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Doctors
of Canada



Médecins
résidents
du Canada



Resiliency Curriculum Program Evaluation Report



Resiliency
CURRICULUM



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Executive Summary

Physician health and wellness has become a topic of major interest in national and international medical societies in recent years. Resident physicians face a particularly high incidence of mental illness and burnout. According to the 2018 Canadian Medical Association (CMA) National Physician Health Survey^[1], significantly more residents report burnout (38%) and depression (48%) than in-practice physicians (29% and 32% respectively).

Resident Doctors of Canada (RDoC) has developed a national, peer-led Resiliency Curriculum that draws on the experience of training programs created and implemented by the Department of National Defence and the Mental Health Commission of Canada. RDoC's Resiliency Curriculum is designed to provide practical, skills-based training to help foster the ability to effectively identify, cope with, and recover from adverse events.

Presented here are the results of our Resident Module pre- and post-workshop surveys, provided to resident participants from 2016 to 2018. We anonymized the results by asking each respondent to create a unique personal identifier code. For this analysis, we only used data where the pre- and post-workshop personal identifier codes were identical, in order to perform a before-and-after analysis of participant attributes, attitudes, and beliefs. This approach limited our sample size to 96 respondents.

The majority of respondents were female (62%), aged 25-29 years (78%), and in their first year of residency (54%). Family Medicine (31%) and Pediatrics (25%) were the highest-represented specialties. Our respondents reported a reasonably high level of mental health and confidence in their ability to recognize signs of burnout and distress. Over 80% rated their current level of mental health as a 7 or above out of 10, and only 6% rated their current mental health as lower than 5.

Post-workshop, we noted significant improvements in respondents' perceived ability to recognize signs of burnout in themselves (79% to 88%) and in a peer (53% to 67%). 66% felt pre-workshop that they had the skills to cope with mental health stressors, traumatic events, and adverse situations. This improved to 80% after the workshop and suggests that the Resiliency Curriculum has been effective in teaching residents about evidence-based skills meant to help them thrive in challenging working environments.

However, we did not find compelling evidence that the respondents were able to make the leap from recognizing they had these skills to employing them and increasing self-reported resiliency scores. This may be due to a number of factors, including small sample size. Furthermore, we noted the persistence of stigma around mental illness, particularly at work. A large proportion of respondents noted that they would view it as a weakness if they had a mental illness and could not fix it on their own; a similar proportion said that they would be reluctant to seek help for a mental illness. There were small, non-significant improvements in each of these areas post-workshop.

Before and after the workshop, most residents cited lifestyle and social supports as actions they would take if experiencing burnout. After the workshop, there was a significant increase in the proportion of residents who

said they would say “no” to new commitments, but overall, only a minority endorsed taking time off or seeking medical attention to help manage burnout. In terms of retention, residents were most likely to have employed Tactical Breathing following the workshop, followed by meditation or reflection on their well-being.

Our evaluation is limited by the small sample size, largely related to the difficulty in acquiring responses from individual residents both pre- and post-workshop. Future evaluations need to be adjusted to streamline the evaluation process and introduce mechanisms to ensure better post-workshop response rates. Despite this limitation, this initial analysis suggests that the RDoC Resiliency Curriculum has been successful in improving resident confidence to manage adverse situations and to identify distress and burnout. It provides residents with practical tools that they take away and use in the weeks following the workshop. Further work needs to be done to address stigma and other barriers to seeking help. RDoC must provide residents with ongoing resiliency education and advocate for working environments which do not put residents at undue risk of burnout and mental trauma.

Background

About Resident Doctors of Canada

[Resident Doctors of Canada \(RDoC\)](#) represents over 10,000 resident doctors across Canada. Established in 1972, we are a not-for-profit organization providing a unified, national voice for our members. RDoC collaborates with other national health organizations to foster excellence in training, wellness, and patient care.

About the Resiliency Curriculum

Resiliency is the ability to recover from or adjust easily to adverse events. It is a critical trait for individuals working in high-risk environments such as healthcare. Resiliency can be fostered through the development of skills that allow individuals to effectively identify, cope with, and recover from challenging experiences.

RDoC has focused on the development of a Resiliency Curriculum that is national in scope, drawing from the highly successful [Road to Mental Readiness \(R2MR\)](#) program created and implemented by the Canadian Armed Forces and [The Working Mind](#) program taught by the Mental Health Commission of Canada (MHCC).

RDoC's Resiliency Curriculum is a practical, skills-based program that is designed to help mitigate stress and optimize performance. It is instrumental in helping residents overcome both the anticipated and the unexpected adversities of medical training. The Resiliency Curriculum promotes the importance of fostering supportive learning environments and advocates for a systematic approach to understanding and addressing stressors.

The primary component of RDoC's Resiliency Curriculum, and the subject of this evaluation, is the Resident Module, a half-day workshop delivered to residents by resident facilitators. A complementary Leadership Module for broader audiences was created to help promote a culture of wellness throughout the hierarchy of medical education, including administrative staff and attending physicians. Facilitators for the Resident Module and the Leadership Module are trained in a weekend-long Train-the-Trainer Course.

All data in this report is from the 3-hour Resident Module, which has the following learning objectives:

1. Identify early signs of distress and relevant early interventions.
2. Apply evidence-based skills to improve performance and thrive in challenging work environments.
3. Recognize when and how to seek support.

The workshop was delivered to over 1,100 residents across Canada between 2016 and 2018.

Methodology

Survey Design

Participants of the Resident Module were surveyed pre- and post- workshop using two versions of a survey that was designed by RDoC’s 2016-2017 Resiliency Working Group.

The first version of the survey was a hybrid of items from the Brief Resilience Scale (BRS)^[2], the Opening Minds Stigma Scale for Health Care Providers (OMS-HC)^[3], and The Working Mind Follow-up Questionnaire^[4]. The BRS and the OMS-HC are validated scales intended for use in research, the OMS-HC being specifically designed for healthcare providers. These scales, however, are limited by the reliance on participant self-assessment and tend to focus on attitudes more than actual behaviours.

The second version of the survey was adapted from the first version in 2017 to reduce the number of questions and increase response rate. Many of the questions were duplicated between version one and version two. Results from the two versions of the survey instruments were pooled where possible.

Distribution of the pre- and post-workshop survey links was coordinated with the programs whose residents participated in RDoC’s resiliency training from 2016 to 2018. Pre-workshop surveys were distributed one week prior to the workshop. Post-workshop surveys were distributed four weeks after the workshop date.

In each iteration of the pre- and post-workshop survey, respondents were asked to create a Personal Identifier Code based on personal information (i.e. first letter of the first street they lived on, last digit of their phone number, last number of their postal code, first letter of their birth month, first letter of high school name). This algorithm-based Personal Identifier Code was used to ensure respondent anonymity while comparing individuals to themselves across time (before and after the workshop).

Data Analysis

The dataset used for the analysis was limited to survey respondents whose self-generated Personal Identifier Code could be matched pre- and post-workshop. Over 1,100 residents participated in a Resident Module workshop, and 777 completed at least the pre-workshop survey. Of the respondents who completed the pre-workshop survey, 96 contributed post-workshop survey responses with a matched Personal Identifier Code. The analytical sample thus consisted of 96 respondents, which we will also refer to as the ‘matched’ dataset.

Matched Dataset (n=96)	Count	Percent (%)
Survey version 1	33	34.4
Survey version 2	63	65.6

Analyses to test if the characteristics of the matched sample differed significantly from the full pre-workshop sample (777 respondents) showed no apparent differences (Pearson's chi-squared test, $p < 0.05$) when testing on gender, age range, postgraduate training year, or residency program.

Subgroup analyses were not conducted because of the small number of matched respondents.

To reduce the complexity of analyzing five-point scale answer categories and focus on meaningful changes, the pre- and post-workshop findings were compared using an approach that pooled and dichotomized the agreement scale response categories. Here is how this was accomplished:

Standard coding refers to items where agreement with a statement was considered to constitute the desired outcome (e.g. "I feel confident that I could recognize signs of burnout in myself"). An increase in the proportion of respondents who either agreed or strongly agreed was considered to represent improvement in the domain or attitude being assessed.

For questions using the standard coding, strongly agree and agree responses were pooled into the "Agree" response and compared to the remaining categories, which were pooled and renamed "Did not agree".

In reverse-coded questions, agreement with a statement was considered to be the unfavourable outcome (e.g. "I would be reluctant to seek help if I had mental illness"). A decrease in the proportion of respondents who either disagreed or strongly disagreed with the statement was considered to represent improvement in the domain or attitude being assessed.

For the questions that were reverse coded, strongly disagree and disagree responses were pooled into the "Disagree" response and compared to the remaining categories, which were pooled and renamed "Did not disagree".

Results for the standard and the reverse-coded questions are reported in separate tables.

McNemar's Test (at a significance level of $p < 0.05$) was used to measure the before and after improvement. If the percentage of agreement after the workshop was greater than the percentage of agreement before the workshop, we considered this an improvement.

For questions limited to the first version of the survey, the number of respondents was often 27 or lower. In order to present data where there is better sample size, we have only included questions that appeared in both the first and second versions of the survey.

Results

Respondent Characteristics

This section reports on the characteristics (demographic information and mental health-related self-assessment) of the resiliency workshop participants. This information was only reported pre-workshop.

62% of respondents were female, in contrast to 37% reported by Resident Doctors of Canada’s (RDoC) 2018 National Resident Survey^[5]. This may be because Family Medicine and Pediatrics, the two specialties with highest representation in this evaluation, tend to have more female trainees than male^[6]. The majority of respondents were aged between 25 and 29 years (78%), which is consistent with RDoC’s findings. 54% of all respondents were in their first year of residency, compared to 33% respondents of RDoC’s National Resident Survey. 31% of respondents were training in Family Medicine, 25% were in Pediatrics, 19% were in Internal Medicine, another 19% were in a surgical program, and the remaining respondents’ specialties (6%) were categorized as “Medicine” (excluding Internal Medicine and Pediatrics). The Resiliency Curriculum was promoted heavily towards first year residents and Family Medicine residents in particular during the pilot project.

80% of respondents rated their current state of mental health 7 or above on a scale of 1 to 10, where 10 is defined as excellent. Only 6% rated their mental health less than 5. This is in line with the Canadian Medical Association’s (CMA) 2018 National Physician Health Survey^[1], where “high” psychological well-being was reported in 82% of resident respondents. Mental health ratings did not change from pre- to post-workshop. Despite these positive mental health self-assessments, both the CMA and RDoC also reported high rates of burnout in residents (38% and 52%, respectively). This discrepancy may be because residents (perhaps even physicians in general) have normalized the feelings of burnout to some extent, and may point to a need for greater awareness on how burnout is experienced in medicine.

Demographic Information

Gender

Gender (n=84)	Matched, %
Female	61.9
Male	38.1

Age Range

Age Range (n=95)	Matched, %
20 to 24 years	1.1
25 to 29 years	77.9
30 to 34 years	16.8
35 to 39 years	2.1
40 to 44 years	1.1
45 years and above	1.1

Postgraduate Training Year

Postgraduate Training Year (n=95)	Matched, %
PG Year 1	53.7
PG Year 2	27.4
PG Year 3	15.8
PG Year 4	2.1
PG Year 5	1.1
PG Year 6 and above	0.0

Residency Program

Residency Program (n=96)	Matched, %
Family Medicine	31.3
Medicine (excluding Internal Medicine and Pediatrics)	6.3
Internal Medicine	18.7
Pediatrics	25.0
Surgery	18.8

Mental Health Status

Self-Rated Mental Health

Please rate your current state of mental health on a scale from 1 (Very poor) to 10 (Excellent). (n=96)	Matched, %
1	0.0
2	0.0
3	3.1
4	3.1
5	6.3
6	7.3
7	21.9
8	30.2
9	18.8
10	9.4

General Mental Health Status

In general, how would you characterize your mental health? (n=96)	Matched, %
I have never had any mental health difficulties	19.8
I rarely have mental health difficulties	39.6
I periodically have mental health difficulties	34.4
I frequently have mental health difficulties	6.3
I constantly have mental health difficulties	0.0

Prior Diagnosis of Mental Illness

Have you ever been diagnosed with a mental illness (e.g. anxiety, depression, OCD, eating disorder, etc.)? (n=96)	Matched, %
No	78.1
Yes	21.9

Agreement Scale Questions

The next section reports on the pre- and post-workshop questions asking participants to rate their level of agreement with statements focused on stigma and resilience.

For the changes in agreement on the dichotomous 2-point scale, improvements were identified in 17 of the 18 standard coded statements; 8 of these changes were statistically significant. For the reverse coded statements, 4 of the 8 statements showed improvements; none of these changes were statistically significant.

Our observation, which is consistent with the findings of the Department of National Defense's evaluation of their Road to Mental Readiness curriculum^[7], is that there is a significant improvement in confidence in the ability to recognize signs of burnout or distress in oneself and others (questions 1, 4). Although there is still evidence of stigma and fear of disclosure of diagnoses of mental illness in the workplace (questions 10, 12), there was also evidence of improved comfort in discussing such issues with peers (question 11) and talking about mental illness at work (question 13) or with a junior colleague (question 14).

Respondents noted significant improvement in their belief that they have the skills to adapt to or cope with mental stressors, traumatic events, or adverse situations (questions 16, 17), but it is less clear that this translates into resiliency as defined as the ability to bounce back or recover from such events. While there were improvements in three of the six items from the Brief Resilience Scale (questions 21 through 26), none of these changes were statistically significant. Providing residents with skills to manage stressors is certainly a positive and intended outcome of the workshop. However, the next step is to help provide ongoing training and advocate for a learning environment where these skills can be implemented effectively to hopefully increase residents' ability to bounce back in the face of expected and unexpected work and life stressors.

Only 8% of respondents on the pre-workshop survey said that they would tell a supervisor if they had a mental illness, and this had no significant improvement at the post-workshop survey (12%). 50% of respondents on the pre-workshop survey said that they would be reluctant to seek help for a mental illness, with non-significant improvement to 39% at the post-workshop survey.

In summary, while it appears that RDoC has made some progress in addressing stigma, barriers to seeking care, and the confidence in using skills to reduce stress, there remain significant concerns which are difficult to tackle. There should be ongoing focus on building mental health education throughout the medical education hierarchy, as residents may rely on the understanding and openness of attendings and supervisors in order to be able to seek help. Furthermore, RDoC must continue its advocacy work to address other systemic conditions that contribute to burnout, poor mental health, and difficulties in accessing help. The Canadian Armed Forces, since their widespread adoption of resiliency education, has seen a significant increase in the number of members seeking mental health support^[7]. Their experience suggests that our goals to tackle stigma, improve resiliency, and facilitate help-seeking, are well within reach, with continued work and determination.

Matched Before and After: 2-Pt Scale Agreement Questions, Regular Coding

Percentages reflect respondents who agreed or strongly agreed with the statement.

Q #	Statement	n	Percent, Before	Percent, After	Improvement	p-value	Sign.
1	I feel confident that I could recognize signs of burnout in myself.	87	78.9	87.5	Yes	0.0290	Yes
2	I feel confident that I could identify early signs of distress in myself.	87	80.0	87.5	Yes	0.1088	No
3*	I feel confident that I could use specific coping strategies to reduce stress.	59	59.0	75.4	Yes	0.0075	Yes
4	I feel confident that I could identify a peer suffering from burnout.	60	53.2	67.2	Yes	0.0067	Yes
5	I feel confident that I could find resources for residents in distress.	86	54.8	62.5	Yes	0.0947	No
11	If I had mental illness, I would tell my friends.	87	35.1	46.6	Yes	0.0389	Yes
12	If I had mental illness, I would tell my supervisor.	87	8.4	12.5	Yes	0.2568	No
13	I would feel comfortable talking about mental illness at work.	87	26.3	38.6	Yes	0.0076	Yes
14	If a more junior colleague had mental illness, I would want him/her to tell me.	87	53.2	67.0	Yes	0.0184	Yes
15	Special effort should be made to accommodate the particular needs of residents with mental illness.	87	77.9	76.1	No	0.7963	No
16*	I have the skills to adapt to mental health stressors.	57	65.6	81.4	Yes	0.0209	Yes
17	I have the skills to cope with traumatic events or adverse situations that are beyond my control.	85	66.3	80.2	Yes	0.0218	Yes
18*	I believe I can cope well when facing challenging situations and adversity.	58	72.6	79.7	Yes	0.2850	No
19	I believe I can resist being negatively affected by traumatic events or adverse situations.	83	46.8	58.3	Yes	0.0833	No
20	I believe I can recover quickly if I am negatively affected by traumatic events or adverse situations.	85	58.9	60.5	Yes	1.0000	No
21*	I tend to bounce back quickly after hard times.	58	64.5	67.8	Yes	0.5930	No
23*	It does not take me long to recover from a stressful event.	58	50.0	64.4	Yes	0.1167	No
25*	I usually come through difficult times with little trouble.	58	50.0	57.6	Yes	0.4386	No

*Question numbers with an asterisk were only asked in version two of the survey. All other questions were asked in both versions one and two.

Matched Before and After: 2-Pt Scale (Dis)Agreement Questions, Reverse Coding

Percentages reflect respondents who disagreed or strongly disagreed with the statement.

Q #	Statement	n	Percent, Before	Percent, After	Improvement	p-value	Sign.
6*	I feel more comfortable helping a patient who has a physical illness than helping a patient who has mental illness.	60	22.6	18.0	Yes	0.5271	No
7	All things being equal, I would rather not work with a colleague who has mental illness.	87	79.8	71.6	Yes	0.0522	No
8	If I had mental illness and could not fix it myself, I would see it as a personal weakness.	87	43.2	38.6	Yes	0.5127	No
9	I would be reluctant to seek help if I had mental illness.	87	49.5	39.8	Yes	0.1060	No
10	If I were receiving treatment for mental illness, I would not disclose this to any of my colleagues.	86	14.9	18.2	No	0.7389	No
22*	I have a hard time making it through stressful events.	57	54.1	61.0	No	0.3458	No
24*	It is hard for me to snap back when something bad happens.	58	66.1	66.1	No	0.7630	No
26*	I tend to take a long time to get over setbacks in my life.	58	66.1	69.5	No	0.6171	No

*Question numbers with an asterisk were only asked in version two of the survey. All other questions were asked in both versions one and two.

Retention of Resiliency Training Knowledge

This final section reports on the retention of knowledge and concepts discussed during the resiliency workshop, including the following topics:

- Actions that can be taken if one might be experiencing burnout
- Frequency of reflecting on one's own mental health
- Utilization of tools taught during the resiliency workshop

Respondents indicated that if they thought they might be experiencing burnout, the most common actions they would employ would be to: 1) try to get adequate rest, food and exercise; 2) talk with friends, family and/or colleagues; and 3) say “no” to new commitments. In fact, there was a significant increase in the number of residents who said that they would say “no” to new commitments. These results suggest that residents take burnout seriously and have plans in place to help manage this. However, actions that require alterations to work or study, or require taking time to access resources, are less frequently cited. Whether for stigma, practical, career-related, or other reasons, respondents were less likely to employ interventions such as taking time off for seeking medical attention.

When asked about their frequency of reflecting on mental health in the past month, “once or twice” was the most frequently cited answer; however, there were no significant differences between pre- and post-workshop. This may be due to the fact that the workshop is offered as a one-time intervention and did not present any opportunities for follow-up at the time these evaluation tools were in use. We are developing the Resiliency Curriculum to become a more longitudinal approach to improving resident wellness, including the launch in 2020 of a Resiliency Mobile App to help residents practice the skills they learn in the workshop on a day-to-day basis.

The second version of the survey had a post-workshop question that asked respondents to report the tools from the resiliency workshop that they had used in the past three weeks. Twenty-eight residents responded to this open-ended question. The most common tool appeared to be Tactical Breathing (from the Big Four+), mentioned nine times. Other Big Four+ tools were mentioned four times. The Mental Health Continuum was mentioned twice. Seven respondents reported not using any of the tools in the three weeks following the workshop.

Action(s) Taken If Experiencing Burnout

What action(s) would you take if you felt that you might be experiencing burnout? (Please select all that apply.) (n=63)	Pre-Workshop, % Selected	Post-Workshop, % Selected
Familiarize yourself with mental health resources	42.9	46.0
Access mental health resources	38.1	42.9
Say “no” to new commitments*	58.7	76.2
Try to get adequate rest, food and exercise	90.5	87.5
Talk with friends, family and/or colleagues	85.7	81.0
Take breaks	50.8	57.1
Take formal time off	20.6	20.6
Seek medical attention	28.6	31.7

*Observed difference is statistically significant using McNemar’s test, $p < 0.05$.

Frequency of Reflecting on Mental Health in the Past Month

How often have you actively reflected on your mental health over the past month?* (n=63)	Pre-Workshop, % Selected	Post-Workshop, % Selected
Not at all	5.3	0.0
Once or twice	43.9	40.4
Once a week or more	29.8	36.8
Daily or almost daily	21.0	22.8

*Observed differences are not statistically significant using Wilcoxon signed rank sum test, $p < 0.05$.

Tools from The Resiliency Workshop Used in the Past 3 Weeks

Response Themes (n=28)	Frequency Count
Tactical Breathing	9
Goal Setting	2
Visualization	1
Big Four+ (unspecified)	1
Mental Health Continuum	2
Other topics discussed in the workshop	
Reflection/meditation	5
Social time, connecting with friends & family	3
Taking care of one's body (exercise, sleep)	3
Taking a break	2
Reviewing available resources	1
None	7

Limitations

The caveat of our matched pairs approach is that there was a limited number of matches. Cases that had to be dropped included respondents who completed the pre-workshop survey but not the post-workshop survey and vice-versa, as well as any respondents who may have completed both surveys but failed to report a consistent Personal Identifier Code. The consequence of the lower sample size available for analysis generally translates to low power, meaning that large changes have to be observed before a finding can be deemed statistically significant.

Furthermore, there is potential for selection bias. While the matched sample of 96 showed no apparent differences compared to the full pre-workshop sample of 777 when testing on gender, age range, postgraduate training year, or residency program, it could still be that the subset of residents who completed the two surveys may be different from the general population of residents participating in the workshops. For instance, it is possible that residents with better mental health may have felt more comfortable answering the questions, thus skewing the results of our evaluation.

We were also limited by our use of two survey versions. While we pooled results from both versions were possible, we had particularly low response rates for questions that only appeared in version one and ultimately could not use this data.

Future evaluation planning should focus on increasing response rate, particularly of the post-workshop survey, and simplifying the evaluation process. The Resiliency Curriculum's Leadership Module and Train-the-Trainer Course should also be included in future evaluations.

Despite these limitations, we are excited to see that RDoC's Resiliency Curriculum appears to support residents' ability to recognize signs of burnout and augment their confidence in managing stressful situations. RDoC continues to advocate for systemic changes in medicine that will further reduce stigma and other barriers to seeking help, and foster a safe and positive working environment for Canadian residents.

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