LE BULLETIN

VOL. 45 NO. 2 WINTER-SPRING 2023

Triple C – CBD
EPAs, milestones, observations

UPDATE ON COMPETENCY-BASED PEDAGOGICAL APPROACHES IN QUEBEC

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC

AVAILABLE POSITIONS

PAGES 24 TO 43

TABLE OF CONTENTS

Return undeliverable Canadian addresses to:
FMRQ 510-630 Sherbrooke Street West, Montreal, QC H3A 1E4
Tel.: 514-282-0256 or 1-800-465-0215
www.fmrq.qc.ca – info@fmrq.qc.ca

ISBN/ISSN: Canada Post Publication Agreement 1484699

COMPETENCY-BASED APPROACH IN MEDICAL EDUCATION: A HARMFUL PARADIGM SHIFT IN SPECIALTIES OTHER THAN FAMILY MEDICINE

Dear Colleagues,

Competence by Design (CBD) and its impact on the quality of training in the programs where it has been introduced demands special attention, particularly from members in specialties other than family medicine. While the family medicine curriculum evolved toward a new competency-based approach, known as Triple C, some 10 years ago, to virtually no fanfare, CBD has provoked a wave of discontent and concerns in the past few years from the resident doctors subjected to it, who note significant inconveniences and no pedagogical gain. That is why CBD was the theme of 2022 Resident Doctor Day, a yearly Federation event attended by 775 resident physicians.

As you will see from this *Bulletin*, CBD, that pedagogical approach being gradually implemented since July 2017, has since been the topic of numerous discussions, meetings with the different authorities concerned, worries, and significant additional stress among resident doctors, and an ongoing process of monitoring by the FMRQ aimed at gathering comments from members subject to CBD.

We have met on several occasions with the medical faculty deans and associate deans for postgraduate medical education from Quebec and other medical schools in Canada. Indeed, I had the opportunity to present the findings of our survey on pedagogical interactions between resident doctors and teaching physicians in this new CBD context to participants at the most recent Canadian Conference on Medical Education (CCME), and we have presented the data to the different Quebec partners involved in medical education, too.

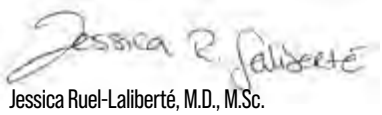
We have also been in touch on several occasions specifically with the *Collège des médecins du Québec* (CMQ) and the Ministry of Health and Social Services (MSSS) to make them aware of the situation, but also to seek their support in our struggle for better harmonization of the positive elements of the competency-based approach with the tried and true traditional pedagogical approach in our training sites, based on learning through coaching within the framework of medical education of pre-determined duration through the tangible delivery of direct care to patients.

At a recent meeting, on December 15, 2022, the principal key players in this regard in Quebec—our four medical faculties, the CMQ, and the FMRQ—met with executives of the RCPSC to provide a refresher on the main difficulties and challenges encountered in training sites with the CBD method, as designed by the Royal College, and to stress that only a major change in approach can lead to CBD being a positive shift, that being clearly far from the case at present. As this *Bulletin* went to press, the RCPSC was to launch open consultations toward a version 2.0 of CBD, but we hope that this time, their leaders will listen to those experiencing on a day-to-day basis the effects of this pedagogical approach and will avoid proposing merely a version updated in terms of form but built on the same basic concepts for teaching and assessing medicine that have never had a solid scientific basis.

I hope the content of this *Bulletin* will provide food for thought on the pros and cons of CBD and the other competency-based pedagogical methods.

In closing, I reiterate my hope that at the FMRQ, we can always defend an improvement in the quality of our training. We are not against change—far from it—but in favour of changes that bring improvements, and the implementation of CBD has clearly shown that it is not always necessary to do away completely with the existing system in order to enhance it. Let us keep the best of the traditional approach based on genuine coaching, and the more positive aspects of CBD—including the identification of the tangible competencies to be developed during residency—so as to meet the goal we all share of enhancing the quality of medical education.

I take this opportunity to thank all the members who have contributed to the success of our actions, whether in responding to our numerous surveys or participating in the interviews that were held in the past few years. It is as a result of your contribution that we have been able to draw up an accurate profile of the quality of your training and your interactions with your staff physicians. Thank you, also, to fellow Board members, delegates, including the members of the two Academic Affairs Committees (Specialties, and Family Medicine), and the permanent staff who support our steps to improve our work and learning conditions on a daily basis.



Jessica Ruel-Laliberté, M.D., M.Sc.
President

1.

INTRODUCTION

In this *Bulletin*, the *Fédération des médecins résidents du Québec* (FMRQ) aims to provide an update on the competency-based approach progressively introduced since July 2017 by the Royal College of Physicians and Surgeons of Canada (RCPSC) in all Canadian medical schools, through Competence by Design (CBD), and 10 years ago by the College of Family Physicians of Canada (CFMC), using the *Triple C* model.

While Triple C appears to integrate smoothly with the family medicine curriculum, CBD has led to numerous difficulties in training sites, particularly for resident doctors who were since rushed into the venture, but also for teaching physicians, medical faculties, and several other system stakeholders sustaining the impact of the rushed implementation of this pedagogical approach that has no recognized scientific basis, at least in medicine.

The following pages contain personal accounts and interviews, as well as the findings of a recent study on CBD conducted by independent researchers.

There is an article reflecting the personal experience of two doctors, one of whom, anesthesiologist Dr Vincent Gravel, was under CBD from the start of his residency, and the other, former FMRQ President, Dr Olivier Fortin, who did his entire residency under the traditional model, but is very familiar with CBD, having put forward the FMRQ's position on it in various forums over the past few years. This article sheds unique light on the perception of this pedagogical approach on the ground.

We invite you to pay special attention to two interviews we conducted for this *Bulletin*. The first concerning the transition of training in family medicine to a competency-based approach geared to that discipline a little over 10 years ago, Triple C, has received much less attention, and seems to have been integrated much more smoothly. For an update on the competency-based approach in family medicine, we talked with Dr Gilbert Sanche, a family physician who teaches at the Marigot UFMG in Laval and is a clinical professor at the University of Montreal, who had a front-row seat for this transformation.

The second, with educational consultant and lead researcher Christian Boyer, concerns CBD. His study, *Analyse critique d'un changement de paradigme pédagogique dans le cadre de la résidence en médecine au Québec*, co-authored with professors Steve Bissonnette and Frédéric Morneau-Guérin, of the TELUQ Department of Education, and philosopher and essayist, Normand Baillargeon, also a columnist at *Le Devoir*, was published in September 2022. The English version, *Critical analysis of a pedagogical paradigm shift in medical residency in Quebec*, was released in March 2023. The study pinpoints an essential element of this new approach as deployed by the Royal College, namely, that there is no scientific evidence to support it.

TRIPLE C

The Triple C Curriculum was developed by family medicine programs in Canada in the early 2010s. Its purpose was to create a curriculum based on the development of competencies in family medicine aimed at **comprehensive** care, geared toward **continuity** of care and learning, **centered** on family medicine, whence the name of Triplex C Curriculum based on development of competencies.

Initially, learning in family medicine (FM) was intended to be a series of rotations in other specialties aimed at exposing residents to the largest amount of varied knowledge, and not the learning of competencies specific to the practice of FM. The introduction of Triple C was carried out on the basis of a recommendation to family medicine programs from the College of Family Physicians of Canada (CFPC), but not through the imposition of the curriculum on programs across the country. The idea of introducing a competency-based approach originated with the training sites, and was ratified subsequently by the CFPC.

Implementation of Triple C made far fewer waves than deployment of CBD. Triple C was introduced much more smoothly in training sites. Of course, training in FM is spread over two years of residency, rather than five or more years in other specialties, but the fact remains that integration of Triple C was carried out completely transparently, and apparently seamlessly.

CBD

Competence by Design (CBD) is an initiative of the Royal College of Physicians and Surgeons of Canada (RCPSC), and has been introduced progressively in all Canadian medical schools, in specific specialties, starting in July 2017. The stated goal of CBD is to normalize, indeed systematize, the competencies to be acquired in all specialties other than family medicine. To begin with, this method even proposed reducing the duration of postgraduate medical education on the basis of the acquisition of the different competencies. That proposal is no longer mentioned by the initiators of CBD, but there is nothing to say it has been completely removed from the picture.

According to the Royal College, CBD is a hybrid model of the competency-based approach adapted to the Canadian medical education system. Competencies to be acquired are grouped together in a framework and structured progressively. Also, under CBD, responsibility for planning clinical exposure and learning of competencies essentially falls on resident doctors, who have to plan and complete entrustable professional activities (EPAs), and then have them approved by their staff physicians, within a more or less defined time frame, to meet the objectives they are given at the start of the year or rotation.

2.

CHALLENGES OF GOVERNANCE IN MEDICAL EDUCATION

Since the introduction of Competence by Design (CBD) in postgraduate education sites in Quebec, the FMRQ has continually reminded the various medical education stakeholders that health and education, including higher education, are under provincial jurisdiction in Canada, and that this constitutional fact involves issues all too often ignored by some of our partners, who take for granted the feasibility of Canada-wide initiatives without taking those jurisdictional factors into account. When they see these issues at all, they often see them as merely red tape limiting their action rather than part of the real dynamics of Canada's federalism and its Constitution, regardless of anyone's political views on the topic.

When we lobby organizations associated with your training in the faculties and healthcare establishments, or the *Collège des médecins du Québec* (CMQ), College of Family Physicians of Canada (CFPC), and Royal College of Physicians and Surgeons of Canada (RCPSC), issues of jurisdiction come up constantly. Does the situation require lobbying of the program, faculty, university, or healthcare establishment? Is it an issue that comes under the jurisdiction of the *Collège des médecins du Québec* or a Canadian college? If we were to take legal action, under which court or which judicial body would the proceedings take place, and on which statute or regulation would they be based? The answers to these questions are sometimes complex, and the questions are never merely a matter of red tape, as some individuals who are leading important organizations involved in the world of medical education appear—mistakenly—to believe. We grant that questions of jurisdiction may seem abstract or theoretical, but the day they are asked in the context of disputes potentially transferred to a courtroom, they may then be seen to be very real, and tangible, with significant consequences, if they have not previously been treated seriously.

Even with partners representing well-established organizations such as the *Collège des médecins du Québec*, we sometimes see shortcomings in terms of knowledge of the jurisdiction applicable in matters we are involved in. For other organizations, such as the Canadian colleges, their representatives may sometimes be well aware of jurisdictional questions, but it can be to their advantage politically to act as if such questions did not exist, so as to broaden their sphere of action. The CBD issue is unfortunately the prime example of this. The question of how teachers associated with a university in Quebec should teach or how they should assess resident doctors is a matter, legally speaking, for which no authority other than the university itself is responsible.

Another example: the criteria for entitlement to a permit to practise medicine in Quebec cannot be determined by an authority other than the legally empowered professional corporation—or the CMQ in the case of Quebec. But over time, as we explained in a previous issue of the *Bulletin*, in spring 2021, on the theme of the requirements for practising medicine in Quebec (see page 5, *In medical education, who has the real authority to decide?* and page 8, *Who does what*), various political dynamics have meant that certain partners in Quebec have partly abandoned the exercise of their jurisdiction to other organizations who actually have no legal basis for their action in Quebec (nor often any stronger a basis in the rest of Canada). This is the case for the Canada-wide colleges, such as the Royal College of Physicians and Surgeons of Canada (RCPSC), which have no legal authority for imposing anything whatsoever in medical education in Quebec, except if our medical faculties (in fact, our universities) or the *Collège des médecins du Québec* want them to, and ultimately, if the Quebec government expresses no objection to it. But our medical education leaders in Quebec still need to be very aware of this legal reality, and they have to be prepared to exercise their jurisdiction fully. Otherwise, we end up with the situation we have been seeing for the past several years: other organizations will actually take up the empty space, since as nature abhors a vacuum, so does the political world. And one cannot blame these organizations that fill in these abandoned political spaces, they are simply defending their interests.

On the other hand, we can nevertheless wonder about this reality: when the leaders of our organizations sometimes put convenience or easy solutions ahead of responsibility ("oh, the Royal College – or the College of Family Physicians of Canada – will take care of it, it'll be easier that way!"), are they defending the interests of their organizations properly? These questions come under governance, and we are convinced that systems function more effectively when their components properly play the roles legally assigned to them and take on their responsibilities fully. This should go without saying, in the world of medical education as well, but sadly that is not always the case. It is these principles of sound governance that we defend at the FMRQ in matters affecting our members. Our lobbying is never aimed at hampering or slowing the development of initiatives, but when we raise such questions concerning jurisdiction, it is in order to ensure that the foundation is solid, in the interest of long-term success.

As we have already stated, if our medical faculties and the CMQ (along with the MSSS) had really done their homework properly when the RCPSC sold its pedagogical revolution—CBD—in around 2015-2016 to all stakeholders in Canada, we might possibly have avoided the botched implementation that ensued in 2017 and even possibly contributed to making it something that was more finely constructed. But some partners placed blind trust in a third-party organization that was, however, much less close to the realities of our training sites, choosing to just let it happen and become mere bystanders.

For nearly three years now, the CFPC has been proposing to add a mandatory third year of residency in family medicine, and we have seen the same players from the same Quebec organizations preparing to repeat the mistake they made with CBD, by giving the CFPC the go-ahead without performing any serious analysis. But we alerted the MSSS in time, and committees to analyse the feasibility of the measure have finally been set up in Quebec. So we are improving collectively, but poor attitudes remain—for instance, we recently heard partners claiming that we will have to wait for the CFPC to decide on the content of a potential additional third year to analyse the proposal properly. As if no one in Quebec, in our family medicine programs or at the CMQ, had any views on this topic, and that they had to depend on the work of an organization whose mandate should not even be to decide what our future family physicians should or should not learn in the context of their postgraduate education.

But let us look on the bright side, telling ourselves that best organizational governance practices, which should include an understanding of the important questions of jurisdiction, are increasingly well known and taken into account. That may clearly lead to more consistent action and more effective interaction between the different organizations that have to hold discussions about shared objectives. The FMRQ will continue to call for issues associated with improving the quality of postgraduate education to be treated with all the rigour that the importance of such a matter supposes for Quebec's resident doctors.

3.

TRIPLE C: A SUCCESSFUL REFORM

COMPREHENSIVE CARE CONTINUITY OF EDUCATION AND PATIENT CARE CENTERED IN FAMILY MEDICINE

Interview with Dr Gilbert Sanche

Introduced progressively in the early 2010s in family medicine programs across Canada, Triple C aimed to respond to different challenges, including effectiveness of training, social accountability, and the global trend toward competency-based training. To meet these challenges, the Working Group on Postgraduate Curriculum Review of the College of Family Physicians of Canada (CFPC) determined that the curriculum should be aiming for comprehensive, ongoing care, be oriented toward continuity of education and patient care, and be centered in family medicine. "The Future of Medical Education in Canada project outlined the importance of linking training to community needs, learning in community contexts, exposure to intraprofessionalism and interprofessionalism, the use of a competency-based approach to education, and the importance of generalism." [1]

To understand the background to Triple C more clearly and be aware of its impact on training and on family physician instructors who were stakeholders in this change over the past few years, we talked to a doctor who took part in drawing up and implementing the curriculum, family physician Dr Gilbert Sanche, who teaches at the Marigot university family medicine group (UFMG) in Laval and is a clinical professor in the University of Montreal Faculty of Medicine.

Dr Sanche, how did you become involved in the implementation of Triple C in family medicine programs in Quebec?

In 2011, I was Assistant Director of the Family Medicine program at the University of Montreal Faculty of Medicine. With the teaching physicians, we were the trendsetters for this approach. In fact, we had already integrated several aspects of this model ahead of the regular accreditation survey of 2008. We had already seen in 2001 that the program was not perfectly adapted for training future family doctors to meet Quebecers' needs. Our key recommendation in 2001 was to move from two years of training to three years, and we lobbied to that effect until 2004. Then, because the recommendation was not taken up, we decided to reform our program's structure and pedagogy. I took up the position in 2006, notably to carry out the renewal of our program. That was the context in which the competency-based approach was adopted, first in the Faculty of Medicine, and then in our program. Between 2006 and 2008, we worked with the College of Family Physicians of Canada (CFPC) to adapt the curriculum, with Dr Louise Authier, who was project leader at that time. Triple C would appear later, in 2011. You have to remember that Triple C consists of principles concerning the structure of a family medicine residency, whereas the competency-based approach is an educational paradigm. In 2011, we had already adopted the competency-based approach as pedagogical model, and we were already following the principles of Triple C before they were formally expressed.

[1] Kerr, Jonathan et al. 2011. *Canadian Family Physician*: 57 (8) 963–¬4. "Renewing postgraduate family medicine education: the rationale for Triple C." https://www.afmc.ca/wp-content/uploads/2022/10/2012-FMEC-MD_EN.pdf

Was Quebec able to instil its vision of the competency-based approach in training sites, or was it the College of Family Physicians of Canada that made all the decisions?

The CFPC always collaborated with us on panels bringing together representatives of the different family medicine residency programs. The idea grew, we had discussions, considered changes, and arrived at the new curriculum in 2011, thinking that was what we had to put in place in our programs. All programs were allowed input into the approach. The curriculum reform was imposed, yes, but after considerable co-construction work with the medical faculties. Each faculty was able to put its own stamp on it, and bring in its own initiatives. In Montreal, the curriculum had already been constructed in that vein. It was the principle that was at the heart of the changes proposed by the program.

What problems were identified to justify the decision to revamp the training completely?

At that time there was a strong current of reflection on training in family medicine. The AFMC's Future of Medical Education in Canada (FMEC) project, which brought together many stakeholders from the education and medical system, fed into this reflection. It was in fact the starting point for the curriculum reform, at a time when the population was changing, needs were increasing and altering, particularly with respect to demographic changes, funding was no longer the same, and the mass of knowledge necessary for learning family medicine was constantly growing. Also noted was a lack of social accountability within the profession. Fundamentally, there was questioning as to whether the population's needs were being met. More importance had to be given to the educational aspect, questions had to be asked as to whether teaching was being done the right way to ensure that our future family physicians were trained properly. Some serious questioning had been going on.

How did resident doctors react? Staff physicians? How did it go in the field in concrete terms?

Triple C was implemented very gradually. We sensed no anxiety from resident doctors. Comprehensive care is part of what physicians will have to provide in their practice. Continuity of education has meant that as far as possible it is family doctors who train family medicine residents. And we emphasized continuity of care, ensuring that learners follow patients during their two years of training, bringing them an enriched experience in the field. We wanted to increase the relevance of their clinical exposure and their learning. During the restructuring, there was certainly a little pushback from teaching physicians. But, after two or three years, under the leadership of Dr Louise Authier, everyone came to agree, with respect and through listening to one another. The project was well designed and well presented, and follow-up was done properly, listening to people in the field and adapting in line with the challenges and over time.

Resident doctors in family medicine have been following the Triple C training curriculum since 2011. What are the main gains/benefits of this new competency-based pedagogical approach?

In order to rebalance training, we did away with some rotations; for instance, the General Surgery rotation, which was not very effective educationally, was replaced by a family medicine rotation. The duration and means could vary from one Family Medicine Unit (FMU) to another. Learning activities leading to attainment of the objectives of the abolished rotation, such as Surgery, that were deemed relevant for a future family doctor's practice were integrated into the family medicine rotation periods. It was in how this integration was carried out that we gave the FMUs a lot of leeway.

How was the process for implementing this measure determined?

The process was carried out for all resident doctors at the same time, both R1s and R2s, but progressively. Everyone adapted at the same time. We went about it cautiously. So everybody was able to set up the system in the same period. The approaches were a little different in urban compared with rural FMUs, but overall, everyone was on the same wavelength. We wanted to attain our goals while respecting local care missions. The competency-based approach aims to lead learners to the expected level of mastery of each competency in family medicine. But faculty rules, such as the number of periods, still also have to be followed. More broadly speaking, the objective-based approach remains for assessment of whether training is successfully completed. For the rest (teaching, learning, formative assessment), the program complies with the principles of the competency-based approach.

Are there documents, training, or specific assessments that were developed or put in place to implement Triple C more effectively?

The entire process has to be benchmarked, certainly. Resident doctors deliver varied (preventive, curative, palliative) care to patients of all ages, from newborns to the elderly.

For comprehensive care, follow-up clinics have to be offered in all FMUs/UFMGs, by appointment or on a walk-in basis, home care, inpatient care, community care, and a diversified practice.

Continuity of education and patient care translates into 2-3 days a week of follow-up on clientele, 2-3 half days, not to mention the half day back at the FMU for resident doctors on rotation outside the FMU to offer their clientele clinical availability. For continuity of education, a small number of instructors supervise resident doctors over the two years of their training, thus making it possible to help them more effectively to progress.

The speed of implementation and the model are the training site's responsibility. For instance, training sites were given one year to attain their objectives. Visits were made to the FMUs to assess the situation, but also to provide support for the physicians on site. The specifications were quite detailed, but there was considerable freedom as to the means to be used. We also created numerous baselines (competency development trajectories, entrustable professional activities, learning goals, handbook for marking assessment sheets, etc.) and provided several training sessions to accompany FMUs through the changes to be made in their local programs.

Has Triple C really changed the way you teach future family physicians?
Primary care changes over time. Family physicians now have more advanced expertise, and also deliver secondary care. There is a dearth of doctors in the other specialties, so there is a marked decrease in access to specialist physicians for referrals. With Triple C, future family doctors are allowed to broaden their practice, adapting it to the needs in the field.

How is Triple C managed now? Are there reports to be produced? Still changes to be made? Are there competence committees as there are for resident doctors in the other specialties?
Each FMU assesses its resident doctors, whether through formative or summative evaluations. But the final pass or fail decision on a rotation is not made by the local committee. It is the central Competence Committee that decides on progression and successfully completed rotations. Note that this process stems from a faculty rule introduced in 2006, prior to the educational reforms, and applies for all University of Montreal residency programs. The central program committee manages pedagogical directions and ensures that they are complied with, while local program committees in each FMU are responsible for local application of central committee requirements and for reporting on that.

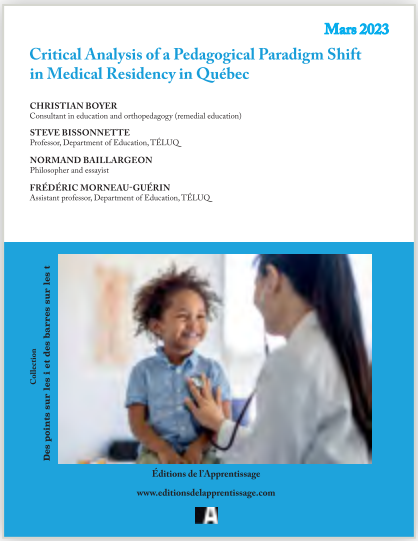
Will Triple C change over time? Do you see any significant changes to be implemented in the next few years?
We are always striving to improve. Reflection on pedagogy is constantly evolving. It takes place both in the university programs and at the College of Family Physicians of Canada, most often in close collaboration. I believe the basic principles of Triple C are still helpful and relevant for structuring a curriculum path in family medicine, and that they are here to stay. But certainly periodic questioning of the quality of our program and ongoing pursuit of best educational practices will lead to changes that will improve the quality of the training we provide for our residents.

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 do not wish to continue receiving *Le Bulletin* by mail, write us at **bulletin@fmrq.qc.ca**.

4.

COMPETENCE BY DESIGN (CBD): COMPARATIVE ANALYSIS BY INDEPENDENT RESEARCHERS



On September 13, 2022, Éditions de l'Apprentissage published *Analyse critique d'un changement de paradigme pédagogique dans le cadre de la résidence au Québec*, which appeared in English in March 2023 as *Critical Analysis of a Pedagogical Paradigm Shift in Medical Residency in Quebec*. This document analysed the emergence of competency-based education (CBE), which led the College of Family Physicians of Canada (CFPC) to put *Triple C* in place 10 years or so ago, and the Royal College of Physicians and Surgeons of Canada (RCPSC) to promote and initiate *Competence by Design* (CBD) in training sites in the other specialties, across Canada. Deployment of CBD began on July 1, 2017, and has been implemented progressively since. The analysis was drafted by Christian Boyer, educational consultant, and his colleagues, Steve Bissonnette, Professor in the TÉLUQ Department of Education, Normand Baillargeon, philosopher and essayist,[2] and Frédéric Morneau-Guérin, Assistant Professor in the TÉLUQ Department of Education.

What some independent researchers think of the competency-based approach

We had the chance to talk with Christian Boyer, the report's lead author, to discuss the conclusions of the team of researchers concerning CBE and its implementation in the field of medical education, which we share with you below.

Christian Boyer

Frédéric Morneau-Morin

Christian Boyer, can you first give us an idea of the origins of medical residency?

In 1889, Dr William Halstead, the first Professor of Surgery at Johns Hopkins Hospital, inaugurated medical *residency*, based on the gradual attribution of responsibility for performing medical acts. The formula was summed up in the expression "see one, do one, teach one." For more than a century, this training model has defined medical residency in the West. In 1910, a report dealing with the training of physicians in the United States and Canada was released by Abraham Flexner, an American educator known for his role in the reform of medical and higher education in the 20th century in the USA and Canada. The Flexner Report was influenced by Germany's rigorous medical system, and favoured raising requirements.

[2] Normand Baillargeon has PhDs in both philosophy and education. For more than 20 years a professor at UQAM, focussing on the foundations of education, he is an Emeritus Member of the Quebec Order of Excellence in Education.

Medicine based on scientific evidence had taken root in the mid-19th century, promoting the use of the best available scientific evidence in decisions concerning the care delivered to patients.

How did your group set about analysing the impact of the change proposed by the Royal College of Physicians and Surgeons of Canada (RCPSC), namely, the Canada-wide implementation of Competence by Design (CBD) since July 2017?

After familiarizing ourselves with the issue of CBD in postgraduate medical education sites in Quebec and elsewhere in Canada, we conducted a literature review, and selected 275 articles and papers dealing with the competency-based approach in education, out of a total of 17,000 identified at the outset. In light of the data we analysed, which comes from all over the world, we focussed our research on different subjects, including the history of medical residency, the birth of competency-based education (CBE), self-regulation, adverse medical events, medical certification, lifelong learning, impact of the RCPSC's CBE (CBD) in residency, ePortfolio, and different types of pedagogy (e.g., deliberate practice, mastery learning, etc.) which sometimes operate alongside CBE. We drew the parallel between general education and medical education, and consulted quantitative data on the impact of CBE in both fields of application (general and medical education).

What conclusions did your research lead you to on CBE in general, and more specifically Competence by Design, particularly in a context of medical education?

In the 21st century, the content of medical education clearly favours evidence and rigour. CBD is a direct descendant of CBE, which emerged around 1957. Today, this current is to be found in general education (elementary, secondary, and post-secondary), vocational education, and medical education. But, to judge by what we observed in the published experimental research, CBE, in both general education and medical education, is not backed by any evidence. In the case of CBD, a type of CBE pedagogy, the RCSPC neither built on evidence from scientific research, nor put in place a rigorous process for monitoring the impact on resident doctors and patients in its widespread application. In our view, by proceeding this way, the Canadian and Quebec medical world has moved away from its usual rigour and caution with respect to medical innovation.

How is Competence by Design different from the family medicine approach known as Triple C?

CBE as applied to family medicine in Canada and Quebec uses, among other things, a concept of key competencies rather than the concepts of entrustable professional activities (EPAs) put forward by CBD to describe the professional competencies to be acquired. To judge by the documents we consulted, Triple C appears to be more flexible in its structure and application, and this also comes across in the FMRQ's surveys. On the other hand, CBD and Triple C are not evidence-based at the outset, and have still not objectively shown their positive impact beyond perceptions and opinions.

Wasn't your judgment of CBD and CBE (which underpins CBD) rather harsh?

Yes. But you have to be harsh, like the judgments after more than 140 COVID vaccine projects were abandoned because they did not deliver the anticipated effects. I would remind you that even the Institut Pasteur in Paris failed in this!

To date, no doubt more than 90% of the articles that have been published on the competency-based approach in education have not been scientific papers, but are comments on the question. In our view, CBE was introduced in medical education without any scientific basis. But we are not the only ones to hold this view. Through our research, we identified numerous authors and researchers in medical education who pointed out as early as the end of the 20th century that the introduction of CBE in medicine was being caried out without the support of evidence justifying it. Also, in Canada and Quebec, the RCPSC and the *Collège des médecins du Québec* still have not, in 2023, performed any rigorous follow-up on the impact of CBD on residents (skills and performed + workload and psychological state), or on patients. In our view, it is essential to evaluate the impact of CBD on the quality of the healthcare services delivered by resident doctors when they start their practice, and this does not appear to have been done.

The FMRQ for its part has monitored developments in the deployment of Competence by Design (CBD) since it was first introduced in July 2017. Unfortunately, it appears to be the only body in the world of education and the medical world systematically to have polled its members on the question.

The available evidence is scattered and quite insufficient for CBD in medical residency to be considered to have a solid, scientific basis. Its usefulness, particularly in the version implemented by the RCPSC, has yet to be demonstrated. Curiously, the medical world does not apply the same rigour in choosing and monitoring educational methods as it applies in medical training for the advancement of knowledge and delivery of medical treatment.

Could the competency-based approach not be a tool more for learning technical skills (in surgery, for example) than for medical knowledge and acts in non-surgical specialties?

To date, as we do not have sufficient data, there is nothing to allow us to confirm the effectiveness of CBD in one specialty more than another. That being said, can the data observed in Orthopedic Surgery, for instance, be extended to other programs, such as Neurosurgery or Psychiatry? We do not know. One can envisage CBD being relatively effective in Orthopedic Surgery, not very effective in Neurosurgery, and totally ineffective in Psychiatry. Everything is theoretically possible.

What do you think of the ePortfolio as an assessment tool?

The electronic portfolio or ePortfolio increases the variability and inaccuracy of assessments. And, to date, studies do not allow us to say whether the ePortfolio is more effective than any other assessment method, and many studies indicate the heavy load involved in applying it that does not necessarily lead to an objective (and not a theoretical) benefit. Indeed, fortunately several programs are continuing to use the traditional assessment model to complement the suggested model under CBD.

CBD has often been associated with a pedagogical method that would enable resident doctors to complete their postgraduate education more quickly. Have the studies corroborated this premiss, as promoted by the RCPSC?

Not at all. The only studies conducted on this topic in Canada looked at a limited number of participants, sometimes even fewer than 10, in a favoured context. This "promise" announced at the start of implementation of CBD in Canadian medical faculties has not been confirmed at all by the medical faculties, or by the provincial governments, which largely fund medical residency.

Christian Boyer, you analysed the studies conducted by the *Fédération des médecins résidents du Québec* in your report. What did you find that enables you to grasp more clearly the current situation in our postgraduate education sites?

We observed that implementation of CBE as formulated by the Royal College appears to have been difficult in most training sites in Quebec. Despite some improvements introduced over the years, it remains ill-perceived by resident doctors, whether in their first or their final year of residency. Also, one of the most important objectives associated with this reform, enhanced feedback, is not being seen, despite being absolutely essential to all learning. The psychological burden imposed on resident doctors, who have to "pester" their supervisors to have them assess residents' EPAs is another issue that goes beyond the interest the supporters of CBD probably want, wishing to make resident doctors more accountable for their own academic paths. Even after five years, resident physicians unfortunately still cannot see the benefits of this.

Which weaknesses of CBD do you see emerging from the FMRQ's studies?

Currently, to judge by the personal accounts gathered from resident doctors in Quebec and the other studies consulted, CBD does not save time, but rather involves time wasted by learners, by imposing on them the need to run after their evaluators to have assessment sheets and the ePortfolio completed. No pedagogical benefit is seen from this at the moment in terms of acquisition of knowledge. Moreover, CBD entails additional mental overload for resident doctors on a day-to-day basis, not to mention their fear of being unable to sit their exams if they do not complete all the entrustable professional activities (EPAs) in the time required.

In conclusion, what are the next stages in evaluating CBD?

The implementation of Triple C in family medicine was viewed much more positively than the introduction of Competence by Design (CBD), although neither of these two versions of medical CBE is built on past or present evidence. It is also a matter of concern that we were unable to identify any publications evaluating the impact of CBD from the medical faculties, the Quebec Ministry of Health and Social Services (MSSS), or the *Collège des médecins du Québec*. The *Collège* appears to have ceded responsibility for pedagogy and medical training in Quebec to the Royal College. And what do the Ministry of Higher Education have to say about it? Do they have only one opinion based on data? Finally, why, aside from the FMRQ, have resident doctor associations elsewhere in Canada not been more proactive on this issue?

We believe changes in medical education have to be evidence-based, building on objective measurements of their impact (resident doctors, patients, etc.), and ongoing, rigorous monitoring, as is the general practice in the medical world.

We repeat: it would have been and still remains essential to measure the learning targeted, the impact on patient care, clinical results, and the decrease in adverse medical events. Has quality of care improved? Has the rate of adverse events fallen?

What is the purpose of a paradigm shift if the impact on the weaknesses one is seeking to correct is not measured? In our view, priority should go to investing in types of medical education that have begun to yield useful, evidence-based data, such as *mastery learning*, *deliberate practice*, and *competency-based progression*. In short, future pedagogical changes in medical residency should be carried out with the medical world's usual caution.

You may consult the study by C. Boyer et al **here**, and on the FMRQ website, in the Postgraduate Training section under Competence by Design.

COMPETENCE BY DESIGN (CBD): COMPARATIVE ANALYSIS BY INDEPENDENT RESEARCHERS

CBD IN THE MEDIA

Last fall, Competence by Design (CBD) was front-page news in *Le Devoir*. Two articles and an editorial highlighted the failures of this pedagogical approach. On September 3, 2022, in an article entitled *Levée de boucliers contre la formation des médecins spécialistes* (Outcry against specialist physician training), journalist Marco Fortier restated the Federation's position that this educational reform was improvised and detrimental to learning by the medical profession, the goal of this operation being to foster feedback from instructors to their students. The author pointed out that CBD brought with it a lot of red tape that was exhausting for students and generated anxiety.

On September 13, 2022, Mr Fortier wrote a second article entitled *Nouveau coup de semonce sur la formation des médecins* (Wake-up call concerning doctors' training), announcing the publication of a study by a group of education experts which showed that the competency-based pedagogical method put in place in 2017 for residency training was not tried and tested and was based on no scientific evidence. One of the authors, Christian Boyer, emphasized in an interview that "far from being a success, this method is an example of how not to do things." We invite you to read our interview with Mr Boyer in this issue.

A few days later, on September 16, *Le Devoir* editorialist Louise-Maude Rioux-Soucy had an article published, entitled *Les Cobayes* (Guinea pigs), in which she called out the Legault government for maintaining complete "radio silence" concerning the disastrous reform in residency education. She agreed with the FMRQ that cultural shifts take time and that the goals underlying this reform should not be completely scrapped. Ms Rioux-Soucy also stressed that this entire approach brought only zero pedagogical gain along with a heavier emotional cognitive burden, and she described resident doctors as the guinea pigs in a failed educational experiment. She concluded her editorial by saying that building a plane when it is already up in the air always involves a certain degree of risk. For five years, they have been working hard, in vain, to cobble together a reform, when all the indicators are flashing red. The solutions, stated Ms Rioux-Soucy, will not come from the Royal College, which cares nothing about the Quebec exception, and often has a very poor understanding of it. It is time Quebec took back control, she concluded.

5.

CBD DAY TO DAY – PERSONAL ACCOUNTS

CONSEQUENCES OF THIS NEW PEDAGOGICAL APPROACH ON PHYSICIANS IN TRAINING

In the following pages, we present personal accounts concerning their perceptions of CBD from two former colleagues now in practice: former FMRQ President, Dr Olivier Fortin, who trained in Pediatric Neurology at McGill University, and Dr Vincent Gravel, an Anesthesiologist trained at Laval University. Dr Fortin followed a traditional (time-based) program, not under CBD, while Dr Gravel was one of the very first guinea pigs, having started his residency under CBD in 2017, when only two programs were targeted by that pedagogical approach—Anesthesiology, and Otolaryngology/Head and Neck Surgery. Both doctors were asked about their academic paths, and the influence of the pedagogical approach adopted in their respective programs on the quality of their training, and its impact on their preparedness for their certification exams and their practice. Note that the interviews were carried out while they were both still residents.

DR OLIVIER FORTIN

Dr Fortin, you work 70-80-hour weeks—like most of your colleagues. Tell us about your relationships with your staff physicians on the pedagogical front. Do you see them primarily as assessors, coaches, or observers?

Regardless of the method, there are marked differences between small programs and those with many residents. My program was smaller, so the path is less complex. To start with, of course there is a forced hierarchical order, but as you acquire knowledge and become more self-confident over time, it gets easier. Staff physicians are not coaches. Rather, they are assessors and supervisors. Over the years, the relationship evolves, you feel there is respect, and staff physicians become more like colleagues by the time you reach the final year of residency.

What are the strengths and weaknesses of the traditional, time-based approach?

Personally, I benefitted from the traditional, time-based system of training, in a highly niche program, where there are very small numbers of resident doctors in each cohort. I'd like to stress the strength of the time-based education system, which has existed for years and works well, and produces very good doctors, who have passed their exams and enter practice to serve the public. But the traditional system also has weaknesses: the principle of coaching is often missing from it, everything depends on the supervising teaching physicians. Clinical responsibilities are assigned on the basis of time spent in residency, and not always in line with the individuals' capabilities in the program.

Did you experience a great deal of stress during your training?

Late in my R2 year and early in R3, I hit the wall. I had acquired competencies, but could see I still had many to learn, and I was already thinking about the fellowship I wanted to do. I took some control therapy, and that helped me get through those difficulties. Today, I feel more solid, more confident, and I am being given more responsibilities.

Looking at your colleagues under CBD, what do you think of that approach?

I'm very familiar with CBD, even if it's from the outside, because I helped follow up with the faculties and the Royal College on the failures of this major change in the sites where medicine is taught, when I was Director responsible for Academic Affairs – Specialties (2019-2020), then President of the *Fédération des médecins résidents du Québec* (2020-2021). I also think my R1 and R2 colleagues who are currently under CBD are more stressed.

"CBD is all-consuming. It's also harder to find a position (PEM), additional training is increasingly required, they feel they're heading straight for the wall. It's inhuman!"
– Dr Olivier Fortin

What advice would you have for a resident doctor training in a program based on the traditional model?
I would tell them to find one or two mentors who can accompany them in their academic and clinical path, and help them understand how it works. That would make the training more positive. I try to do that as much as possible with my juniors, and I'll carry on that way when I start my career in a university setting.

DR VINCENT GRAVEL

Dr Gravel, you were part of the first cohort to have been trained entirely under this new pedagogical approach in Anesthesiology, along with R1s in Otolaryngology/Head and Neck Surgery starting in 2017-2018. Please tell us briefly what CBD represents for you.
CBD consists of different pre-set steps allowing junior candidates to progress toward a more advanced stage in their training, and thus to become seniors. The medical acts and other clinical activities such as management are rated, which make it possible to tell whether a doctor is competent, and can do everything without the help or presence of a staff physician in the operating room, with respect to his or her specialty. Assessments are based on the Ottawa Surgical Competency Operating Room Evaluation, or O-SCORE. Learning under CBD occurs through repetition, following different steps.

The number of EPAs to be carried out is very high, Dr Gravel stresses, sometimes as many as 100. Some residents are threatened with having to redo rotations, and thus seeing completion of their residency delayed, or not being able to attend the certification exam.

"I had no choice but to jump into the CBD arena and switch my mind into *Hunt Down The EPA* mode" – Dr Vincent Gravel

I had to search for where I could do entrustable professional activities (EPAs) and have them assessed so as not to be hassled on a day-to-day basis by staff physicians because I hadn't done enough of them. In my view, each resident doctor should in theory move forward at his or her own speed. My reality in Anesthesiology is different from my colleagues in other disciplines. We are always matched with a staff physician. But there are a very large number of EPAs. Sometimes you have to repeat the same action 25 times before obtaining the EPA. We have to tell our supervisors: "You have to observe and assess me, because the clock is ticking."

"When these demands are added to the number of acts we have to carry out, it becomes a mountain which for most resident doctors seems insurmountable" – Dr Vincent Gravel

This assessment model involves an academic task that is not much appreciated by staff physicians. As an approach, it contrasts greatly to when a staff physician tells you what he or she would have done in the same situation so you can improve.

How are your relationships with your staff physicians? Are they open to assessing EPAs?
Absolutely not! The Royal College of Physicians and Surgeons of Canada, which is behind this pedagogical turn, offers little incentive to require staff physicians to assess EPAs. Here as a resident doctor you're faced with a structure where you have 100 or so EPAs to carry out, and the staff physicians will see no more than 15 or 20 of them at most. It's extremely hard to get what you need with EPAs.

Another element is assessment by staff physicians. You said you were pushed to perform the activity without them intervening, whereas the Royal College says that should be coaching?
That vision's a complete aberration. For instance, when I was a senior Anesthesiology resident, there was a rare situation which, by definition, I won't be exposed to 200 times during my residency. It's rather unrealistic to ask a resident doctor, who's going to see a situation 5-10 times during their residency, to pretend to demonstrate competency in that act. Resident physicians will benefit far more when the staff physician who's present is invested in the situation, gives the learner tips, and takes part with them as a colleague. Even if, as a senior, the goal is for staff physicians not to take part in the activity that the resident wants to acquire to confirm an EPA, if he doesn't obtain it, he'll be rapped on the knuckles.

"Where's the in-person feedback in this method? It occurs via the EPA and the portal." – Dr Vincent Gravel

EPAs are usually completed after a few days, and the results are confirmed to the person concerned via email. If you're lucky, the staff physician will rate you as having passed the EPA. But if you failed it, you're faced with a scenario where you don't necessarily feel comfortable challenging the staff physician to find out why they failed you on it. They won't necessarily give feedback, if only because their daily schedule is overloaded. So this feedback that was supposed to be more proactive, more targeted, is completely lost.

Coaching's completely lost with the CBD approach, postgraduate diplomas are awarded through the programs' Competence Committee, a group of teaching physicians who issue an opinion on resident doctors' progressions, and accompany them in the acquisition of the competencies necessary for the autonomous practice of their discipline, but who also have a pass-or-fail approach. Resident physicians are under enormous pressure. EPAs are the topic of the day, every day, even for terminating residents.

In terms of assessment, how does the Competence Committee work?
Diplomas are granted via the Competence Committee. That's the committee that will say the candidate is competent, and can take the certification exam and receive their diploma. Committee members look at EPAs but, fortunately, they also have access to traditional rotation assessments that provide a more longitudinal view of performance during a rotation. The committee can rule that an individual hasn't completed enough EPAs, so resident doctors generally try to do them all. The threat of having to redo rotations is constantly hanging over you, of having to redo EPAs that haven't been completed and, as the staff physicians didn't go through it themselves, they don't always understand the reality we experience and are exposed to on a daily basis. EPAs differ depending on the program, but the interpretation of these requirements put in place by the Royal College also differs considerably depending on the teaching physicians and their understanding of this new learning model based on the acquisition of competencies. Responsibility for having EPAs assessed rests almost entirely on the shoulders of the physicians-in-training.

How about interaction with staff physicians?
Each program's different. It's a group of people who will issue an opinion and contact the resident doctor. Yes, they get in touch with us, and it's transparent, but it's additional pressure for us.

What about more junior residents?
I had the good luck—or the bad luck—to have been one of the first to train under CBD. Of course, a lot of people went easy on us, this pedagogical approach is so complex. We were given a bit of flexibility. But it's been five years now since it was implemented, it's becoming more important to attain the objectives set by the committee.

"Junior residents are under such pressure that they will miss out on learning opportunities because they have to do EPAs." – Dr Vincent Gravel

The stress level's palpable, and everyone's topic of discussion during residency is CBD. It's constantly coming back when you meet colleagues: "I have to complete my EPAs. I'm still missing so many of them." Candidates make themselves Excel spreadsheets to monitor how their EPAs are going, as well as follow-up from the Competence Committee. This adds a layer to programs that are already overloaded in terms of requirements. Resident doctors feel overwhelmed.

What advice would you have for a junior resident on how to survive CBD?
I think one good thing to do is unfortunately to play the game. The positive thing is that as future professionals we have some say in our training. We have to try to complete EPAs honestly, and seek help when we need it. I also hope each resident doctor who has gone through the process will be a future spokesperson for the young generation when they're in practice and are teaching.

"We're probably the only ones to have a more critical look at it because we've experienced it from the inside, and we see its impact day by day. Most staff physicians have good intentions, but they haven't lived through it themselves." – Dr Vincent Gravel

More tangibly, how helpful was this training under CBD in preparing for your exams and practice? Did it make you a better doctor?
CBD didn't contribute at all to enhancing my training. Before us, the anesthesiologists who were trained were competent and were involved in university and non-university settings. In my view, CBD had more of a negative impact on my day-to-day work, and prevented me from being exposed to certain medical acts; it led to an enormous amount of stress for me, generating conflicts with certain individuals and in certain situations. As to preparing for the certification exams, it had no impact. Am I a better doctor? If I'm a competent physician, I don't think it has anything to do with CBD whatsoever.

HOW TO SURVIVE CBD

Our interviewees had some suggestions and tips for getting the most out of residency under CBD.

DR GRAVEL

"Playing the game" is the first expression that comes to mind. That approach is unfortunate, but the fact remains that you just have to live with it. You have to break free of it, and seek help when you need it. Indeed, there's a hope that those certified under CBD will be able to help improve and rectify the situation when they teach resident doctors. CBD made zero contribution to making me a better anesthesiologist, but it did considerably raise my stress level, and I wasn't better prepared for the exams.

DR FORTIN

In my view, EPAs should encourage teaching physicians to coach, but in the field, day to day, that doesn't happen. In a CBD context, the right staff physician isn't necessarily the best one for teaching you, but the one who agrees to complete EPA assessments. CBD represents political positioning by the Royal College, which wants to be recognized internationally as the trendsetter of this approach.

"Teaching physicians are also the victims of this new pedagogical approach" – Dr Olivier Fortin

The notion of entrustable professional activity is no guarantee of competence, and the pressure should be on staff physicians' shoulders, and the system, not on resident doctors.

Note that the FMRQ has set up surveys and held meetings with resident doctors under CBD since implementation began. Four reports were drafted and submitted to the Royal College, and to faculty and *Collège des médecins du Québec* representatives, to try to prompt them to review the implementation process and certain aspects of CBD, notably, the number of EPAs, milestones, and observations required to confirm residents' competency. The most recent meeting with all the stakeholders concerned was held on December 15, 2022. The Year 5 report on implementation of CBD is in the process of being finalized. It is based on comments from resident doctors in the first year of CBD, midway through, and in the final stages of residency, who completed their postgraduate education in Anesthesiology and Otolaryngology/Head and Neck Surgery in June 2022. The report will be released in the coming months. Note that since the start of 2022-2023 there have been 49 programs under CBD, and its deployment continues. A further 18 disciplines remain to be launched under CBD between 2023 and 2025.

What's a good staff physician?

DR FORTIN

A good staff physician's a coach, someone who's capable of recognizing my level of competence, how far I've got. That can vary, depending on the rotation or the experience acquired. A good coach can recognize where you are at this point, and how far you should've got after the rotation, for instance. It's someone who's able to say: "Listen, you're good here, but you're having some difficulties there. We'll work on some things, and then do feedback." It's someone who brings added value, who's there to observe you. I hope to be able to do that myself in the future.

DR GRAVEL

I wholeheartedly agree. A staff physician is a coach, someone who's available, capable of targeting the resident doctor's needs and adapting their teaching accordingly, offering the resident the autonomy they need, and being there on a timely basis. It's an extremely complex, difficult task.

Has CBD meant there's more coaching, staff physicians have got better?

DR GRAVEL

The answer is no. CBD isn't designed in such a way that there are better coaches. It could be the case—CBD encourages staff physicians to provide feedback—but in a clinical setting, the way it's applied, especially in a program when you're already very close to the staff physicians, it does nothing to improve feedback. I see no connection whatsoever between CBD and whether a staff physician is good or bad. Unfortunately, we sometimes feel a good physician is one who completes our EPA assessments. That's a very sad state of affairs.

DR FORTIN

I wasn't part of the groups under CBD, but my participation in the question as FMRQ director and president fuelled my perception of this learning model. For me, a coach can provide a longitudinal assessment, watch you progress, and give you increasing freedom, while maintaining a degree of supervision. CBD adds nothing to feedback. They are observations used to complete checklists, it's very mechanical. A coach is someone who accompanies you day by day, and because it takes so much energy to complete the checklists, that even takes away time for the coaching facet. It just makes things worse.

The objectives seem laudable, but the system doesn't achieve them. Who's CBD for, and why?

"CBD is a political choice from the Royal College" – Dr Olivier Fortin

DR FORTIN

The Royal College wants to achieve an international reputation for having implemented a competency-based approach across Canada in all specialties other than family medicine. Its promoters don't care about the impact of this approach on resident doctors on a day-to-day basis. The long-term goal isn't postgraduate education, but rather international recognition of the ability to implement such an educational model. That's why it's so hard to have a conversation with them about this pedagogical approach.

DR GRAVEL

I also wonder what CBD's useful for. Certainly not for resident doctors, or staff physicians. Both groups—teachers and learners—are the victims of this transition to CBD. We're the ones undergoing it, and teaching physicians are the victims of having to apply this new, highly imperfect pedagogical approach.

6.

IMPACT OF CBD SINCE 2017

Highlights from the Report on Year 4 of Competence by Design - Urgency of more effectively harmonizing CBD's strengths with the educational and political ecosystem on which the organization of medical residency in Quebec is based.

Four years after implementation of CBD began, the verdict is clear: botched pedagogical reform. Since July 2017, the FMRQ has been monitoring the implementation of Competence by Design (CBD) very closely. Sadly, despite the numerous recommendations we have made, the situation has worsened. In our latest report, we invite collaboration from the stakeholders responsible for the quality of medical training and healthcare in Quebec in paying attention to the training of the upcoming generation of doctors, who are hard hit by this new pedagogical approach. It will not be before time!

Despite some targeted improvements in familiarity with the theoretical aspects of CBD, our resident doctors unfortunately drew a dismal profile of CBD in 2020-2021. The survey of those newly under CBD highlighted similar problems to previous years, despite the fact that some programs had already been under CBD for several years. And the same observation goes for the points raised by resident doctors midway through residency.

A number of improvements were noted, such as training of resident doctors on the basic concepts of the assessment model, and introduction of curriculum mapping, but these theoretical elements did not appear to bring any real improvement to the process in which residents function each day. Resident doctors feel pressure to complete all their EPAs successfully in order to be able to continue their academic progression, but are well aware that they are likely not to manage to complete all of them in the allotted time. The helpfulness of EPAs is seriously questioned. The cognitive load on resident physicians is a heavy one. Residency is focussed on successfully completing EPAs, but many bemoan the fact that unique opportunities for exposure to rare or more complex cases are sometimes lost.

In fact, CBD largely fails in its educational objectives of enhancing feedback from teaching physicians. What use is the CBD model if it does not provide more feedback or quality coaching, and serves only to list the number of EPAs completed?

> So what can we take from this learning model proposed by the Royal College after all these years: **no pedagogical benefit**; **increased cognitive and emotional load**; **detrimental effect on resident doctors' mental health and learning**. **Should implementation of CBD continue?** For the FMRQ, implementation of CBD was premature and incomplete, and it is our resident doctors who are paying for those failures.

Between 2017 and 2020, we drafted no less than 43 recommendations for improving CBD and sent them, to the Royal College and other healthcare system stakeholders in Quebec and elsewhere in Canada. The FMRQ would have liked greater transparency and self-criticism from the RCPSC with respect to the proposed educational model that is built on a theoretical foundation which clearly deserved to have been subject to more evaluation, testing, and debate before being applied on such a large scale. There was a desire to speed up this cultural shift in postgraduate education sites in Canada by any means whatsoever. It is time we moved away from this paradigm of rhetorical arguments aimed at avoiding recognizing, or at minimizing, the negative impact reported by resident physicians from Quebec and, we understand, other provinces. It is indeed most astonishing that the FMRQ alone, at least publicly, appears to be concerned with these issues.

In the FMRQ's view, the current implementation model has to be revised, and deployment should be favoured that respects the time factor—the traditional duration and time-based framework on which postgraduate education is based, depending on the discipline, particularly since time is a key factor in managing training in the medical faculties and organization of care, and for the process of distribution and management of physician resources in Quebec.

At the end of the fourth year of implementation of CDB, rather than merely repeating its previous recommendations—most of which were actually not taken up—the FMRQ wanted to stress the Urgency of more effectively harmonizing CBD's strengths with the ecosystem on which the organization of medical residency in Quebec is based. In seeking to revolutionize medical education in Canada, the RCPSC unfortunately decided to do away altogether with a system that was already one of the best in the world. It is regrettable that the Royal College did not attempt instead to enhance this system by integrating into it the most useful concepts of CBD, rather than scrapping the existing system completely. The time-based framework within which residency is organized in Quebec has to remain the reference for the purpose of resident doctors' academic progression. In that sense, the FMRQ continues to be involved with the medical faculties, Ministry of Health and Social Services, and *Collège des médecins du Québec* to ensure that Quebec ceases relying solely on Canada-wide groups in medical education and decides what it best for our upcoming generation of doctors, our healthcare system, and Quebecers in general. For that to happen, it will be necessary to:

- Guarantee quality feedback;
- Emerge from this new EPA "trade";
- Find a way to introduce real pedagogical benefits;
- Avoid making resident doctors guinea pigs for a pedagogical experiment;
- Avoid favouring the theoretical logic of CBD to the detriment of quality of training and care for the public.

BRIEF LOOK BACK OVER THE FIRST YEARS OF IMPLEMENTATION OF CBD

Report #1 – Impact of Competence by Design (CBD)

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

In January-February 2018, the FMRQ conducted semi-structured interviews with close to 30 or so resident doctors (R1s) whose residency was under CBD, namely in the **Anesthesiology and Otolaryngology/Head and Neck Surgery** programs, to take stock of this first cohort confronted with the competency-based approach. The Federation wished to inform the different stakeholders in postgraduate medical education in Quebec and Canada of the challenges experienced by resident doctors in CBD programs, to understand and identify the special features of this pedagogical approach, and track its evolution, and thus better defend resident physicians' interests with the authorities responsible for applying CBD. The FMRQ then issued **15 recommendations** in connection with CBD. These concerned in particular resident doctors' information and preparation prior to the start of residency; training and pedagogical follow-up during residency; clarification of assessments, milestones, and the number of EPAs, and the role of the Competence Committee. The report concluded that changes were urgently needed, as six new programs were about to be added in July 2018.

Report #2 – Implementation of Competence by Design in Quebec – Year 2: Ongoing challenges

As the second year of implementation of CBD was under way, with resident doctors in Anesthesiology and Otolaryngology/Head and Neck Surgery now R2s, CBD arrived in July 2018 in six other residency programs: **Emergency Medicine, Forensic Pathology, Medical Oncology, Nephrology, Surgical Foundations, and Urology**. So the FMRQ drew up a questionnaire that it sent out in February 2019 to all resident physicians concerned. The findings of this survey led to the drafting of the Report on Year 2 of CBD, which contained **15 new recommendations**. Some of them targeted situations that had not been resolved since the first report, and proposed specific enhancements to improve the CBD implementation process. They concerned the following elements:

- Provide more flexibility in total number of observations per EPA;
- Clarify the function and composition of the Competence Committee for each program;
- Clearly explain at the start of training the process for promotion of resident doctors in the competence continuum (Foundations of discipline, Core of discipline, Transition to practice);
- Make verbal feedback mandatory immediately following evaluation of the act;
- Ensure that the department provides resident doctors with support to ensure their assessments are completed;
- Provide supervising physicians with more detailed training concerning CBD, particularly on the O-SCORE entrustability scale, feedback methods, and integration of observations into regular clinical activities;
- Simplify statements describing EPAs and milestones;
- Ensure that responsibility for completing EPA forms is shared between teaching physicians and resident doctors;
- Recognize senior resident doctors' supervisory role;
- Optimize the ePlatform (enhancement of functions, use on mobile devices, etc.);
- Ensure the adoption of a policy on protection of personal information (privacy) by the medical faculties;
- Adapt each program's curriculum, to accommodate the progression of EPAs within the competence continuum;
- Ensure the recognition of off-service rotations in progress under CBD;
- Ensure continuous improvement in the faculties by integrating more systematic evaluation of supervising physicians' viewpoints;
- Have the Royal College agree to introduce a rigorous mechanism for monitoring and implementation of CBD.

Report #3 – Year 3 of implementation of Competence by Design

Negative Impact Still Outweighs Theoretical Benefits – Observations on the day-to-day reality of CBD and its progression since 2017.

Since July 2017, when the FMRQ launched its series of surveys of and discussions with resident doctors under CBD—R1s and R3s in 2019-2020—20 disciplines had moved to CBD. The surveys and discussions led to **13 recommendations**. The FMRQ wanted to gauge how implementation of CBD in Quebec had progressed in relation to the recommendations it had made one year earlier. Aside from the programs already mentioned, **12 new programs** were targeted that year, namely, **Anatomical Pathology, Cardiac Surgery, Critical Care Medicine, Gastroenterology, General Internal Medicine, General Pathology, Geriatric Medicine, Internal Medicine, Neurosurgery, Obstetrics and Gynecology, Radiation Oncology, and Rheumatology**. Sadly, we had to conclude that much work remained to be done. Below are the elements raised by resident doctors in the third year of implementation of CBD:

- Enhance training of resident doctors;
- Provide adequate training for supervising physicians;
- Clarify the statements accompanying EPAs;
- Provide adequate mapping between expected competencies and training rotations;
- Put user-friendly online platforms in place;
- Put in place a process for continuous reassessment of the number and relevance of EPAs;
- Put local mechanisms in place for quality control on feedback;
- Put administrative structures in place to document EPA observations in a timely manner;
- Enhance the transparency of the decision-making process within the Competence Committee;
- Put communication strategies in place with respect to programs, supervising physicians, and resident doctors to reinforce the holistic approach (growth mindset) rather than basing assessments on an automated count of completed EPAs;
- Put communication strategies in place with respect to programs and universities to avoid prolonging training;
- Put comprehensive measures in place to reduce the detrimental effects of implementation of CBD on resident doctors' mental health;
- Permit more progressive, flexible implementation of CBD, until such time as the culture shift is completed.

To consult the reports on the first four years of implementation of CBD, visit the FMRQ website: https://fmrq.qc.ca/en/postgraduate-training/competence-by-design/

IN CONCLUSION

Year 5

The FMRQ followed the evolution of CBD for Year 5 (2021-2022) and gathered comments from resident physicians through surveys and individual interviews, particularly with final-year residents in Anesthesiology and Otolaryngology/Head and Neck Surgery who had begun their residency under CBD. Analysis of data from this exercise will lead to the drafting of the Report on Year 5 of implementation of CBD, which is currently being finalized. Recommendations have already been made to the different key players in this area to improve the situation for resident doctors already in those programs, but also those whose programs are soon to be included in CBD, namely, 18 new programs, by 2025. These stakeholders of course include the Royal College, medical faculties, *Collège des médecins du Québec*, Quebec Ministry of Health and Social Services (MSSS), and our fellow residents belonging to Resident Doctors of Canada (RDoC).

Year 6

The process will continue for Year 6, in the second part of 2022-2023, to confirm with resident doctors whether the measures and changes we proposed have materialized in training sites.

Independent researchers point out that the principles of CBD are not evidence-based

It is important to underscore the publication in September 2022 of a study conducted by independent researchers on the competency-based approach in general, vocational, and medical education, more specifically in the field of medicine: ***Analyse critique d'un changement de paradigme pédagogique dans le cadre de la résidence en médecine au Québec*** (C. Boyer et al, Éditions de l'Apprentissage. The English version of this study, ***Critical analysis of a pedagogical paradigm shift in medical residency in Quebec***), was released in March 2023. The researchers concluded that CBD was not based on any genuine scientific evidence. A brief extract is printed below. For further details, do not miss the article presenting the lead researcher's comments elsewhere in this *Bulletin*.

> *"Paradigm changes in science are generally based on evidence or end up being supported by evidence that confirms their validity. The current weakness of the scientific demonstration of CBE in general and vocational education and in medical education should have limited the dissemination of this pedagogy, this paradigm change, but that was not the case. The current generalization of this pedagogy and its maintenance in all spheres of education is not a reflection of rationality and evidence but, at least in part, the adoption of purely ideological paths which do not get bogged down in providing an empirical demonstration of what they say, being satisfied simply with the enthusiasm they elicit."* (C Boyer et al, Éditions de l'Apprentissage, March 2023)

FÉDÉRATION DES
MÉDECINS RÉSIDENTS
DU QUÉBEC

THE FMRQ MOBILE APP, A MUST!

Available on the App Store

GET IT ON Google Play

COMING JUNE 16, 2023

Don't miss

FMRQ's Resident Doctor Day

- **A symposium on stress and burnout**, being held virtually, in the morning;
- **Health and wellness local activities** currently being planned by each affiliated association in the afternoon

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC

For more information, keep an eye on your email over the next few weeks.

VOUS ÊTES RÉSIDENT EN MÉDECINE FAMILIALE ?

VOUS CHERCHEZ UNE CLINIQUE MÉDICALE OÙ VOUS INSTALLER ?

Nos médecins de famille ayant pris leur retraite cette année laissent ainsi beaucoup de patients orphelins. Notre clinique a été conçue pour être occupée par 3 médecins et une secrétaire incluant un stationnement gratuit.

Située dans un secteur résidentiel complet, notre clinique se trouve au rez-de-chaussée d'un complexe médical ayant plus de 40 ans.

Voisin d'une pharmacie des plus collaboratrices comprenant une infirmière offrant les services de prises de sang, de vaccins, etc.

Nous possédons tous les équipements nécessaires au bon travail et sommes ouverts à la possibilité d'agrandissement.

PROXIMED KINDA & ROUA BOUZ

Clinique médicale Côteau Rouge

780, chemin du Côteau-Rouge, Longueuil (Québec) J4J 1Z3

514.991.8038

kinda_bouz@hotmail.com

CARDIOGENIX
CENTRE MÉDICAL - MEDICAL CENTRE

Médecin généraliste
Médecin de famille

Centre médical Cardiogenix, Montréal (Québec)

Le Centre médical Cardiogenix, un établissement médical privé en activité depuis 2006, accepte les candidatures pour un médecin généraliste (médecin de famille).

Le candidat idéal sera :

- Dédié à l'excellence du service, avec des compétences interpersonnelles exceptionnelles
- Engagé dans la mission et les valeurs du Centre médical Cardiogenix
- Intéressé par la pratique de la médecine dans un environnement collégial, peu fréquenté

Le Centre médical Cardiogenix est un établissement privé à service complet qui comprend :

- Une technologie de pointe
- Un système de purification de l'air de qualité hospitalière, une salle d'examen virtuelle avant l'examen et des équipements de protection individuelle de qualité supérieure pour les médecins, le personnel et les patients
- Un ratio de 1:1 personnel de première ligne / soutien administratif - médecin
- Une charge patient limitée par médecin
- Des spécialistes médicaux (cardiologie, dermatologie, endocrinologie, gynécologie, allergie et immunologie, gastro-entérologie et spécialistes de chirurgie) sur place
- Un milieu collégial et de soutien; travailler aux côtés de médecins de famille expérimentés
- Un salaire annuel de premier ordre (non basé sur les visites des patients)
- Être situé au centre de la ville, à proximité de tous les quartiers de Montréal et du centre-ville
- Être accessible en métro; un parking gratuit également disponible

Visitez notre site Web : https://cardiogenix.com

Pour postuler, veuillez envoyer votre CV et des références à :

Dr. Ashok Oommen, directeur médical

Courriel : cheryl@cardiogenix.ca

cardiogenix.ca

CHEZ CARDIOGENIX, NOUS MISONS SUR UN ACCÈS ET DES SERVICES COMPLETS

Après avoir travaillé 15 ans aux urgences du Centre hospitalier de St. Mary à traiter des milliers de patients atteints de problèmes cardiaques et de cancer, la frustration du Dr Ashok Oommen grandissait. Il savait qu'un grand nombre de ces patients gravement malades auraient pu éviter ce destin si, des années auparavant, ils avaient pu bénéficier d'un niveau de soins que les médecins de famille du système de santé canadien ne peuvent simplement pas offrir. « Dans le système de santé québécois, un médecin de famille qui maintient un cabinet de plus de 1 500 patients est inévitablement pressé; pour connaître véritablement votre patient et offrir les meilleurs soins, vous devez passer suffisamment de temps ensemble », une réalité qui a motivé le Dr Oommen à ouvrir le Centre médical Cardiogenix, une clinique impressionnante qui offre tous les services et qui est située sur Décarie, près du métro De La Savane.

Depuis 17 ans, le nombre de patients de chaque médecin est limité, et les patients demeurent avec leur médecin aussi longtemps que nécessaire. « Les deux aptitudes les plus importantes pour un médecin sont l'écoute et l'observation. Les patients ont besoin de temps pour discuter non seulement de leurs symptômes, mais de ce qui se passe dans leur vie. Plutôt que se concentrer uniquement sur la maladie, nous visons à améliorer la longévité et la qualité de vie d'une personne. »

Les médecins du Centre médical Cardiogenix ont accès à la division Spécialistes, situé dans le même édifice.

« Toute l'équipe de Cardiogenix a joué un rôle déterminant pour s'assurer que je suis à mon meilleur. Avoir un horaire aussi chargé et partir en tournée signifie que tous les problèmes doivent être diagnostiqués et traités tôt et aussi efficacement que possible. Ils sont disponibles pour moi chaque fois que j'en ai besoin : en personne, au téléphone ou par courriel. C'est excellent pour mon bien-être et ma paix d'esprit. »

Sugar Sammy, humoriste

Choisissez le CISSS de Lanaudière

Diverses possibilités d'emploi, plus particulièrement dans les secteurs suivants :

- La chirurgie plastique
- La gériatrie
- L'hémato-oncologie
- La neurologie
- La rhumatologie
- La pédiatrie
- La médecine physique
- La médecine générale

Soigner chez nous

- Pratique diversifiée et stimulante
- Plus de 800 médecins
- 63 installations, dont 2 hôpitaux
- Équipes dynamiques
- Travail interdisciplinaire
- Modernisation et agrandissement (projets immobiliers d'envergure)

Nous offrons un **cheminement de carrière** centré sur vos intérêts et sur vos projets de vie dans une **région majestueuse et innovante** qui est remplie d'espaces verts, urbains et culturels.

Joignez-vous à nous

pour une qualité de vie et de pratique!

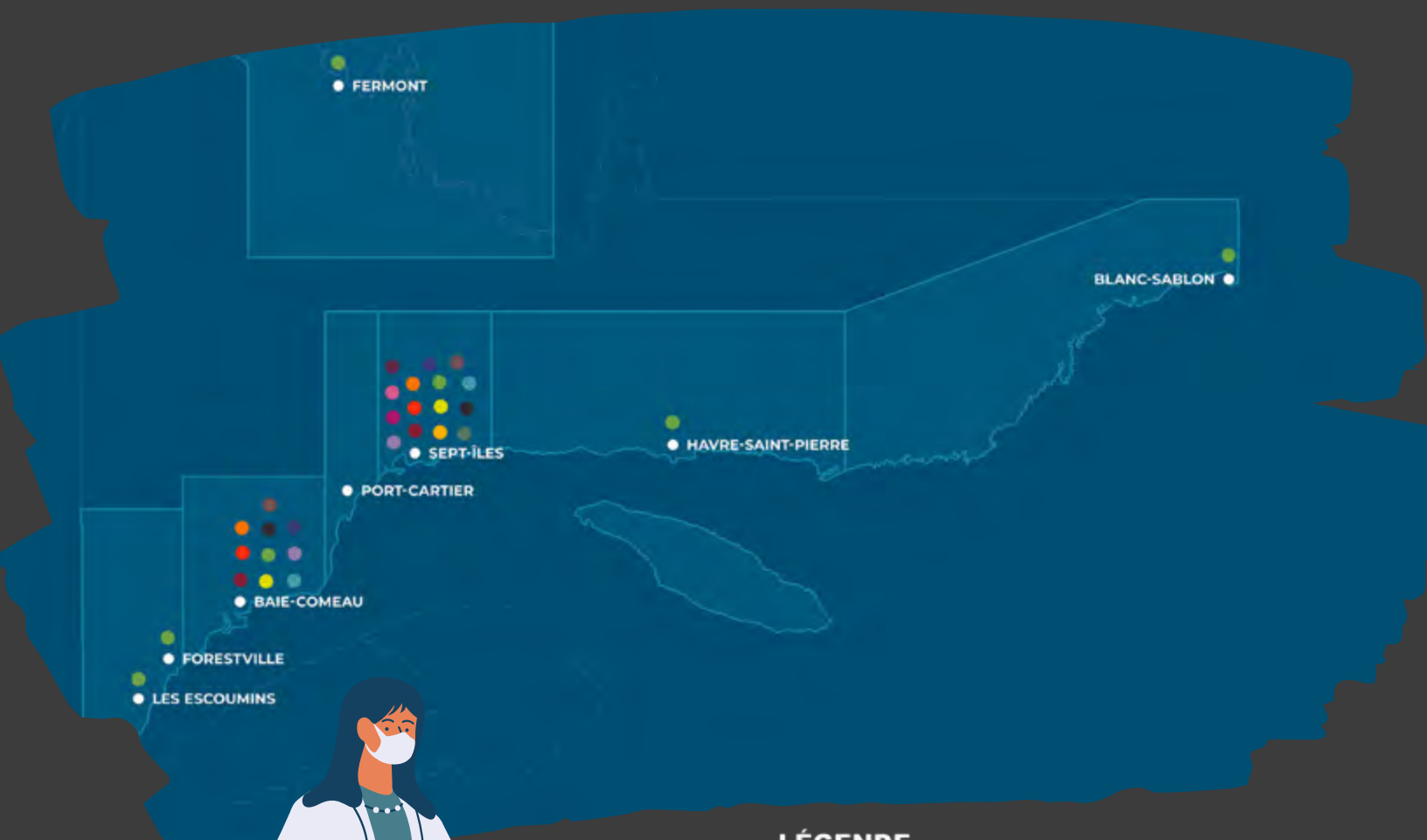
Pour information : Lyne Marcotte
Directrice adjointe des services professionnels
450 654-7525, poste 43644 | lyne.marcotte@ssss.gouv.qc.ca

cisss-lanaudiere.gouv.qc.ca/carrieres

Centre intégré de santé et de services sociaux de Lanaudière
Québec

LA CÔTE-NORD RECRUTE!

Nos 8 RLS offrent des pratiques variées,
trouvez celui qui correspond à vos aspirations...



LÉGENDE

- Anesthésiologie*
- Chirurgie générale
- Chirurgie orthopédique*
- Dermatologie*
- Médecine interne*
- Médecine familiale*
- Ophtalmologie
- Oto-rhino-laryngologie
- Obstétrique (médecine familiale)
- Obstétrique-gynécologique*
- Pédiatrie *
- Pédopsychiatrie*
- Pneumologie
- Psychiatrie*
- Radiologie diagnostique*

*Postes disponibles

CONTACTEZ-NOUS!

RECRUTEMENT MÉDICAL CÔTE-NORD
www.cisss-cotenord.gouv.qc.ca
09.recrutementmedical@ssss.gouv.qc.ca

Centre intégré de santé et de services sociaux de la Côte-Nord
Québec

Pratiquer et vivre à fond

Une pratique stimulante alliée à une qualité de vie exceptionnelle, une région aux paysages époustouflants, voilà qui donne envie de vivre à fond!

Une région qui se démarque

- ✔ Équipes dynamiques
- ✔ Travail interdisciplinaire
- ✔ Polyvalence et autonomie
- ✔ Pratique valorisante et diversifiée

Médecins de famille et médecins spécialistes recherchés en :

- allergie-immunologie
- anatomo-pathologie
- anesthésiologie
- biochimie médicale
- cardiologie
- chirurgie plastique
- chirurgie thoracique
- gériatrie
- hémato-oncologie
- médecine d'urgence
- médecine interne
- médecine nucléaire
- néphrologie
- neurologie
- obstétrique-gynécologie
- ophtalmologie
- physiatrie
- pneumologie
- psychiatrie adulte
- radiologie diagnostique
- rhumatologie
- urologie

CHEZ NOUS, ON SE DÉMARQUE EN GRAND

Envie de tenter l'aventure? Contactez :

Mme Véronique Bossé
418 899-0214, poste 10202
recrutement.medical.cisssbsl@ssss.gouv.qc.ca

medecin.cisssbsl.com

Centre intégré de santé et de services sociaux du Bas-Saint-Laurent

Québec

JEUNES MÉDECINS

VOTRE RÉUSSITE FINANCIÈRE COMMENCE MAINTENANT...

RENSEIGNEZ-VOUS SUR LES PROMOTIONS DESTINÉES AUX MÉDECINS RÉSIDENT-E-S.

Votre prospérité se joue dès les premières années de votre résidence. Bien gérer le remboursement des dettes, profiter des stratégies d'optimisation fiscale, évaluer la pertinence de l'incorporation, mettre en place un plan d'épargne pour l'achat d'une propriété ou autres… rien ne doit être laissé au hasard pour tirer le maximum de chaque dollar gagné.

Filiale de la FMOQ, notre société demeure fidèle à sa mission : **contribuer à la prospérité des médecins omnipraticiens**. Profitez des services spécialement conçus pour vous, **en toute confiance, sans pression ni sentiment d'urgence**.

GESTION DES DETTES
Élaboration des stratégies optimales, en tenant compte des aspects fiscaux. **Sans frais**.

ÉPARGNE ET INVESTISSEMENT
Accompagnement dans le choix des régimes d'épargne et dans la sélection des meilleurs produits d'investissement pour vous. **Recommandations objectives**.

INCORPORATION
Analyse des gains et du coût de cette stratégie fiscale. Conseils en matière de structure corporative à mettre en place. **Aucune vente de produits**.

FACTURATION MÉDICALE
Service clé en main, assuré par une équipe maîtrisant toutes les nuances de la facturation médicale. **Gain de temps pour votre pratique**.

ATELIERS DE FORMATION FINANCIÈRE
Formation gratuite sur les aspects financiers et juridiques pour les médecins en début de carrière. **Un incontournable pour votre santé financière**.

FAITES PARTIE DE LA FAMILLE !

MONTRÉAL
514 868-2081
1 888 542-8597
info@fondsfmoq.com

QUÉBEC
418 657-5777
1 877 323-5777
FONDSFMOQ.COM

FONDS FMOQ

Services aux professionnels de la santé RBC[MC]

« Le passage de la faculté de médecine à la résidence est une période à la fois stimulante et stressante qui comporte tout un lot de choses à faire et d'incertitude. »

- Diplômé de la faculté de médecine de l'Université Queen's, 2021

Soutien durant votre programme de résidence

Les spécialistes, Services aux professionnels de la santé RBC, comprennent le parcours particulier d'un médecin résident et peuvent vous aider à franchir vos prochaines étapes avec assurance. Il y a beaucoup d'éléments à prendre en compte. Voici comment nous pouvons vous aider.

Finances personnelles

Gestion de l'endettement – Devriez-vous augmenter le montant des versements sur votre prêt d'études ou épargner ? Est-il possible de faire les deux ?

Établissement d'un budget et d'objectifs de placement

Réponses à vos questions de planification fiscale

Les étapes de la vie

Gestion des frais de relogement, si votre résidence exige une délocalisation

Est-ce le bon moment pour acheter un appartement en copropriété ou une maison, ou est-il préférable de continuer de louer ?

Stratégies d'épargne pour les étapes ultérieures de la vie, comme fonder une famille

Planification d'affaires

Quels facteurs devez-vous prendre en compte si vous vous joignez à un cabinet ou si vous en ouvrez un ?

Savoir quand constituer son entreprise en société

Faire les meilleurs choix financiers pour vous mettre sur la voie de la réussite

Allez à **rbc.com/medecinresident** pour en savoir plus

127863 (03/2022)

Une offre pour les médecins résidents

Une offre pensée et développée pour vos besoins personnels et professionnels.

Faites comme plusieurs médecins résidents et profitez de l'offre Exclusive.

Découvrez l'offre

1 844 778-1795 poste 30

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC | Desjardins

Une force conseil
branché sur votre profession

Sogemec Assurances, filiale de la FMSQ, a été concue par des médecins pour des médecins.

Nous connaissons bien votre mode de vie exigeant et son évolution. Nous reconnaissons votre besoin d'être bien conseillé, et ce, en toute intégrité.

Offez-vous la tranquilité d'esprit offerte par les produits d'assurance vie et invalidité recommandés par votre Fédération.

FÉDÉRATION DES MÉDECINS RÉSIDENTS DU QUÉBEC

Pour tous vos besoins d'assurances vie et invalidité

PARTOUT AU QUÉBEC : **1 800 361-5303**
information@sogemec.qc.ca

Sogemec ASSURANCES

Une force conseil
branchée sur votre profession

Ta différence, ça passe aussi par tes finances.

fdp Gestion privée

Créée pour les médecins, par les médecins. Depuis 1978.

Contacte un conseiller fdp

Filiale de FMSQ

Partenaire de FMRQ

Futur hôpital de VAUDREUIL-SOULANGES

Technologique
Innovant
Humain

D'ici l'ouverture de l'Hôpital de Vaudreuil-Soulanges en 2026, pratiquez dans l'une de nos installations.

Médecine spécialisée
recrutement_md_specialiste.cisssmo16@ssss.gouv.qc.ca

Médecine familiale
recrutement_omnis.cisssmo16@ssss.gouv.qc.ca

santemonteregie.qc.ca/ouest/pratique-medicale

Centre intégré de santé et de services sociaux de la Montérégie-Ouest
Québec

L'OUTAOUAIS, AU-DELÀ DE L'OPPORTUNITÉ D'EMPLOI...

Évènements variés, festivals, musées, parcs nationaux, pistes cyclables, restauration diversifiée, sentiers pédestres, ski, activités nautiques et plus encore.

Pour en découvrir davantage :

- **Tourisme Outaouais (tourismeoutaouais.com)**
- **Outaouaispleinair.ca**
- **CISSS-outaouais.gouv.qc.ca**

L'OUTAOUAIS VOUS ATTEND !

- Anesthésiologie
- Cardiologie
- Chirurgie générale
- Dermatologie
- Endocrinologie et métabolisme
- Gastroentérologie
- Médecine de famille
- Médecine d'urgence
- Médecine interne
- Microbiologie médicale et infectiologie
- Néphrologie
- Neurologie
- Obstétrique et gynécologie
- Pédiatrie
- Pneumologie
- Psychiatrie adulte et enfant/ado
- Radiologie diagnostique

Contactez l'équipe de recrutement :

recrutement.md.outaouais@ssss.gouv.qc.ca
819-966-6000 poste 334566

SAR ROS

Centre intégré de santé et de services sociaux de l'Outaouais
Québec

Facturation.net
Solutions et services de facturation médicale

Évitez les pièges.
Confiez vos factures aux pros.

Offre pour les résidents

6 mois gratuits

Formations et accompagnements en début de pratique

Service gratuit en tout temps pour fellowship et moonlight

Le choix #1 des médecins au Québec.

Découvrez notre nouvelle application mobile. Contactez-nous!

Code promotionnel : FMRQ 2022

1 866 332-2638
Facturation.net

En région, pour élargir vos horizons.

Dre Renée D'Amours
Bas-Saint-Laurent

Devenir médecin en région, c'est faire un choix sensé et différent.

C'est tirer avantage d'une pratique multidisciplinaire, tout en s'offrant un cadre de vie humain, entouré de nature. Allez-y, élargissez vos horizons en adoptant l'une de nos magnifiques régions.

SARROS | Soutien aux régions pour le recrutement d'omnipraticiens et de spécialistes

EQUIPESARROS
SARROS_QC
SARROS

SARROS.CA

Xacte

Nouveaux patrons :

Tout sur la facturation médicale RAMQ

Formations gratuites et sans engagement

À chaque année, au-delà de 700 résidents s'inscrivent à nos formations sur la facturation médicale. Plus de 98% des participants les recommandent fortement à leurs collègues. Maîtrisez vous aussi l'essentiel de la facturation médicale en réservant votre place dès maintenant.

Inscrivez-vous afin de recevoir en priorité les dates de webinaires
www.xacte.net/formations-facturation

Places diponibles pour les PREM !

ELNA Médical

Nous embauchons en médecine familiale et dans plus de 30 spécialités au sein de nos GMF et cliniques privées dans la grande région de Montréal.

Le plus grand réseau
de cliniques de soins primaires
et spécialisés au Canada.

elnamedical.com/pratiquez-avec-nous

Cliniques GMF neuves et modernes recherchent

médecins

de famille + spécialistes

- ***GMF Lévis-Les Rivières***
  Lévis secteur St-Nicolas
- ***GMF Taniata***
  Lévis secteur St-Jean Chrysostome
- ***GMF des Ponts***
  Lévis secteur St-Romuald
- ***GMF Lévis-Lauzon***
  Lévis
- ***GMF Pierre-Bertrand***
  Québec secteur Vanier
- ***GMF de l'Hêtrière***
  Québec secteur Cap Rouge
- ***GMF Donnacona***
  Donnacona
- ***GMF Lafontaine***
  Rivière-du-Loup
- ***GMF Pont-Rouge***
  Pont-Rouge
- ***GMF Côte-de-Beaupré***
  Sainte-Anne-de-Beaupré
- ***GMF Saint-Raphaël***
  Saint-Raphaël-de-Bellechasse

Visitez-nous et découvrez encore plus de +

Prenez rendez-vous avec l'équipe: 581-200-0860

Aux p'tits soins pour nos médecins • med-way.ca

MEDWAY

VOTRE **COMPLEXE SANTÉ**

La Tuque recherche médecin de famille en périnatalité!

— Joins-toi à nous!

Fière d'être médecin à La Tuque!

L'installation de La Tuque, seule région SARROS en Mauricie, est à la recherche d'un à deux médecins de famille souhaitant pratiquer dans un milieu stimulant et diversifié, entourés d'une équipe dynamique et engagée.

Optez pour une pratique « Prise en charge de patients et obstétrique » au Centre multi-services de santé et de services sociaux du Haut-Saint-Maurice à La Tuque. Tous les services de santé et les services sociaux sont sous un même toit, même le GMF!

« Pratiquer à La Tuque me donne le privilège d'accompagner des familles entières dans toutes les étapes de leur vie, tout en ayant un excellent équilibre travail-famille. »

- Dre Annie Blais

Pour information ou pour planifier une visite, contactez :

Chantal Guay
Agente de planification et de communication
819 523-4581 poste 2108
04SARROS_HSM_CIUSSSMCQ@ssss.gouv.qc.ca

ciusssmcq.ca
sarros.ca
choisirlatuque.ca

Centre intégré universitaire de santé et de services sociaux de la Mauricie-et-du-Centre-du-Québec

Québec