
CONFERENCE ABSTRACTS

Thriving in uncertainty: residency education in a world of change

2026 International Conference on Residency Education

Exceller en temps d'incertitude : la résidence dans un monde en évolution

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085 An expert-informed, pilot-tested bilingual survey to assess AI learning needs in Canadian anesthesiology training

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Introduction: Artificial intelligence (AI) tools increasingly influence perioperative care and research, yet formal anesthesiology AI training remains limited. We developed and pilot-tested a bilingual (English/French) survey to quantify AI knowledge and perceived learning needs among Canadian anesthesiology residents and fellows to inform Competency-Based Medical Education (CBME) curriculum design.

Methods: After Research Ethics Board approval, we drafted items from a targeted literature search and refined content through a two-round Delphi with national experts in anesthesiology education and AI (7/10 participated), using 70% consensus threshold. We pilot-tested the English survey with 16 second-year medical trainees to assess clarity, usability, and completeness; summarized responses using descriptive statistics; and revised items based on feedback prior to deployment. The finalized English and French surveys will be distributed electronically through Canadian anesthesiology training programs and in collaboration with the Canadian Anesthesiologists' Society to anesthesiology trainees (PGY1–5 residents and fellows) for one month starting June 2026.

Results: Five consensus domains emerged: (1) AI knowledge and technical literacy, (2) attitudes and confidence, (3) ethical and legal awareness, (4) learning facilitators and barriers, and (5) readiness for integration. The 24-item survey uses 5-point Likert scales and distinguishes generative from non-generative AI. In pilot testing, 88% found items clear and 81% found domains complete. Most rated section flow excellent or good (81%), and mental demand as low or very low (62%). Feedback led to minor edits to reduce redundancy and clarify terms.

Conclusion: We developed an expert-informed, pilot-tested bilingual survey to characterize AI learning needs in Canadian anesthesiology training. National results will inform CBME objectives, faculty development, and guidance for responsible AI integration in perioperative practice. Limitations include a small pilot sample and testing with medical students rather than anesthesiology trainees. Next steps include national deployment in June 2026 and psychometric evaluation among trainee cohorts.

086 Understanding how ambient AI scribes are studied in clinical practice: a rapid scoping review

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Introduction: Artificial intelligence (AI) scribes are increasingly adopted in clinical practice. Despite this rapid uptake, scholarship in this domain appears to largely focus on reducing documentation burden and improving efficiency, with comparatively limited attention to other forms of inquiry. Understanding how AI scribes are currently studied is essential to advancing a more progressive, theoretically robust, and context-sensitive research agenda for a technology with significant potential to shape how clinicians and learners engage with patients.

Methods: A search of MEDLINE and supplementary sources identified 1,073 records published from 2018 onward. After duplicate removal, 1,067 titles and abstracts were screened using a hybrid approach in which a GPT-4.1 (Open AI) model conducted screening in parallel with a human reviewer; discrepancies were resolved by a second human reviewer. Thirty-seven full-text articles were assessed for eligibility. Data extraction focused on research questions and scholarly orientation (coded using the METRICS pattern language of scholarship), and outcomes assessed.

Results: 20 studies met inclusion criteria. All included studies were coded within the Evaluation pattern of the METRICS model, with a small number also exhibiting features of innovation or synthesis; however, evaluation remained the dominant scholarly orientation. 19 Studies primarily assessed efficiency-related outcomes such as documentation time, note completeness, and clinician satisfaction. Two examined impacts on clinician–patient communication, professional identity, workflow adaptation, or ethical and relational dimensions of care. Most (85%) employed observational or pre–post designs, with limited use of theory-informed or mechanism-focused approaches.

Conclusion: Scholarship on ambient AI scribes is dominated by an evaluation-oriented pattern that shapes both the questions asked and the outcomes emphasized. While necessary, evaluation alone is insufficient to support a progressive understanding of how AI scribes impact practice. Greater engagement with diverse scholarly patterns—such as innovation, synthesis, and theory-building—is needed to guide responsible integration of AI scribes into clinical care and teaching.

087 Closing the feedback loop integrating post-exam analytics into item bank development and review

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Introduction: In postgraduate medical education, high-quality assessment tools are essential for accurate evaluation of learners. Yet many programs struggle to systematically integrate post-exam analytics and faculty/learner feedback into item bank redesign. This project aimed to develop and evaluate a structured multistage model for using post-exam data and feedback loops to improve item-bank quality, assessment alignment, and resident learning outcomes within a competency-based residency program.

Methods: We employed a three-phase intervention in a residency program: (1) Baseline review of existing item-bank performance metrics (item difficulty, discrimination, flags for revision) and stakeholders' feedback; (2) Faculty development workshops focused on evidence-based item-writing, feedback interpretation, and aligning items with program outcomes; (3) Implementation of revised item-bank protocols and continuous monitoring of assessment metrics over two subsequent cycles. Key outcomes included changes in item discrimination index, rate of item revision, faculty satisfaction with item writing process, and resident perceptions of assessment relevance.

Results: Preliminary data showed the mean item-discrimination index improved from 0.28 to 0.41. The proportion of items flagged for revision fell from 12% to 6%. Faculty self-reported improved confidence (Likert scale mean increased from 3.2 to 4.5). Resident feedback indicated perceptions of better alignment between assessment and learning objectives; more believed the assessment more accurately reflected their learning and supported their development.

Conclusion: This multistage model offers a replicable framework for integrating feedback and analytics into item-bank improvement, particularly suited to residency education environments. For program directors and educational leaders, such a model supports continuous assessment quality enhancement, faculty engagement, and resident learning outcomes. In the era of competency-based medical education (CBME), adopting systematic loops of data-driven item bank management may advance accreditation readiness and educational effectiveness.

088 Dreaming, designing, and doing justice: applying co-design to develop Justice-Oriented Assessment solutions in graduate medical education

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Introduction: There is a growing body of evidence that structures of assessment lead to inequities and marginalization for some learners. Despite recent work to reduce inequities, much remains unknown about how to effectively dismantle sources of inequity in assessment and how to design solutions. One way to fill this gap is to use Justice-Oriented Assessment (JOA), a theory-informed approach based on the concept that assessment systems reflect the social and cultural characteristics, histories, and knowledge sources of dominant groups in society, however well-intended, lead to inequities for non-dominant groups. Learner co-design and centering the experiences of marginalized groups are key features of JOA. Our study group sought to see if it was feasible to use JOA to develop assessment solutions in 5 pediatric post-graduate training programs.

Methods: We applied JOA to guide multiple co-design sessions at each site. Our intention was to adhere to JOA principles during the design process, such as centering marginalized voices and seeing change as part of the process rather than just the outcome of the process. At each session, groups of learners, faculty, staff, and leadership worked to build consensus on local needs regarding equity, then co-created hopes and values for an equitable assessment system. Facilitators systematically collected demographics of participants and qualitative data (e.g., audio recordings of design sessions) from each site. All data was then analyzed to examine alignment with JOA.

Results: We found that our co-design process demonstrated *high* engagement across all programs with representation from learners, faculty, staff, and leadership, including high participation rates of marginalized groups. Each program successfully co-produced the intended process elements and prototype design solutions for a more equitable assessment system. JOA principles were salient across all steps.

Conclusion: This project showed that it is possible to operationalize JOA to develop assessment solutions in GME.

089 Streamlining EPA data interpretation: usage of LLM to determine the most frequently used evaluation criteria for EPAs

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Introduction: One of the greatest challenges in competency based medical education (CBME) relates to the need to analyze large volumes of assessment data collected. To reduce the burden of interpreting large volumes of assessment data by competency committees, we explored whether machine learning techniques can be used to determine the most frequent probable evaluation criteria used by ER faculty assessors in assessing residents.

Methods: LLM was used to perform behavioural analysis of assessor ($n = 363$) feedback on core of discipline EPAs completed by ER residents ($n = 31$). We assessed two locally run small LLM-based models to generate structured outputs capturing assessor feedback summaries, assessor recommendations, resident actions, and feedback sentiment. Both Mistral and Qwen models were used to explore the most frequent probable evaluation criteria used by assessors to assess residents.

Results: The results from both models suggest that assessors focused mostly on knowledge, communication skills, clinical assessment or decision making and reasoning. Other less frequent criteria used by assessors include patient management, work ethic, independence, efficiency, and teamwork.

Conclusion: The use of LLM to evaluate large assessment narrative feedback data in CBME has the potential to reduce the burden on competency committees by drawing attention to what assessors actually focus on when providing feedback.

090 A la carte longitudinal training to reinforce CanMEDS intrinsic roles across residency programs

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Introduction: Residency programs share common goals for developing intrinsic CanMEDS roles (e.g., shared decision making, patient safety, time management). Interdisciplinary, shared training offers an efficient strategy to address these objectives, particularly when delivered through a longitudinal curriculum that supports just-in-time learning. Program directors favoured an à la carte model allowing them to opt out of sessions deemed non-relevant for their program. Given the logistical complexity of such tailoring, we conducted a quality-assurance study to examine program participation and resident satisfaction.

Methods: Twenty-three structured training sessions were offered across multiple residency levels: R1 ($n = 6$), R2–R3 ($n = 7$), R4–R5 ($n = 8$), and multi-level sessions ($n = 2$). Each session was mapped to relevant CanMEDS milestones. Faculty contributors included Family and Emergency Medicine ($n = 15$), Medical Specialties ($n = 10$), Anesthesiology and Critical Care ($n = 4$), Psychiatry ($n = 2$), and external experts and patient partners ($n = 7$). Sessions were delivered using varied modalities—workshops ($n = 12$), webinars ($n = 10$), online modules ($n = 6$), simulation sessions ($n = 2$), and retreats ($n = 1$). All CanMEDS roles were represented: Collaborator ($n = 6$), Professional ($n = 4$), Scholar ($n = 5$), Communicator ($n = 3$), Health Advocate ($n = 2$), and Leader ($n = 1$).

Results: Of 39 residency programs, 32 (82%) opted into the curriculum and selected an average of 72% of available sessions. Participating programs spanned medical ($n = 19$), surgical ($n = 9$), laboratory and imaging ($n = 3$), and mental health ($n = 3$) specialties. Sessions were declined due to existing equivalent training (37%), anticipated future development (11%), or perceived irrelevance to required competencies (47%). The least selected content addressed the Collaborator (36%), Scholar (21%), Leader (15%), Professional (13%), Health Advocate (9%), and Communicator (6%) roles. A total of 1,154 questionnaires provided satisfaction ratings on six criteria, presented as a heat map.

Conclusion: A structured yet flexible longitudinal curriculum can address all intrinsic CanMEDS roles while accommodating diverse program needs. High participation and favourable resident feedback support this approach as a scalable model for shared competency-based training.

091 Determining the scope of practice of hypertension specialists in Canada

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Introduction: Hypertension is the largest risk factor for cardiovascular disease and death. Hypertension is predominantly managed by primary care physicians but may require coordinated care by specialists trained in Internal Medicine, Nephrology, Cardiology or Endocrinology. Most specialists undergo further training to gain expertise in the management of clinical hypertension. Unlike the United States of America, Canada does not have a hypertension specialist certification program. A national curriculum for training of hypertension specialists that is recognized by the Royal College of Physicians and Surgeons of Canada allows for standardization of the training required to achieve expertise in hypertension, thus, improving overall quality of care. The first step of this process is determining the scope of practice of a hypertension specialist in Canada.

Methods: A team of twelve hypertension specialists from across Canada was formed by purposive and snowball sampling. The scope of practice was determined using a virtual nominal group technique (NGT). The idea generation step (online survey) collated information on aspects of hypertension specialist practice. Data from the online survey informed the virtual discussion between all participants. Consensus on the scope of practice of Canadian hypertension specialists was reached via anonymous online voting. A survey was sent to the twelve participants to obtain their feedback on the virtual NGT.

Results: Consensus was obtained on all items after one round of voting. There was consensus on type of practice, work setting, referral sources, investigations they should order and interpret, treatments they should offer, composition of the care team, technology they would require, length of training and prerequisites to enroll in a hypertension specialist training program.

Conclusion: At the completion of the NGT, a description of the scope of practice of a hypertension specialist was created. This will help inform the creation of a national curriculum for hypertension specialists in Canada.

092 Bridging the gap in pediatric ECG interpretation through interactive, experiential learning

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Introduction: Electrocardiogram (EKG) interpretation is an essential diagnostic skill in pediatric emergency and inpatient care. In resource-limited settings, where access to pediatric cardiologists is scarce, frontline pediatricians must independently interpret EKGs. However, prior studies demonstrate poor EKG interpretation accuracy among residents (approximately 55.8%). A local needs assessment at the University Hospital of Mirebalais revealed similar deficiencies, highlighting a critical educational gap. To address this, program directors collaborated with a visiting pediatric cardiologist to develop an interactive, pattern-recognition-based pediatric EKG curriculum.

Methods: The objectives of this project were to design and implement a pediatric-specific, interactive EKG curriculum focused on key interpretation patterns, and to evaluate its effectiveness through pre- and post-training assessments and resident satisfaction surveys. The curriculum was implemented in four phases. Phase 1 (Needs Assessment) included a baseline survey and Objective Structured Clinical Examination (OSCE) to assess initial competency. Phase 2 (Curriculum Delivery) spanned three months and consisted of weekly didactic lectures on normal and abnormal pediatric EKGs, weekly interactive case-based workshops with faculty feedback, and weekly simulator sessions allowing residents to interpret live EKGs with targeted feedback. Phase 3 (Post-Training Assessment) involved a repeat OSCE using case-based scenarios to evaluate skill acquisition. Phase 4 (Evaluation) included post-curriculum surveys and structured feedback sessions to assess resident confidence and perceptions.

Results: Nineteen pediatric residents participated. At baseline, 22% reported high confidence, 16% could identify abnormal patterns, and only 15.7% passed the OSCE. Post-intervention, 94% reported increased confidence, 93% correctly identified abnormal EKGs, and 94.7% passed the OSCE, with strongest performance among the senior residents. These outcomes demonstrate a clear improvement in competency and confidence in pediatric EKG.

Conclusion: This low-cost, structured curriculum significantly improved pediatric residents' EKG interpretation skills and confidence. It provides a scalable model for strengthening diagnostic capacity in resource-limited training programs.

093 Transition to practice: describing an emerging stage of postgraduate training

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Introduction: The ideal curriculum for a transition to practice (TTP) stage within residency has not been delineated. We describe what the 28 Canadian specialty committees included in their depiction of this stage.

Methods: We extracted data from the Royal College of Physicians and Surgeons of Canada website. We used descriptive statistics for stage duration and changes to the timing of certification examinations. We used a deductive and inductive approach to content analysis to explore training experiences and entrustable professional activities. The recommended duration of the TTP stage (months) was 2-3 minimum, 12-15 maximum, and 6-9 median. The written portion of the certification examinations was moved to earlier in training.

Results: Qualitative analysis of the entrustable professional activities and training experiences identified 9 codes predefined by literature review and 9 inductively added during analysis. The codes were grouped into the 4 themes. Preparation for autonomous clinical care: providing clinical care and engaging in administrative aspects of patient care and interprofessional interactions as most responsible physician, as well as sophistication of existing skills/new skills and navigating logistics of the health care system. Preparation for the logistics of setting up and running a practice: billing/practice management and financial management. Preparation for responsibilities beyond patient care: teaching and supervision, mentorship, health advocacy, quality improvement, scholarly activity, and medicolegal.

Preparation for entry into the community of professional practice: lifelong learning, professional identity formation and career development, and issues related to work life balance/reclaiming personhood and professionalism/ethics.

Conclusion: Specialty committees' conceptualized the TTP stage as dedicated months free from the distractions of a written examination. The curriculum was aligned with literature-identified learning needs and added content areas not previously identified for incorporation into training, including experiences and instruction in responsibilities beyond patient care and preparation for entry into the community of professional practice.

094 Optimizing a blended curriculum to teach residents pediatric procedural and resuscitation skills

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Introduction: Residents rotating through Pediatric Emergency Medicine (PEM) acquire knowledge and skills through clinical shifts and an academic half-day curriculum of online lectures and virtual simulations. Procedural and resuscitation skills require hands-on opportunities for skill development and competency; however, clinical experiences are insufficient for exposure to a standardized set of skills. Our curriculum adds in-person simulation and skills training, supported by asynchronous modules, to enhance resident comfort with these skills.

Methods: To design, implement and evaluate the curriculum, Kern's six step approach was used. Objectives of training and Entrustable Professional Activities from the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada were reviewed and program directors were surveyed to prioritize learning objectives. Participants include junior residents (PGY1-2) rotating through PEM from: pediatrics, pediatric neurology, emergency medicine, anesthesiology, family medicine, and public health and preventive medicine. In-person sessions include: advanced airway, casting, intraosseous insertion, suturing, anaphylaxis and seizures. Asynchronous modules will be implemented and cover: airway, shock, trauma and NRP. Descriptive statistics of post-curriculum surveys evaluate resident comfort in procedural and resuscitation skills pre and post-curriculum, as a Kirkpatrick level 1 learning outcome towards competency.

Results: Respondents $n = 34$. Resident comfort with procedural skills improved (pre, post, need more teaching): casting (23.5%, 73.5%, 35.3%), suturing (61.8%, 85.3%, 20.6%), LMA (29.4%, 38.2%, 38.2%), intraosseous insertion (20.6%, 41.2%, 41.2%). Intubation (23.5%, 20.6%, 50%) and BVM comfort decreased (70.6%, 58.8%, 8.8%). Resident comfort with acute care improved: respiratory distress (27.3%, 61.8%, 41.2%), seizure (21.2%, 47.1%, 44.1%), shock (18.2%, 32.4%, 41.2%), NRP (6.1%, 17.6%, 73.5%), anaphylaxis (36.4%, 47.1%, 32.4%), trauma (18.2%, 32.4%, 61.8%).

Conclusion: Resident comfort improved in most skills. Smaller gains (and losses) in multi-step skills reflect the learner's transition from unconscious to conscious incompetence as they appreciate skill complexity. Exposure builds awareness, while practice builds competence.

095 Competence by Design in Canadian specialty programs: trends in standards development

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Introduction: The Royal College of Physicians and Surgeons of Canada (Royal College) began disseminating its Competence by Design (CBD) standards in 2017 and has since continued transitioning all specialties to CBD. Although informal inter-specialty comparisons have occasionally been generated to support specialty committees and guide data-informed revisions, a formal cross-specialty comparison has not previously been conducted.

Methods: This project examined measures of central tendency for Entrustable Professional Activities (EPAs) across all specialties, and all disseminated versions, from the inception of CBD through 2025. In total, 79 unique specialties or streams were included, representing 114 versions.

Results: Across all specialties, streams, and versions, the average number of EPAs was 31, with an average decrease of 6 EPAs between successive versions. Further analysis showed an average of 26.4 EPAs per version for subspecialties, compared with 36.4 in primary specialties, and 36.4 EPAs per version in surgical specialties compared with 28.9 in medical specialties. There was also an overall downward trend in the number of milestones, observations of achievement, and context requirements across version years.

Conclusion: These findings suggest a growing recognition of assessment burden and an evolution in the approach to EPA development over time. While further—and ongoing—analysis of EPAs and other Royal College specialty-document data is needed, these results can inform future revisions to CBD standards and support the goal of understanding best practices for their creation and maintenance.

096 Unprepared for the tech era: rethinking diabetes technology training in endocrinology

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Introduction: Continuous glucose monitors (CGMs), insulin pumps, and automated insulin delivery systems have revolutionized diabetes care, yet formal training in diabetes technologies during Endocrinology residency remains limited. Existing curricula are not informed by formal needs assessments and rarely include input from diabetes educators, despite their key role in patient care. Our objectives are to describe the existing diabetes technology training landscape for Endocrinology residents across Canada, identify perceived learning gaps, and examine the role of interprofessional education within this context.

Methods: We conducted a national mixed-methods learning needs assessment: a web-based survey of postgraduate year 4-5 Endocrinology residents and recent graduates, and semi-structured interviews (n = 17) with residents, diabetes educators, and program directors. We analyzed survey data using descriptive statistics. Interview data underwent thematic analysis through an iterative process involving codebook development, preliminary theme generation, and subsequent refinement into final themes.

Results: Among 25 survey responses, 60% of respondents reported neutral or low confidence that their training program prepared them to use diabetes technology, with higher confidence for CGMs than insulin pumps. Only two participants reported more than 10 hours of annual half-day teaching with 44% reporting fewer than 5 hours. Most respondents identified diabetes educators as their primary source of diabetes-technology teaching. We identified several key themes: the absence of a clearly articulated program-level curriculum; reliance on opportune and experiential learning; variable faculty expertise with dependence on physician champions; strong interprofessional collaboration with diabetes educators providing practical, patient-centered skills; and structural barriers such as limited protected time and rapid technological change.

Conclusion: There are several gaps in structured diabetes technology training for Canadian Endocrinology residents. Integrating diabetes educators into formal curricula, strengthening training structures,

and ensuring protected time for learning may improve resident preparedness. These findings support targeted curriculum reform and inform future interprofessional education initiatives.

097 Utilization of a centralized Ethics, Professionalism and Policy curriculum across residency programs: an institutional update

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Introduction: The Baylor College of Medicine (BCM) Ethics, Professionalism, and Policy Program (EP3) was developed in 2014 to provide a centralized curriculum for residency and fellowship programs in these areas while addressing institution-wide learning needs. Understanding which topics are most frequently utilized can inform ongoing curricular refinement and targeted resource development.

Methods: We conducted a descriptive review of EP3 curriculum utilization across residency programs over the past 2.5 years. Trends in topic choice were identified and evaluations were analyzed for satisfaction with the topics and their delivery formats. Topics were grouped into the core EP3 domains of ethics, professionalism, and policy. Utilization data were aggregated at the institutional level.

Results: The EP3 curriculum was utilized by all BCM residency programs to which it was made available: a total of 21 programs spanning multiple specialties. The most frequently utilized topics included healthcare economics, confidentiality and social media, and wellness and moral distress. Less frequently used modules addressed cultural competency, firearm safety, and research ethics. A total of 894 participants asynchronously completed video modules in comparison to 600 participants who attended in-person engagement sessions. These findings highlight patterns of demand and areas for potential curricular expansion. Evaluation data over the past 4.5 years indicates overall satisfaction with this curriculum and their delivery formats (scores of 4.6 out of 5 for “clear and engaging content”, 4.5 out of 5 for “would recommend”).

Conclusion: Early utilization data demonstrate strong engagement with a centralized EP3 curriculum. Ongoing analysis of topic utilization will guide iterative curriculum development, ensuring alignment with resident and program needs while supporting institution-wide professionalism and ethics education.

098 Factors influencing fellowship choices among surgical residents in Ghana

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Introduction: The number of surgical residents in Ghana has increased over the years since the establishment of Ghana College of Physicians and Surgeons (GCPS) to train surgeons locally two decades ago. Despite the increasing number of residents in surgery, some fellowship programs are undersubscribed. This is a growing concern that some fellowship training posts in the faculty of surgery and subspecialties may be vacant.

Methods: This study was conducted to determine surgical residents' choices and the factors that influence their decisions to pursue fellowship training. A descriptive cross-sectional study was carried out from 1st September 2024 to 30th September 2024 among 135 residents in Ghana. Questionnaires were administered to residents and distributed via WhatsApp messenger. The survey required their demographics, level of training, geographical distribution of residents, intended fellowship preference and 15 influential factors that affected residents' choices in the form of Likert Scale.

Results: A total of the 177 surgical residents from 10 training institutions across Ghana were contacted. 135 (76%) responded and completed the survey. Majority of them were males 120 (89%) and 15 (11%) females. The age distribution ranged from 27 to 42 years with mean of 33.88 years.

General Surgery 30 (24%) and Urology 28 (23%) are the most preferred specialties whilst Orthopedic Surgery 6 (5%) is the least preferred. Personal interest (88%), potential for research and academia (64%) are the principal factors that drive the selection of fellowship programs whilst perceived workload (27%), influence from family (18%) and institutional request (18%) are less impactful.

Conclusion: General surgery is the preferred fellowship program of choice for surgical resident in Ghana. Residents are greatly influenced by their personal interest and potential for research and academia when selecting fellowship programs. Residents should be motivated to undertake fellowship training in deprived surgical programs to meet the surgical needs of Ghana.

099 Advancing residency education through longitudinal faculty development: fifteen years of Donald Wasylenki Education Day

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Introduction: Following a departmental reorganization that consolidated divisions and placed education within broader administrative structures, a Canadian university Department of Psychiatry's longstanding Research Day highlighted inequities in the recognition of education. Amid the growth of education scholarship, the Vice-Chair Education at the time advocated for an academic day that valued excellence in teaching on par with research. This advocacy led to the launch of Donald Wasylenki Education Day (DWED) in 2012. While education academic days were novel at the time, similar initiatives have since emerged across institutions. Despite this expansion, little is known about the impact of longitudinal education days. Existing literature suggests that sustained faculty development, rather than isolated workshops, is more likely to produce lasting outcomes. This study addresses gaps in the literature by describing the evolution of DWED over fifteen years and evaluating its impact.

Methods: This descriptive study draws on thematic analysis of DWED agendas, interviews and email exchanges with former chairs/co-chairs and annual evaluation data informed by a developmental evaluation approach. Quantitative data were analyzed using descriptive statistics while qualitative feedback was examined thematically. Analyses focused on core elements tracked consistently over time, despite evolving evaluation instruments.

Results: DWED affirms the legitimacy of education and the role of teachers, both symbolically and as a viable academic pathway. It enhances the visibility of education scholarship, fosters a community of practice, supports professional identity formation, academic career development, and promotes collaboration across professions/disciplines.

Conclusion: DWED has responded proactively to emerging trends in residency education and reimagined the poster showcase as an inclusive forum for diverse education scholarship. Attendance and engagement have increased steadily, with most participants reporting relevance to their practice and intent to implement change. Over fifteen years, DWED has demonstrated itself to be a robust, adaptive, and sustainable longitudinal faculty development initiative.

100 Augmenting a 1:1 mentorship model for faculty with mentorship groups/communities of practice to support academic roles and social identity

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Introduction: Mentorship is an important tool for helping academic faculty, including resident teachers, navigate their careers with confidence and resilience. Traditional dyadic mentorship and group mentorship offer different and complementary strengths. Combining these models can potentially serve academic faculty even better than either alone. Our Psychiatry Department Mentorship Program, launched in 2021, incorporates a traditional mentor/mentee model supported with mentorship groups focused on academic roles or social identity.

Methods: Seven mentorship groups were launched with invitation to faculty. To support academic roles, three groups were offered: i) Clinician Scientists & Investigators; ii) Clinician Teachers; and iii) PhD faculty. Other groups support social identity: International Medical Graduates; LGBTQ2S+; and "Uplifting Women & Underrepresented Genders in Academia", which also has a subgroup, "Racialized Women's Mentorship Group". Sessions were virtual and groups met 3-10 times/year. Participant numbers varied (8-24/meeting). Content included faculty wellness, promotion, feedback, self-advocacy, and supporting resident wellness. Process incorporated best practices; sessions were interactive, incorporating adult/case learning. Groups determine aims/goals and format with faculty participant solicited input. Some groups focused on providing peer support around goals. Others were structured with guest presenters to support knowledge/skill development and role socialization (grantsmanship, identity as clinician teacher). Evaluation of participant experience involved quantitative surveys/qualitative interviews. Surveys included closed/open questions, administered 1 year post. Descriptive statistical techniques were used for survey data analysis, open questions/interviews were analyzed thematically.

Results: Sessions were well-received; majority of participants "strongly agreed/agreed" format was interesting/engaging, program was excellent, greater sense of connectedness to academic community, improved understanding of career needs, supported academic life/learning new teaching strategies. Qualitative data showed faculty valued: shar-

ing of experiences, validation; role socialization, format/leadership.

Conclusion: Group mentorship can improve faculty's understanding of career needs, academic role, promote connection to their academic community, and serve a complimentary role to traditional dyadic mentorship alone.

101 New faculty orientation in an academic Psychiatry Department: a seven-year evaluation

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Introduction: The Department of Psychiatry at a Canadian University introduced an Orientation Program for new faculty members, including resident teachers, in 2013. Since then, the Program has been offered annually, to provide an orientation to resident teaching, quality improvement, and research in the Department.

Methods: To conduct a trend and thematic analysis of the New Faculty Orientation Program evaluations received between 2013-2019 (in-person). Findings will be used for continuous quality improvement and will inform future offerings of the program. The New Faculty Orientation Program post-evaluations were administered to participants immediately after their attendance. We conducted a thematic analysis on the participants' free-form responses. Qualitative responses were reviewed and coded by two independent analysts to identify themes.

Results: Program participants appreciated the opportunity to network with colleagues and be part of a teaching community of practice. They reported a desire to change their current teaching practice to incorporate goal setting and providing learner feedback. Participants requested more career development content for future workshops. Suggested areas of improvement included a better balance between clinical content and approaches to research and grant writing.

Conclusion: The positive feedback suggests faculty found the Orientation Program to be useful and thus represents an effective method of facilitating the transition to their teaching and academic roles. Of note, requests for career-oriented topics, such as faculty development, increased from 2013-2019, suggesting more attention on self-development among new faculty. It will be of interest to compare the post 2019 (virtual) New Faculty Orientation Program evaluations with our findings to identify further quality improvement opportunities. The findings from this analysis can inform future faculty development programming for resident teachers in our department as well as at other academic institutions, globally.

102 Improving Entrustable Professional Activity completion rates through faculty development

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Introduction: Four medical imaging residency disciplines in Canada have completed at least one year in Competency by Design (Nuclear Medicine (2020), Diagnostic Radiology (2022), Pediatric Radiology (2024) and Neuroradiology (2024)). Residents require up to 307 observations depending on the program. Residency programs in North America have reported that documentation of Entrustable Professional Activity (EPA) observations are often low, and that faculty development is required to improve engagement with the EPA process, particularly within the first 5 years.

Methods: Total EPAs completed, and percentage completed, for each faculty member in a Diagnostic Radiology Department (4 residency programs) were recorded annually for 2 years. Faculty FTE, payment model, primary clinical site, years of practice and EPA percent completion were recorded. Three step intervention was performed to improve completion rates: report comparing individual faculty to the department mean (level 1); Department Chair discussion during annual performance review for faculty with 3-10 EPAs completed (level 2); and personalized one-on-one support for faculty with less than 3 EPA completions (level 3). EPA rates were measured post intervention.

Results: Data was available for 73 faculty members at 3 teaching sites. EPA rates increased from year one to year two. Among faculty sent at least one EPA pre intervention, a mean of 16 EPAs were completed (SD17) and completion percentage was 72% (SD31%). 34 faculty (47%) completed at least 10 EPAs annually, 15 (21%) between 3 and 10, and 24 (33%) between 0 and 2. Stronger EPA performance was associated with fee-for-service and primary appointment to the largest teaching site. Years in practice and clinical FTE was not associated with EPA rates. EPA rates improved post intervention, particularly for faculty who completed level 3 intervention.

Conclusion: Distributing EPA data improved EPA completion numbers. Targeted one-on-one faculty development improved EPA completion for faculty with very low participation.

103 Facilitating adaptive expertise development through targeted faculty development for a low-fidelity simulation in medical education

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Introduction: A low-fidelity simulation–deteriorating patient scenario (DPS) seminar–was implemented to facilitate development of adaptive expertise in medical students. DPS seminar is a complex educational intervention that requires tutors to provide the simulation while managing learning environment and facilitating learner reflection. The objective of this project was to address areas of improvement identified in past DPS seminar student evaluations through a targeted faculty development (FD) intervention.

Methods: The 1.5-hour targeted FD session was implemented in 2022 to align with instructional principles that promote growth in adaptive expertise. Tutors were provided guidance on identifying comfort with uncertainty and cognitive integration as learning objectives; integrating productive struggle/failure in a safe learning environment; and structuring the debrief to facilitate deeper understanding of the clinical reasoning made in the simulation. Learners completed anonymous evaluations on the DPS seminar and the tutors using the MD Program standard evaluation form. An unpaired t-test was used to compare student evaluations before and after the targeted FD.

Results: The 2019 and 2021 student evaluations were combined as pre-FD with the 2020 iteration being canceled due to pandemic-related restrictions. The 2022-2024 student evaluations were aggregated as post-FD. The overall response rate was 11.2% ($n = 145$) between 2019-2024, with 260 medical students enrolled annually. All evaluation items on the DPS seminar and tutors were statistically significantly higher post-FD, including the overall seminar score (from 3.99/5 to 4.65/5, $p < 0.001$) and tutor score (from 4.21/5 to 4.77/5, $p < 0.001$). Student evaluations reflected a positive experience with tutor preparedness, stimulation of enthusiasm, promotion of a positive learning environment, and ability to ask effective questions and provide clear explanations.

Conclusion: FD can be leveraged not only to address quality improvement opportunities but also foster adaptive expertise development in low-fidelity simulation-based medical education.

104 Supporting late career faculty members in the department of medicine

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Introduction: The transition from an active academic and clinical career to retirement is an inevitable part of a physician's journey. Many physicians feel a loss of relevance as they transition away from leadership roles, academic duties, and research initiatives, while their clinical practice evolves and ultimately winds down. Transitioning into retirement should be a planned and rewarding part of an academic medical career.

Methods: In 2020, the University of Toronto Department of Medicine established the Vice Chair, Culture and Inclusion (CI) portfolio to advance well-being, equity, diversity, inclusion, and mentorship across the academic lifespan. Drawing on qualitative and quantitative data from departmental surveys (2015–2019), as well as feedback from town halls and one-on-one meetings with late-career faculty (2020–2021), equitable strategies were developed to address mentorship and wellness needs. This work led to the creation of a transition-planning framework, including the launch of *Career Transition Workshops* and the development of a *Late Career Transition document*.

Results: Workshops have been running annually since 2021. 75 people have attended to-date and feedback has been extremely positive. The document provides practical advice and resources to late career faculty members to facilitate planning for career transition process and to support our late career faculty members (who are either contemplating or deciding to retire) in a respectful, thoughtful, and compassionate manner. The document is available on the CI official website and has been broadly distributed across departmental and other relevant online sources. These initiatives promoted a start of culture change that see career transition as a planned process instead of an ad hoc and feared one.

Conclusion: Thoughtful career transitions and retirement supports help to ensure that the final stages of an academic career are as impactful and fulfilling as its beginning. Resources are needed to support both personal and professional wellbeing of late-career faculty members.

105 Updates in educating for compassion: our new approach to fostering understanding in the health sciences

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Introduction: Global conflicts and societal shifts increasingly influence the health professions education environment. In response to community and faculty requests, Queen's Faculty Development (FacDev) has expanded its cultural, racial-ethnic, and faith-based educational offerings to foster greater understanding, compassion, safe learning spaces, and collaborative environments for trainees, faculty and staff.

Methods: We highlight the ongoing development of self-assessment learning modules that link to additional resources and assets addressing diverse equity-deserving groups. Informed by iterative consensus-building, needs assessments, and recent institutional events, these evidence-based modules were developed collaboratively by subject-matter experts with support from Queen's FacDev and QHS EDIIA Initiatives under the Deans' leadership. Queen's FacDev has thus far developed modules on Islam, Islamophobia and anti-Arab discrimination, Jewish Identity, Antisemitism, hidden curriculum, navigating privilege, and anti-Black racism. The modules, delivered through Articulate RISE, have reached over 710 participants. They are available for all health professions learners' professional development and accredited for physicians.

Results: Engaging learners in foundational explorations of cultural, racial-ethnic, and faith-based identities enhances empathy and understanding amongst patients, trainees, faculty and staff. Such education challenges bias and stereotypes, promotes respect and allyship, and cultivates safer, more inclusive communities.

Conclusion: These modules serve as proactive tools to strengthen patient and community safety and belonging and will continue to be expanded to represent other equity-deserving groups within health professions education for the benefit of learners, peers, and patient care.

106 Understanding the processes, challenges and supports needed for transitioning out of practice for Canadian specialists: a Royal College needs assessment

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Introduction: Late career transitioning and retirement for specialists can be a time of mixed emotions ranging from exhilaration to trepidation. In 2024, the Royal College of Physicians and Surgeons of Canada (Royal College) formed a Transition out of Practice National Advisory Committee to support specialists in this process. The primary objective of this needs assessment was to identify the processes, challenges and support required during this transition and to provide actionable recommendations for the Royal College to consider.

Methods: Using a participatory approach, an exploratory, sequential mixed-methods design was employed, consisting of 4 stages: a scoping review of current literature, focus groups and individual interviews, two large scale national surveys targeting active physician members (55+) and retired members and follow up focus groups to deepen insights.

Results: Five categorical themes emerged from the focus groups/interviews including intrapersonal, environmental and retirement logistical issues, the impact of Covid, and several suggestions for the Royal College to consider to best support specialists in the retirement process. Substantial numbers of physicians both retired or in late career were worried about giving up something they loved doing, loss of their professional identity, feelings of guilt, loss of their professional community and personal financial issues. Retired physicians had often retired because they were financially secure, feeling confident they were “going out on top” and excited about the possibilities of new adventures, learning and interests. Physicians were enthusiastic about the Royal College providing more specific support during the retirement process.

Conclusion: We have illuminated the complex and deeply personal nature of transitioning out of clinical practice for Canadian specialists. The findings underscore that retirement is not a singular event, but a multifaceted process influenced by internal factors such as identity and emotional well-being, external pressures within the clinical environment, and practical considerations like succession planning and finances.

107 Assessment of burnout among trainees in postgraduate medical training programs: a study of 19 training programs at the Academic Medical Center of Imam Abdulrahman Bin Faisal University (King Fahad University Hospital, Al-Khobar) using a burnout assessment tool

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Introduction: Burnout is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job¹. In the medical field, it adversely affects both physicians and patients (2,3). Due to paucity of data on burnout among postgraduate medical trainees, we sought to assess burnout at our 19 postgraduate training programs.

Methods: This cross-sectional study included 114 postgraduate medical trainees. Burnout was assessed utilizing the Burnout Assessment Tool (BAT-23). Which is a validated 23-item questionnaire that measures four key domains: exhaustion, mental distance, emotional impairment and cognitive impairment. Data were analyzed using IBM SPSS Statistics version 26. Categorical variables were compared using Fisher's exact test, and continuous variables using independent sample t-tests. Multivariate logistic regression was performed to identify independent predictors of burnout, with statistical significance set at $p < 0.05$.

Results: One hundred and fourteen residents participated in this study. The largest age group was those aged 26–30 years (61.4%), reflecting a cohort still navigating the steepest part of the learning curve. Males formed the majority (59.6%), and just over half were single (51.8%), though a meaningful portion carried the added burden of caregiving responsibilities (67.5% without children, meaning only a third had family duties). Training levels mirrored this early-career profile: the highest proportions were in R2 and R3 (each 28.1%), and most residents had completed 2–3 years in their program (51.8%).

Conclusion: Overall, the results emphasize the multifaceted relationship between residents' demographics, level of training, and personal obligations, and how these factors may influence their well-being and professional development. The findings point to important opportunities for focused educational and support strategies that could improve residents' training experience, adaptability, and quality of life during the most challenging phases of residency.

108 This abstract has been withdrawn.

109 Equity, diversity and inclusion in Canadian medical school admissions: what barriers and facilitators did medical students experience throughout the application process?

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Introduction: Diversity in the physician workforce is associated with improved patient satisfaction and quality of care. Yet, Canadian medical students disproportionately come from higher socioeconomic and urban backgrounds. Data describing Canadian student demographics and barriers in the admissions process are limited. This study characterized Canadian medical students' sociodemographic profiles and examine perceived barriers and facilitators during medical school applications. We hypothesized that students from racialized and lower socioeconomic backgrounds experience more barriers.

Methods: Cross-sectional survey of Canadian medical students was conducted using online questionnaire. Participants were recruited, via email and social media, from September 1 to December 31, 2023. Outcomes included self-reported demographic, educational, financial, sociocultural, and recruitment barriers/facilitators, and number of application cycles. Group comparisons were performed using Mann-Whitney U tests. Qualitative free-text responses were analyzed using thematic analysis.

Results: In total, 420 individuals responded out of an estimated 1450 medical students (response rate of 29%). Most respondents were from Ontario (62.9%), 20 and 29 years of age (85%). Forty-two percent identified as racialized minorities, including East Asian (23%), Indigenous (7%), and Black (11.7%). Forty percent reported household incomes above \$100,000. Racialized respondents reported significantly greater educational (mean = 2.41, (SD = 1.79) vs. 1.83 (1.46); $p < 0.002$), sociocultural (1.78 (1.31) vs. 1.27 (1.03)); ($p < 0.001$), and recruitment barriers (2.45 (1.63) vs. 1.75 (0.92); $p < 0.001$). Students from households earning under \$100,000 reported greater barriers across all domains ($p < 0.001$) and completed more application cycles on average than higher-income applicants (2.64 (2.34) vs. 1.88 (1.13); $p < 0.001$). Financial and mentorship constraints emerged as key themes.

Conclusion: Canadian students from racialized, lower-income backgrounds face increased barriers during admission processes. Financial support and structured mentorship initiatives may mitigate these inequities. Limitations include selection bias and low response rates. Future research should investigate unsuccessful applicants' experiences to identify persistent systemic barriers.

110 Integrating eConsults into hematology residency training to address specialist access and digital care readiness: a prospective pilot study

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Introduction: Electronic consultations (eConsults) improve access to specialist expertise and are increasingly embedded in clinical practice, yet residency programs rarely provide structured preparation for this mode of care. In hematology, graduating specialists may lack readiness to deliver high-quality electronic advice for complex diagnostic and management questions. This study evaluated the feasibility, engagement, and educational value of integrating simulated eConsults into hematology residency training.

Methods: We conducted a single-arm, post-intervention study involving hematology residents from three Ontario programs. Participants received one mock eConsults weekly over 12 weeks, derived from real eConsults, followed by virtual group debriefing every 4 weeks. Responses were assessed using the eConsult Specialist Quality of Response (eSQUARE) tool and a modified O-Score entrustability scale. Outcomes included participant engagement and retention, response time and timeliness, and quality and entrustability ratings. Quantitative data were analyzed descriptively; narrative comments were coded inductively.

Results: Seven of 27 eligible residents participated without withdrawals. Overall open and completion rates were 38% (32/84) and 29% (24/84), respectively; among opened eConsults, the conditional completion rate was 75%. Most completed eConsults were submitted within 7 days (92%). Engagement declined over time and was unevenly distributed, with a median of 2 completed eConsults per participant (range 0–10). Median response time remained short (10–15 minutes). Mean eSQUARE scores ranged from 3.5 to 5.0, with 94% rated acceptable or exemplary. Entrustability ratings were predominantly ≥ 4 (62.5%). Narrative comments aligned with quantitative ratings, emphasizing clear reasoning, direct responsiveness, and patient-specific recommendations. Research ethics approval was obtained from all sites.

Conclusion: Although completed eConsults demonstrated high quality and entrustable perfor-

mance, this intervention failed to achieve sustained engagement or broad participation. These findings suggest that voluntary, formative eConsults are insufficient as standalone curricular innovations and require stronger structural integration, protected time, and alignment with assessment frameworks to be scalable within residency training.

111 Just a physician? A thematic analysis of identity diversification among early career physicians

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Introduction: Physicians face disproportionately high levels of stress, burnout, and depression. Research suggests that cultivating diverse identities in individuals may help protect against burnout, as individuals with multiple independent identities are better able to buffer stressors and regulate negative emotions. To date, research in identity formation in medical education has emphasized the professional identity. This study explores the barriers and enablers to constructing diverse identities alongside professional identity in the early career period.

Methods: In this constructivist exploratory qualitative study, we undertook ten semi-structured interviews with early-career physicians practicing across Canada. We included physicians who completed a Royal College of Physicians and Surgeons of Canada accredited residency program between 2019-2024. Physicians who completed training in Family Medicine or surgical specialties were excluded. Interviews were conducted virtually and analyzed using Braun and Clarke's reflexive thematic analysis.

Results: Participants (M=5, F=5) were within their first four years of independent practice. While participants sought to diversify their identities as they transitioned to early career, most continued to struggle with the dominance of professional identity that was consolidated during periods of training. Six themes were developed, reflecting the enablers and barriers to cultivating identities in medicine: (1) Siloing of Identity and the Loss of Personal Identity, (2) Professional Autonomy in Early Career, (3) Decision Making that Aligns with One's Values, (4) A Sense of Security and Stability, (5) Being Well and (6) Importance of Personal Anchors.

Conclusion: Identity diversification remains particularly challenging during training but can be cultivated in early career physicians. Early intervention has been thought to be advantageous, as identities are more malleable. Our finding that medical training may contribute significantly to identity-related struggles lends further weight to this proposition. Facilitating identity-diversification in physicians is possible but requires structural supports to normalize and promote exploring and sustaining identities beyond being just a doctor.

112 Teaching medical trainees intercultural education through arts, storytelling, and experiential learning in preparation for a future career in medicine

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Introduction: Canada's healthcare system faces increasing cultural diversity due to immigration alongside a shortage of family physicians, leaving more than six million residents in Canada without timely access to care. As Martin Luther King Jr. stated, "Of all forms of discrimination and inequalities, injustices in health is the most shocking and inhumane." Addressing inequities requires medical education that equips trainees to deliver culturally sensitive and compassionate care. Dr. Cindy Sinclair, PhD, developed an Arts in Intercultural Education Program (IEP) that integrates arts, experiential learning, and storytelling to foster cultural awareness among medical students and residents. The program also leverages the expertise of immigrant physicians, who face systemic barriers to licensure but bring invaluable global perspectives.

Methods: The pilot program was implemented with Canadian medical students, immigrant doctors, and community healthcare leaders and delivered to medical students and residents who were mentees and their mentors. A pre- and post-test evaluation assessed changes in trainees' awareness, attitudes, and perceived relevance of intercultural education.

Results: Evaluation data demonstrated a positive shift in participants' understanding of cultural diversity and its impact on healthcare delivery. Trainees reported increased confidence in engaging with diverse patient populations and expressed support for continuing and expanding the program. Immigrant physicians contributed unique insights into healthcare practices across global contexts, enriching the learning experience and fostering mutual respect between Canadian trainees and internationally trained doctors. There were four objectives: examine arts-based and storytelling approaches in intercultural medical education; evaluate outcomes of the pilot program; discuss immigrant physicians' contributions to Canadian medical education; advocate for integration of IC into residency training.

Conclusion: The IEP shows promise as a scalable model for integrating intercultural awareness into residency training. This creative pedagogy with lived experiences of immigrant physicians will help provide doctors with greater awareness of culturally sensitive care, ultimately reducing inequities and improving health outcomes.

113 Chart pollution: how stigmatizing clinical documentation undermines equity and solutions to address the issue

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Introduction: Chart pollution, the presence of stigmatizing and biased language in clinical documentation, is a pervasive threat to equitable, patient-centered healthcare. While biased documentation pre-ates electronic health records (EHRs), EHRs and copy-paste practices have amplified its spread. Such language disproportionately harms racialized, economically-disadvantaged, and stigmatized groups, influences clinician attitudes and decisions, and risks damaging patient trust as records become increasingly accessible.

Methods: We reviewed literature and integrated structural competency and professionalism frameworks to propose "clean charting," the intentional use of respectful, unbiased language as a core competency. We developed a conceptual framework for embedding clean charting into residency education. Recommended strategies include targeted workshops, institutional policies on documentation language, routine documentation feedback, and leveraging EHR features to flag biased language and suggest alternatives.

Results: This framework outlines practical interventions addressing chart pollution at multiple levels in medical education and clinical practice. Faculty workshops on identifying and removing biased language, combined with institutional guidelines and EHR alerts, increased clinician awareness and improved documentation habits. Pilot programs reported greater sensitivity to documentation bias and stronger engagement with structural competency among faculty and learners.

Conclusion: Treating stigmatizing clinical documentation as a site of bias is vital for advancing health equity. Embedding clean charting into residency curricula can disrupt patterns of prejudice entrenched in medical records, improve patient-clinician trust, and foster a culture of respectful, patient-centered care. Medical education must broaden to include documentation ethics, giving chart language the same critical attention as verbal communication and clinical reasoning.

114 Local faith, systemic fear: a rural lens on Just Culture and the validation of an adapted resident assessment tool

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Introduction: Adverse events (AEs) which include medical errors and institutional mistreatment frequently result from systemic failures, not individual deficits. "Just Culture" emphasizes system-level learning and fair accountability instead of personal blame to enhance reporting. However, rural residency sites confront unique resource and hierarchy constraints which may negatively impact psychological safety. This research sought to assess the utility of an adapted Just Culture Assessment Tool (JCAT) within rural Family Medicine residents and pinpoint specific design and applicability enhancements.

Methods: We conducted a prospective, cross-sectional survey study of rural Family Medicine residents at the University of Calgary. Participants were electronically recruited and completed an online adapted JCAT (Likert scale, short answer and multiple-choice questions). Responses were analyzed descriptively for tool usability and performance. The Friedman test was applied to non-parametrically compare perceptions across different levels of authority.

Results: We had 29 complete responses yielding a 72.5% response rate. When reporting AEs, residents perceived their immediate residency programs and clinical departments as significantly more approachable, comfortable to report to, serious about taking steps for improvement and more likely to do the right thing than the Office of Postgraduate Medical Education (PGME) and the Health Authority ($p < 0.001$ for all four comparisons). Moreover, when asked about safety culture, a majority of residents indicated their clinical areas adhere to their own rules (55%). Crucially, most believed that reporting AEs would make clinical areas a safer place (69%) and that AEs represent vital opportunities to make improvements (62%).

Conclusion: Fear and ambivalence regarding system-level accountability among rural Family Medicine residents highlight potential distrust in PGME structures and the broader health care system. This study is critical to identify areas to create targeted interventions to strengthen psychological safety and reinforce a just culture within rural training environments.

115 Where are they going instead? A national analysis of Family Medicine applicant attrition to other specialties using Bayesian compositional time series (2009-2025)

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Introduction: Canadian Medical Graduates (CMGs) have been losing interest in Family Medicine, but it is unclear which specialties they have shifted towards. Advanced statistical methods are required to account for how both the number of CMGs and quotas for each specialty changes over time, and also how Family Medicine is much larger than other specialties. I used Bayesian compositional data analysis to investigate career choice substitution between different specialties, analogous to studying Family Medicine's market share in the CaRMS match. I hypothesized that the greatest proportional losses would be to generalist specialties like Internal Medicine, Emergency Medicine, and Pediatrics.

Methods: I analyzed CMGs' first-choice specialty data from the 2009-2025 matches. First, I used Bayesian time series decomposition and found with 98% probability that Family Medicine applications decreased significantly starting in 2016. Second, I used Bayesian piecewise regression to identify specialties forming a subcomposition whose applications significantly increased after 2016, reflecting attrition from Family Medicine.

Results: On aggregate, Family Medicine is losing the most applicants to Anesthesiology, with >99% probability of a cumulative trend decrease of 7.9 applicants per year since 2016. Applicants are also shifting towards Orthopedic Surgery (3.3 applicants/year; >99% probability), Diagnostic Radiology (2.3 applicants/year; >99% probability), Ophthalmology (2.1 applicants/year; >99% probability), Radiation Oncology (1.5 applicants/year; 96% probability), and other narrower-scope specialties which collectively account for losing 21 applicants/year. Because trend effects compound annually, this amounts to losing 1160 Family Medicine applicants from 2016-2025.

Conclusion: CMG interest in Family Medicine has significantly decreased since 2016. Contrary to my hypothesis, applicants are not substituting this career choice for other generalist specialties. Instead, the attrition from Family Medicine is accompanied by a diffuse shift toward a range of specialties that all have narrower practice scopes. These results show how compositional data analysis provides insights on career choice that traditional statistics cannot.

116 Enhancing the Clinical Learning Environment in Psychiatry Emergency Services: a mixed-method learning health systems approach

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Introduction: The Clinical Learning Environment (CLE) encompasses the social interactions, organizational cultures, and physical and virtual contexts that shape the experiences and learning of healthcare participants. Within Psychiatry Emergency Services (PES), the CLE uniquely integrates patient care and education, often creating tensions between service delivery and learning priorities. A recent Quality Improvement (QI) initiative within the University of Ottawa's Psychiatry Residency Program revealed significant challenges in the PES CLE, including limited familiarity among team members, reduced in-person supervision, and perceptions of amplified power imbalances—all contributing to diminished psychological safety.

Methods: This presentation adopts a value-based learning health systems (LHS) framework to evaluate and enhance the PES CLE. It reports findings of a mixed-methods study aimed at strengthening familiarity and direct supervision through the implementation of structured in-person supervision shifts. Using reflexive thematic analysis of rich qualitative data collected from anonymous surveys of PES residents and supervising staff, this study explores the perceived effectiveness of the intervention, as well as the barriers and facilitators to cultivating psychological safety within this high-acuity clinical context.

Results: The results ascertain the effectiveness of an intentional, relationship-centered supervisory engagement on the PES CLE.

Conclusion: These findings will inform iterative interventions designed to co-create a psychologically safe, inclusive, and educationally rich CLE that supports both optimal patient care and professional development for all team members, aligning with the broader principles of learning health systems.

117 Exploring the influence of near-peer teaching on fourth-year medical students' readiness for the Canadian residency match: a mixed-methods study using self-determination theory

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Introduction: The Canadian post-graduate match is a high-stakes transition associated with significant uncertainty and stress for medical students. Near-peer teaching (NPT) is frequently used informally to support match preparation, yet little is known about how curricular NPT influences learners' perceived readiness when examined through a theoretical lens. We used self-determination theory (SDT) as a conceptual lens to explore how a near-peer intervention shaped students' perceptions of readiness for the residency match.

Methods: We conducted a mixed-methods study with fourth-year medical students at a Canadian medical school who attended a three-part "CaRMS Primer" lecture series delivered by junior residents. Quantitative data were collected using post-session surveys adapted from the Learning Climate Questionnaire and the Perceived Competence Scale, rated on seven-point Likert scales. Internal consistency was assessed using Cronbach's alpha, and differences across sessions were analyzed using one-way ANOVA. Qualitative data were collected through semi-structured interviews with students who attended all sessions and analyzed using reflexive thematic analysis. Findings were integrated during interpretation using SDT as a conceptual lens.

Results: Fifty-six of ninety-four (59.6%) students completed post-session surveys, and twenty-five (26.6%) participated in semi-structured interviews. Learning climate scores were consistently high across all sessions. Perceived competence increased significantly by the final interview-focused session ($p < .001$), though internal consistency for this subscale at that timepoint was lower. Qualitative data revealed four themes: stress and anxiety, perceived competence and readiness, autonomy and control, and relatedness and peer support. Students described NPT as credible, reassuring, and empowering, while also noting challenges related to peer comparison and limited presenter diversity.

Conclusion: NPT appears to support learner readiness for the PG match by fostering psychological safety, boosting self-efficacy, and leveraging the relatability of near-peer experiences, which align with SDT principles. Structured near-peer interventions may serve as a replicable, theory-informed approach to supporting learners through high-stakes transitions in medical education.

118 Beyond individualism and independence: Exploring collectivism and interdependence as paradigms of healthcare and health professions education

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Introduction: Healthcare is delivered by teams, yet individualism continues to be foregrounded in training and assessments. In contrast to individualism is collectivism, a sociocultural phenomenological lens that considers the degree to which people are integrated into groups, and interdependence, which characterizes how two or more people or things are interconnected with one another. The purpose of this review is to examine the current body of work on collectivism and interdependence and their potential implications within health professions education (HPE).

Methods: This narrative review included English-language publications from peer-reviewed journals between 1990 and 2024, and excluded non-English articles, perspective pieces, commentaries, and studies that were unrelated to healthcare or HPE. The initial search in January 2024 included MEDLINE, Embase, PsycINFO and ERIC databases and was updated in November 2024 with forward and backward reference mining.

Results: In total, 3,415 articles were identified, of which 63 were included in the review. We used reflexive thematic analysis to consolidate the literature. Our analysis revealed four themes: 1) reshaping the culture of healthcare and the learning climate of HPE, 2) accounting for individual contributions to the team, 3) the many facets of leadership, and 4) belongingness as an essential step towards collective well-being.

Conclusion: Healthcare and HPE can be effectively examined through the paradigms of collectivism and interdependence, which transcend and challenge the current models of individualism and independence. By embracing interdependence and collectivism as guiding principles, healthcare workers and educators can better prepare for the collaborative, team-based nature of healthcare, and create protective and transformative learning environments.

119 Nursing as influencers of the hidden curriculum in Labour and Delivery and the implications on resident learning

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Introduction: The hidden curriculum (HC) exerts a powerful influence on resident education. Previous work has examined the HC in OBGYN training from resident and physician perspectives, identifying its impact on learning environments and departmental culture. While nursing staff in Labour and Delivery (L&D) were identified as influential contributors, their perspectives have not been directly examined. Given the interdependent workflows and sustained collaboration in L&D, nurses are key stakeholders in shaping the HC within OBGYN residency. This study aimed to examine nursing perspectives to better understand how unit culture and interprofessional dynamics influence resident education and the clinical learning environment.

Methods: A focused ethnographic study was conducted using focus group discussions with L&D nursing staff. Sessions were audio recorded, transcribed verbatim and analyzed alongside field notes using inductive iterative latent content analysis. Analysis occurred concurrently with data collection using qualitative data handling software (Quirkos 2.3 TA). Thematic analysis was triangulated among co-investigators to enhance methodological rigor. Local ethics and operational approval were obtained.

Results: Three interrelated themes emerged: realization and recognition of professional scope, discontentment with a static vertical hierarchy, and tension between alternative planes of existence. Nurses described underutilization of their professional scope and competing priorities between nursing and resident workflows. These dynamics influenced collaboration, morale, and learning opportunities within L&D for residents and nurses.

Conclusion: By foregrounding nursing perspectives, this study conceptualizes the HC as an interprofessional phenomenon rather than a resident-centered experience. Findings are informing initiatives to expand nursing scope in L&D, strengthen resident–nursing communication, and improve collaborative workflows, with the potential to support resident learning, reduce burnout, and foster more effective clinical learning environments.

120 Impression management in the era of competency based medical education

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Introduction: With the Royal College's recent competency based medical education (CBME) adaptations, how performance is perceived remains central to judgements of competence. Impression management (IM) refers to the conscious or subconscious actions one takes to control how they are perceived during interactions. Prior studies have illustrated learners utilize IM during medical residency interviews as well as through moments of patient care, prior to the implementation of CBME. However, how IM influences resident approaches to entrustable professional activity (EPA) assessment remain poorly understood. This study aimed to explore how IM affects the residents' approach to requesting EPA assessments at our institution.

Methods: We utilized a multi-method study design involving surveys and interviews. All resident physicians at Dalhousie University were invited to complete a survey containing both multiple-choice and open-ended questions and to participate in semi-structured interviews. We analyzed the multiple-choice responses with descriptive statistics. Three investigators conducted a thematic analysis of the open-ended survey responses and interview transcripts.

Results: The survey was completed by 54 resident physicians, and interviews were conducted with 5 participants. Greater than 80% of the participants used IM when asking for EPA assessments, most commonly through the avoidance of sending EPA assessments to supervisors when they viewed their performance as poor. Other IM strategies included controlling the timing of EPA assessments, and adjusting performance to the supervisor. The fear of negative consequences, such as poor evaluations and impact to training progression, were also key themes in residents use of IM.

Conclusion: IM is intrinsic to the current system of EPA assessments. Our study provides insights into how IM is utilized by residents in EPA assessment requests and highlights important resident perceptions regarding CBME implementation impairing a growth mindset. Evidence from this study can be used to inform other programs in the adjustment of assessment and feedback strategies.

121 This abstract has been withdrawn.

122 Prevalence and predictors of burnout among surgeons in Quebec

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Introduction: Burnout and suicidal ideation have been identified as common among surgeons and are shaped by workplace and training environments. These environments are at the core of surgical residency training, yet less is known about their impact on practicing surgeons. This study aimed to identify the prevalence and risk factors for burnout and suicidal ideation among practicing surgeons, with the goal of informing residency training reform.

Methods: A cross-sectional survey of staff surgeons from all specialties was conducted at a single-center university hospital in Quebec, Canada (CHUM). 45 participants completed a 120-item questionnaire including the Maslach Burnout Inventory (MBI), questions assessing suicidal ideation (SI) and previously identified occupational and personal risk factors. Descriptive statistics were used to summarize participant characteristics and outcome prevalence. Univariate and multivariate logistic regression models were developed to identify predictors for the end point of burnout. Sex-stratified analyses were also performed.

Results: Of 45 surveyed staff surgeons from nine specialties, 25 (55.6%) had complete burnout data and were included; 20 were excluded for missing outcomes. Burnout prevalence was 44.0% in the cohort. Suicidal ideation was reported and was more frequent among surgeons meeting burnout criteria. In univariate analyses, burnout was associated with hours of clinical work performed at home (OR 3.20, 95% CI 1.34–7.68), higher work schedule intensity (OR 7.50, 95% CI 1.28–44.15), and work–personal responsibility conflict ($p < 0.05$). In the multivariable model, only hours of clinical work performed at home remained independently associated with burnout (adjusted OR 3.27, 95% CI 1.16–9.25) without any sex-based differences identified.

Conclusion: Forty-four percent of the included participants met criteria for burnout. Working after hours was the most consistent predictor of burnout, suggesting workload spillover and scheduling pressure as key contributors.

123 “They have a huge say down the road”: exploring medical trainees’ concerns around consultant-mediated consequences of their own actions

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Introduction: In the hierarchical system of responsibility scaffolding the clinical learning environment, learners encounter physicians who are simultaneously educators and supervising assessors. Previous studies have shown trainees are concerned about the consequences of their actions, mediated through supervisory responses. What remains unclear, however, is how such concerns arise, which consultant powers trainees are attempting to navigate, and how these perceptions influence trainee actions. Understanding the origin and propagation of trainee beliefs around consultant powers is important to address the diversion of trainee cognitive and emotional labour away from learning the practice of medicine toward impression management.

Methods: A qualitative exploration of medical students’ and residents’ views around consultant powers, and the origin of beliefs which trainees hold around the consequences of their actions, was conducted. Semi-structured interviews with 12 trainees, ranging from early medical students to senior residents, were conducted and analyzed using reflexive thematic analysis.

Results: Three core themes were developed from the data: a) views of what matters to consultants are both constructed and adopted, b) trainees view potential consultant actions as impactful on their careers, and c) trainees focus on deliberate action and behaviours.

Conclusion: An overarching sense of anxiety wove through all three themes. Participants described a predominant mental model where impressions were believed to prompt consultants’ actions that could shape trainee career advancement, assessment, and future opportunities. This was developed largely through contemplation-led constructivism, with potential confirmation bias solidifying beliefs. Resultantly, trainees described engaging in inauthentic or performative behaviours that detracted from authentic learning and engagement. Our findings suggest an urgent need to explore and more openly discuss consultant power and expectations in the learning environment, to transparently address trainee

expectations and boundaries. This may reduce unnecessary cognitive burden and promote psychologically safe learning environments to contribute to a resilient future health workforce.

124 Improving patient safety and inpatient care efficiency during holiday coverage through structured resident team-based scheduling in a neurology residency program

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Introduction: Extended holiday periods present patient safety and workflow challenges for residency programs due to reduced staffing and increased workload. In the IAU Neurology Program at King Fahd University Hospital, holiday coverage previously relied on a single junior and senior resident pair responsible for all inpatient care and emergency consultations, frequently resulting in delayed rounds, prolonged decision-making for complex cases, and increased risk to patient safety. This quality improvement project aimed to improve inpatient care efficiency and patient safety during holiday coverage by restructuring resident scheduling using a team-based model.

Methods: The intervention introduced structured team-based scheduling, dividing holiday coverage into two equally divided periods, with defined inpatient responsibilities, supplemented by regular evening on-call coverage. Outcome measures included time to completion of inpatient rounds and care plan initiation, evaluates frequency of delayed clinical decisions, resident workload distribution, and reported patient safety concerns. Resident satisfaction and perceived workflow efficiency were also assessed. Pre- and post-intervention outcomes were compared using descriptive statistics.

Results: Following implementation, completion of inpatient rounds occurred earlier and more consistently, enabling timely formulation and execution of management plans for complex neurological cases. Delays in addressing active inpatient issues decreased, and responsiveness to consultations improved during evening hours. Resident workload became more evenly distributed across holiday coverage, reducing individual cognitive burden and physical exhaustion. Reported patient safety concerns related to delayed assessments and handover ambiguity decreased compared to the pre-intervention period. Overall workflow efficiency and resident mental wellbeing improved during holiday coverage.

Conclusion: Implementation of structured, team-based resident scheduling during holiday coverage improved inpatient workflow efficiency and supported safer patient care in a neurology residency

program. This new project enhanced continuity, reduced delays in clinical decision-making, and reduced patient safety risks during periods of staff shortage. Limitations include single-center implementation and reliance on descriptive data.

125 Perceived impact of RCPS Accreditation and CBME implementation on an Internal Medicine Residency Program: a quality improvement survey

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Introduction: Following Royal College of Physicians & Surgeons (RCPS) accreditation and implementation of Competence-Based Medical Education (CBME), we assessed early perceived impact among trainees and trainers in the Imam Abdulrahman bin Faisal University Internal Medicine Residency Program.

Methods: In December 2025, we conducted an anonymous voluntary survey of trainees (R1–R4) and trainers (university staff/consultants) assessing overall program rating pre/post-accreditation, understanding of CBME constructs (CBME, EPAs, milestones/stages, CanMEDs), perceived impact on training objectives/clinical skills, program organization/rotations, mentorship, research skills, wellbeing, assessment methodology, and administrative support.

Results: A total of 36 responses were analyzed (12 trainees: R1=5, R2=2, R3=2, R4=,3 and 24 trainers; 17 male, 19 female). Overall program ratings improved after RCPS involvement, with increased “Excellent/Very Good” and fewer “Fair/Poor” ratings. Post-implementation understanding of CBME concepts was generally rated “Very Good/Excellent” for CBME and CanMEDs, and “Good–Very Good” for EPAs. Respondents reported high agreement that changes improved CanMEDs understanding, training objectives, and clinical skills, while mentorship and research skills showed mixed responses; wellbeing and rights/responsibilities showed more neutral responses. Administrative support was rated highly (Resident Program Committee: Excellent 16, Very Good 1,3 supportive administrative employees: Excellent 12, Very Good 13).

Conclusion: Perceptions indicate that RCPS accreditation and CBME adoption were associated with improved overall program ratings and stronger alignment with CanMEDs competencies, while mentorship, research capacity-building, and wellbeing remain priority QI targets.

126 From evaluation to impact: strengthening faculty feedback systems

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Introduction: Faculty evaluations are essential for supporting quality teaching, faculty development, and accreditation. At Queen's University (Queen's), the Postgraduate Medical Education (PGME) office oversees 36 residency programs. To strengthen educational quality and drive continuous quality improvement strategies in faculty assessment, we evaluated systemic gaps in our faculty assessment processes. We employed an approach designed to understand challenges, support change to build resilience, sustain excellence, and implement targeted strategies for improvement.

Methods: This mixed-methods case study integrated survey questions and open-ended narrative data from 271 participants (160 faculty, 111 trainees) across all our PGME programs at Queen's. Quantitative data were analyzed descriptively, and qualitative responses underwent thematic analysis.

Results: Two critical gaps emerged. First, a feedback flow disconnect where 62% of trainees reported completing evaluations regularly and only 41% of Geographically Full-Time (GFT) faculty and 7% of non-GFT faculty reported receiving evaluation reports. Second, a purpose misalignment where faculty viewed evaluations as tools for teaching improvement and promotion, whereas trainees emphasized policy enforcement and flagging inappropriate behaviour. This misalignment likely influences how residents provide feedback and how faculty intend to use it. Additional barriers included technical challenges with the online evaluation system, confidentiality concerns, and evaluation fatigue.

Conclusion: Continuous improvement initiatives are underway to address these gaps, including strengthening confidentiality by merging evaluations from undergraduate medical students and residents using a standardized form. Additional measures include increasing transparency through development of flowcharts and clear communication about how evaluation data is used, and improving actionable feedback by ensuring faculty receive timely, specific reports and guidance on how to apply them. These strategies are supported by departmental engagement and practical resources. Collectively, these actions aim to create a culture of open and honest feedback to support teaching improvement.

127 Exploring the definition of "service" in postgraduate Obstetrics and Gynecology residency

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Introduction: Clinical service requirements are central to postgraduate resident program evaluation, yet the definition of 'service' is somewhat ambiguous. Our objective was to explore perceptions of service within a postgraduate Obstetrics and Gynecology (OBGYN) residency program, and identify interventions to optimize the ratio of service and education.

Methods: A mixed-methods approach was utilized, within a focused ethnographic study framework. An initial resident focus group discussion was held to explore perceptions of service. Open-ended questions, based on literature review, were used to frame this discussion. Notes were synthesized into categories that informed survey design. The survey was distributed to OBGYN residents and faculty at the University of Alberta. Quantitative responses between residents and faculty were compared utilizing Cliff's delta. Qualitative responses were analyzed through thematic analysis.

Results: Themes from the resident focus group discussion informed the creation of a survey that explored perceptions of service, assessed resident tasks, and collected proposed interventions. The survey yielded 50 responses (32 staff physicians, 18 residents), (33% response rate). Residents reported a higher service-oriented perception compared to staff (Cliff's delta 0.49, $p = 0.005$). Qualitative responses described the value of experiential learning amongst both groups. Residents more commonly referred to the educational value of formal teaching sessions, whereas staff emphasized procedural mastery. Both groups recognized impacts of service obligations on education, with residents citing issues of "role coverage" and maintaining protected time for teaching sessions. Common themes from proposed interventions included the addition of support staff, improved interprofessional communication between physicians and allied healthcare, and clear delineation of responsibility over documentation.

Conclusion: We identified that perceptions of service differ between trainees and faculty. Future directions include implementation of interventions on a program level to improve the resident learning experience amongst high service demands.

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128 Illuminating an essential role: using multisource feedback to support program administrators

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Introduction: Multisource (360-degree) feedback (MSF) integrates perspectives from multiple stakeholders to foster professional development and quality improvement. Though MSF is established for physicians and physician leaders in postgraduate medical education, its application to program administrators (PAs) is underexplored. Given the complexity and interdependent nature of the PA role, MSF offers a valuable approach.

Methods: A voluntary MSF process was implemented for PAs at Dalhousie University. Participants completed self-assessments and identified raters, who provided feedback via an online survey covering key PA domains: administrative support, communication, program management, accreditation, committee functioning, and resident support. Quantitative data were summarized descriptively; open-text responses underwent thematic analysis. Participants later completed a follow-up survey on the usefulness and impact of MSF.

Results: Forty percent ($N = 26$) of eligible PAs elected to participate. Each received feedback from 3–10 raters ($M = 6.7$). Across nearly all domains, self-ratings were lower than rater ratings, suggesting a pattern of self-critique. Mean scores reflected performance at or above "consistently meets expectations." Qualitative feedback emphasized strong organizational skills, communication, professionalism, and advocacy for resident well-being, while common areas for improvement included workload management, delegation, and navigating institutional change.

Seven participants completed the follow-up survey. All reviewed their reports; two had met with their Program Director to discuss the feedback, and one reported plans to do so. Most respondents reported changes to their work practices following the process and rated the process as highly useful; all indicated they would participate again or recommend the process to colleagues.

Conclusion: MSF yielded meaningful, actionable insights for PAs, supporting reflection, professional growth, and practice change. This initiative underscores MSF's value in recognizing and strengthening administrative leadership within postgraduate medical education.

129 Applying quality improvement to competence committees: improving consistency and efficiency amid system change

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Introduction: Competence committees (CCs) are central to competency based medical education (CBME), synthesizing multisource assessment data and making entrustment decisions for entrustable professional activities (EPAs) to guide learner progression. The volume and granularity of EPA data make this work complex and time-intensive. CCs must maintain consistency while adopting new tools and processes. In this multiphase project, the University of Calgary Pediatric postgraduate program CC aims to preserve consistency while improving efficiency of CC data review during the transition to a new EPA data management system (DMS).

Methods: This two-phase project aligned with implementation of a new EPA DMS. Phase 1 (Fall 2024-current) evaluated CC processes during the transition; Phase 2 will follow full implementation. Two outcome measures were collected for each CC meeting: CC rater agreement for EPA entrustment decisions and mean time per learner portfolio review. The balancing measure was agreement on EPA entrustment decisions between CC and faculty advisor progress reports. Phase 1 aimed to maintain strong rater agreement while preventing anticipated increases in review time. Guided by the Model for Improvement, interventions included standardizing CC processes through process mapping, multisource data review templates, and EPA DMS training. System performance was monitored using run charts and statistical process control charts.

Results: During Phase 1, control charts demonstrated a stable system with strong rater agreement. Phase 1 aims were achieved. Agreement improved both within the CC (Kappa 91% to 95%) and between CC ratings and faculty advisor progress reports for EPA entrustment decisions (Exact agreement 91% to 96%). Gains occurred without a persistent increase in mean review time. The target mean review time of <90 minutes was achieved (mean 72 minutes).

Conclusion: A quality improvement approach can support consistent decision-making during system transition. CC is positioned to further enhance process efficiency in Phase 2 following full EPA DMS implementation.

130 Programmatic assessment of resident wellness in Diagnostic & Clinical Pathology in Saskatoon: We walk the talk

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Introduction: Resident burnout is common in high-intensity training. We developed a structured, resident-led wellness program grounded in an eight-facet wellness framework to move beyond ad hoc events toward measurable, sustainable programming.

Methods: Diagnostic & Clinical Pathology is a 5-year program with 10 residents. Wellness programming was structured using eight operationally defined domains (Intellectual, Social, Financial, Environmental, Emotional, Digital, Spiritual, Physical). These domains were translated into a unifying visual identity via an eight-segment wellness logo, later adopted as program branding (including residency sweater/logo) to provide a shared language for mapping activities and reinforcing unified professional identity. Over six months, five resident-led wellness events were organized and evaluated using attendance tracking, post-event surveys, and qualitative feedback with thematic analysis. Financial stewardship was tracked against the annual wellness budget.

Results: Across five events, mean participation was 8.2 ± 0.4 residents. Participation by training level was high: PGY5 $80 \pm 16.3\%$, PGY4 $90 \pm 20\%$, PGY3 $70 \pm 24.4\%$, and PGY1–2 100%. Mean post-event survey response rate was $73.1 \pm 9.6\%$. All events were rated 5/5 (100%), and 100% of respondents indicated they would attend similar events again. Reported impacts included de-stressing ($79.4 \pm 13.4\%$), improved connection with co-residents ($90.3 \pm 12.2\%$), encouragement of physical activity ($70.7 \pm 12.4\%$), and improved outlook/motivation ($67.4 \pm 11.2\%$). No respondents reported “no impact.” Logistics/coordination by the wellness lead was rated excellent ($89.8 \pm 8.5\%$). Qualitative feedback clustered into seven themes: 1) cognitive refresh through novelty/play; 2) strengthened belonging/peer cohesion with hierarchy flattening; 3) emotional recovery via psychological ‘hospital’ detachment; 4) restorative environments (nature and safe “third spaces”); 5) intentional digital detox; 6) accessible wellness/cost-conscious design reducing barriers; and 7) embedded physical activity countering sedentary work.

Excluding a separately funded retreat, the first four events used 38.2% of the annual wellness budget.

Conclusion: An eight-facet, logo-anchored wellness framework enabled high-engagement, equitable, and measurable programming with consistent perceived benefit, supporting feasibility for sustained multi-domain resident wellness.

131 Assessing reflective capacity in medical students: evaluating the utility of the Reflective Practice Questionnaire in the CaRMS interview process

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Introduction: The Reflective Practice Questionnaire (RPQ) measures reflective capacity among healthcare professionals. This study aimed to assess the utility of the RPQ in evaluating reflective capacity among medical students compared to a standardized reflective practice station during the Canadian Resident Matching Service's (CaRMS) interview process.

Methods: Canadian and international applicants who interviewed with the Obstetrics and Gynecology Residency program at McMaster University in 2023 participated in this cross-sectional observational study. During the interview, applicants completed the RPQ instrument and a standardized reflective practice station co-designed by a psychologist and clinician educator. RPQ data were compared to the scores from 2 independent interviewers using Spearman's rank correlation coefficient. Interviewers were blinded to RPQ data and the other interviewer's scores.

Results: All 60 applicants interviewed participated. Participants had a mean RPQ score of 45.85 (maximum 60, SD 2.85), a mean Interviewer 1 score of 10.03 (SD 2.88), a mean Interviewer 2 score of 9.96 (SD 2.51), and a mean Interviewer total score of 10.00 (SD 2.36, maximum 15.00 each). The RPQ score did not significantly correlate with Interviewer 1 ($\rho = -0.086$, $P = .512$), 2 ($\rho = 0.010$, $P = .946$) or total scores ($\rho = 0.034$, $P = .811$). However, Interviewer 1 and 2 scores demonstrated a significant moderate positive correlation ($\rho = 0.333$, $P = 0.016$).

Conclusion: While the RPQ is a previously validated tool for measuring reflective capacity, it may have limited utility as a predictor of reflective practices demonstrated in a standardized reflective practice CaRMS interview station. Interviewers demonstrated a moderate positive degree of correlation demonstrating reliability in assessing candidate reflective practices using a standardized interview station. A limitation was the single program study design. Future research should investigate additional factors that influence reflective learning and refine methodologies for assessing reflective practice in admissions processes.

132 Improving Entrustable Professional Activity (EPA) knowledge, completion timeliness, and educational value through a Fishbone-informed video and poster-based educational intervention: a pre-post study in a neurology training program

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Introduction: Entrustable Professional Activities (EPAs) are central to Competence by Design (CBD), supporting workplace-based assessment, formative feedback, and defensible entrustment decisions. However, early implementation is frequently challenged by delayed completion, inconsistent feedback, and variable understanding among trainees and faculty, limiting their educational value. The aim of this study is to evaluate the impact of a Fishbone-informed, multimodal educational intervention on EPA knowledge, completion timeliness, and utilization within a neurology residency program.

Methods: A pre-post interventional study was conducted at King Fahd University Hospital, Imam Abdulrahman Bin Faisal University. Root cause analysis using an Ishikawa framework informed the development of short educational videos and poster-based visual reinforcements addressing EPA purpose, timing, entrustment scales, and feedback quality. EPA knowledge was assessed using a structured questionnaire before and after the intervention, distributed amongst staff and residents in our neurology department ($n = 32$). Objective EPA metrics were extracted from the One45 platform, including completion rates and time to completion. Paired and non-parametric statistical analyses were applied.

Results: Post-intervention, overall EPA knowledge scores improved significantly (15.2 ± 4.9 vs. 18.1 ± 3.1 , $p = 0.003$), with gains observed across trainees and faculty. Timeliness improved, with average days to completion decreasing from 5.4 to 3.7 days ($p < 0.001$) and a higher proportion of EPAs completed within 24–48 hours. Completion rates remained stable, while sustained improvements in timely engagement were observed over four months.

Conclusion: A Fishbone-informed video- and poster-based educational strategy effectively improved EPA knowledge and documentation timeliness. This low-resource, scalable intervention strengthens programmatic assessment and supports reliable CBD implementation in postgraduate neu-

rology training. Limitations include small sample size. Hence, future research warrants a larger sample size.

133 “Doing well”: a qualitative study of how faculty in psychiatry assess resident competence in well-being

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Introduction: Medical training increasingly emphasizes clinician wellness as it shifts to competency-based approaches involving outcome-focused assessments based on observable criteria. Unfortunately, what it means to be “competent” in wellness remains uncertain.

Methods: This study qualitatively explored the wellness-as-competency concept in psychiatric residency, determining psychiatrists’ definition of it, how they observe it, and their attitudes about formally assessing it. Thirteen semi-structured interviews with academic psychiatrists at Western University were conducted and simultaneously analyzed using constructivist grounded theory.

Results: Faculty conceptualized wellness competence as residents’ *situated capability* to regulate personal well-being and professional functioning through *cultivated insight* into the dynamic relationship between clinical work and wellness, and through *context-responsive adaptation*. Cultivated insight entails awareness of wellness state, comprehension of how wellness impacts clinical performance and vice versa, and appraisal of coping strategy effectiveness. Context-responsive adaptation involves restorative actions taken to address impairment when wellness or clinical function is affected, as well as anticipatory modification of habits or professional behaviours to reduce future vulnerability to wellness deterioration or impaired function under stress. The competence is shaped specifically by psychiatry’s emotional demands, relational work, and sociocultural context. Faculty most often noticed the absence of wellness competence through impaired clinical performance, while inferring its presence from consistent clinical functioning. Observability was mediated by the supervisory relationship, supervisor’s own wellness definitions, and the training environment, all of which shaped interpretation. Faculty expressed apprehension about formal assessment, citing concerns related to subjectivity, stigma, privacy, risk of “performative” wellness, and uncertainty about appropriate remediation—particularly when systemic contributors are insufficiently addressed.

Conclusion: Wellness-as-competence in psychiatry can be defined as the integration of insight and adaptive action in specific clinical contexts. While it is observable, translation into competency-based assessment raises concerns that warrant a careful and nuanced approach, a formative emphasis, and attention to both relational and systemic factors.

134 An inter-institutional, collaborative residents-as-educators program: educational outcomes of a joint initiative

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Introduction: Residents play a critical role in medical education, and accrediting bodies such as the LCME and ACGME emphasize preparing residents to be effective educators. Although residents and program directors value residents-as-teachers training, programs vary widely and are often housed within single departments or institutions, limiting reach and efficiency. Inter-institutional collaboration may offer a strategy to expand access and optimize resources; however, outcomes of jointly delivered residents-as-teachers programs remain underrepresented in the literature. This study evaluated the educational outcomes and perceived value of a collaboratively implemented residents-as-teachers program between an academic medical school and an independent academic teaching hospital. Given increasing constraints on faculty time and educational resources, scalable collaborative approaches are needed. We hypothesized the joint program would significantly improve resident teaching skills and be highly valued.

Methods: Participants were 92 residents and fellows from UTHealth Houston and Houston Methodist Hospital who completed a delivered program during the 2023–2025 academic years. UTHealth Houston contributed an established residents-as-teachers program, while Houston Methodist Hospital lacked such infrastructure, motivating collaboration. The program included eight workshops delivered across both institutions. Using a retrospective pre/post design, participants self-rated competence across eight teaching domains. Paired t tests analyzed outcomes.

Results: Residents demonstrated significant improvements across all teaching domains ($p < 0.01$), with mean increases of 1.14–1.76 points and large effect sizes (Cohen's $d_z = 1.26$ – 2.32). Overall teaching competence increased from 2.13 ± 0.55 to 3.53 ± 0.38 (mean difference 1.40, 95% CI [1.27, 1.53]). Nearly all participants rated sessions as helpful, and 88% reported increased interest in academic careers.

Conclusion: A collaboratively implemented residents-as-teachers program was associated with significant improvements in teaching skills and high

learner satisfaction, supporting shared delivery as a feasible, high-impact model. Inter-institutional collaboration expands access to structured training without duplicating resources. Limitations include self-reported outcomes and the absence of a control group.

135 Discussing illness on paper: a qualitative case study of case report writing among Traditional Chinese Medicine residents

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Introduction: Taiwan's Traditional Chinese Medicine (TCM) residency program, formally established in 2009 to modernize training, utilizes structured monthly case reports as a primary assessment tool. These reports aim to integrate biomedical frameworks with TCM-specific logic, such as etiology diagrams and treatment principles. However, trainees frequently report excessive workloads and a disconnect between these assignments and actual clinical practice. This research explores how these textually-mediated requirements shape the learning motivations and strategies of TCM residents.

Methods: Purposive sampling was used to recruit participants undergoing TCM residency training at a teaching hospital in Taiwan. Semi-structured, in-depth, one-on-one interviews were conducted with 4 residents (2 men, 2 women), each lasting 60–90 minutes. Verbatim transcripts were analyzed using thematic analysis, with both within-case and across-case comparisons.

Results: Findings indicate that rigid reporting formats often lead to formalism, where the goal shifts from learning to simply fulfilling bureaucratic regulations. Participants reported a significant imbalance between the extensive time invested in redundant writing and the perceived educational gain. The narrative perspective of these reports often causes residents to lose their sense of subjectivity in the learning process. Furthermore, the attitude and feedback of clinical supervisors are decisive factors; while active feedback enhances motivation, authoritative or absent responses lead residents to adopt survival strategies. Residents often decide their level of investment based on peer rumors or past experiences regarding a specific supervisor's feedback style.

Conclusion: While case reports are historically vital to TCM education, current redundant formats may hinder student-centered learning. To improve training, the curriculum should prioritize meaningful clinical dialogue and constructive feedback over administrative compliance. A major limitation of this study is its reliance on preliminary data from a single site. Future research must include additional interviews and expand to other teaching hospitals to ensure broader generalizability.

136 Daily feedback in the emergency department: barriers, enablers, and evidence of the fear of retaliation

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Introduction: Daily feedback is foundational to competency-based medical education, yet feedback conversations in emergency medicine (EM) are often inconsistent, incomplete, or avoided—particularly when addressing performance gaps. Emerging anecdotal evidence suggests that clinical teachers may withhold constructive feedback due to fear of retaliation or negative consequences. This study explored how trainees and clinical teachers experience daily feedback conversations and the interpersonal and system-level factors that influence them.

Methods: We conducted a cross-sectional, multi-site survey of EM clinical teachers and trainees across three academic hospitals in a single university context. Using DeVellis' framework, we developed, piloted, and refined a survey incorporating Likert-scale items and free-text responses. Data were analyzed using descriptive statistics and directed qualitative content analysis. Tracy's Big-Tent criteria underpinned study rigor.

Results: Eighty-seven participants responded (39 clinical teachers; 48 trainees). Both groups valued daily feedback for supporting communication skills, procedural competence, and professionalism. While 97% of clinical teachers believed their feedback enhanced learning, only 75% of trainees reported satisfaction. Clinical teachers frequently softened or avoided constructive feedback due to concerns about trainee defensiveness, being perceived as mistreating learners, and fear of negative teaching evaluations; 47% worried honest feedback could harm their evaluation scores (i.e., learners would retaliate). Structural barriers included limited privacy, time pressures, inadequate observation opportunities, and a burdensome remediation process. Trainees, in contrast, desired more specific and transparent feedback and rarely perceived constructive comments as punitive. Misalignment between teacher intentions and learner needs contributed to incomplete feedback exchanges.

Conclusion: Daily feedback in EM is shaped by complex interpersonal dynamics and systemic constraints. Fear of retaliation emerged as a novel and influential barrier to providing constructive feedback. Strengthening feedback literacy for both train-

ees and educators, improving privacy and time allocation, and clarifying distinctions between constructive feedback and mistreatment may foster psychologically safe, high-quality feedback conversations in residency training.

137 Characterizing the clinical teaching environment: a narrative review

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Introduction: In medical education, the clinical learning environment has been extensively studied, with clear links to improved learner education, well-being, and patient care. In contrast, little attention has been paid to the clinical environment from the teacher's perspective. Defining and understanding the ecosystem in which clinical teachers work is essential to address their rising rates of burnout, underappreciation, and disengagement, all of which affect their ability to deliver high-quality education. This study therefore aimed to explore how the 'clinical teaching environment' is defined and conceptualized in existing higher education literature.

Methods: MEDLINE, CINAHL, ERIC, Web of Science and Google Scholar databases were searched in March 2025 using keywords 'teaching environment', 'teaching setting', 'teaching context'. English and French language publications focused on the teaching environment in higher education from the last 10 years were included. Citations and reference lists were manually searched and grey literature reviewed. Papers were analyzed using descriptive and thematic analyses. Themes were interpreted through the lens of the authors' expertise as teachers, leaders in academic medicine, and faculty developers.

Results: 2,708 titles and abstracts were screened, of which 49 met inclusion criteria. Twenty (41%) were about online teaching and seven (14%) were about clinical teachers. Key components of the clinical teaching environment were identified as the people, resources, and institutional policies that affect teaching, all moderated by the surrounding teaching culture. No concrete published definition of this environment was found.

Conclusion: Despite their fundamental role in medical education, the clinical teachers' point of view remains largely overlooked. A conceptualization of the clinical teaching environment is proposed and a critical gap in medical education research is identified. Further studies are needed to explore and characterize the clinical teaching environment to support clinical teachers and high-quality medical education.

138 Empathy experience in internal medicine residency training: a qualitative study

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Introduction: Empathy has been linked to improved clinical outcomes and is an expected competency of medical training. Research points toward a potential decline in empathetic behavior during medical education, however outcomes are not conclusive, reflecting the conceptual complexity of empathy. Psychologists and philosophers describe this complexity, including costs and abuses such as secondary traumatic stress and the exaggeration of power differentials. Given this complexity, a deeper exploration of empathy in medical training is vital to navigating empathy development that balances patient care and resident wellbeing.

Methods: We used reflexive thematic analysis to explore empathy experiences among internal medicine residents. Fifteen residents were included with representatives from all three postgraduate years. Participants completed a prompted freewriting exercise describing a challenging personal experience with empathy followed by an interview about their empathy experiences during residency. Exercises and interview transcripts were read and coded. A code book was developed and applied to all transcripts and narratives. Coding reports were reviewed by the research team, and themes were identified through group discussion and consensus.

Results: We identified two major themes: setting boundaries and navigating expectations. Residents described setting boundaries around empathy and identified several factors that influenced why, how, and where those boundaries were set. Moving boundaries based on changing personal and experiential contexts led to a definitional fluidity of empathy. These contexts evolved during residency, with systems-based factors influencing boundaries in early residency and values-based factors prominent in later years. Residents also navigated the tension between implicit and explicit expectations for empathy from themselves and others. Balancing conflicting expectations caused moral, emotional, and professional stress throughout residency.

Conclusion: Empathy evolves as residents learn, grow, and mature through medical training. Residents' reflections on empathy give nuanced insight into its dynamic influence of trainee experiences on empathy development.

139 “Good busy, bad busy”: patient volume, complexity, and perceived preparedness for independent practice in internal medicine

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Introduction: As competency-based medical education (CBME) becomes the dominant framework for residency training in Canada, ensuring that internal medicine graduates are prepared for independent practice is a priority. While patient volume and clinical complexity are considered essential to developing clinical expertise, the optimal balance of these factors is unclear. This study explores how patient volume and clinical complexity influence perceived preparedness for independent practice.

Methods: PGY4–5 general internal medicine (GIM) subspecialty trainees and early-career GIM physicians within their first five years of practice in Toronto were purposively sampled to participate in one-to-one semi-structured interviews. 15 participants reflected on training experiences and early-career readiness. Interviews were using constructivist grounded theory.

Results: Four major themes were identified. First, the skill of efficiency was identified as a critical competency, developed through sustained exposure to high patient volume and time pressure, and perceived to diminish in lower volume settings. Participants described a “pressure-cooker effect,” whereby repeated exposure to high patient volume and acuity under time constraints accelerated skill acquisition and readiness for practice. Workloads exceeding capacity (“bad busy”) resulted in cognitive overload and diminished learning, whereas manageable, purposeful workload (“good busy”) promoted skill development. Supervised autonomy, defined as gradual independence with remote oversight and coaching, was viewed as essential for translating volume and complexity into meaningful learning. Preparedness was perceived to be optimized when workload, case complexity, and autonomy were balanced with level-appropriate supervision and opportunities to be challenged.

Conclusion: High patient volume and complexity can enhance preparedness for independent practice through building efficiency, provided workload is purposeful and supported by supervised autonomy. Both excessive, misaligned workload, and insufficient clinical exposure may hinder learning. Residency programs should intentionally balance clinical volume, complexity, efficiency expectations, and supervision to support readiness for independent practice.

140 Exploring the impact of simulation-based training on surgical residents' educational and job satisfaction

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Introduction: Simulation training has shown potential to enhance technical competence. Limited research however, investigates simulation's impact on educational and job satisfaction compared to standard teaching. This study explores simulation's impact on Canadian surgical residents' professional satisfaction.

Methods: This study was conducted at a National Minimally Invasive Surgery resident workshop in September 2025. All surgical residents attending the workshop participated, engaging in the intervention—a high-fidelity simulation for minimally invasive surgical skills—and they were invited to also complete pre- and post-workshop surveys. Survey questions assessed elements of professional fulfillment including perceived educational quality, motivation, growth and development, and rewarding nature of work using Likert-scale responses. Descriptive statistics summarized quantitative findings while qualitative responses were analyzed thematically.

Results: Pre-workshop surveys were completed by 13 residents (100%), and post-workshop surveys by 8 residents (62%). Pre-workshop responses demonstrated high baseline satisfaction, with 77% agreeing or strongly agreeing that they were satisfied with overall quality of their surgical education. However, satisfaction with balance between hands-on and theoretical learning was lower (54%). Post-workshop responses indicated all respondents (100%) agreed or strongly agreed that the workshop addressed a gap in their learning. Satisfaction with training balance remained lower (63%). Qualitative responses suggested residents valued the workshop for applying foundational and advanced surgical skills, increasing upper gastrointestinal skill exposure, gaining perspectives beyond home programs, networking, and preparing for their certifying examination.

Conclusion: Simulation may address gaps in traditional surgical education and support residents' professional satisfaction beyond technical skill acquisition, though optimization of the balance between theoretical and hands-on learning remains necessary in traditional training. Limitations include overrepresentation of senior residents and a single

workshop setting. Future qualitative interviews will explore how simulation can be integrated to optimize training balance and resident satisfaction.

141 Exploring pediatric residents' needs in experiential learning and applying cultural safety for Indigenous children and families

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Introduction: Indigenous patients and families (First Nation, Inuit, and Métis in Canada) experience inequality in healthcare settings, impacting the care they receive. Cultural safety aims to mitigate inequities and seeks to bridge these gaps through safe and reflective practices. Didactic curriculum is often already integrated into the pediatric residency curriculum; however, residents' needs concerning experiential knowledge (i.e. working directly with Indigenous children and families in a clinical setting) have not been identified. The objective of this study is to identify the perceived needs of residents regarding experiential training in cultural safety with Indigenous people in a pediatric tertiary care hospital.

Methods: The research protocol was approved by the local Institutional Review Board. An online questionnaire was sent to general pediatrics residents. The questionnaire has been developed in collaboration with Indigenous healthcare professionals. It included open-ended questions about residents' prior experiences, residents' preferred methods of experiential training, and Likert scale statements on perceived needs in Indigenous cultural safety. Thematic analysis and descriptive statistics was used for analysis.

Results: Of the 50 residents contacted, 22 completed the questionnaire. Most respondents reported having previous clinical interactions with Indigenous patients. Several perceived barriers to providing culturally safe care for Indigenous children and their families were identified, including a lack of clinical exposure and insufficient resources regarding various aspects of care, such as internal logistics, patient transfers, and the coordination of medical appointments. Results suggest that residents are interested in expanding experiential learning opportunities, particularly through practical workshops and clinical rotations.

Conclusion: The data collected provides valuable insights into potential strategies for enhancing the current pediatric residency curriculum regarding experiential learning in cultural safety with Indige-

nous children and families. To evaluate the impact of such strategies on the delivery of culturally safe care, future assessments should include feedback from Indigenous patients and their families.

142 Work based assessment's – useful, useless or under utilized

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Introduction: Work-based assessments (WBAs) are increasingly vital for documenting feedback, tracking trainee progress, and mapping competencies in competency-based training. However, variation in WBA use may affect their reliability as training tools.

Methods: Orthopaedic trainers in South Yorkshire, UK were invited to participate if they were recognized trainers, had worked with trainees in the past 12 months, and were registered on the UK surgical ePortfolio (ISCP). Trainers were asked to submit their ISCP WBA assessment summary data, typically recorded in the trainer area—most were unaware this data existed. Trainees were also contacted for their experience with WBAs via questionnaire.

Results: We had a 68% response rate. On average, each trainer completed 37 PBAs for 153 trainees. Feedback averaged 70 words (range: 30–154). PBAs were submitted a mean of 18 days post-training event (range: 1–135). The average time from trainee submission to trainer validation was 19 days (range: 0–193) compared to the national average of 21 days. This resulted in a mean total episode time of 37 days from the learning event to final sign-off. Trainees reported they saw these assessments as a way of keeping a record for CCT requirements rather than a feedback source, with 25% never having read any assessment post validation.

Conclusion: Trainer data in this region compares with national figures, indicating engagement in the process. However, the 37-day average from training to PBA completion suggests a gap between intended and actual WBA usage. Implementing changes to the structure of these forms could lead to better utilization as a learning experience. This routinely collected data could also be a valuable tool for trainer appraisal and program performance review.

143 Residents as educators in a world of change: Teaching and learning virtual clinical simulation

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Introduction: The purpose of resident education is to develop professional competencies, including those related to their role as educators. Clinical simulation is a teaching strategy that enables healthcare professionals to develop clinical skills, critical reasoning, decision-making, and teamwork skills in a controlled environment. This study describes a virtual clinical simulation (VCS) for residents as part of the “Medical Education” course.

Methods: Residents from a multicentric program in seven specialties in the 'Medical Education' course participated in a VCS session in the role of the treating physician providing information for decision-making to the patient's relative. The study used a post-intervention online survey to collect the residents' feedback. Multiple-choice and Likert-scale items were quantitatively analyzed.

Results: In 2025, 54 residents participated in the VCS and answered the online survey. Most residents (72.2%–81.4%) found the simulations productive for learning and beneficial in exploring the ethical aspects, to practice communication skills, and to address psychosocial aspects. Issues like poor understanding of instructions and technical difficulties were noted as significant challenges by 22%. The main issues addressed in the simulation were communicating bad news (88.9%), humanism and empathy (68.5%), compassion and empathy (59.3%). Emotions played a crucial role with 42%–33% residents experiencing feelings of sadness, anxiety, and emotional pain. The positive feedback about the debriefing sessions highlights the importance of a safe learning environment (85%), reflection and self-discovery in medical training (66%).

Conclusion: Virtual clinical simulation is an effective teaching strategy for residents, it closely replicates real-life situations and fosters learning in multiple areas (ethics, communication and psychosocial aspects). The study's limitations include small sample size, technical issues and poor communication can impede the experience. Future research should explore larger sample sizes and diverse specialties, long-term impacts on clinical performance and patient outcomes would provide a deeper understanding of the benefits of this educational strategy.

144 This abstract has been withdrawn.

145 Through the smoke: observing how current University of Alberta pediatric residents approach history taking and counseling around vaping with adolescent patients, using traditional objective structured clinical exam format

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Introduction: With rising rates of youth e-cigarette use, 29% of Canadian grade 7-12 students report involvement. Clinical screening for e-cigarette use varies, and up to 83% of providers report lacking knowledge and comfort with counseling. Given this ever-evolving landscape, pediatric resident physicians must competently obtain a confidential history and propose plans for change with the patient. This study aims to assess resident approach to history taking and counseling, and highlight participant-identified areas of need for future education.

Methods: This observational study utilizes the objective structured clinical examination to assess a convenient sample of 18 University of Alberta pediatric residents when presented with a standardized adolescent patient using e-cigarettes and experiencing respiratory symptoms. The scoring rubric focuses on specific aspects of the substance use history, differential diagnosis, complications, and suggestions for management. Descriptive statistical analysis was performed and cut scoring done using a borderline regression method. Braun and Clarke's six-phase framework for thematic analysis was used to categorize suggestions for curriculum improvement.

Results: Due to sample size, statistical significance was not achieved. $N = 11$ passed the examination per the cut score. Participants fared well with routine history however most did not explore withdrawal symptoms or the context of substance use. Post Graduate Year1 trainees scored lowest across all global domains, with less variability amongst the remaining trainees. Future educational needs were categorized into 4 themes: *knowledge gaps around e-cigarettes*, *skill development in counselling*, *gaps in clinical management skills*, and *limited experiential exposure*.

Conclusion: Evolving patterns of youth substance use must be recognized and explored to provoke change, a developing skill amongst pediatric residents. Hands-on education on e-cigarettes and motivational interviewing techniques appears the most likely intervention to increase resident competence. This study is limited by sample size, therefore future investigation may encompass a larger population to yield statistical significance.

146 Where is the trust: defining trustworthiness for independent call in a Canadian Anesthesia residency program

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Introduction: Buddy call is a period where Anesthesia PGY1 residents are supported by senior residents while on-call. After a pre-determined time-period, decisions are made regarding the progression to independent call where residents will have significantly less supervision. The concept of trust is integral to this assessment and decision-making process. This study aimed to define what makes a PGY 1 trustworthy through the perspective of key stakeholders in the process.

Methods: Virtual nominal group interviews were completed with three key stakeholder groups at the University of Ottawa: Junior and Senior residents, and Faculty. Each group developed a consensus list of ideas related to the nominal question: "What do you think is an important aspect of trustworthiness that a junior resident must demonstrate to progress to independent call?". The transcripts and consensus list underwent thematic analysis to identify key domains which were compared across groups.

Results: Three major domains were identified during the analysis. 1) "The What" consisting of skills and actions that can be directly observed. 2) "The Why" consisting of the internal cognitive and emotional processes that drive behaviours. 3) "The Context" which consists of the systemic and cultural factors that affect behaviours. Our results demonstrated that junior residents prioritized elements of domain 1, while senior residents focused primarily on domain 2. Faculty focused on constructs related to domain 2 while also recognizing the importance of domain 3.

Conclusion: This study demonstrates that there is a hierarchical shift in what constitutes trustworthiness for independence on call: Junior residents prioritize observable skills. Senior residents view residents as an educational investment, valuing coachability over medical knowledge. Faculty highlighted constructs such as accountability, reliability, and integrity rather than objective skills. This study helps define trustworthiness across multiple stakeholders which has implications for assessment and education during this time-period.

147 Factors influencing family medicine residents' decision-making in pregnancy care and patient referral: a qualitative study

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Introduction: Decisions about when to continue care and when to transfer care of a patient to another provider require resident physicians to consider multiple factors. Despite the centrality of referral to medical practice there is limited literature examining residents' decision-making through the process. Generalist family physicians (FPs) are often the first point of contact for pregnant patients, play an important role in prenatal care and counseling, and eventually transfer care to another provider for late antepartum and intrapartum care. Family medicine obstetrics (FMOB) physicians (who practice intrapartum care) are well positioned to train family medicine (FM) residents in perinatal care. At our institution, FM residents complete a longitudinal clinical experience (LCE) with FMOB preceptors, emphasizing informed choice, equitable access, and alignment of care with patients' medical needs and personal values-principles consistent with the WHO's Respectful Maternity Care Framework. This study explored factors influencing FM residents' decision-making when caring for pregnant patients and when referring them to another provider.

Methods: We conducted a qualitative descriptive study using semi-structured interviews with first-year FM residents completing the FMOB LCE. Eighteen interviews were audio-recorded, transcribed, and descriptively analyzed. Clinical vignettes were used to probe decision-making. Transcripts were analyzed using descriptive qualitative analysis to identify recurring themes.

Results: Factors influencing residents' decision-making clustered into 3 categories: systemic, patient/relational, and individual/personal. Systemic influences included societal, organizational, and local practice culture. Patient factors encompassed clinical presentation, knowledge and perspectives, and preferences. Physician individual/personal factors included educational exposures, confidence in pregnancy care, awareness of different providers' scope of practice, and personal experiences or interests/motivations.

Conclusion: Preliminary analysis suggests FM residents consider a composite of systemic, patient, and personal factors when making decisions in pregnancy care and referral practice. Their decision-making reflects patient autonomy, shared decision-making, access to care, and safe triage — elements central to high-quality, respectful pregnancy care.

148 Using numerical methods and computational modelling to teach clinical uncertainty in residency education

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Introduction: Managing uncertainty is a core competency in residency education; however, many training programs continue to rely on static instructional approaches that inadequately reflect the dynamic, probabilistic, and often hidden nature of clinical reasoning. In domains such as auditory health and environmental exposure, clinical risk arises from complex, nonlinear, and highly variable mechanisms. Numerical methods and computational modelling provide a structured means to explicitly represent uncertainty within controlled, transparent, and reproducible environments. This study examined how numerical modelling can be systematically organized to represent clinical uncertainty and generate educationally meaningful decision-making scenarios for residency training, without involving human participants.

Methods: A computational framework was developed to simulate noise-induced auditory damage across varying clinical and environmental conditions. Key parameters—including exposure intensity, exposure duration, and individual susceptibility—were systematically manipulated using deterministic numerical methods and sensitivity analyses. The model generated simulated clinical cases and corresponding diagnostic and management pathways based on predefined decision rules. Educational metrics included numerical stability, parameter sensitivity, scenario diversity, and interpretability of outputs for instructional use. Model outputs were quantitatively analyzed to evaluate variability, reproducibility, and the breadth of uncertainty represented across simulated scenarios.

Results: The framework consistently generated multiple distinct clinical scenarios with stable computational performance. Sensitivity analyses revealed nonlinear interactions between exposure parameters and simulated outcomes, producing divergent decision pathways even under similar initial conditions. The model reproduced clinically plausible patterns of uncertainty while maintaining transparency of internal mechanisms. Quantitative metrics demonstrated high scenario diversity and nu-

merical robustness, supporting its suitability for educational applications.

Conclusion: Numerical methods and computational modelling provide an effective strategy for structuring and teaching clinical uncertainty in residency education. By generating transparent and reproducible decision-making scenarios, this approach supports the development of curricula.

149. This abstract has been withdrawn.

150 From intern to senior: a qualitative study examining the transition, key characteristics, and professional fulfillment in internal medicine residents

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Introduction: Internal medicine senior residents (PGY2–3) supervise care, coach interns and students, and coordinate consultants, yet the transition from intern to senior is poorly defined. We examined residents' understanding of the senior role, perceived characteristics of effective seniors, and experiences of the transition to inform a resident-centered leadership curriculum.

Methods: We conducted a qualitative study using six 60-minute PGY-stratified focus groups (two per PGY level) at a large academic internal medicine residency. Sessions were recorded, transcribed, and coded using a consensus codebook developed by three investigators, with discrepancies resolved until thematic saturation was reached.

Results: Twenty-seven residents participated. Seniors were described as “mini-attendings” responsible for the big-picture hospital course—communication with consultants, order oversight, disposition planning, and sign-out—while protecting intern ownership of daily tasks. The transition to senior was perceived as abrupt, largely learned “by osmosis,” with persistent uncertainty about expectations, including who calls consultants and how to balance autonomy with supervision. Effective seniors were calm, organized, and explicit about priorities; they allowed autonomy for routine decisions, remained readily available, and stepped in during high workload periods. Interrupting intern presentations in front of attendings was viewed as harmful to confidence, whereas running the list together, sharing real-time feedback, and visibly advocating for interns fostered psychological safety. Residents reported that they mainly learned senior skills by observing role models manage complex tasks such as coordinating case management, managing medically complex patients, and troubleshooting overnight issues.

Conclusion: Residents experience senioring as a pivotal but under-supported transition, with key leadership and communication skills acquired almost entirely informally. Findings support the need for a structured curriculum that clarifies expecta-

tions for interns and seniors, teaches communication and feedback skills, and creates graduated opportunities to “practice being the senior” before PGY2 to improve preparedness, confidence, and team culture.

151 Decoding precision medical education in residency: exploring how residents learn from clinical experience

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Introduction: Precision medical education (PME) is a burgeoning educational model that uses data and technology to make learning opportunities more personalized and efficient. For residents, whose training is almost entirely experiential, PME strategies largely leverage clinical practice data in the electronic health record as a basis for interventions to enhance learning from clinical experiences. However, little is actually known about *how* exactly residents learn best from patient care experiences - what workplace learning cues are important and how they are interpreted to drive learning within clinical workplaces. Here, we sought to better understand the specific factors that residents rely on to transform clinical experiences into learning opportunities to provide a blueprint for building effective PME strategies for residents.

Methods: We conducted a qualitative, constructivist grounded theory study among categorical internal medicine residents at a single training program. Ten one-on-one semi-structured interviews explored patient care experiences which stimulated residents to engage in deliberate, effortful learning. Interviews were transcribed, coded, analyzed using the constant comparison method, and emergent themes were generated.

Results: Interviews yielded 16 codes organized into five themes explaining ways in which residents’ clinical experiences trigger opportunities for deliberate learning. Themes included clinical cues (e.g. unexpected patient outcomes), individual cues (e.g. self-identification of a knowledge gap), team-based cues (e.g. the need to ‘measure up’ to a peer), emotional cues (e.g. salient emotional responses motivating learning), and systems-based cues (e.g. hospital demands as barriers to learning). The concept of accountability cut across each theme, and was a central component modulating resident’s motivation to respond to each learning cue and turn clinical experience into learning opportunities.

Conclusion: Residents use various clinical learning cues, mediated by their sense of accountability to each, to transform patient care experiences into deliberate learning opportunities. PME strategies that harness resident’s sense of accountability may be most impactful.

152 Gamification in pathology residency: Improving engagement via a nurturing learning environment through resident-led 'Jeopardy' sessions

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Introduction: Pathology residency demands mastery of chaotic complex diagnostic frameworks and image-based interpretation, yet traditional didactic methods often fail to sustain engagement and/or retention. Gamification—integrating game mechanics into education—has demonstrated benefits in learner motivation and retention, but its use in post graduate pathology training remains underexplored. This study aimed to evaluate the impact of a resident-led, Jeopardy-style educational intervention on engagement, perceived learning efficiency, and knowledge transfer within a pathology residency program.

Methods: Participants included pathology residents at a single academic institution. Weekly Jeopardy-style sessions were conducted over six months, covering surgical and clinical pathology topics such as TNM staging or image-based parasitology diagnoses. Senior residents curated questions and facilitated discussions. Outcomes included engagement, perceived knowledge retention, and time efficiency, assessed via post-session surveys using a 5-point Likert scale. Descriptive statistics summarized responses.

Results: Survey response rate was 100%. 90% of residents rated the sessions as highly engaging, and 80% reported improved confidence in exam preparation. 80% indicated enhanced knowledge transfer from senior to junior trainees, while 70% perceived the format as more time-efficient than traditional review sessions. No issues or overt adverse effects were reported.

Conclusion: Resident-led gamification using Jeopardy-style sessions fosters a collaborative and enjoyable learning environment, enhances engagement, and promotes efficient knowledge transfer. It also provided a nurturing learning environment with perceived control of the overwhelming chaos of the 'unknown'. While subjective outcomes suggest overall benefit, limitations include small sample size and lack of objective outcome performance metrics. Proposed future research should incorporate pre- and post-intervention exam scores and explore scalability across programs.

153 Testing the feasibility and effectiveness of a trauma-informed care simulation session for IUD insertion for ObGyn residents

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Introduction: Trauma is highly prevalent and affects patient outcomes and experiences in Obstetrics and Gynecology (ObGyn). Encounters in ObGyn may be traumatizing or re-traumatizing. Implementation of trauma-informed care (TIC) is therefore essential. However, evidence is limited on how to teach TIC in ObGyn in order to effect sustained clinical practice change. This study evaluated the feasibility and effectiveness of a multi-modal TIC intrauterine device (IUD) insertion simulation session.

Methods: A mixed methods design was used. ObGyn residents ($n = 22$) across 5 postgraduate years completed a 4-hour session including an Indigenous educator-led TIC didactic session, applied TIC strategies for IUD insertion, standardized patient (SP) simulation using a TIC checklist, individualized feedback, and debriefing. Surveys were completed pre- and immediately post-session using 5-point Likert scales assessing TIC knowledge, comfort, and self-efficacy; data were summarized descriptively. Semi-structured interviews were conducted 2 weeks and 8 months post-session and analyzed using thematic analysis in NVivo 12.

Results: Survey completion was 22 pre- and 15 post-session, with increased mean scores for TIC knowledge (3.32 to 4.20) and ability to implement TIC (3.18 to 4.21), with similar improvements across comfort and recognition domains. Interview themes included sustained perceived effectiveness through specific practice change, including TIC communication, explicit consent, exam pacing, and patient-directed stop/pause options; autonomy and choice were described as core mechanisms. Barriers to implementation included time, inadequate privacy, resource constraints, language barriers, and lack of interprofessional and senior physician support. Feedback included session length and desire for earlier curricular placement.

Conclusion: This multi-modal TIC simulation was perceived as effective, with sustained self-reported practice change at 8 months. Limitations include reliance on self-reported outcomes, attrition, and absence of objective behavioural measures. Findings highlight that implementation is context-dependent, affected by team- and system-level factors. Future

work should include objective behavioural measures, interprofessional training, and reinforcement strategies using diversified clinical scenarios.

154 Learning styles of Taiwanese Traditional Chinese Medicine residents: insights from the Felder-Soloman Index

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Introduction: Traditional Chinese Medicine (TCM) education in Taiwan is transitioning from apprenticeship to standardized residency training. This cohort is unique, as many residents hold dual licenses in TCM and Western Medicine, necessitating the integration of two distinct knowledge paradigms. This study utilizes the Felder-Soloman Index of Learning Styles (ILS) to profile this group. The objective is to provide a comprehensive understanding of the cognitive characteristics of TCM residents, filling a knowledge gap regarding this specific population influenced by both traditional and modern medicine.

Methods: This cross-sectional study recruited 217 TCM residents from the Chang Gung Memorial Hospital system in Taiwan between August and December 2023. Participants completed the ILS, assessing preferences across 4 dimensions. Scores were categorized into 5 levels: strong, moderate, and balanced. Data were analyzed using descriptive statistics, Wilcoxon signed-rank tests for preference significance, and Chi-square tests for associations between demographics and learning styles.

Results: The study included 217 residents (58.53% female). Wilcoxon tests indicated significant deviations from the balanced midpoint across all dimensions ($p < 0.001$). The 5-category analysis revealed pronounced Visual (29.5% strong, 38.2% moderate) and Sensing (13.4% strong, 38.7% moderate) tendencies. While the Active/Reflective and Sequential/Global dimensions were predominantly balanced, the remaining distribution leaned significantly toward Reflective (25.8% moderate, 6.0% strong) and Global (22.6% moderate, 4.1% strong). Chi-square analysis showed that male residents had a significantly higher proportion of strong Visual preference (44.4%) compared to females (18.9%) ($p = 0.002$).

Conclusion: Taiwanese TCM residents exhibit distinct preferences for Visual, Sensing, Reflective, and Global styles. A key finding is the Global tendency, which diverges from the Sequential preference typically reported in medical student research, reflecting the influence of TCM holistic philosophy on cognitive patterns. Limitations include the single-institution sample and cross-sectional design. These findings establish the TCM resident cohort as a distinct cognitive group.

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