Medicine
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March 4, 2024

CHAIR'S RESPONSE TO THE EXTERNAL REVIEW OF THE DEPARTMENT OF MEDICINE (2018-2023)

We are very grateful to the reviewers for their praise of the department's progress and achievements, and their acknowledgement of the tremendous challenges the department has faced over the past few years related to both the COVID-19 pandemic and the Royal College accreditation. This has been a very tough five years and, looking back, I am proud of what we have accomplished despite these challenges.

The recommendations largely amplify the message that there is a mismatch of resources to responsibilities and, thus, acknowledge concerns regarding the sustainability of the academic excellence of this department. I am personally very grateful for this acknowledgement as for years, I and Departmental leadership have worried about the sustainability of the academic mission. In the face of such limited resources, how will we meet the needs of our world-class researchers and educators?

With input from the department Vice Chairs and the Physicians-in-Chief of our six fully affiliated teaching hospitals, I have the following responses to the reviewers' comments and recommendations:

EDUCATION

UNDERGRADUATE MEDICAL EDUCATION (UGME)

We were delighted to hear that MD learners value the educational experiences received in the department. We were grateful that the learners acknowledged our Clinician Teachers (CTs) for their devotion to providing high-quality clinical teaching across all teaching sites.

POSTGRADUATE MEDICAL EDUCATION (PGME)

<u>Residency Programs:</u>

The external departmental review occurred just prior to the Royal College (RC) review of the Internal Medicine training program (IMTP), which we now know was a success. We have received the preliminary report which provided much praise for our efforts and the satisfaction referenced by reviewers implies success at the RC level is highly likely. RC IMTP reviewers were particularly impressed with the enormous effort made by everyone involved, including not only the DoM and its leaders, but also the hospitals, their leadership and PGME. As the Royal College reviewers commented in their debrief with us, the change demonstrated and reflected by the residents they interviewed was "unprecedented." We expect the final accreditation report in the spring of 2024. The outcome of the IM review is a testament to both the commitment of the department and all its key stakeholders to the academic mission, and our ability to work as a team toward a common goal despite our size and complexity.

I would like to acknowledge the major contributions of our hospital partners to the successful IM accreditation. To off-load patients from the Clinical Teaching Units (CTUs), our fully affiliated teaching hospitals created *multiple* resident independent units, established hospitalist training programs, and hired hospitalists and other health professionals in record time and at great financial cost. Every one of our subspecialty programs has developed guidelines for the IM learner experience on their services. We saw many changes, including recruitment and retirements to ensure sufficient and appropriate attending coverage on weeknights and weekends. These efforts were critical in addressing residents' workload concerns and in enabling our teachers to teach while attending on the CTUs. The department is extremely grateful to our Physicians-in-Chief and their senior hospital leaders for their contributions.

Fellowships:

The External Reviewers devoted much attention to our fellowship programs – the very large (and rapidly expanding) number of fellows and the predominance of international trainees. Although not articulated in a formal recommendation, the reviewers raise several important issues that the department has been working hard to address. As detailed in our Self-Study report, the department had identified fellowships as needing review and oversight at the beginning of my first term as Chair and appointed the first-ever DoM Fellowship Director, Dr. Cheryl Jaigobin, seven years ago. Her role has been to oversee the review of hundreds of fellowship programs, to develop policies and procedures that promote fairness and transparency in fellow selection, formalization of contracts, minimum stipends, PGME enrollment, WSIB coverage, and to ensure fellows had someone to speak with when issues arose.

Over the past decade, there has been a major growth in the number of fellowships in our department. This is attributed to the exceptional international standing of the U of T DoM training program; major increases in clinical pressures that are coupled with the need to sustain academic activities and to the need to ensure appropriate after-hours coverage of both patients and learners; and the lack of increased residency training positions at a time of increasing health care demands.

The situation whereby fellows are 'employees' of a hospital, yet also TFoM learners with educational licenses, registered with PGME, causes confusion about who is ultimately responsible for these individuals and why. This ambiguity also skews financial planning for adequate support of this growing cohort.

Most of the funding for fellowship stipends comes from the faculty members themselves; hospital divisions are frequently tithing on top of practice plan tithes to provide a pooled resource to support fellowships. At the newly agreed stipend rate, the cost to our faculty members will approach $35M annually. Despite major efforts to raise funds for fellowships through philanthropy, it is a hard sell. While some success has been had, it has largely been through one-off term-limited donations. From the fellows' perspective, the costs incurred in coming to Toronto to train are not significant. This, on top of the logistics of permits/visas, etc. means that we need to continue to improve the value-add of the experience.

We believe our fellowship programs are evidence of the reputation of our faculty and programs, bring us ongoing global recognition, *provide vital (more than ever) highly skilled clinical care to our patients*, and contribute to the health of other countries when these fellows return home to practice new skills.

There is also a financial incentive for faculty to work with fellows who are International Medical Graduates (IMGs) on academic licenses as the fellows cannot directly bill OHIP. Thus, the supervisor is billing for the fellow's clinical activities. The department is in discussion about how best to sustain fellowship programs within the TFoM environment and would welcome conversation and input from other clinical departments facing similar challenges.

Within the education section, the reviewers have also commented on the need to better support our Clinician Teachers (CTs). This is also covered in their recommendations and is addressed below.

Learner Wellbeing

RECOMMENDATION 2.
"Steady, sustained attention from DoM leaders to the issues raised in the Residency Review will be important, even in the midst of formidable challenges of the health care environment. Dr Hawker has catalyzed a cultural transformation that must be sustained."

RESPONSE (to Recommendation 2):
The department is fully committed to sustaining and augmenting the cultural shift we have begun towards equity, diversity, and professionalism in our department to ensure that all members – faculty, learners, and staff – feel respected and valued. I am hopeful that the foundation we have laid will hold strong for the future.

The Faculty Lead for Valuing the Clinician Teacher, the Division of Endocrinology Program Director and the Vice Chair of Education have designed a workshop for residents on giving constructive feedback. This has been provided at Academic Half Days for the IM Program and other subspecialty programs (Infectious Diseases and Nephrology) and is now a part of the required New Resident and Fellow Orientation for the DoM.

RECOMMENDATION 3.
*"Expand efforts to promote well-being of faculty, staff, **and learners**, with appropriate resources."*

RESPONSE (to recommendation 3):
The DoM fully supports this recommendation, and we believe that the many actions already taken have had a visible impact on the happiness of our learners (along with lessening of the pandemic and other environmental factors). The changes made are outlined in detail in our Self-Study report.

With respect to the resources required to support learner wellbeing, this is also important to discuss. To provide social events, food at rounds and academic half days, and other such efforts to raise morale among our learners comes at a cost to the department. For example, prior to the pandemic, the department moved the annual PGY2 IM resident retreat from Niagara on the Lake to Toronto to reduce costs. This met with major backlash from residents and was cited in the 2021 Royal College IM review. Last year, we agreed to hold the event once again at NOTL and it was clear that the event was an uplifting and bonding event for learners. Still, with the number of residency programs the department has and our current financial state, not to mention the rise in costs for everything, it is becoming more and more difficult to provide these 'extras.' Some TFoM guidance regarding what is reasonable would be useful, perhaps even nationally as we know that trainees compare across programs.

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QUALITY AND INNOVATION

The reviewers note the lack of alignment between hospital and university expectations of faculty members who are appointed as Clinicians in Quality and Innovation (CQI). The department conducted a 10-year review of the CQI position description in 2022, which was wholeheartedly positive (please see Self-Study report). While it is true that two CQI 'phenotypes' have evolved: the CQI who is engaged in hospital level leadership of QI activities and the CQI who is doing scholarly work / research and Creative Professional Activity (CPA) in the field of quality improvement and patient safety, we are not finding that phenotype impacts academic progression. Of the now 90 faculty appointed as CQIs, all have been successful at their continuing faculty appointment review, as have all of the CQIs who have gone forward for promotion.

Regarding senior promotion for CQI faculty, reviewers' comment that "…*CQI faculty are being told to wait because of the lack of output associated with traditional scholarship…"* All CQIs thus far have been promoted based on CPA; all have been successful thus far at the decanal committee. Time from last promotion or appointment to next promotion is currently shortest for the CQI group, even compared with our Clinician Scientists.

RESEARCH

We are very grateful to the reviewers for their praise of the scope, quality, and relevance of the department's research activities, especially given the department's role in the pandemic. The department is recognized internationally as a significant center of research, with notable discoveries and innovations spanning the full spectrum of biomedical investigation. At present, there are 208 clinician scientists (75-90% research, 10-25% clinical) and 212 clinician investigators (50% research, 50% clinical) in the DoM. However, we are fully aware that all our faculty members irrespective of their academic position description contribute to scholarly productivity. We also thank the reviewers for highlighting the value of our city-wide interdisciplinary research networks and Clinician Scientist Training Program (CSTP). Indeed, we agree that the caliber of our CSTP trainees is extremely high, thus the enormous pressure to keep them in Toronto!

The reviewers also note potential threats to our research mission. Please see our response to RECOMMENDATION 10, below, regarding a) *Decline in the number of CSTP trainees pursuing careers in the basic sciences, b) Stagnant support for the CSTP and CS faculty, raising concerns regarding recruitment and retention, and c) Perception that the DoM support provided to CSs has eroded over time*. Please see our response to RECOMMENDATIONS 10 & 13, below, regarding concerns raised regarding the *role of the hospital Research Institutes (RIs) in mutually supporting CS recruits, including hospital-university fund-raising efforts.* Please see our response to RECOMMENDATION 7, below, regarding *Inter-institutional collaborations bogged down by siloing on REB/contract efforts.*

In addition to the above-noted concerns, the reviewers also noted a *decline in the rate of growth of extramural funding from 19% growth from 2017-18 to 2018-29 to 13%, 5%, and 1% in subsequent years.*

Over the five-year period from 2017-2022, DoM faculty held $1.23 Billion in funded research across our university wide enterprise. These figures include funds held both on-campus and at our affiliated hospitals. Funding has increased year over year from $195M in 2017-18 to $274M in 2021-22 (the last

complete data year). This funding represents more than 13,100 individual awards, including 22 Canada Research Chairs.

Research funding is from the not-for-profit sector (43%; health charities, etc.), the private sector (29%; industry), tri-council agencies (20%); and other government sources (8%). Over the five-year period of this review, funding across these four sources increased ~40% for the not-for-profit and private sectors, 34% from tri-council agencies, and 64% from other sources.

The reviewers have correctly pointed out that on a year-by-year basis, funding has declined over the past five-years. They do speculate that this may reflect the impact of the COVID pandemic, which I think it does. However, only time will tell. In our fall 2022 Faculty Survey, many respondents reported that the patient volumes, increased clinical administrative load, and increased demands regarding resident supervision had reduced their ability to attend to other academic activities. It will be very important for the department to monitor publications, citations, grants and other indicators of research impact closely in the near future.

Another concern that is raised by the data provided by the university is that the proportion of funding for research that is from tri-council agencies has declined. I think this reflects lack of increase in the overall budget for CIHR, NSERC and SSHRC, rather than lack of success of our researchers in these competitions, but I will ask our Vice Chair, Research, to explore this more fully.

RECOMMENDATION 7.
"Harmonized pre-award research procedures, such as IRB and contracting, across TAHSN."

RESPONSE (to recommendation 7):
City-wide multi-disciplinary research initiatives are critical to building a sense of belonging to the department and the university – they provide clear value to our faculty and trainees and leverage the excellence of the entire university. Lack of harmonization of REB and contracts across the TAHSN institutions has been a long-standing concern, identified at our department's five-year external review as well. This has been a barrier to attracting and sustaining relationships with both peer-review agencies and industry-sponsored programs.

This issue is strongly related to the 'value proposition' of academic medicine. The 'value add' of TFoM is its broad span of research and scholarship across multiple sites and on campus. Enabling ready access to these rich resources would be a major plus for full-time faculty members. While people may have put up with the lengthy contract and ethics processes in the past, in the context of all the other challenges our faculty are facing, this is a low hanging fruit to be addressed once and for all.

This issue has been a Faculty of Medicine Strategic Priority for years. We continue to function in a collective of hospitals where each has its own board and foundation, and where there is direct competition across sites. Each of our fully affiliated teaching hospitals has a contract with the university – perhaps it is time for the development of inter-TAHSN hospital agreements as well. The competition across sites is holding us all back; it remains necessary for it to be addressed by the new Dean and CEOs. Our Vice Chair, Research, sees this as a top priority, as do I. This has never been more important to overcome than now.

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RECOMMENDATION 10:
"Insofar as possible, increase TFOM/DoM investment in attracting and developing the next generation of CS."

RESPONSE (to recommendation 10):
First, I think it is important to clarify that DoM support of our CS faculty members has not declined over time, as the reviewers noted: ("*Stagnant support for the CSTP and CS faculty, raising concerns regarding recruitment and retention, and Perception that the DoM support provided to CSs has eroded over time*"). As noted in our Self-Study report, we introduced start-up salary support for all new recruits to the department in the CS position description, which provides up to five-years of support at $40K per annum. Individuals who are successful in obtaining salary support awards, e.g., a Tier 2 Chair or Professorship, during the first-five years have the funding held for the duration of the award, but restart support once the award ends. After start-up support ends, all FT-CS faculty are eligible to compete for a DoM CS Salary Award of $40K/annum x 3 years, renewable, provided they do not hold salary support funding at or above $50K/annum. As a result of these changes, our annual allocation of funds to support our CSs has increased from $3 million in 2017 to $3.6 million in 2023. An additional $500,000 is allocated annually to support the management and oversight of the department's research funds, including on- and off-site research labs, grants applications and utilizations, support staff, and students. These initiatives have been well-received by the hospital PICs and Practice Plan leads, clearly indicating we have a stake in the future of the physician scientist. However, given the major pressures and need to expand support of our educational portfolio, support for the CS is now at serious risk. This will be the focus of discussion at our upcoming DoM Executive Committee meeting in January 2024.

Regarding the comment about *"a decline in the number of CSTP trainees pursuing careers in the basic sciences…",* this is also very much on our radar. While we have seen no decline in the number of applicants to our Clinician Scientist Training Program (CSTP), most are pursuing advanced research training in the clinical research disciplines. We feel strongly that physicians play a critical integrating role in science, and we must foster the development of physician scientists across all research disciplines, particularly in bench to bedside translational research. This is a major focus of our new CSTP Director, Mamatha Bhat – herself a translational researcher in hepatology, and our new Vice Chair, Research, Jane Batt, a basic scientist in respirology. In brief, they are collaborating with the Vice Chair, Education, the Internal Medicine Program Director (IM PD), and the Integrated Physician Scientist Training Program Director to develop a more robust pipeline from the MD-PhD program at U of T into DoM residency training and are discussing implementing a research "special track" within the core IM residency program to attract individuals aiming for a future career as a CS. Working with the IM PD and Vice Chair, Education, discussion on curriculum for these research-track residents continues to identify as many opportunities as possible to continue to engage in their research while completing residency training. More discussion on pathways will occur in the coming months. I am really excited about these efforts and stress their importance.

RECOMMENDATION 13.
"Assess needs for research space and explore whether those needs can be met with space other than that controlled by the Research Institutes."

RESPONSE (to recommendation 13):
We appreciate that space is at a premium, especially wet lab space. Over the past decade, we have

observed increasing difficulty finding wet lab space for CS faculty recruits, with preference generally given to PhD scientists by the research institutes. This is contributing to the slow but steady decline in basic science trainees within our CSTP, discussed above. I see this issue as important for TAHSN-Research to be aware of. This is also a priority of our new Vice Chair, Research who is working closely with Antonio Strafella, TFoM Director, Clinical Research & Translation, to bring these issues to the attention of TAHSN-R.

FACULTY

RECOMMENDATION 2.
"Steady, sustained attention from DoM leaders to the issues raised in the Residency Review will be important, even in the midst the formidable challenges of the health care environment. Dr Hawker has catalyzed a cultural transformation that must be sustained."

RESPONSE (to recommendation 2):
The department has been diligent in promoting professionalism among our faculty and learners, in close partnership with the hospitals and TFoM. While I cannot speak for the next DoM Chair, I do believe that there is full support among departmental leadership and general faculty members for the direction we have taken in this respect. I am hopeful that we have laid a strong and long-lasting foundation.

Our department has worked very hard to develop a culture in which microaggressions are considered unacceptable; repercussions include implications for leadership roles and faculty appointments.

<u>Clinician Teachers</u>

RECOMMENDATION 1.
"Expand recognition of DoM leaders and faculty, with special attention to CTs."

RECOMMENDATION 9.
"Review the role of CTs and the resources available to them, with the goal of sustaining them and their substantial contributions."

RESPONSE (to recommendations 1 and 9):
We are fully supportive of these broad recommendations. Appreciation of the outstanding efforts of the clinician teachers (CTs) who contribute significantly to the department is critical to their wellbeing and motivation to continue in academic medicine. Thus, we were delighted to hear the rave reviews given by our learners of the quality of teaching they receive in our department. As summarized in the Self Study report, the department has made enormous efforts to demonstrate our respect for and support of our CTs, with evidence of some success based on the number of faculty now seeking senior promotion based on sustained excellence in teaching and the number of CTs seeking promotion on any basis.

One issue raised by the reviewers requires support from TFoM. That is the issue of how one defines "sustained excellence in teaching" with respect to TES evaluations (scores and comments) and duration of time. The department has made some gains with the Decanal Committee, but there remains the status quo of a 10-year period as a requirement for 'sustained excellence.'

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RECOMMENDATION 3.
*"Expand efforts to promote well-being of **faculty, staff**, and learners, with appropriate resources."*

RESPONSE (to recommendation 3):
This is a top concern for the department. Burnout among our faculty members is extremely high, as we have documented through our biennial faculty surveys. Unfortunately, the major drivers of burnout (clinical volume coupled with scholarly administration) are beyond the department's control – sadly, we have little leverage. Still, we have observed that the faculty member's well-being is positively impacted through formal recognition and celebration of successes, knowledge that the department is advocating on their behalf (at the hospitals, TFoM, Royal College, and government), mentorship and sponsorship opportunities, including our Valuing the CT initiatives, and through creation of opportunities for city-wide collaboration and celebration. Thus, continued efforts to bring people together is a top priority for the Department.

Dr. Simron Singh, the department's appointed faculty lead for Physician Wellness, will be completing his term in June 2024. We are currently discussing this role and visioning on if folding wellbeing explicitly into everything we do in the department is the future of this priority. The executive committee with the Vice Chair of Culture and Inclusion will explore this more fully in the coming months.

EQUITY AND DIVERSITY

We were delighted to see that the external reviewers felt our Culture and Inclusion portfolio worthy of adoption by departments elsewhere. We are incredibly fortunate to have such dedicated faculty and staff leadership, and the buy-in of most of our enormous department in shaping a new identity for this department – one that is respectful, diverse, and inclusive.

Biennial faculty surveys, which began in 2015, have been critical to setting the direction of Culture and Inclusion portfolio, and modifications over time. These surveys have also allowed us to evaluate prospectively the impact of these initiatives on faculty career satisfaction, mentorship experiences, work-place experiences, and well-being. I am confident that the changes we have made and continue to make will be sustained for the future.

ORGANIZATIONAL AND FINANCIAL STRUCTURE

RECOMMENDATION 4.
"TFOM increases transparency in how DoM funding is determined, which DoM investments are considered worthwhile."

RECOMMENDATION 5.
"TFOM and DoM design a funding strategy that will sustainably increase funding for DoM."

RECOMMENDATION 8.
"Consider a formal review of priorities and initiatives by the Chair to inform allocation of resources and to clarify realistic expectations."

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RESPONSE (to recommendations 4, 5 and 8):
We are grateful to the external reviewers for the attention they paid to the current imbalance of demands and resources in the department. The department sees itself as 'value add' to the TFoM. We believe that our efforts have positively influenced TFoM in many ways (EDI efforts; mistreatment of learners; valuing the clinician teacher, scholarly productivity & impact; global recognition, etc.) and the University of Toronto overall (brand and international prominence; as reported, U of T was ranked 2nd in the world by Nature for health sciences research output; the Department of Medicine, UofT was ranked 3rd). Thus, it has been difficult for us to understand why we are seeing a significant reduction in overall support over time. The current uncertainty surrounding strategic investment raises serious concerns for our dedicated Faculty, who contribute tirelessly to an academic mission that has not reciprocated adequately. The next Chair will need to continue advocacy efforts for transparency and proportionality of investment support into DoM by TFoM.

As stated in our Self-Study, overall funding to the development (PGME/trainees, budget allocation, income from investments) has declined significantly over the past 10 years, and our carry forward has been severely reduced, with > $8M in claw backs. At the same time, the department has grown tremendously in size and scope (major increase in clinical demands and complexity of care) and expectations of our faculty have risen substantially (CBD, accreditation, EMRs, etc.). As a result, full-time faculty are asking what the value proposition for academic medicine is – they complete years of advanced training and forgo potentially higher income in an increasingly expensive city in order to teach, educate, conduct research, thereby improving quality of care. Our leadership team is asking why our budget has declined despite our accomplishments and growth.

As DoM Chair, I find myself unable to respond adequately to these questions. I cannot state with certainty that the DoM is being treated unfairly and inequitably relative to other departments; I do not know what evidence there is to show that TFoM is being treated unfairly and inequitably relative to other Faculties at the University. Greater clarity regarding these questions is critical to enable the department to plan. I will be meeting with the Interim Dean and finance leads with the hope of gaining greater understanding in early January 2024. The outcome of this discussion will inform our priority setting (RECOMMENDATION 8).

Of note: Section 6 of the External Review includes a suggestion to consider taxing department members to support departmental activities. Our department members are already tithed substantially by their practice plans.

RECOMMENDATION 6.
"Assess resource needs to increase training sites and programs and determine the unintended consequences of disseminating faculty appointments without maintaining current standards and expectations."

RESPONSE (to recommendation 6):
Many of our senior executive members feel that the expansion of residency training to Mississauga and Scarborough has the potential to negatively impact the DoM. We feel this is contributing to the many questions regarding the 'value proposition' of full-time academic medicine.

The decision has been made to send U of T MD learners and residents to community sites when we have unmet capacity in the fully affiliated sites. The perception is that this has occurred without sufficient discussion of the objectives, plan for implementation, including resources that will be required, and unintended consequences. While we recognize that the decision has been made, we feel there is an urgent need to discuss how best to move forward.

Our full-time CTs sign on to a full-time career of teaching, have completed advanced training in health professionals' education (our Master Teacher Program, which the DoM developed and runs for our faculty for free), contribute the majority of leadership/curriculum development of the education portfolio, and are held to a higher expectation by PGME/RCPSC than their parttime and adjunct colleagues (accreditation as an example, wellness, learner environment, etc.).

TFoM has implemented the requirement for an academic position description assigned to all faculty appointments to help set expectations and hold all faculty accountable. This has increased our appointments workload with no additional resources provided to the DoM. When we asked to charge a minor 'reappointment' fee to part-time and adjunct faculty members (which our community chiefs had told us was reasonable), we were told we could not. Instead, it was suggested that the associated administrative workload might be reduced by decreasing the frequency of review from annual to every 2-3 years for the part-time and adjunct faculty. This would further exacerbate the sense of lack of fairness and inequity.

Nearly every day, I get asked about the value of being full-time if it is no longer necessary to be full-time to access learners/teach or conduct research without the constraints of practice plans. In the DoM, the community sites do not contribute financially to the operation of the Department. Our new graduates have debt, want to buy a home, and are not driven to do more for less. We need to increase the attraction of full-time faculty appointments through open discussion.

RECOMMENDATION 11.
"With TFOM, identify programs of little value, as some think CBD is, and work together to eliminate or modify such programs."

RESPONSE (to recommendation 11):
We wholeheartedly agree that we need to reduce unnecessary workload wherever possible. The department played an important role in encouraging the Royal College to hold a series of Summits earlier this year to discuss experiences across the country with the roll-out of CBD. We were delighted with the subsequent decision by the Royal College to allow programs to innovate in how CBD is operationalized across our programs. We agree that it would be helpful if there was more collective decision making across TFOM's clinical departments.

RECOMMENDATION 12.
"With TFOM, determine TFOM resources that might be valued by DoM faculty and develop strategies to make them available."

RESPONSE (to recommendation 12):
We are not clear what this recommendation entails and, therefore, are unable to respond.

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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 Temerty Faculty of Medicine leadership team and staff for supporting me and in turn us all through my second term as Chair.

All the best,

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