ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
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Commitment to Action

Royal College statement on updated expectations for CBD program implementation

Updated draft April 12

Rationale for immediate change

As we approach year six of implementation of Competence by Design (CBD), clear signals about the benefits and challenges of the CBD model have emerged from both formal program evaluation and feedback from our invested partner groups. Important challenges include the burden of using Entrustable Professional Activities (EPAs) to both frame regular feedback to residents and to assemble excessive data points for resident assessment, time and resources required to implement all aspects of CBD as designed, deploying an electronic learner portfolio, and associated impacts of CBD-related changes on resident and faculty wellness.

It is apparent that our approach to improving education and patient care through the introduction of CBD across Canada has had several unintended negative impacts. While we remain confident in the merits of competency-based medical education (CBME) and are committed to the implementation of related key principles across all specialties, we recognize that a "one size fits all" approach does not consider unique obstacles and opportunities within each local institution, discipline, and program. We also recognize that part of the solution involves addressing barriers of CBD that are at the systems level, outside of the control of individual programs. We trust that postgraduate education leaders will continue delivering quality medical education expected by society, if given flexibility to best adapt CBME within the context of their programs.

It is time to refocus efforts on orienting the CBD model to the core principles of CBME intended to improve residency education, while respecting the resources available across institutions and incorporating lessons learned thus far. Increased flexibility of implementation is needed, along with enhanced opportunities for local institutional education leaders to deliver CBD in more meaningful, efficient and authentic ways. In providing this needed relief from what has been seen by some as an overly rigid system, we must accept that program curriculum design, examination eligibility and certification decisions are all predicated on CBME approaches working effectively in our residency programs. Programs are encouraged to optimize implementation within their own contexts and resources while maintaining the spirit of the standards articulated by the specialty committees including the program directors.

This document is intended to give programs more agency over how they implement specialty-specific standards and CBD document suites, with a distinct focus on easing the

burden of assessment that many have experienced. Retaining the principles of increased regular meaningful feedback to learners and enabling confident promotion decisions will require thoughtful integration of EPAs and other modalities into a coherent system of assessment. We hereby emphasize that Royal College technical guides (e.g. #1 or #3) provide detailed advice for high fidelity CBD implementation that is compatible with accreditation standards but are intended to be exemplar guidelines and should not, in themselves, be used to determine minimum expected standards.

The Committee on Specialty Education (CSE) has approved this document, effective immediately, which outlines the minimum expectations (essential requirements) for program adherence to CBD principles as reflected in the general and specialty-specific accreditation standards, as well as Royal College policies. Critical requirements for meeting accreditation standards will continue to include use of specialty-specific competencies and required educational experiences, the need for deliberate promotion decisions by competence committees, entrustment of each resident in the portfolio of specialty-specific EPAs in some manner, and evidence of regular, ongoing feedback and coaching. The requirements of these basic principles of CBD are explained below.

ESSENTIAL REQUIREMENTS OF CBD PRINCIPLES FOR ACCREDITATION

1. **Stages of training**
   CBD organizes residency training into four developmental stages and clearly lays out markers for teaching and required training experiences at each stage. Each stage of training has associated learning experiences, assessment plans, and identified outcomes.

   - Programs must be structured such that there is clear and deliberate decision-making about resident progression through the stages.
   - Programs are expected to deliberately map all required competencies to a learning experience and assessment strategies.
   - Programs have the flexibility to determine the evidence on which stage-promotion decisions are made and how it will be reviewed and assessed, based on individualized resident learning plans.
   - While EPAs are identified as being part of a particular stage of training, residents can pursue EPAs outside of their current stage if an opportunity presents itself. Also, a resident may be promoted to the next stage with a limited number of EPAs remaining in the previous stage, providing all EPAs are entrusted by the end of training. How this is operationalized is at the discretion of the program competence committee.

2. **Assessment of learning**
   Assessment methods should be purposefully chosen for their alignment with desired resident outcomes. While the Royal College developed sample assessment forms to assist with EPA observation, procedural competencies, multiple-source feedback, and

narrative observation, institutions and programs may use any or 'thoughtfully chosen assessment instruments of their choosing,

- Programs are expected to use multiple types of assessment tools and/or methodologies across their system of assessment to obtain qualitative and quantitative data.
- The specialty committee of a discipline recommends assessment tools and provides guidance on how they can be implemented locally. However, each institution has the authority and mandate to adopt, develop and use the assessment tools that are best suited to their programs.
- Assessment methods must be documented, accessible to residents, and the basis of competence committee decision-making.
- For accreditation, programs are expected to show a curriculum plan that links assessment strategies with expected stage-specific competencies, including EPAs.
- Not everything that is important to assess should be assessed using EPAs. Assessment tools should be multimodal and capture the full range of resident learning across various learning experiences. Specifically, EPAs should not be the sole source of data to inform decisions, nor should entrustment in an EPA be construed as evidence that no further exposure to related content is required.
- At the end of training, a resident's postgraduate dean and program director, in consultation with a competence committee, must submit an attestation confirming the achievement of all training requirements, including demonstration of competence in the required EPAs by the resident. This is the evidence on which access to the examination and certification is based.

3. Assessment of Entrustable Professional Activities

EPAs are authentic tasks of a discipline as defined by the specialty committee of that discipline and form an important part of the assessment strategy in contemporary competency-based programs.

- Discipline-specific training standards provide guidance on a suggested number of entrusted EPA observations, and these are not intended to be used as quotas that will be audited at the time of accreditation. Local programs can determine the number of entrusted observations required for each EPA and align this with the need to assess residents relative to all contextual variables. A specific number of observations is not required for Royal College accreditation.
- Qualitative-focused observations (e.g. narrative text/comments) that are timely, constructive, and specific are highly valuable to guide resident learning and should be an integral part of the work-based assessment design,
- A program, or its PGME office may determine which combination of EPA observation form components to include (e.g. bolded or unbolded milestones, entrustment scales (O-score or other), types and number of comment boxes), so long as the chosen components enable robust decision making by their competence committee(s).

- Competence committees must have evidence, based on direct observation, to enable decision-making about resident entrustment relative to the required EPAs. Programs and competence committees have the authority to determine the appropriate amount and type of both qualitative and quantitative evidence required in the system of assessment to make decisions within their training environments, as long as both types of evidence are used.
- [Repeated from 1, above] While EPAs are identified as being part of a particular stage of training, residents can pursue EPAs outside of their current stage if an opportunity presents itself. Also, a resident may be promoted to the next stage with a limited number of EPAs remaining in the previous stage, providing all EPAs are entrusted by the end of training. How this is operationalized is at the discretion of the program competence committee.

4. Feedback and coaching

   In CBD, it is desired that the role of clinical teacher evolves from pure supervisor to also include observer and coach. When clinical teachers directly or indirectly observe the work residents do, these observations provide learning opportunities.

   - Supervisors should provide resident physicians with specific and actionable feedback based on observations to guide them through a growth process resulting in performance enhancement. This "coaching in the moment" should occur as part of daily work and over the course of a learning experience.
   - Programs are expected to demonstrate that regular feedback is being provided and used meaningfully in longitudinal educational programming.

5. Evidence-informed decision-making

   Competence committees regularly review the status of a resident's progress and make periodic recommendations as to residents' readiness to be promoted between stages of training, sit their exam ('exam-eligible'), and begin unsupervised practice ('certification-eligible').

   - All programs require a competence committee or equivalent that collates, synthesizes, and appraises qualitative with quantitative data to assess a resident's progress towards competence. Competence committees must make deliberate, data-informed decisions about resident promotion to the next stage of training.
   - Residency program committees (RPCs) have overall responsibility for resident assessment, and competence committees report to RPCs. As such, the RPC is responsible for and must be aware of CC decisions. Programs have the flexibility to determine the communication and decision-making processes between the CC and RPC, in alignment with their institution's policies and procedures.

The context of CBD within accreditation

Accreditation is a holistic evaluation of a program. It is not an evaluation of CBD implementation. Accreditation seeks to verify that residents have a safe learning

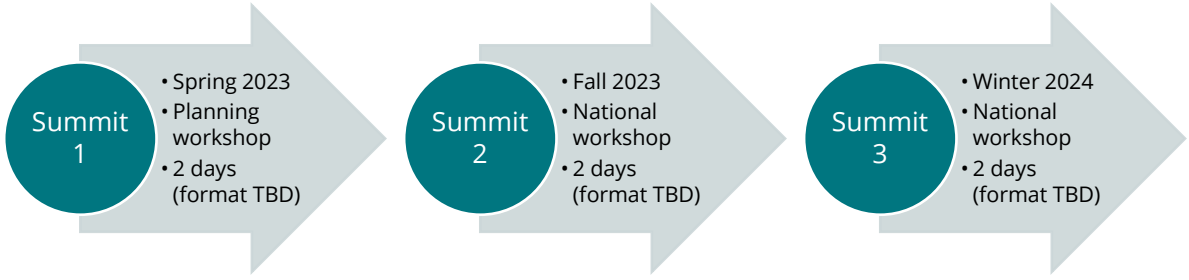
environment with appropriate supervision, that there is a continuous quality improvement process in place and functioning, that programs are appropriately resourced, and that there are effective leadership and communication processes. The standards and evaluation process focus on the principles of sound educational design. Those involved in the accreditation review and decision-making (surveyors, specialty committees, accreditation committees) seek to verify that the minimum requirements for CBD implementation, as outlined above and detailed in the general and specialty-specific standards of accreditation, are in place.

We recognize, however, that it can feel like accreditation puts an undue emphasis on certain components of CBD. We hope this statement helps to clarify for institutions and programs what are and are not requirements articulated in standards. In turn, we also commit to ensuring that both volunteers and staff involved in the accreditation process have a clear and renewed understanding of the level of focus and the type and amount of information reviewed, as well as the importance of considering the wider context in which residency training takes place, including factors that impose limitations beyond a program's control, such as hospital staffing shortages and challenges of poorly functioning electronic systems.

The path forward

The purpose of this document is to provide clarity on the enhanced degrees of flexibility in the system and leverages the tremendous efforts of educational champions across the country to build a stronger educational system for residents to thrive in throughout their training. We acknowledge that more formal design adaptations in the CBD model are required to achieve the intended impacts of competency-based medical education, improve the training experience, and address the impact on faculty and residents. With a renewed commitment to action, the Royal College will invest in a national collaborative process over the next 12-18 months to reimagine how CBD can enhance residency training across Canada.

This will involve a series of three Royal College National Summits with key leaders from our invested partner groups to co-create the path forward - the evolution to CBD 2.0.



After extensive member checking and opportunities for review from the various invested groups across the country, this collaborative work will then be finalized based on further input and refinement. A final CBD Summit will be held to finalize the national consensus document before submission to the Royal College Committee on Specialty Education (CSE)

for decision (Spring 2024). It is hoped initial modifications from the national summits on CBD can begin on July 1, 2024 – with the understanding that some changes to the CBD Framework will occur over a multi-year timeline.

Please direct questions or comments to cbdsecretariat@royalcollege.ca.