Medicine
UNIVERSITY OF TORONTO

Chair's Response to the External Review of the Department of Medicine

I am very grateful to the reviewers for their praise of the Department's progress. Their recommendations are very helpful. While in most cases, they reinforce our current thinking and the value of initiatives we have already launched, the recommendations have also provoked 'new thinking' about the opportunities and challenges we face. With input from the department Vice Chairs, I have the following responses to the reviewers' recommendations:

EDUCATION

UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION 2: Consider improving the UME ambulatory medicine experience including developing a separate, dedicated ambulatory rotation.

We are delighted at the interest shown by medical students in expanding ambulatory care experiences during their Medicine Clerkship. This is in keeping with a top departmental educational priority in Postgraduate Medical Education and aligns well with the Department's Strategic Priorities.

Last year, we appointed a Departmental Faculty Lead to perform an environmental scan of ambulatory care rotations and opportunities for residents in Internal Medicine and Subspecialty Training programs; to liaise with the Division of General Internal Medicine, which is working to enhance ambulatory training in the division; and to develop and pilot ambulatory care educational experiences. These experiences include rotations in refugee health (the Crossroads Clinic), Addiction Medicine, and novel collaborative projects between the Departments of Medicine and Family and Community Medicine in which internists or subspecialists and trainees are "embedded" in Family Medicine clinics to provide on-the-spot consultations and to teach medicine residents effective collaboration with family physicians in patient-centered care.

Given this framework, we will begin planning the development of a third-year ambulatory care rotation within the Medicine Clerkship that can take advantage of the work being done in this area on a postgraduate level.

RECOMMENDATION 3: Consider appointing a DOM liaison to the pre-clinical UME curriculum.

The DoM is disproportionately represented among educators and educational leadership in the Foundations Curriculum of the pre-clinical years, and with the appointment of the current

Director of UGME for the Department, Dr. Luke Devine, the role has been intentionally expanded to oversee the pre-clinical and clinical years of the MD Program. Furthermore, while many DoM faculty teach in the Foundations courses, the actual administrative control of the curriculum rests outside of the Department with the Faculty of Medicine. Nevertheless, smooth integration of education, not only within UGME, but between UGME and PGME training is a DoM priority.

Consequently, we will consider the implications and logistics of an appointment of a faculty lead focusing explicitly on the pre-clinical Foundations Curriculum to better link the disparate parts of undergraduate and postgraduate education together.

POSTGRADUATE MEDICAL EDUCATION

RECOMMENDATION 4: The department will need to work with its partners in the hospital system to develop alternative staffing models to support inpatients and the training program.

Addressing the education to patient care ratio is a top educational priority of the DoM, as well as the individual hospitals making up the U of T system. Addressing the growing number and complexity of hospitalized patients, declining resident numbers, limitations imposed by resident duty hours, and concerns over increasing clinical burdens of academic physicians requires close collaboration between hospital leadership and the Department.

Possible solutions will not be “quick-fixes;” they will require a reconfiguration of the structure of Clinical Teaching Units (CTUs), consideration of alternative staffing and care models, such as an increase in the number and types of practice of specialized allied health professionals (e.g., nurse practitioners, physician assistants, pharmacists), an increase in the number of hospitalists or so-called “nocturnists” (hospitalists who staff at night), greater availability of faculty when attending (which may require cancelling of ambulatory clinics or procedures, and would impact the academic mission), and a more prominent role of non-teaching inpatient services.

Implementation of these changes has been done on a variable basis across the teaching hospitals. The Division of General Internal Medicine (GIM) is currently working on a restructuring of the CTUs and call schedules for services within GIM. However, any change to CTU call or staffing has potential to impact the quality of rotations in subspecialty services. Thus, any reorganization of CTUs and/or resident staffing must be coupled with examination of the impact on training experiences in the subspecialty programs.

To this end, the Vice Chair for Education will strike a committee comprising faculty from GIM and sub-specialty programs to determine the most effective immediate responses the DoM can take to consider current anticipated changes in work flow and educational demand.

We will also continue to work with the Physicians-in-Chief (and Vice Presidents, Medicine) to advocate for alternative care models (e.g., rapid access clinics, acute ambulatory care units) to reduce emergency department visits and need for hospitalization.

RECOMMENDATION 5: The department should continue to work diligently to make the implementation of CBD as seamless and streamlined as possible.

The staged roll-out of CBD across the twenty specialties in medicine is ongoing. The greatest challenges are the tremendous need for faculty development and the development of specialty-specific assessment methods and analytics to provide competency committees. We will continue to work with PGME to foster innovation and avoid duplication of efforts (e.g., development of assessment, analytics, etc.). We will also continue to encourage high-quality, collaborative educational research scholarship on all aspects of competency-based medical education, including CBD.

RECOMMENDATION 6: Because point of care ultrasound (POCUS) is a core competency for all internists in the future, the curriculum in this regard should be enhanced and expanded.

The DoM is grateful to the reviewers for pointing out this area of possible development. The educational expertise in this area within the DoM is both broad and deep—particularly in the divisions of GIM, Emergency Medicine, and Respirology. However, we have not carried out a department-wide assessment of educational activities in this area.

The Vice Chair of Education has identified key individuals from each of the divisions dedicating significant time and effort to this area; these individuals will be asked to convene a committee to perform an environmental scan, summarize the evidence supporting use of POCUS in clinical care, and make recommendations to the department on optimizing teaching and education of POCUS. They will also be asked to compare educational best practices and to foster collaborations and educational scholarship in this area.

RECOMMENDATION 7: Attending presence in the evenings should be evaluated across the inpatient services to ensure that teaching and care is optimized.

This issue has been identified in the External Review as a concern for learners. Effective supervision of learners, as well as issues of patient safety, is a top education priority for the DoM. This challenge will need to be addressed in close conjunction with the discussion of, and action on, the educational to patient care ratio (including alternative models of care) outlined above (recommendation 4).

In collaboration with the hospitals, we will consider ways by which to increase evening staffing of CTUs and clinical consultation services. One strategy that has been discussed already is through more flexible hours of care, e.g., later start-times for consultation services who typically receive consult requests later in the day.

QUALITY AND INNOVATION (QI)

RECOMMENDATION 8: Consider a special track for QI research ethics to be developed as part of the ethics harmonization process.

Historically, the ethics problem impacting QI efforts has been that traditional REBs have reviewed QI projects as if they carried the same risks as controlled clinical trials. Although things have improved somewhat in recent years as REBs gain experience with QI proposals, improvement is still needed. Some of the hospitals have developed dedicated processes for approval of QI projects whereby the REB defers to a QI committee regarding need for full REB review. *We will continue our existing activities aimed at establishing dedicated QI ethics processes at more of the TAHSN hospitals.*

Another major barrier to the conduct of QI work is the process for ethics approval of multi-site projects. Unfortunately, the provincial process for having a single REB review for multi-site clinical trials specifically excludes QI work. *Given the critical mass of faculty members conducting QI work, it may be time to consider a similar centralized process for ethics review of QI projects. We will explore this possibility with the Vice Dean, Research.*

In the same vein as REB approval, we also face substantial barriers to the conduct of QI work as a result of the complexity of data sharing agreements across the TAHSN hospitals in multisite QI projects. Each hospital has its own process for handling these (often through their own contracts and grants office or legal department). These processes vary substantially across hospitals. *This recommendation has renewed our desire to resume discussions with the hospitals regarding potential for a 'plain vanilla' Data Sharing Agreement for multi-site QI projects where there are no intellectual property or privacy concerns.* These goals align well with the Dean's new strategic goals.

RECOMMENDATION 9: Continue to invest in mentorship and advancement of junior faculty with a QI focus in partnership with the hospital leadership.

We have hitherto pursued such partnerships very much on an *ad hoc* basis. For example, for a given Clinician in QI (CQI) faculty member, a hospital or divisional leader might suggest a role funded in whole or in part by the hospital. However, given the current critical mass of CQI faculty members, we agree that a more systematic approach is needed. It would be useful for the department to have greater awareness of the range of QI-related roles that hospital leaders are seeking to fill and for hospital leaders to have greater awareness of the breadth and depth of expertise in QI among our department faculty members. *Moving forward, the DoM will liaise more closely with PICs and hospital leaders to identify new and existing positions that would benefit from a physician with QI expertise.*

Our 2017 faculty survey identified the CQI faculty as needing attention. However, it was unclear to what extent the anxieties expressed by survey respondents were due to the fact that essentially all are within their first few years on faculty OR whether there was something specific to the CQI role. We believe it is probably a combination of both. *Since receiving this feedback, Dr. Shojania has conducted a further in-depth survey of the CQI faculty members*

followed by a faculty retreat to provide an opportunity for engagement, listening, mentorship and career development. Dr. Shojania will be debriefing me on these activities and proposed next steps at an upcoming meeting.

RESEARCH

RECOMMENDATION 10: The department should work with relevant stakeholders to ensure that Clinician Investigators are receiving appropriate support for their research at all sites.

The Clinician Investigator (CI) track has been maintained and continues to thrive despite the recommendation to disband it at the previous external review. In our 2017 faculty survey, the major obstacle identified by CIs was lack of support from their respective research institutes (for many RIs, CIs were not eligible for appointment*). We have recently sent out a detailed survey to all of our CIs to explore this further and have arranged to meet with the Vice-Presidents Research of the TAHSN hospitals to convey the need for better alignment between the DoM and research institutes regarding the CI track.*

RECOMMENDATION 11: The department could be more proactive in ensuring clinical placements for trainees in the Clinician Scientist Training Program (CSTP).

We have been encouraged by the support provided by our Departmental Division Directors (DDDs) to ensure adequate clinical time for our CSTP trainees. *Availability of a clinical associate position to enable the trainee to maintain clinical skills which pursuing graduate training has now been implemented as a requirement for acceptance into the CSTP.*

RECOMMENDATION 12: Efforts should continue to be made to recruit more women into the CSTP.

CSTP leadership is working with the Mentoring, Equity and Diversity (MED) committee to promote the CSTP program to all trainees; they meet with medicine residents as they enter the Internal Medicine core training program and annually at a dedicated Academic Half Day. We will be expanding/revising our CSTP selection committee and have established a diverse College of Supervisors to ensure diversity of clinician scientist role models.

RECOMMENDATION 13: The department and the associated institutions should consider making a commitment of a faculty position to clinician scientist trainees while they are still in the program, especially when they have fulfilled all of the milestones that were set for them.

This is a major challenge. The potential for a faculty position has always been considered in our assessment of CSTP candidates. *Going forward, we plan to meet with DDDs and PICs after the interviews of CSTP candidates to work towards a plan for faculty recruitment at the end of training either at the University of Toronto or at another academic institution*. We are also encouraging interviewing of potential candidates for recruitment 1-2 years prior to completion

of their graduate training in order to provide offers to these individuals earlier, contingent on successful completion of training. An anticipated push back on this is from the hospitals, where fiscal restraints have meant increased diligence regarding human resource impact on hospital costs. I will also bring this issue to the attention of the TAHSN medicine committee.

RECOMMENDATION 14: Attention needs to be given to the pipeline of basic clinician scientists and configurations that allow continuous exposure to research during the core residency, such as a hemi-doc program, should be considered.

We have made progress on a number of fronts to increase the pipeline of basic science trainees, but there is clearly still more to do. From experience to date, a "one size fits all" approach will not work. *We have appointed an early career graduate of the University of Toronto MD/PhD program, Raymond Kim, to chair a committee to assess and make recommendations on how to optimize the basic science careers of these trainees. In addition, we will be establishing a Basic Science Mentoring Committee to meet with and advise medicine trainees with prior graduate degrees in the basic sciences.*

RECOMMENDATION 15: Harmonization of ethics and contracts between sites remains an issue. While the former is about to be fixed, the latter needs to be addressed expeditiously.

As noted above (response to recommendation 8), we agree completely. Harmonization of contracts across the TAHSN institutions is an immediate concern. This has been a barrier to attracting and sustaining relationships with both peer-review agencies and Industry-sponsored programs. This is addressed in the Faculty of Medicine's new Strategic Plan and we are fully engaged with the TAHSH Research Committee to provide all of our support in improving this pressing issue.

RECOMMENDATION 16: Efforts to develop relationships similar to that with Computer Science with other basic science departments on campus should be considered.

We are in agreement with this recommendation and numerous initiatives have been launched to this end. For example, in the past two years, we have developed a robust Research Network program in the DoM that promotes cross-institutional and cross-disciplinary collaboration. Our networks in HIV research, Stroke, and Antimicrobial Resistance, for example, have been very successful in attracting peer-reviewed funding by fostering university wide multidisciplinary programs. *We are encouraged by the success of the networks and we have recently announced a funding call for meritorious network projects.*

RECOMMENDATION 17: Contributions to mentorship should be recognized as part of the promotions package at the level of the faculty.

We concur that mentorship is an important and valuable contribution to the academic mission that should be recognized in the senior promotion process, as it is in peer institutions, e.g. Harvard. *We suggest that mentorship activities should be included in the new online faculty CV*

template and expectations for mentorship established for senior promotion. We would be happy to work with the Dean and Decanal Committee leadership on this initiative.

RECOMMENDATION 18: Consideration should be given to make sure that junior scientific faculty have mentors outside their own division or even department, in addition to mentors in their own divisions.

In the DoM, faculty members are required to identify a formal mentor at the time of their initial appointment; they are expected to have at least one mentor that is not a collaborator or someone to whom they directly report to insure that they have the opportunity for mentoring relationships that are free of conflicts of interest. We agree that mentors that are outside of one's division or department should be encouraged and may provide unique perspectives on career development. *We will remind our divisional mentorship facilitators that mentors do not need to be within the division, department of medicine, home hospital or even province or country! We will work with the departmental leaders to help facilitate these linkages for their faculty where appropriate.*

RECOMMENDATION 19: The DOM should consider a reverse mentorship program for senior faculty by junior faculty.

From feedback received from review participants, this specific recommendation was put forward in the context of junior people providing coaching to senior colleagues around use of social media, point of care ultrasound and other discrete tasks. We agree that reverse coaching may be useful particularly in an era of advanced molecular laboratory tools, digital health and social media and we have many examples of where these activities have been well received. *The MED committee will be asked to make recommendations to the department with respect to where task-specific reverse coaching should be considered.*

FACULTY

RECOMMENDATION 20: The DOM should continue its efforts to develop a robust process for facilitating career transitions.

This has been a major issue for us with the aging workforce and lack of requirement for retirement at a given age. A number of initiatives have been introduced to address this issue. For example, based on results of our 2015 Faculty Survey, a task force on Late Career Transitions was struck by the MED committee under the leadership of Dr. Liesly Lee. *The committee has developed a toolkit for faculty considering retirement, which incorporates FAQs and suggestions for ongoing engagement with the department following retirement. We will be introducing confidential retirement coaches at each of the full-affiliated hospitals to address local practice plan / financial questions.*

We have developed and are introducing a "welcome letter", cosigned by the hospital chief and

department chair with the goal of being explicit about the expectations of full practice plan members and clinical faculty appointees. This letter has now been reviewed by TAHSNm and may be modified for use by any department going forward. We have also developed and received executive committee approval for a standardized checklist for annual faculty review and accountability for conducting these reviews. The checklist incorporates review of expectations of the academic position description, financial planning for retirement and planned career transitions irrespective of age or stage of career.

Finally, we have implemented processes to ensure appropriate candidates are put forward for Emeritus appointment at the university upon retirement; we celebrate these individuals at our Annual Day and we are establishing an Emeritus Lounge in our new space at the Naylor Building to provide a place for retired faculty to meet and interact with current trainees and faculty.

We are seeking legal input on these documents and processes on an ongoing basis.

RECOMMENDATION 21: Consideration should be given to developing a better performance management system to be applied at all ages that may assist with some of these difficult discussions.

The department has been diligent in promoting professionalism among our faculty and learners, in close partnership with the hospitals, PGME and UGME. *Consistent demonstration of professionalism is now required for appointment, successful continuing faculty appointment review, senior promotion, and receipt of departmental leadership positions and awards*. We are extremely grateful to John Bohnen and Sara Gotlieb, in their Faculty of Medicine roles, for their support in advancing this work. We are also working closely with the Physician Health Program of the Ontario Medical Association and with the PGME Communications Coach, Dawn Martin, to address these concerns.

With respect to academic performance, we have revised our academic position descriptions to be more explicit with respect to teaching and scholarly contributions. Similarly, revisions to the initial Academic Planning Document, Annual Faculty Review, and the Continuing Faculty Appointment Review processes have enabled improved attention to the alignment of faculty members' activities with expectations.

A systematic approach to ensuring faculty members' clinical competence is, however, not in place and the subject of much discussion among department leadership. We are increasingly using pivot 360 reviews to gather information on clinical performance, but this is clearly inadequate. We are largely reliant on patient, staff and CPSO complaints to alert us to quality of care issues that may signal mental health, addiction or cognitive issues. Developing competence among our departmental leaders in proactively identifying and addressing such issues is a goal going forward. *I will bring this discussion to the TAHSN medical committee for further input and advice.*

EQUITY AND DIVERSITY:

RECOMMENDATION 22: Continue to pursue the equity program with a focus on increasing the number of women in the department and their progress through the ranks.

We will continue with our efforts in this area, which include the establishment of a data dashboard for faculty members and their leaders. We will also continue to monitor adherence to our department's guidelines with respect to searches and recruitment, and on additional diversity metrics, including presentation at medical grand rounds, time to senior promotion, and success in departmental competitions. We believe these strategies to address gender inequity are working. As of the end of 2018, 50% of our 20 departmental division directors are women!

RECOMMENDATION 23: Continue to collect data on diversity and move forward with the task force expeditiously.

Our next Faculty Survey will be launched in March 2019 and continue its focus on equity, diversity, professionalism and wellness. These surveys has been critical to driving departmental initiatives.

We have established a working group focused on diversity led by Dr. Sam Sabbah. In February, we will hold the third annual Summit on Women in Academic Medicine; this year, the Summit will be open to all DoM faculty members. We have developed and implemented faculty and trainee workshops on a variety of topics, e.g. ally-ship. We will likely conduct additional faculty one-on-one interviews in 2020, using the survey data to drive the questions, to allow us to have more detailed info on future departmental activities.

We are keen to publish our survey findings and generate more scholarly work in the area of equity and diversity. *Consideration will be given to creation of a university-wide research network on this topic, potentially in collaboration with another faculty, e.g. Rotman. We will engage the Faculty Diversity leads in this respect.*

CHAIR'S OFFICE

RECOMMENDATION 24: Continue to bolster cross-divisional research efforts and investment to ensure the future success of the research enterprise across all Divisions.

Former Chair, Dr. Wendy Levinson, had initiated Challenge Grants for this purpose. These were wildly successful, but fiscal restraints prevented their continuation. In their place, *we have implemented the research networks outlined above (recommendation 16) and assisted our divisions in fund-raising to enable city-wide research/QI initiatives; many have been successful.* We have found that city-wide multi-disciplinary initiatives are critical to building a sense of belonging to the department and the university – they provide clear value add to our faculty and trainees. *We have recently launched our fund-raising for the 2019 celebration of the Eaton Chair's establishment 100 years ago. We are fund-raising by division and focusing on our alumni*

as, we believe, allegiance to one's specialty and colleagues is most likely to be successful in bringing in additional financial support for such activities.

ORGANIZATIONAL, FINANCIAL RESOURCES AND OTHER

RECOMMENDATION 25: The department should aggressively pursue other sources of funding to replace high risk revenue sources such as tuition fees from Saudi Residents.

Advancement is a major focus of my activities as Chair – more so than I had expected! While we have had modest success, the current year, 2019, and 2021, have the highest potential for major gifts to the department due to milestone celebrations (Eaton legacy endowment and discovery of insulin, respectively). *We are working closely with our Senior Development Officer, Chris Adamson, and the Faculty of Medicine Advancement Office to raise substantial new funds through philanthropy. Additional fund-raising opportunities are being pursued through introduction of CME divisional activities, alumni events and diversification of our funded fellowships.*

RECOMMENDATION 26: The department should consider further fundraising training for selected faculty.

We have sent selected faculty leaders to attend the CASE conference, to which I was referred on appointment as Chair. I agree this is very useful for physicians, who have little or no training in this area. *Based on this recommendation, I will explore the possibility of an on-site program for our leadership group – this might also be something that could be useful for other departments.*

RECOMMENDATION 27: The DOM should consider applying for an Alberta or Queen's style AFP.

We strongly support moving from the current fee-for-service (FFS) model of funding of our physicians; FFS is unquestionably a deterrent to shifting clinical care from the in-patient to the out-patient environment. A proposal was made prior to the Ford government but is unlikely to move forward under the current leadership, and while arbitration is ongoing between the OMA and MOHLTC. Advice regarding how best to proceed with this initiative in the current situation is welcome.

RECOMMENDATION 28: The faculty leadership should make every effort to ensure that the departmental staff are moved into consolidated space as soon as possible, since this will maximize efficiency and effectiveness.

Thank you – we obviously agree. In particular, our business manager, Clare Mitchell, is expending substantial valuable time in transit between our two offices at TGH and the Naylor Building. Further, given the above-noted importance of 2019 fund-raising activities, the sooner

we are in our new space at Naylor the better as we had hoped to leverage the move in these fund raising activities.

RECOMMENDATION 29: The faculty should consider increased IT support for the large postgraduate programs of the department, particularly with the implementation of competency by design.

We agree that this is an enormous problem for the department, which has over 1000 residents and approximately 450 fellows. We are using obsolete methods to schedule trainees, which include paper/pen and excel spreadsheets, and are reliant on the hospitals for on-call scheduling. The hospital chiefs and division heads have been asking for some time for centralized scheduling; this would reduce confusion about which resident is where and enhance the ability of the hospitals to proactively plan for gaps in resident coverage. A better system would also enhance our ability to account for resident attendance and has the potential to free up substantial staff time. This would enable some resources to be reallocated to other areas in education, notably CBD.

Recommendation 30: The health system should consider adopting an integrated electronic medical record for all the teaching hospitals in Toronto, as this would have significant benefits for clinical care, clinical research and the training program.

I think everyone would agree with this recommendation, but given the recent investments in different EMRs, this is unlikely to happen. However, we do believe the university, and particularly PGME, could flex its muscles more in terms of requiring smoother transition of our trainees from site to site if the sites are to receive trainees. Currently, it can take up to a day for a new trainee to be oriented to a hospital's EMR and policies and procedures.

Recommendation 31: The department should continue its plans to involve patient advisors in all aspects of the mission.

We were delighted with this recommendation. We believe there is an important opportunity to advance not only patient care and clinical teaching, but also scholarship in the field of patient engagement/involvement. *Under the leadership of Dr. Andreas Laupacis, this work has progressed amazingly quickly. He has developed formal recommendations for integration of patients into the administration, research, education and QI activities of the department, which he will be presenting to the department executive in March.*

SUMMARY

Once again, thank you to the reviewers for their thoughtful feedback and recommendations. I am very proud of our department and its many accomplishments over the past five years, and indebted to the support of our leadership team. Thank you as well to the Faculty of Medicine leadership team and staff for supporting me and in turn us all through this first term.

All the best,

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