LE BULLETIN

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UNDERSTANDING REQUIREMENTS FOR PRACTISING MEDICINE IN QUEBEC

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC

AVAILABLE POSITIONS

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YOUNG GENERATION OF PHYSICIANS DESERVE BETTER

For more than a year now, we've been in mid-pandemic, at the mercy of the different waves, confinement, deconfinement, and reconfinement. We've experienced hope, frustration, surprise, incomprehension. Despite vaccinations and the foreseeable emergence from the crisis, the distress among our members is palpable. I see it in our establishments. I see it in our clinical units. I see it on my rotations. I see it in myself, too.

It has to be said: this distress is normal. It's normal to be affected when patients die by the dozen while under our care. It's normal when clinical obligations become so huge that we feel overwhelmed and even forget our own learning needs because of it. It's normal when we're constantly confronted with the moral dilemma of choosing patient care over our training. It's normal to feel frustration when authority figures make decisions without considering their profound impact on our physical and mental health.

For more than a year now, the FMRQ has been proclaiming loud and clear on every forum possible that care must be taken to ensure that resident physicians-in-training do not become other collateral victims of this pandemic.

FOR MORE THAN A YEAR NOW, WE'VE LOBBIED THE DIFFERENT ORGANIZATIONS, WHICH HAVE OBSTINATELY MAINTAINED THEIR POSITIONS, WITHOUT MUCH CONSIDERATION OF OUR NEEDS.

Certification exams are a first example of this. Since the pandemic began, the Royal College toyed with our emotions when it announced in turn that the exams would be maintained, then postponed, then cancelled, with no clear plan for what would follow, through tweeted information releases. The College of Family Physicians of Canada did the same, then offering us an exam with countless technical difficulties in fall 2020. The Medical Council of Canada, despite serious defects in the administration of the MCCQE Part I in spring 2020 and despite our clearly expressed fears, maintained the MCCQE Part II, then went on to close down its exam centres at 72 hours' notice the following fall. The MCC dug itself further into a hole in preparing a rushed new virtual MCCQE Part II, announced this spring, but the worst of it was that it did not make a sufficient number of places available for all resident doctors waiting for that exam, which had no longer been offered for more than a year. Why this headlong rush? To save face, justify its existence, and cash the funds from hundreds of young physicians and resident doctors held hostage who had already paid the exam fees a year earlier? And all that for an exam that has become irrelevant, which is no longer more than a mandatory rite of passage, laughable, but still very costly (see text box on page 13) and, above all, highly profitable for the MCC. At time of writing, the MCC had once again cancelled its exams, and its subsequent intentions remained unclear.

The *Collège des médecins du Québec* (CMQ), for its part, has remained inflexible in its certification requirements for resident doctors graduating in these exceptional circumstances, particularly with respect to the MCCQE Part II, offering only a single solution, that of issuing a temporary permit—the restrictive permit for those completing residency—while their colleagues at the MCC attempt to fix their organizational problems. The CMQ simply presented its temporary permit as a magic balm that it can reapply as often as terminating residents need it.

THIS AD-HOC SOLUTION, THOUGH, WILL HAVE HAD THE EFFECT OF CREATING TWO CLASSES OF PHYSICIANS: REAL DOCTORS WITH REAL, REGULAR PERMITS, AND DOCTORS WITH TEMPORARY PERMITS THAT CAN BE WITHDRAWN AT ANY MOMENT.

This temporary permit has continued to exist for months, solely because the CMQ is maintaining the requirement for the MCCQE Part II, an irrelevant exam that the MCC has finally never been able to offer. Because, yes, just imagine, the leaders of the MCC announced a limited number of places for their new, virtual exam for May and June 2021, knowing all the while that they would be unable to give candidates their results any earlier than September! In other words, the MCC and CMQ knew that the requirement for a pass in the MCCQE Part II was impossible to meet as of July 1, 2021. The CMQ appeared to be reconsidering its position over the past few weeks, and, fortunately, just recently came round to our position as to the need to cancel the MCCQE Part II.

Luckily, those responsible for university education at the MSSS and the faculty authorities have defended our rights as learners, since the start of the pandemic. We were successful, owing to this political work that must be acknowledged,

in preserving our invaluable clinical exposure, despite the context. Because healthcare establishment administrators would have been happy to use us as salaried employees, without regard for our training obligations. Of course, some of our members were in fact harder hit than others—in particular, our members in Internal Medicine or Emergency Medicine, who made up for the lack of staff on clinical units at the height of the pandemic and found themselves front and centre delivering care to COVID patients.

For resident doctors in several specialties, all this came on top of the implementation of Competence by Design (CBD). It has been nearly four years now since the FMRQ conducted close follow-up on the first implementation of this new assessment model inspired, rather imperfectly, by the competency-based approach.

IT'S BEEN CLEAR FROM THE OUTSET THAT THE CBD MODEL, WHOSE THEORETICAL BASIS MAY APPEAR ATTRACTIVE, BRINGS WITH IT A RISK OF DETRIMENTAL IMPACT ON RESIDENT DOCTORS' TRAINING, PROGRESS, AND MENTAL HEALTH.

Unfortunately, the Royal College is constantly trying to contradict our observations, and the *Collège des médecins* has shown little interest in the matter since 2016. Also, the medical faculties seem limited in their ability to assert their prerogative as teaching institutions in the face of the Royal College's secret weapon that enables it to impose its views: the power to recommend—or not to recommend—program accreditation. But in Quebec this power cannot be exercised without the CMQ's agreement [see other text on page 6]. Our faculties are not wrong to fear the Royal College, though, since for the past 10 years the CMQ has delegated to it much of the *Collège*'s responsibility for medical education, and has essentially left the exercise of its responsibility to national organizations, as it has also done with the MCC and CFPC.

That is why it is increasingly clear that resident doctors are paying the price for a medical education system that is incapable of protecting them. That was already the case, but has only become more starkly evident since the pandemic began. But this has to end.

Resident doctors deserve better than to be shuffled off to establishments, without support and supervision, to perform tasks there all too often of no pedagogical relevance.

Resident doctors deserve better than to be guinea pigs for a new assessment model presented as "innovative" by the utopian fantasists of the Royal College, whereas it actually endangers residents' mental health and brings no pedagogical benefits with it.

That is why the Federation is continuing to lobby for change, on your behalf.

Follow us in our deliberations and actions, in this *Bulletin*, but also on our different committees and platforms in the coming months. It is time those with responsibilities toward us, but who sometimes seem to forget that fact, were held to account.

In the meantime, we thank you for the work and the exemplary professionalism you have shown as a group since the start of this pandemic, and of which we trust the end is in sight.

Olivier Fortin, M.D.
President

1.

IN MEDICAL EDUCATION, WHO HAS THE REAL AUTHORITY TO DECIDE?

Constitutional Law 101, or Understanding the legal foundation that should determine the roles of the different stakeholders in medical education.

Why was Canadian resident doctors' 2020 initiative to require the Royal College (RCPSC) to hold an extraordinary general meeting in order to have the certification exam requirement cancelled legally bound to fail? Because even if the resolutions submitted had passed, the Royal College has no power whatsoever to decide whether or not its exams should be prerequisites for practising medicine in Quebec, or even in the other provinces. In fact, in Quebec, only the province's college of physicians—the *Collège des médecins du Québec* (CMQ)—has this power as a professional order mandated by the Quebec government to regulate the profession of physician in Quebec. That is why in the case of the controversial MCCQE Part II, it was from the CMQ and the Quebec government that the FMRQ demanded a moratorium on the requirement for a pass on that exam. The Medical Council of Canada (MCC) has no legal authority whatsoever to decide the question. The MCC can do only what it has regrettably done all too well for a number of years: convince the CMQ and the other colleges of physicians in Canada to require a pass on its controversial exam that brings it millions of dollars in income each year (see text 13 in this issue) at the expense of the upcoming generation of doctors. The only power involved here is that of influence, with no basis in law. Why is that the case? Actually, it's quite simple: the Canadian Constitution makes it so. Let us try to figure this important topic out, seriously underestimated as it is by the great majority of doctors involved in medical education, who mistakenly tend to believe that issues of constitutional jurisdiction are merely administrative hurdles.

It is unfortunately sometimes good form to consider constitutional issues and jurisdictions to be rather old-fashioned, whereas legal documents sometimes going back more than a century nevertheless impact our daily lives. That is the case, for instance, with the Constitution Act, 1867, the text that is the basis for Canadian Confederation, setting out how jurisdiction is shared between the Canadian federal government and the provincial governments.

But why are health and education provincial jurisdictions, and why can they not be made Canada-wide jurisdictions, as many in Canada's medical education world would like to see? To understand this, we must take a brief look back at some basic Quebec and Canadian history. In fact, this 1867 text which provides for the sharing of jurisdictions between the federal government and the provinces is the synthesis of political conflicts spread over at least three centuries.

- More active introduction of the rules of French Civil Law in New France from the founding of Quebec City by Champlain, in 1608. The close urban cohabitation of the "Canadiens," descendants of French colonists, supposed more rules for communal life. Health care and education are of course activities central to social life;
- At the close of the global conflict pitting France against Great Britain (the Seven Years War), the territory of New France, by then known as "Canada," came under British rule following the end of the French and Indian War of 1760. Through the Royal Proclamation of 1763, Britain established a new British colony, the Province of Quebec, which included most of the territory of today's Quebec, as well as part of present-day Ontario, instituting British Common Law there, to control the new subjects of the British Crown;

- As French Canadians resisted this change and were very hostile to the British troops, the British tried to bring some peace through the Quebec Act, in 1774, which re-established French Civil Law in Quebec for the rules of communal life, but maintained British Common Law for criminal matters;
- Territorial disputes would follow: the splitting of Quebec into two (Upper Canada and Lower Canada) by Britain in 1791 (Constitutional Act 1791), which led notably to the Lower Canada Rebellion of 1837-1838, followed by the Durham Report, calling for the assimilation of French Canadians, then Britain's decision to reunite Upper and Lower Canada (Act of Union 1840) into a single political entity governed by Britain;
- But cohabitation and the governance of Britain's new colony, the Province of Canada, proved difficult, and Britain would establish the important Constitution Act, 1867, laying the foundation for the Canadian federation we know today, providing for a sharing of jurisdictions between the federal entity and the new provinces: Upper Canada became the new Province of Ontario; Lower Canada took back the name of Province of Quebec, but with a smaller territory; and two other British colonies, Nova Scotia and New Brunswick, were added;
- Following the 1980 Quebec referendum, the government of Pierre Trudeau altered the conditions allowing for future amendments to the 1867 Constitution through the Canada Act 1982. The 1982 statute added a Canadian charter of rights and freedoms, to Quebec's own charter of rights and freedoms adopted in 1976. The new constitutional amendment mechanisms made it politically virtually unalterable, according to the wishes of Pierre Trudeau, who said "the federation was set to last a thousand years." History would prove him right, with the failures of the reforms of 1987-1990 (Meech Lake Accord) and the 1992 Charlottetown Accord;
- In short, regardless of one's political views, the sharing of Canada's constitutional powers set out in 1867 – whereby health and education are provincial jurisdictions – is here to stay. Although the constitutional legislation of 1982 (Canada Act 1982) is a text the Quebec government has never accepted to sign, it nevertheless does apply to Quebec, pursuant to a Supreme Court of Canada judgment[1] and, ironically, today protects Quebec's jurisdiction over health and education.

Somewhat surprisingly, Quebec has historically retained within its boundaries its law deriving from France (except for criminal matters), for regulating and governing the affairs of daily civil life.

The 1867 text is rightfully presented as the foundational act of Canadian Confederation. Canada's political shape today stems from it, including the question of jurisdiction over health and education. The 1867 Constitution essentially provides that "strategic" powers, including armed forces and currency, are entrusted to the central, "federal" power, while "social affairs" powers, including health and education, are entrusted to subnational states, the "provinces." Eventually, in the 20th century, the provinces, including Quebec, would create municipalities to whom they delegated even more local responsibilities, such as garbage collection and city planning, and establish several other bodies, including professional corporations, such as the *Collège des médecins du Québec*, to regulate the practice of certain professions.

Of course, Canada's political evolution has seen the federal government increasingly involved in areas of provincial jurisdiction, notably health, through "federal spending power" in the form of Canadian transfer payments. That is still topical today, with, for instance, the desire of Justin Trudeau's government to determine nationwide standards for management of long-term residential care facilities (CHSLDs). But how can that be, since health is a provincial jurisdiction? Simple enough: the federal government collects far more in income taxes than it needs for managing its areas of constitutional jurisdiction (whence the notion of fiscal imbalance in Canada). This enables it to redistribute significant sums to the provinces, subjecting the transfers to conditions or standards. The federal government does not have the constitutional jurisdiction, but from its financial surpluses (or its debt, should we be saying since the start of the pandemic), it redistributes funds to the provinces in exchange for a say in how those funds are spent. Is that good or bad? It depends on one's point of view. What is certain is that it is part of Canada's political dynamics. Remember, for instance, in 2015 that even an avowed sovereigntist such as Amir Khadir of Québec solidaire had asked the federal government to intervene to put pressure on Quebec's Minister of Health, Gaétan Barrette, threatening to withdraw sums paid by the federal government if the Quebec government did not act to limit the use of accessory fees by physicians. An example of how the dynamics of federal-provincial jurisdiction has moved beyond the sovereigntist-federalist polarity that was the hallmark of the 1980s and 1990s in Quebec.

Now let us return specifically to medical education. Health and education being areas of Quebec's exclusive jurisdiction, our universities, and their medical schools, are legal persons subject to the Quebec government's authority. Certainly, over the years, the federal government has used its notorious spending power to fund universities indirectly, notably by injecting hundreds of millions of dollars into them through the establishment of Canada Research Chairs. But the fact remains that these universities are the exclusive responsibility of the Quebec government. The same goes for our healthcare establishments, and for our college of physicians, the *Collège des médecins du Québec* (CMQ). These are all legal persons, whose establishment lies with the Quebec state, to which ultimately they are legally subject. The *Collège des médecins du Québec* exists because Quebec passed legislation (the *Professional Code*) which governs the creation and administration of Quebec's different professional orders (CMQ for physicians, Quebec Bar for lawyers, OIIQ for nurses, Order of Architects, etc.).

[1] Re: Objection by Quebec to a Resolution to amend the Constitution

Of course, provincial jurisdiction in health and higher education does not preclude the provinces agreeing among themselves to administrative arrangements setting out a nationwide common basis. The CMQ did that in the early 2000s when it stopped administering its own medical certification exams and entrusted their administration to the Royal College, College of Family Physicians of Canada, and Medical Council of Canada. But this delegation of authority did not in any way have the effect of transferring the power to decide on the requirements for the practice of medicine in Quebec to those Canada-wide groups. The CMQ does not have the legal authority to give away its powers. Since it is a creation of the Quebec state, it cannot decide to amend the Canadian Constitution and the sharing of jurisdictions. The CMQ can decide only to delegate the performance of some of its responsibilities, insofar as it deems this relevant or as long as the Quebec Professions Board (*Office des professions du Québec*) or, ultimately, the Quebec government considers it positive for the Quebec population. Failing that, the professional order may simply decide to take back its responsibilities or be required to do so by the authorities to which it is answerable in Quebec. Between those alternatives, though, it all comes down to political choices.

That is why it is always a little surprising for an observer well versed in the constitutional realities to hear leaders of the RCPSC, CFPC or MCC speak as if they were able decide what is or is not good for practising medicine across Canada. In fact, those organizations have no legal authority whatsoever to decide the conditions for practising in Quebec. And yet, they place a great deal of energy into it and sometimes are even successful in imposing their aims quite effectively. Implementation of CBD in medical faculties is the best example. How is that possible? Only if the CMQ and the medical faculties decide to submit to these aims, either because they consider them to be positive, or simply through institutional inertia. That is how CBD was implemented in our medical faculties, with the passive assent of the CMQ, essentially without any debate beyond the Royal College's closed circles. Even if our faculties had had reservations about CBD (some of which they shared with us as early as 2016), it was hard for them to say no to the Royal College, which can, remember, under the ultimate authority of the CMQ in Quebec, influence whether or not those very medical faculties receive accreditation. Another example is the work of the Association of Faculties of Medicine of Canada (AFMC), which has been working for some years now, with federal government participation and funding, on setting up a nationwide physician resource planning project and a project for a Canada-wide permit for medical practice. All these projects are ultimately destined to come up hard against a reality that some people appear to wish to forget: health, civil law, and labour law are not areas of federal jurisdiction, and a proposal for a Canada-wide work permit, regardless of the profession, will always have to receive the approval of each of the provinces concerned. But these doctors involved in these projects, doubtless in good faith, all too often appear to ignore this fundamental reality, and when they address the question of jurisdiction, it is often in terms of obstacles or constraints, as if complying with the terms of a country's constitution were merely an administrative detail.

It is, however, far from a mere detail, and indeed that is why Ontario and Nova Scotia could make the decision to lift the requirement for a pass in the MCCQE Part II while the CMQ, for its part, continued obstinately to maintain such a requirement.

That is why, in future, in different matters of a pedagogical nature, the FMRQ will rely more on the organizations that really hold the authority to change things. The FMRQ hopes to convince the CMQ, our medical faculties, and the Quebec government to assume fully their responsibility to ensure medical education of high quality in Quebec. To cease relying constantly on Canada-wide partners which do not even hold real authority in these areas. Everyone will agree that there are ways of organizing care, delivering care, and teaching that can be specific to certain communities—one has only to think of First Nations, francophone communities outside Quebec, or communities away from major urban centres, including in Quebec. Consider the role of the specialized nurse practitioner (SNP) or the existence of certain professions, such as physician assistants outside Quebec, which differ by region or province. Why should we always have to stay with the desire to standardize and centralize everything, even in Quebec? To what end? And how do we deal with the different cultural realities? Why try to move decision centres away from where those affected by those decisions live? You don't need to be trained in political science to understand that nationwide organizations may possibly have an interest in aiming for pan-Canadian standardization in the areas they are working on. But is that in our interest, in the interest of our members and of Quebecers? Maybe. But can we at least talk about it before introducing major reforms in medical education? It is time for change, for action, for the CMQ and the medical faculties to show more leadership and be more involved in deciding what is good for medical education in Quebec. This has do with, not nationalism or lack of openness, but, rather, with ensuring a medical education and health system on a more human scale, closer to the concerns of the individuals who comprise that system and for whom it exists. But for our medical faculties to be able to do such a thing, they have to have the assurance that the CMQ will support and follow them. And if the CMQ refuses to play that role, then someone in the Quebec government will have to intervene. Because, when it comes down to it, the pandemic has clearly shown that in a crisis, we have to go back to basics, and ultimately ask ourselves the question: who has the responsibility, and who has the real authority to act?

*The **hyperlinks** in this article are active in our electronic version.*

2.

WHO DOES WHAT

REQUIREMENTS FOR CERTIFICATION IN MEDICINE IN QUEBEC AND CANADA

KEY DATES	
1847	Establishment of Professional Corporation of Physicians of Quebec (CPMQ), now *Collège des médecins du Québec* (Quebec College of Physicians, CMQ)
1912	Adoption of Canada Health Act Establishment of Medical Council of Canada
1929	Establishment of Royal College of Physicians and Surgeons of Canada (RCPSC)
1954	Establishment of College of General Practice of Canada (name changed in 1967 to College of Family Physicians of Canada (CFPC)) First exams for specialties other than family medicine
1967	CMQ uses Royal College's written exam with multiple-choice questions
1969	CFPC's first certification exam in family medicine First residency program in family medicine in Quebec (UofM)
1970	CMQ uses Royal College's written component
1981	Canadian Medical Association asks for national FM training exam
1984	CFPC recommends two-year residency training for all future family physicians
1991	Administrative cooperation agreement signed between CMQ and RCPSC
1994	Use by CMQ of RCPSC exam oral, clinical, electronic, practical, and audiovisual components
1996	New CMQ requirement – Successful completion of ALDO-Quebec exam
1998	Continued CMQ/RCPSC collaboration for exams but with Quebec-specific component maintained
2000	Amendment of CMQ Regulation respecting standards for equivalence for physicians from outside Quebec, use of practice permit, and recognition of specialist certification
2001	Use by CMQ of comprehensive objective examination (COE) in 23 specialties Use of MCC and CFPC exam for permit to practise in FM
2004	Establishment of CMQ/RCPSC Advisory Committee on Harmonization of Specialty Exams
2006	Update of table of requirements for specialties recognized in Quebec (35)/Specific exams (CMQ); exams partly shared with RCPSC; and fully harmonized exams
2009	Addition of new requirement for certification in Internal Medicine and Pediatrics: successful completion of MCC exam (MCCQE Part II)
2010	Transition to Triple C Competency-based Curriculum in FM
2012	Addition of Certificates of Added Competence in FM
2017	Start of implementation of Competence by Design (CBD) in specialties

CERTIFICATION REQUIREMENTS FOR PHYSICIANS IN QUEBEC

Much has been written about physician certification over the past year. Demands going back several years have become even more pressing owing to the difficulties entailed by the COVID-19 pandemic. Questioning by physicians in training and practice about the administration of the exams, and also about the relevance of certain exams required for obtaining a permit to practise, continue to provide fodder for debate across Canada. To set the scene, we offer you a timeline of the evolution of postgraduate education and requirements for practising medicine in Quebec.

Central role of *Collège des médecins du Québec* (CMQ)

Since its establishment in 1847, the *Collège des médecins du Québec* (CMQ), then operating as the Professional Corporation of Physicians of Quebec (*Corporation professionnelle des médecins du Québec*), has had exclusive legal responsibility for issuing permits to practise and controlling the practice of medicine in Quebec. In the exercise of its responsibility to protect the public, as a college of physicians, the CMQ has the mission of ensuring the delivery of quality health care. So it is the CMQ that has the power to establish the requirements for obtaining a permit to practise medicine in Quebec.

As we explain below, in 2000s, the CMQ has delegated a number of its responsibilities to Canada-wide bodies, including that of confirming candidates' competence for a permit to practise in Quebec, through exams.

But, in view of the legal characteristics specific to Quebec's civil law that are not taken into account in the national exams, the CMQ added a requirement in 1996: a pass in ALDO-Quebec, an exam on the legal, ethical, and organizational aspects of medical practice in Quebec. In 2009, the exam was superseded by a 3-hour training session given by the CMQ, to be taken at any point during postgraduate education, after at least 12 months of residency.

TABLE OF REQUIREMENTS FOR OBTAINING A PERMIT TO PRACTISE IN QUEBEC

- Specialist certification in family medicine (CFPC) or one of the other 59 specialties (RCPSC) recognized by the CMQ
- Medical Council of Canada licensing
- Participation in ALDO-Quebec, the CMQ's training on the legal, ethical, and organizational aspects of medical practice in Quebec
- Other requirements, depending on whether undergraduate (MD) training was done in Canada or elsewhere, including the *Office québécois de la langue française* French language test

Role of College of Family Physicians of Canada (CFPC)

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA / LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

The College of Family Physicians of Canada issues certification in family medicine, takes part in accreditation surveys, defends the interests of family medicine, and administers certification exams.

Initially, in 1954, the CFPC was known as the College of General Practice of Canada. In the early 1960s, the College worked to set up a postgraduate education and certification program in family/general medicine. A few years later, in 1966, Canada's first two residency programs were created, at the University of Calgary and the University of Western Ontario (now Western University). In 1967, the College changed its name to the College of Family Physicians of Canada (CFPC). In 1981, the Canadian Medical Association (CMA) called for a national review of family practice training. At the time, nearly half the medical students entering family practice in Canada had completed residency training, while the others had completed one-year rotating internships. In 1984, it was recommended there be a minimum requirement of two years of prelicensure training and one preferred route of residency training for general practice. In 2010, the CFPC proposes the Competency-based Triple C Curriculum, and in 2012, it added for exams to obtain Certificates of Added Competence (e.g., EM3).

Since spring 2001, the CMQ has required a pass in the OSCE component of the MCC Qualifying Exam Part II for family medicine, as well as the SAMP and SOO components of the CFPC exam.

Role of Royal College of Physicians and Surgeons of Canada (RCPSC)

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA / COLLÈGE ROYAL DES MÉDECINS ET CHIRURGIENS DU CANADA

The Royal College of Physicians and Surgeons of Canada grants certification in more than 60 medical specialties and subspecialties, takes part in program accreditation surveys, defends the interests of the different specialties, and administers certification exams for each specialty program.

The Royal College was established in June 1929, under special legislation from the federal Parliament to govern postgraduate medical education in specialties in Canada. At the outset, the qualification process targeted two specialties: one certification in Medicine, and another in General Surgery. Today, the Royal College recognizes close to 100 specialties, subspecialties, special programs, and accredited programs in target areas of competence (diplomas). Note that certification exams in specialties other than FM have not always existed. In 1950, a number of new medical and surgical specialties appeared. The first specialty exams would come into effect four years later, in 1954. At the outset, doctors completed their clerkship, then immediately

started practice. Subsequently, a number would specialize. Since issuance of permits to practise medicine in Quebec is the responsibility of the CMQ, it can be said that the RCPSC acts as a subcontractor to the CMQ in evaluating the competencies of candidates for medical practice in Quebec through the administration of certification exams.

Our members receive a "certification" from the RCSPC, and the CMQ requires a proof of this certification to deliver a permit to practice.

CMQ delegates its responsibilities to RCPSC

In fact, it was in the early 1990s that a cooperation agreement was signed between the CMQ and the RCPSC, whereby notably the Royal College exam was recognized by the CMQ to avoid the situation where Quebec candidates wishing to practise elsewhere in Canada had to pass two different exams. The *Collège* and the RCPSC then shared exam components in 23 of the 35 specialties recognized in Quebec. But the CMQ maintained its own oral component, independent of the Royal College's, which comprises the second part of the exams.

In February 2000, the regulations concerning standards for equivalence of diplomas for doctors from outside Quebec, granting of permits to practise, and recognition of specialist certification were completely overhauled. In 2001, it was confirmed that the CMQ used Comprehensive Objective Examinations (COEs) in 23 specialties. The COE components were incorporated as the first part of the specialty exams. Furthermore, the CMQ retained specific exams for 12 specialties whose criteria for eligibility for practice were different from the Royal College's. The CMQ considered those specialties to be full-blown medical specialties, and not subspecialties of Internal Medicine. During the same period, the *Collège* set up a CMQ/RCPSC Advisory Committee on Harmonization of Specialty Exams, marking the real start of an in-depth debate on the relevance of maintaining two exams (one Quebec exam and one national exam) for Quebec's resident doctors. Four years later, in 2004, the two parties agreed on the details for harmonization and sharing of the majority of specialty exams. For more than 15 years now, all candidates for the practice of medicine in Quebec no longer have a Quebec exam to pass, but only the national exam in their specialty.

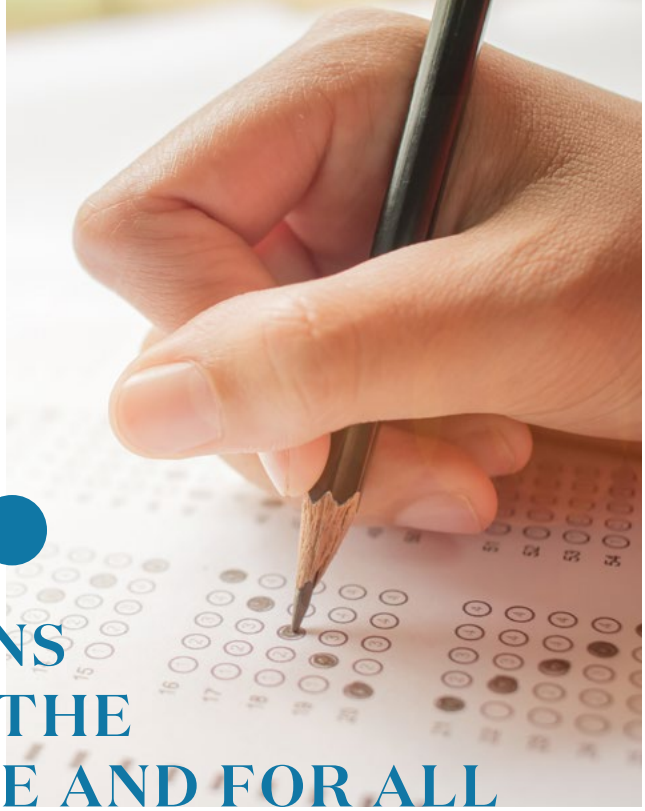
Role of Medical Council of Canada

MEDICAL COUNCIL OF CANADA / LE CONSEIL MÉDICAL DU CANADA

Since spring 2001, the CMQ has required MCC licensing, which means passing the MCCQE Part I and Part II to obtain a permit to practice in Quebec. This requirement was being reviewed by the CMQ as we were about to publish.

Passing the MCCQE Part I is a prerequisite for entering residency in Quebec. A pass on the MCCQE Part II is still required, to date, for entering practice. The two parts of the exam are combined by the MCC to comprise "certification," but it is still the prerogative of the college of physicians of each province or territory to decide whether or not to make this a requirement for practice.

Some provinces no longer require a pass in the MCCQE Part II, recently including Nova Scotia and Ontario. At time of writing, the debate was still ongoing in Quebec.



3.

FOUR GOOD REASONS TO PUT AN END TO THE MCCQE PART II ONCE AND FOR ALL

1 AN EXAM EVALUATING COMPETENCIES ALREADY EVALUATED

Resident doctors' training, and their competencies, including those with respect to communication and professionalism, are not only evaluated throughout their postgraduate education by the medical faculties, but their knowledge – in terms both of medical expertise and of communication – are also assessed at the close of their residency through the RCPSC and CFPC exams. Moreover, since necessary competencies are evaluated from the start of residency, the MCCQE Part II exam does not have even the slightest relevance at the postgraduate level;

2 AN EXAM WHOSE ALLEGED RELEVANCE IS BASED ON STUDIES WITH LITTLE CREDIBILITY

The MCC claims that studies show the MCCQE Part II helps predict which learners are most likely to lack professionalism once in practice. Representatives of the *Collège des médecins du Québec* have regularly repeated this mantra. But the FMRQ conducted a rigorous review of the studies on which such claims are based, and concluded (see article page 13) that there were problems with the methodology used by these studies, their conclusions were difficult to generalize, and there is therefore very little scientific evidence worthy of the name;

3 AN EXAM WHICH FOR A YEAR HAS BECOME A PROFESSIONAL BARRIER TO A FULL PERMIT

Since the MCC has not been able to offer its exam for a year, with multiple foul-ups and last-minute cancellations, its exam has become what is preventing hundreds of young staff physicians from being able to obtain regular permits at the end of their residency, despite having successfully passed their specialty exams;

4 AN EXAM WHICH SEEMS ABOVE ALL TO HAVE BECOME A SOURCE OF INCOME FOR THE MCC

Many have wondered why the MCC has invested so much energy in the rushed development of a new virtual exam botched in mid-pandemic. Rightly or wrongly, some people have deduced that this rush was probably intended to avoid having to reimburse the thousands of candidates waiting for the MCCQE Part II who had already paid months previously the high fees for the constantly deferred exam. In the same vein, what explains the fact that the MCC's audited financial statements for 2019 and 2020 posted some $12 million in income per year compared with $6 million or so in expenditures for the MCCQE Part II alone (see Table on page 13). These figures do indeed pose worrying questions. Through its inaction, the *Collège des médecins du Québec* has for too long seemed to sanction a Canada-wide body's enrichment at the expense of the upcoming generation of physicians.

That is why, in 2020, the FMRQ has asked for a moratorium on the requirement for a pass in the MCCQE Part II in order to practise in Quebec. We pointed out to the leaders of the MCC that they could have acted responsibly as early as fall 2020 by transparently indicating to the different colleges of physicians—including the *Collège des médecins du Québec*—that they were logistically incapable of administering the MCCQE Part II. It would than have been possible to grant full MCC licensure to candidates passing the MCCQE Part I, but unable to sit Part II. We would thus all have been more open to discussing future solutions, at a time when a Canada-wide consultation on the topic was launched by the MCC, rather than rushing to introduce a new, virtual exam, which will have been the umpteenth failure by the MCC. The FMRQ will continue to follow this matter closely, considering that the intentions of the actors involved are not clear. But, in all cases, we will make sure that never again will Canadian lobbies in health finance themselves on the back of the upcoming generations of physicians.

UPDATE ON STUDIES PURPORTING TO SUPPORT RELEVANCE OF MCCQE PART II

The MCC claims that studies show the MCCQE Part II helps predict which learners are most likely to lack professionalism once in practice. Representatives of the *Collège des médecins du Québec* have regularly repeated these pretensions. But the FMRQ conducted a rigorous review of the studies on which such claims are based, and concluded that there were problems with the methodology used by these studies, their conclusions were difficult to generalize, and there is therefore very little scientific evidence worthy of the name.

In that regard, an initial group of studies (Tamblyn et al, 1998; Tamblyn et al, 2002) evaluated a cohort of doctors who started out in practice before the MCCQE Part II even existed, so that tends to invalidate those studies in the argument in support of this exam. Several other publications (Tamblyn et al, 2007; Wenghofer et al, 2009; Tamblyn et al, 2010; Cadieux et al, 2011; Meguerditchian et al, 2012) concern the cohort of resident doctors who took the MCCQE Part II between 1993 and 1996. These articles all stem from the same primary study funded by the MCC itself, but never published[2]. That study in fact correlates MCCQE Part I and Part II subscores with so-called "practice indicators" that manifestly have little connection with actual clinical practice. A final, more recent study (De Champlain et al, 2020), apparently also funded by the MCC, shows a correlation between the score on the MCCQE Part I and the likelihood of complaints from patients, and a correlation between the score on the MCCQE Part II and the prescription of opioids and benzodiazepines, all in Alberta.

In all, there are problems with the methodology of these studies, and their conclusions are difficult to generalize, particularly in view of the tenuous link between the practice indicators and actual clinical practice. So there are many studies, but when we look at them all closely, there is very little scientific evidence worthy of the name.

MCC – DETAILS FROM FINANCIAL STATEMENTS 2019 AND 2020 RELATING TO THE MCCQE, PART II

YEAR	REVENUES ($)	EXPENSES ($)
MCC QUALIFYING EXAMINATION PART II		
2018	12, 590, 251	5, 404, 422
2019	12, 539, 670	5, 668, 212
2020	12, 036, 360	6, 286, 102

[2] https://mcc.ca/media/Tamblyn_Score-Association_MCCQE-Part-II_Clinical-Practice-Performance_2009.pdf

4. COMPETENCE BY DESIGN: THEORETICAL MODEL FAILS

On the Royal College of Physicians and Surgeons of Canada (RCPSC) drawing board for more than 10 years, Competence by Design was the Royal College's interpretation of a model of competency-based medical education, or CBME. We were promised miracle improvements in how medicine is taught and learned in Canada. The prospect was held out to us that resident doctors would benefit from regular observations, relevant, helpful feedback, longitudinal tracking of their progress through residency, and clinical tasks geared to their level of training and expertise. An entire issue of the prestigious journal *Medical Teacher*, authored by several Royal College representatives, was even devoted to this new model.

The FMRQ followed from the outset the Royal College's discussions with Canada's medical schools. It must be understood that there had previously been pilot projects in some Ontario medical faculties that reinforced the Royal College in its certainty as to the relevance of the model. But we should remember that the faculties taking part in these projects received several million dollars to make these CBD trials successful. That is an important detail. Despite that, people from those sites more than once reported to us that they also had the problems we observe with CBD in Quebec. So imagine the situation in faculties where CBD was clearly imposed without any additional resources being provided! Because it has to be said that CBD was imposed on our faculties. FMRQ representatives were there at the very beginning of the active "consultations" on CBD, back in 2015 and 2016. Those meetings where representatives of the Royal College brought together the 17 medical faculties in impressive surroundings in Ottawa and presented charming PowerPoints to them, along with the question: do you want to teach and evaluate resident doctors better? Imagine the dynamics: the main body that can recommend, or not recommend, accreditation whereby the faculties can teach medicine asking them whether they want to do better. It is no surprise that, since that time, our faculties barely dare tell us, in private, that they share our criticisms of CBD, but quickly change their tune in meetings where they would have the opportunity to do so in front of representatives of the Royal College. That's politics! Back in December 2016, we were already talking with some faculty representatives, and in response to our questions, they admitted they were not too sure exactly what they had agreed to in meetings with the Royal College, whose interpretation was that it had received unanimous agreement to launch its reform. The same fuzzy discourse was then maintained by the Royal College when it was time to decide whether or not to launch new CBD programs, in 2018 and 2019, when some faculties were beginning to bring up the lack of financial resources for implementing this reform. Royal College representatives even went so far as to cancel a secret ballot that had none the less been announced, when they observed that the faculties were going to object and ask for the rate of implementation to be slowed down. As if by magic, the vote was not held, and preference was given to consultations by program, rather than with the faculties concerned. And always the allegory was presented by the supporters of CBD of a transatlantic liner that could not lose way once it was launched. That is why the FMRQ would recall in the conclusion of its 2020 report that this was how the sinking of the Titanic unfortunately went down in history, the desire to sail full speed ahead without slowing the advance of its new prototype presented as the latest wonder of evolution.

It was in 2017 that the first two specialties – Anesthesiology and ENT/HNS – were launched into the CBD arena as guinea pig programs. Implementation of

CBD was meant in theory to be gradual, testing the strengths and weaknesses of the model, without any negative impact on resident doctors' training and progress. In actuality, programs, and especially resident physicians, were catapulted into a completely redesigned evaluation mode, with woefully inadequate preparation. Staff physicians did not even know how to provide feedback, the competence committees did not understand how to track resident doctors in their progress, while the very existence of those committees was essentially unknown to resident doctors in those programs. Resident physicians were faced with an astronomical number of EPAs to be completed, with no support other than a pat on the back reminding them it was their duty to take charge of their own teaching. Certainly, adjustments have since been made, but rather than taking the time to rethink and correct their model, the Royal College launched program after program into the arena, without providing any tangible support other than yearly seminars to the programs concerned. And unfortunately our faculties essentially followed without much argument, incapable of objecting to what had been presented to them as a better way of doing things, imposed by the main body responsible for subsequently verifying whether they actually were doing things better.

The FMRQ has been closely following developments with CBD and its impact on resident doctors. We have published three survey reports in that regard, with a fourth to be released shortly. The findings from the reports are quite simply deplorable. The promises of CBD, with individualized, feedback-based longitudinal tracking, have been perverted by the application of a straitjacket based on a set number of entrustable professional activities[3] (EPAs) to be checked off lists. In fact, in an apparent desire to make the assessment of acquisition of a competency more tangible, the Royal College has as it were made its measuring tool, the EPA, the target outcome of the exercise. So resident doctors find themselves more collecting EPAs, artificial requirements of this defective system, than actually acquiring competencies. In the end, the feedback remains irrelevant and unhelpful, and the pedagogical benefits are non-existent. That is why we can only wonder now whether this assessment method is justified, with so many negative impacts and so few pedagogical benefits. Moreover, resident doctors are exhausted and distressed by it, to judge by what they tell us in our consultations.

On the political front, we have now submitted three reports, notably to the Royal College and our faculties, in order to raise a red flag concerning the major negative impact of implementation of this reform on resident physicians' mental health, and on the vast disconnect between the unceasing efforts demanded from resident doctors and the level of pedagogical benefits, essentially close to zero. For three years now, the Royal College has said it is listening to us, inviting us to discussion panels to put our viewpoint forward. For three years now, nothing has changed on their side, and the Royal College implies that this problem exists only in Quebec, whereas that is simply because the FMRQ, surprisingly, is the only medical education body in Canada to have instituted a process for following up on the implementation of CBD independent of the Royal College's own process.

Does all the fault lie with the Royal College? No. The faculties are trapped in the face of an organization that imposes a straitjacket on them in how they can teach medicine and assess resident doctors. They clearly have their faults and, in our view, sometimes exaggerate the fears relating to their accreditation in performing their own university responsibilities. But we can partly understand them, because this reputation as an all-powerful body attributed by some to the Royal College exists for one simple reason: the relinquishment by the regulatory authorities, the *Collège des médecins du Québec* (CMQ) among them, of a significant part of their role. It is the CMQ and no other body that has the legal authority in Quebec to decide whether or not accreditation is granted to any of our four medical schools. Not the Royal College. But, most unfortunately, people have ended up believing that nothing could any longer be done in Quebec for medical education. These are nevertheless two areas of exclusive provincial jurisdiction in Canada (see other text on page 6), namely, higher education and health care. That is also why for three years we have been presenting our reports on CBD to the CMQ to raise its representatives' awareness of the negative impact of this model on medical education in Quebec. For three years, the CMQ has continued to leave it to the Royal College, which, over the years, has filled the void left by the *Collège*, with the result that the CMQ is in danger of losing its expertise in this area. That is why the uniformity of medical education across Canada is now presented to us as inevitable, whereas that was above all a political choice made by the *Collège* 15 years ago. A choice, indeed, that was made without any real political debate beyond the restricted circles of those initiated into the medical world.

Also, for three years now we have been submitting our reports to the medical faculties in Quebec and elsewhere in Canada. And for three years they have been congratulating us on our reports and sharing some of our reservations. But in their ability to act they still all too often face barriers from leaders of our programs who now talk together outside the university framework on a national basis through different channels, primarily including the Canada-wide program committees set up by the Royal College.

Thus, between the Royal College, which pretends to listen to us and does everything to limit the scope of our observations, a *Collège des médecins du Québec* completely disengaged from this issue, and medical faculties limited in their ability to act, who is still left to help us mitigate the negative impact of CBD on resident doctors?

A major effort is, however, more necessary than ever if the situation is to be rectified and the feeling of pedagogical futility we all feel with respect to CBD is to change. It is essential that the negative impact of the first years of CBD implementation on a generation of resident physicians already on the verge of burnout be minimized.

[3] The term "entrustable professional activities" is rather vague in English, but is nevertheless considerably clearer than its official French translation, "*activités professionnelles confiables*" (APC).

It is high time the CMQ and the Quebec government, including the Ministry of Health and Social Services (MSSS) and the Ministry of Higher Education, became involved in this issue. Complete cohorts of resident doctors could potentially be delayed in starting out in practice owing to CBD. This could translate into patients without access to appropriate care.

The FMRQ is currently evaluating all options, including legal action, should a strict application of the flawed mechanisms of CBD translate into resident physicians' inability to enter practice.

Let us now at the very least invite the bodies associated with postgraduate education in Quebec, including the *Collège des médecins*, to make tangible efforts to fight against the detrimental impact of a pedagogical model that has all the makings of a collective failure.

RESIDENT DOCTORS' VIEW OF CBD, ACCORDING TO A WORD CLOUD FROM OUR 2019 REPORT

In line with the principles set out in our **Policy for Socially and Ecologically Responsible Action**, *Le Bulletin* de la FMRQ is no longer mailed automatically to all members. An electronic version will be accessible at all times via the mobile app and on the website.

If you want to continue receiving or not *Le Bulletin* by mail, write us at **bulletin@fmrq.qc.ca**.

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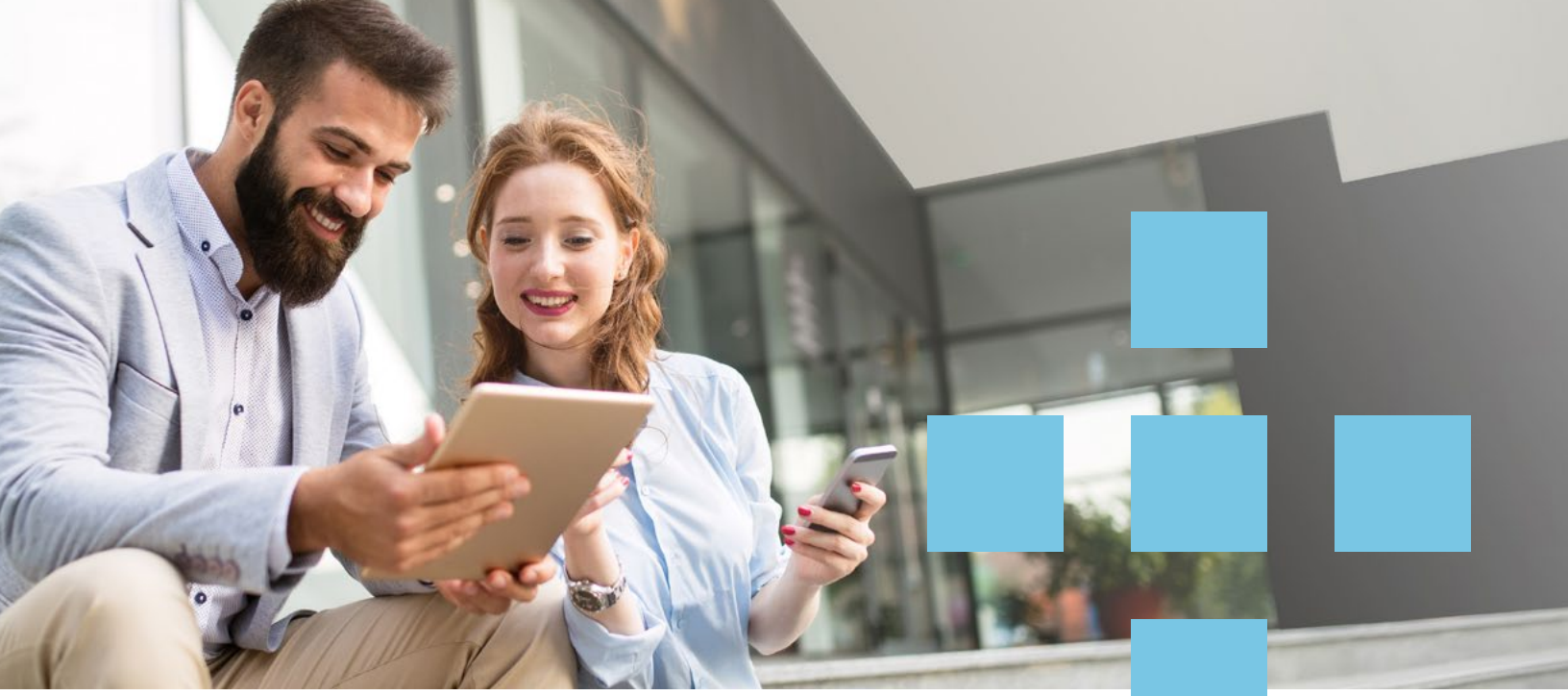

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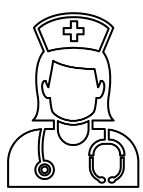
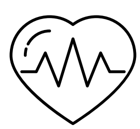
Si vous êtes tentés par l'expérience, veuillez communiquer avec Dre Nathalie Boulanger, directrice des services professionnels (nathalie.boulanger.med@ssss.gouv.qc.ca). Et mettre Josée Lambert (josee.lambert.rr17@ssss.gouv.qc.ca) en c.c. svp.



1 POSTE EN PÉDIATRIE



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CENTRE DE SANTÉ INUULITSIVIK
Dr Gabriel Chouinard
et Dre Margaret-May Raymond
Co-chefs du département de médecine générale
chefferie.med.csi@ssss.gouv.qc.ca

CENTRE DE SANTÉ TULATTAVIK DE L'UNGAVA
Dr David Saab
Chef du département de médecine générale
chefferie.med.cstu@ssss.gouv.qc.ca

POUR DES RENSEIGNEMENTS GÉNÉRAUX SUR LA MÉDECINE FAMILIALE

Dre Geneviève Auclair
Chef du DMRG
genevieve.auclair@ssss.gouv.qc.ca
Et mettre Josée Lambert en c.c. svp.
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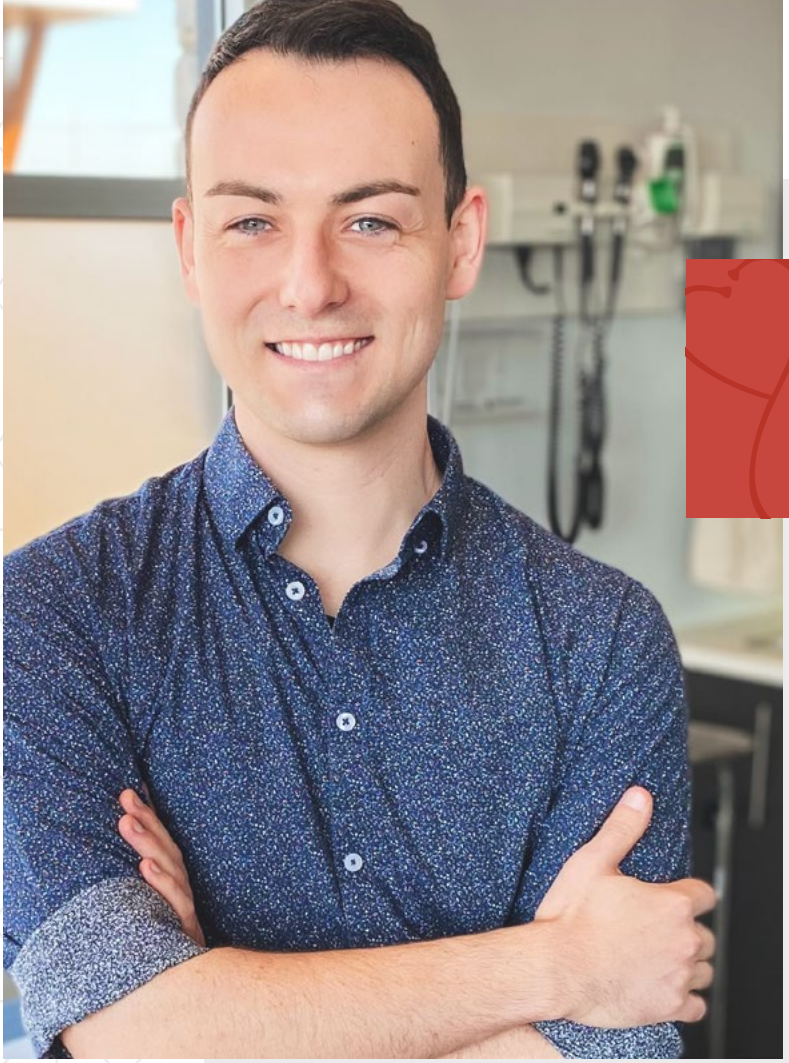

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