WELCOME

All Program Directors & FM Site Directors Meeting

Friday, December 15, 2017

Post MD Education
UNIVERSITY OF TORONTO

AGENDA

- Welcome & General Updates
- Charles Mickle Fellowship Address
- Q & A with Dr. Sarita Verma
- Medical Assistance in Dying (MAID) Educational Resources Kit
- CBME Update
- Unmatched Medical Students & Resident Involvement in Undergraduate Teaching
- Simulation Education Advisory Committee (SEAC) - Update

Post MD Education
UNIVERSITY OF TORONTO

PGME Strategic Plan

VISION:
Leadership in improving health through innovation and research in Postgraduate Medical Education (PGME) at local, national and international levels

MISSION:
We fulfill our social responsibility by developing leaders and educators, contributing to our communities, and improving the health of individuals and populations through the discovery, application and communication of knowledge in Postgraduate Medical Education (PGME)

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PGME Strategic Plan

Leadership	Innovation	Scholarship	Community
1 Promote leadership among PGME learners, educators, administrators and faculty	2 Support and develop local, national and international evidence-based curricular innovation	3 Advance Postgraduate Medical Education locally, nationally and internationally through dissemination of our PGME experience to stakeholders and audiences	4 Provide an exemplary customer experience to our key community members: learners, educators, administrators and faculty within and beyond the university

2017 Charles Mickle Fellowship

Awarded annually to a member of the medical profession anywhere in the world who has "..done the most within the preceding 10 years to advance and promote sound knowledge of a practical kind in medical art or science by careful and thorough work."

2017 Charles Mickle Fellowship Address

Current Issues in Medical Education: A Metamorphosis

Dr. Sarita Verma, LLB MD CCFP

Vice President, Education
The Association of Faculties of Medicine of Canada
Professor Emerita DFCM
Former PG Dean, University of Toronto & Queen’s University
Former Deputy Dean and Associate Vice Provost, University of Toronto

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A Mickles Talk In Three Parts

At the end of this presentation Participants will be comfortable discussing:

- Preparing the Next Physician in the context of Rapid Evolution
- A Key Issue in Physician Workforce: uCMG
- The Metamorphosis of Leadership based on my journey

Conflict of Interest

- Many COI issues.
- Personal and Intellectual Investment over 25 years
- History Repeating Itself
- Legacy challenges with Academic Medicine
- Attributions: Julio Frenk; Brian Hodges; ARMC/AFMC; BMJ; NAC

Health Professional Education

- HPE undergone substantial and exponential, changes during the past decade.
- Within the context of ongoing experimentation in the health care system, unprecedented and rapid technology and learning modalities.
- Experimentation on those who learn in today's world but who will practice in the "revolution" of the age of digital and artificial intelligence.

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Warning

Pressure on Health System to Change

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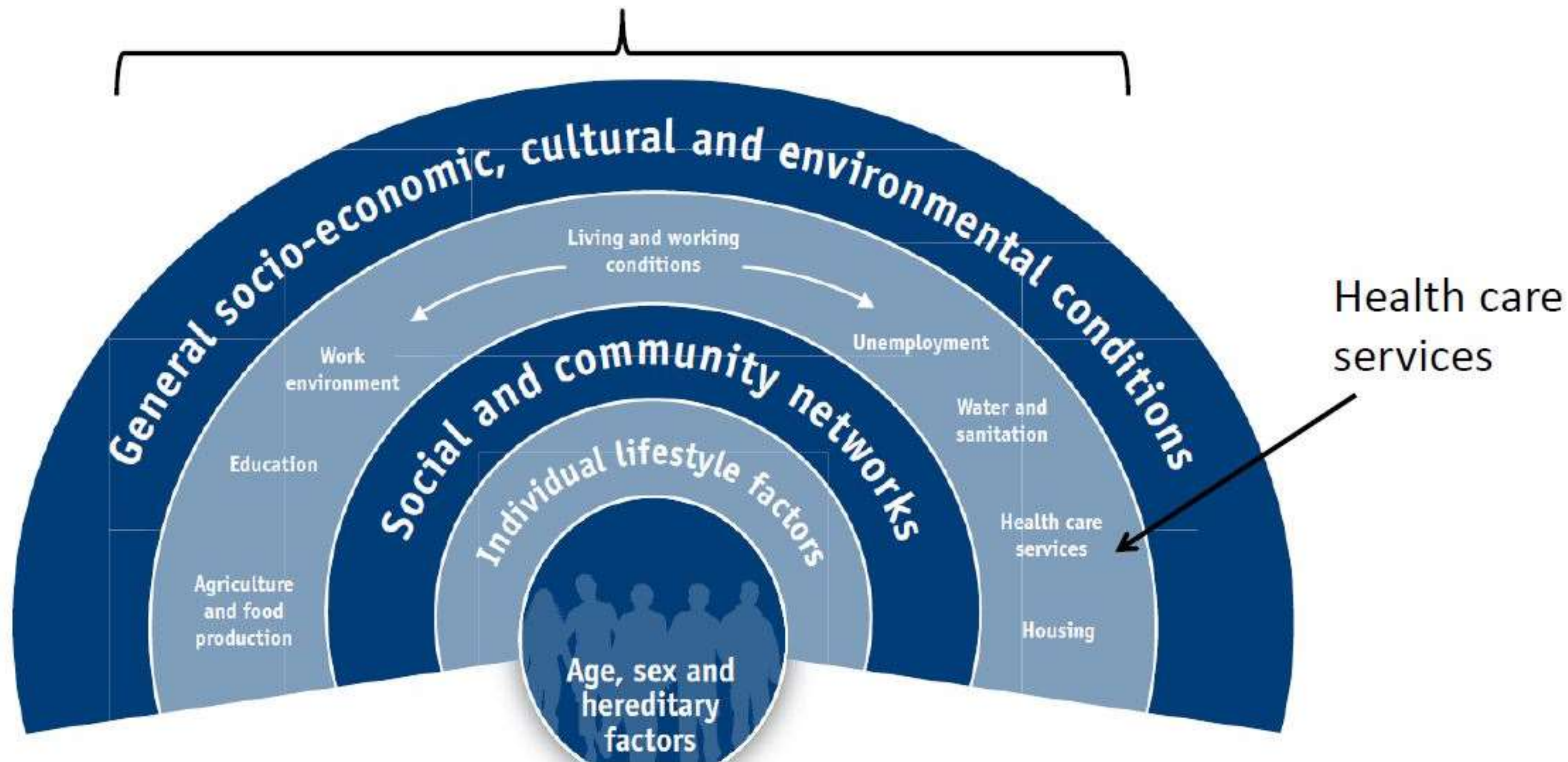
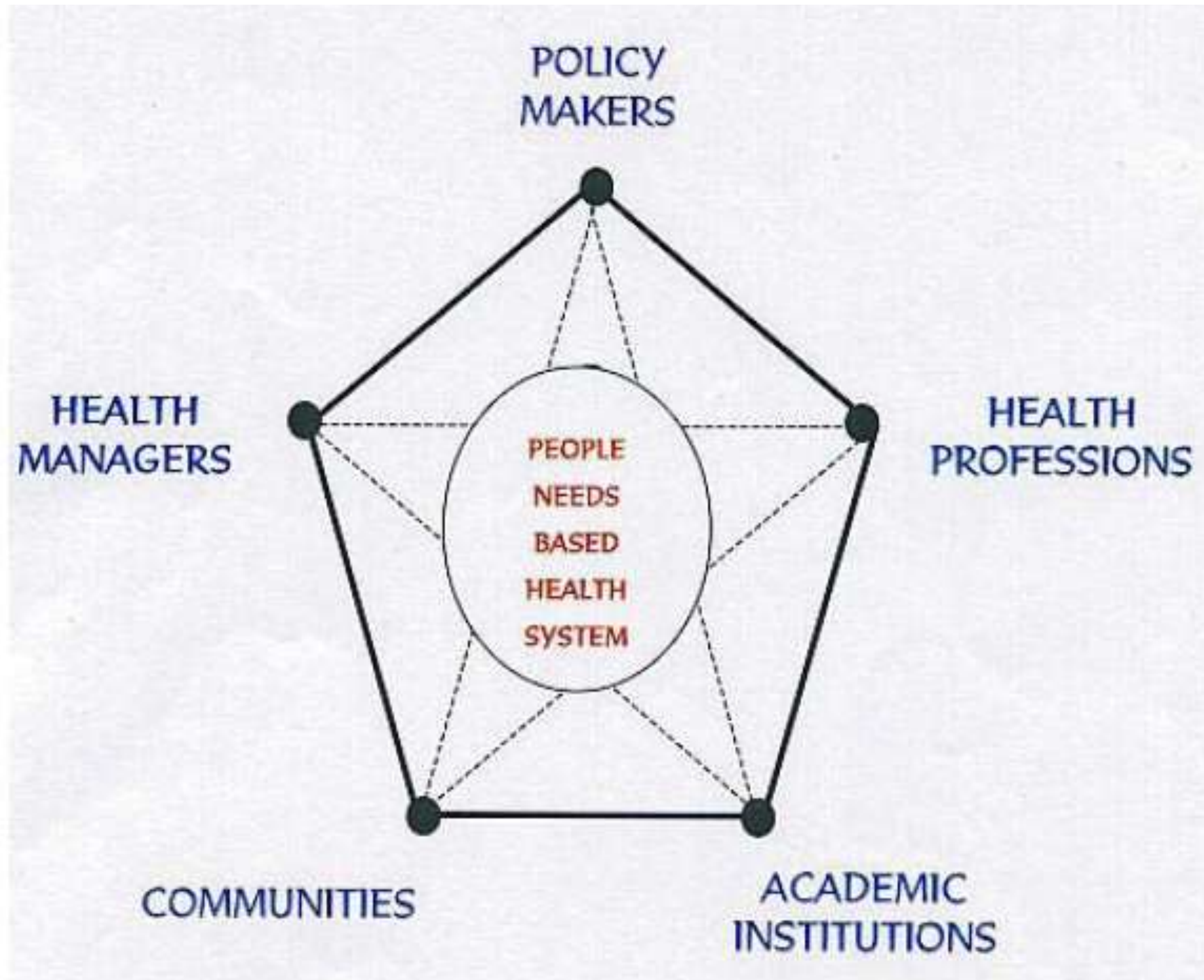
Determinants of Population Health



Source: Butler-Jones D. The Chief Public Health Officer's report on the state of public health in Canada: Addressing health inequalities, 2008.
Adapted from: Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute for futures studies, 1991.

Social Accountability Framework



OLD WORLD	NEW WORLD
The doctor is on top of the hierarchy	Health care is part of a complex organization

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OLD WORLD

Source of knowledge is expert opinion

NEW WORLD

Source of knowledge is evidence based

OLD WORLD

Each of our professions practice in silos as individuals

NEW WORLD

All of us work predominantly in teams

OLD WORLD	NEW WORLD
Duration based education	Competency based education

OLD WORLD

Countries can produce their own health force

NEW WORLD

International migration: the workforce is constantly moving and evolving

OLD WORLD

Determinants of health were contained by geography

NEW WORLD

Disease and Infections know no boundaries

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OLD WORLD	NEW WORLD
Technology was adapted for our use	We are slaves to technology

OLD WORLD

Doctor was the holder of knowledge

NEW WORLD

Anyone can Google anything and assess the evidence

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Are doctors becoming obsolete?

- Robots
- Artificial Intelligence
- The Internet of All Things

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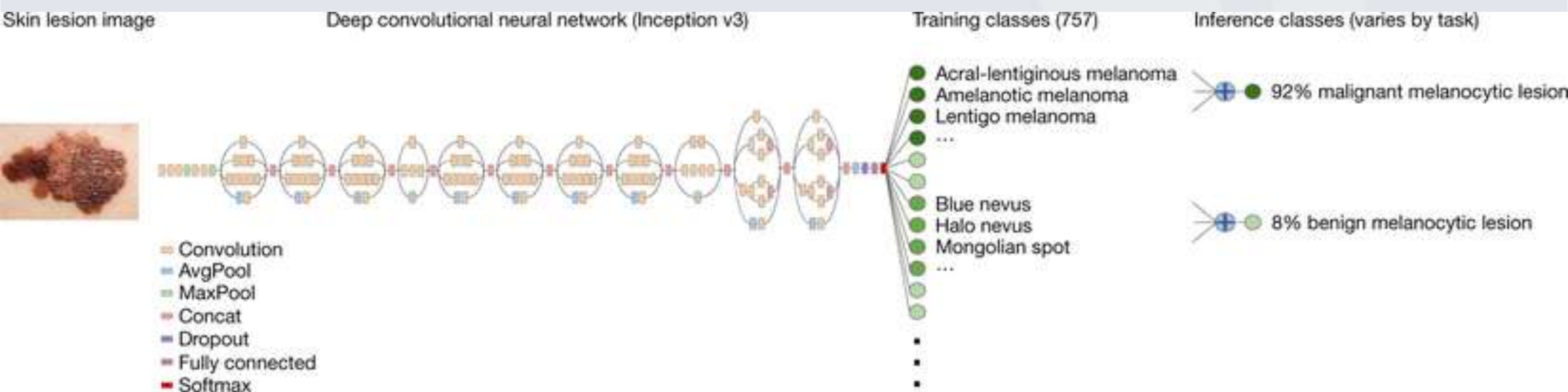
Evidence technology is replacing humans

Nature 2017-02



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Da Vinci: A Perspective on the New OR Team

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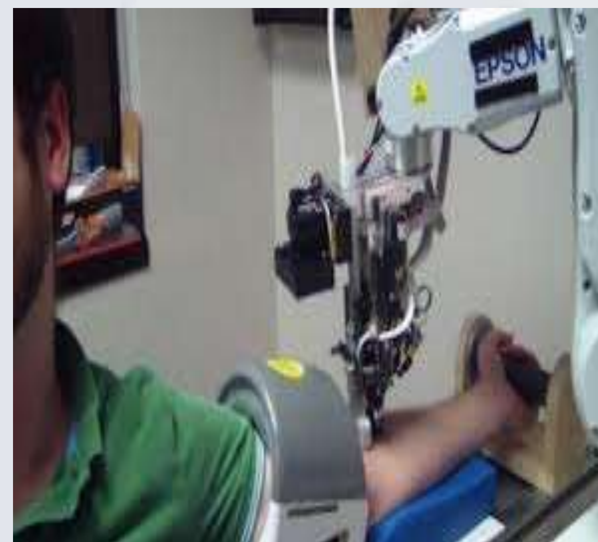
Pepper the robot and the new Phlebotomist



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The Qualcomm Tricorder

- **Required Core Health Conditions (10):** Anemia, Atrial Fibrillation (AFib), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Leukocytosis, Pneumonia, Otitis Media, Sleep Apnea, Urinary Tract Infection, Absence of condition.
- **Elective Health Conditions (Choice of 3):** Cholesterol Screen, Food-borne Illness, HIV Screen, Hypertension, Hypothyroidism/Hyperthyroidism, Melanoma, Mononucleosis, Pertussis (Whooping Cough), Shingles, Strep Throat.
- **Required Health Vital Signs (5):** Blood Pressure, Heart Rate, Oxygen Saturation, Respiratory Rate, Temperature

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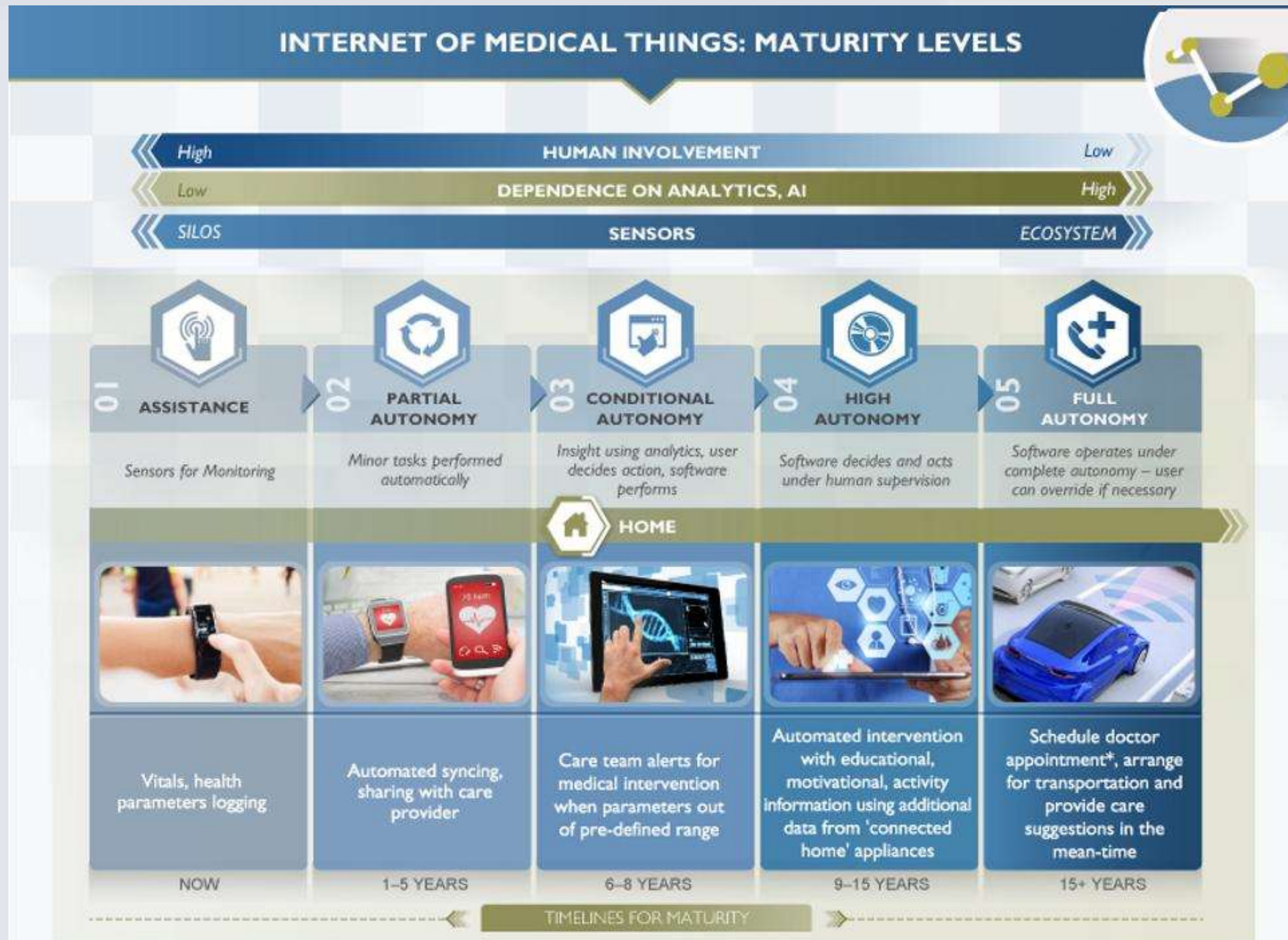
Darwinian step of medical practice evolution



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The future is here

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Ten Trends in Health Care already Here
Harvard Business Review

- EMRs
- Patient Portals
- Robotics
- Virtual Visits
- Personalized Medicine (genetic medicine)
- Scope Creep between professions (in and out)
- Generics and Big Markets- On line purchasing
- Entrepreneurial Medicine (for profit)
- Digital Economy – Privacy and Information
- Catalytic Knowledge Explosion

Knowledge Revolution

Medical Knowledge in Relative Units

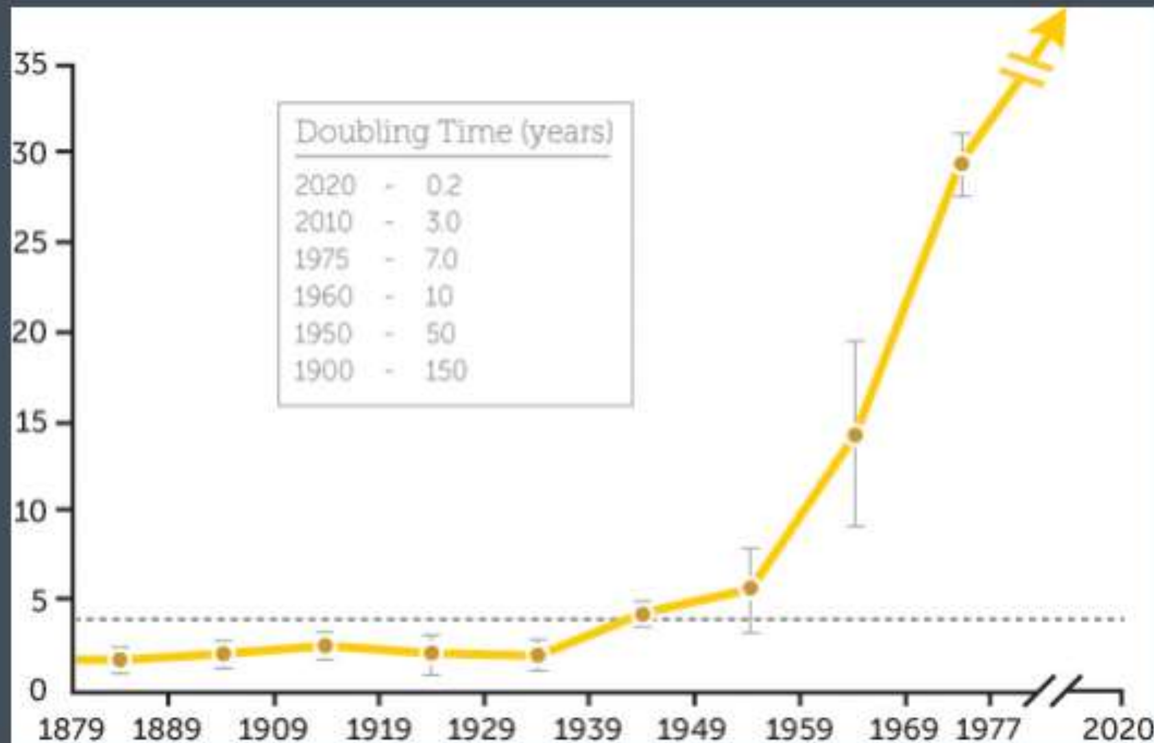

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Figure 1.1 Monthly prevalence estimates of illness in the community. Roles of physicians, hospital, and university medical centres providing medical care to patients 16 years and older.

1000 — Adult population at risk

750 — Adults reporting one or more illness or injuries per month

250 — Adults consulting physicians one or more times per month

9 — Adults admitted to hospital per month

5 — Adult patients referred to another physician per month

1 — Adult patients referred to a university medical centre per month

Source: (White et al., 1961)

Are you training the Doctors of the Future?

What will be role of the doctor in 2020?
Will we even need physicians as we use them now?

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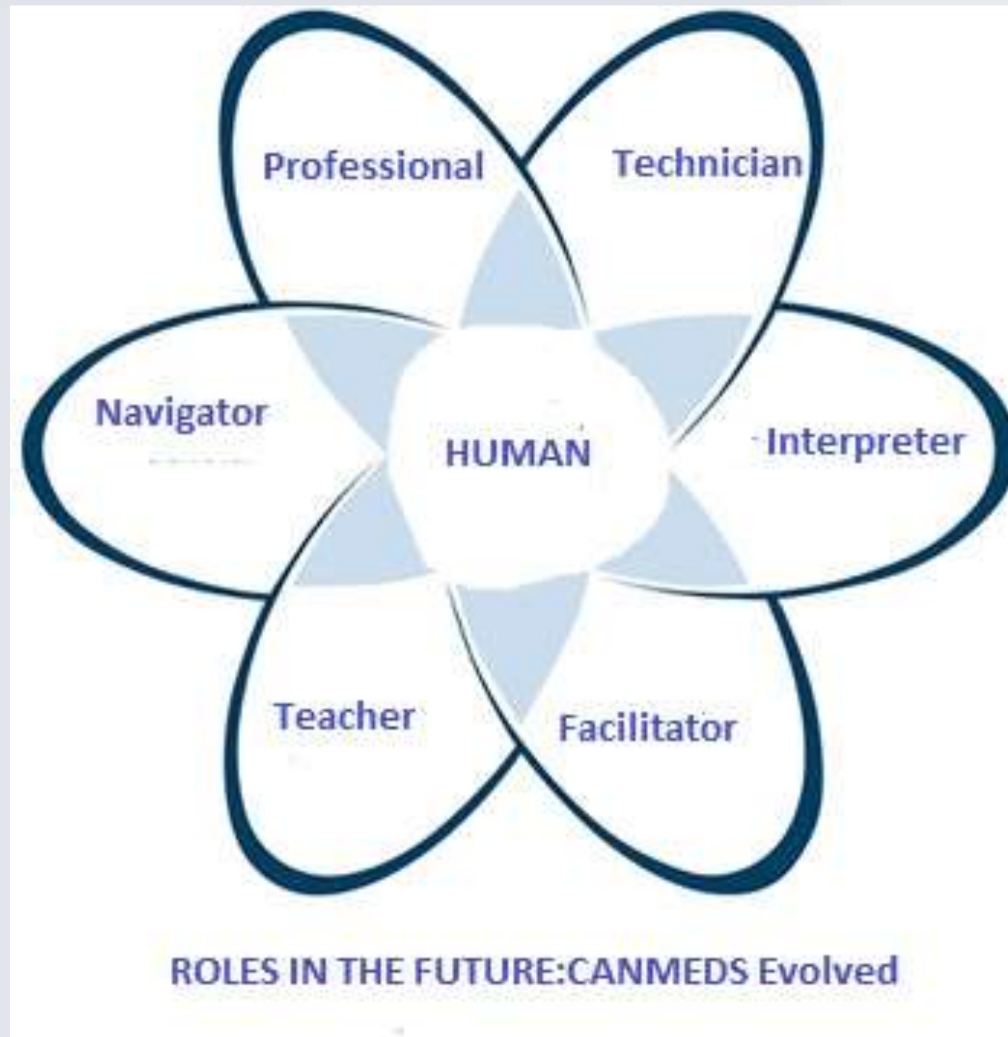
The role of Physicians in the next decade



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The Evolution

A Challenge: The uCMG

One of many problems

Unmatched CMGs Increasing

In **2009**, number of unmatched CMGs was **11**

Increasing steadily to **46 in 2016** and **68 in 2017**

Unmatched CMGs from previous years **compete** with current year CMGs **for total 114 in 2017**

April 2017 AFMC Board asked that **ARMC ramp up analysis** on uCMG issue and report back

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Current Construct of Match

CMG and USMG treated equally as relates to being a graduate of a CACMS/LCME accredited school

Grads from **all other schools** treated equally as International Medical Graduates (**IMG**s) regardless of country of origin

First iteration of match **separate** CMG and IMG positions. **Second** iteration all positions **combined**. (Québec exception)

No consistency in how **policy decisions** made in the past

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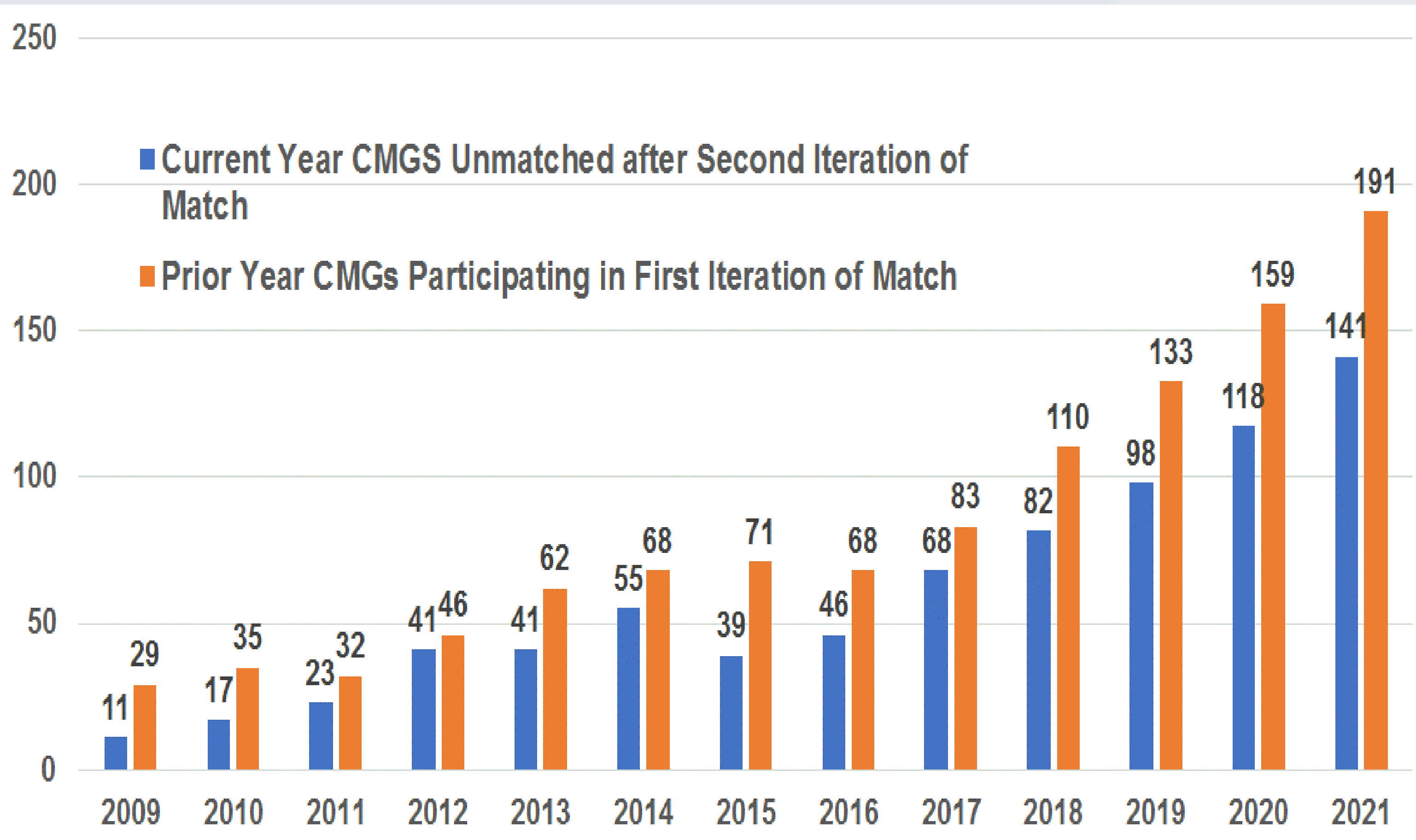
By 2021: 141 current and 191 prior uCMG



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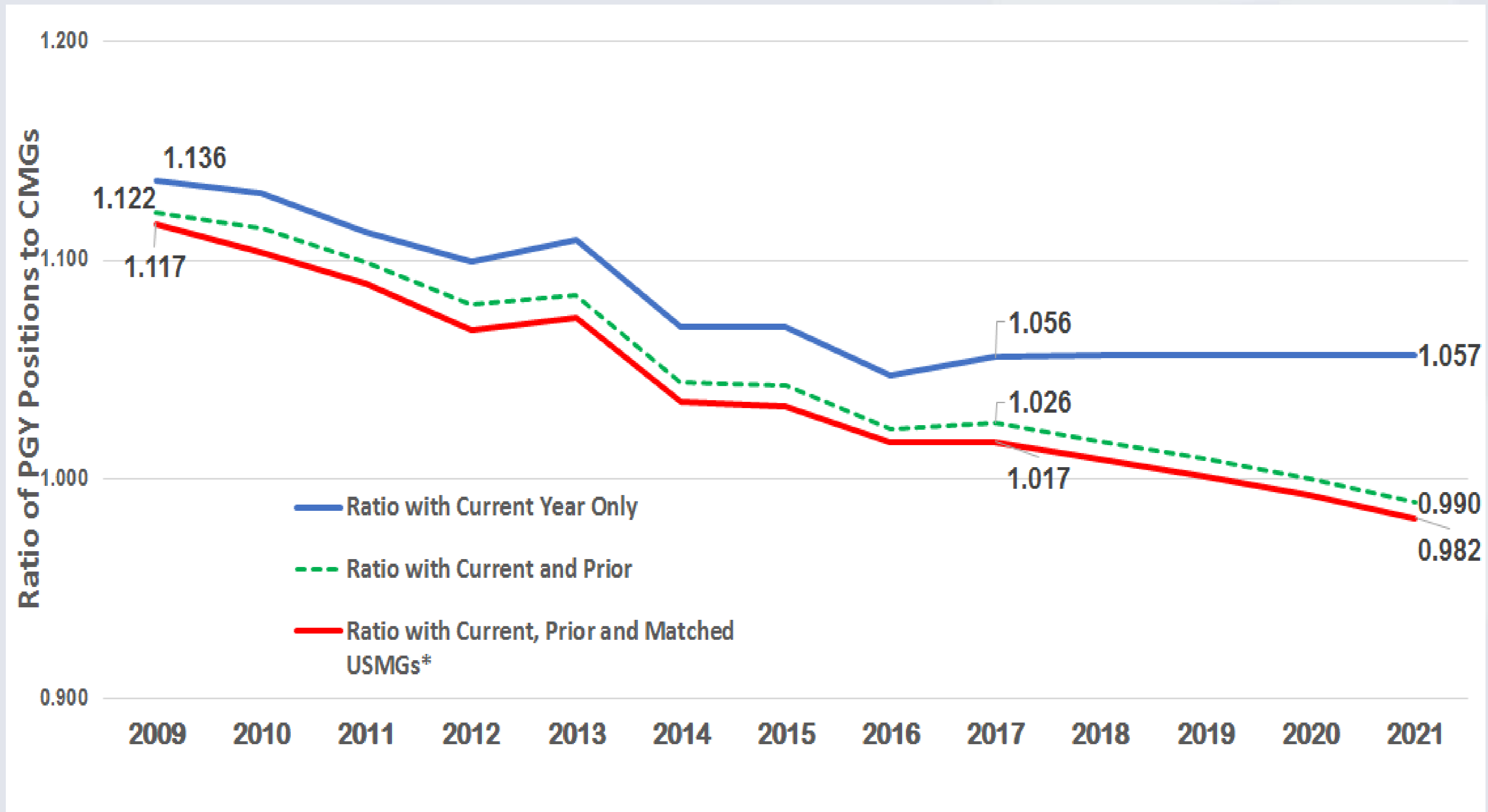
UG:PG Ratio from 1.1 to 1.026 to 0.98



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Many Stakeholders, Different Priorities

Stakeholder	Priorities
Patients	• Right care at the right time and place
Provincial Governments	• Population health needs • Right number, mix and distribution of physicians • Return on investment and cost containment
Learners	• To match to first choice discipline • Career choice • Flexibility to switch career choice • Manageable costs (electives, match interview process)
IMGs	• Access to PG positions • Eligibility to practice in Canada

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Many Stakeholders, Different Priorities

Stakeholder	Priorities
UGME	• Quality and breadth of competence in UG learners • Matched students • Meaningful, educational electives
Student Affairs Offices	• Access to accurate physician HR data, program selection processes and requirements information • Balanced student needs, well-being and career management decisions
PGME	• Quality and breadth of competence in PG learners • Capacity to train residents • Flexibility for transfers • BPAS, selection transparency
Residency Programs	• Best candidate • Manageable number of applications and interviews

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Provinces making unilateral decisions

Ontario cut 25 CMG positions and considering cutting 25 IMG (on hold)

Québec cutting 17 medical school positions for 3 years

NFLD has no IMG positions in 1st iteration of match

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IMGs – Important Resource

Provinces have created **IMG positions above CMG positions** to assist with physician resource plan

IMG positions in past 5 years remain steady overall

In recent past **20% drop in IMG applications** as new IMG assessment criteria/exams introduced

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Faculties Limited in Ability to Support

Faculties not all able to support unmatched CMGs as **no longer students of the faculty**.

Some uCMGs have **no student affairs** support or **access to electives**.

Not all faculties have options for the unmatched such as a delay of graduation and a 5th year

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11% of QC grads leave QC, only 1% grads go to QC

	Rest of Canada Graduates			Quebec Graduates		
Year	Matched to Quebec	Matched outside of Quebec	%	Matched to Quebec	Matched outside of Quebec	%
2017	26	1901	1%	783	96	11%
2016	27	1917	1%	807	82	9%
2015	32	1909	2%	773	87	10%

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203 CMG positions and 16 (7%) IMG positions are combined IMGs matched to 34% of positions

	1st Iteration Vacancies			2nd Iteration Matches			
	IMG Vacancies	CMG Vacancies	% that are IMG Vacancies	Current Year CMG matches	Prior Year CMG Matches	IMG matches	% that are IMG Matches
2017	16	203	7%	70	32	53	34%
2016	29	184	14%	77	20	65	40%
2015	21	195	10%	55	18	70	49%
2014	15	213	7%	73	16	75	46%

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More USMGs match to CAN than CMGs match to US

	Total # of USMGs Matched to Canadian Residency Positions	Total # of CMGs Matched to US Residency Positions
2017	24	7
2016	18	13
2015	26	17
2014	27	6
2013	25	14
2012	31	12
2011	22	11
2010	25	18

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Previously Matched Re-enter as Transfers

Progressive reduction in **capacity of Faculties to accommodate resident transfers** within the faculty, within a province or inter-provincially

Previously Matched Residents Re-enter the R1 Match as Transfers in the 2nd iteration

The number of **transfers has doubled** from 10 to 20 in 3 years. This "displaces" more current year CMGs

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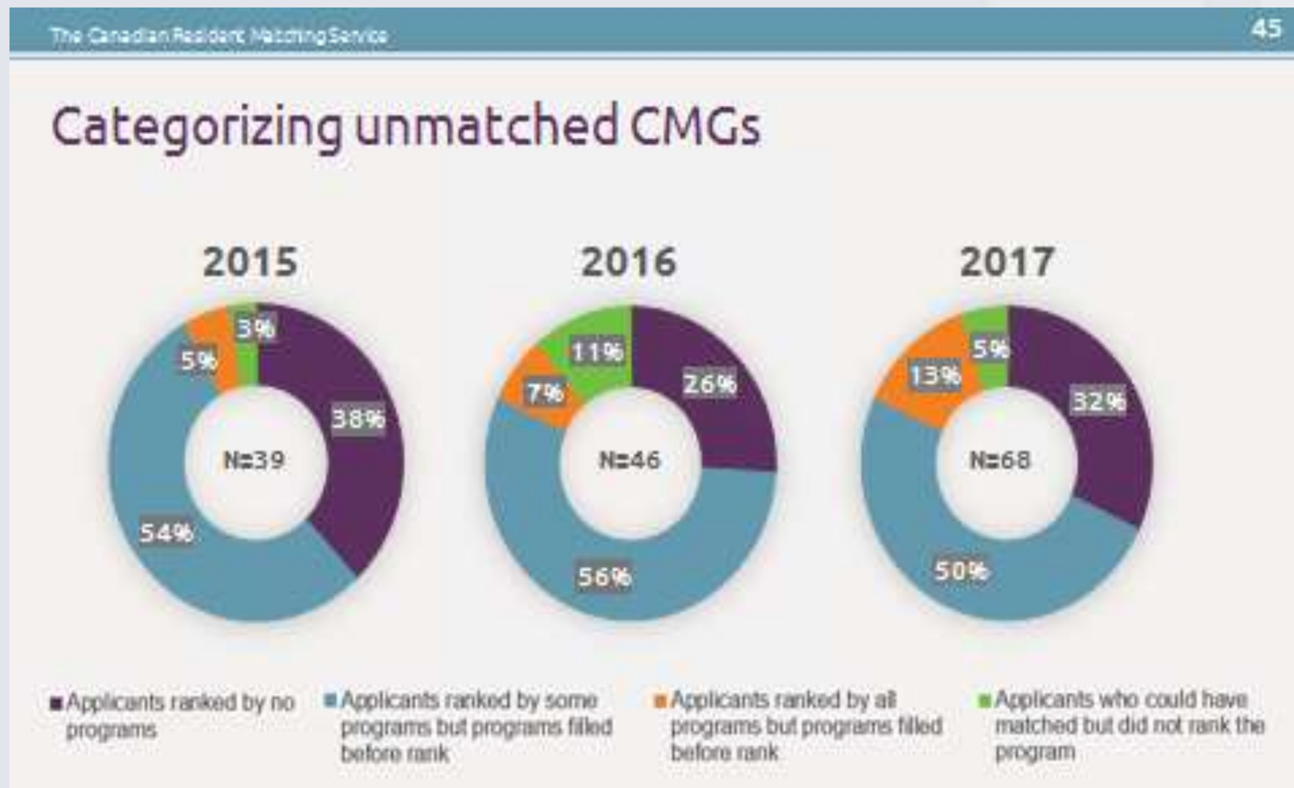
Qualified CMGs Go Unmatched

68% of unmatched CMGs are applicants who could match if positions were available



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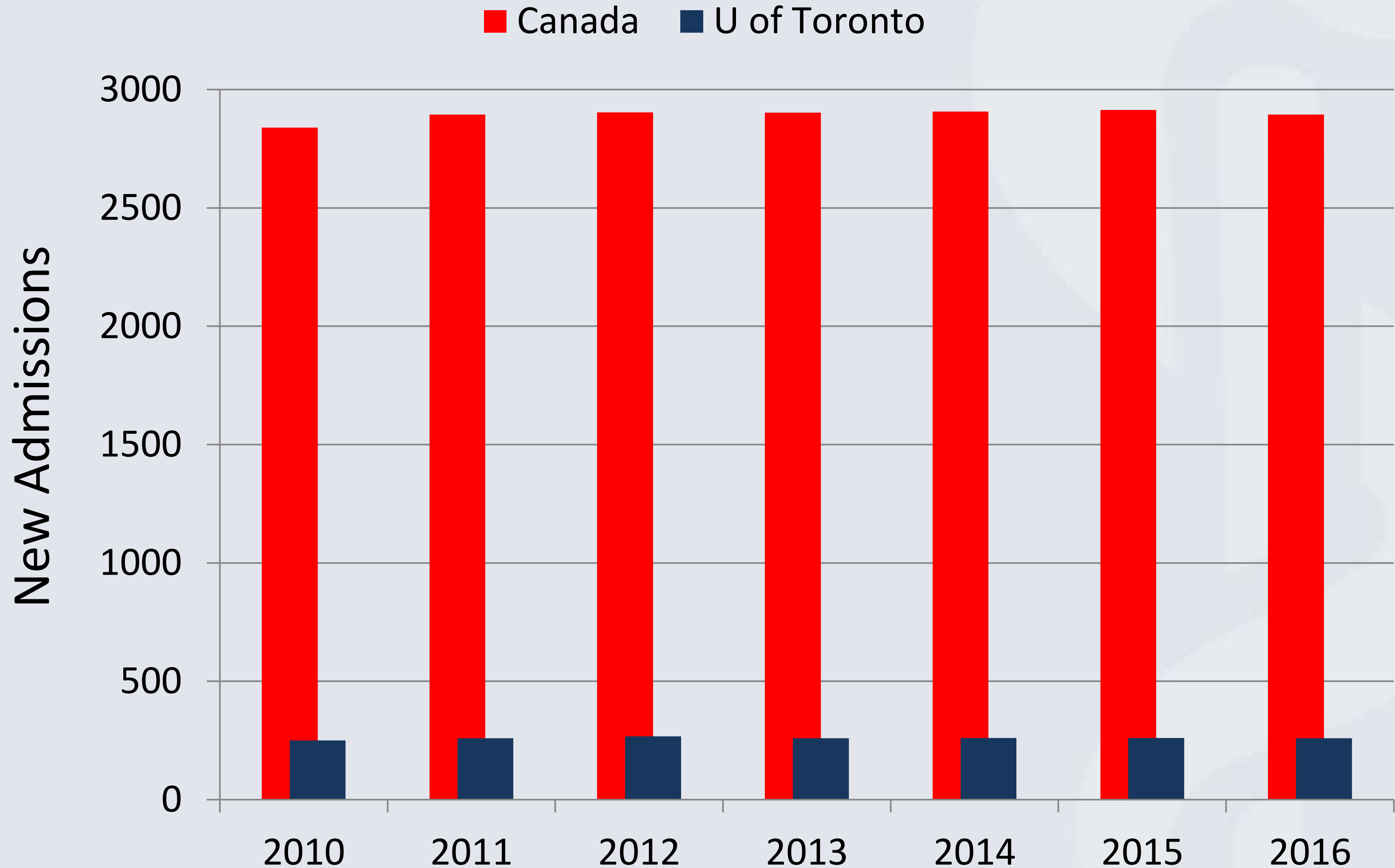
So what does this mean to U of T?

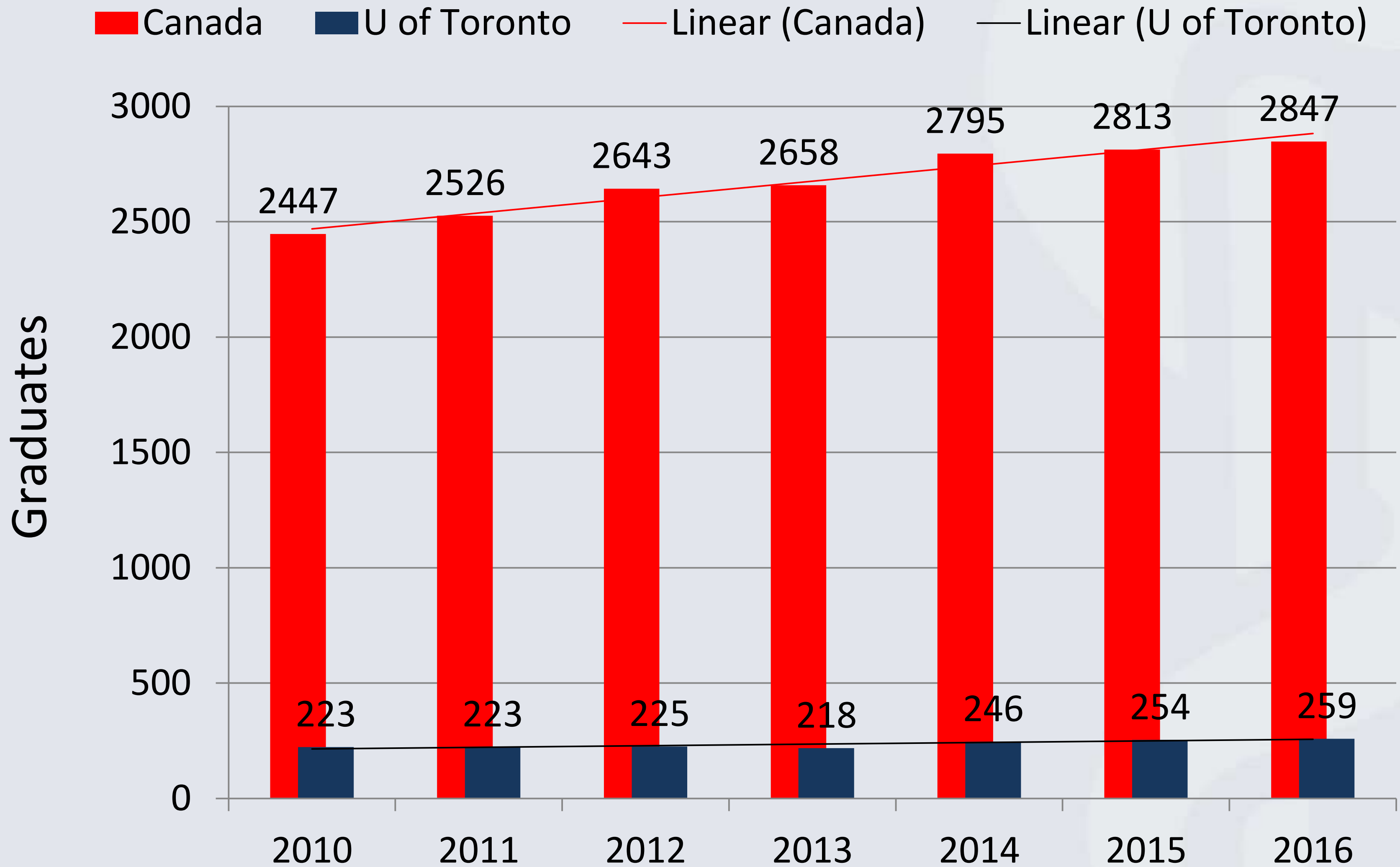
Size Matters

Innovation Starts Here

New Admissions to Canadian Faculties of Medicine, 2010 - 2016



Graduates of Canadian Faculties of Medicine, 2010 - 2016



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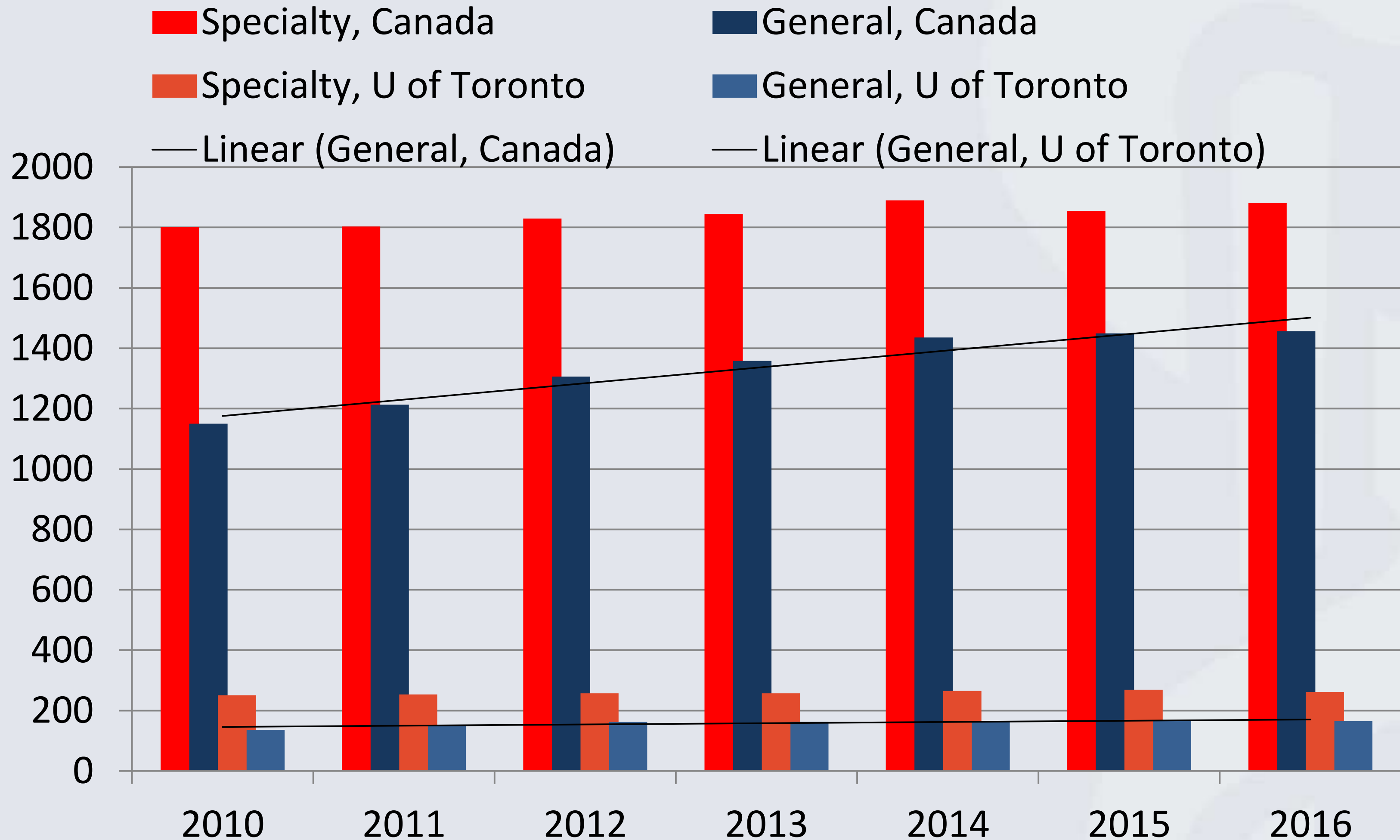
First Year Residents in Canadian Faculties of Medicine, 2010 - 2016



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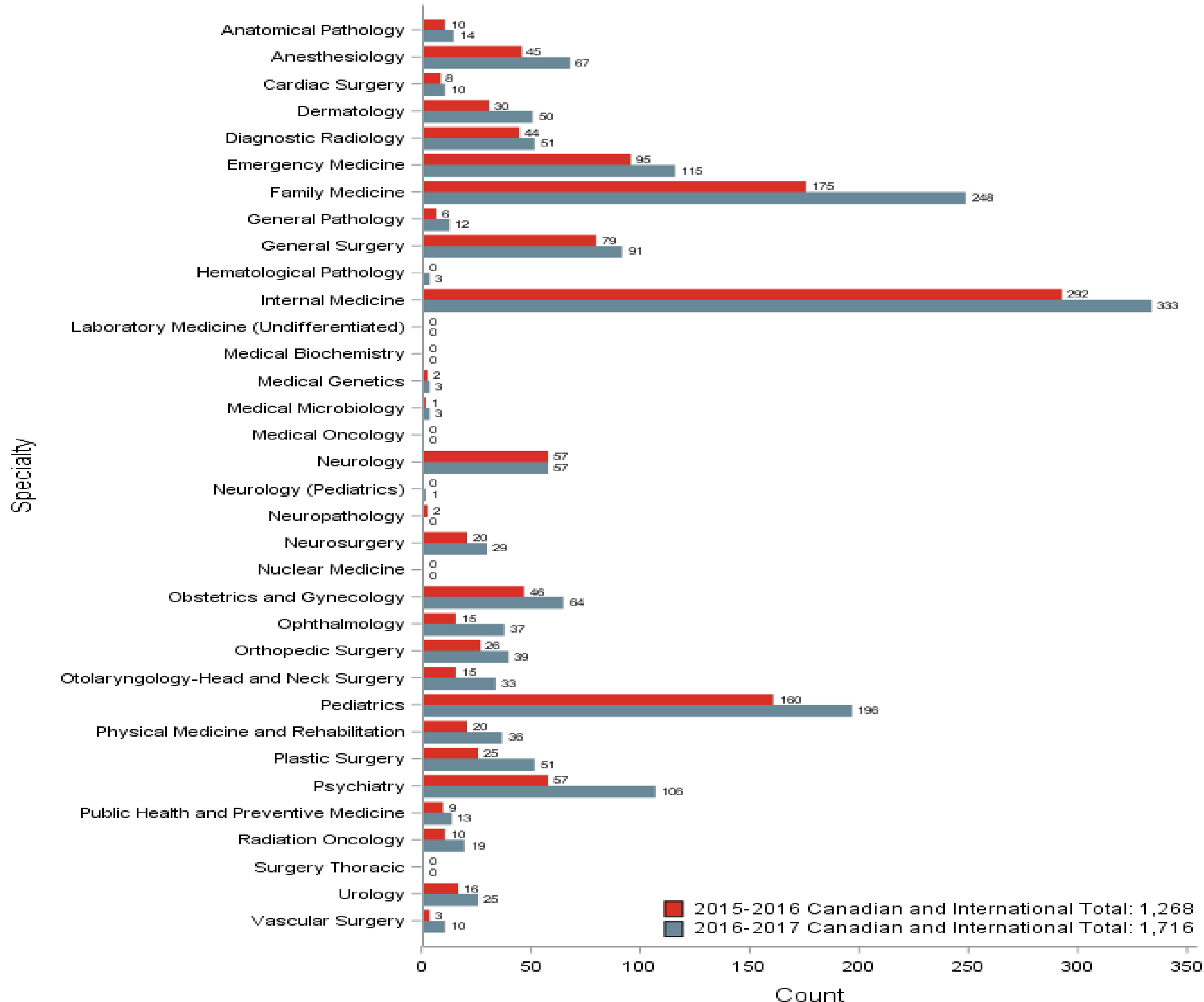
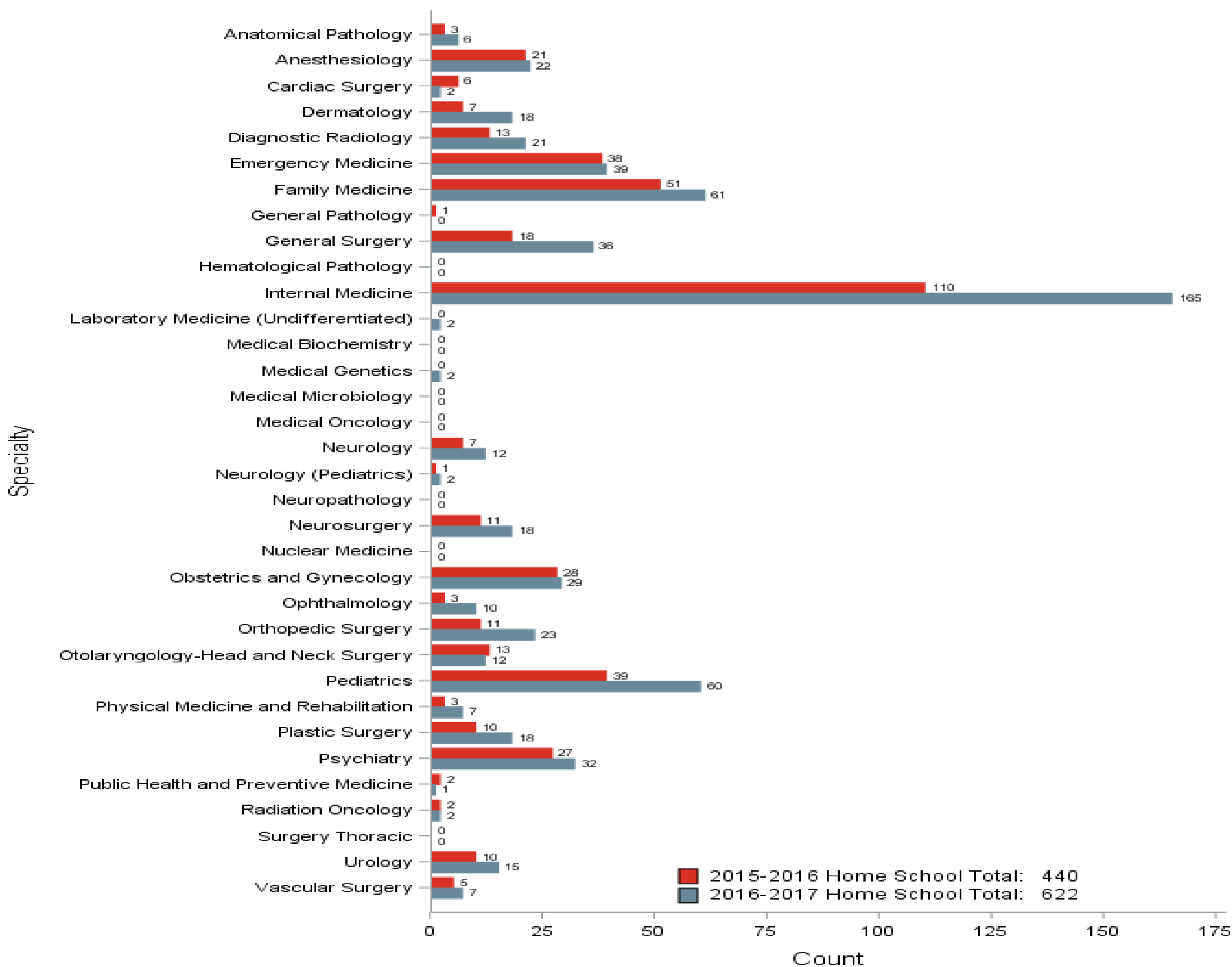
Confirmed Visiting Electives at University of Toronto
Comparison by year | Canadian and international applicants



Confirmed Visiting Electives by University of Toronto Students Comparison by year



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Residency Program Selection Behaviours

Perception that PG selection committees corelate **number of electives** in a discipline **and an elective at their site** as commitment to the program

Perception that **reference letters** from colleagues in the discipline are **better perceived** by selection committee

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Student Electives Behaviours

Perception, and shift toward, use of **electives to increase match chances** in a specific disciplines decreases diversity

Risk for students that go **unmatched with limited exposure** to other disciplines

Concern about **‘unofficial’ electives** taking place on weekends which are not accessible to all students

Students incur significant costs for elective applications

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Residency Program Selection Solutions

UG/PG deans Working Group on electives developing policy on maximum time spent in one discipline

Best Practices in Applications & Selection (BPAS) report created to provide evidence-informed approach to resident selection

Supported by PG deans, UG deans and validated by Program Directors

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Best Practices in Applications & Selection

Principles

- Selection criteria
- Multiple independent objective assessments
- UG/PG Collaborative planning, applicant performance
- Applicants understanding of HHR considerations
- PG programs consider individual educational needs, value broad clinical experiences and resident diversity

Best Practices

- Transparency
- Fairness
- Selection Criteria
- Process
- Assessors
- Assessment Instruments
- Knowledge Translation
- Ranking

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Metamorphosis: A Journey in Leadership

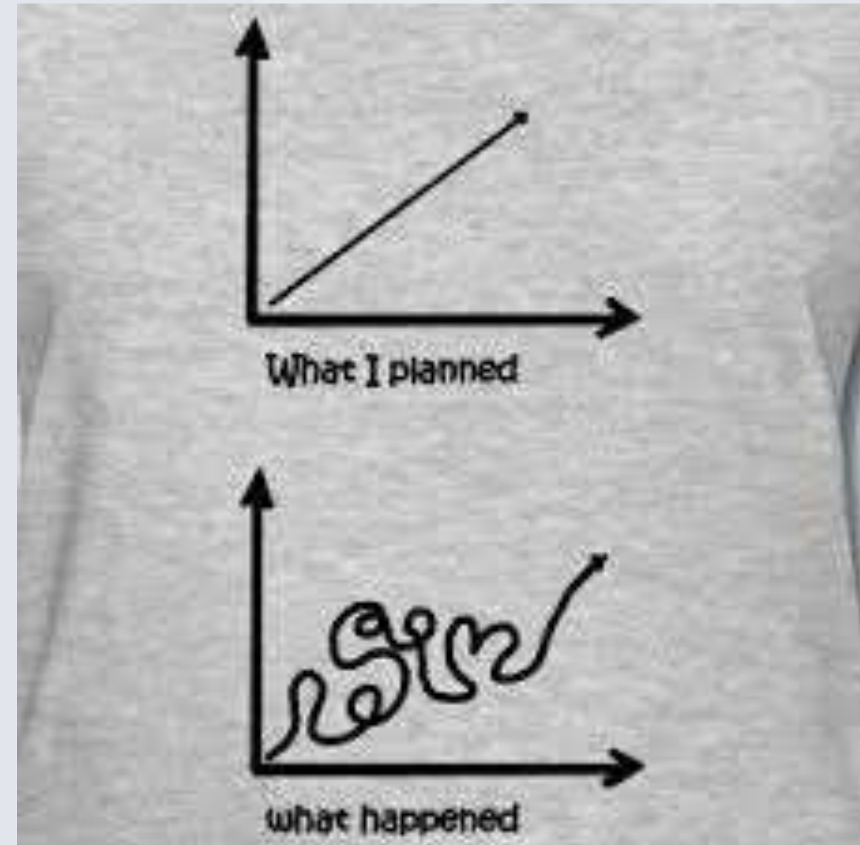
Lots of Change: What I have learned

Sharing MY Reflections Since 2015

Imposter Syndrome

- **Giving your first lecture**
- **Publishing your first paper**
- **Taking the job as Program Director**
- **Chairing your first meeting of Snr Colleagues**
- **Disciplining/Failing a Learner**
- **Admitting a Mistake in Public**
- **Moving On**

What was planned, and what happened



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Sometimes you just have to Reinvent Yourself

- Maintain your Integrity
- Embrace Complexity.
- Uncertainty and Change Happen
- Keep your Options Open
- Remember – on the way up to acknowledge others – you will see them on the way down
- Be kind

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Thank you!

Ask Sarita…

Medical Assistance in Dying (MAID) Educational Resources Kit

Dr. Irene Ying

Palliative Care, Sunnybrook Health Sciences Centre

Post MD Education
UNIVERSITY OF TORONTO

Medical Assistance in Dying (MAID):

Introduction to the PGME Educational Resource Kit

All PDs & Family Medicine Site Directors Meeting

Friday, December 15, 2017

Dori Seccareccia | Irene Ying | Elie Isenberg-Grzeda

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Objectives

- Understand rationale for the Educational Resource Kit (ERK)
- Review components of the ERK
  - Slide show & videos
  - 4 case scenarios (small group)
- Discuss roll-out of ERK
- Time for questions

Rationale for the Educational Resource Kit

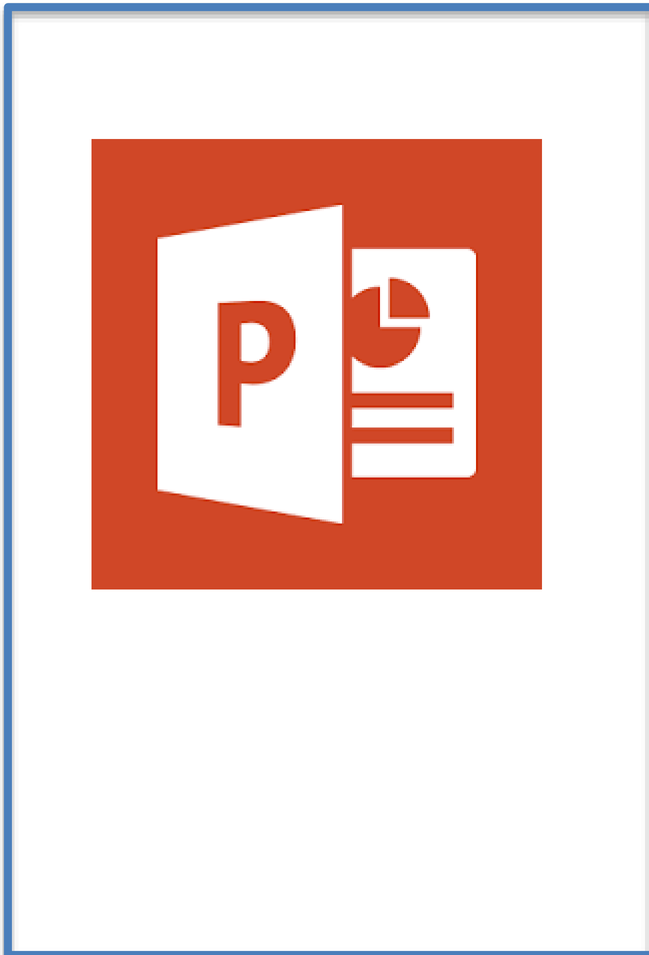
- *Carter vs Canada* (2015, SCC) decision and subsequent passing of Bill C-14
- Significant MD discomfort with discussing end-of-life, dying, “desire for hastened death”
- 50% of GPs in Netherlands avoided discussing euthanasia because it went against values or was emotionally burdensome

Potential harms of discomfort with discussing "desire for hastened death" (DHD)

- Patients feel abandoned
- Clinicians feel emotionally burdened
- Referral to the wrong services
- Delay in appropriate assessments and treatments

Educational Resource Kit

Slideshow with videos



Small group: 4 cases

MAiD Case #1 **Facilitator Guide**

You are a surgical resident. You meet Ms. K, an 80 year old woman with newly diagnosed **locally advanced pancreatic cancer** after a 3 month history of progressive abdominal pain. She is in the surgical oncology clinic to discuss if the mass is resectable. After reviewing the imaging, your attending staff feels it would be too risky to proceed with surgery. Your staff explains to the patient that the cancer is not curable and a referral will be made to medical and radiation oncology to discuss treatment options to slow down progression and control symptoms. After your attending staff leaves the room, Ms. K says to you:
"What's the point if it can't be cured? Why prolong things? I'd rather just die sooner. Can't patients request assisted suicide now?"

1. **When a patient asks about MAID what is your initial gut reaction?**
   a. This can be an emotionally challenging question and can impact residents in different ways. MAID is a controversial topic and physicians have varying viewpoints.These viewpoints are often based on the moral or religious beliefs that we acquire throughout a lifetime and can be deeply ingrained.
   b. When a patient asks a question that is so controversial and touches on our core beliefs, we can be quick to respond before understanding the entirety and complexity of a situation.

2. **When a patient like Ms. K asks about MAID, how would you initially respond?**
   Consider: The most important initial response is to validate the patient's emotions.

   For example: "I'm sorry. You've just heard some very bad news" or "I can't imagine how you are feeling right now".

   Caution: It may be tempting to answer in a factual way.

   For example: "Yes, Medical Assistance in Dying is legal. Do you want a referral for an assessment?"

   For most patients this is a premature statement without a better understanding why they are asking for hastened death.

Slideshow

- Didactic portion of the ERK
- Reviews historical context of MAID
  - Carter v Canada
  - Bill C-14
- Definition of MAID
- Residents' role in MAID
  - Explore request, have goals of care discussion
  - Should not be first or second assessor
- 10 Step Process Map for MAID
- Complex situations (4 videos)

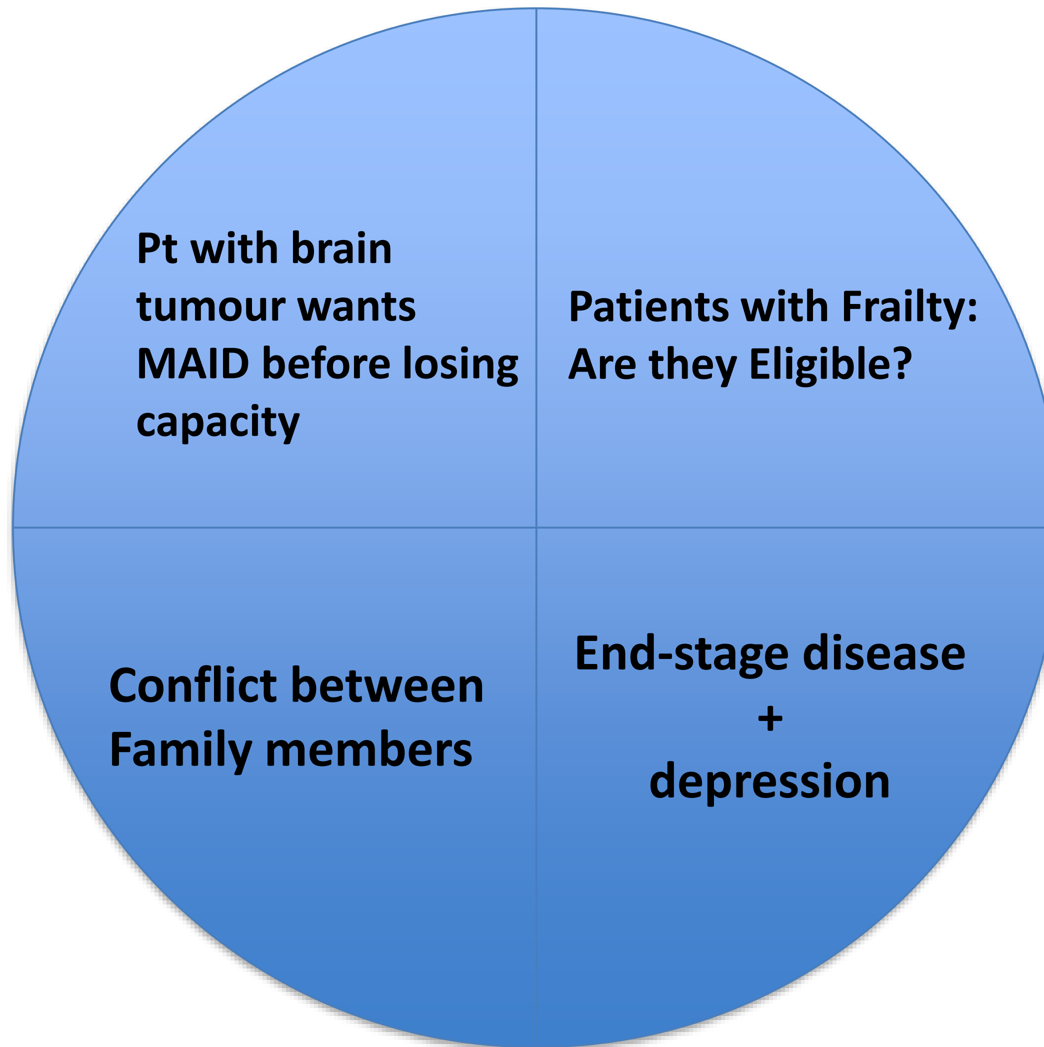
10 Step Process Map for MAID

1. Patient makes initial inquiry
2. Assess the patient against eligibility criteria
3. Patient makes written request
4. Remind patient of ability to rescind request
5. 2nd physician assess for eligibility
6. Period of reflection
7. Informing the pharmacy
8. Provision of MAID
9. Certification of Death
10. Wellness and resiliency post MAID

Complex Situations (videos)

- Goal of ERK is to provide foundational skills and knowledge around MAID and assessing a voiced desire for hastened death
- However, there are numerous emotional and ethical complexities that may arise
- 4 videos of MDs who assess for or provide MAID commenting on some potential complex situations

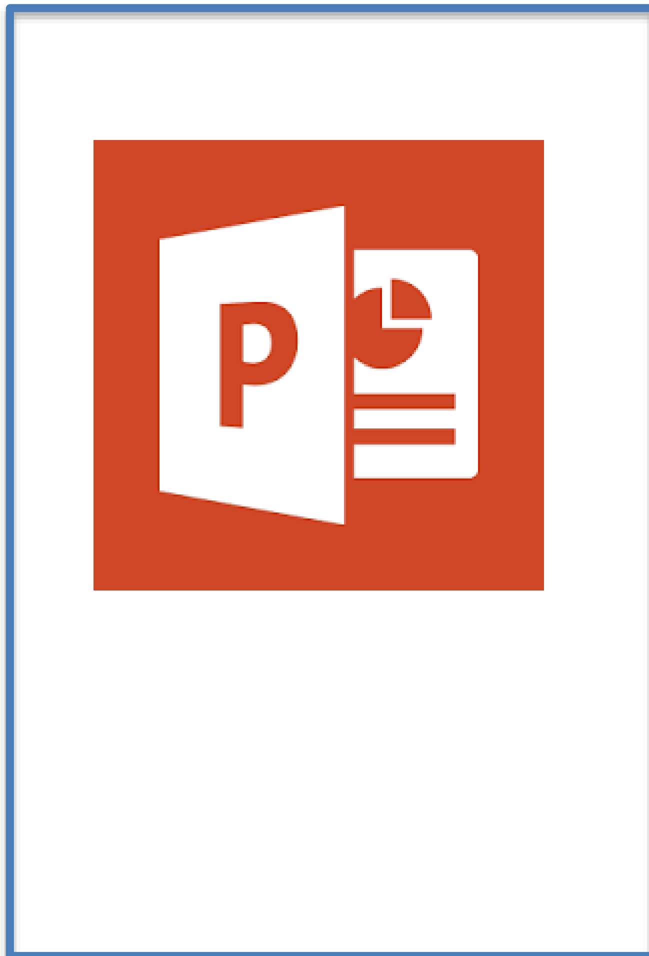
Complex Situations



What are some good strategies to mitigate the complex situation where there is conflict amongst family members when MAID has been requested?

Educational Resource Kit

Slideshow with videos



Small group: 4 cases

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Small Group: 4 Cases

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Small Group: 4 Cases

For Cases 1-3 the general objectives are:
(1) Gain comfort with responding to patients who request MAID
(2) Understand how to explore patients' motivations behind MAID requests

Slight variability between the cases cover topics such as:

- Differentiate between Palliative Sedation Therapy and MAID
- Approach to a patient requesting MAID who may be depressed

Case 4 focuses on

- understanding what happens when a patient receives MAID
- variations in institutional policies and procedures
- importance of reflection and self-care

How is the ERK meant to be utilized?

- It is a toolkit meant as a resource to all programs in PGME
- Can be used in whole or in parts as the curriculum requires (with attribution to the PGME MAID ERK)
- Ideally, each program would identify its own facilitator(s)

How is the ERK meant to be utilized?

- The ERK team can provide as-needed support (especially in the initial phases) but cannot teach the modules to all programs
- A workshop is being planned for early 2018 for interested parties to gain more familiarity with the ERK
- Landscape of MAID continues to change – ERK will require occasional updating
- Very open to feedback

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CBME Update

Dr. Susan Glover Takahashi

Director, Education & Research

and

Dr. Caroline Abrahams

Director, Policy, Analysis & Systems

Post MD Education

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CBD UPDATE @ University of Toronto

S. Glover Takahashi, C. Abrahams

All PDs & FM Site Directors

December 15, 2017

Overview

1. CBD update
2. BPEA Advisory Committee
3. CBD technology update

REFRESHER:
Key CBD differences

1. **Developmental** approach
2. **TIME** is not THE parameter for success but is *part of* the considerations
3. **Assessment plan**
   - Focus on workplace assessments
   - Instead of G & O, focus on what can 'do' (i.e. EPAs).
4. '**Trust**' is explicitly assessed.
5. Enhanced **feedback** & **coaching**

WHY????

➔ ➔ IMPROVEMENTS to PGME

1. **More accurate, varied and focused assessments**
2. **Improved frequency, transparency, and quality of data** for PD, faculty and residents, shared decision making
3. **Improved engagement of trainees** in learning activities, incl soliciting & incorporating feedback
4. **More confident and knowledgeable trainees** regarding their performance strengths and limitations

Principles Guiding CBME @ U of T

☑ Quality of patient care will not be adversely affected.

☑ Health care team functioning should not be negatively impacted

☑ Implementation will build on the excellence in residency education programs and practices.

CBD @ U of T is a PARTNERSHIP

1. **Residency Program**
   – Director, Learners, Program Admin, Residency Program Committee, Site Directors
2. **Department**
   – Chairs, Vice Chair Education, Division Chair, Faculty Development Lead
3. **PGME Office**
   – PGME Assoc Dean, Lead & EIG Team, Post MD Dean, IT teams
4. **Hospitals**
   – Cross hospital needs, systems support

July 2017 - 18 @ U of T

- 2 programs — Full RC national implementation
- 12 programs — Partial local launch at U of T using online tools
- 12+ programs — Meantime local activities

July 2018-19 @ U of T

- **2** programs/specialties:

  → → → **Yr 1 & 2 - Full RC nat'l implementation**

- **14** programs/6 specialties

  → → → **Yr 1 - Full RC national implementation**

- **+ programs** Meantime local activities

BPEA Advisory Committee

Purpose

To provide ongoing advice to the Postgraduate Medical Education Advisory Committee (PGMEAC) about best practices, tools and systems for learner assessment and program evaluation (e.g. teacher evaluations, rotation evaluations) for residency education at University of Toronto

Members

– PDs incl RC, FM

Priorities for Dec/Jan

– In Training assessments
– Entrustment assessments

Watch for draft materials for input in January

CBD Technology: IT Platforms for July 2018

- Entrada (new)
  - All programs onboarding to CBD as of July 2018 plus programs on-boarded in July 2017 and Orthopedic Surgery as part of Entrada Pilot - new CBME assessments plus teacher evaluations if requested
- medsquares (newish)
  - All programs wishing to trial CBD tools, in advance of national launch, and requesting support through PGME
- POWER (existing)
  - Will remain as IT platform for ITERs/ITARs, teacher evaluations and rotation evaluations plus scheduling, on-call stipends and registration.
- Multiple platforms – programs will be required to use 2 (i.e. Entrada and POWER) but **not all 3**

CBD New Technology - Why Entrada?

- A CBME solution for ***new*** assessment tools and assessment practices
- *Customizable* to U of T's needs:
  - User friendly and intuitive
  - Designed for a CBME model of assessment
  - Can add other features (e.g. rotation scheduling, teacher & rotation evaluations reporting and data visualization,)
- *confidential* assessment data resides on U of T servers
- Opportunity to collaborate via ***consortium model***

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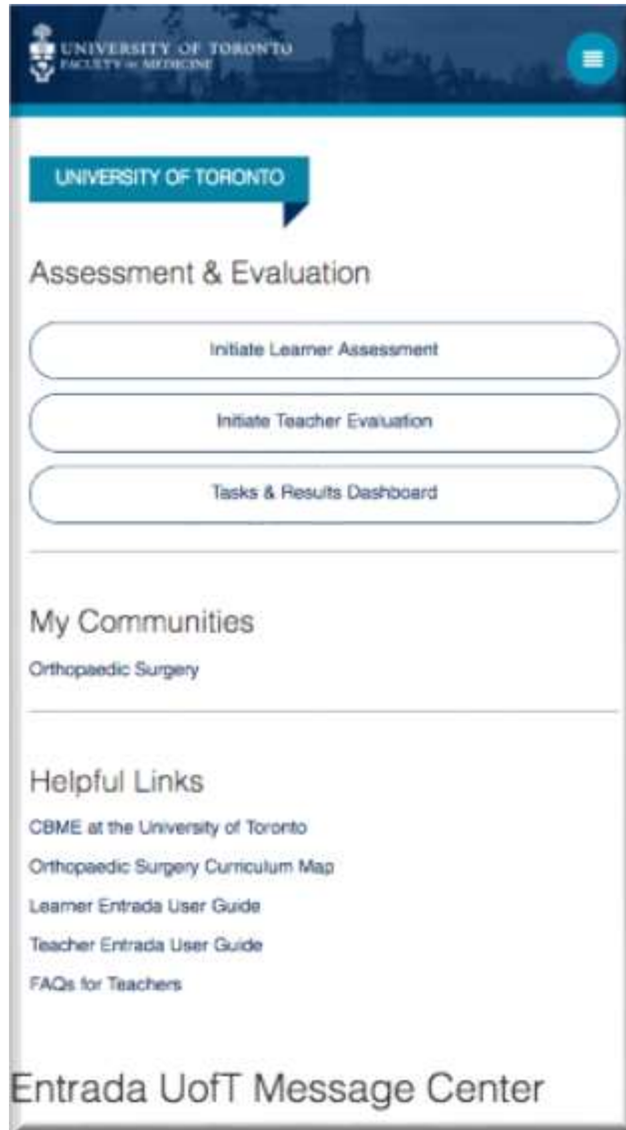
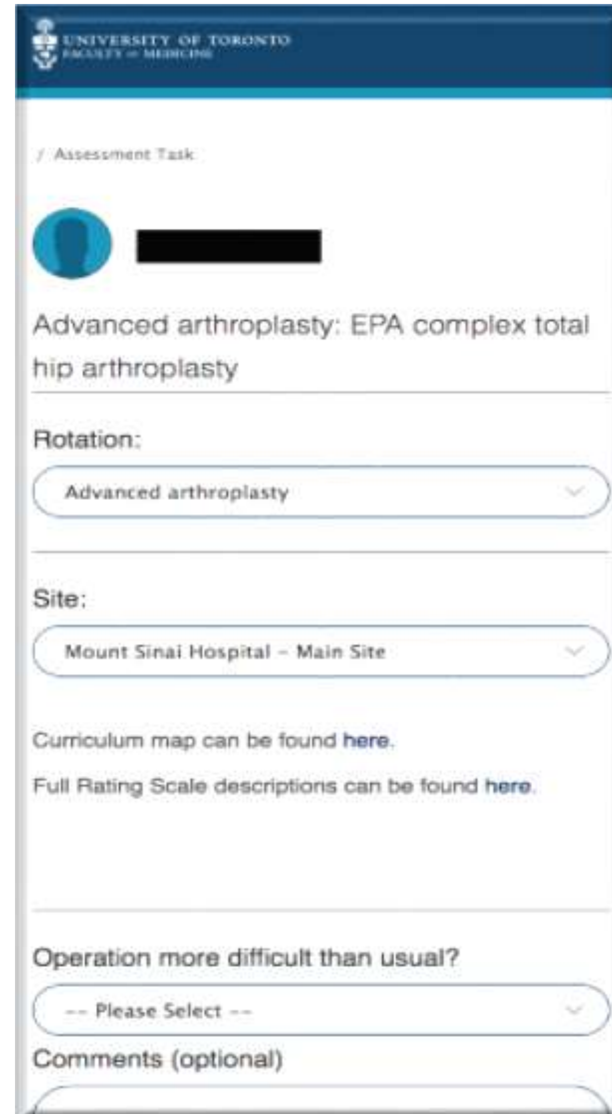
Entrada @ U of T - mobile device





Programs onboarding to Entrada @ U of T as of July 2018

1. Emergency Medicine
2. Medical Oncology
3. Urology
4. Adult Nephrology
5. Peds Nephrology
6. Forensic Pathology

Plus

- Anesthesia
- OHNS
- Orthopedic Surgery

7. Surgical Foundations
   - *General Surgery*
   - *Neurosurgery*
   - *Vascular Surgery*
   - *Orthopedic Surgery*
   - *Plastic Surgery*
   - *Cardiac Surgery*
   - *Urology*
   - *Obs/Gyn*
   - *OHNS*

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ENTRADA PROJECT GOVERNANCE

Project Sponsor: Associate Dean, PGME

Entrada Steering Committee

PGME

Director, Operations – L. Muharuma
Director, EIG - SGT
Director, P,A & Systems – C. Abrahams
Manager, Instructional Design – T. Bahr
Project Manager – A. Pattern

Discovery Commons

Director, IT – S. Chan
Associate Director, Applications – F. Khurshid

Technical Working Group

PGME

Director, EIG - SGT
Director, P,A & Systems – C. Abrahams
Project Manager – A. Pattern
Additional PGME Staff as required

Discovery Commons

Director, IT – S. Chan
Associate Director, Applications – F. Khurshid
Business Systems Analyst – C. Van Beek

Advisory Group

Best Practices on Evaluation and Assessment (BPEA)

Entrada @ U of T – ONBOARDING STRATEGY

July 2017 ---

- **Launched Pilot with Orthopedic Surgery using version v.1.8**
- CBME assessments plus ITERs, teacher evaluations and rotation evaluations

Nov to Dec 2017

- Building **Entrada v. 1.11** and creating templates for upload

Jan to Mar 2018

- **Uploading content** and creating forms with EIG and DC
- Tagging questions/items to EPAs, milestones and required training experiences
- Development and User testing

April to June 2018

- **User testing, report building, more development**
- Faculty development, training materials for all users

July 2018

- **Launch for all new programs onboarding for 2018/19** plus OHNS, Anesthesia and Orthopaedic Surgery

Questions

Unmatched Medical Students & Resident Involvement in Undergraduate Teaching

Dr. Patricia Houston

Vice-Dean, MD Program

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Unmatched Medical Students and Resident Involvement in Undergraduate Teaching

Dr. Patricia Houston, Vice Dean, MD Program

PGME Program Directors Meeting

December 15, 2017

Unmatched medical students

DIVERSITY

CURRICULUM INNOVATION

Curriculum mapping

Student assessment

Career counselling

Program evaluation

LEARNER EXPERIENCE

TEACHING & PARTNERSHIPS

Pre-match career advising (1 of 2)

- Career management content and shadowing (EEE) opportunities integrated into core curriculum (Years 1 & 2)
- Access provided to AAMC CIM (Careers in Medicine) portal
- Individual career counselling available across all four years
- Individual electives counselling/guidance provided in Year 3

Pre-match career advising (2 of 2)

- Individual pre-CaRMS supports/advising including:
  - CV and personal statement reviews/feedback
  - at least one practice interview with physician
  - opportunities for additional practice interviews with career counsellors
- Letter of reference toolkit
- Workshops and presentations
- Academy supports

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Unmatched student advising (1 of 2)

After first iteration

- Group meeting with Associate Dean on match day, OHPSA counsellor and PGME reps
- Individual meetings with Associate Dean and career counsellor within 24 hours
- Opportunities for additional practice interviews and application supports/feedback
- Adjustments to clinical duties/experiences

Unmatched student advising (1 of 2)

After second iteration

- Individual meetings with career counsellor
- Offered option of MD Program Extended Clerkship (MEC)
- Access to all pre-CaRMS supports/advising as they approach second CaRMS cycle
- Additional workshop focusing on process skills, performance, confidence, resilience skills, and interview strategies

What can PGME do to help? (1 of 2)

- Provide reliable information regarding criteria, elective expectations, etc.
- Consider feasibility of providing every U of T medical student an interview
- Choose U of T applicants when there are applicants who are close in rank

What can PGME do to help? (2 of 2)

- Central oversight/accountability to help ensure implementation of BPAS recommendations and sustained fair and transparent selection process
- Internal review in cases where there is no identifiable evidence contributing to a U of T medical student being unmatched

Resident involvement in UG teaching

Curriculum mapping

Student assessment

Career counselling

Program evaluation

Accreditation (1 of 3)

✓ **3.1 Resident Participation in Medical Student Education**:

Each medical student participates in at least one required clinical learning experience with a resident.

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Accreditation (2 of 3)

9.1 Preparation of Resident Instructors:
Residents are prepared for teaching and assessment roles before they being teaching, with centralized monitoring of preparation.

- PGME departments and sites must assure resident awareness of learning objectives and methods of assessment.

Accreditation (3 of 3)

- Starting July 2018, Teaching In Residency module to be completed prior to completion of transition to discipline curriculum (no later than September 30th of PGY1)
- Residents will not pass to the next level of training without PGCorEd completion
- PGME tracking of each residency program's 'teaching residents to teach' curriculum as part of internal review process

Academy of Resident Teachers (ART) Program (1 of 3)

Background and Rationale

- Post-graduate trainees would benefit from increased opportunities to teach in the MD Program (strengthen sub-specialty/job application, allow for career exploration, facilitate professional development)
- Although post-graduate trainees are already teaching in the MD Program,
  - there may currently be inequities in access to the teaching opportunities
  - there is room for improving the mentorship and recognition that resident teachers receive

Academy of Resident Teachers (ART) Program (2 of 3)

Proposal

- Provide a program to support resident teachers in the MD Program's Clinical Skills course
  - Clinical Skills comprised of weekly half-day classes in Years 1 & 2 occurring at major academic hospitals
  - Students learn basic medical interviewing, physical examination, and counseling
  - Subject area within clinical skills assigned to resident teacher can be matched to resident's/PD preference
  - ART leaders can work with Program Directors to specify quantity of teaching and other parameters (e.g. resident must be in good academic, etc.)

Academy of Resident Teachers (ART) Program (3 of 3)

Resident Support

- Resident teachers matched to Clinical Skills faculty teaching mentors, who will provide role modeling, direct observation and coaching
- Resident teachers will be offered faculty development and recognition

Program Evaluation

- Quantitative: pre- and post-resident teaching confidence scores and resident TES
- Qualitative: focus group with resident teachers and students to assess benefits and challenges

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Discussion

Simulation Education Advisory Committee (SEAC) Update

Dr. Douglas Campbell

Chair, Simulation Education Advisory Group

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Simulation Education Advisory Committee (SEAC) update

Douglas Campbell, MD, FRCPC

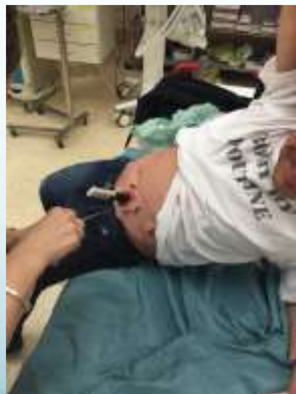
Integration Lead - Simulation,

Chair SEAC

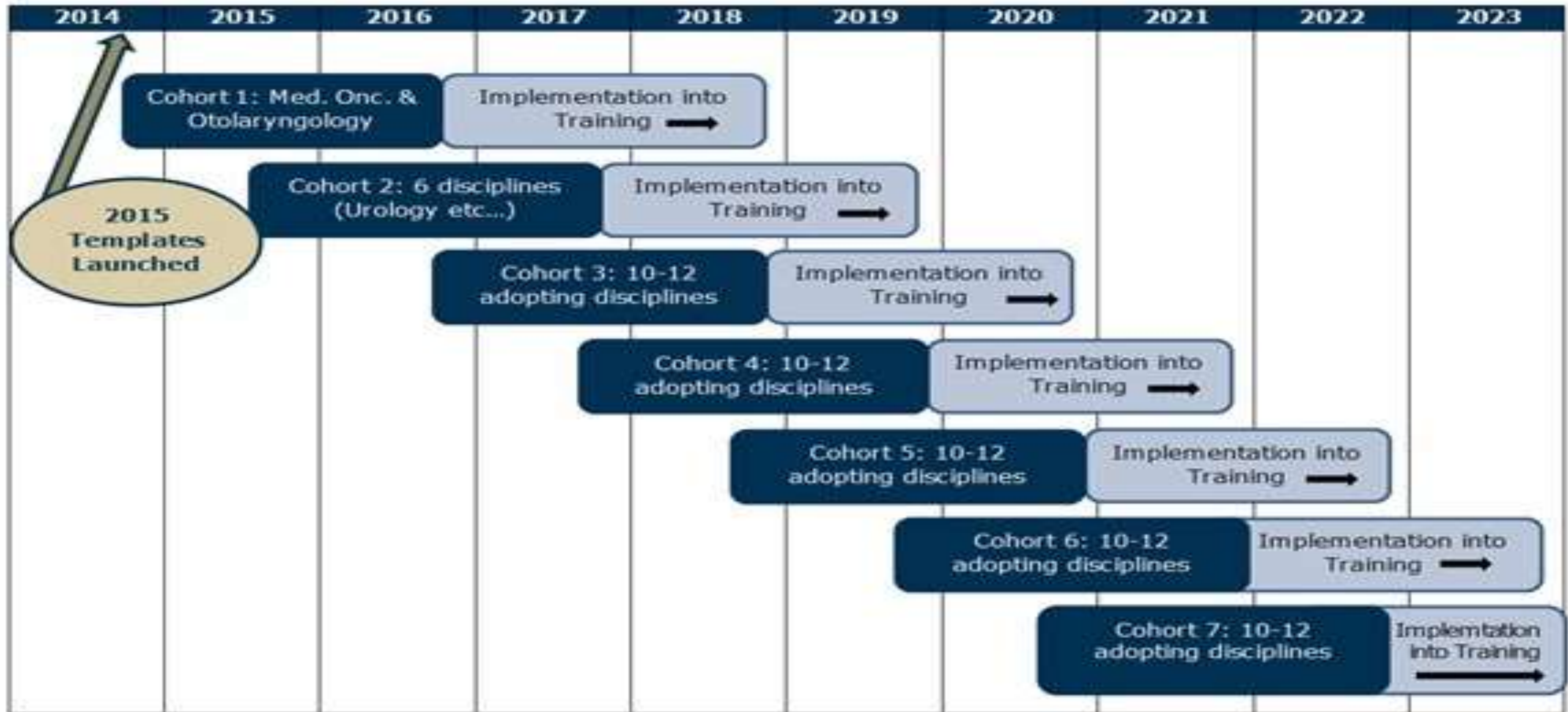
Faculty of Medicine, University of Toronto

Associate Professor, Department of Pediatrics

CRISIS RESOURCE MANAGEMENT
CRM KEY POINTS
Call for Help Early
Designate Leadership
Establish Role Clarity
Distribute the Workload
Communicate Effectively
Use Cognitive Aids



CBD Discipline Rollout: Proposed Implementation Plan



Technology-enhanced simulation training improves outcomes

- Cook D & Hamstra S performed meta-analysis, identified 609 studies enrolling 35,000 trainees
- In comparison with no intervention effect sizes were significant for: knowledge outcomes, time skills, time behaviors and direct benefit to patients

Cook DA et al. *Technology-Enhanced simulation for Health Professions Education. A systematic Review and Meta-Analysis JAMA 2011; 306(9):978-988. doi:10.10001/jama.2011.1234*

Simulation and assessment

- Simulation undoubtedly has a key role to play across specialties in formative evaluation utilizing principles of deliberate practice & mastery learning
- Simulation and summative evaluation is likely also important especially with high-stakes assessment

Chiu M et al. Can J Anesth 2016'(63):1357-1363

Nguyen L et al Can Urol Assoc J 2015;9(1-2):32-36

Simulation and patient safety

- Simulation programs are already heavily invested in patient safety and quality improvement within organizations
- An opportunity exists, particularly at University of Toronto, to lead the way and leverage existing simulation resources for all health professions

Barriers to integrating simulation into curriculum

- Logistics
- Cost
- Space
- Faculty development
- Assessment

Current Simulation centres

- Largely funded by TAHSNe centers and partners
- Accreditation:
  - Royal College of Physicians and Surgeons
  - American College of Surgeons
  - Society for Simulation in Healthcare
- Non-accredited programs
- Informal/ad hoc

SEAC - Mandate

- Engage the active players in the field of simulation currently involved in Faculty of Medicine, University of Toronto education across the GTA
- Bring together key partners with expertise in the delivery and formulation of simulation activity (TAHSNe, SimONE, CFD)
- Understand current strengths and future capacity (expertise, equipment, resources, scholarly activity)
- Lay the foundation for a future network in order to: improve the delivery of efficient and effective education, foster collaborative academic activity (annual symposium, external review)

Initial Findings

- Wealth of resources and expertise within simulation across all specialties
- Isolation of sim programs
- Only a small amount of innovation, clinical research occurring
- Costs are variable and often prohibit collaborative work for educators and administrators alike

SEAC - Deliverables

- Held 6 meetings with all the major TAHSNe simulation program managers and medical leads, along with our valued simulation partners
- Developed and administered an environmental scan of these major program sites (Structure, Resources, Scholarship, Strengths & Weaknesses)
- Collated and summarized data, currently in preparation for an initial report to the Dean of Medicine

SEAC - Deliverables

- Inaugural University of Toronto Simulation Symposium – January 24th, 2018
- Next steps:
  - External review
  - Second round of survey, in order to bring in other institutions and key players in the delivery of simulation

Simulation Network
Faculty of Medicine

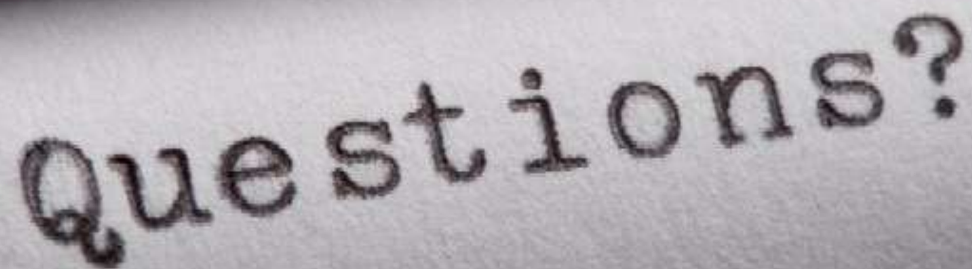
- Common administrative platform
- Provide quality learning experience for our continuum of learners (UME, PGME, CME) using evidence-based principles
- Seamless integration of allied health disciplines (existing local staff, partnerships with other organizations)
- Foster a collective environment for clinicians, and engage researchers, innovators, industry

Inaugural Simulation Symposium

Save the Date!

January 24, 2018

8 am -1 pm


Questions?

Thank You

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