gradual change in the culture of medical training. Support for lifestyle management should also include the promotion of healthy habits such as having access to fitness centers within the hospital, access to healthy food, weight loss initiatives and stress management training including activities centered around mindfulness[9, 10*].

Resident training invariably involves residents mirroring their staff's behaviour. For this reason, the promotion and establishment of resident wellness and the minimising of presenteeism cannot be possible without the promotion of staff wellness.

An interesting solution would be for faculties to suggest a list of physicians who are willing to see and follow residents for their personal medical needs. The Faculty of Medicine at McGill University entered into an agreement with such a clinic outside the faculty and with extended hours in order to answer the health needs of their residents.

CONCLUSION

Presenteeism in residents training in Quebec is the silent assassin of trainee wellbeing. This phenomenon is often ignored, unacknowledged and not studied in residents training in Quebec, which leads to an inability to establish preventative measures. Medical faculties, training programs, resident preceptors and residents need to be educated in the phenomenon of presenteeism.

* It is important to note that the phenomenon of presenteeism is not researched in residents. Included references derive from studies in non-physician private and public employees.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
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The challenges facing international medical graduates in Quebec

RECOMMENDATIONS

 # 1 Encourage faculties to establish a rigorous and supervised integration process to commence before the start of residency so as to facilitate the entry of international medical graduates into residency training programs.

 # 2 Encourage each faculty to establish an international medical graduate office that caters to the specific needs and understands the cultural determinants of foreign residents.

 # 3 Each faculty should establish a well organized and systematic mentoring program for international medical graduates that should commence prior to the start of residency and continue for the first half of each resident's PGY1.

 # 4 Each program director, with the support of site training directors and the faculty, should provide more rigorous supervision of international graduates, especially during the early stages of training.

 # 5 Each university should ensure that foreign graduates are fluent in the predominant language of their training milieu.

SITUATION SUMMARY

Quebec has the second highest number of international foreign graduates (IMG) (second only to Ontario) and the greatest proportion of foreign students coming from the Middle East and Asia[1]. Presently, foreign graduates in Quebec start their residency with the same curriculum used for all Quebec residents. This is justifiable since foreign graduates choose to train in Quebec. However, this approach assumes that foreign graduates enter residency with the scientific and clinical knowledge equal to that of local residents and this is often not the case[2].

Other obstacles that bear a significant burden on IMGs are language deficits, acculturation and discrimination. Foreign graduates training in Quebec need to be fluent in English and/or French. However, a great many are not as comfortable as they should be or as expected in their milieu. This entails obvious challenges in clinical and learning environments for both the resident and training programs. Acculturation, defined as the psychosocial adjustment and adaption to a new culture, is another significant stressor for foreign graduates. IMGs in Quebec are not supported

in this transition, which causes them significant strain on top of the normal stress of residency training. Foreign graduates also face discrimination from patients, peers and residency programs[3]. More needs to be done in order to curtail this significant and delicate issue.

All of the challenges noted above translate into great distress for many foreign residents. In fact, about half the calls for assistance made to the *Fédération des médecins residents du Québec* (FMRQ) are initiated by foreign graduates.

ACTION TAKEN

To date, some initiatives have been taken in order to help integrate IMGs in their residency programs in Quebec. Aside from the FMRQ and the Quebec Physician Health Program (QPHP) who provide assistance for IMGs, a recent government initiative has been established by the Health and Social Services Minister of Québec, to prepare IMGs before they enter residency. This program offers internship positions for a short period to selected IMGs at two locations, St. Mary's Hospital and Hôpital de Verdun. But, this doesn't continue when these candidates access a residency program. There is still much to do in order to support IMGs in our faculties.

NEEDS IDENTIFIED

There has been much work and research undertaken, especially in the US, to attempt to address the many issues facing IMGs. Firstly, it has long been suggested that IMGs receive extra clinical training[4] and a thorough orientation program specifically designed for them[5]. Extra clinical training could be in the form of a pre-residency preparatory program and/or more thorough supervision during the first year of training. Secondly, medical faculties should support measures facilitating acculturation and these must include adequate language training and education on local customs and cultures[6]. Thirdly, a peer-based mentoring program should be developed to allow for the smoother integration of IMGs into their training programs[7]. Mentoring will not only provide extra clinical training, but will also allow for a smoother integration into life as a resident in Quebec. Finally, training programs and directors should receive adequate support in not only addressing the special training requirements of IMGs but also in identifying and addressing issues surrounding discrimination.

CONLUSION

The training and acculturation needs of IMGs have to be addressed more systematically across all Quebec medical faculties, considering the important number of trainees who come from other countries. Faculties, individual programs and residents need to participate in addressing the serious issues facing IMGs in Quebec.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Debt and finances

RECOMMENDATIONS

 # 1 Inform medical residents and offer them training in financial planning and budgeting.

 # 2 Promote financial planner consulting services.

 # 3 Warn medical residents of the pitfalls to be avoided and the consequences of short-, medium- and long-term debt.

 # 4 Integrate financial management goals into the medical faculties' curriculum, in line with the CanMeds management role.

SITUATION SUMMARY

Student debt is omnipresent among medical students and residents, and represents a heavy burden upon completion of training, despite the prospect of a virtually guaranteed position and salary that are the envy of many. In fact, to all intents and purposes borrowing opportunities are infinite, from the start of medical training.

We have not conducted any specific study on medical residents' debt but, according to the information available to us, the level of indebtedness among medical residents is approximately four times as high as among subjects of the same age in the general population. Also, 40% of Canadian doctors aged under 40 report debt of more than $250,000, including 10% who owe more than $500,000[3].

The amounts paid by government in the form of loans and bursaries are often quite inadequate to cover academic and personal expenses, thus forcing medical students to borrow elsewhere, since the requirements of their training prevent them from holding another job, as soon as they reach the clinical clerkship stage. A number of documents show that more than half of physicians have performed other studies before going into medicine, and this has the effect of increasing the amount and duration of their debt.

The magnitude of the debt and the financial burden are often a source of stress and conflict. A study conducted on 35 individuals overloaded with debt published in 2008 by the *Centre d'intervention budgétaire et sociale de la Mauricie* (CIBES) concluded that 92% of those with high debt felt depressed; 95% said they were anxious; 85% suffered from insomnia; 61% suffered from chronic fatigue; and 6% were diagnosed with burnout and 23% with depression[4]. A study carried out by Collier et al showed a strong association between the level of debt and symptoms of depression.

Over the past few years, there has been a noteworthy increase in the number of young doctors in serious financial difficulty. Several declared bankruptcy, but none were successful in doing so, since the Registrar of Bankruptcies ruled that an absolute discharge of debt could not be granted owing to the doctors' future earnings[1]. Many medical residents wrongly believe they do not have the time to look after their financial management during their training, that their financial situation will be guaranteed once their residence is completed or that they do not have sufficient income to repay their student debt.

ACTION TAKEN

The *Fédération des médecins résidents du Québec* has negotiated agreements with financial partners which include group or individual information sessions for medical residents, in order to enhance their knowledge concerning financial planning and asset management. These presentations are available on request. The FMRQ has also disseminated advice on the dangers of borrowing against a future salary, both in its quarterly *Le Bulletin* and in *Actualité médicale*.

NEEDS IDENTIFIED

Sound financial planning should be included in the preventive steps taken with respect to medical residents' health. The FMRQ has negotiated agreements with partners in the financial and banking sectors whereby medical residents can be equipped with budget models and financial planning guides. The FMRQ encourages budgeting and consultation of a financial planner, accountant or even billing agent in order to avoid jeopardizing medical residents' financial future.

Some medical faculties have integrated financial management training into their curriculum, particularly at the pre-doctoral level. All faculties should follow this lead and provide the academic resources necessary to prevent this problem.

CONCLUSION

Financial management is an individual affair but, in view of the length of medical training, it is essential that stakeholders and organizations associated with medical residents be aware of the impact of indebtedness on the latter's health and academic performance. In view of this, everyone should act to prevent and avoid excessive debt during postgraduate education.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Work conditions and climate

RECOMMENDATIONS

 # 1 Ensure that the collective agreement be followed by establishments, staff physicians, chief residents and medical residents belonging to the FMRQ.

 # 2 Ensure that training programs put policies in place to reduce the solicitation of medical residents on call, in particular by reducing the number of calls and use of the pager and lowering the number of clinical demands imposed on residents (drawing up of protocols in the different establishments/departments).

 # 3 Encourage teaching concerning means of dealing with long work hours as part of the training curriculum.

 # 4 Define the notions of call duty handovers as an essential competency in medical residents' teaching objectives.

 # 5 Allocate special time to the performance of non-clinical tasks already provided for in medical residents' schedule in each program.

SITUATION SUMMARY

Medical residents are faced with a substantial clinical workload. In Quebec, the regular work schedule usually falls between 08:00 and 18:00 and can, under the collective agreement, be extended to 20:00, quite often without a fixed meal time or break. The findings of a survey conducted on Quebec medical residents reveal that the medical resident's average week comprises around 50 hours of clinical activities.[1] During that period, medical residents are constantly exposed to the limitations of the health system. They are on the front line, and are faced with over-solicitation owing to the growing number of patients with ever-more complex medical and social problems. The complexity of the task often leads to dissatisfaction. A number of Quebec medical residents, who said they were tempted to change specialty or leave medicine, worked longer hours per week on average, were less satisfied with the organizational aspects of work and experienced more work-family conflicts than others.[1]

Finally, the university system also requires non-clinical work from medical residents. Whether this involves teaching, preparing class presentations, research, academic training activities or exams, non-clinical demands are numerous and take up a considerable part of the rest time remaining to residents.

ACTION TAKEN

Over the past five years, the *Fédération des médecins résidents du Québec* has worked on revising call duty schedules in an establishment and the number of consecutive work hours required of medical residents. A growing number of studies point to the negative impact of sleep deprivation on both medical residents' health and their patients' safety. Since July 1, 2012, the maximum number of consecutive work hours has gone from 24 to 16 hours. This measure is associated with the FMRQ's new collective agreement, and with an arbitration award handed down on June 7, 2011 which invalidated the provisions of the collective agreement with respect to call duty in an establishment, on the basis of the *Canadian Charter of Rights and Freedoms* and the Quebec *Charter of Human Rights and Freedoms*.

At night, between 17:00 and 08:00, medical residents most often constitute the majority of physician resources present in establishments where they are on rotation. Fortunately, the rearrangement of call duty schedules in an establishment to a maximum of 16 consecutive hours will most certainly have a positive impact on medical residents' health and their patients' safety. Several publications have been disseminated by the *Fédération* in that regard.

NEEDS IDENTIFIED

With respect to work schedules, it is essential that the collective agreement be followed by establishments, staff physicians, chief residents and medical residents. A change in culture and the implementation of a policy in the various residency programs are essential in order for residents not to be over-solicited for clinical tasks. A transition period is necessary in order gradually to implement the new call schedules, not forgetting to emphasize the introduction of protocols or means aimed at enhancing the patient handover process, in order to ensure optimum care. Training programs should set aside special time in the form of half or full days or even periods free of any clinical responsibility, for academic activities or studying for exams. Research time should also be protected, and rotation periods specifically dedicated to research should be instituted if a research project is required as part of the medical resident's training. It would also be worthwhile introducing sports centre services, and weight loss or stress management initiatives.

CONCLUSION

Despite the numerous changes, notably the abolition of 24-hour call duty in an establishment and its rearrangement at a maximum of 16 hours in a row, medical residents remain over-solicited during their training and can compromise the care delivered and their own quality of life. It is important to foster an optimum learning climate for medical residents, in order to offset the imbalance caused by the numerous requirements of the profession.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Regional physician resource plans (PREMs)

RECOMMENDATIONS

 # 1 **Provide medical residents with more opportunities to obtain information on PREMs.**

 # 2 **Ensure the elimination of "virtual" positions currently listed in the five-year plan, to ensure the establishment of all Quebec-trained physicians where the real needs are.**

 # 3 **Acknowledge the high level of stress experienced by medical residents owing to the constraints imposed by PREMs.**

SITUATION SUMMARY

PREMs were established in 1987 to foster more effective distribution of physicians in the different regions of Quebec. None the less, numerous problems have arisen since, bringing into question the helpfulness of PREMs and their ability to keep doctors in Quebec. Among the problem issues have been *virtual positions, solo positions in remote regions, hospitals' limited reception capacity, the date on which PREMs are adopted and the fact that they are being increasingly tightened up, selected physicians, positions in university settings for fellows, and the issuance of compliance notices in family medicine.*[1]

In fact, the management of physician resources in Quebec has seen considerable upheaval in the past few years. This has a direct impact on medical residents, most of whom wish to practise in Quebec.[2] Recruitment opportunities are beginning to be inadequate in several specialties, including family medicine in some regions, and among those that are available, increasingly few meet terminating residents' career goals. At the end of many years of training, then, residents have to find their way through the twists and turns of a coercive, excessively rigid government policy in order to determine where they will be practising.

The *Ad-hoc working group on the evaluation of recruitment opportunities for Quebec medical residents on completion of their postgraduate education*[4] has identified eight specialties for which recruitment opportunities are likely to mean not all terminating residents are able to work in Quebec: cardiac surgery, neurosurgery, urology, radiation oncology, anesthesiology, general surgery, ophthalmology and otolaryngology. The reasons given to explain this apparent "surplus" of doctors generally include limited access to technical platforms (the establishment of which can take a great deal of time), poor evaluation of needs and limited budgets[3] and, a lack of human resources.

In May 2012, a survey conducted on all residents registered in specialty programs in Quebec (n=986, including 215 terminating residents) showed that close to 50% of terminating residents did not have a PREM two months before they complete their training[2]. While residents not holding PREMs have already starting taking steps in that regard, this professional uncertainty within two months of starting out in practice, at a very demanding period in their training, is a major source of stress for medical residents. Indeed, 55.6% of all residents rate the stress associated with seeking a position as high (≥8/10). This proportion correlates positively with residency level ($r=0.992$; $p<0.05$), rising to 62.4% among terminating residents. This situation is all the more worrisome for those residents because these steps are often taken during the period of studying for and taking certification exams. Also, clinical activities become increasingly demanding on the eve of the transition to the fully autonomous practice of their discipline, not to mention the more practical aspect of setting up in a new city for many of them and their families. According to medical residents, among the obstacles exacerbating the process are the lack of positions in their specialties (48% of cases) and the unattractiveness of the positions posted (22% of cases). The presence of virtual positions (positions that are posted but for which the recruitment is not actually active) is also a major hurdle that aggravates the paucity of recruitment opportunities. Some 60 problem situations

with virtual positions were recorded for 2012 alone, and this list is not complete, because it takes into account only those positions reported by medical residents.

In addition, a significant proportion of medical residents are not confident of obtaining positions in the setting of their choice (67.9%) or of obtaining a position in Quebec (35.9%). The difficulty of finding positions in Quebec has an impact on residents' life choices. In fact, terminating residents are under greater pressure than their colleagues not as far along in their residency to find positions outside Quebec or perform locums when they do not have a PEM/PREM ($p<0.0001$).[2]

ACTION TAKEN

- Establishment of the Ad-hoc committee on physician resources (CADEM)
- Organization, among other things via local associations, of information meetings on PREMs for residents
- Yearly staging of the Quebec and Outside Quebec Career Days
- *FMRQ Bulletin*, January 2011: "PREMs: Status report and procedure"
- Symposium on PREMs in family medicine
- Annual survey of terminating medical residents (R3 and higher)
- Individual or group support (targeted specialties), as applicable, for medical residents seeking positions in Quebec
- Targeted intervention vis-à-vis the authorities concerned (medical federations, faculties, Ministry of Health and Social Services) aimed at guaranteeing positions in Quebec for all physicians trained in our medical schools

NEEDS IDENTIFIED

- Increase measures and create more tools to facilitate the process of seeking a position in Quebec:
  - provide more information sessions on the process;
  - train and involve program directors and other system stakeholders with respect to the procedure for obtaining a position (PEMs and PREMs);
- Increase recruitment opportunities so they offer a selection of positions greater than the number of terminating medical residents in Quebec;
- Limit the recruitment of foreign doctors to needs that cannot be met by Quebec-trained doctors, particularly in specialties where there is a real or potential surplus of physician resources;
- Hold a yearly information and training session on PREMs, which could be combined with Quebec Career Day;
- Maintain a constant watch for virtual positions and identify virtual PREMs:
  - Train medical residents to be able to identify virtual PREMs;
  - Encourage the identification of problems specific to each setting leading to virtual PREMs (e.g., technical platform, refusal of doctors already holding positions to split clinical throughput), so as to correct the situation.

CONCLUSION

Obtaining a PREM in Quebec is a stressful process, and the current shortage of positions in certain specialties merely accentuates the difficulties already being experienced by medical residents in finding a practice setting corresponding to their competencies and their professional and personal aspirations, and meeting the public's needs. Different measures can be put in place to facilitate this process and reduce the negative impact of the search for a position, particularly in the final stages of training and of preparation for certification exams. The stakeholders and bodies concerned with physician resource planning and distribution in Quebec have to start rethinking in depth the future of PEMs and PREMs, in the current context.

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Position Statement
on medical resident
health and wellness

Fédération des
médecins résidents
du Québec

Transition from residency to practice

RECOMMENDATIONS

 # 1 Promote a pedagogical review of the exam certification process, in order to avoid a negative impact on medical residents' health and work.

 # 2 Limit sources of additional stress during preparation for exams, and foster initiatives to grant protected study time.

 # 3 Integrate learning of the new role of practising professionals for medical residents by implementing mechanisms conducive to learning about the administrative aspects of starting out in practice (registration with professional corporations, financial management, health system administration, etc.).

 # 4 Promote practical exercises (mock exams) in order to empower terminating residents and ensure their success.

 # 5 Provide information on the lifelong learning process in medicine, in conjunction with the medical faculties and certification bodies, and introduce medical residents to training tools in that regard.

SITUATION SUMMARY

At the end of their training, medical residents prepare themselves to embark on a new phase in their professional lives: the autonomous practice of medicine. This transition from residency to practice affects numerous aspects of medical residents' lives and calls for support mechanisms to be put in place. Currently, this support varies from one training site and program to another, if it exists at all, and this generates significant stress for medical residents. A comprehensive approach involving support for the transition to practice is therefore desirable.

New professional role

Between the time their specialty training officially ends and their autonomous practice begins, medical residents undergo a dramatic status and role change, and as autonomous physicians they have to face new, ever-growing demands. Henceforth, they have sole responsibility for their clinical decisions, while handling their own lifelong learning. This transition means they have to modify both how they see things and how they operate.[2]

Thus, passing the certification exams does not mean that education and training are over, since they will continue in other forms throughout the doctors' lives. The Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC) and *Collège des médecins du Québec* have put in place processes to govern lifelong learning in medicine, but this approach is not integrated in the training framework. According to the RCPSC, certification should in fact mean entering a new training phase.[1] This training is no longer governed by a standardized, pre-defined curriculum, nor sanctioned by regular evaluations. Performance is not clearly standardized, and there is no feedback.[4] Each physician becomes responsible for his or her own training and performance. Unfortunately, medical residents do not appear to be adequately prepared to make this change.

Teaching physicians and the bodies representing them, which include the faculties and accreditation-granting colleges, have to facilitate the transition to practice by optimizing the acquisition of this new role as a learner. The transition could be initiated during postgraduate education, in providing medical residents with the supervision and support necessary for establishing methods of operation that will follow them throughout their careers. Without completely erasing the stress associated with the new professional role to be assumed in practice, this would help reduce that stress and optimize the start of practice. Indeed, this approach was proposed by an RCPSC study group led by Jocelyn Lockyer, in January 2011.[1]

Certification exams

One of the greatest sources of stress for medical residents is without doubt preparing for and passing certification exams. Studying for final exams begins at least one year before the exams are taken, culminating in a 4 to 6 month-long intensive study period. The amount of knowledge to be consolidated for the exams is considerable, and the challenge is a large one: the culmination of many years' work and the doctors' professional future will be sealed in just a few hours.

During the intensive study period, medical residents sometimes study more than 10 hours a day, to which are added the hours imposed by the clinical responsibilities involved in rotations. Extended consecutive hours of clinical work along with accumulated fatigue have been shown to be detrimental to medical residents' attention, performance and quality of life, even having an impact on patient care.[6,8] This has also been recognized in recent work on the future of medical education in Canada[5] and by U.S. accreditation bodies, which have chosen to limit the number of hours worked by residents in the United States.[7] In Quebec, a maximum of 16 consecutive hours' work is now the norm, as stipulated in Article 12 of the 2010-2015 collective agreement between the Ministry of Health and Social Services (MSSS) and the *Fédération des médecins résidents du Québec*, signed in December 2011.

The impact of extended study hours on top of clinical work has for its part never been evaluated. It can, however, be estimated that the effect may be similar to that observed in connection with work hours, and this must be taken into account. Nor can one ignore the effects of the stress and resulting fatigue on residents' quality of life, but also on the quality of their work.

As mentioned in the project on the future of medical education in Canada, the work and learning climate directly influences retention.[5] Thus, the disposition for clinical learning and the attainment of complex clinical competencies in the later stages of residency certainly suffer from the intensive study period forced on terminating residents. But these competencies appear more important for future practice than the mark on the exams does. In fact, studies evaluating the association between performance on certification exams and successful practice have shown no conclusive correlation.[9] Thus, the stress and workload involved in studying for certification exams potentially occur to the detriment of medical residents' training.

Preparing for setting up in practice

Numerous aspects of the management of medical practice are new for medical residents when they complete their training: registration with professional corporations, financial management, health system administration, etc. Indeed, a number of U.S. studies have observed that these important aspects of practice should be explored further during postgraduate education.[10, 11]

These steps are mostly lengthy, complex and costly and offer medical residents little support in that regard. Moreover, this occurs following an intense, stressful period of study in the closing stages of residency.

It therefore seems essential that medical residents be informed in a timely manner of all the steps to be undertaken, and that they be given adequate support so that these are facilitated.

ACTION TAKEN

- Collaboration in the in-depth review of the processes for evaluating the competencies of physicians-in-training by the accreditation-granting bodies (RCPSC, CFPC and *Collège*), so as to foster an optimum learning climate, particularly close to exam time, and a smooth transition from residency to practice.
- Intervention vis-à-vis colleagues on the different issues involved in medical education.
- FMRQ Bulletin, "December 2009 - From residency to practice: YOUR HANDBOOK."

NEEDS IDENTIFIED

New role of practising professional

Integrate learning concerning the new role of practising professionals in residency training.

Provide information on the lifelong-learning-in-medicine process, in conjunction with the medical faculties and certification-granting bodies (RCPSC, Collège, CFPC), and introduce medical residents to these tools toward the end of training.

Certification exams

- Promote a review of the process for evaluating competencies, and in particular of the time at which the certification exams are integrated in the curriculum, by the bodies delivering this certification.
  - Avoid an excessive time lag between the written and oral components of certification in specialties other than family medicine.
  - Schedule certification exams earlier in training, so as to foster the consolidation of acquired knowledge in the final year of residency.
- Limit additional sources of stress in the final stages of training.
- Provide protected study time for medical residents sitting exams toward the end of their training.
- Avoid the imposition of additional academic requirements during the final year of training.

Preparing to set up in practice

- Put in place mechanisms to support starting out in practice in conjunction with the training programs and accreditation-granting bodies:
  - establish a common source of information on starting out in practice (Internet platform), in conjunction with the different health system stakeholders;
  - offer information sessions on starting out in practice, in the fall of the final year of training;
  - publicize existing services.

CONCLUSION

The transition to practice is the final stage in physicians' training, and the different components of the final stages of residency and the start of practice entail additional stress that is detrimental to terminating medical residents' health. Several steps supporting, among other things, setting up in practice and adequate preparation for certification exams can be put in place to minimize the negative impact of this transitional period.

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