



TOP TEN TIPS: A Guide for CBME from a resident perspective

INTRODUCTION

Competency-Based Medical Education (CBME) refers to an approach during residency training whereby residents must develop and achieve specialty-specific abilities that are necessary for their future practice as physicians. CBME de-emphasizes time-based training and instead focuses on ensuring that residents are trained to meet the needs of patients. In doing so, CBME promotes a greater focus on accountability and learner-centeredness and allows for greater flexibility in training.

Through the Royal College's Competence by Design (CBD) framework and the College of Family Physicians of Canada's (CFPC) Triple C initiative, CBME is being integrated into all postgraduate medical training programs across Canada. To monitor resident physician competencies, various entrustable professional activities (EPAs) [for Royal College specialties], and Priority Topics and Key Features [for Family Medicine], that learners need to complete during their training have been created. These enable residents to meet various milestones.

The transition to a CBME curriculum has significant implications for trainees. According to the 2018 RDoC National Resident Survey, evaluation fatigue, time burden and uncertainty around

training timelines were identified as the greatest challenges for residents.¹ Magnifying these challenges are parallel changes in medical education and training - and health care delivery as a whole - including greater emphasis on learner wellness, the importance of creating safe and supportive learning environments, educational innovations, reduction in duty hours, and greater learner and patient engagement.²

RDoC therefore recognizes that, as with any transition, CBME has its challenges and frustrations. It is therefore critical that resident physicians be supported as CBME is implemented across postgraduate education.

PURPOSE

RDoC has created this Top Ten Tip document that can ease the transition to CBME for resident physicians. As you read through these tips, keep in mind that it's normal for you to have questions about what CBME is, including how to ensure that you will achieve the necessary outcomes, how you will be evaluated, and more. YOU ARE NOT ALONE! By reading through these tips, becoming familiar with the principles of CBME, and discussing your questions and concerns with others, you can become better prepared for the utilization of

CBME during your postgraduate training.

Competency-based medical education (CBME):
A new approach to medical education programs

Resident Doctors of Canada | Médecins résidents du Canada

Less emphasis on time-based training.

More emphasis on graduate outcome abilities.

Targets competencies based on societal and patient needs.

Affects the entire Canadian medical education community.

Areas where collaboration will equal success:

- Planning a Smooth Transition
- Innovating in Curriculum Design
- Re-engineering Assessment and Promotion Activities
- Allocating New Resources to Support Residents and Faculty

For more information on the transition to CBME, visit our website at: residentdoctors.ca.

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TOP TEN TIPS

1. Learn the language and concepts of CBME to better navigate through this new model

CBME has developed a new language to describe concepts and frameworks to facilitate its integration.³ By understanding key descriptions and expectations early, you will be better equipped to navigate this new system at a time when many programs and assessors are still adjusting. Ask your program to provide an orientation with resources. Find out more information about CBME from the following sources:

- Royal College of Physicians and Surgeons of Canada. [Competence by Design Cheat Sheet](#).
- College of Family Physicians of Canada. [Triple C Competency Based Curriculum](#).

2. Use entrustable professional activities (EPAs) [Royal College specialty] or priority topics and key features [Family Medicine], to Feed-UP and Feed-FORWARD⁴⁵

Feed-UP: Clarify the Goal

Use EPAs or priority topics/key features, to understand what's expected of you at each stage of your training. You can then formulate your personal learning objectives around achieving those goals. Ask your program director what EPAs or priority topics/key features need to be completed within your current rotation, over your training, and at different timepoints. Use curriculum mapping of rotations (if available), to formulate targeted learning objectives.

Feed-FORWARD: Focus on the Future

Based on prior feedback obtained on assessments, identify gaps in your knowledge and try to structure your future learning to address these areas. At the end of each assessment three questions should be answered: 1) How good am I at X? 2) Is that good enough?, and 3) How can I improve X?⁶

3. Ask your program or preceptor/evaluator for performance standards to decrease subjectivity of feedback.

Assessment and feedback can sometimes be subjective. As trainees, we recognize that this can be frustrating. EPA and priority topics/key feature de-

scriptions can be useful to help clarify these expectations. Reduce the subjectivity of your evaluations by requesting performance standards in advance of the clinical encounter or observation. This reminds both evaluators/preceptors and trainees of performance expectation. Try to have the assessment and feedback completed in a timely manner.

4. Ask for feedback delivery that works best for you.

For feedback to be effective, its content must be specific, actionable, and constructive. However, feedback delivery and reception are equally important for making it effective. We encourage you to reflect on your experiences receiving feedback and identify what works best for you: do you prefer group feedback or individualized feedback? Do prefer your feedback to be given immediately or to have a chance to reflect on your own performance first? If possible, try to communicate these preferences to your staff ahead of time so you can get the most out of their feedback and coaching.

Ideally, your supervisor will provide you feedback in a safe environment, which includes a relatively private setting, not post-call, and with enough time to allow you to seek clarification. If this is not the case, consider asking your supervisor to optimize the setting for giving feedback. There should not be a significant delay between the observed task and the feedback.

5. Consider incorporating informal sources of feedback to prepare for EPAs and competencies.

In residency training we often work closely with other allied health professionals (i.e. physiotherapists, pharmacists, occupational therapists, psychologists, etc.) and registered nurses. In these situations, there may be certain EPAs and priority topics/key features, that you could seek feedback informally in order to gain competency skills. For example, Psychiatry resident physicians often work on-call shifts with psychiatric nurses in the emergency department and nurses can provide insight into communication skills. Radiation oncology residents often confer with planners about radiation plans and surgery residents with a circulating nurse about staff preferences.

6. Capitalize on existing clinical activities for assessment, feedback, and observation.

It can be challenging to seek assessment opportunities during a busy workday. Many residents find the time for assessment, feedback, and observation to be stressful. However, when you consider your general workday, there are many routine clinical activities that qualify as EPAs and priority topics/key features. This could include bedside teaching, morning rounds, handover, case-reviews and clerk and junior-resident teaching. It can also include time when your supervisor is present and able to give feedback, such as in-between patients. By keeping assessments in mind while reviewing your daily or weekly schedule, you may find many of these activities are already scheduled. Capitalizing on these moments takes advantage of existing opportunities and reduces the anxiety of needing to “squeeze” them in.

7. Protect the confidentiality of your phone and other electronic devices.

Phones are often used to document assessments by preceptors/evaluators and can contain sensitive personal information. Ensure that your message/app notification settings do not display message content in order to protect personal information from being shared with evaluators. When available, complete assessments on on-site computers instead of your personal devices. If your program or institution is still using paper to document assessments - Save the trees! Advocate for electronic field notes and EPA assessment tracking.

8. Embrace your coaching role to support your junior resident physicians.

As residents, we have the opportunity to be coaches, in addition to our role as learners and physicians. Senior resident physicians can assist their junior colleagues by providing feedback and completing assessment forms for them. The CBME model provides even more opportunities for senior resident physicians to develop their coaching skills. However, the increased frequency of observation and assessment of junior trainees may place more demands on your time. We encourage you to speak with your attending physician and establish expectations for your role in coaching junior trainees. This way, you can

advocate for an equitable distribution of this responsibility between you and your staff physician, while balancing your own learning needs, clinical responsibilities, and personal wellness.

You can support junior resident physician learning by making sure your feedback is delivered and received in the safest and most helpful way. Consider checking in with junior trainees to find out about their preferences for how they would like to receive feedback, prior to providing it. Be mindful of providing the feedback in a safe environment, making sure it is in a reasonably private setting, at a time when the trainee is most receptive to feedback, and giving them a chance to ask for clarification. You can consult coaching resources (e.g. Coaching Primers: R2C2⁷ or Rx-OCR⁸), to give you a framework for providing feedback.

CBME-trained resident physicians can also play an informal coaching role by passing program-specific CBME best-practices to junior resident physicians. There are many documents with suggestions on how to navigate CBME (including this one!), and there is no better resource than YOUR lived experience in YOUR program; pay it forward and share your tips with new residents.

9. Identify staff championing CBME in your program; they help support your learning

Although CBME is a new paradigm shift in medical education and training in Canada, many physicians and educators have been championing this transition for a long time. Others may be new to the process, but are enthusiastic about the change. Identify staff physicians within your program who provide supportive and effective feedback. If possible, talk to senior resident physicians about their experiences and who they recommend as approachable supervisors. If you are in a program new to CBME, work as a cohort to identify supportive staff physicians early on.

The benefits are not limited to completion of assessments. Staff physicians may have ideas on how to best navigate CBME within your program and can provide mentorship as you progress. They can also advocate for improved implementation on your behalf and help trouble-shoot queries or complications when they arise.

10. Advocate with your peers to ensure you are best represented in CBME's implementation.

As CBME continues to be implemented throughout Canada it is important that resident physicians are included in the implementation process with representation on local competency committees. This allows resident representatives to provide peer experiences, ensuring a robust quality improvement mechanism. RDoC encourages resident physicians to advocate locally within their program, department, and university for this to occur in all programs. RDoC also recognizes there are systemic barriers to effective implementation of CBME that are outside a resident physician's control. These include efficient and accessible systems to document assessments, engagement level of local staff physicians and organization of schedules. RDoC will continue to advocate for continued improvements to the Universities, Royal College and the CFPC on behalf of resident

physicians across Canada. We are always looking for your feedback and experiences - please email us at training@residentdoctors.ca

- 1 Resident Doctors of Canada. [2018 National Resident Survey](#). Ottawa, On.
- 2 Josiah Macy Jr. Foundation. Conference Summary: Achieving Competency-based, Time-Variable Health Professions Education [Internet]. Available at: <http://macyfoundation.org/publications/publication/conference-summary-achieving-competency-based-time-variable-education>
- 3 E. Englander et al. Toward a shared language for competency-based medical education. *Medical Teacher* 39(6):582-587. June 2017.
- 4 Olle Ten Cate. Entrustment Decision-Making in Competency-Based Teaching and Assessment in Health Professions Education. *Med Sci Educ* (2016) 26 (Suppl 1):S5-S7.
- 5 M. Levine and G. Shorten. Competency-based medical education: Its time has arrived. Editorial. *Canadian Journal of Anesthesia* (2016) 63:802–806.
- 6 M. Levine and G. Shorten. Competency-based medical education: Its time has arrived. Editorial. *Canadian Journal of Anesthesia* (2016) 63:802–806.
- 7 J. Sargeant, H. Armson, E. Driessen, E. Holmboe and K. Konings. Evidence-Informed Facilitated Feedback: The R2C2 Feedback Model. *MedEd-PORTAL*. Available at: <https://www.mededportal.org/publication/10387/>
- 8 The Royal College of Physicians and Surgeons of Canada. RX-OCR Toolkit. Available at: <http://www.royalcollege.ca/mssites/rxocr/en/content/index.html#/>