CBD Anesthesia

Background, design, implementation
Objectives

• Review rationale for a move to ‘Competence by Design’

• Provide an overview of the key educational components of a CBD curriculum

• Provide a detailed overview of the Anesthesia CBD curriculum at uOttawa
Journey of the Resident

Current Model

Competence by Design

med.uOttawa.ca
Current Residency Curriculum Model

Basic Clinical year
Junior Residency
Senior Residency
Exam Preparation/Electives
Certification

ITERs
In-training exams
← Exams

Problems with current residency training model

**Educational Tensions**
- Failure to fail
- Pass or fail
- Greater burden placed on faculty
- Residents can be disempowered
- Little direct observation
- High stakes national exams
- ‘Recipe’ for success is too simple

**System Challenges**
- Learning judged by time spent, not ability
- Trainees unprepared at stages
- Variable workplace assessment/failure to fail
- Concerns about patient harm
- Missing content/experiences
- Faculty overload & educational inefficiency
- Lack of support for lifelong learning

New World: Competence by Design (CBD)

**Figure 2.** Spectrum of skills acquisition (Dreyfus & Dreyfus 1980).

**Figure 3.** General curve of skills acquisition reproduced from ten Cate (2010).

Conceptual framework for performance assessment. Khan and Ramachandran, Medical Teacher 2012; 34: 920-928
New World: Competence by Design (CBD)

Competence is about performance – the right thing, for the context, at the right time

- Multi-year, transformational change initiative in specialty medical education
- Focused on the learning continuum from the start of residency to retirement
- Based on a competency model of education and assessment
- Designed to address societal health need and patient outcomes
RC CBD: Not Time Free

• “Pure” competency-based medical education (CBME) is time free

• CBD is a hybrid model of CBME - it is **NOT** time free

• The number of years of residency to remain the same.
  
  – Residents will be able to achieve competencies (measured by milestones and Entrustable Professional Activities (EPAs) at their own rate within the defined residency program timeframe.

Why CBD? Why Now?

We need a system that:

- Addresses changes to patient and societal needs
- Assesses competence, but teaches for excellence
- Ensures competencies in all domains evolve across the continuum of medical education (residency to retirement) and
- Enables flexibility; allows physicians to identify when and how changes apply to practice

RC’s Proposed CBD Residency Model

Transition to Discipline / Orientation
• Portfolios

Foundation
• Multi-faceted assessment

Core / Electives

Transition to Practice
• Final Competency Assessment

Certification

← Exams

How do we move from current training model to competency based model?
Key Concept of EPAs: Entrustment

“What can I safely delegate with indirect supervision?”

EPAs and milestones

Entrustable Professional Activities (EPAs): for assessment
An essential task of a "discipline" that an individual can be trusted to perform independently in a given context

- E.g. Recognize and manage conflicts of interest in independent practice

Milestones: for teaching
A defined, observable marker of an individual's ability along a developmental continuum

- E.g. Demonstrate a commitment to patient safety and quality improvement through adherence to institutional policies and procedures

# Example of Draft Leader Milestones (generic)

<table>
<thead>
<tr>
<th>Key &amp; enabling competencies</th>
<th>Requirements for Residency</th>
<th>Transition to Discipline</th>
<th>Foundations of Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Contribute to the improvement of health care delivery in teams, organizations, and systems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Apply the science of quality improvement to contribute to improving systems of patient care</strong></td>
<td>Describe the relevance of system theories in health care at the practice, organization, and health system levels. Describe a patient’s longitudinal exp. through the health care system. ...etc</td>
<td></td>
<td>Describe quality improvement Methodologies. Compare and contrast the traditional methods of research design with those of improvement science...etc</td>
</tr>
<tr>
<td><strong>1.2 Analyze adverse events and near misses to enhance systems of care</strong></td>
<td>Describe the elements of the health care system that facilitate or protect against adverse events or near misses. ...etc</td>
<td>Describe the process for reporting adverse events and near misses. ...etc</td>
<td>Report patient safety hazards and adverse events. ...etc</td>
</tr>
</tbody>
</table>
Medical Oncology Example: EPA and milestones

Medical Oncology EPA
(*the task that must be accomplished*)
- Initial care for urgent and emergent oncologic situations.

Milestones which make up the Medical Oncology EPA
(*abilities needed to accomplish the task*)
- Recognize urgent and emergent oncologic issues, including but not limited to, pain crisis, febrile neutropenia, uncontrolled diarrhea, hypocalcemia, epidural cord compression and malignant bowel obstruction.
- Select and administer appropriate interventions for urgent and emergent oncologic issues.
- Identify the limits of their own expertise and appropriately seek assistance and supervision.

Benefits of EPAs and milestones

Curriculum

Abilities expected of a resident at a defined stage of training

Assessment

Meaningful, measurable markers of progression of competence
CanMEDS 2015: Milestones and EPAs

- More frequent assessment and meaningful supervision
- Greater engagement in the pursuit of abilities, not just knowledge
- Clearly defined targets for acquiring competency and meeting standards throughout training
- Better preparation to serve patients and communities
- More flexible timeframe, focusing on personal development
- Ability to continue to strive towards mastery of skills and abilities beyond training and throughout practice
Phased Implementation with Specialties: RC’s Proposed Plan

RC’s Phased Implementation: First & Second Adopters

First round of adopters – begin July 2016

- Medical Oncology
- Otolaryngology – Head and Neck Surgery

Second round of adopters – begin July 2017

- Anesthesiology
- Forensic Pathology
- Gastroenterology
- Internal Medicine
- Surgical Foundations
- Urology
# RC’s Proposed Implementation: All Disciplines

<table>
<thead>
<tr>
<th>2018 (Cohort 3)</th>
<th>2019 (Cohort 4)</th>
<th>2020 (Cohort 5)</th>
<th>2021 (Cohort 6)</th>
<th>2022 (Cohort 7)</th>
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<tr>
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<td>PMR</td>
<td>Neurology</td>
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<tr>
<td>Adolescent Med.</td>
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</table>
CBD at uOttawa – Anesthesiology Residency Program

• CBD curriculum has been in development for over 2 years

• Hybrid model based on accepted Royal College FIRE Grant

• 1st cohort of residents started on July 1, 2015
WHY Change?

• Problems with the educational model
  • Move to competency assessment
  • Problems with evaluation

• Patient safety
  • Increased accountability at all levels of medical training

• Restricted duty hours
  • CAIRS, ACGME, Europe, and ANZCA have imposed limits in continuous work hours

• Escalating costs
  • Training costs $285,000 - $760,000 per resident
  • Average resident debt load $158,000
  • Current training requires 5-15 years of post-secondary education
WHY Change?

Current Approach
• Anesthesia training programs in Canada are 5 years in duration
• Based on National Curriculum for Canadian Anesthesia Residency

Better Approach
• Modules replacing current block schedule system
• Learner-centered approach
• Outcome-based approach
• Active learning vs. passive learning
• Rigorous, robust, and regular (3 R’s) formative and summative assessments
• Advancement based on milestone achievement rather than time, resulting in the potential for a shorter training period
CBD Curriculum Overview

Stages of Training

Transition to Discipline → Foundations of Discipline → Core I → Core II → Transition to Practice

“Woven” within the Stages of Training

Intrinsic CanMEDS roles

Simulation
# Sample Schedule (4 years)

<table>
<thead>
<tr>
<th>T2D</th>
<th>Block 1</th>
<th>Intro Anesthesia</th>
<th>Block 2</th>
<th>Boot Camp</th>
<th>Block 3</th>
<th>Boot Camp</th>
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<th>Boot Camp</th>
<th>Block 5</th>
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<td>Block 16</td>
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<td>Block 23</td>
<td>Cardiac Anesth</td>
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<td>Airway</td>
<td>Block 25</td>
<td>Complex Surgery</td>
<td>Block 26</td>
<td>Remediation/Elective</td>
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<td>Independent Practice</td>
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<td>Block 52</td>
<td>Independent Practice</td>
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</tbody>
</table>
Transition to Discipline

Orientation (1 day) +

General anesthesia clinical rotation (4 weeks)

Purpose:

- Introduction to other residents, anesthesia staff, and support personnel
- Learn the culture of the operating room, hospital, and Department of Anesthesiology
- Gain clinical experience that will provide reference for the education provided in the Foundation Stage
Transition to Discipline

- Resources to review prior to start (e.g. CCAT, SIMs, logbook, survival guide, one45, ACUPAM)
- Orientation – call room, consults, billing, tour, library, OR
- Lectures: machine check, SIMS, intro to CanMEDS
- OR experience: L&D, APS, call, gyne/urology/plastics/general surgery/ortho
- Booked with small group of staff
- 12 CCATs
- AKT-0 and AKT post-test
- Tasks – preop assessment and presentation, PACU handover, IV insertion, bag mask ventilation, LMA insertion, intubation, steps for spinal
Foundations I (aka bootcamp)

- 12 weeks in duration
- 2 days/week in the operating room
- 3 days/week of education
  - Self study
  - Interactive lectures
  - Case/problem based learning
  - Partial task training
  - Low fidelity simulation
  - High fidelity simulation
Foundation

Self Study/Interactive lectures/PBL

• Derived from current PGY 1 core curriculum

• Adult learners: expectations
  • Resident-led PBL and lectures
  • Expert-led (staff/fellow) teaching
Foundations

Partial Task Training

• Basic airway skills
• Advanced airway skills
  • Difficult airway cart troubleshooting
  • Basic FOB
• Central line placement
• Arterial line placement
• Basic regional blocks
• Spinal ultrasound
Foundations

High Fidelity Simulation

- Demonstrate an approach to common and uncommon perioperative events
  - PACU: angina, hypotension, hypoxia
  - Code 333 / Double setup
  - Code Blue/ Code Trauma
  - PAU consults: DNR/JW
  - Handover workshop
- Demonstrate appropriate crisis resource management skills
- Demonstrate reflective behavior in a facilitated debrief
Foundations

Additional Courses

• Advanced Cardiac Life Support
• Advanced Trauma Life Support
• Acute Critical Events Simulation
• U of O Academic Symposium
Foundations II (OR)

- 12 weeks in duration
- OR experience to consolidate knowledge and skills acquired in bootcamp stage
- General anesthesia exposure
- Buddy call
- Ready for independent call by the end of foundations
- 12 CCATs per block
- Skills – routine intubation with direct laryngoscopy and glidescope, LMA insertion, arterial line insertion, epidural insertion, spinal insertion (**using assessment tools/checklists when able)
- Simulated assessments – machine check, FOB, central line, arterial line, epidural insertion
- Self-learning – simulated crisis critical reflexion, online modules (epidural trouble shooting, sterility)
- Summative assessments – AKT-6, OSCE
Foundation Assessments

- Daily CCAT
- Epidural CEX (5 Competent)
- Spinal CEX (5 Competent)
- 2 Narrative Case Summaries
- AKT 6 (Dec.14th)
- OSCE 8 Stations (Dec.9th-14th)
Core I and Core II

- Organized into Modules

- Built on a Spiral Curriculum

- Each module will consist of:
  - Non-clinical time
  - Learning cases
  - CCAT (Clinical Case Assessment Tool)
  - Module ITER
  - Resident 6-month progress meeting
  - Other assessment modalities...TBD
Module Components

1. **Non-clinical time**
   - 2-4 days/module (replaces academic half-day)
   - Up front or divided throughout module
   - Open-ended in regards to content
     - “Imagination of the module leaders”
   - **Bare minimum**: Self-directed learning (reviewing learning cases)

2. **Learning cases** (plan for 200 over Core I/II)
   - 2-3 cases per EPA
   - Completing learning cases → “specific competence achieved”
Module Components

3. Assessment

• CCAT (Clinical Case Assessment Tool)
  • Daily evaluation

• Completed on the resident’s iPad by the staff physician
Electronic Platforms
# Department of Anesthesiology

## Clinical Case Assessment Tool

**Resident:**  
**Staff:**  
**Date:**

**Case:**

The purpose of this assessment is to evaluate the resident’s ability to complete the case safely and independently. With that in mind, please use the scale below to evaluate each stage of this case, irrespective of the resident’s level of training.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&quot;Staff had to do&quot; (e.g., resident required complete hands-on guidance by staff, resident did not do case, resident was not given the opportunity to do case)</td>
</tr>
<tr>
<td>2</td>
<td>&quot;Staff had to talk resident through&quot; (e.g., resident able to perform tasks but needed constant direction)</td>
</tr>
<tr>
<td>3</td>
<td>&quot;Staff had to prompt resident from time to time&quot; (e.g., resident demonstrated some independence but required intermittent direction)</td>
</tr>
<tr>
<td>4</td>
<td>&quot;Staff needed to be in the room just in case&quot; (e.g., resident was independent but unaware of risks and required supervision for safe practice)</td>
</tr>
<tr>
<td>5</td>
<td>&quot;Staff did not need to be there&quot; (e.g., resident completely independent, understood risks and performed safely, ready for practice)</td>
</tr>
</tbody>
</table>

*All 6 questions are mandatory*

<table>
<thead>
<tr>
<th>Q1-3 to be completed by staff</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td><strong>In OR</strong></td>
<td></td>
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</tr>
<tr>
<td>1. Pre-operative Assessment</td>
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<tr>
<td>2. Intra-operative Problem list</td>
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<tr>
<td>3. Post-operative Management plan</td>
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<tr>
<td><strong>In Clinic</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Q4-6 to be completed by resident and staff</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>4. What did the resident do well? comment on at least two CanMUSIUS roles</td>
<td></td>
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</tr>
<tr>
<td>5. What should the resident do differently next time? comment on at least two CanMUSIUS roles</td>
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</tr>
<tr>
<td>6. What should the resident do next to further his/her learning? comment on at least two CanMUSIUS roles</td>
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</tr>
</tbody>
</table>

**Medical Expert**  
**Communicator**  
**Collaborator**  
**Manager**  
**Health Advocate**  
**Scholar**  
**Professional**

Completion forms should be directed to the resident site coordinator.

**Staff Signature:**  
**Resident Signature:**
Medical Expert:
- Smooth induction/intubation in elderly patient with cardiac disease. Good understanding of anatomy and technique with thoracic paravertebral block.

Communicator:
- Identification of a potential adverse event with laterality of surgery. Consent and booking were done as "R axillary dissection" but imaging, pathology and previous notes alluded.

Collaborator:
- Needling technique with PVB - identifying and recognizing the needle tip at all times, use of hydro-dissection as required to help identify needle tip.

Leader:
- Sometimes difficult to communicate with patients who are hard of hearing. Especially when trying to get consent for a procedure (ex PVB). Not sure how to best address this.
### Staff Physician Evaluation

**Scale:**

1. "Staff had to do" (e.g., resident required complete hands-on guidance by staff, resident did not do case, resident was not given the opportunity to do case)
2. "Staff had to talk resident through" (e.g., resident able to perform tasks but needed constant direction)
3. "Staff had to prompt resident from time to time" (e.g., resident demonstrated some independence but required intermittent direction)
4. "Staff needed to be in the room just in case" (e.g., resident was independent but did not fully appreciate all the risks and required supervision for safe practice)
5. "Staff did not need to be there" (e.g., resident completely independent, understood risks and performed safely, ready for practice)

| Pre-operative | 4 |
| Intra-operative | 3 |
| Post-operative | 3 |

#### What did the resident do well?

- **Medical Expert:** Well read and was prepared for the case and the block.
- **Communicator:**
- **Collaborator:**
- **Leader:**
- **Health Advocate:** Absolutely fabulous. A separate email with full details has been sent. Also a PSLS will be documented.
- **Scholar:**
- **Professional:**

#### What should the resident do differently next time?

- **Medical Expert:** The PVB is a very challenging block.
- **Communicator:** Very well done. Listening to a patient despite hand of hearing saved 2 wrong sized procedures.
- **Collaborator:**
- **Leader:**
- **Health Advocate:**
- **Scholar:**
- **Professional:**

#### What are the next steps in the resident's learning plan?

- Also consider reading around spinal additives. Miller.

#### Overall assessment/General comments

Fabulous job preventing a wrong sized surgery.
### Staff Physician Assessment

<table>
<thead>
<tr>
<th>Resident</th>
<th>Stage</th>
<th>Date</th>
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<tbody>
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<td>PGY5</td>
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<tr>
<td>Smith, Alistair</td>
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# CCATs completed by case complexity

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<tr>
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<th></th>
<th>Moderate</th>
<th>High</th>
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<tbody>
<tr>
<td>Low</td>
<td>4</td>
<td>7</td>
<td>1</td>
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<td></td>
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<td>High</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>2</td>
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</table>

**Average score in OR by case complexity**

<table>
<thead>
<tr>
<th>Pre-operative</th>
<th>Intra-operative</th>
<th>Post-operative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-operative</th>
<th>Intra-operative</th>
<th>Post-operative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
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<td>Moderate</td>
</tr>
<tr>
<td>High</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-operative</th>
<th>Intra-operative</th>
<th>Post-operative</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Low</td>
<td>Low</td>
</tr>
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<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td>High</td>
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</tbody>
</table>

**Average score in Clinic by case complexity**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Problem list</th>
<th>Management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>2.5</td>
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<tr>
<td>High</td>
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</table>

**Medical Expert**

<table>
<thead>
<tr>
<th>Date</th>
<th>Case</th>
<th>Case Complexity</th>
<th>Resident comments</th>
<th>Staff comments</th>
<th>Resident comments</th>
<th>Staff comments</th>
<th>Resident comments</th>
<th>Staff comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-07-06</td>
<td>Low</td>
<td>Moderate</td>
<td>Demonstrated some knowledge of basic anesthetic drugs. Knew many of the considerations for the planned procedure.</td>
<td>Agree.</td>
<td>Was unsuccessful in visualizing cords - learned to ask for burp to facilitate better view.</td>
<td>Agree.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015-07-09</td>
<td>Low</td>
<td>Moderate</td>
<td>Successful IV cannulation as supervised by Staff.</td>
<td>Agree.</td>
<td>Had a reasonable plan for the anesthetic management. Did a nice job with arterial line. Day 4 of residency!</td>
<td>Agree.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015-07-10</td>
<td>Low</td>
<td>Low</td>
<td>First epidural with guidance. He followed verbal guidance very well and showed technical ease ahead of his level of training.</td>
<td>Agree.</td>
<td>Continue to develop practical skills of intubation and line placement</td>
<td>Agree.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015-07-10</td>
<td>Low</td>
<td>Low</td>
<td>We went over several of the finer points of IV starting today, with good improvement in technique. Alarms were difficult today, so he was unable to intubate 2, but I struggled with both as well! I did not see any deficiencies of technique. We went over how to get a better seal with cheeks for BMV.</td>
<td>Agree.</td>
<td></td>
<td>Agree.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Airway Trauma after MVA

Case developed by Crosby, Edward, MD, FRCPC, Department of Anesthesiology, University of Ottawa

Prerequisite cases: None
Suggested next cases: None
EPA: Management and support of airway and ventilation
Milestone: Demonstrates management of the anticipated difficult airway

Case Description – Part I

A 14-year-old girl, who was an unrestrained front seat passenger in a motor vehicle accident, has been brought to the emergency department. The windshield shattered in the impact and the patient was impaled on the shattered windshield, apparently lacerating her neck and airway but sparing her neck vessels. She is in a resuscitation bay in the emergency department. When you arrive you find her alert and oriented, sitting up and maintaining her airway, and with stable vital signs. You are told that the on-call ENT surgeon has been called and she is on her way into the hospital.

Questions

1. What are your considerations regarding airway management?
2. What are your options for securing the airway?

Required Level of Competence

The resident should address the following in their responses:

1. What are your considerations regarding airway management?
   - Airway laceration although stable now may worsen quickly.
Module Components

4. ITER
   - Sign off of Milestones/EPAs
   - Completion of Educational Requirements
     - Learning Cases
     - CanMEDS roles
     - Review of daily encounter assessments (12)
     - Other (MCQ, DO, Checklist)

5. Resident 6-month progress meeting
   - An assessment subcommittee of the RPC will review each resident’s progress every 6 months
     - Larger formative assessment
   - Academic Advisor will meet individually with the resident to discuss progress every 3 months
Intrinsic CanMEDS roles

• **Formal Curriculum**
  • TTD (1/2 day workshop per CanMEDS role)
  • Core (1/2 day workshop per CanMEDS role)
  • CanMEDS roles embedded in clinical modules and learning cases

• **Assessment**
  • Coaching platform (1 reflective piece per CanMEDS role per year)
  • Coaching sessions with CanMEDS leads
  • CCAT
New Posting

CanMEDS Role *

Communicator

As Communicators, physicians form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care.

Key Competencies:
- Establish professional therapeutic relationships with patients and their families.
- Elicit and synthesize accurate and relevant information, incorporating the perspectives of patients and their families.
- Share health care information and plans with patients and their families.
- Engage patients and their families in developing plans that reflect the patient’s health care needs and goals.
- Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy.

For a full description of this role view the CanMEDS 2015 Physician Competency Framework and the CanMEDS Milestones Guide.
Posting - Communicator

Throughout my palliative care elective I picked up a lot of valuable communication and interaction skills through observation of my preceptor. There were things that he would do, that I felt, indirectly let the patient know his attention was undivided and completely devoted to them. For example, as soon as he entered the room, he would remove his stethoscope from around his neck and lay it down on the table. Furthermore he would grab a seat and sit down comfortably before beginning his interview with the patient. I felt that these little gestures showed the patients that he was there only for them.

Also, he always emphasized to me, that although these patients are very sick and bed ridden, they have an entire history behind them. He felt it was important to gather that information so that we could get to know the “person” rather than the “patient”. So before getting into medical issues, he always asked about their occupation, where they came from, about family members etc. Patients always seemed to enjoy telling their life story and all the eventful things they had gone through in the past.

He also made sure to acknowledge their suffering and pain. He felt sympathy was not enough, and that empathy was integral. He taught me that empathy was the ability to acknowledge and understand a patient’s grief and suffering. Many people believe empathy is the ability to feel one’s pain, however he emphasized that we can never totally understand or know someone else’s pain but we can acknowledge their pain.

In addition to the above, he made physical gestures as well. If someone was in pain or in emotional distress he went on to hold their hand. From my observation, it seemed to soothe the patients and it appeared quite comforting.

As stated above, I had observed my preceptor closely. I vividly remember his interactions with patients and it was inspiration. I hope that I am able to take forth what I had seen and learned from and use that, not only in my practice, but in my day to day life interactions with people.
Simulation

• Longitudinal throughout the 4 years

4 year rotation of core topics

+ 

Canadian National Anesthesiology Simulation Curriculum (CanNASC)
COMPETENCY COMMITTEE
Electronic Platform - VISION
WELCOME RONNIE RESIDENT!

COMPETENCE SUMMARY

TRANSITION TO DISCIPLINE  COMPLETE

FOUNDATIONS OF DISCIPLINE  IN PROGRESS

CORE OF DISCIPLINE

- ACUTE PAIN  PASS
- AIRWAY  PASS
- CARDIAC ANESTHESIA I  INCOMPLETE
- CARDIAC ANESTHESIA II
- CHRONIC PAIN
- CLINICAL PHARMACOLOGY AND COMPLEX SURGERY I
- CLINICAL PHARMACOLOGY AND COMPLEX SURGERY II
- NEURO ANESTHESIA I
- NEURO ANESTHESIA II
- OBSTETRICAL ANESTHESIA I
- OBSTETRICAL ANESTHESIA II
- PEDIATRIC ANESTHESIA I
- PEDIATRIC ANESTHESIA II
- PERIOPERATIVE MEDICINE I
- PERIOPERATIVE MEDICINE II
- REGIONAL ANESTHESIA I
- REGIONAL ANESTHESIA II
- REMOTE ANESTHESIA II
- THORACIC ANESTHESIA I
- THORACIC ANESTHESIA II
- VASCULAR ANESTHESIA I
- VASCULAR ANESTHESIA II

TRANSITION TO PRACTICE

PAST EVALUATIONS:
- JULY 1 - JULY 27, 2015
- JUNE 2 - JUNE 30, 2015
- MAY 5 - JUNE 1, 2015
- APR 7 - MAY 4, 2015

MODULES:
- ACUTE PAIN  PASS
- AIRWAY  PASS
- CARDIAC I  INCOMPLETE
- NEURO I  MAY 3 - MAY 30, 2016

COACHING PLATFORM:
- COMMUNICATOR  COMPLETE
- COLLABORATOR
- LEADER  OVERDUE
- HEALTH ADVOCATE
- SCHOLAR
- PROFESSIONAL  COMPLETE
Resident Dashboard

Trainee Dashboard

Overall Progress

Training Levels
- Transition to Discipline: COMPLETED
- Foundations: COMPLETED
- Core I: IN PROGRESS
- Core II: NOT STARTED
- Transition to Practice: NOT STARTED

ITERs
- 18
- May 22, 2014
- April 13, 2014
- March 18, 2014
- February 9, 2014

Learning Cases
- 66/200
- Case #86 Title: 2014-05-23
- Case #85 Title: 2014-05-21
- Case #84 Title: 2014-05-17
- Case #83 Title: 2014-05-12

ePortfolio Entries
- 14/30
- May 12, 2014
- April 29, 2014
- April 20, 2014
- March 28, 2014

EPAs
- 20/45

Milestones

Export Report
Activity Data
Performance Data
Learning Cases

Trainee Dashboard

Core I (66/100)
Core II (0/100)

Edwyn Ng
Resident since July 2013

Training Level: Core I

Export Report
Activity Data
Performance Data

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<tr>
<th>CASE</th>
<th>STATUS</th>
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<th>PRECEPTOR</th>
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<td>2014-05-24</td>
<td>Dr. Wong</td>
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<td>Case #65 Title</td>
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<td>Case #64 Title</td>
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<td>Dr. Su</td>
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Transition to Practice

• If all competencies are met, residents will proceed into Transition to Practice
  • AKT-24
  • If NOT, individual learning plans can be tailored to meet the resident’s needs

• Residents will perform anesthesia cases more or less independently
  • Staff will be immediately available
  • Minimum of 3 daily encounter assessments/week
  • Minimum of 1 Royal College Oral exam question/day
CBD....a long time coming

QUESTIONS??