CMAJ NEWS

July 5, 2013

Residents prepare for switch to competency-based medical education

Beginning in 2017, medical residents training in Canadian teaching hospitals will be part of the biggest transformational change in medical education since 1910, when Sir William Osler introduced the residency training model still in use today.

The change will signal a shift away from "time-based" residency programs to a "competency-based" model, and will eventually cover all 78 specialties governed by the Royal College of Physicians and Surgeons of Canada. Family physicians will also be included.

"Our current residency programs are weighted toward 'knowledge' and that's not enough," says Dr. Jason Frank, director of specialty education with the Royal College.

"Knowledge" does not equal "competence," and some residents are able to do well on exams without having acquired certain competencies, says Frank.

Residency programs have what he bluntly called a "failure to fail" culture. Residents might not be entirely aware of what is expected of them. Supervisors and preceptors don't inform the resident of what is expected, or don't know what the resident's skill level in a certain area might be. The result is that some residents enter independent practice without ever mastering some needed skills, says Frank.

Under the Royal College's new Competency-Based Medical Education (CBME) model, residents will be required to demonstrate competencies that will be spelled out according to their stage of development as a physician, not simply by the number of years in a residency program.

Completion of specific competencies will represent "milestones" that are fundamental to the CBME model and will provide clearly defined targets for learning and assessment. A resident will not be able to complete the program, or write the college's certification exams, until all milestones have been reached.

"The goal will be to show that you have met these milestones — not just that you have put in time," says Frank.

For example, a first-year resident's assessment might note that a particular skill or competency was at "orientation" level. Over the years of the program, the resident would progress to the foundational, core and translational levels.

So far, the response to the new model from academics and residents seems favourable.

CBME will impose more work on preceptors, because they will have to take more time to evaluate whether each resident has achieved every specified competency leading to each milestone, says Dr. Michael Ott, program director for the General Surgery Residency Program at the Schulich School of Medicine and Dentistry, in London, Ontario.

However, the new system will help simplify how the Final In-Training Evaluation Report (FITER) is done. FITER, the cumulative summation of the resident's skills, is required before a resident can write the Royal College certification exams. The problem

is that FITERs are usually prepared by the program director earlier in the final year, but the exams are written in June. There is no way of ensuring that the resident will have mastered all the needed competencies by then, says Ott.

The CBME model should also make it easier for preceptors to identify residents who are falling short on the required competencies — and offer remedial help — before the resident progresses too far into the program, he adds.

The Canadian Association of Internes and Residents sees the change as necessary. Vice President Dr. Mathieu Dufour, a resident in forensic psychiatry, says more work for the preceptors and residents is to be expected during the transition years when the new model is being introduced.

"To me, this [added workload] is necessary to improve medical education. We want to make sure that what we learn in our residencies will be exactly what we need to learn to practise. The education will be more focused on what we really need to learn."

As for how smoothly the new model works in practice, Duford pointed out that the CanMeds framework, which spells out competencies all doctors should have, and has now been adopted in 26 countries, was originally introduced in 1995. "And we're still trying to optimize it."

Dr. Taryn Taylor, a third-year resident in obstetrics and gynecology in London, said the new model could benefit many residents. "With this model, residents will know where they need remediation. A discipline like ob/gyn is two-track, so I would be able to see fairly easily that maybe my obstetrics is fine but I need more work on the gynecology skills," she says.

This is a good thing, according to Dr. Chris Watling, Schulich's director of postgraduate medical education. "With this new system the responsibility for meeting those milestones is in the resident's hands. There will be more incentive for the resident to work with the program director to see how he or she can reach those milestones. It is up to the resident to demonstrate that he or she is ready to move on." — Cameron Johnston, London, Ont.

DOI:10.1503/cmaj.109-4530