THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CHAIRS' REPORT: EXTERNAL REVIEW of the UNIVERSITY OF TORONTO POSTGRADUATE MEDICAL EDUCATION OFFICE

NOVEMBER 7TH AND 8TH, 2011

I. INTRODUCTION

The external review of the Postgraduate Medical Education Office (PGME) at the University of Toronto was organized over two days (November 7th and 8th, 2011). The survey team was composed of four members:

- Dr. Mark Walton, Assistant Dean, Postgraduate Medical Education, McMaster University
- Dr. Jill Kernahan, Associate Dean, Postgraduate Medical Education, University of British Columbia
- Dr. Kristin Vaga, CCFP-EM resident, Queens University
- Dr. Jennifer Tang, Royal College Emergency resident, Queens University

Each member of the survey team had expertise in residency education and was selected to give an overview with combination of residents' viewpoints, taking into account the conjoint A standards of the Royal College of Physicians and Surgeons of Canada (RCPSC), and the College of Family Physicians of Canada (CFPC). The review occurred in the boardroom of the Postgraduate Medical Education Office at the University of Toronto, with opportunities to videoconference and teleconference to other affiliated teaching sites within Toronto and Mississauga.

The survey team would like to thank Dr. Salvatore Spadafora and Ms. Loreta Muharuma for the organization of the review. Dr. Catharine Whiteside, the Dean of the Faculty of Medicine was on an administrative leave and in her place the survey team also had the pleasure of meeting with Dr. Sarita Verma, the Acting Dean.

i. ORGANIZATION OF THE SURVEY

The survey team met with the following people and groups over the two day review:

Dr. Salvatore Spadafora, Vice-Dean, Postgraduate Medical Education

Dr. Sarita Verma, Acting Dean, Faculty of Medicine

PGME Staff-Directors
Loreta Muharuma – Director of Operations- PGME
Sue Glover Takahashi PhD – Director of Education and Research- PGME
Caroline Abrahams – Director of Policy and Analysis - PGME
Dr. Susan Edwards, Director, Resident Wellness- PGME

Postgraduate Medical Education Advisory Committee, Resident representatives, PAIRO representatives, and Hospital Education Leads

A group of Chief residents as well as a group of various year residents

Mississauga team of Dr. Norm Hill, Kathleen Clements, Mitzi Bindoo

Internal Review Committee - PGME, chaired by Dr. Glen Bandiera

Postgraduate Medical Education - Board of Examiners

Vice Presidents of Education and Directors of Education from a sample of both full affiliates and community teaching hospitals, selected Department Chairs and other members of the Hospital University Education Committee (HUEC)

Dr. John Bohnen, Vice Dean, Clinical Affairs, Faculty of Medicine, U of T

Department of Family and Community Medicine representatives including:

- Dr. Karl Iglar, Program Director
- Dr. Lynn Wilson, Department Chair
- Dr. Marcus Law, Residency Recruitment Coordinator and FM Site Director, Toronto East General Hospital
- Dr. Patrick Skalenda, FM Remediation Coordinator
- Dr. Roy Wyman, FM Enhanced Skills Coordinator
- Dr. Paul Philbrook, FM Integrated Medical Education Coordinator

Dr. Norm Rosenblum, Associate Dean, Physician Scientist Training and Postgraduate Director, Clinician Investigator Program (CIP)

Dr. Kevin Imrie, Vice-Chair Education, Department of Medicine and Chair, Postgraduate Web Evaluation and Registration (POWER) Steering Committee

Documents that were available for review include:

The Postgraduate Medical Education Advisory Committee (PGMEAC) Agendas and Minutes

Minutes of the PGMEAC Subcommittees

Pre-survey questionnaire with multiple appendices covering various policies regarding

1. Quota Allocations
2. Terms of Reference for the PGMEAC and Subcommittees
3. PGCorED
4. Immunization
5. Blood borne pathogens
6. Medical learners with special needs
7. Terms of reference and policies regarding the Board of Examiners and the Board of Medical Assessors
8. A number of reference appendices were also available including research funding by the Faculty of Medicine by department
9. PGME scholarly activities over July 2010 – June 2011
10. In addition, the 2010-11 PGME annual report was available which gave a good overview of the activities of the Postgraduate Medical Education office at the University of Toronto

Extensive additional information was submitted during the 2 day survey.

ii. FACULTY RESPONSE TO PREVIOUS CONCERNS FROM THE ROYAL COLLEGE AND COLLEGE OF FAMILY PHYSICIANS OF CANADA CHAIRS' REPORT APRIL15-20TH, 2007

1. Variable engagement of residents in Quality Assurance (QA)/Quality Improvement (QI).

Resolved. There were concerns at the last review that there was little or no engagement by residents in any ongoing quality review program throughout their residency. There has been increased attention paid to QA and QI in order to meet this accreditation standard as well as to provide more direct instruction to the residents. Many programs do initiate quality improvement activities and, as well, in the PGCorEd™ program there is exposure within patient safety module and also in other parts of the PGCorEd™ curriculum. Participation of the residents in these mandatory modules is monitored.

2. Loss of opportunity for formative face-to-face evaluations of residents.

Closely monitored. As with many institutions that have web-based evaluation systems, there were problems in the past with decreasing frequency of face to face evaluations. This has been addressed through implementation of the POWER Program Report (report cards) for Program Directors. This has been tracked and there has been an increase in the face to face evaluations from the ITERs by nearly 15%

from 2008 to 2009 academic year. There has been ongoing focus on this from the program directors point of view. In some programs, the supervisor and resident fill out the ITER on the computer screen together near the end of the rotation. In addition, there has been modification in the wording at the end of the ITER so that it is more explicit that a face-to-face meeting had occurred and that the evaluation was discussed. There is ongoing harmonization between the undergraduate and postgraduate processes of evaluation.

3. *Variable engagement by residents in program/teacher evaluation.*

Improved and being monitored. At the last review there were challenges and questions about how actively the residents' input was sought into the evaluation of sites, rotations and specific teachers. This has been dealt with through a number of initiatives using the POWER system, including the "report cards" noted previously. The rate of evaluation of rotations and teachers is centrally tracked and reported using POWER. There is also heightened focus on evaluation in the internal reviews and also research into the best practices of teacher evaluation.

Clinical teachers now have a Teacher Effectiveness Score (TES) which is an aggregate of three or more individual evaluations shared (usually annually) with the teacher as well as the leader of their division or department and the Program Director of the residency program in which they teach.. This TES is presented along with similar UG evaluations. Forms have also been shortened to make them more practical and there is an opportunity for free form texting on forms to give that added context to some of the evaluations. There has also been an initiative called "BEST PRACTICES IN TEACHER ASSESSMENT" (BPTA) WORKING GROUP which worked through a number of challenges and improved the process.

4. *Limited clinical information system interfunctionality across sites.*

Unresolved. At the last review there were problems with information transfer and registration of residents between sites and there was concern about patient safety risks and inefficiencies in care and training. **This is an ongoing issue** and highlights the challenges between various hospital sites. Even though there is a very active forum for Vice Presidents and Directors of Education in hospitals to meet with university representatives (HUEC) representatives, there continues to be definite silos between individual hospitals. These are barriers not only to clinical information systems but also hospital medical education office registration for postgraduate medical education trainees as they move between sites. More will be presented

within the report.

5. *Incomplete funding of the full PGME enterprise.*

Continues although improved. There were challenges with proper comprehensive funding of PGME at the last review. This issue has been addressed as best as possible through better funding by the Ministry of Health and Long Term Care. In addition, there has been additional funding for supervisors of postgraduate medical education in the various community-based settings. This is a work in progress as full funding has not yet occurred but is anticipated to be in place for community preceptors in the next 1 – 2 years. At present the Ministry is funding further expansion of the 26 RCPSC PGY-1 spots that U of T has designated to increase from 2011 to 2015 with $25,000 startup for each specialty resident position as well as ongoing money of $20,000 per year per resident. In addition to this, there is money for community preceptors for direct supervision of residents doing RCPSC specialty rotations ($1,000 for 4 weeks). There is anticipation with that there may be an additional $500 per 4-week block for "indirect" supervision once the full budget is realized provincially.

6. *Lack of fully developed, coherent provincial Human Health Resource planning which does not enable the faculty to meet fully some of its social accountability objectives.*

Improved. At the time of the last review, there were challenges with very short time lines in adding PGY-1 positions. This has improved and there is a quota allocation subcommittee of PGMEAC which meets regularly once to twice per year and considers the physician requirements modeling that has been accepted by the Ministry of Health, along with other factors. As well, there are large numbers (~65 per year) of International Medical Graduates that are accepted into the University of Toronto residency education structured to meet other societal needs.

7. *The development of new partners fully committed to postgraduate medical education mission will be critical to the success of the expansion to the Mississauga campus.*

Resolved. At the time of the last review, the Mississauga campus was just in development. Now much work has been put into developing the Mississauga campus. The two hospitals (Trillium Health Centre and Credit Valley Hospital) have just merged and the previously identified challenges were dealt with in a number of ways. Drs. Carol Herbert and Joanna Bates reviewed the Distributed Medical Education issues in 2009 and this has guided the University of Toronto's initiative to develop the Mississauga campus. Coordination of this ongoing expansion was led by Dr. Catharine Whiteside with the full involvement of Dr. Salvatore

Spadafora, Dr. Sarita Verma and Postgraduate Medical Education. The hospital CEOs and Vice-Deans of both UGME and PGME are fully engaged and a budget has been developed and accepted. There are now initiatives in place to recruit and develop faculty. In our meeting with the leadership of the Mississauga group, there seems to be full engagement and excited anticipation of this development.

Recently the Office of Integrated Medical Education has been developed to coordinate integrated (distributed) medical education. Two thirds of the funding is from PG sources and at present there is only one staff member.

II. UNIVERSITY STRUCTURE FOR POSTGRADUATE MEDICAL EDUCATION (Standard A1)

i. SENIOR FACULTY OFFICER (A1.1)

Dr. Salvatore Spadafora is the Vice Dean Postgraduate Medical Education. He has been in his position since January 2010 and his position is 0.75 FTE. Dr Spadafora is seen as a very knowledgeable leader and the "go to" person. In addition to this, since July 2011, Dr. Glen Bandiera is now the Associate Dean, Postgraduate Medical Education with direct responsibility for admissions and evaluation. This position is a 0.5 FTE. Even though the migration to having two associate leaders for postgraduate medical education at the University of Toronto has just occurred, it seems to be a relatively seamless transition. This structure had been in place previously when Dr. Sarita Verma was the Vice Dean, Postgraduate Medical Education. The role of the Vice Dean, Postgraduate Medical Education is appropriate and does meet the accreditation standards for overall conduct and supervision of PGME within the Faculty of Medicine at the University of Toronto. The Vice Dean reports directly to the Dean and sits on the Faculty Executive Committee and the Dean's Executive Committee Co-academic Group. In addition, Dr. Spadafora is a member of the Clinical Chairs' Committee as well as the Clinical and Basic Science Chairs' Committee. He chairs the Postgraduate Medical Education Advisory Committee. Dr Spadafora, the Vice Dean, PGME is directly involved with the Mississauga development through the Academy Steering Committee and the Academic Partnership Steering Committee. He sits on a number of other local, provincial and national committees related to postgraduate medical education and distributed medical education for the University of Toronto.

In addition to the central infrastructure many departments have an

extensive educational infrastructure including Vice Chairs of Education. The administrative and educational infrastructure at University of Toronto is enviable.

ii. POSTGRADUATE MEDICAL EDUCATION COMMITTEE

a. Description (A1.2)

There are terms of reference, which were recently revised (May 2010). There are representatives from the Departments as well as the hospitals, PAIRO and the CI program (see below). The committee meets 7 – 8 times per year with appropriate agenda and minutes and the PG representatives of the major departments are present.

The full cadre of program directors meets twice a year. The meeting incorporates information sharing and Program Director development.

Developments that the committee has completed recently include engagement with industry policy, remediation plans template, and ongoing internal reviews. The meetings are described as productive and collegial.

b. Composition (A1.2)

Subcommittee(s) (A1.2.2)
Membership (A1.2.4)

Subcommittees include the

1. POWER Steering Committee which meets quarterly
2. Internal Review Committee which meets monthly (for the three years prior to accreditation)
3. Postgraduate Awards Committee (meets once per year)
4. Awards Adjudication Committee (meets twice a year)
5. Quota Allocation Subcommittee which meets a minimum of once per year but usually meets 2 – 3 times per year.

Membership includes PG representatives (in the form of key program directors) from the Departments of Pediatrics, Family Medicine, Medicine, Ophthalmology, Anesthesia, Surgery, Radiation Oncology, Psychiatry, Otolaryngology, Diagnostic Radiology, Obstetrics and Gynecology and Lab Medicine. The Program Director for CIP sits on the committee. There are also a number of hospital representatives including Sunnybrook Health Centre, St. Michael's Hospital, and Mount Sinai. There are four residents from PAIRO that sit on the committee.

It was noted throughout the two-day meeting that residents were very well engaged and represented within the committee structure of postgraduate medical education. They were also empowered as full members of the committees. PGME office has no difficulty in obtaining committee participants.

iii. POLICIES & FUNCTIONS

a. Policies (A1.3.1)

There are a full number of policies that cover postgraduate medical education. Policies are developed by the committee and existing policies are reviewed regularly.

b. Resources (A1.3.4)
   1. Postgraduate Office Staff
   2. Residency Programs

There are 31 staff (in 2005 there were 7) within the PG office that are divided into 4 areas with Directors for each:

Policy and Analysis
Operations
Resident Wellness
Education and Research

The PG office is seen to be well run and incredibly helpful, especially with challenging problems. Support for legal issues has been excellent. This was echoed by Program Directors and administrative assistants. Loreta Muharuma was seen as a wealth of experience and knowledge.

Departments are responsible for their programs. Inadequate resources did not seem to be an issue. The Vice Dean identified office space as a potential issue for PGME, however, at the present time, postgraduate education appeared to have an adequate amount of space to house their current endeavors. There seemed to be adequate resources within the PG office.

c. Evaluation & Promotion (A1.3.5)

There is a well developed evaluation policy that has recently been reviewed. This links into the Board of Examiners, which as a process, is very resident friendly. The Board of Examiners process is intensive, requiring Program Directors to

demonstrate and justify remediation programs suitable for the residents. The Board of Examiners provides useful guidance for the Family Medicine Program when dealing with residents in difficulty although the process was referred to as "rigorous and laborious". The Family Medicine program did note some faculty burnout from the prolonged remediation efforts that are developed in conjunction with the Board. The POWER system was seen to be a very effective system to facilitate evaluation for residents, rotations and faculty. The POWER Steering Committee, started in 2006, has been a very helpful structure to enable changes for improvement.

d. Appeals (A1.3.6)

Because of the efficacy of the Board of Examiners there have been very few Appeals as vetting of the remediation process is robust. There was concern by the survey team as to whether the rigor of the BOE process was a barrier to programs from bringing forward residents in difficulty. In reality there was little evidence of this (except please see comments re: Family Medicine).

In addition to the Board of Examiners there is a separate board that looks at effects of medical conditions for success of a resident. The Board of Medical Assessors (BMA) is advisory to the Dean and serves as a confidential process that assesses whether a resident has a medical condition which may impact participation or performance in a training program and advises regarding further participation or required accommodations. Programs may be modified according to challenges that a resident may have within a residency or as they return to their residency from a leave. This was seen as a strength.

e. Environment (A1.3.7)
1. Intimidation & Harassment
2. Safety

During the two day review the survey team did not encounter any situations of Intimidation or Harassment. There was concern about some inconsistencies dealing with safety between sites e.g. Sunnybrook call rooms are isolated in the basement. Please see resident report.

The Resident Wellness office was seen to be an asset with Dr Susan Edwards as the (half time) director and Christopher Hurst as a fulltime consultant who counsels but also provides education and research in trainee well being and performance. In 2010-11, this office saw 103 PG trainees (out of 3000) for a

total number of 338 visits with numbers of trainees and visits increasing yearly.

f. Supervision (A1.3.9)

Supervision was appropriate and there was appropriate graded responsibility for residents and fellows. The BOE provides oversight with respect to modifications for supervision in the context of residents in difficulty. Patient safety is always the prime concern for all supervision assessments.

g. CanMEDS (A1.3.10)

Much is done within the individual programs regarding training and evaluation of residents within the CanMEDS framework. The survey team did not evaluate individual programs but did hear from individual residents of CanMEDS initiatives.

PGME has developed a core program for the junior residents (PGY-1-2), known as PGCorED™. Consistent feedback during the 2 day review was that PGCorEd™ was a valuable initiative but did lack some program specific context. However in this form it was meant to be applicable to all junior residents. Evaluations that were shared with the survey team showed that overall residents felt it was helpful with improved pre- and post-testing scores. Clearly PGCorEd™ is challenged to meet the needs of all PG learners as residents come from many different backgrounds. Some learners that have graduated from Canadian Medical Schools may have had extensive curricula in these topics while other learners may not have had an extensive exposure. The potential for this Core program is huge and perhaps individual programs can adopt this further in order to be relevant to their program. As such PGCorEd™ is a work in process. It was also not clear to the survey team as to how much residency programs solely relied on PGCorEd™ for all their CanMEDS needs. Several residents and faculty commented that it would be better for their learning if the PGCorEd™ modules were further tailored and more discipline-specific. For example, the communication skills necessary in diagnostic radiology or pathology might require a different skill set than those of family medicine. The Palliative Care Module uniformly was felt to be good.

Similarly the Family Medicine Program felt that the PGCorEd™ program could be developed further and made more relevant to Family Medicine. However it was felt to be useful in ensuring a basal level of knowledge as well it could have some applicability to IMG training or for focused areas of training

such as end of life care.

h. Faculty Development (A1.3.11)

PGME offers Faculty development for mainly program directors but also for preceptors. The Wellness Office has planned to run 21 workshops for RESIDENTS in 2011-12 and is embarking on a partnership with faculty development.

IV. INTERNAL REVIEW PROCESS (A1.3.3)

The Internal Review process was viewed as robust with an Internal Review Committee (IRC) that functions very well. Dr Glen Bandiera chairs the Internal Review Committee but during his sabbatical, Dr Ari Zaretsky seamlessly chaired the IRC. The Committee meets monthly with 4-6 programs reviewed per meeting. A comprehensive schedule and process was shared with the survey team. The Internal Review reports were done to standard. Repeat reviews are occurring in programs where concerns remain. There is extensive resident involvement. Dr Sue Glover-Takahashi and the PG office are commended for the extensive support for the IRC.

Family Medicine department felt that the Internal Review Committee does not fully follow the CFPC accreditation process but is felt to be useful in examining each of the sites in detail. This may need further discussion to assess concerns, as there has been a national harmonization of the RC and CFP accreditation process.

V. RELATIONSHIP AMONGST RESIDENCY PROGRAMS, PARTICULARLY FAMILY MEDICINE AND SPECIALTIES

There seems to be excellent relationships between various programs within and between departments.

The surveyors met with members from the Department Family and Community Medicine. The Postgraduate program in Family Medicine has undergone rapid expansion, with the addition of 4 new training sites in the last 5 years. The Program reports good support from the PGME office in helping to achieve this expansion. Family medicine resident numbers will reach steady state by 2013.

Although residents from Royal College specialties are sometimes directed by the BOE to apply to Family Medicine,

the FM Program does not feel pressured by the PGME office to take unsuitable candidates. They did, however, allude to some pressure and challenges from the residents themselves related to not taking these residents. Within their limited experience with the Board of Medical Assessors, the program feels it works well for dealing with residents with challenging circumstances. The PGME office has subsidized remedial training for IMGs, which has been appreciated. Family Medicine feels that there has been a cultural shift within PGME at U of T over the last 15 years towards Family Medicine training.

During the two-day review it was felt there were very collegial relationships between various departments and training programs.

VI. RELATIONSHIP WITH THE LICENSING BODIES

The relationship with the CPSO is highly functional. CPSO is a member of the PGMEAC and also interacts at the provincial committee (PGE-COFM). The CPSO and the PG office communicate constantly and easily as needed about residents and fellows.

III. HOSPITALS AND OTHER INSTITUTIONS PARTICIPATING IN POSTGRADUATE PROGRAMS (Standard A2)

There is good communication between Hospital University Education Committee and PGME but there was confusion about where some issues lay whether it is at HUEC, which is more granular and has a medical education focus or TAHSNe which has more of an Interprofessional flavor. There are affiliation agreements covering all 28 Hospital sites, both academic and community affiliates, and spanning 5 LHINs. The Medical Education Offices within the hospitals are well structured and very supportive of postgraduate medical education.

There seems to be at times inconsistent funding/resources for hospitals to implement PGME education initiatives. There was concern expressed that with deepening budget challenges funding of PG education will become more challenging in the future.

The Department of Family and Community Medicine raised concern regarding the Family Medicine teaching units. With fiscal restraints, there is concern that support to these Hospital based units may be cut. Members of HUEC echoed this concern. However it is noted that the majority of fiscal support to Family Medicine travels directly to the Family Medicine Teaching units and the Family Health Teams, not

through the hospitals.

The most recent development is the merger of Credit Valley Hospital and Trillium resulting in one institution with 1200 beds and 185,000 ER visits annually. In discussion with the Mississauga team there was enthusiasm for their involvement in Medical Education and a sense that there was adequate funding.

IV. LIAISON AND COMMUNICATION BETWEEN THE FACULTY AND PARTICIPATING INSTITUTIONS (Standard A3)

This liaison is robust and there are up to date affiliation agreements between the University and the participatory hospitals and other institutions. There was some confusion as to where issues lay in specific cases i.e. with HUEC and TAHSNe committees.

Streamlining of the appointment process for community faculty is seen as a good step forward and the academic departments in Toronto are much more engaged in the process. Dr Bohnen as Vice Dean Clinical Affairs has simplified the process and this was shared with the survey team.

V. REVIEW OF ISSUES PERTAINING TO ALL PROGRAMS

i. RESEARCH

Research at the University of Toronto is an impressive initiative with many research opportunities available within basic science, clinical and education venues. Overall the Faculty has over $600 million in funding with approximately a third of all Canada Research Chairs. The largest Clinician Investigator Program in the country is based in Toronto and the Program Director of CIP was very engaged. In addition the CIP has developed a CIP-specific PGCorED research module.

ii. BIOMEDICAL ETHICS

No concerns were encountered in Biomedical Ethics in the 2 day review. There are active Research Ethics Boards (REB) in all institutions. There is a TASHNE Research Ethics Committee (Terms of Reference Jan 2010) that has been struck to assist with University and Hospital REBs.

iii. COMMUNICATION SKILLS

Well covered centrally. The survey did not review individual programs but in discussion with the small sample of residents it seems as though this is well covered within programs.

iv. MEDICAL AND LEGAL CONSTRAINTS WHICH AFFECT RESIDENCY EDUCATION

There seemed to be no concerns from a legal or medical point of view that adversely affected postgraduate medical education.

v. TEACHING SKILLS

Teaching is highly valued at the University of Toronto. Residents are expected to teach medical students as well as other health care professionals. Teaching activity is recognized as criteria for Faculty promotion.

vi. QUALITY ASSURANCE/IMPROVEMENT (CQA/CQI)

This is now a resolved issue as these initiatives have a much greater level of importance amongst the programs. PGCorEd™ modules have assisted with this and at the more senior levels there are program specific initiatives.

vii. OTHER

There were concerns raised by both surgical and non surgical residents about the exemption by the Department of Surgery in meeting the current PAIRO call/duty hour requirements. It was felt that the Educational motivation for this was actually much more based in a service requirement than education (See #10 under Meetings with residents).

Even though the survey team did not meet with individual programs it was apparent that there seemed to be variable protection of academic half-day time in a small number of programs.

Fellows were seen as a great assistance to the residents during their training. The only exception, cited by some residents, was in which communications were challenging with some fellows who have English as a second language. The Hospital for Sick Children was given as an example in which there were challenges of communications between residents and fellows.

The Office of Integrated Medical Education has recently been developed and is under the direct supervision of the Deputy Dean Dr Sarita Verma. With one staff member, Ms. Wendy Kubasik (and an assistant), variable funding for residents between departments and new initiatives in Mississauga (University of Toronto – Mississauga Academy of Medicine) it will need to be monitored closely.

VI. GENERAL COMMENTS

i. Meetings with residents

Residents were well engaged with PGME office and as such were active members of the many committees we met with over the 2 days. The high level of resident involvement on committees was impressive. The PGME office should be commended on its efforts to actively involve residents in committees and in the Faculty Council's Board of Examiners-PG.
Some specific comments made:

1. PGCorEd™ – see CanMEDS (A1.3.9)

2. Transitions between sites – residents are frustrated with the amount of time and effort required for each rotation change between hospital sites to register e.g. obtaining scrubs, ID cards, learn new computer systems etc. Residents are often taking a half day post call or at the beginning of a rotation to complete these administrative tasks. Residents in Royal College programs often have to do multiple computer training sessions at the same site during their training. Suggestions were made that it would be much more efficient for them to obtain either a standard badge or have a centralized location to obtain badges (perhaps the PGME office). Rigid timelines for expiration of passwords was seen as a barrier for patient care, patient safety, and potentiating medical error.

3. Variance of Occupational health expectations – Occupation related health risks such as needle sticks appear to be handled differently at different institutions. In some sites following a possible body fluid exposure, residents are required to obtain consent from the patient source for blood borne illness testing.

4. Safety – Residents raised isolated concerns about safety (e.g. Sunnybrook – lockers in an isolated area of the basement), but generally residents feel that that they have access to support such as security. There have been concerns in the past with paging at hospitals giving patients resident cell phones numbers to patients. This however was rectified quickly when identified.

5. Call rooms-concerns were expressed about rooms at Sunnybrook (location concerns) and St Joseph's Hospital (cleanliness concerns, with report of cockroaches)

6. Central evaluation forms (in POWER) worked very well – residents able to complete these without difficulty

7. Inconsistent funding for out-of-town/distributed medical education rotation – funding appears to vary by individual program. With the integration of the new Mississauga Academy of Medicine and its teaching hospital sites in Mississauga, it will become even more important for there to be a unified, comprehensive infrastructure and policy for Integrated ME funding regarding travel and accommodation. The residents did mention that there is a cost burden associated with mandatory rotations that are at a distance from their home site.

8. Residents feel they could access the Resident Wellness resources within the PGME office if needed. This was felt to be a strength.

9. Career Advice: Multiple residents (especially from the surgical disciplines) expressed concerns regarding the number of new residency spots/fellows being accepted, despite the difficulties obtaining a job in these disciplines. More information about job-seeking and career prospects would be appreciated by the residents. Residents felt that many of the chief residents go on to do fellowships partly because that was the ethos of the training program but also to await employment opportunities.

10. Regarding PAIRO home after handover/home by noon standards, residents from the surgical and non surgical specialties commented that programs/staff are not fully compliant. Comments from some of the residents indicated that there was an unspoken expectation of house staff to stay post-call despite PAIRO rules. There was concern expressed by many residents that they (the residents) did not understand the need for surgical residents to not comply with PAIRO requirements for home after handover.

ii. Other

There remained some confusion where HUEC vs. TAHSNe fit into the PGME enterprise. Continued clarification of roles and responsibilities of the 2 committees will need to be monitored.

VII. STRENGTHS & AREAS TO IMPROVE (A standards - July 2011)

Strengths

1. PG office resources and administrative support-The PG office, with the 4 directors, seems to work seamlessly. Ms Loreta Muharuma is seen as a wealth of information. Caroline Abrahams and Susan Glover-Takahashi guide their parts of the PG office with expertise. The office has a clear organizational structure and with so many people involved the communication is seen to be exemplary. (A1.2, A1.3)
2. PG Dean/Deanery-Dr Spadafora is seen as approachable, energetic and always available. The addition of Dr Bandiera to the PG Deanery is seen as very positive. Excellent support from the Dean and Deputy Dean. (A1.1)
3. Strong resident involvement-throughout the 2 days review the resident involvement was laudatory. (A1.2.4.3)
4. Resident wellness program-Dr Susan Edwards is a dedicated director of the program. She is to be congratulated on an excellent program that is a resource, and has one that has developed similar initiatives within the individual PG training programs (A1.3.7)
5. POWER- developing nicely and allows scheduling, assessments as well as support for the Integrated Medical Education Initiative (A1.3.9)
6. Faculty Engagement (A1.3.9, A1.3.11)
7. Hospital Engagement (A2.2, A3)
8. Board of Examiners and Medical Assessors (A1.3.5, A1.3.6)
9. Internal Review Committee (A1.3.3)

Areas to Improve

Ongoing Challenges

1. Hospital Sites (A2)

    - Call rooms-Sunnybrook Hospital and St Joseph's Hospital (A2)

    - Variability for occupational health and safety for residents (ie needle stick) (A1.3.8, A2.6)

    - Variable Computer systems between hospitals (A2.1)

    - Lack of Coordination between Various Hospitals for Administrative requirements for residents, when transitioning between sites-frequent renewal of computer orientation and annual renewal of badges (A2.1)

New Challenges

1. PGCorEd™ – This program may need to develop further, from a generic program, to give examples that are specialty specific. It was felt by the survey team that this was a good idea that needed to be made more program-centric than as it presently exists. Program Directors need to take further ownership of this initiative. (A1.3.10)

Vulnerabilities not encompassed by A standards:

1. PAIRO-CAHO guidelines - Concern regarding challenges within the surgical programs to adhere to the home post call/handover requirements

2. Integrated Medical Education

   (i) Extent of support:
   With only one staff member for O-IME there is concern whether this will be adequate to support this large initiative

   (ii) Consistent and Ongoing Funding for Integrated Medical Education:
   There is variability for funding between various department and programs. As mandatory community rotations are being established in some specialty programs, questions regarding travel and related expenses have arisen from the residents.

3. Community Sites-ongoing expansion to community sites to support the 26 new Royal College positions will need to be followed closely to ensure that overall training programs remain robust.