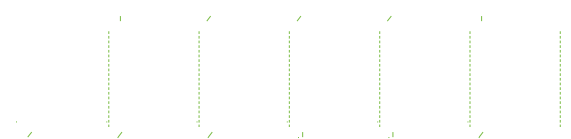




FÉDÉRATION DES
MÉDECINS RÉSIDENTS
DU QUÉBEC



Implementation of *Competence by Design* in Quebec — Year 2: Ongoing Issues

Report on the survey conducted by the *Fédération des médecins résidents du Québec* (FMRQ)
on the 2017-2018 and 2018-2019 cohorts registered in CBD in Québec

August 2019



NOTA BENE:

In case of incompatibility between the English and French versions, the French version prevails.

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1. INTRODUCTION

Since July 2017, the Royal College of Physicians and Surgeons of Canada (RCPSC) has been deploying a new system for training and evaluating resident doctors using the approach known as Competence by Design (CBD). The main feature of CBD is that it emphasizes the learning of competencies rather than the length of resident doctors' training rotations. Early in 2018, the FMRQ conducted a study on the experience of R1-level resident doctors in two CBD programs, Anesthesiology, and Otolaryngology/Head and Neck Surgery (OTO/HNS). The group then comprised 32 resident doctors, and we obtained an 81% participation rate. The findings of the semi-structured interviews led the FMRQ to draft [15 recommendations](#) (pages 15 to 17 of that report) for enhancing the CBD implementation process in the programs concerned. Twelve months later, the FMRQ wanted to measure how the implementation of CBD in Quebec had progressed in relation to the recommendations it had made one year earlier following the 2018 semi-structured interviews. In view of the number of programs and resident doctors now trained and evaluated under the competency-based approach, the FMRQ decided to draw up a questionnaire and administer it to all Quebec resident doctors performing their residency in a CBD program, by means of an electronic survey on the SurveyMonkey platform.

2. NOTE ON METHODOLOGY

The questionnaire was developed from the main recommendations made by the FMRQ in spring 2018. The questions generally attempt to measure the extent to which the Federation's recommendations have been implemented, particularly with respect to the problem elements raised in the study conducted by the FMRQ on resident doctors under CBD in 2017-2018. The questionnaire was tested and revised, in both languages, both by the Federation's Academic Affairs Committee – Specialties and by other resident doctors, two of whom are under CBD. The questionnaire comprised some 60 questions, including 12 extended-answer questions. It was also agreed to administer the questionnaire exactly one year after the semi-structured interviews conducted for the 2018 study were held, i.e., after seven months' exposure to CBD for resident doctors in CBD programs in 2018-2019, and after 19 months for those who began their training under CBD in July 2017.

A total of 173 Quebec resident doctors, including clinical fellows, in all programs following the CBD model in 2018-2019 and from all Quebec faculties of medicine received an email invitation to take part in the survey. The following specialties were targeted by the survey: Anesthesiology, and ENT/Head and Neck Surgery (Cohorts 1 and 2), and, for 2018-2019 (Cohort 2), resident doctors in Critical Care Medicine, Forensic Pathology, Medical Oncology, Nephrology, Surgical Foundations, and Urology. The invitation was sent out on February 8, 2019, and two email reminders followed, on February 15 and 21, with telephone reminders following between February 19 and 25. The poll was closed on February 27, 2019. The overall response rate to this survey was 67% (116/173), or 85% of Cohort 1 (2017-2018) and 63% of Cohort 2 (2018-2019).

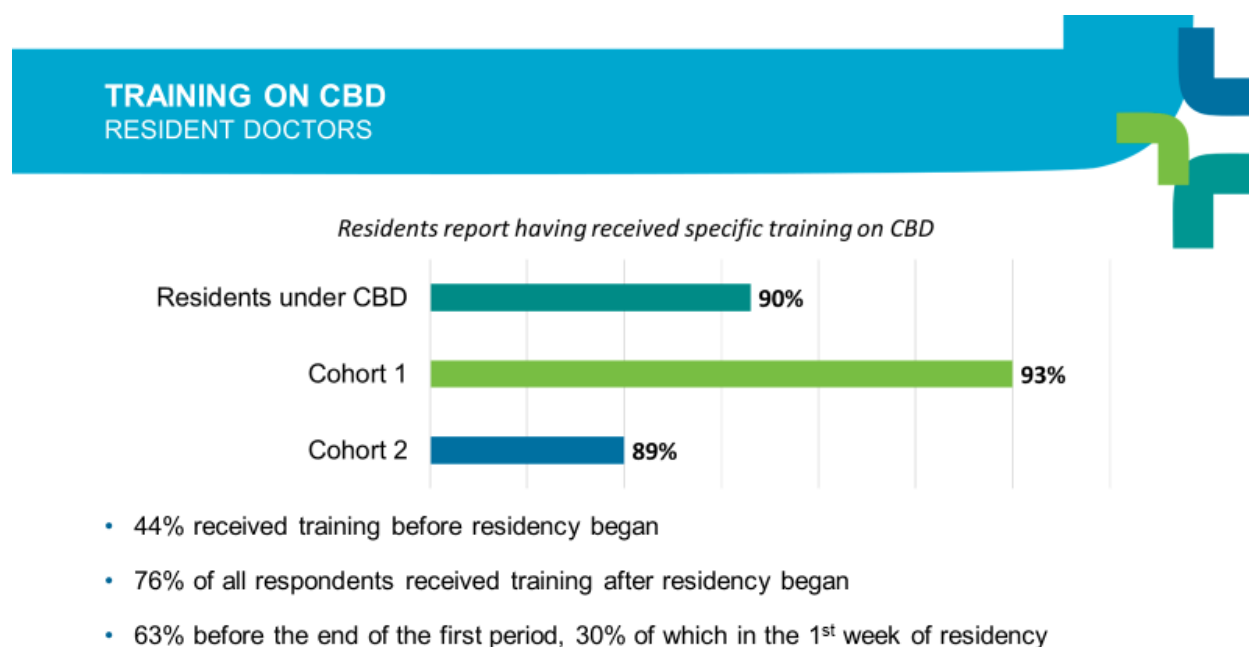
3. FINDINGS BY THEME

3.1. THEME 1: Training and preparation

Training of resident doctors

In spring 2018, the FMRQ had recommended that dissemination of information for and training of resident doctors and supervising physicians, including senior resident doctors in the programs concerned who are not in a CBD cohort but whose program is under CBD, should take place before or at the very beginning of the academic year, no later than the first week of residency. So we wanted to check whether this recommendation had been taken on board by the authorities concerned, and to measure the day-to-day impact of these measures in the field. The findings below suggest a noteworthy improvement compared with the comments gathered in the semi-structured interviews in 2018.

A total of 90.3% of respondents reported having received training on CBD (93% in the 2017-2018 cohort, and 89% in the 2018-2019 cohort). Of all resident doctors surveyed, 44% received training before their residency began, and 76% received training after the start of their residency. Note that respondents may have received training on two occasions, both before and after the start of residency; 63% of resident doctors received their training after their residency began, but before the end of the first period, and of that number, 30% received it during the first week of residency.

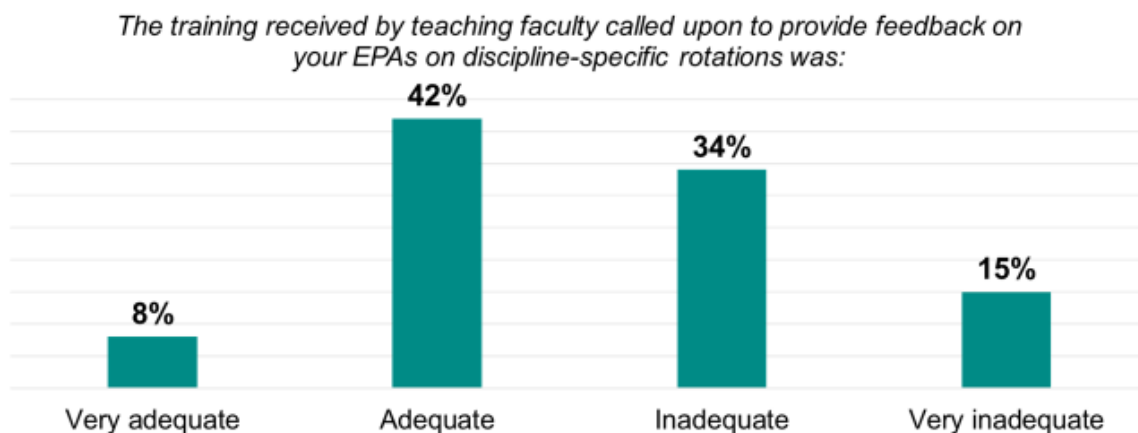


Training is mostly given by the program director or a faculty member. The duration of training is between one and three hours for 63.5% of respondents, most (58%) of whom considered that the information received and the duration of training enabled them to acquire the overall knowledge necessary for their residency to run smoothly under CBD.

While resident doctors generally appear satisfied with the CBD training provided at the start of the year, many none the less report that they feel left to themselves thereafter, and have to read a great deal to be able to understand their tasks in their training under CBD properly. Resident doctors who received no training on CBD (c. 10%) appeared particularly anxious and overwhelmed by this new system. A number of resident doctors even said they were unable to attend CBD training because they were not released from their rotation sites (off-site rotations).

Preparation of supervising physicians

It should be noted that 49% of resident doctors considered training of faculty members in their specialty to be inadequate or very inadequate, and this percentage rose significantly to 68% for physicians supervising off-service rotations.



Many respondents reported having the impression of being themselves responsible for teaching supervising physicians how CBD works, and how to fill out entrustable professional activity (EPA) evaluations.

Resident doctors reported a degree of confusion among supervising physicians as to understanding and applying the O-SCORE (Ottawa Surgical Competency Operating Room Evaluation) entrustability scale for assessing surgical competence. Indeed, supervising physicians appear to be poorly informed about EPA evaluation criteria when completing forms. It was noted in the comments that respondents have the impression that supervising physicians lack training on the appropriate level of autonomy for an R1 or the adequate level of autonomy for successfully completing an EPA.

None the less, resident doctors in the 2017-2018 cohort noticed an improvement between last year and this year; in their view, supervising physicians appear to have a better understanding of the concept of CBD, but participation remains very variable, and is sometimes very hard to obtain.

3.2. THEME 2: Pedagogical aspects

Review of curriculum mapping

Following the study conducted last year, it had been recommended that the programs make sure they provided a firm timeline for matching each EPA with a specific rotation conducive to its evaluation. Indeed, this practice is part of the programs' tasks, ahead of implementation of CBD, as recommended by the Royal College. This year, a considerable improvement was observed in that regard, with 71% of resident doctors reporting having received such a tool.

On the other hand, a number of specific problems persist in terms of organization of the curriculum and rotation grids. Several resident doctors reported that the curriculum was not very or not at all geared to the new reality of CBD, entailing difficulties for completing certain EPAs in the current context. This is particularly true for certain Surgical Foundations programs. For instance, in Obstetrics and Gynecology, resident doctors are expected to be exposed to Traumatology, whereas it is not offered in all sites.

Day-to-day feedback process

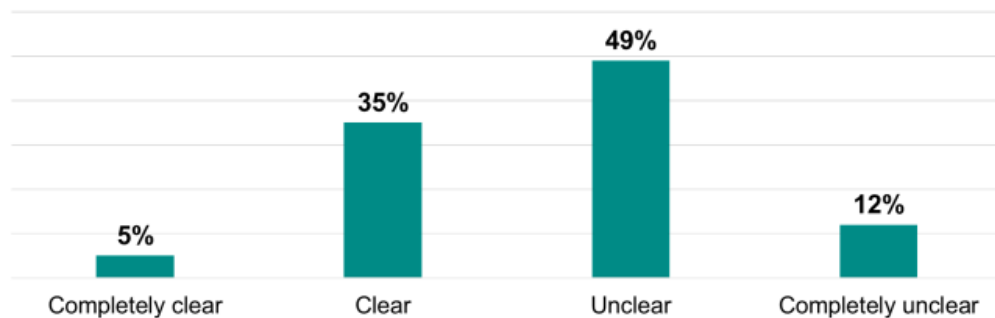
Resident doctors reported the same difficulties as last year in obtaining daily evaluations. Some groups of supervising physicians refuse to take part in CBD and complete EPA evaluations, because they consider this procedure to constitute additional workload. Others prefer to put off completing evaluations, without necessarily giving resident doctors verbal feedback. When that is the case, resident doctors have to remind them several times in order for the EPA to be recorded. Resident doctors would like the faculties to become more involved in the matter and encourage supervising physicians in clinical settings to be more rigorous in managing evaluations.

Progression in competence curriculum

The rules governing decisions concerning promotion of resident doctors from one stage to another within the framework of the CBD competence curriculum are unclear or completely unclear for 61% of respondents. Close to three quarters (74%) of resident doctors in the 2017-2018 cohort continue to think that the process is nebulous, despite one year of operating under CBD, although progression through the different stages appears flexible to them. The regulatory framework and Competence Committee decisions remain ill-defined. Among other things, there is a great deal of uncertainty as to the number of observations required, and the need to fill out all evaluations for promotion from one stage to another, and to complete all EPAs successfully.

PEDAGOGICAL ASPECTS PROGRESSING TO THE NEXT STEP

The rules governing decisions concerning promotion are:



- 74 % of Cohort 1 respondents feel the process is nebulous
- A great deal of uncertainty

Competence Committee

When the survey was completed, despite six months under CBD for resident doctors who began this year, one quarter of respondents from Cohort 2 (26%) reported not having been informed of the role, operation, and composition of the Competence Committee. Furthermore, 38% of all respondents in Cohorts 1 and 2 who had received information on the Competence Committee said it was only partial information.

Of respondents in Cohort 1, 52% had received a decision from their Competence Committee at the time of the poll. It seems unlikely to us that all these resident doctors are still at the “Transition to discipline” stage after 19 months of training. A decision was probably issued by the Competence Committee, but without the resident doctors being clearly and transparently informed of it. The progression seems implicit, whereas it should be explicit and objective in line with the criteria agreed upon under CBD, as described by the Royal College. Among resident doctors in Cohort 2 (2018-2019), 69% reported not having yet received a decision from their Competence Committee after more than six months under CBD. It was not possible to determine the reasons for this delay (committee operations or problems of communication with resident doctors). For those who have received such a decision, the flexibility, transparency, and objectivity of the decision appeared to be appreciated.

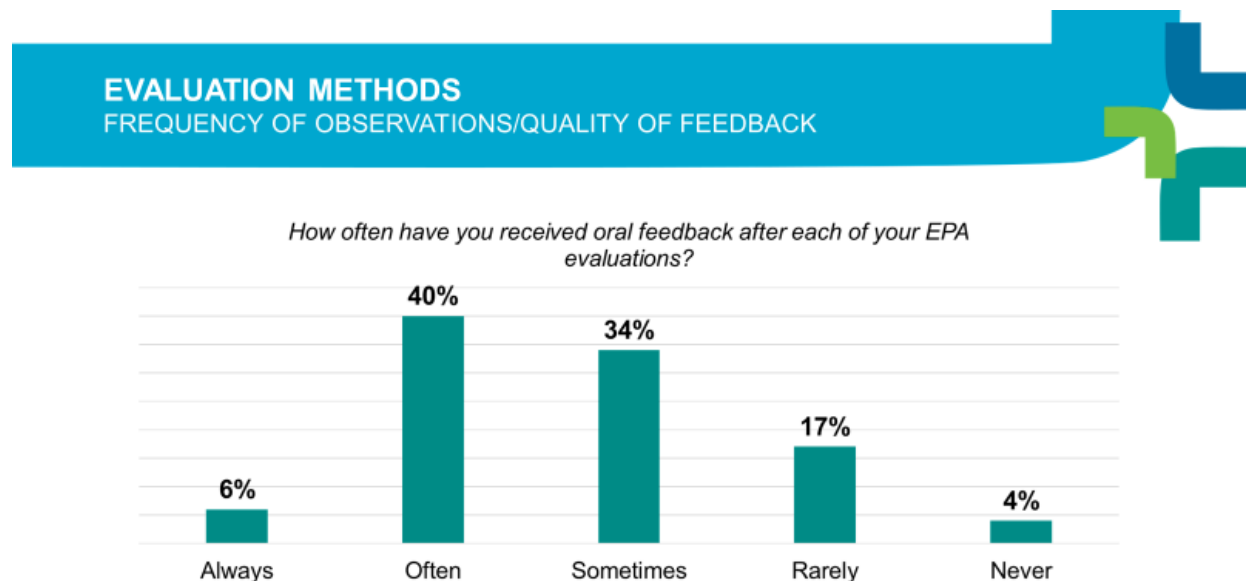
3.3. THEME 3: Evaluation methods

Quality of feedback

In theory, evaluations under CBD should lead to increased feedback from supervising physicians. But this approach is associated with a certain amount of red tape, as resident doctors pointed out on several occasions.

Resident doctors reported having obtained EPA evaluations through indirect observations, i.e., by describing to the supervising physician what they did or would do in a specific situation. That said, 95% of resident doctors pointed out that their non-technical EPAs were evaluated in real learning situations, and this appears to be an improvement over the situation that prevailed in 2017-2018.

Nevertheless, some resident doctors have the impression that they receive less feedback on their overall progression than under the old evaluation model, but, fortunately, many residents noted an increase in direct observations and daily feedback. Thus, 65% of respondents reported having received individualized feedback on their progress under CBD. Some 21% of respondents reported having never, or rarely, received verbal feedback following EPA evaluations (4% for Cohort 1, 26% for Cohort 2).



Resident doctors also emphasized having to ask supervising physicians several times to complete their evaluations. These were often completed several weeks or months following the observation, thus limiting the quality of the feedback. Only 28% of resident doctors said they had support from their department or program to ensure that EPA evaluations were completed within a reasonable timeframe (30% partial support, 43% no support). In addition, in view of the large number of EPAs to be performed, evaluations were often completed in a hurry.

Use of O-SCORE Entrustability Scale

Evaluation of milestones and EPAs under CBD, as promoted by the Royal College, is based on the O-SCORE (Ottawa Surgical Competency Operating Room Evaluation) entrustability scale. This scale is meant to evaluate “entrustability,” i.e., resident doctors’ ability to perform an action independently. While the philosophy behind the scale is simple, its application in the field remains rather complex.

As reported earlier, resident doctors perceive a degree of confusion among supervising physicians concerning the use of the O-SCORE Entrustability Scale in evaluating EPAs. Also, residents consider that the criteria determining whether an EPA is passed or not are not clear, and they see subjective application there that varies according to the context. The notion of “entrustability” and how it is evaluated also appears to be an abstract, poorly understood concept.

Cohabitation of evaluation models

Resident doctors noted a considerable increase in the red tape associated with implementation of CBD, and distress levels have increased accordingly: 93% of respondents in Cohort 1 reported experiencing duplication of evaluation methods in their learning sites, compared with 57% of resident doctors in Cohort 2.

Among resident doctors reporting duplication of pre- and post-CBD evaluation methods, only 22% of respondents in Cohort 1 said there was a policy in their faculty, department or program benchmarking how the two evaluation methods overlap. This figure was down to 12% for Cohort 2.

Application of CBD in off-service rotations

Another issue raised by respondents was their difficulty obtaining evaluations on their off-service rotations. Close to one third (29%) of respondents reported not having been able to receive evaluations during their off-service rotations. The main reasons mentioned were supervising physicians’ lack of training and motivation. This is particularly problematic in a context where off-service rotations under CBD are often added to the curriculum to make it easier to complete certain EPAs that are harder to obtain in rotations in the main specialty.

Also, 43% of resident doctors mentioned that EPAs successfully completed on off-service rotations are not counted in their record. Respondents reported that this entails additional workload, since resident doctors have to repeat EPAs that have already been successfully completed.

Role of senior resident doctors

On a day-to-day basis, resident doctors were unanimous in saying that the seniors supervising them play an essential role in their learning. Indeed, the seniors work closely with their junior colleagues, and regularly provide formal teaching, clinical supervision, and an evaluation. They are also generally more available than supervising physicians.

Despite this positive interaction, only 63% of resident doctors under CBD reported having resorted to seniors for evaluation of an EPA. It was noted that Cohort 2 (2018-2019) calls on seniors more frequently for evaluations, in a proportion of 67% compared with 48% for Cohort 1. This situation could be related to the fact that some programs, including Anesthesiology, do not use seniors to train resident doctors to the same extent as others. Furthermore, the role of seniors in CBD still remains very poorly defined, despite a recommendation in our previous report that their role should be recognized and they should be trained. This role appears to vary according to the site, and certain programs appear to have clearly established that seniors cannot complete an EPA. At this point, we unfortunately have no information on the reasons behind such a decision. It is important to mention, as well, that CBD is also being implemented in certain medical subspecialties which concern R4s and above, such as Medical Oncology.

3.4. THEME 4: Structure of CBD

Appropriateness of EPAs and milestones

Generally speaking, resident doctors have a sound understanding of how CBD works, including EPAs, milestones, and the number of observations required. It is also encouraging to note that 59% of respondents stated that EPAs and milestones specific to their specialty accurately reflected practice in their setting. Nevertheless, only 32% of survey respondents reported having had a presentation and clear definitions of EPAs and milestones before their evaluation.

Furthermore, several comments were made as to the excessive number and the complexity of EPAs and milestones. Resident doctors said they were dissatisfied, and even disheartened, by the number of EPAs, milestones, and observations to be attained. This trend is quite widespread across the different CBD programs, despite the adjustments that were made in the OTO/HNS and Anesthesiology programs, in which this problem had been identified through the semi-structured interviews conducted in 2018 with resident doctors in the 2017-2018 cohort.

It was noted on several occasions that milestones, more specifically, would benefit from being simplified as far as possible, to make them easier to understand. Statements are sometimes clumsy or excessively long, leading to frustration among both resident doctors and the supervising physicians who complete the evaluations. It was reported, too, that some French translations contain errors, or are even incomprehensible.

Also, respondents reported numerous examples of a number of EPAs, milestones, or observations that were impossible to attain. That is particularly true for certain surgical specialties which did not adapt the curriculum for their first year of training to attain EPAs for Surgical Foundations. Resident doctors also noted that certain “patient management” EPAs, particularly in emergency situations, require a rapid response before the supervising physicians arrive, or are poorly adapted to the R1 level. Clinical exposure and supervision in training sites should therefore be modified accordingly. Where applicable, adjustments to these EPAs should be made in order to reflect the reality in training sites more closely.

While it had been recommended by the Royal College that the number of EPAs, milestones and observations to be attained should serve as a guide and be adapted to each program in line with local particularities, it would seem that this recommendation is not consistently applied. A degree of rigidity was noted, and even a lack of understanding, on the part of certain programs concerning the number of observations required, and this generates undue pressure on resident doctors. Thus, 43% of respondents stated that the number of EPAs, milestones, and observations does not reflect the constraints associated with practice in their training site.

Changes since last year

Concerning changes made to the number of EPAs, milestones, and observations, the results from Cohort 1 show us that requirements have been updated, at least in some disciplines. In fact, 44% of respondents in Cohort 1 had observed a decrease in the number of EPAs to be attained, and 30% a decline in the number of observations and milestones, even if some adjustments remain to be made in order for these parameters more accurately to reflect the reality of practice in training sites, according to some respondents.

Moreover, several resident doctors reported local issues generated by changes in the rules surrounding CBD along the way. In this context, the policy adopted concerning standards versioning in CBD, which provides for the new changes to CBD to be integrated in the next stage, appears completely appropriate and should be applied, both for major changes proposed by the Royal College and for local changes within a program. For instance, a number of resident doctors in Cohort 1 were apparently told at the end of the year that the EPAs completed by senior resident doctors, notably on off-service rotations during the year, would not be counted, and this led to a substantial shortfall in the number of observations completed.

IT platform

In our first report in 2018, the importance of having an adapted, functional IT platform was raised. The use of an ePortfolio, which has become widespread since, seems to improve the collection of EPAs. Of Cohort 1, 15% reported using the paper format, while 59% used both formats (paper, and electronic platform). But only 10% of resident doctors in Cohort 2 responded that they used only the paper format to complete their EPA evaluations, while 23% reported using both paper and the IT medium. Whereas resident doctors reported an improvement in accessibility and in the ease of completing EPA evaluation forms in paper format, the mechanisms for counting and reviewing those data are unclear. Several resident doctors reported that their paper evaluations had still not been entered in their record in the ePortfolio or even taken into account during their evaluation. It is clear to us that, without an easy way of uploading paper data to an electronic platform, the paper format will rapidly become inadequate for supporting CBD, particularly in a context where the number of observations will be increasing over time.

Furthermore, opinion is divided as to the operation of IT platforms. Whereas some programs use homemade systems that are apparently very functional, several respondents mentioned the difficulties they encounter with the platform provided by the Royal College (ePortfolio). The limitations on its use appear to be primarily associated with issues of connectivity or access. Thus, resident doctors frequently reported that several supervising physicians did not have access to the software or frequently forgot their access codes and passwords, thus limiting opportunities for evaluation. This was particularly true on off-service rotations in specialties that had not yet begun CBD. There had nevertheless been an improvement in this regard, with some programs being more proactive than others.

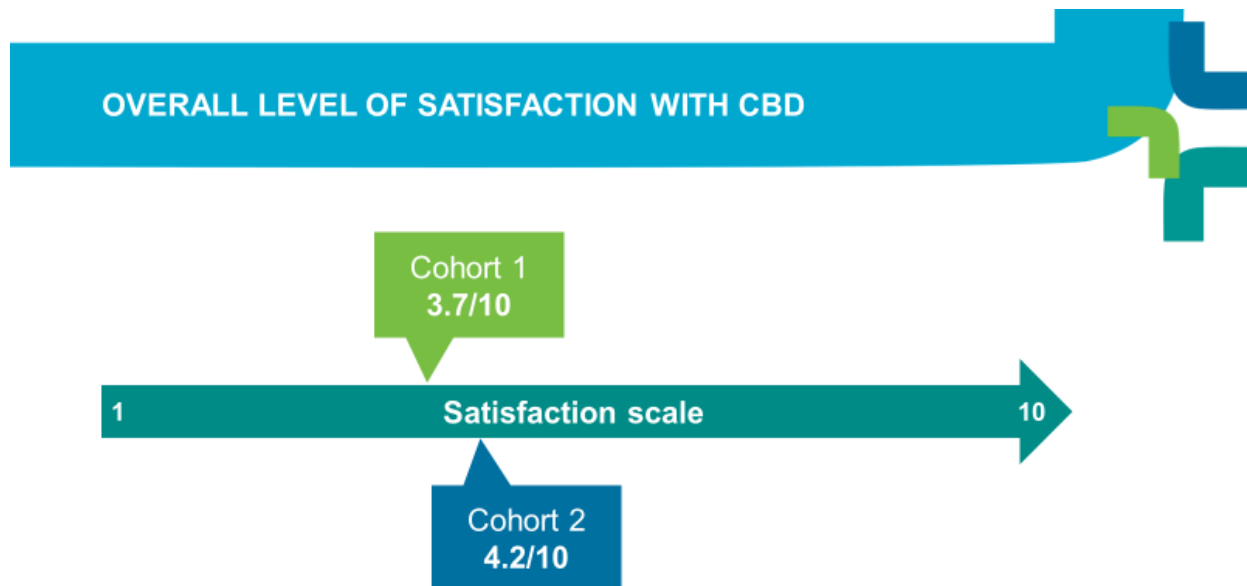
It was also reported that an electronic platform would reduce the number of real-time evaluations. It was not possible to determine the exact cause of that observation. But it is probable that many factors account for the phenomenon, considering the variety of responses provided by resident doctors: access problems, lack of fluidity, instability of the mobile app, and complexity of EPAs limiting the use of the platform on mobile devices. It is interesting to note that several resident doctors suggested possible enhancements to the different software.

Furthermore, only 24% of respondents said they had been informed of an alternative procedure for recording their EPAs in the event of a computer breakdown or unavailability of the platform.

We should note here that the FMRQ is continuing to lobby the Royal College and the medical faculties to emphasize the importance of protecting resident doctors' personal information (privacy), in the context of data transfers via electronic platforms, in particular concerning rights of access to this information, including evaluations, to which only resident doctors and representatives authorized by the faculties of medicine should have access.

3.5. THEME 5: Satisfaction

When we asked resident doctors to rate their level of satisfaction with CBD on a scale from 1 to 10 (1 representing the lowest and 10 the highest satisfaction level), we obtained a weighted average of 4.1 (3.7 for Cohort 1, 4.2 for Cohort 2).



Currently, it is clear that CBD entails additional workload for resident doctors and supervisors in certain sites. In a clinical context that is already overloaded, the different stakeholders have little time and few resources to devote to it.

Resident doctors' anxiety and wellness

As we mentioned earlier, the responsibility inherent in completing EPAs is left to resident doctors, who have to identify their own learning opportunities and find supervising physicians who are ready to carry out the observations and complete an EPA evaluation form. In the current context, this represents a demanding additional task for many resident doctors, who generally do not manage to obtain enough direct or indirect observations to complete the requirements for each EPA. Even when resident doctors are successful in obtaining direct observations, the feedback is often not up to their expectations, and the EPA evaluation form is not completed on the online platform.

All these difficulties generate a significant level of anxiety in some resident doctors. Several reported that CBD is “the most stressful element in their residency.” Others regret performing their residency in a program under CBD, or are bitter at being guinea pigs for a training and evaluation system that was implemented too quickly, requiring a great deal of improvisation by both the faculties and the Royal College in the implementation phase. Too many resident doctors have the impression that they are the ones paying for this poor planning, again this year. Several respondents recognized the potential advantages of CBD, but did not feel to be reaping the anticipated benefits. Residency is stressful and exhausting in itself, and the addition of CBD appears to have a significant negative impact on resident doctors’ general wellness.

Supervising physicians’ perception

This survey evaluated only resident doctors’ perception. Resident doctors told us of their perception of supervising physicians’ level of motivation and lukewarm interest in completing EPA evaluation forms, milestones, and observations, but is that really the case? We are unable to confirm it. That is why we feel it would be important to conduct a similar exercise on supervisors, to gain a clearer understanding of the difficulties facing them. Is there really a lack of motivation and interest on the part of supervising physicians? Or is it simply a lack of training and information concerning EPAs and milestones? Is there also a lack of administrative and faculty support for supervising physicians? There is probably some truth to all these responses, but it would be extremely helpful to have their version of the facts. In any case, it is essential that the problems experienced by supervising physicians be dealt with, because resident doctors currently feel overwhelmed by all the changes inherent in CBD.

Administrative and faculty resources

Generally speaking, the administrative and faculty resources in support of CBD appear to be inadequate. Resident doctors have to handle numerous administrative details concerning CBD, including identifying evaluation opportunities and participating supervising physicians, as well as having constantly to remind supervisors to ensure that EPA evaluations are completed. It is also important to note that resident doctors frequently reported having to explain how CBD works and the content of EPAs to supervising physicians. These additional tasks are extremely burdensome for resident doctors, as they are piled on top of regular clinical duties, which, however, have not been reduced, and are often superimposed on the old evaluation system, which is still operating in many programs.

4. CONCLUSION

In conclusion, the application of CBD in Quebec in 2018-2019 remains problematic in many respects, and these difficulties have to be pointed out. A number of improvements were noted in our survey compared with Year 1 of CBD, particularly as regards resident doctors' preparation at the start of training, and the number of EPAs and milestones. None the less, much remains to be done before we can claim that CBD has been implemented at all successfully.

In terms of resident doctors' preparation, they still seem to be missing numerous details, which should be clarified in future training offered by the Royal College and the universities. In particular, the very existence of competence committees, and their operation, and the rules governing the promotion of resident doctors within the competence continuum remain very unclear. We find it quite inadequate that many resident doctors who had completed the "Transition to discipline" and were approaching the end of the "Foundations of discipline" period, in some cases, had received no general feedback from the Competence Committee as to their progression along the continuum.

Resident doctors also perceived that supervising physicians' preparation is still suboptimum, leading to several difficulties in applying CBD in the field. One particularly contentious element appears to be the use of the O-SCORE entrustability scale and the lack of transparency with respect to the criteria underlying whether a milestone or EPA is passed.

Moreover, regular completion, in the field, of the observations necessary for passing each EPA remains a problem. From lack of motivation, training, resources, or even time, far too many supervising physicians remain reluctant to observe resident doctors and complete evaluations regularly with them. Also, even when an observation is carried out, resident doctors still often have difficulty obtaining immediate, appropriate feedback, and they have the impression of having to chase constantly after their supervising physicians to have them complete the evaluation sheets.

Particularly with respect to CBD's IT platforms, while these are an essential tool for collecting evaluation data, system performance nevertheless currently remains suboptimum. Numerous enhancements are desirable in that regard, with a view to facilitating their access and use, while strictly respecting resident doctors' right to privacy and protection of their personal information, an issue the FMRQ has been emphasizing since implementation of CBD began.

While many resident doctors try to remain optimistic as to the future operation of CBD and retain the hope that the theoretical benefits held out to them before implementation will actually materialize, they currently feel to be the victims of a hasty, imperfect implementation over which they have only very little control.

We cannot neglect to mention here that, last year, voices were raised across Canada daring to propose a moratorium on implementation of CBD. While the FMRQ was not one of those groups demanding a complete stop to the implementation, its leaders were indeed highly concerned at the prospect of allowing the Internal Medicine program — the largest contingent of resident doctors in specialties in Quebec — to begin operating under CBD in July 2019, when the small programs that have already experienced CBD since 2017 are still grappling with serious problems and taking a long time demonstrating that there are any real gains in terms of quality of training as a result of CBD. Also raised was the relevant issue of the additional financial resources needed by the universities to implement CBD — an important issue which the Royal College appears to have taken seriously on board during Year 2 of implementation of CBD. The FMRQ encourages the main parties involved to continue their discussions in that regard so as to ensure that resident doctors do not continue paying the price of a reform implemented without the necessary resources being made available.

This state of improvisation may leave an unfortunate impression that the instigators of this reform of postgraduate medical education methods appear to favour rapid, sustained implementation to the detriment of better planned implementation with the best chance of success. In the same vein, it emerged from our poll that the feeling of an “EPA marathon” appears to exist, where obtaining a single evaluation involves an exorbitant amount of time and work. It is certain that this level of effort is not viable in the long term for resident doctors, and merely leads to a feeling of exhaustion that may be inferred from respondents’ comments. Note here that resident doctors raised the fact that maintaining the evaluation methods that existed until implementation of CBD alongside CBD evaluations represents an additional burden, while in certain specific cases, such as for off-service rotations, the situation is somewhat inevitable during the CBD implementation phase.

Each stage is brimming with pitfalls, and resident doctors have the impression of being on their own in overcoming them; this leads to numerous unhealthy consequences in the current context. Resident doctors feel that they alone are shouldering the burden of implementation of CBD, adding further stress to their already busy lives, with no perceived benefit in terms of their personal or professional training. It is certain that the feeling that it is not worth their while is another major obstacle to the appropriate implementation of CBD in residency programs.

Through this report, the FMRQ hopes to contribute to enhanced implementation of CBD in postgraduate medical education in Quebec and elsewhere in Canada, notably in conjunction with its colleagues from Resident Doctors of Canada (RDoC). In that context, it presents in the following pages its recommendations based on the feedback from Quebec resident doctors arising from our survey.

In closing, the FMRQ believes that in the next few years it could be worthwhile setting minimum standards for application of CBD in order to standardize the transition. As was mentioned earlier, missing from this picture is feedback from supervising physicians. We recognize that it is also on their shoulders that the success of such a reform in training methods and evaluation of medical education resides. Thus, we can only hope that the organizations concerned also seek to gather the views of their members and colleagues.

5. RECOMMENDATIONS

Recommendation #1 (Flexibility in total number of observations per EPA)

That the associate deans for postgraduate medical education inform program directors, supervising physicians, and above all Competence Committee members, that the total number of observations per EPA to be attained remains a flexible objective, not an obligation. The Competence Committee's decisions should not be based solely on the number of clinical observations; the goal is to ensure that resident doctors are competent in the area, regardless of the number of observations. Resident doctors should be informed of this flexibility.

Recommendation #2 (Competence Committee)

That resident doctors be clearly informed of the function and composition of their program's Competence Committee. Decision-making concerning academic promotion, for which competence committees are responsible, should be objective, transparent, and detailed. In that regard, the Competence Committee's decisions should be conveyed clearly to resident doctors on a timely basis.

Recommendation #3 (Process for promoting resident doctors in the competence continuum)

That the rules and process governing decisions concerning the promotion of resident doctors from one stage to another in the competence continuum (Foundations of discipline, Core of discipline, Transition to practice), for which the Competence Committee is responsible, be clearly explained at the start of training and at each new stage in their progression along the competence continuum.

Recommendation #4 (Mandatory verbal feedback)

That supervising physicians be informed that verbal feedback should be mandatory immediately following the evaluation.

Recommendation #5 (Department support for evaluations)

That all resident doctors receive help from the department or service in having their evaluations completed in a timely manner.

Recommendation #6 (Training for supervising physicians)

That supervising physicians be offered more detailed training so they have a better understanding of the CBD environment and better tools for a smooth transition to CBD, particularly with respect to application of the O-SCORE entrustability scale, use of feedback methods within the framework of CBD, and integration of observations into regular clinical activities. Moreover, supervising physicians should have a better understanding of the criteria for evaluating resident doctors' performance as "entrustable" and "pre-entrustable," depending on the EPA in question.

Recommendation #7 (Simplification of statements describing EPAs and milestones)

That the statements describing EPAs and, more particularly, milestones be simplified to make them more readily understandable for resident doctors and the supervising physicians who complete the evaluations.

Recommendation #8 (Shared responsibility for completion of EPA forms)

That responsibility for completing EPA forms, milestones, and observations be shared, and not rest solely on resident doctors' shoulders.

Recommendation #9 (Recognition of senior resident doctors' supervisory role)

That the role of senior resident doctors as supervisors and evaluators be recognized, and that they be trained accordingly, including on off-service rotations.

Recommendation #10 (Use of ePlatform)

That the ePlatform be optimized (enhancement of functions, use on mobile devices, etc.). To that end, the stakeholders involved in the process of implementing CBD in the medical faculties should regularly seek feedback from the main users (resident doctors, program directors, supervising physicians, competence committees, etc.) with a view to enhancing the software used, through surveys or focus groups.

Recommendation #11 (Privacy policy)

That all faculties adopt a formal data protection (privacy) policy concerning resident doctors and their personal information which sets out the conditions under which such data and information may be consulted, used, and transferred.

Recommendation #12 (Program curriculum organization)

That each program's curriculum be adapted to accommodate the progression of EPAs within the competence continuum. The rotation grid should also be adapted to reflect the reality of practice in the various training sites.

Recommendation #13 (Off-service rotations)

That the programs ensure that resident doctors performing off-service rotations (not yet under CBD) can have their successful completion of such rotations recognized in their progress under CBD.

Recommendation #14 (Continuous improvement)

That the faculties take steps to obtain an accurate overall picture of the situation in CBD sites, particularly by integrating more systematic evaluation of supervising physicians' viewpoints.

Recommendation #15 (Continuous improvement)

That the Royal College introduce a rigorous mechanism for monitoring and implementation of CBD.