Postgraduate Medical Education
UNIVERSITY OF TORONTO

**Postgraduate Medical Education Advisory Committee (PGMEAC)**

**Friday, March 25, 2011**

**12:30 – 2:15 pm**

**PG Boardroom, 500 University Avenue, #602**

## AGENDA

**Agenda/Minutes**

| | | | |
|---|---|---|---|
| 1. | a) Agenda Approval | S. Spadafora | Approval |
| | b) Approval of Minutes, February 25, 2011 | S. Spadafora | Approval |

**New Business**

| | | | |
|---|---|---|---|
| 2. | Residency Program Director Leadership Inventory | S. Lieff | Presentation |
| 3. | Guideline/Policy Review: | S. Spadafora | Consultation |

*Resolution of Resident Disagreement with Attending Physician or Supervisor - Procedural Memorandum, PGME 2002*
Reference Document: *Resolution of Resident Conflict with Attending Physician or Supervisor on an Issue of Patient Care, Nov 2009*

| | | | |
|---|---|---|---|
| 4. | *Approval of the revised Transfer Policy, Feb 2011 (track changes version attached)* | *S. Spadafora* | *Vote* |
| 5. | CARMS 2011 Match Report | C. Abrahams | Presentation |

**Matters Arising/Regular Updates/Follow-up**

| | | | |
|---|---|---|---|
| 6. | COFM Report | S. Spadafora | Information |
| 7. | HUEC Report | S. Spadafora | Information |
| 8. | Resident Issues | Resident Rep | Information |
| 9. | Internal Review Committee | A. Zaretsky | Information |
| 10. | Integrated Medical Education/Expansion | S. Spadafora | Information |

**IMPORTANT DATES/REMINDERS:**

**Canadian Conference on Medical Education**: May 7-11, 2011 Toronto

| **2010-11 PGMEAC Meeting Dates:** | |
|---|---|
| September 17, 2010 | February 25, 2011 |
| October 22, 2010 | March 25, 2011 |
| November – no meeting | April – no meeting |
| **December 3, 2010: ALL PDs** | May 20, 2011 |
| January 28, 2011 | **June 10, 2011: ALL PDS** |

**RSVP:** nicole.bryant@utoronto.ca

# Walking the talk;

An MSF instrument for the leadership capabilities of residency program directors

S. Lieff, A. Zaretsky, G. Bandiera,
S. Spadafora, K. Imrie,
S. Glover Takahashi

# Background – In PGME

The environment is one of constantly changing educational needs, requirements and contexts.

# Background – In PGME

This requires leadership capabilities in residency program directors (RPD)

Yet, most have little development or feedback regarding their leadership

# Purpose

To design a a competency-based multi-source feedback instrument for the leadership of RPD's in order to:

- offer a fair & objective "arm's length" assessment of their leadership abilities
- provide a vehicle to diagnose their learning & development needs
- guide in the development of a learning action plan
- enable them to measure their progress
- provide information on shared development needs that could inform the design of faculty development.

# Goals

- Formative program
- Voluntary
- Arms length from performance appraisal

(Sargeant 2009)

# Lit review & development of key domains of performance

- Communication and Relationship Management
- Leadership
- Professionalism and Self-Management
- Environmental Engagement
- Management Skills and Knowledge

# MSF Instrument Validation: Part 1

- 55 item inventory
- Convenience sample – 50 key informants
  - Residents, Residency program directors & committee members, Chairs or vice-chairs, Staff, Postgrad deans, Education opinion leaders
- Rate from not essential (1) to very essential (5)
- 70 % response rate
- Most provided feedback on all five domains, rather than the minimum three requested

# MSF Instrument Validation: Part 2

You

- Instrument ?
- Utility ?
- Implementation ?

# Respondent Characteristics

| Role | Response Percent |
|---|---|
| Chair | 0% |
| Chief | 3% |
| Vice Chair – Education (i.e. or equivalent for Department) | 3% |
| Faculty | 3% |
| Residency Program Committee members | 6% |
| Program Director | 72% |
| Site Director | 31% |
| Resident | 0% |
| Administrative Staff | 0% |
| Vice Dean | 0% |
| PGME office personnel | 3% |

| Years in role | Response Percent |
|---|---|
| < 5 years | 63% |
| 5-10 years | 31% |
| > 10 years | 6% |

| Number of Residents | Response Percent |
|---|---|
| < 25 residents | 54% |
| 25-100 residents | 31% |
| > 100 residents | 14% |

| Age | Response Percent |
|---|---|
| < 30 | 0% |
| 30-50 | 69% |
| > 50 | 31% |

| Gender | Response Percent |
|---|---|
| Male | 49% |
| Female | 51% |

# Domains Essential to Effectiveness

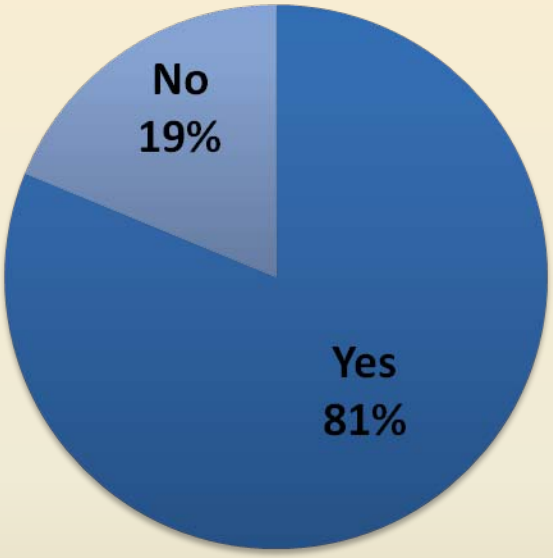
| | Completely Agree | Agree |
|---|---|---|
| 1. Communication and Relationship Management | **76%** | **18%** |
| 2. Leadership | **68%** | **29%** |
| 3. Professionalism and Self-Management | **76%** | **21%** |
| 4. Environmental Engagement | **59%** | **32%** |
| 5. Management Skills and Knowledge | **74%** | **24%** |

# Utility of the RPDLI

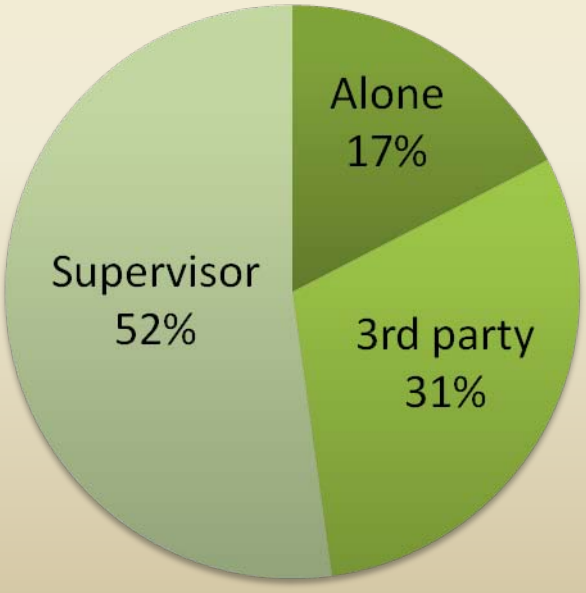
| | Completely Agree | Agree |
|---|---|---|
| C. Having a Leadership Inventory for Residency Program Directors to orient new program directors would be helpful | **52%** | **30%** |
| F. Having a Leadership inventory would be useful for feedback purposes | **45%** | **24%** |
| E. Having a Leadership inventory would be useful for self assessment purposes | **42%** | **36%** |
| D. Having a Leadership Inventory for Residency Program Directors to orient others (e.g. Chairs, Residents, Faculty) about the 'job' of Residency Program director would be helpful | **39%** | **36%** |
| A. Having a Leadership Inventory for Residency Program Directors would be helpful to me in my role | **30%** | **33%** |
| B. Having a Leadership Inventory to recruit new program directors would be helpful | **27%** | **42%** |

# Having a Leadership Inventory Would be Useful for Feedback Purposes

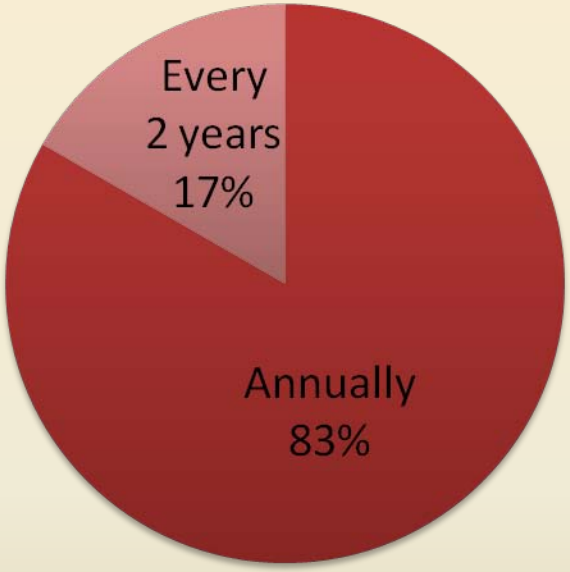
***Usefulness***




***Debrief***




***Frequency of Feedback***



# Who Should be Involved in Collection

| | Completely Agree | Agree |
|---|---|---|
| A. Chair | 50% | 33% |
| B. Chief | 70% | 13% |
| C. Vice Chair – Education (i.e. or equivalent for Department) | 39% | 35% |
| D. Faculty | 48% | 35% |
| E. Residency Program Committee members | 70% | 26% |
| F. Program Director | 70% | 13% |
| G. Site Director(s) | 65% | 13% |
| H. Residents | 68% | 23% |
| I. Administrative Staff | 36% | 32% |
| J. Vice Dean | 30% | 30% |
| K. PGME office personnel | 27% | 27% |
| L. Other | 17% | 0% |

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# Resolution of Resident Disagreement with Attending Physician or Supervisor - Procedural Memorandum

*(cross-referenced in the "Principles re Supervision of Postgraduate Medical Trainees" document endorsed by COFM)*

**Preamble:**

At the beginning of each rotation, the program director must provide the resident with the phone/pager number of the local hospital postgraduate program director **(academic)** AND service chief **(hospital)** to call in case of a complaint or disagreement while in training.

When there is a complaint or disagreement between the postgraduate medical trainee and the attending physician or supervisor, the premise is that the issue will be dealt with as close to the source as possible thereby limiting the number of people involved. The conflict can be handled either through the academic or hospital protocol, with the understanding that each side will keep the other informed. It is expected that collegiality in a "no-fault" environment will be such that the resident will feel comfortable discussing the issue with a staff person.

Examples of complaints or disagreements include (but are not limited to):

(a) Perceived inappropriate professional behaviour

(b) Perceived inadequate or poor teaching

(c) Perceived inadequate or poor patient care

(d) Perceived inadequate supervision

**Procedure for Academic Route of Resolution of Supervision Conflict:**

1. The resident consults with the local hospital postgraduate program director (or designate) about the issue.

2. The local hospital postgraduate program director (or designate) will speak with the attending physician/supervisor and attempt to resolve the issue.

3. If the resident does not feel that the issue had been resolved, she/he may approach the university program director.

4. If the issue still remains unresolved, the resident may approach the Associate Dean, Postgraduate Medicine.

In cases where immediate resolution is required (#1 and #2 above), it is expected the resident will telephone those involved. Regardless of the outcome of the immediate intervention and/or resolution, there shall be no repercussions to the resident for lodging the complaint. The local hospital postgraduate program director will provide a follow-up written report of the incident to the university program director **(academic),** and the service chief **(hospital).**

This revised version of the Procedural Memorandum approved at Toronto PGMEAC January 18, 2002 as part of the "Principles re Supervision of Postgraduate Medical Trainees" document

PGMEAC
Original Date: January 18th, 2002

COUNCIL OF
ONTARIO FACULTIES
OF MEDICINE

*An affiliate of the Council of Ontario Universities*

# POSTGRADUATE EDUCATION COMMITTEE OF COFM

# RESOLUTION OF RESIDENT CONFLICT WITH ATTENDING PHYSICIAN OR SUPERVISOR ON AN ISSUE OF PATIENT CARE

**May 10, 2002**
**Revised Aug. 2009**

(See also *College of Physicians and Surgeons of Ontario Professional Responsibilities in Postgraduate Medical Education.* http://www.cpso.on.ca/policies/policies/default.aspx?ID=1846)

## Purpose

This document provides a provincial guideline to resolve situations where a resident experiences conflict with his/her attending physician[1] or supervisor[2] on an issue of patient care.

It is recognized that it may be very appropriate for two professional individuals to disagree on a medical issue. Most disagreements do not require the initiation of this process. Individual universities may also consider additional conflict resolution measures or processes.

## Process

Each resident must be provided with the contact information for each site coordinator involved in their program. This should be readily available via the Resident Handbook or the internet. When there is a conflict or disagreement between the postgraduate medical learner and the attending physician or supervisor, the premise is that the issue will be dealt with as close to the source as possible thereby limiting the number of people involved. The conflict can be handled either through the academic or hospital/site protocol, with the understanding that all involved parties will keep each other informed.

Examples of disagreements include, but are not limited to:

(a) Perceived concerns regarding quality of care.
(b) Perceived inappropriate professional behaviour.
(c) Perceived inadequate supervision.
(d) Perceived inadequate or unsatisfactory teaching.

## Procedure for Academic Route of Resolution of Resident/Supervisor Disagreement:

1. Ideally the resident and supervisor have a face-to-face discussion about the concern.
2. The resident consults with the site coordinator about the issue.
3. The site coordinator will speak with the MRP/supervisor to inform him/her of the concern.
4. The site coordinator will arrange a joint meeting with the resident and attending physician/supervisor to reach a resolution.

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[1] Attending Physician: is the physician who has final responsibility and is accountable for the medical care of a patient.
[2] Supervisor: are clinical teachers who are delegated by their respective training programs to guide, observe and assess the educational activities of the learners. The supervisor of a learner involved in the care of a patient may or may not be the most responsible physician for that patient.

5. If the resident does not believe that the issue has been resolved, she/he should approach the university program director.
6. If the issue still remains unresolved, the resident should approach the Associate Dean, Postgraduate Medicine.

In cases where immediate resolution is required, the resident will immediately contact the site coordinator for direction.

Recognizing that disagreements/conflicts occur, there is an expectation that a collegial, “no-fault” environment is in place. Regardless of the outcome of the immediate intervention and/or resolution, there shall be no repercussions to the resident for lodging a complaint made in good faith. The site coordinator will provide a follow-up written report of the incident to the university program director (academic), and/or the service chief (hospital/site), when appropriate.

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**Transfer of Residency Programs from program to program or school to school**

The University of Toronto Postgraduate Medical Education Office tries to provide opportunities for program transfer to its trainees. At the beginning of January each year, the Postgraduate Dean sends an email to PGY1 and PGY2 residents informing them of this opportunity and advising them of the principles and procedures of the transfer process, as follows:

**A. GENERAL PRINCIPLES:**

1. Wherever possible, transfers should not subvert the CaRMS match and/or PGM: COFM Health Human Resources policies.

2. Residents must be accepted by their requested program

3. Residents must be released by their home program

4. Final approval of any internal transfer lies with the Postgraduate Dean.

5. The Postgraduate Deans at the respective Ontario schools will have the final approval regarding intra-provincial transfers, including funding availability.

**B. SPECIFIC PRINCIPLES:**

In addition to fulfilling the requirements of the general principles above, the following specific principles will apply to all transfer requests:

1. Residents must have at least 6 months of residency in the discipline from which they request a transfer. PGY-1 transfer requests will be considered after January 1st each year.

2. Residents should have sufficient exposure to the discipline to which they are requesting transfer either in the last year of medical school or during their residency.

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4. Residents must be of similar quality to successful candidates through the CaRMS match by the receiving program, utilizing similar selection methods and rating systems where they are used.

5. **Transfer requests from the Family Medicine program will only be considered from residents at the PGY1 level with the exception of those considering entry to Public Health and Preventive Medicine**

6. Consideration of transfer requests from residents in specialty programs at the PGY2 level and above will be based on evidence of wrong career choice or demonstrated need, e.g. disability, health or family issues that prevent residents from completing their initial program, etc.

7. Transfers at the PGY2 or higher level will be dependent on availability of funding.

**C. PROCESS:**

1. Residents wishing to transfer programs will submit their names and preferred programs to the PGME Office in January of each year.
2. Requests will be compiled and reviewed by the PGME Office. The PGME office will immediately contact residents whose transfer requests are not approved by the Postgraduate Dean due to capacity and therefore will not be forwarded to Program Directors

3. The PGME office will send approved program transfer requests to the Program Director with the residents' name and contact information as well as the number of positions the program may potentially fill. All requests are sent at the same time to the Program Directors.

4. Program Directors are not obligated to accept trainees who do not meet admission requirements. Also, some Program Directors may not be able to increase their numbers even by one, if clinical training resources do not permit this.

5. Program Directors/Program Assistants will contact residents individually to request documentation for review and possible interview and prepare a rank list of its acceptable applicants and discuss with the PGME Office regarding funding availability. Transfer requests are confidential and the potential "new" Program Director may not contact the applicant's current Program Director without the applicant's authorization.

6. After consultation with the PGME Office, the Program Director will inform the transfer applicant of acceptance/refusal verbally or by email. This process should be completed by the end of February.

7. The PGME Office will treat transfer requests as confidential and will not advise current Program Directors of the acceptance of residents to other programs -- this is the responsibility of the resident. An applicant who is accepted as a transfer resident must arrange a meeting or contact his/her current Program Director to request a release from the program as of July 1st or a date which is mutually acceptable to both Program Directors. Due to rotation and call schedule requirements, both program directors must agree on the start/release date if other than July 1st.

8. The PGME Office will issue a revised Letter of Appointment to successfully transferred residents after receipt of authorization letters from the new and former Program Directors.

9. An intra-provincial (within Ontario) transfer process will take place in March, following the internal University of Toronto transfer process. Transfer requests to programs in other Ontario schools will be considered during this period to accommodate residents who are requesting a transfer of medical school, or have been unsuccessful in the internal transfer process. However, as funding years are not transferable among schools, direct and equal swaps are usually sought during this process. Residents at each school who wish to be considered for the intra-provincial transfer process must "register" their transfer request with the PGME Office. The transfer requests are compiled centrally and reviewed by the Ontario Postgraduate Deans after the 2nd iteration of CARMS. For UofT, please contact loreta.muharuma@utoronto.ca by the end of February regarding your request to transfer to programs at other Ontario schools.

Approved PGMEAC, November 21, 2008
Revised PGMEAC, February 25, 2011

# 2011 First Iteration CARMS Results

University of Toronto

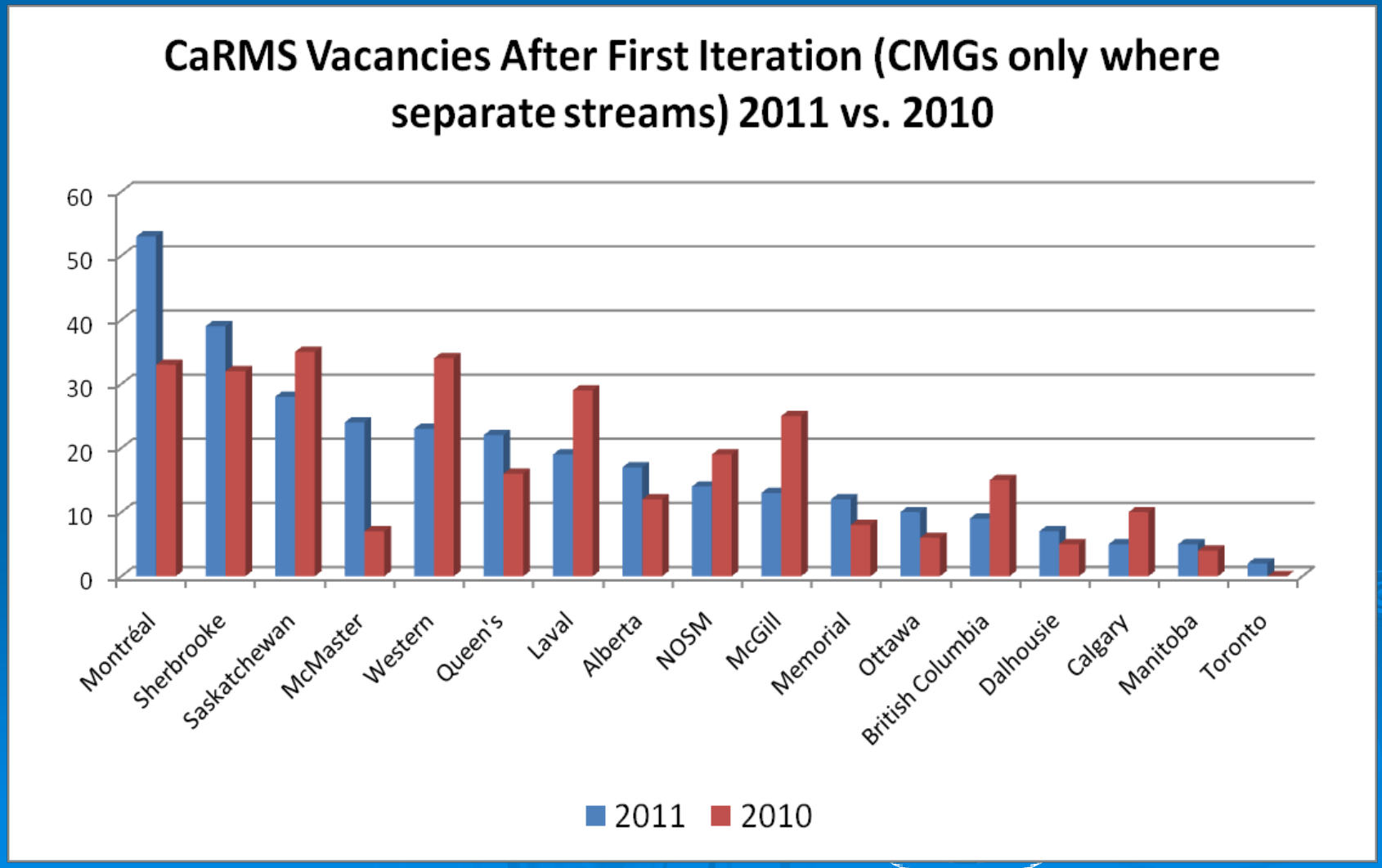
PGMEAC,

March 25, 2011

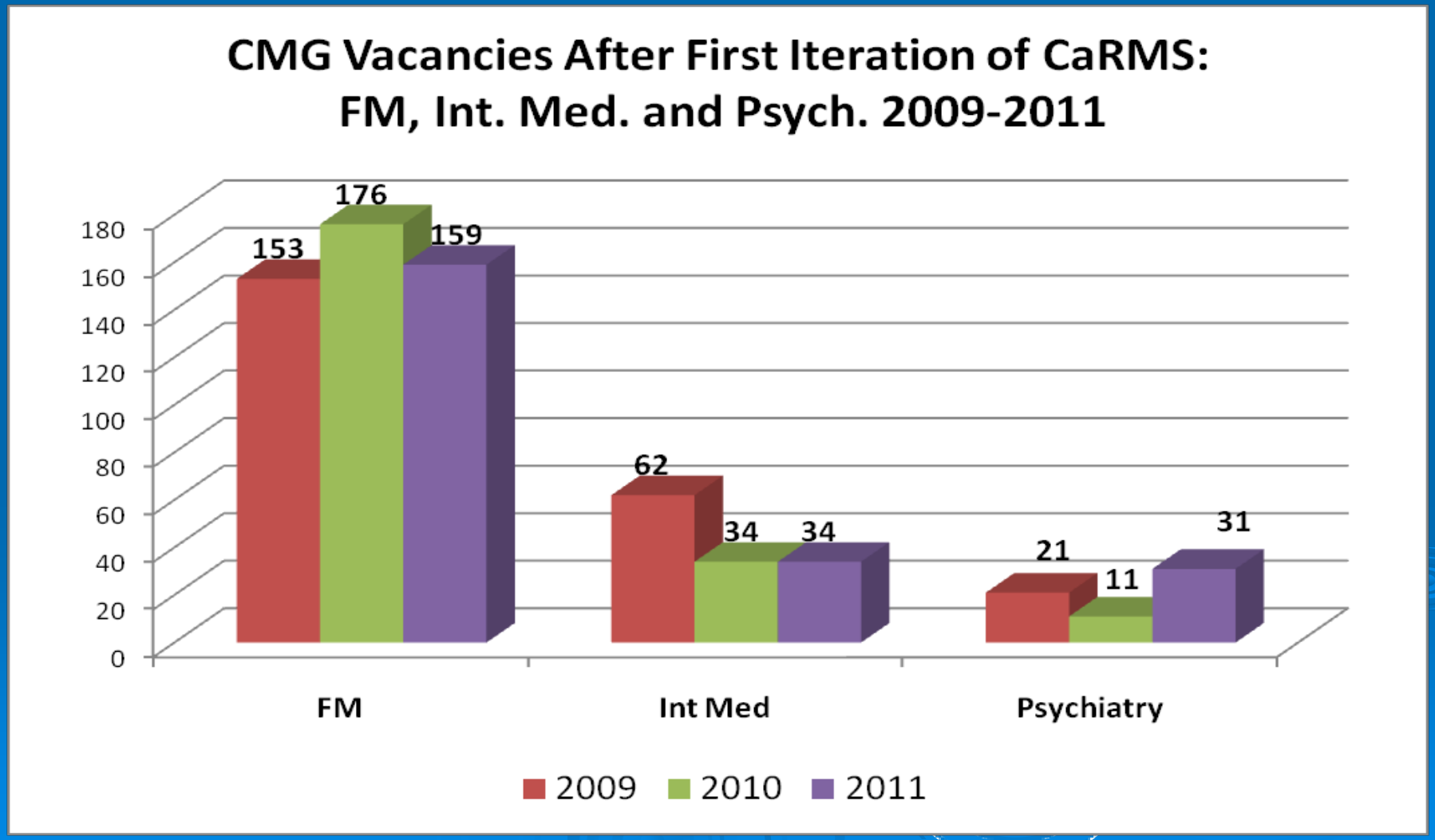
# First Iteration National Results Overview - PG

- 2778 positions in the match = 1 to 1.1 ratio of UG to PG (CMGs only – except Man. and Que.)
- 303 vacancies nationally - 159 (52%) in FM and 144 (48%) in specialties. Last year, 302 vacancies with 176 (58%) in FM and 126 (42%) in specialties
- 95 CMG vacancies in Ontario – 52 (55%) in FM and 43 (45%) in specialty. Last year 93 vacancies in Ontario – 53 (57%) in FM and 40 (43%) in specialty
- Less than 5% of students unmatched across country

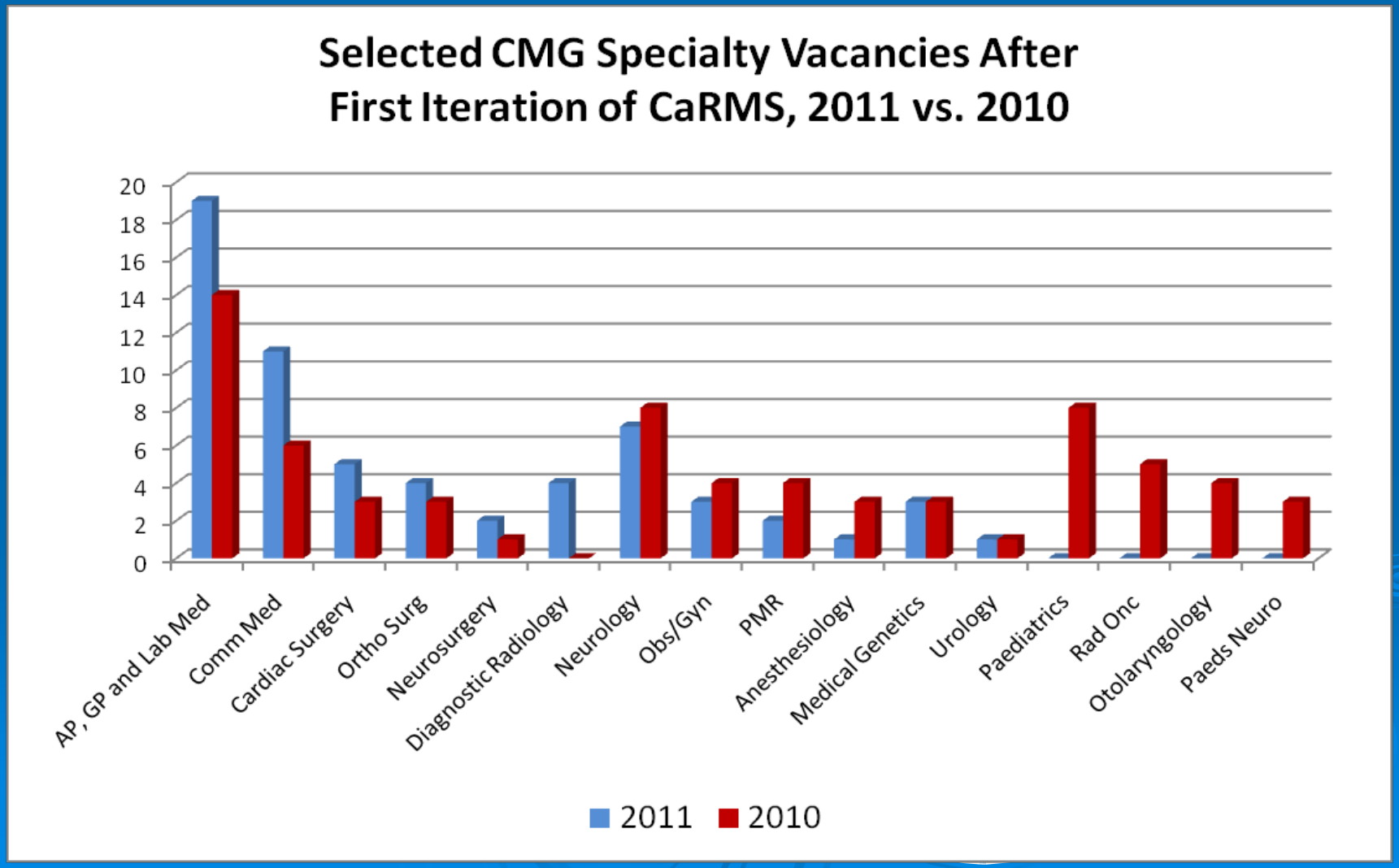
# National Vacancy Overview by University



# National Vacancy Overview: Large Programs



# National Vacancy Overview by Selected Programs



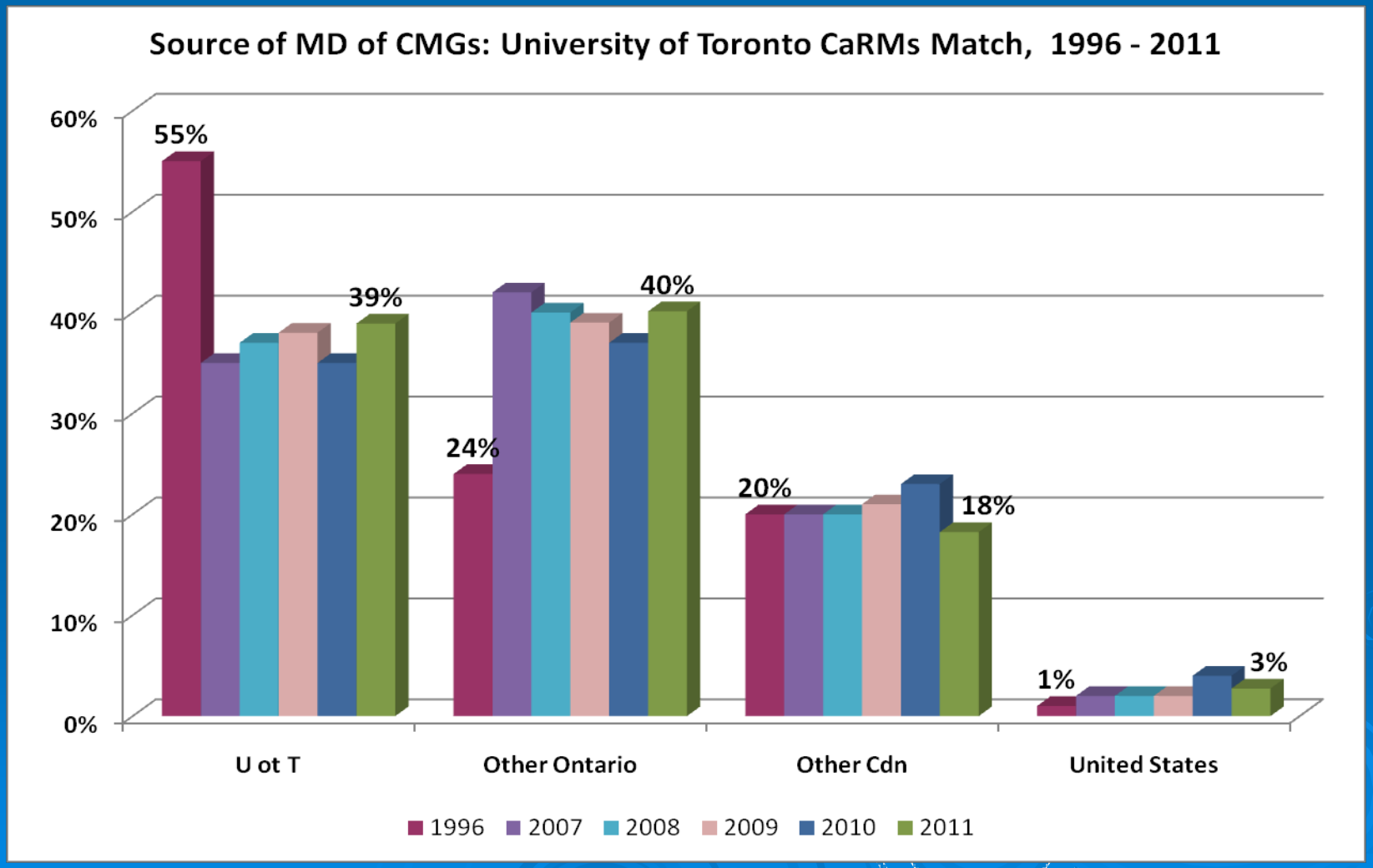
# CMG/IMG Vacancies by FM vs. RCPSC Specialty, Ontario Universities

| School | Family Med | Specialty | Total |
|---|---|---|---|
| McMaster | 10 | 14 | 24 |
| Queen's | 16 | 6 | 22 |
| NOSM | 7 | 7 | 14 |
| Ottawa | 0 | 10 | 10 |
| UWO | 17 | 6 | 23 |
| Toronto | 2 | 0 | 2 |
| TOTAL | 52 | 43 | 95 |

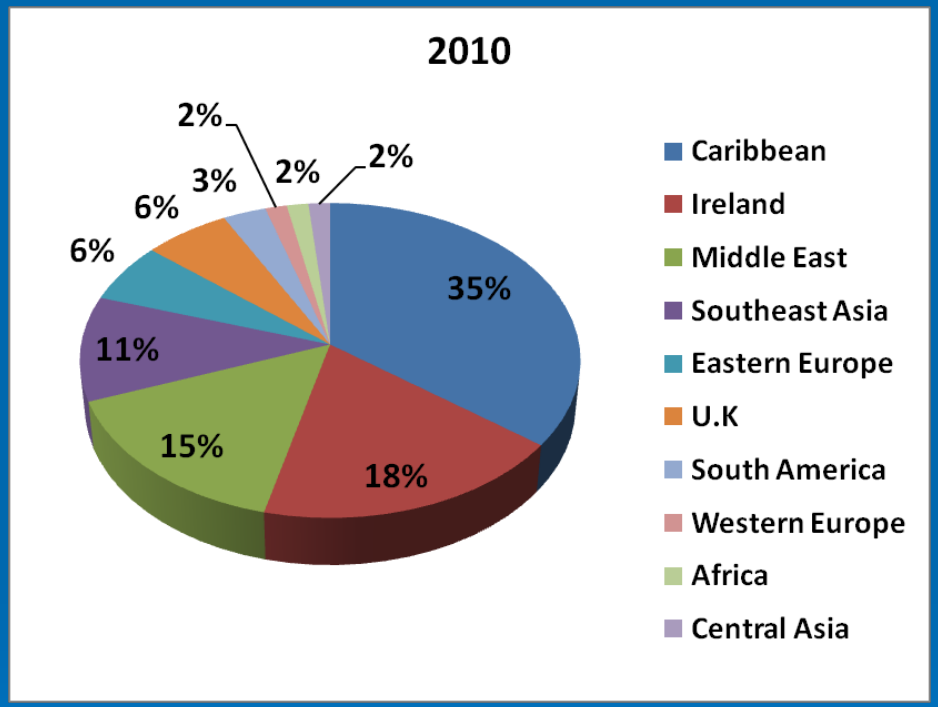
# Results Overview for U of T

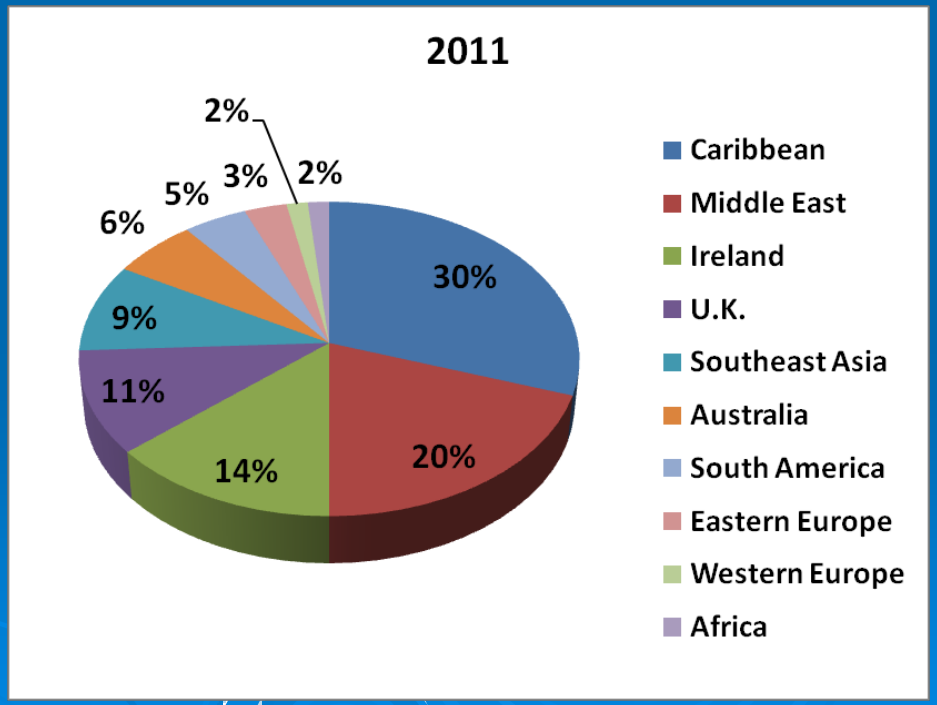
- Quota:
  - 329 CMG Positions (126 FM and 203 Specialty)
  - 66 IMG Positions  (24 FM and 42 Specialty)
- Results
  - 2 Vacancies (Rural FM)
- Reversions
  - 2 reversions from FM Rural into FM Core
  - 4 IMG reversions to Gen. Surg, Peds, Derm and PMR

# Source of MD: CMGs



# Country of MD – IMGs in CaRMS 2010 vs. 2011

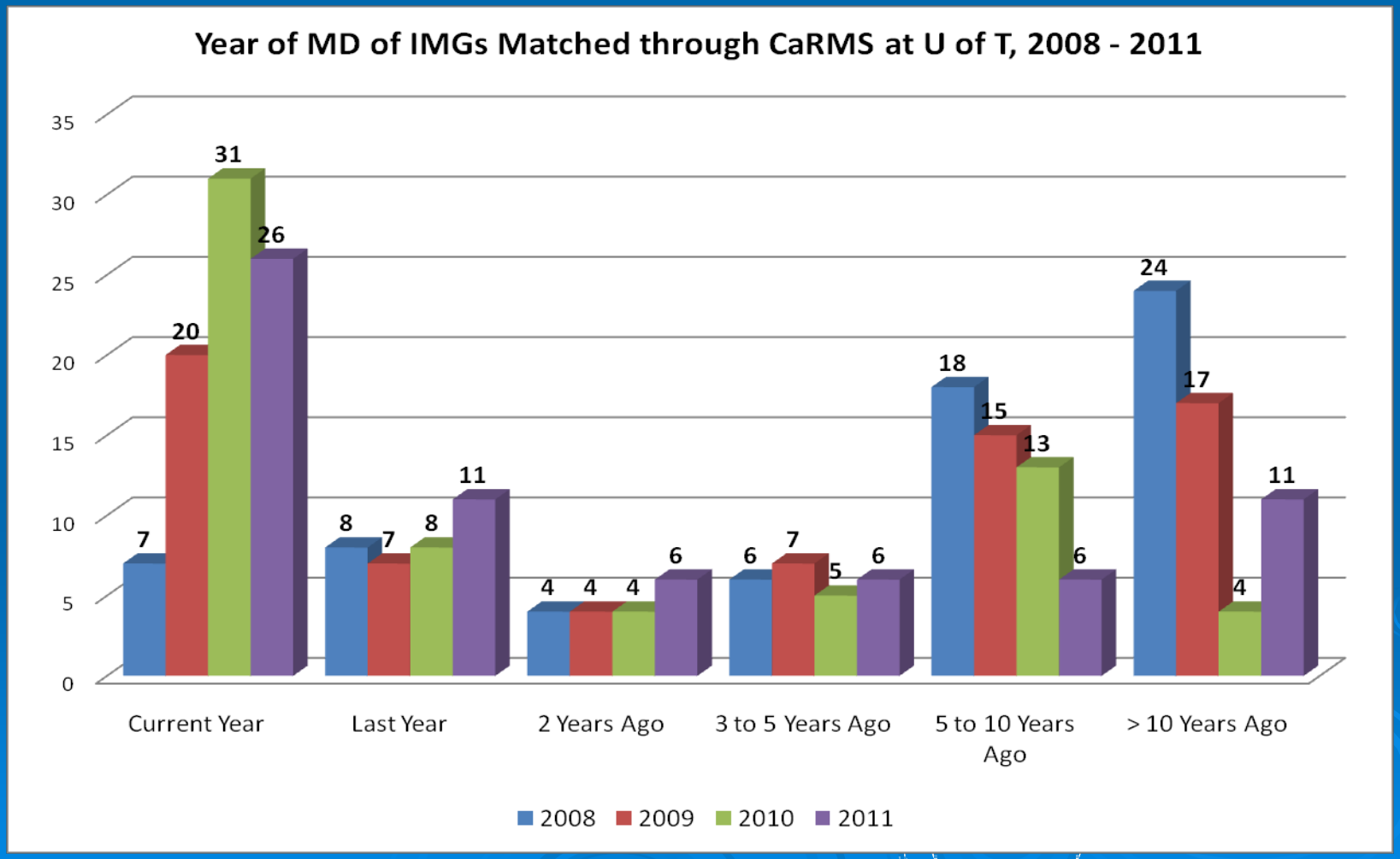


# Age Distribution of CMGs and IMGs matched through CaRMs: 2009-2011

| Match Year | CMGs | IMGs |
|---|---|---|
| **2011** | 27.1 | 30.5 |
| **2010** | 26.8 | 29.3 |
| **2009** | 28.8 | 35.3 |

# Year of MD of IMGs matched through CaRMS, 2008-2011

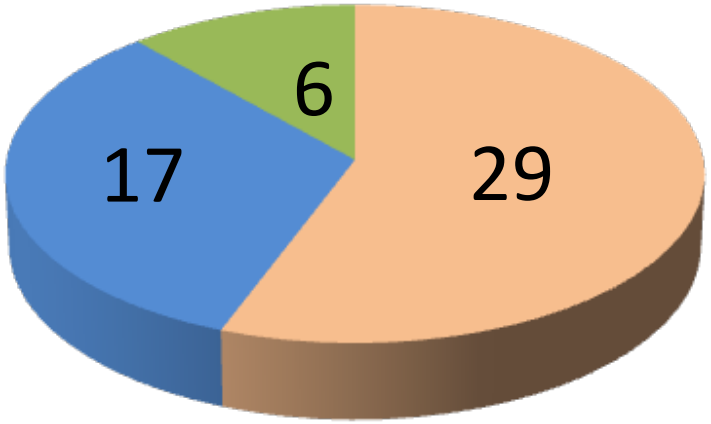


# Internal Review Cycle
# As of March 25, 2011

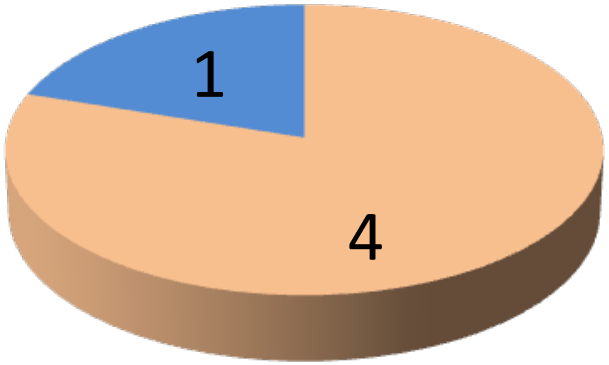
| | Completed |
|---|---|
| Routine mid-cycle reviews of RCPSC programs | 50 |
| Routine mid-cycle reviews of CFPC sites | 6 |
| Update reports of RCPSC programs received | 10 |
| Follow-up reviews of RCPSC programs | 8 |

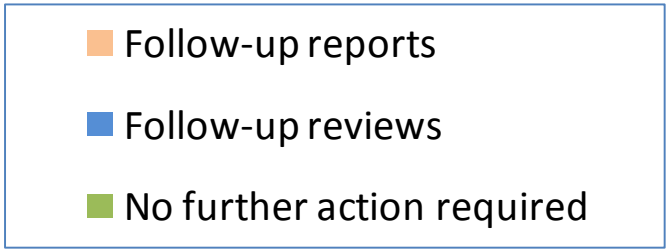
# Internal Review Committee Decisions since Jan. 2009

**Summary of Recommendations for RCPSC programs (N = 52)**




**Summary of Recommendations for CFPC sites (N = 5)**



| Upcoming Activities… | Mar – Nov 11 |
|---|---|
| Routine mid-cycle internal reviews of Royal College Programs | 18 |
| Update reports of Royal College Programs | 20 |
| Follow-up reviews of Royal College Programs | 8 |
| Routine Family Medicine site/program reviews | 12 |
| Follow-up Family Medicine site review | 1 |
| Update reports from Family Medicine site | 4 |