



**UNIVERSITY OF TORONTO
REGULAR ON-SITE SURVEY**

APRIL 7 TO 12, 2013

I. INTRODUCTION

i. ORGANIZATION OF THE SURVEY

Two teams of surveyors representing the Royal College of Physicians and Surgeons of Canada (Royal College) and the College of Family Physicians of Canada (CFPC) visited the University of Toronto during the week of April 7 through 12, 2013. Forty-nine currently active residency programs (42 Royal College, 6 CFPC and 1 jointly accredited) were surveyed. The University of Toronto consented to participate in a pilot that resulted in the exemption from site visit of twenty-three Royal College programs. In addition five Royal College programs were not scheduled for survey at this time and three programs were inactive.

The Royal College survey team, chaired by Dr. Kamal Rungta (deputy chairs, Drs. Joanne Todesco and Anurag Saxena) comprised 29 members from 9 Canadian universities with broad experience in postgraduate medical education and familiarity with the Royal College accreditation process. Representatives of the Federation of Medical Regulatory Authorities of Canada (FMRAC), and the Canadian Association of Internes and Residents (CAIR) provided uniquely valuable perspectives and input.

The CFPC survey team, chaired by Dr. Jennifer Hall included 15 surveyors from 10 Canadian universities with similar residency education and accreditation experience. This team also included representation from CAIR and the Federation of Medical Regulatory Authorities of Canada (FMRAC).

The Chairs Team reviewed the A Standards and included Dr. Kamal Rungta, Dr. Joanne Todesco, Dr. Anurag Saxena, Dr. Samantha Kelleher and Dr. Tom Laughlin. We are very grateful for all their work during the survey but also for their significant contribution to the writing of this report.

SURVEY TEAM MEMBERS

Royal College	CFPC
CHAIR Dr. Kam Rungta	CHAIR Dr. Jennifer Hall
DEPUTY CHAIRS Dr. Anurag Saxena Dr. Joanne Todesco	A STANDARDS REVIEWER Dr. Tom Laughlin

SURVEY TEAM MEMBERS

Royal College		CFPC
SURVEYORS		SURVEYORS
Dr. Hallgrimur Benediktsson	Dr. Roderick MacArthur	Dr. Steve Beerman
Dr. Mary Bennett	Dr. Donald Palisaitis	Dr. Carolle Bernier
Dr. Jacques Bouchard	Dr. Kimberly St. John	Dr. Alan Chaput
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Dr. Karen Fung Kee Fung	Dr. Theresa Trotter	Dr. Karlyne Dufour
Dr. Anne Fournier	Dr. Cathy Vardy	Dr. Geoff Hodgetts
Dr. Christopher Glover	Dr. Mary Wells	Dr. Doug Klein
Dr. Stephanie Kaiser	Dr. Clinton Wong	Dr. Andries Muller
Dr. Barry Kassen	Dr. Clifford Yaffe	Dr. Sonja Reichert
Dr. Sheryl Koski	Dr. Verna Yiu	Dr. Karen Schultz
Dr. Tammy Keough-Ryan		Dr. Allyn Walsh
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The survey teams thank all the residents, faculty, staff and administrative leads at the University of Toronto (UT) and the affiliated sites of the Toronto Academic Health Sciences Network (TAHSN) for the tremendous effort they put in to assure the excellence of their residency programs and thorough and thoughtful preparation for our visit.

We were humbled by the incredible hospitality, open and constructive dialogue in an environment of warmth and generosity at every level, from the Provost Dr. Cheryl Misak, the Decanal team led by Dean Dr. Catharine Whiteside and Deputy Dean Dr. Sarita Verma, the CEOs and senior education leads at the 14 of 27 affiliated sites visited but particularly the Postgraduate Medical Education (PGME) office led by Vice Dean Sal Spadafora, Associate Dean Glen Bandiera and four directors, Ms. Caroline Abrahams, Ms. Loretta Muharuma, Dr. Susan Edwards and Dr. Susan Glover-Takahashi. A special thank you to all the department and division chairs, program directors, program administrators and residency program committees for all the work they contribute to the training of residents.

ii. CONCERNS NOTED AT THE TIME OF THE LAST SURVEY

1. Variable engagement of residents in QA/QI.
2. Loss of opportunity for formative face-to-face evaluation of residents.
3. Variable engagement by residents in program/teacher evaluation.
4. Limited Clinical Information System inter-functionality across sites.
5. Incomplete funding of the full PGME enterprise.
6. Lack of fully developed, coherent provincial Human Health Resource planning does not enable the Faculty to meet fully some of its social accountability objectives.
7. The development of new partners fully committed to the PGME mission will be critical to the success of the expansion to the Mississauga campus.

iii. FACULTY RESPONSE TO PREVIOUS CONCERNS**1. *Variable engagement of residents in QA/QI.***

The hands-on engagement of residents in QA/QI programs has improved. An intensified focus through the internal review process has been helpful. The PGME web-based modules (PGCorEd) as an effective way to educate residents regarding patient safety and QA concepts will require re-examination. Residents did not support PGCorEd as a valuable educational experience. The hospital environments offer rich and welcoming opportunities for residents to be involved in QA/QI projects, however many residents indicated a tendency to participate in non-hospital-based QA/QI projects with some exceptions, including Southlake Hospital and Toronto East General.

2. *Loss of opportunity for formative face-to-face evaluation of residents.*

There has been considerable improvement in face-to-face evaluation of residents. The PGME initiatives that include faculty development, program report cards and revised resident reporting on In-Training Evaluation Reports (ITER), are highly successful in bringing this about.

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

The PGME office has championed several initiatives that have helped substantially reduce the variability in residents completing evaluations of programs/rotations and teachers. The Postgraduate Web Evaluation and Registration (POWER) platform has had significant systems-level enhancements in the central tracking and reporting of completion rates. The sharing of aggregate rotation and teaching effectiveness scores with the TAHSN hospital education leaders is an excellent development in closing a very important feedback loop.

Many programs cited some limitations in the evaluation of teachers by residents. These included; residents only being required to complete one teacher evaluation even though a few might have been involved in their teaching, evaluations of teachers in programs with residents from multiple feeder programs are not being aggregated and as a result not released till there were a minimum of three evaluations present in each feeder program. There is inconsistent use by programs of the available toggle function that ensures that residents are not able to view their online ITER until after they have completed their teacher evaluations.

4. *Limited Clinical Information System inter-functionality across sites.*

There has been relatively little improvement on this system wide issue. There is considerable impact related to the optimal infrastructure not being available to PGME for the clinical training of residents. In 2007 it was noted, "The existing Clinical Information Systems of the affiliated hospitals are not inter-functional. These systems appear to have been developed independently resulting in loss of ready information between sites. This presents potential risks to patient safety and results in frequent citations by residents of resulting inefficiencies in their care delivery and training". This statement remains

accurate today. Initiatives including Connect GTA and Patient results Online (PRO) show some hope of a comprehensive system being in place by the time of the next regular survey.

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

To state that the funding of PGME at the University of Toronto is complicated is an understatement. There have been substantial increases to PGME funding from a variety of sources. Of particular importance is the academic and overhead support provided based on medical learner days, to four large community affiliates (Trillium Health Partners, St. Joseph's Health Centre, North York General hospital and Toronto East General Hospital) and compensation for all community based faculty preceptors. There has been one time start-up and base funding support for infrastructure and equipment for specialty expansion. There has been however a reduction in the funding of IMGs which will require monitoring. The uneven support to residency programs will be detailed under II iii (b) – Resources.

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

The Quota Allocation subcommittee reports to the PGMEAC and is charged with determining the criteria and processes for the allocation of residency positions to programs. Training the right number, mix and distribution of physician specialists to meet societal needs is endorsed as a recommendation in the Future of Medical Education (FMEC) MD and PG reports. The Postgraduate Management Committee (PGM:COFM) as it's terms of reference confirm, uses a collaborative approach including the Ontario Faculties of Medicine and the Ontario Ministry of Health and Long-Term Care (MOHLTC) to decide on appropriate allocation of PGY 1 CMG and IMG positions. They use a number of models to assist, the most prominent being the 2010 MOHLTC, Ontario Medical Association (OMA) and Conference Board of Canada report "Filling an Evidence Gap". In 2012, a provincial human resource subcommittee was struck to look at the process and outcomes of the annual quotas allocation for Ontario. The membership includes the Associate Dean-PGME Admissions and Evaluation as well as the PGME Director of policy and Analysis. These initiatives are excellent developments in the very complex and often poorly predictable domain of human health resource planning.

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

The Office of Integrated Medical Education (OIME) initiatives have been successful in building these partnerships through faculty development, streamlining faculty appointments, relationship building both with the medical communities and other allied health care professionals, development of an awards program and appropriate payment of undergraduate and postgraduate non AFP medical educators. The next challenge to ensure payment of other professionals has been identified.

The Mississauga Campus is well represented on the various postgraduate committees. The leadership of this initiative in integrated medical education are highly motivated and the sites are well-resourced. The education mission is a clear priority for the President and CEO as well as the Chief of Staff, Department Heads, and Education site leaders. They have been proactive and realistic in preparing for the expansion of learner numbers. This includes appropriate policy development, infrastructure, and excellent resident orientation process. Their main concern is that the annual intake of learners will be predictable and stable. There is some apprehension regarding sufficient living accommodation for residents near the Mississauga teaching sites.

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

i. SENIOR FACULTY OFFICER (A1.1)

Dr. Salvatore Spadafora was appointed Vice Dean, Postgraduate Medical Education, in July 2010, and is the senior faculty officer responsible for the overall conduct and supervision of PGME within the faculty. He reports to the Dean of Medicine, Dr. Catharine Whiteside. He delegates as appropriate to Dr. Glen Bandiera, Associate Dean – PGME, Admissions and Evaluation. Postgraduate medical education at the University is large and complex. There are 1992 residents in 76 active programs. This represents a 36% increase from the previous survey in 2007. The faculty PGME office is very well resourced and is effectively organized into four primary units each managed by a very capable director.

The Vice Dean also co-chairs the Hospital University Education Committee (HUEC) that includes senior education leaders from each of the 27 affiliated sites of the Toronto Academic Health Sciences Network (TAHSN). This committee serves to enhance the partnership between the Faculty of Medicine and its affiliated teaching hospitals. It defines joint responsibilities for the education and training of residents, defines lines of responsibility and accountability for the delivery of the programs, identifies resources provided by the partners and plans for appropriate resources to sustain the joint education mission. The hospitals are committed to providing excellence in postgraduate medical education.

Dr. Spadafora and his team are highly valued and respected by residents, faculty, staff, university and hospital leaders. They are to be commended for their commitment to quality education for all residents. Their timely responsiveness to residency programs and affiliated partners is a notable strength.

ii. POSTGRADUATE MEDICAL EDUCATION COMMITTEE

a. Description (A1.2)

The Postgraduate Medical Education Advisory Committee (PGMEAC) and/or its subcommittees are responsible for development and review of all aspects of residency education. It is chaired by the Vice Dean, Postgraduate Medical Education. The committee consists of 14 program directors, 4 residents elected by PAIRO, and 5 hospital representatives appointed by the Hospital University Education Committee. Other members include the Associate Dean, PGME, Associate Dean, Equity and Professionalism, Vice Dean, UGME, Representative, CPSO and an Education director, medicine programs. The PGMEAC meets 7 or 8 times per year and keeps minutes of its activity. The six subcommittees (SC) include the Internal Review SC, Quota Allocation SC, PGCorEd SC, Awards Adjudication SC, Postgraduate Awards SC and the POWER SC. They all have clearly defined terms of reference and keep minutes. In addition, there are 2 meetings a year which include program directors from all accredited programs. The strengths of this committee include easily accessible PGME office and central support, well integrated hospital coordinators, learner centric, resident focused for their wellness and effective communications.

iii. POLICIES & FUNCTIONS

a. Policies (A1.3.1)

The PGMEAC establishes and monitors general policies for residency education. All policies are reviewed within the six-year accreditation cycle. This is accomplished by the review of one or two policies at each of its meetings. The policies are available on the central FOM Education Policy web archive and new and updated policies are distributed to all the appropriate people.

b. Resources (A1.3.4)

The PGME office is very well resourced. It includes the Vice Dean, Associate Dean, four directors and thirty staff. It is organized into four units that function effectively in a very co-ordinated and collaborative manner. Program directors and administrators were particularly impressed with the timely and helpful responsiveness of the office staff.

Although there is distribution of resources necessary for effective education in the residency programs, the distribution is not equitable, such that several programs did not have adequate resources for program directors and particularly program administrators to carry out their responsibilities. Many program directors reported not having enough protected time/stipends. Program administrators in a number of programs felt their workload was excessive and did not seem to have an effective mechanism in place to deal with this issue. This uneven resourcing of programs requires immediate review and there should be accountability for the educational resources disbursed to departments and divisions for the delivery of residency programs.

c. Assessment & Promotion (A1.3.5)

The Postgraduate Web Evaluation and Registration (POWER) platform developed specifically to serve PGME has had significant enhancements that have been largely effective in increasing face-to-face resident assessments and improving the engagement of residents to consistently evaluate rotations and teachers. There continue to be challenges in ensuring all teachers are assessed when residents are taught by two or more teachers during a rotation. There is also an impediment for teachers receiving their assessments in a timely way in some programs because assessments by residents from different programs are not aggregated to achieve the threshold of three evaluations being available as a condition of release.

There is a superb mechanism for dealing with underperforming and unwell residents. The Board of Examiners (BOE) – PG is appointed by the Faculty Council. It examines the plans made by program directors through their Residency Program Committees regarding underperforming residents including professionalism issues. The BOE –PG weighs in and monitors remediation and probation plans and also uses the services of the office of Resident Wellness in the PGME office and the Board of Medical Assessors where appropriate for residents who are unwell. The outcomes of the BOE are impressive in that residents who are not successfully remediated are transferred to other programs or counselled to choose other careers. There have been no appeals related to their work since the previous survey and very few dismissals.

d. Appeals (A1.3.6)

There is a clearly defined policy on appeals related to postgraduate education decisions that is consistent with appropriate remediation and competency based education.

e. Environment (A1.3.7)

The PGMEAC maintains a policy related to intimidation, harassment and abuse as well as a policy on resident safety. The resident safety policy includes travel, patient encounters and patient transfers. There is a clearly defined mechanism to follow when residents feel they are in an unsafe environment. Program surveys confirmed their satisfaction with the learning environment and attention to their safety. A particular strength is the Red Button found on all web pages that opens up specific instructions to residents on accessing needed help.

f. Supervision (A1.3.9)

There is a well-articulated policy on resident supervision, including resident supervision, developed by the CPSO which the University has adopted for use. There is also an excellent mechanism for the remediation of faculty related to their teaching including professionalism issues.

g. CanMEDS (A1.3.10)

There has been considerable effort in ensuring that all programs teach and evaluate residents' competencies as defined by the CanMEDS and CanMEDS-FM framework. In 2007 the PGME office launched a web-based curriculum called PGCorEd organized in distinct modules designed to teach and assess the intrinsic CanMEDS/CanMEDS-FM roles. Residents are required to complete the modules and achieve a passing score by the end of PGY2. There is a subcommittee of the PGMEAC that provides oversight, monitors and evaluates the outcomes. Although it appeared from the data provided that the intended outcomes were being met through pre and post test scores, residents almost universally voiced their concern about these modules not being an effective way of learning the intrinsic competencies.

Many said that learning regarding CanMEDS/CanMEDS-FM was much more effective while engaged in their clinical work. This may also explain to some extent the data showing that most residents complete the modules in the final 2 months of their PGY2. There may also be a faculty development issue in the comfort and valuing of the CanMEDS/CanMEDS-FM competencies by faculty. The PGMEAC will need to re-examine this initiative.

h. Faculty Development (A1.3.11)

There is a strong emphasis on Faculty development to assist faculty in teaching assessing and mentoring residents' competencies. There are several groups and units involved including the PGME office. Of noteworthy mention is the Centre for Faculty Development at St. Michael's Hospital and the faculty development program at the Mississauga Academy of Medicine.

iv. INTERNAL REVIEW PROCESS (A1.3.3)

The Internal Review process is carried out through the Internal Review Committee (IRC), a subcommittee of the PGMEAC. Since the previous survey a Family Medicine Internal Review Subcommittee (FM-IRSC) has been created reporting to the IRC. They provide detailed, qualitative, formative program evaluation for Royal College and CFPC residency programs. There is an excellent follow up mechanism through update reports and additional reviews as required meeting their mandate to monitor continuous improvement in educational structure, process and outcomes.

Given the apparent rigor of the IRC processes, the survey team noted that a few of the programs surveyed did not meet some basic standards, for example, having program goals and objectives and/or rotation specific objectives organized within the CanMEDS framework; or having In-Training Evaluation reports (ITER) that were not aligned with the objectives. This may be related to inconsistent knowledge and skill among the internal reviewers and merits further examination. In some cases, the IRC did note appropriate weaknesses well in advance of the Royal College survey that were not corrected. Finally, the IRC did not appear to have detected some systemic issues such as inconsistent support for program directors and the problems with PGCorEd noted above.

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

From discussions with multiple groups of residents from multiple sites both Family Medicine and other Specialties there appears to be very good working and interpersonal relationship development. This was particularly obvious at sites that have traditionally trained Family Medicine residents only, and are now taking on more residents from other specialities. In such cases, a Family Medicine resident was often the resident representative on various committees and took great care to ensure the voice of non-Family Medicine residents was included.

vi. RELATIONSHIP WITH THE LICENSING BODIES

The postgraduate program has a good working relationship with the college of physicians and surgeons of Ontario. This is reflected in the incorporation of a CPSO representative on the PGMEAC. This allows for the views and priorities of the CPSO to be directly communicated. The PGMEAC and the fellowship education advisory committee have worked to establish criteria for incoming fellows to document the learning objectives and goals for fellowship training. This document is shared with CPSO to support the appropriate licensing of learners. The post graduate office has incorporated CPSO document regarding supervision as a way to describe the role of residents in the clinical area.

The postgrad office has developed guidelines (similar to policies) to determine processes around blood borne pathogens and harassment. The development of these guidelines has considered the CPSO documents on these topics so that the processes are aligned. There are clear lines of communication for notifying the college when residents are absent from practice for health reasons.

vii. OTHER

There are excellent system wide simulation facilities at Mount Sinai Hospital, Hospital for Sick Children, St. Michael's Hospital and Sunnybrook HSC to mention a few. Access by residents and programs can be an issue as no cohesive faculty/ PGME-wide strategy for effective use, curriculum development and resourcing exists to take full advantage of this excellent educational resource in an equitable manner.

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

The Chair's team visited numerous sites and wishes to acknowledge the hospitality, generosity, and pride demonstrated by our various hosts and tour guides.

The numerous affiliated sites were generally found to be organized to promote the education of residents, with active teaching services, provision of the Standards of Training for each discipline, and opportunities for collaborative practice. The education leads were uniformly praised for their work. All sites were fully accredited by Accreditation Canada at their most recent visit. As noted above there is a robust supervision policy provided to the sites by the PGME Office and in general there was good awareness and adherence. Any individual exceptions are noted in the program survey reports.

There are however a number of logistical problems for residents who train at more than one site. These include difficulty obtaining lab results and other patient information among sites, having a different pager at each site, and being required to repeat modules such as hand-washing, privacy, registration, IT, and mask fitting when changing sites. There were also problems related to the lapsing of passwords and getting assistance from the IT help desks.

Other issues included limited time allotted for scrub exchanges at some sites and the roaming ID badge system including long line-ups on July 1.

A wealth of CQI activities is present among the sites, although as noted above, many residents choose to achieve their CQI requirements outside of the hospital system. This may represent a missed opportunity for both parties.

The importance of resident safety was acknowledged at all levels and few issues were noted. The concerns that were identified tend to overlap with patient safety and require urgent focus. These concerns will be noted in the hospital summaries below.

University Health Network - UHN (includes Toronto General - TGH, Toronto Western - TWH, Princess Margaret, and the Toronto Rehabilitation Institute)

TGH and TWH are tertiary to quaternary hospitals; the former being located downtown and the latter being community based. Both are busy, high acuity hospitals. Princess Margaret is a cancer care facility. The Toronto Rehabilitation Institute comprises widely dispersed facilities, 3 of which offer resident training. Resident Education is a clear priority for the Network, along with interprofessional education and measurement of teacher and learner performance. The Vice President Education, Dr. Brian Hodges collaborates closely with the CEO, Dr. Bob Bell, the Vice Dean, Dr. Spadafora, and the Wilson Institute of which he is a scholar and past Director.

Residents report a high level of patient complexity, excellent exposure to a breadth and quantity of diseases and presentations. They provide a large amount of cross coverage and some residents expressed serious concerns regarding the coverage system. Cross coverage of Code Blue at the Princess Margaret Hospital presents residents with particular logistical issues both in getting themselves to the code within a reasonable time, along with similar issues transporting the patient afterwards. Residents also reported not being able to order x-rays at night at the Princess Margaret.

The Hospital for Sick Children

HSC is committed to education and collaborative learning and has established a Learning Institute. The mission of the Learning Institute is to facilitate learning throughout the organization. This mission is embraced by leadership, including the CEO with the view that HSC is the "hub" of paediatric services and educates and collaborates with community partners to ensure good use of resources.

The Chief of Education position was developed and is committed to education in all forms and to all audiences, residents and other learners, staff, families and the public. There are many opportunities for interprofessional education and this is valued in the organization, (mock codes as an example). The facility includes three simulation labs with high and low fidelity simulation equipment.

The leadership in the organization is aware of the needs of learners. There are links to the University and PGME through a variety of committees including PGMEAC, FEAC, TAHSN, and HUEC. The leadership supports the idea that "learners are woven into the fabric of the organization". This is reflected in the residents' experiences at HSC. Residents feel respected and have good support through the Program Director in Pediatrics. Residents reported having adequate space for work and easy access to computers for patient care and information gathering. Although the hospital library has limited hours, residents did not see this hampering their access to information as on-line resources are utilized.

Residents identified that issues with call rooms such as allocation and equipment have been addressed; this has included assigning call rooms to specific services to ensure space is available, providing a computer in each call room (underway) and provision of food for residents on call. Residents have an annual retreat to review experiences and provide feedback to the Program Director. There were no expressed concerns about safety. All learners at HSC have access to wellness initiatives within the organization.

Residents are involved in quality assurance activities in the hospital, primarily through presentation at morbidity and mortality rounds, other opportunities exist such as critical incident reviews. A Medical Safety Committee exists, which could provide further experience for residents in quality assurance.

It was identified that given the specialized services within HSC, there is excellent exposure to subspecialty areas. There are limitations in terms of access to general

paediatric learning experiences. In addition, the Mental Health Services provided at HSC are limited to outpatient clinics, 2 in-patient beds and the specialized Eating Disorders Unit. The services are currently being reviewed.

HSC accommodates many fellows for training. Proposed fellowships are approved through the Fellowship Education Advisory Committee to ensure that resident learning opportunities are not negatively impacted by the presence of fellows. The education and administrative leads in the hospital ensure that learning contracts for fellows are formalized so that the fellows' role in the clinical setting is clear and distinct from the residents' role. Residents did not perceive competition with fellows for procedures or learning opportunities.

Centre for Addiction and Mental Health (CAMH)

CAMH is a unique facility that has undergone a transformation from an institution setting to a facility providing a broad range of psychiatric assessment and care. The organization has reviewed and reorganized services to utilize resources most appropriately. The emergency department at CAMH is unique as it is designed to deliver urgent and emergent psychiatric assessment and treatment and is staffed by psychiatrists. The hospital has an agreement with Mount Sinai Hospital to address any medical needs of patients seen. CAMH has also developed links to the community through sponsoring health teams, Ontario Network of Shared Care, Telepsychiatry and outreach services to remote areas of Ontario. The Chief of Child Psychiatry is now a link between CAMH and the Hospital for Sick Children.

Through the transformation that CAMH has undergone, the leadership has identified the provision of education as a priority. The commitment to education is demonstrated in the development of the VP of Medical Education position. CAMH has linkages to the University Extra Departmental Education Units and is fostering relationships to enhance Interprofessional Education. There are links to the University and PGME through a variety of committees including PGMEAC, FEAC, TAHSN, and HUEC.

CAMH leadership has recognized the needs of learners as it has undergone review and revision. Safety of residents has been a priority in all areas and is being specifically addressed in the redesign of the new Emergency Department. Residents are provided with personal alarms and incidents that raise concern about safety are thoroughly reviewed with opportunities for learning and skill development. Residents have individual offices, which are safe and clean, especially in newer parts of the facility. There are policies in place for seeing patients in private offices and within the Forensic area; patients are not seen alone or off the unit. Call rooms are in close proximity to the Emergency department and located behind the security office.

The leadership has evaluated the workload within the Emergency department and determined the most appropriate level of coverage by residents and staff to ensure adequate learning. The volume of patient attendances in the emergency department has led the staff to commit to an evening shift on site, working with the resident, providing clinical teaching and supervision.

The educational, research and clinical leaders are clear on the needs of learners and are committed to providing optimal educational experiences to residents in psychiatry. The organization emphasizes meeting the needs of all patients, including addressing the needs of underserved populations and providing culturally sensitive care. The leadership also identifies the importance of training psychiatrists to work in interdisciplinary teams.

Residents identified CAMH as an excellent learning site with a wide range of patients and access to great teachers. They noted that there are many different rotation opportunities from child and adolescent to geriatric psychiatry. There is also a range of research

opportunities for residents to engage in through CAMH. Given that CAMH is a psychiatric hospital, residents did recognize that the experience was different than being in a full service hospital. However, residents noted that they rotate through various hospitals throughout their residency and therefore have other opportunities to work within more traditional hospital settings. The resident offices were noted to be safe with adequate space. The offices are used for seeing stable outpatients or psychotherapy patients and for personal work and study. Residents felt that the office space and common space were adequate and useful.

CAMH is valued as a learning site for psychiatry residents. It was noted that opportunities exist to develop and expand partnerships in shared care at the level of postgraduate residency training to foster appropriate intra-professional relationships and learn the competencies required for collaborative practice.

One concern that was mentioned is that community family physicians are excluded from the patient care team and are discouraged from providing continuity information and care for their patients by requiring written patient consent.

St Michael's Hospital

St Michael's due to its location has a patient population with high acuity and multiple demographics. The volume and variety of patients that present make it an excellent environment for medical training. The Hospital promotes and provides educational opportunities for a wide range of allied health care students and both undergraduate and post graduate medical trainees. One guiding principle of the hospital "Proper education optimizes patient care as well as the educational experience" is consistently implemented. We met with an enthusiastic group of residents who reinforced this was the current day to day functioning of the hospital. The unification of educational purpose created by Dr. Patricia Houston as VP of Education with the Centre for Faculty Development and the education of staff, patients, allied health care professionals and undergraduate and postgraduate medical trainees under her mandate is ideal. The Multi-Disciplinary Student Centre that welcomes and orientates all learners from all professions further advantages St Michael's in this area and has eased the challenges of transitions from other institutions. This centre was identified by multiple groups of residents as best practice that should be duplicated widely. The accreditation team found St. Michael's well connected to the university structure through its affiliation agreements, membership in TAHSN, HUEC and representation on the PGMEAC.

Through the leadership of President and CEO, Dr. Bob Howard St. Michael's has created and maintained a culture of collaboration between clinical services and education. The commitment to education and education development through support of facilities and their programs like the Li Ka Shing International Health Care Education Centre and the Centre for Faculty Development is a strength used and valued by the entire university.

St Michael's Hospital has a very broad range of specialty services with learners in medicine in multiple specialties and at multiple levels. This provides a rich environment for the development of intra-professional relationships in medicine. One exception was noted, in that community Family Physicians do not provide care as the most responsible physician in the institution, which excludes family medicine residents from engaging in this process in their future role as family physicians. It also impact the education of other specialty residents in medicine who may in the future be working in a hospital with robust family medicine involvement as the most responsible physician.

St. Michael's Hospital has a well-developed program for quality assurance which is reviewed annually through a publicly published Quality Improvement Plan. Residents have the opportunity to engage in M and M rounds, case conferences and audits with implementation and follow up of initiatives for improvement. Residents are also

encouraged to lead quality improvement projects.

There were issues expressed by some residents about on call room and locker availability close to their clinical responsibilities, but as a group the residents felt they were either minor, being addressed or an issue for which there was no apparent solution. This facility is in a disadvantaged part of town and has no access for resident parking. This was not viewed as a significant problem by residents as they felt comfortable with the easy access public transit with an escort service (Safe Walk Program) as needed.

The Council of Residents for Education (CORE) is a committee created to ensure appropriate resident training and comfort at St. Michael's. Chief and senior residents are responsible to canvass residents for issues of concern. As needed issues can be taken to the Student Experience Committee to implement appropriate change or referred to the Education Council. This organisation is positively reviewed by the residents. In programs that do not have a chief resident at the facility for the entire academic year, some problems have been identified ensuring off service residents have their specialty specific and individual objectives defined and met. This requires review.

Mount Sinai Hospital

Mount Sinai is a comprehensive health care centre in Toronto with a reputation for excellence in-patient care, teaching and research. Dr. Jacqueline James is the Vice-President Education, who also represents Mount Sinai on the Toronto Academic Health Sciences Network. There is a very strong education culture in the hospital and this is reflected in the consistently higher scores on learner engagement surveys, comments by the residents and the site education leads. The specific strengths include a positive nurturing collaborative and respectful culture, simulation facilities, interprofessional education and the Family Medicine teaching centre.

Mount Sinai is cross-covered by multiple programs. Residents reported problems with evening access to the hospital, difficulty obtaining ID badges, and the necessity of using a side door that feels unsafe and where snow often remains unshovelled. The underground tunnel is not seen as a viable alternative for many residents.

Sunnybrook Hospital

Sunnybrook Hospital is a comprehensive care hospital with "partnership with the University of Toronto" and "teaching" incorporated in its mission statement. Education is integral to the hospital's mission and vision and this reflected in the strategic plan and the fund-raising priorities.

Dr. Joshua Tepper is the Vice-President of Education. The teaching and learning are very high calibre as evidenced in the comments by the residents and site education leads who referred to; a culture of hard working staff who value teaching as integral to the practice of medicine," residents supported actively by staff, comprehensive exposure, role modelling, high acuity of cases, really good teaching, strong leadership, and good exposure despite geographic penalty. The hospital has been at the forefront of addressing resident duty hours issue.

The residents identified electronic order entry, blood work results and team-based (as opposed to ward-based) care as issues requiring improvement.

St. Joseph's Hospital

St. Joseph's is a community hospital, largely serving marginalized populations. There has been a recent expansion of clinical services and service relocations, which do not appear to have had any negative impact on residency education. Dr. Jerry Maniate is the well-respected residency education lead as Chief of the newly formed Department of Medical Education and Scholarship. He has recently founded an Education Council that he co-

chairs with the Director of Interprofessional Education. Dr. Maniate has a mandate to increase the hospital's profile with respect to education, with a focus on collaborative health education and faculty development. His current staffing given all the above is insufficient however the office was hiring several new staff at the time of the survey.

Twenty-four Family Medicine residents are located at St Joseph's along with residents from approximately 7 other specialties for rotations of varying lengths. St. Joseph's is described by the residents as a caring environment with a low learner:preceptor ratio. No conflicts or issues were noted with respect to the presence of non-teaching staff. Response times for some code blues were thought to be long, particularly when elevators were not functioning.

Residents expressed concern regarding the Psychiatry Emergency Department as it can be very crowded and is perceived to be disorganized, despite the best efforts of the staff and security officers. In addition, residents noted a lack of safe bicycle parking. Many residents prefer bicycle transportation to this hospital and many have had their bicycles stolen there.

Toronto East General Hospital

Toronto East General is a community hospital, largely serving multicultural and marginalized populations. The Director of Medical Education is Dr. Marcus Law. Dr. Law has been an effective and well-respected leader.

Residents reported a culture of one-on-one teaching and feeling a part of the team. They noted some difficulty getting and tracking stat blood work. They also noted a paucity of sinks, particularly on the Internal Medicine ward. Please also see the note below under IV regarding faculty appointments.

North York Hospital

The North York General Hospital is a community academic teaching hospital with a strong emphasis on "learning", quality of interprofessional education and research in field and population-based research. Dr. Donna McRitchie is the Vice-President of Medical and Academic Affairs and Dr. Rick Pencier is the Director of Medical education. The residents value their entire training experience and specifically mentioned, opportunities for involvement in quality endeavors, interprofessional care, collegial atmosphere, individualized learning and WIFI access.

At North York Hospital, hospital funding for postgraduate medical education is an ongoing issue since a portion of the billing based upon medical trainee days is embedded in the operational budget. This is a significant limiting factor for expansion. Residents expressed concern about the limited access when registering at the hospital as learners.

Scarborough Hospital

Scarborough Hospital is a community centre, serving as home base for Family Medicine trainees and a small number of residents rotating through from other specialties. There is a focus on Palliative Care, Mental Health and dialysis. The Acting Medical Education Director, Dr. Lawrence Erlick has been highly effective. Residents report receiving highly tailored training with almost no service component.

Although the hospital's mission statement does not refer to education, it was written 5 years ago and a hospital clinical director has recently been appointed with the mandate to accelerate the education mission. Approximately 50% of staff have faculty appointments with the exception of the Department of Pediatrics in which there was 100% sign up. The individual departmental leads do not meet or fall under any structure within the hospital and would welcome a more structured approach in the future.

Southlake Regional Health Centre

Southlake is a very recent addition to the community teaching centres for residency training at the University of Toronto. There have been 2 classes of graduates from the Family Medicine program at this site. Other specialties send residents for electives. There was some concern expressed on the part of the hospital administration regarding the potential for trainees to affect patient flow. The Mission and Vision do not specifically include education at this point.

Dr. Zaeve Wulffhart is the Director of Medical Education. He chairs two committees in this capacity and has plans for a more structured approach to the educational mission of the hospital. Residents reported experiencing a good balance of community and tertiary care. They specifically praised teaching of the Manager Role at this site and the one-to-one teaching.

Trillium Health Partners

Trillium Health Partners comprise the Mississauga Campus including Credit Valley Hospital, Mississauga Hospital, Queensway Health Centre (ambulatory and complex continuing care), outpatient renal programs, and Peel Behavioural Services (Mental Health). Dr. Normal Hill is the VP Medical Education and is largely responsible for the major expansion of residency education to the Mississauga Campus. There is widespread evidence that this is a well-resourced initiative. Change management has been undertaken with care and collaboration with the multiple stakeholders. There are other comments on this initiative elsewhere in this report.

The Mississauga Academy of Medicine also has undergraduate medical students about to enter clinical training. This will result in 27 additional learners this year with more each subsequent year. The numbers of Royal College trainees will also increase with the result that by 2021 approximately 300 extra learners will be at the Mississauga Campus. To date Mississauga has trained Family Medicine residents (24/year) and elective residents from other specialties. Plans are to more than triple the overall number of resident-weeks by 2022. The leadership in Mississauga feel they are ready in terms of infrastructure and faculty development. However the impact of this expansion on learning opportunities and specifically a change from the 1:1 learner to preceptor Family Medicine model to a team based model needs to be monitored.

Trillium Health Partners represents the recent merger of the institutions noted above. With this merger there will be a single "Primary Care Lead" for the Trillium Health Partners. It was suggested during the survey that this lead may be also shared between Family Medicine and Rehabilitation. The review team has some concern that this governance model may inappropriately dilute the voice of Family Medicine, create potential conflict of interest, and not allow for leadership that sufficiently represents site differences, even within the Family Medicine programs themselves. This should also be monitored closely.

Residents report a very good learning environment, an efficient registration system that is completed before their arrival, and a good orientation to the Mississauga Campus.

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

The hospital affiliation agreements were consistent and robust. They included appropriate deference to the university where appropriate. The application of policy was generally sound, with rapid notification of an appropriate university official where residents were involved.

The Hospital University Education Committee (HUEC) comprised of VPs of Education from each hospital site and education leads is an advisory committee to the Dean and is concerned with partnerships between the university and health care centers. This committee's work has involved cross-boundary issues such as PAIRO contracts and HIV policies. The issues discussed are either responsive (e.g., non-violent crisis intervention) or strategic e.g., library of the future, e-technology across all partners, and interprofessional education. The work although initially based upon individual relationships has now led to established institutional relationships that will survive change in leadership.

Physicians involved in teaching have appropriate university appointments. At the Community Affiliated sites, not all staff are required to have a faculty appointment. No conflicts or interference with resident education were perceived as a result of having non-teaching faculty at some sites. One exception is the Department of Radiology at Toronto East General, where residents expressed concern that none of the Radiologists have requested a faculty appointment.

The University has established agreements with 9 hospitals in the Greater Toronto Area that are considered 'fully affiliated'. They include:

- Baycrest Center for Geriatric Care
- Holland Bloorview Kids Rehabilitation Hospital
- Centre for Addiction and Mental Health
- Hospital for Sick Children
- Mount Sinai Hospital
- Sunnybrook Health Science Centre
- St. Michael's Hospital
- University Health Network (i.e., Toronto General, Toronto Western, Princess Margaret Hospital, Toronto Rehabilitation Institute)
- Women's College Hospital

The University also has established agreements with 18 community hospitals and health care institutions. They include:

- Bridgepoint Health
- George Hull Centre for Children & Families
- The Hincks-Dellcrest Treatment Centre
- Humber River Regional Hospital
- Lakeridge Health Network
- Markham Stouffville Hospital
- North York General Hospital
- Ontario Shores Centre for Mental Health Sciences
- Providence Healthcare
- Royal Victoria Hospital
- The Scarborough Hospital
- Southlake Regional Health Centre
- St. Joseph's Health Centre
- Surrey Place Centre
- Toronto East General Hospital
- Trillium Health Partners
- Waypoint Centre for Mental Health Care (Penetanguishine)
- West Park Healthcare Centre

Separate teaching agreements have been signed with Family Medicine teaching practice sites, as well as various Public Health Units, and separate sites where mandatory or long rotations are taking place such as the Kensington Eye Institute, and Youthdale. Separate

individual teaching agreements to accommodate training at unaffiliated sites is done on a case-by-case basis.

V. REVIEW OF ISSUES PERTAINING TO ALL PROGRAMS

i. RESEARCH

The research environment is strong with excellent support, opportunities, and mentorship through a network of University and Faculty Research centers and numerous research institutes based in hospitals and departments. There is effective collaboration and alignment between various research structures and streams. The specialty residents have opportunities for the Clinician Investigator Program (CIP) and the family medicine residents have access to the clinician scholar program. The Wilson Centre offers opportunities for research in education. Residents are actively recruited onto research programs immediately after selection into residency programs. The effectiveness of the research endeavour is evident through the research funding, output, resident involvement in research and resident satisfaction.

ii. BIOMEDICAL ETHICS

Biomedical ethics is taught/learned in individual programs through clinical exposure didactic teaching in academic sessions and through modules in the centrally offered PGCorEd. Ethics in research is formalized in the "Guidelines for ethical standards in research" document.

iii. COMMUNICATION SKILLS

Communication skills are taught/learned through multiple methods in different settings including opportunities through the PGC or Ed modules, service-settings and academic sessions. The skills are assessed through multiple tools in the individual programs.

iv. MEDICAL AND LEGAL CONSTRAINTS WHICH AFFECT RESIDENCY EDUCATION

There are no systemic medical-legal constraints effecting residency education. Rarely, training of an individual resident may be affected due to licensure restrictions imposed on a resident by the College of Physicians and Surgeons. The post graduate office has a good working relationship with CPSO and understands registration and licensing requirements as well as issues that could limit residents practice (blood borne pathogens for example).

v. TEACHING SKILLS

Teaching skills for residents is provided centrally through the PGCorEd modules and it is the responsibility of specific programs to ensure that residents are provided with appropriate opportunities to teach and be assessed on their skills.

vi. CONTINUOUS QUALITY ASSURANCE/IMPROVEMENT (CQA/CQI)

There appears to have been recognition that involving residents in quality assurance and improvement is an important educational objective. Hospitals are looking at how to engage residents in QA/QI initiatives.

Previously addressed under Faculty response to previous concerns - I iii (1).

vii. OTHER

There is a robust presence of fellows at the University of Toronto. A separate Fellowship Advisory Committee is in charge of this stream of learners. In general, the presence of fellows is considered beneficial by the faculty members, administrative leads, hospital administrators, and the residents, except in rare instances (see individual program reports). It is well understood that the learning of the residents takes precedence and that fellows will be accommodated after the residents' needs have been met. The residents view the fellows as a valuable learning resource, who do not take away their learning opportunities and positively affect service to education balance. The fellowship

stream is also a net positive revenue stream for the PGME office and the funds are used to enhance residency training programs.

VI. GENERAL COMMENTS

i. MEETINGS WITH RESIDENTS

The residents we met with were generally very proud to be training at the University of Toronto. They mentioned the excellent resources including superb teaching, a wealth of clinical and technical resources, dedicated program directors and administrators and a very responsive PGME office. They felt valued and were inspired by the rich scholarly learning environment.

Their concerns included the poor clinical systems interoperability within TAHSN and frustration regarding resident registration at the multiple sites (badges, passwords, scrubs etc.). The sites within Trillium Health Partners and the Student Centre at St. Michaels Hospital being an exception. The Office of Integrated Medical education has also been helpful in streamlining resident licensing, immunization and mask fitting throughout the system.

They were particularly vocal about their displeasure with the mandated PGCorEd modules as has been mentioned earlier in the report.

VII. STRENGTHS & AREAS TO IMPROVE

Strengths:

1. Very effective and functional system wide leadership integration that includes the University of Toronto, Faculty of Medicine, the 27 affiliated sites of the Toronto Academic Health Sciences Network. A well-developed, collaborative approach that includes the Toronto Academic Health Sciences Network and the Hospital University Education Committee designed to deliver the highest quality patient care that prioritizes education. (A1.3; A2; A3)
2. The Faculty of Medicine decanal leadership matrix works very well. Dean Catharine Whiteside, Deputy Dean Sarita Verma and the Vice Deans work effectively together contributing to a coordinated approach in the delivery of the Postgraduate Medical Education programs. (A1.1)
3. The Postgraduate Medical Education office is sufficiently resourced. The leadership team includes the Vice Dean, Associate Dean and the four unit directors. They have done a superb job of organizing the office to be highly responsive and helpful to residents, program directors, faculty and staff. They have aligned their strategic plan to prioritize the social responsibility mandate of training the right number, mix and distribution of residents. (A1.1)
4. The Board of Examiners, Office of Resident Wellness and the Board of Medical Assessors offer unwell and underperforming residents every opportunity to succeed. (A1.3.5; A1.3.6)
5. The Office of Integrated Medical Education under the leadership of the Deputy Dean is instrumental in the success of a number of initiatives including clinical preceptor payments, streamlining faculty appointments and relationship building with allied health care. This is crucial for the delivery of postgraduate medical education in a large, diverse and complex network. (A2.1; A2.4)
6. Faculty Development program especially inclusive of community and rural faculty. Extensive work has been done to provide family medicine faculty in the Rural Teaching practices with appropriate, faculty-centered faculty development. In addition, the faculty development program offered core faculty is exemplary. (A1.3.11)

7. Inter-professional work environments are plentiful and allied health care professionals are incorporated in the clinical and teaching environments in an effective manner. (A2.4)
8. There is an inspiring research and scholarly learning environment within the faculty. Educational research is highly valued and appropriately supported leading to the development of innovative educational programs and clinical advances. (A1)
9. The Red button access of timely information by residents is well-utilized by residents and provides excellent “just in time” information to help residents with any policy or logistics questions they may have. (A1.3.1)

Areas to improve:

1. Lack of Clinical Systems interoperability within the Toronto Academic Health Sciences Network is a continuing and serious weakness from the previous survey in 2007. (A2.1)
2. Uneven support provided to many program directors and especially program administrators requires immediate attention. Exceptions noted were the departments of Pediatrics and Radiology. (A1.3.4)
3. PGCORed a web-based approach to address the intrinsic CanMEDS/CanMEDS-FM roles is a major concern in terms of uptake by residents. (A1.3.10)
4. Lack of a cohesive Faculty/Postgraduate Medical Education strategy for the effective use and resourcing of the many excellent simulation facilities available throughout the network. (A1.3.4)