Matthew Roberts
Division of Urology, Department of Surgery,
University of Ottawa, Ottawa, ON, Canada

Cite as: Roberts M. Making Competence by Design work is a shared responsibility. *Can Urol Assoc J* 2023;17(4):101-2. http://dx.doi.org/10.5489/cuaj.8346

See related article on page 94

Making Competence by Design work is a shared responsibility

As I read through the report by Aubé-Peterkin et al,[1] on urology resident and faculty experiences during the early years of Competence by Design (CBD), I found myself nodding in recognition of a familiar story — there have been several speed bumps and unintended negative consequences during the rollout of CBD across residency training in Canada. And, although this qualitative study was performed using focus groups of residents and faculty at a single urology residency program, I think the findings can likely be generalized across all urology residency programs (and probably residency programs in all disciplines) in Canada.

I have been a urology program director (PD) since just prior to the initial CBD launch in 2018 and have an almost identical experience to the participants in this study. Through conversations with other PDs in our field, I have observed that all programs have faced similar struggles.

The main concerns identified by the resident and faculty focus group in the Aubé-Peterkin study were increased workload, delayed completion of Entrustable Professional Activities (EPA) assessments leading to low-quality feedback, lack of direct observation in non-surgical activities, variable supervisor guidance and buy-in, and lack of understanding of CBD. There was also a recognition that the adoption and implementation of CBD has had an impact on resident wellness. These match up almost exactly with the results of the Canada-wide "Pulse Check" survey conducted by the Royal College of Physicians and Surgeons of Canada (RCPSC) that included residents from residency programs in all disciplines.[2] The fact that, through qualitative and more open-ended questioning, the investigators have identified the same concerns found in the RCPSC Pulse Check further validates that these are the key topics to focus on as programs work through the process of implementing CBD.

As the authors note, there is little study of the implementation of CBD specifically in surgical specialties. Their finding that direct observation of urology residents occurred almost exclusively in the operating room and rarely in other clinical settings was interesting and familiar. I can count on one hand the number of times in my career that I have gone down to the emergency department to watch a resident conduct a complete patient assessment and generate a treatment plan from start to finish. This highlights a bias we have in surgery towards the importance of assessing surgical skills over other clinical skills and provides one specific area in which surgical educators can potentially use CBD to improve residency training.

So, has CBD enhanced residency education at all? The authors of this study indicate there have been some benefits to CBD realized by supervisors and residents, including better tracking of progress and an increased quantity (although perhaps not quality) of feedback. The RCPSC Resident Pulse Check[2] and the earlier 2019 CBD Program Evaluation Recommendations Report[3] found several positive outcomes, including that residents are receiving more actionable feedback, struggling residents are identified earlier, and that there is enhanced clarity of program requirements.

I have always been a believer that competency-based medical education holds great promise as a tool to enhance the quality of residency education, and in theory, it makes perfect sense: design a curriculum around a defined set of learning objectives (EPAs and milestones), observe the resident performing these, provide and document feedback in a timely fashion and on a regular basis, and have a committee objectively review a resident's performance data before they can progress to the next stage of training. But as we are learning, the devil is in the details of implementation. This study and others serve to shed light on this fact as ***we*** work through the process of adopting CBD. By ***we***, I mean residents, individual

residency programs and PDs, university postgraduate medical education offices and deans, and the RCPSC.

It is clear to me that optimizing the implementation of CBD and ***solving*** some of the problems that have been encountered so far require the participation of all parties involved, including allocation of appropriate resources to resident support, faculty development, and IT infrastructure. The burden of making CBD work cannot be shouldered primarily by residents; it is really a shared responsibility.

COMPETING INTERESTS: The author does not report any competing personal or financial interests related to this work.

REFERENCES

1. Aubé-Peterkin M, Ehlebracht A, Petrella F, et al. Feedback and formative assessment in Competency by Design: The experience of residents and supervisors within a urology training program. Can Urol Assoc J 2023;17:94-100. http:// dx.doi.org/10.5489/cuaj.8103
2. Royal College of Physicians and Surgeons of Canada. Competence by Design: Resident Physician Pulse Check. Report from the 2021 Collaborative Study [2022]. Available at: https://www.royalcollege.ca/rcsite/cbd/cbd-program-evaluation-e. Accessed March 5, 2022
3. Royal College of Physicians and Surgeons of Canada. CBD Program Evaluation Recommendations Report. Findings from FMRQ, RCPSC [2019]. Available at: https://www.royalcollege.ca/rcsite/cbd/cbd-program-evaluation-e. Accessed March 5, 2022

CORRESPONDENCE: Dr. Matthew Roberts, Division of Urology, Department of Surgery, University of Ottawa, Ottawa, ON, Canada; mroberts@toh.ca