

AC Task Force Executive Summary
June 27, 2022

THE PROBLEM:

In November 2020, the Royal College of Physicians and Surgeons of Canada did a review of the Core Internal Medicine residency program at Temerty Medicine's Department of Medicine. In November 2020, the RCPSC conferred a "Notice of Intent to Withdraw Accreditation" to the program, as a result of its findings.

The RCPSC identified two themes for Improvement that are the focus of the Task Force:

1. There is an ongoing issue with resident supervision in the clinical environment, and perceived lack of support, particularly of junior learners on subspecialty services and on CTU during weekends. Residents feel this is impacting patient safety.
2. Residents are afraid to raise substantial questions or issues with the program, for fear of repercussions both within their training program and related to future employment in Toronto. This perception arises from observation of the treatment of residents who have spoken out.

RECOMMENDATIONS:

1. The Task Force recommends that the Department of Medicine leadership develop a policy for supervision by attending physicians on all services with Internal Medicine residents.
2. The Task Force recommends that Department of Medicine leadership and Toronto Academic Health Sciences Network (TAHSN) hospital leadership bolster efforts to address chronic shortages on high volume services across all teaching sites.
3. The Task Force recommends that Department of Medicine leadership and TAHSN leadership determine how best to offload residents from tasks that can be streamlined.
4. The Task Force recommends limiting distractions and maximizing efficiencies for residents, by addressing processes for paging, test booking, and order entry and other tasks.

5. The Task Force recommends that the program improve process and flexibility for residents around requests for vacation time. This will enhance residents' wellness and markedly improve efforts to ensure residents' earned lieu days and educational time are honoured.
6. The Task Force recommends that each rotation ensures that its teaching, outpatient clinics and procedures are organized to enable residents to complete their routine work consistently by 5 p.m. EST, in order to allow appropriate time for sign-over to the on-call team to the evening shifts as well as completion of other tasks.
7. The Task Force recommends that attending physicians on inpatient MRP and consultation services ensure they adjust their outpatient clinical responsibilities, as well as academic and administrative responsibilities, to ensure residents are adequately supported throughout the day and are able to consistently complete their workday on time.
8. The Task Force recommends that Academic Half Days (AHD) be protected across all PGY levels.
9. The Task Force recommends that each hospital service develops explicit policies that describe the expectation of residents, fellows and attending physicians (including junior attendings) in the daily care of patients on their services. This recommendation includes the expectation that one attending physician be present in person for each of the CTU teams without cross-coverage of other teams or services.
10. The Task Force recommends that admission guidelines for patients through the Emergency Department as well as processes to manage disagreements between services be made more explicit and be widely communicated.
11. The Task Force recommends that the emergency departments, medical advisory committees, consulting services, and trainees collaborate to develop a clear, safe, and respectful process for managing disposition of stable patients needing admission between the hours of 5 a.m. to 8 a.m. recognizing the unique patient care pressures being faced by each group. This should include dedicated time for residents to safely complete admissions, review their work, and tend to inpatient issues. The process must be considerate of the ED physician schedule as well. The process of holding stable admissions between 5AM and 7-8AM that is already in place at a number of teaching sites is perceived very positively by the residents.

12. The Task Force recommends that attending physicians ensure that formal post-call teaching is efficient and focused.
13. The Task Force recommends that hospital sites regularly seek anonymous and/or confidential feedback from residents on the support they receive. We recommend this feedback be shared with individual attending physicians in a constructive fashion to promote positive change.
14. The Task Force recommends that the program and Department of Medicine improve the way in which feedback is sought and received at all levels by building a culture of continuous improvement that empowers meaningful change and actively seeks and welcomes feedback.
15. The Task Force recommends that, both at individual hospital sites and program-wide, there is transparency with residents about what will happen with feedback obtained from them, and specific plans to address the concerns raised in a timely fashion.
16. The Task Force recommends that the program and Department actively involve residents as partners in designing and implementing change initiatives. Ideally, this should be at all stages of development of initiatives and include resident leadership beyond the Chief Medical Residents.
17. The Task Force recommends that the program seek out and implement best practices from other programs regarding incorporating resident feedback, rotation organization, and change management.
18. The Task Force recommends that the Internal Medicine program resume the cycle of annual site visits, including a robust component of external review for sensitive feedback.
19. The Task Force recommends that the program reviews its rotation and site debriefings to ensure residents perceive these to be safe spaces. We also recommend that confidential and anonymous mechanisms to provide feedback are incorporated.
20. The Task Force recommends that an ombudsperson is identified that residents can contact to provide feedback or seek advice from. The residents should be consulted in the development of this role and the selection of the ombudsperson.

21. The Task Force recommends that the Department rethink the use of Town Halls to seek feedback from residents.
22. The Task Force recommends that professional development be offered to both residents and faculty on how to provide and receive constructive feedback for system change.
23. The Task Force recommends that time off and protected study time for the Royal College examination be prioritized by the program as per the Professional Association of Residents of Ontario (PARO) contract.
24. The Task Force recommends that the program follow contractual obligations including special arrangements with PARO, and where found to be in non-compliance, immediately resolve such issues.

Internal Medicine Accreditation Task Force Report

Date: June 27, 2022

We are pleased to present the report of the Internal Medicine Accreditation Task Force.

This report is the result of nine months of review.

The members of the Task Force are confident that the findings and recommendations of this report will assist the Temerty Faculty of Medicine's Department of Medicine in addressing the concerns raised by the Royal College of Physicians and Surgeons of Canada (RCPSC) in their 2020 review of the Core Internal Medicine residency program. The Task Force also believes it will improve the overall experience of the program's residents.

This report represents the consensus of six faculty and seven resident members of the Task Force. It incorporates responses to feedback shared by the Departmental Executive and Internal Medicine Residency Program Committees as well as the feedback solicited from DOM residents and faculty members.

Background:

In November 2020, the Royal College of Physicians and Surgeons of Canada did a review of the Core Internal Medicine residency program at Temerty Medicine's Department of Medicine.

In June 2021, the RCPSC conferred a "Notice of Intent to Withdraw Accreditation" to the program, as a result of its findings.

The RCPSC identified two themes for improvement that are the focus of the Task Force:

1. There is an ongoing issue with resident supervision in the clinical environment, and perceived lack of support, particularly of junior learners on subspecialty services and on CTU during weekends. Residents feel this is impacting patient safety.
2. Residents are afraid to raise substantial questions or issues with the program, for fear of repercussions both within their training program and related to future employment in Toronto. This perception arises from observation of the treatment of residents who have spoken out.

In summer 2021, the Department's Chair struck the AC Task Force, in response to the RCPSC's Accreditation Report.

The task force is co-chaired by Dr. Kevin Imrie, a faculty member, and Dr. Michael Elfassy, a senior resident in the program.

The Task Force's mandate is to advise the Department's senior leadership through a safe, arms-length process. This includes collecting information on residents' experiences in the program. It also means seeking residents' advice on ways to address a perceived lack of support and perceived repercussions for speaking out about issues in the program.

The full membership and terms of reference as well as all communications from the Task Force to the Department can be viewed at <https://deptmedicine.utoronto.ca/internal-medicine-residency-accreditation-ac-task-force>.

Work Plan:

The Task Force also analyzed several sources of data which provided insight into residents' experiences of their residency training program.

Data sources included:

- The Report of the RCPSC Accreditation (Conducted November 23, 2020)
- Voice of the Resident reports from the Internal medicine program (June 2019 and 2021)
- Reports from hospital site visits conducted by the Postgraduate Medical Education Office (June 2021)
- Program and Site responses to PGME's hospital site visits (January 2022)
- A 'heat map' and quantitative scoring of PGME POWER Rotation Effectiveness Scores (RES) (2020-2021)
- A qualitative analysis of the comments from RES reports (2020-2021)
- A report on a listening circle held at St. Michael's Hospital (February 2022)

(The Task Force notes that all but the Listening Circle report were collected before July 2021. Additional data will be needed in order to fully assess the impact of changes implemented since July 2021.)

Between July 2021 and March 2022, the Task Force held seven meetings of its members to evaluate the findings of these different analyses. The Task Force also worked to propose

solutions to issues uncovered in their examination, and draft preliminary recommendations to address problems they heard about.

The task force members (both faculty and residents) all explicitly endorsed all of the recommendations

In March 2022, the Task Force's findings were presented to the Department's executive committee and the Internal Medicine Residency Program Committee in March 2022. Their feedback was addressed and integrated before this report was circulated to all faculty and residents in the Department.

In May 2022, the Task Force's findings and preliminary recommendations were shared with all faculty and residents within the Department of Medicine, inviting their feedback and integrating it into the report as described below.

Scope of Review:

The Task Force deemed it essential to take into consideration predominant themes that came up in their review, despite some appearing less directly related to the two overarching themes identified by the Royal College. The Task Force felt strongly that the important issues brought forward by the residents did relate to the two themes within our mandate, even if the relationship was not immediately apparent. Most importantly, the Task Force felt that ignoring residents' vulnerability and sincerity in providing important feedback would directly contribute to theme #1 (lack of support) and/or theme #2 (fear of bringing concerns forward). Purposefully omitting significant resident feedback would also leave the program subject to ongoing accreditation concerns.

Acknowledgement:

The Task Force acknowledges the courage and vulnerability of the Department to choose to undertake this examination, especially reflection done by Site Directors and Internal Medicine program leadership.

These are highly abnormal times.

The pandemic has had, and continues to have, a massive impact on our residents, faculty and leadership.

The Task Force recognizes that the Core Internal Medicine residency program and all training sites are deeply invested in improving the program and have already implemented changes in response to the review.

In keeping with our terms of reference, our efforts were focused on an in-depth exploration of the experiences of our residents.

Key findings:

General:

1. There are many strengths about the Core Internal Medicine residency program contained in the RCPSC report. These include comments about the administrative strength of the program and the commitment to continuous improvement of the program as well as the commitment of the University and partner hospitals to mitigate the impact of increasing workloads. The Task Force found these findings were also strongly supported by evidence from the other data sources.
2. Overall, residents have a positive impression of individual rotations, with the number of positive comments in RES reports far exceeding negative comments. This includes comments relating to the nature and extent of supervision and support.
3. The Task Force found, however, there is a clear perception of a lack of support in the clinical environment and a fear of repercussion. This is substantiated by the Voice of the Resident Surveys, Rotation Effectiveness Scores (both quantitative and qualitative analyses), hospital site visit and the listening circle report. These perceptions are shared by a substantial proportion of the residents in the program and are not restricted to any single training site or PGY year.
4. While a great many Internal Medicine residents perceive their residency training experience very positively, one in 10 rate the culture of respect in the program to be poor or very poor, one in four do not feel that the program supports their health and well-being, and one in two report experiencing discrimination or harassment during their program (with the most frequent perpetrators reported to be nursing staff, followed by patients, and faculty members).
5. Women, PGY2 residents, and non-white residents are more likely to rate the culture of respect and support for health and well-being worse than other groups.

Support:

1. Residents indicate that the extent of support they receive from staff physicians is variable by training site, rotation, and individual staff physician.
2. The ongoing efforts of the program to mitigate the impact of increased clinical volumes on the daytime work on the Clinical Teaching Units (CTU) as well as some subspecialty services have had a significant positive impact to improve the experience of residents, at some sites more than others.
3. Weekend and holiday call on CTU and some subspecialty services are significant areas of concern with residents experiencing heavy workloads across the program and experiencing variable degrees of support across the training sites and from individual staff physicians. The Task Force is aware of the efforts of the program to improve and standardize processes across sites but there remain inconsistencies in residents' experiences across training sites.
4. The variability in the support that residents experience from staff physicians is not only in the amount of direct involvement in patient care staff physicians are willing to assume, but also approachability, willingness to supervise procedures, as well as interest they demonstrate in individual residents' well-being.

Feedback/Fear of repercussion:

1. There is a loss of trust amongst the residents in the mechanisms to provide feedback to the program. The current processes are not perceived to be safe, confidential, and anonymous.
2. There is a perceived lack of proactivity from the program and departmental leadership to address issues that arise.
3. The use of town halls to seek feedback has contributed to this lack of trust. This perception does not relate to a single town hall event, but to multiple occurrences.
4. Specific instances of perceived retaliation for speaking up appear to be rare, but where they are perceived to occur, they have an immediate and wide-spread negative impact

on the resident body.

5. Much more prevalent than instances of direct repercussions for speaking up is the perception that feedback is not welcomed or is dismissed without being considered. This perception is wide-spread and undermines the willingness of residents to speak up.
6. The Chief Medical Residents play an invaluable role in the continuous improvement of the program as well as serving as advocates and supports for residents, but they are not perceived as impartial arbiters. Additional complementary arm's length mechanisms to provide feedback are needed.
7. Given the size and complexity of the program, there remain ongoing concerns about the flexibility and reflexivity of the program to identify concerns from residents (both immediate and ongoing concerns) and implement meaningful change. This includes flexibility around rotation changes, vacation requests, lieu day implementation and wellness issues.

Final Recommendations

The recommendations below are the final recommendations of the task force after incorporating response to the feedback from the Department.

Supervision and support:

Part 1: General services:

1. **RECOMMENDATION 1:** We recommend that the Department of Medicine leadership develop a policy for supervision by attending physicians on all services with Internal Medicine residents.

It is further recommended that this policy ensures that:

1. An attending physician will be always available to provide supervision, feedback, and support for patient care.
2. They must attend in person to review cases with the residents and appropriately share the workload.
3. Trainees be encouraged to contact staff throughout the night with any concerns without fear of repercussions.

4. Clear and effective backup mechanisms be in place in case staff cannot be reached.
5. If a resident or fellow is acting as a junior attending, they must assume all roles as outlined above.

Purpose: Developing policy will promote standardization of supervision across clinical settings and preceptors. While many of these recommendations are already in place at some sites, there is variability in practice across and within training sites.

To address Theme 1 of the Royal College's Accreditation Decision, mandating high standards of clinical supervision is essential.

2. **RECOMMENDATION 2:** We recommend that Department of Medicine leadership and Toronto Academic Health Sciences Network leadership bolster efforts to address chronic shortages on high volume services across all teaching sites.

This recommendation includes that:

1. Each MRP teaching service develop, implement and maintain firm and fixed caps. These caps should be determined in consultation with residents.
 2. An increase in the number of non-teaching teams be considered to accommodate increasing patient volumes.
 3. Recruitment of physician extenders (PA/NPs) and non-teaching physician staff to assist with patient care and administrative tasks.
3. **RECOMMENDATION 3:** We recommend that Department of Medicine leadership and Toronto Academic Health Sciences Network (TAHSN) leadership determine how best to offload residents from tasks that can be streamlined. This recommendation includes reduction of administrative duties (like faxing, labeling, scheduling, applications, etc.).

This is especially important on the weekends and holidays, where there is less clinical and administrative support available.

Purpose: Given the increasing patient complexity and volumes facing hospitals as well as chronic physician shortages, there is a clear need to optimize health human resources to service patients and allow appropriate learning and clinical development in residents.

Our data has shown positive experiences where residents have non-teaching teams and physician extenders to help with workload on busy services. While the Task Force acknowledges that certain administrative work is essential for residents for educational and patient care purposes (such as completing consult requests or preparing discharge summaries), other work (like faxing off the consult request or arranging transport/appointment time in preparation for safe discharge) would be better performed by team members in order to free up physicians for other required tasks.

To address Theme 1 of the Royal College's Accreditation Decision, recommendations 2 and 3 are aimed to improve support in the clinical setting.

4. **RECOMMENDATION 4:** We recommend limiting distractions and maximizing efficiencies for residents, by addressing processes for paging, test booking, and order entry and other tasks.

***Purpose:** Particularly on weekends when clinical services are short-staffed, administrative tasks and other distractions routinely prevent residents from completing their physician responsibilities.*

Many residents have rotated during their training to community sites and described that the interprofessional team-based practice they experienced there allowed them to care safely and efficiently for a higher volume of patients.

Recommendation 4 calls for a more interprofessional model of care that enables all members of the team to function at the peak scope of their practice. If implemented, this would promote a greater culture of support and teamwork.

5. **RECOMMENDATION 5:** We recommend that the program improve process and flexibility for residents around requesting vacation time. This will enhance residents' wellness and markedly improve efforts to ensure residents' earned lieu days and educational time are honoured.

***Purpose:** Residents have repeatedly expressed frustration over the current vacation request processes. This sentiment emerged repeatedly in the data and was difficult to ignore. Ensuring residents are able to take their earned time off is essential for wellness and to prevent high rates of physician burnout.*

If implemented, this recommendation will allow residents to feel supported throughout their training to perform optimally in the clinical setting.

Part 2: Weekday services:

6. **RECOMMENDATION 6:** We recommend that each rotation ensures that its teaching, outpatient clinics and procedures are organized to enable residents to complete their routine work consistently by 5 p.m. EST, in order to allow appropriate time for sign-over to the evening shifts as well as completion of other tasks.
7. **RECOMMENDATION 7:** We recommend that attending physicians attending on inpatient MRP or consultation services ensure they adjust their outpatient clinical responsibilities, as well as academic and administrative responsibilities, to ensure residents are adequately supported throughout the day and are able to consistently complete their workday on time.

***Purpose:** Residents highlighted that many of the issues that made them feel unsupported were a result of process issues within the clinical environment.*

Improved efficiencies in the clinical setting are essential to timely patient care and opportunities for learning for residents. It also means residents can sign-over patient care to the on-call resident on time. Residents recognize that patient care requirements, such as unpredictably high clinical volumes or acuity will necessitate staying late to ensure safe patient care, however it is the responsibility of the clinical service to ensure routine work is reliably completed by 5PM.

To address Theme 1 of the Royal College Accreditation Decision, recommendations 6 and 7 aim to replicate best practices that will lead to a culture of greater respect and support.

8. **RECOMMENDATION 8:** We recommend that Academic Half Days (AHD) be protected across all PGY levels.

This includes the recommendation that:

1. Residents be dismissed at a reasonable hour to attend teaching on time.
2. AHD be regularly scheduled without interruption throughout PGY levels, and if no teaching is scheduled, the time may be used for self-study or wellness initiatives.

***Purpose:** Frustration over the current processes around Academic Half Days was consistently voiced by residents. Protected half days support education, wellness and self-directed learning. To address Theme 1 of the Royal College Accreditation Decision, this recommendation will allow residents to feel supported in their education.*

Part 3: Weekend services:

9. **RECOMMENDATION 9:** We recommend that each hospital service develops, and keep current, explicit policies that describe the expectation of residents, fellows and attending physicians (including junior attendings) in the daily care of patients on their services.

This includes the recommendations that:

- a. Policies should be informed by the volume and acuity of patients being cared for, case mix, number of residents on the service as well as their training level, primary specialty, and time of year.
- b. Each attending physician on an inpatient Most Responsible Physician (MRP) service be present in-person to supervise their MRP inpatient roster and trainees.
- c. One attending physician be present in person for each of the CTU teams without cross-coverage of other teams or services.
- d. That attending physicians will:
 - Review, write notes, and ensure appropriate initial management for all new admissions.
 - Assist residents in identifying any patients who do not require routine rounding on one or both weekend days.
 - Participate as active team members and use judgment regarding allocation of workload with the resident, in a shared fashion. The expectation will be for a fair and safe division of workload between the attending physician and resident(s).
 - Attending physicians make a meaningful contribution to direct patient care by rounding on a reasonable proportion of the patients on the service primarily.
 - See or review all unstable patients prior to leaving the hospital.
 - Review the list of patients with the resident(s) after the resident(s) have finished rounding.
 - Remain on-site supporting the team until residents feel comfortable safely rounding on the remainder of the patient list.

- Consistently be available by phone.

Purpose: *Appropriate weekend supervision is essential to support residents in their clinical development and provide safe care for patients. There is variability across clinical sites as to how weekend supervision is implemented. This variability was cited in the RCPSC report as a principal contributor to the accreditation outcome.*

After extensive discussion with residents and program leadership, it was felt that to adequately support residents, attending physicians must be present in person on weekends as described above. The overwhelming preponderance of feedback we received from both residents and faculty was not supportive of cross-coverage of multiple CTU teams by a single attending.

To meet the objective of Theme 1 of the Royal College Accreditation Decision, recommendations 1 to 5 aim to foster a culture of collaboration, support, and education on weekends.

Part 4: Being On Call:

10. **RECOMMENDATION 10:** We recommend that admission guidelines for patients through the Emergency Department as well as processes to manage disagreements between services be made more explicit and be widely communicated.

This recommendation includes that:

- a. Conflict between clinical services around admissions be resolved by attending physicians rather than by residents, and that residents be encouraged to contact attending physicians to resolve such issues, even after hours.
- b. A venue for two-way communication between the Emergency Department and Consultant services at each site be created to manage conflict through mutual recognition of challenges and workstreams.

Purpose: *The Task Force noted that conflicts between residents and the Emergency Department contributed to the feeling of lack of support and safety for residents. Conflict occurred with ED physicians, nursing staff, and other clinical services where there is a disagreement on admission policy.*

Recommendations 1, 2 and 3 aim to address Theme 1 on the Royal College Accreditation Decision by preventing conflict within the clinical setting allowing residents to feel supported and comfortable within their scope of practice.

11. **RECOMMENDATION 11:** We recommend that the emergency departments, medical advisory committees, consulting services, and trainees collaborate to develop a clear, safe, and respectful process for managing disposition of stable patients needing admission between the hours of 5 a.m. to 8 a.m. recognizing the unique patient care pressures being faced by each group. This should include dedicated time for residents to safely complete admissions, review their work, and tend to inpatient issues. The process must be considerate of the ED physician schedule as well. The process of holding stable admissions between 5AM and 7-8AM that is already in place at a number of teaching sites is perceived very positively by the residents.

Purpose: *The Task Force has recognized that between the hours of 5 a.m. to 8 a.m., residents feel most vulnerable in feeling supported and safe in providing patient care.*

Specifically, residents mention feeling exhaustion with not enough time to complete a comprehensive and safe admission plan at that time. At all sites, residents are encouraged to hand over cases if clinically stable, however, current MAC policies state that once the consultant service verbally accepts the consult they are considered the MRP and residents may be called to provide care when not formally assessed. There were concerns expressed by members about the safety of this policy in the academic teaching environment, which differs when compared to other teaching hospitals around the country where ED physicians remain MRP until formal admission orders are submitted.

In light of this issue, several sites around the city have implemented an agreement for the ED to hold consults between these hours, whereby there will be an attending ED physician present to care for the patient should any complications arise, while leaving time for the IM resident to complete their overnight admissions and attend to the ward in time to review in the morning and sign over on time. At sites where this policy has been enacted, residents report feeling that they are able to provide safer patient care and feel more supported.

This recommendation aims to address Theme 1 of the Royal College Accreditation Decision by standardizing this policy across all sites and programs within the Department to maximize safe patient care and handover.

12. **RECOMMENDATION 12:** We recommend that attending physicians ensure that formal post-call teaching is efficient and focused. In considering post-call teaching, the faculty must be sensitive to the residents' level of fatigue, time constraints, and ability to learn, and concentrate on short, high-yield sessions. Aggressive questioning of learners often associated with public shaming/humiliation should be discouraged in any approach to clinical teaching.

***Purpose:** The Task Force has received feedback from residents that there is variability in the processes of post-call and sign-over across hospital sites. Given the level of mental exhaustion post-call, we recommend that formal teaching and questioning should be limited post-call.*

The focus should be on safe delivery of patient handover with associated high-yield case-based teaching, with the priority to dismiss residents on time.

This recommendation aims to address Theme 1 of the Royal College Accreditation Decision by fostering a culture of support and learning.

Part 5: Monitoring:

13. **RECOMMENDATION 13:** We recommend that sites regularly seek anonymous and/or confidential feedback from residents on the support they receive. We recommend this feedback be shared with individual attending physicians in a constructive fashion to promote positive change.

Feedback/Fear of Repercussion:

14. **RECOMMENDATION 14:** We recommend that the program and Department of Medicine improve the way in which feedback is sought and received at all levels by building a culture of continuous improvement that empowers meaningful change and actively seeks and welcomes feedback.
15. **RECOMMENDATION 15:** We recommend that at hospital sites and program-wide, there is transparency with residents about what will happen with feedback obtained from them, and specific plans to address the concerns raised in a timely fashion.

Purpose: *There is a consistent perception amongst residents that feedback disrupting the status quo is discouraged, given feelings of resistance to change and little response when feedback is provided.*

Recommendations 1 and 2 aim to address Theme 2 of the Royal College's Accreditation Decision by actively communicating with residents regarding their feedback and being accountable to addressing feedback provided to create a culture of humility and improvement.

16. **RECOMMENDATION 16:** We recommend that the program and Department actively involve residents as partners in designing and implementing change initiatives. Ideally, this should be at all stages of development of initiatives and include resident leadership beyond the Chief Medical Residents.

Purpose: *Residents already have a seat at the table in many committees within the program and Department, there is variability in the opportunity they are provided to meaningful impact and shape change. There is a sense from residents that although they are represented on major program committees, their opinion is frequently not sought in designing the changes to the program. This recommendation is intended to address Theme 2 of the Royal College's Accreditation decision by maintaining a high standard of resident involvement in quality improvement and change initiatives across the Department.*

17. **RECOMMENDATION 17:** We recommend that the program seek out and implement best practices from other programs regarding incorporating resident feedback, rotation organization, and change management.

Purpose: *The Task Force has found many grassroots initiatives by residents to survey and communicate with other IM residency programs across the country to implement best practices. Residents feel this process should be routinely undertaken by the program for issues raised by residents as a proactive approach to improving residency training. This recommendation aims to address Theme 2 of the Royal College's Accreditation decision by demonstrating a top down culture of continuous improvement.*

18. **RECOMMENDATION 18:** We recommend that the Internal Medicine program resume the cycle of annual site visits, including a robust component of external review for sensitive feedback. As much as possible, this cycle should continue even if other external reviews are scheduled.

19. **RECOMMENDATION 19:** We recommend that the program reviews its rotation and site debriefings to ensure residents perceive these to be safe spaces. We also recommend that confidential and anonymous mechanisms to provide feedback are incorporated.

***Purpose:** Residents appreciate the annual site visits and reviews to formally provide feedback. However, for certain kinds of feedback, residents feel they require access to a confidential avenue to report issues. A robust external component to site reviews should be routinely implemented.*

Recommendation 5 and 6 aim to address Theme 2 of the Royal College's Accreditation decision by providing residents safe mechanisms to deliver sensitive feedback.

20. **RECOMMENDATION 20:** We recommend that an ombudsperson is identified that residents can contact to provide feedback or seek advice from. While it is recognized that the Site Directors and Chief Medical Residents frequently serve this function, an additional avenue for confidential feedback and advice should be available from an individual who does not have an evaluative role. The residents should be consulted in the development of this role and the selection of the ombudsperson.

***Purpose:** The Task Force found that residents feel that many of the traditional venues to provide feedback are not seen as truly impartial and thus are unwilling to provide frank constructive feedback.*

Residents acknowledge that in most cases, Program Leadership and Chief Medical Residents serve an excellent function to receive and respond to feedback.

This recommendation aims to address Theme 2 of the Royal College Accreditation Decision by ensuring safe feedback is delivered.

21. **RECOMMENDATION 21:** We recommend that the Department rethink the use of Town Halls to seek feedback from residents.

Town halls can be an effective means to deliver information to participants, but if questions are going to be entertained or feedback sought, the venue must be a safe space in which such input can be provided anonymously. In addition, there must be a shared understanding of what input is appropriate.

Purpose: *There is a clear sense from residents and faculty alike that a particular breakdown in communication from certain Town Hall events organized by the Department around sensitive discussions was the impetus for residents losing trust and leading to the aforementioned Accreditation Decision.*

To address Theme 2 of the Royal College's Accreditation Decision, this recommendation aims to prevent unintended communication errors with residents.

22. **RECOMMENDATION 22:** We recommend that professional development be offered to both residents and faculty on how to provide and receive constructive feedback for system change.

Purpose: *Providing and receiving feedback is a critical competency for residents and faculty, though limited formal training is offered.*

This recommendation aims to address Theme 2 of the Royal College's Accreditation Decision by educating academic health care providers involved in residency training best practices in exchanging feedback.

23. **RECOMMENDATION 23:** We recommend that time off and protected study time for the Royal College examination be prioritized by the program as per the Professional Association of Residents of Ontario (PARO) contract.

While there may be rare exceptional circumstances, every effort should be made to adhere to PARO guidelines at the request of residents.

24. **RECOMMENDATION 24:** We recommend that the program follow contractual obligations including special arrangements with PARO and where found to be in non-compliance immediately resolve such issues.

Purpose: *Given the relatively recent change to the Core Internal Medicine Royal College Examination occurring in the PGY3 year, residents have identified some challenges in scheduling that may prevent adequate self-study preparation.*

While this recommendation is not directly related to Theme 2 of the Royal College Accreditation Decision, ensuring that every effort be made to follow contractual obligations with residents will improve trust and confidence in the resident body.

Feedback on Preliminary report

Feedback from Department and Program leadership

The key findings and preliminary recommendations were presented to the Executive Committee of the Department of Medicine, as well as the Internal Medicine Residency Program Committee in March of 2022 and written feedback was obtained from them.

The Task Force reflected upon the feedback provided and made changes to the document in response as appropriate. The findings and recommendations above include these changes. This feedback, as well as the response of the task force are summarized below:

Executive Committee feedback

The Executive committee was generally supportive of the findings and recommendations but made the following suggestions for consideration:

- Reorganize/format the list of recommendations to focus first and foremost on those that specifically address the two Areas for Improvement cited in the Accreditation Report
 - Response: The linkage of individual recommendations to the two themes has been clarified through a purpose statement after each set of recommendations.
- Recognize that the report collected data to the end of June 2021
 - Response: Most (but not all) of the data reviewed was from prior to the 2021-22 academic year. The task force acknowledges that the program has implemented important changes since that time, and feels that careful ongoing evaluation of the impact of these changes is required.
- Requested that the report avoid detailed recommendations about specific models of clinical supervision, which may not be based on evidence or best practices.
 - Response: The Task Force has attempted to find a middle ground between endorsing broad principles and highly prescriptive operational recommendations. We feel that a degree of specificity is needed in relation to weekend coverage, particularly on busy inpatient MRP services such as CTU. The recommendations in this report relating to weekend models of care were the result of extensive conversations with the IM program and GIM division leadership. While the recommendation to eliminate cross coverage of multiple CTU team was debated extensively, it was the unanimous recommendation of the task force and was supported by the majority of feedback we received from both residents and faculty.

- Recognize that the majority of people receiving the report will be faculty who are already performing as expected, but will believe that the report is targeted to them.
 - Response: The Task Force recognizes the tremendous commitment of teachers to the experience of residents in the program. These recommendations are intended to establish standards that apply to all teachers in the program. We hope that clarifying expectations will be of benefit to teachers and residents alike.
- Make it clear that the recommendations will need to be interpreted in the context of the complex healthcare system in which we work.
 - Response: The Task Force recognizes the important role of the University and TAHSN hospitals in the educational experience of the residents. We recognize that implementing these recommendations will require ongoing collaboration between them.
- Make it clear that the individual hospitals are responsible for clinical care operations.
 - Response: We acknowledge the important role the hospitals play in both clinical care and teaching. The IM program is one unified program operating across multiple sites. While there will be differences across the hospitals, it is essential we have consistency in learning opportunities and support for trainees across the program.
- Finally, in the clinical setting, it's vital that all members of the team are able to speak up if something seems to be going wrong irrespective of seniority
 - Response: The Task Force agrees that residents must be made to feel safe to speak up regarding patient safety as well as their own training experiences.

Feedback from the Residency Program Committee (RPC)

The RPC supported the recommendations of the Task Force and raised the following points:

- Weekday services: The RPC strongly supported the recommendation that residents be able to complete their work day consistently by 5 p.m. and suggested a recommendation that other responsibilities on the service end by 2:30 p.m. or 3:00 p.m. in order to allow residents to achieve this goal.
 - Response: The Task Force felt that the proposed end time of 2:30 p.m. or 3 p.m. for other work would be very reasonable for many services, but the specific time would vary depending on the workload of each service. In particular, it was noted that on some busy consult services, rounding would need to start much earlier in order to be completed by 5 p.m. For this reason, we did not add this to the recommendation.

- Weekend services: The RPC strongly recommended that on CTU a 1:1 ratio of faculty to CTU teams be expected.
 - Response: After robust discussion, the Task Force accepted this suggestion and amended the recommendations to indicate one attending per CTU team should be present to round on the weekends.
- Vacation requests: The resident representatives recommended improvements to the process of requesting vacations.
 - Response: The Task Force felt that a specific recommendation addressing operational details of the vacation scheduling process was out of scope of our mandate but was pleased to see the commitment of the program to reviewing and modernizing this process.
- Academic Half-days: The RPC notes that residents must be freed to attend Academic Half-day activities.
 - Response: The Task Force agreed and felt this was adequately captured in our current recommendations.
- The resident representatives on the RPC made specific suggestions for changes to the scheduling of call and academic half days.
 - Response: The Task force felt that these operational issues were outside of its mandate and within the scope of the RPC.

Feedback from the DOM Faculty and residents

After the feedback from the Executive committee and RPC was incorporated, a penultimate draft of the report was circulated to all time-time faculty as well as all PGY1-4 residents in the Internal Medicine Program. Feedback was sought through an online survey as well as feedback sessions as described on page 7. The nature of the feedback provided is summarized below:

Feedback from faculty

Faculty members were able to provide feedback by participating in one of five online feedback sessions led by Dr. Hawker, the Chair of the Department of Medicine, or respond to an online survey. Over 300 faculty members provided input. Of the eighteen members who completed the online survey form, 50% reported that the recommendations fully or mostly resonated with them while 21% reported they did not or mostly did not resonate. Feedback received from the collated department feedback and the survey illustrated that some faculty members felt that the recommendations in the report were too numerous and/or overreached the mandate of the task force and that the impact of the recommendation on faculty was insufficiently considered. Some faculty members felt the recommendations were physician focused rather than patient or health care team focused. A general theme emphasized was the impact of a health care system under

crisis on faculty as well as residents and other team members. Some faculty wanted to see some recommendations strengthened, such as the call for hard caps on teaching teams.

Specific suggestions were made to make changes to recommendations #,3,4, 8, 10, 11

Feedback from Residents

Forty-four residents responded to the online survey. Of these, 89% reported that the recommendations fully or mostly resonated with them. Only one resident reported they did not, or mostly did not resonate. Similar support for the report was voiced in the information sessions held via Zoom. No substantive changes were suggested to the recommendations, though residents felt that the recommendations were not specific enough with respect to timelines and implementation plans. Some residents expressed a desire to see recommendations relating to hospital registration, POWER evaluation form design, entrustable professional activities as well as increased flexibility among other themes. Residents expressed a desire that there be accountability on behalf of Departmental & Program leadership for action on the recommendations. There was also a very strong desire by residents that routine program or site reviews include a robust external component in order to feel safe providing feedback. When reading the executive committee feedback as outlined in the preliminary recommendations, residents were discouraged to find that leadership suggested limiting the scope of the recommendations. The breadth of the recommendations were felt by residents to address many ongoing issues that indirectly contribute to the two major themes and the learning environment. Strong support was voiced for having one staff physician per team in hospital on CTU on weekends (#9c) and for urgently addressing admission of stable patients through the Emergency Department between 5-8AM as the current process as the sites that do not hold consults during that time is deemed to be unworkable.

AC Task Force response to the feedback from Faculty and residents

The task force carefully considered all feedback provided and made changes through a consensus process. These changes were agreed to by all task force members (faculty and residents) and are reflected in the wording of the final recommendations outlined on pages 10-20. As indicated above, the Task Force considered the suggestion that it limit the recommendations to those areas under the exclusive control of the University Department and remove or de-prioritize the recommendations which are dependent on changes to the broader care system. There was a consensus by the AC Task Force that such recommendations will be more complex to implement and will have a longer timeline, but they are also among the potentially most impactful for the residents. The Task Force did not accept the suggestion to limit the scope of the findings and recommendations listed in the report. The Task Force deemed the scope vital in providing a comprehensive examination into the Royal College decision. In addition, as reaffirmed by

resident feedback, artificially limiting the scope of the report would further perpetuate a feeling of lack of support and/or fear of reprisal when providing feedback.

Five recommendations were changed in response to the feedback. The changes are summarized below:

#2: The recruitment of non-teaching faculty in addition to Nurse practitioner and physician assistants was added to the recommendation. The recommendation regarding fixed caps was clarified to be explicit that these not apply only to GIM but include other MRP teaching services and residents should be engaged in the process

#6: The wording of this recommendation was clarified to make it clear that the 5PM finishing time applies to routine work residents may need to stay later to address high patient volumes/acuity, however, it remains the expectation that the service and teachers organize the rotation to ensure routine work is completed consistently by 5PM

#11: The wording of this recommendation has been adjusted to focus on the need on improving the disposition of stable consults during the problematic period of 5AM to 7-8AM rather than to prescribe the specific time frame as the specific solution. However, the Task Force believes that dedicated time should be in place for residents to provide safe patient care and avoid vulnerable handovers. The task force notes that the holding of stable consults during that time, which is the process at multiple TAHSN sites, is perceived very positively by the residents.

#18: The wording of this recommendation was strengthened as per feedback from residents to include that external components to site reviews be routinely organized. The Task Force believes that providing safe feedback should be a priority of the program to address ongoing concerns and implement necessary changes.

#20: After deliberation of the Task Force, it was deemed that the specific job description of the ombudsperson should be created by the Department with consultation from residents. The Task Force does believe that this role should be designated to a faculty member, with residents having a strong voice in the selection process.