TEMERTY FACULTY OF MEDICINE
UNIVERSITY OF TORONTO

EXTERNAL REVIEW REPORT FORM

CLINICAL DEPARTMENT UNDER REVIEW	Dept. of Medicine
COMMISSIONING OFFICER	Professor Trevor Young, Dean
REVIEW DATES	October 2-4, 2023

Reviewers are asked to provide a report that satisfies the following:

- *Identifies and commends the Clinical Department's notably strong and creative attributes*
- *Describes the Clinical Department's respective strengths, areas for improvement, and opportunities for enhancement*
- *Recommends specific steps to be taken to improve the Clinical Department, distinguishing between those the Clinical Department can itself take and those that require external action*
- *Recognizes the institution's autonomy to determine priorities for funding, space, and faculty allocation (For information about the University of Toronto's financial structure, refer to the Planning & Budget Office.)*
- *Respects the confidentiality required for all aspects of the review process*
- *Addresses all elements of the terms of reference*

PREVIOUS EXTERNAL REVIEW *[Indicate if, and how, the Clinical Department addressed the findings of the previous review.]*

The University of Toronto Department of Medicine (DoM) has substantively responded to all of the recommendations within their purview. The recommendation for electronic health record (EHR) implementation in the hospitals was outside their remit and we've learned that the EPIC HER was adopted. The recommendation to address inter-institutional collaboration through better harmonization of the ethics and contract process remains a challenge identified again in this review. The DoM has senior members engaged with the Toronto Academic Health Science Network (TAHSN) and it is a priority, but it may need substantive support from the Temerty Faculty of Medicine (TFOM) to catalyze the needed changes.

1. Education

A. UNDERGRADUATE MEDICAL EDUCATION

- **Please comment on the size, scope, quality, and priority assigned to undergraduate medical education.**

The Vice Chair, Education is Dr Arno Kumagai who is in his second term and there is an active Executive Committee comprised of leads from the various UGME and PGME programs. DoM places a high priority on undergraduate medical education (UGME) and has 270 students in each of its 4 years of medical school. Although the pre-clinical years 1 and 2 are directed by the TFOM, the DoM faculty substantially contribute to the curriculum and teaching in the Preclinical Foundations Curriculum. Dr Luke Devine is the Department of Medicine Program Director and Chair of the UGME working committee, and each teaching hospital has a site lead responsible for the medical students rotating for their clerkship and electives. Since 2017, the Person-Centred Care Curriculum (PCC) was implemented in the 3rd year Internal Medicine clerkship to integrate principles of educational theory and humanities disciplines to optimize learning and critical reflection on patient-physician interactions, equity, and social justice in medical education. During the pandemic they recognized that the students starting clerkship had less physical examination teaching and exposure to patients. The UGME committee developed a 4-hour physical examination crash course with students in small groups to review the Neuro, Cardio, Resp and GI examination. The students now are required to complete entrustable professional activity (EPA) assessments, and these are for formative feedback. It appears that the burden for the faculty is rather low as the EPA can also be completed by supervising residents. The summative evaluation is done separately. There is a recognition that as training sites diversify with expansion to Scarborough, the training experience will be different and there will be a need to adjust to what the faculty development needs are. The MD Program was reviewed by CACMS and in June 2021 received Full Accreditation for eight years. One deficiency was the learning environment standard which is being addressed through the leadership of Dr Reena Pattani to establish several pathways of reporting learner mistreatment as well as faculty development in this area through the Learner Experience Unit. The medical student experience at the TAHSN hospitals and at Trillium were rated highly and they felt the Clinician Teacher (CT) faculty were excellent and devoted to clinical teaching. At the TAHSN there was more structure and regularity to the teaching, but the students felt teaching at all sites was high quality and they were well supported.

B. POSTGRADUATE MEDICAL EDUCATION

- **Please comment on the size, scope, quality, and priorities of postgraduate education programs.**
- **Do current programs offer adequate training in different settings?**

PGME training is distributed across 6 major affiliated teaching hospitals and 12 partially affiliated sites offering training to over 450 residents and 500 clinical fellows. The UofT DoM has the largest core Internal Medicine training program in the country (N=200), as well as direct entry programs to Emergency Medicine, Physical Medicine and Rehabilitation, Dermatology and Neurology. The DoM has well established Royal College (RCPSC) training programs in all 15 medical specialties as well as an impressive number of RCPSC

Areas of Competence and Clinical Fellowships (N=550); 70% international and 30% Canadian. It is notable that the Clinical Fellowships are funded by the Divisions (billings) or by philanthropic support. Each program has a Program Director (PD) and Program Assistant (PA). There is also a Director of Fellowship Programs who works closely with the TFOM PGME to establish policies and procedures. The Director supports the Clinical Fellowship PDs in structuring programs. There was some lack of clarity in terms of reporting when there were issues given that Fellows are trainees of the university but paid as employees of the hospital. The rising cost of living is increasingly a challenge; the minimum salary guideline has recently been increased to $73K per annum starting January 2024, and we heard concerns that this amount is too low, given the cost of living. Most of the fellowship training is at a single hospital but there are some fellowships that are city-wide. Hospitals often have space limitations such as Princess Margaret Hospital, which currently has 85 clinical fellows. It was noted that many of the specialized clinical programs are also dependent on these highly trained clinical fellows, which make them vulnerable. The cost of living has resulted in many basic science research fellows opting not to come to Toronto. Many fellows come to Toronto from abroad, and we learned that some encounter challenges in coming to UofT and working. First, annual registration fees and re-enrolment fees are high relative to salary. Minimization of fees would be helpful. Second, delays occur in visa and work permit applications. Although verbal offers of positions are often made a year or more in advance, official acceptance letters from the University are only generated in February of the start year. These letters (such as the 'Letter of Appointment') are needed for work permit applications. Second, there can be delays in government processing for work permits when letters of appointment are so late, and this can result in a delay in the fellows starting. Third, because a work permit is required for a police verification certificate, which is required for CPSO registration, the delay in a work permit delays CPSO registration. It was suggested that the necessary documents for CPSO registration should be outlined in a clear document for international fellows. The DoM does work with PGME to provide onboarding, an orientation in July, which is recorded and there is also orientation at the local hospital with the supervising faculty. UHN has developed an education module to introduce the Canadian health care system, which they are piloting with the incoming international clinical fellows. It would be helpful to develop a clear process map and timelines particularly for international clinical fellows especially given the myriad of administrative issues that need to be navigated.

The UofT DoM has implemented principles and processes of equity and diversity in its selection process and programs including leadership, resident recruitment, and selection and this was provided in detail in the self-study. The VCE has also struck a Learner Mistreatment Advisory Group that consist of faculty and learners which determined that policies did not sufficiently address numerous issues. They have developed an internal process for collecting disclosures and addressing issues of mistreatment in a safe, confidential, and effective manner.

There are numerous excellent initiatives under Medical Education Scholarship (MEdS) including the Clinician Educator Training Program, the CBME Research Network, Collaboration of Researchers, Educators, Scholars and Teachers (CREST) and the Internal Medicine Medical Education Research Interest Group. In 2021, this portfolio was redesigned with a new strategic vision: Leading in Medical Education Scholarship through commitments to diversity, partnership, and meaningful impacts for our people, patients, and society. MEdS started a bi-annual strategic MEdS grant competition in 2021 and have awarded > $65K in seed funding to support 7 strategic projects focused on competency-based education and knowledge translation, education in EDI, and innovations in teaching. This portfolio has also built a community of practice with quarterly MEdS events and has partnered with the Applied Education Research Operatives team at Unity Health for a Work in Progress rounds.

In 2021, the RCPSC accreditation review resulted in the core Internal Medicine training program being put on Notice of Intent to Withdraw. Of note, the review was conducted during the third COVID-19 wave in Ontario and the health system was highly stressed. We recognize that this was incredibly demoralizing for the faculty who are committed to training Internal Medicine residents. The Internal Medicine RPC and the DoM established two task forces with residents and advisory groups, and created improved communication channels and opportunity for resident feedback. The DoM has invested $400,000 at 5 teaching hospitals (total $2 million) to provide additional support to create resident-independent services due to the large volume of patients and offload the Clinical Teaching Units. There is now increased resident supervision and support in the evenings and weekends by faculty. An internal review was completed, and the results were positive although the faculty are still stressed. The RCPSC review is occurring next month.

Program Directors would appreciate more sharing of program policies to better standardize CaRMS match processes, approaches to residents in difficulty, professionalism issues, and resident code of conduct documentation. They note that the CBD committees were initially funded and now are largely voluntary. CBD has been a huge additional workload for faculty and the programs with unclear value in terms of improvement in the educational outcome for residents. Many programs have had challenges with administrative support in terms of turnover and insufficient funding to cover all the required tasks. The residents did not perceive they derived substantive value from the feedback received on EPAs for the most part.

CTs are feeling at their max with additional asks and stresses from the university and their hospital in the current health system. It is harder to motivate faculty to do extra teaching. There is a need to provide more support and recognition to the CT and this would be greatly appreciated. The DoM has a faculty lead in Valuing the Clinician Teacher who has a focused role to acknowledge and support CTs. The promotion timeline is still longer than other categories and faculty would like the time to promotion for CT to be 6-7 years if for sustained excellence in teaching. There has been difficulty in getting evaluations from problem-based learning, which the TFOM needs to address as it has impact on ability to get recognized and promoted and is part of the students' professionalism. One innovation, MyTE (My Teaching Evaluation), was developed by Dr Esther Bui, Division of Neurology, and offers a mobile online evaluation system to obtain encounter- based assessment and feedback capturing the teaching that often goes unevaluated and documented by learners. This tool has the potential to be scaled as many medical schools and training programs have similar challenges in obtaining sufficient number of assessments for promotion files.

C. CONTINUING EDUCATION

- **Please comment on the size, scope, quality, and priorities of continuing education programs.**

NA

D. LEARNER WELLBEING

- **Describe the initiatives taken to promote learner wellbeing and resiliency in the educational environment.**

There has been a great deal of attention to promote learner wellbeing and resiliency in the educational environment in the past five years. There is a strong focus on EDI in the UofT DoM and the Vice Chair, Culture and Inclusion portfolio has provided additional support to learners. The Black and Indigenous Pathway for CaRMS interviews was recently developed; the core Internal Medicine program now has 4 Black and 2 Indigenous pathway applicants who matched to the UofT core Internal Medicine program as of July 2023. There are numerous human resources available to all residents navigating challenges in the learning environment. Each site has a site director, chief medical resident, and a newly introduced role of Resident Advisor. The Office of Learner Affairs is also available if the resident prefers anonymity compared with a site-specific approach. There is a core Internal Medicine program Wellness Committee with a faculty lead (Dr Rebecca Stovel) and resident representatives, and they have developed resources and initiatives related to resident wellness that are disseminated to all teaching sites. The Clinical Teaching Unit (CTU) underwent a significant redesign based on resident feedback resulting in eliminating 24-hour call for the senior medical residents, integrating ward and consult medicine rotations, and improving the continuity of care for patients and learners. Each Division has developed faculty standards of supervision for learners and clear expectations. There is increased attending physician support in the evenings on call and on the weekends. It is notable that the UofT DoM has invested $2 million dollars to increase support for GIM resident-independent coverage to maintain CTU team census in a range optimized for learning and safe care of patients. In the core Internal Medicine program there is also a Near-Peer Mentoring program that pairs incoming PGY1 residents with more senior residents to provide guidance and support. The faculty are very committed to mentoring trainees. The medical students, residents, clinical fellows, and scientists in training all endorsed a highly supportive learning environment with the exception of during the acute surge of COVID-19 in 2020 where it was felt communication had been suboptimal.

E. Excellence Through Equity

- **Please comment on the Clinical Department's actions to enhance EDIIA.**

The UofT DoM created a Vice-Chair, Culture and Inclusion which is held by Dr Umberin Najeeb. This portfolio is responsible for EDI, wellness and mentorship. Dr Najeeb has developed a number of committees with faculty leads in Physician Wellness (Dr Simron Singh), Equity (Dr Christine Soong), Mentorship (Dr Catherine Yu), Black and Indigenous Resident Application and Mentorship (Dr Mirielle Norris), Late Career Transitions (Dr Eric Cohen), and Valuing the Clinician Teacher (Dr Martina Trinkaus). The UofT DoM is a leader in this area across the country and other departments at the TFOM view the work Dr Gillian Hawker has supported as exemplars that they have adopted including their guidelines for DoM faculty and leadership searches through a gender lens. Intersectionality is also recognized as an important consideration in recruitment and searches. Work is being undertaken to create an environment that is welcoming, and it is important that this is also occurring at the hospital site level. This requires a great deal of faculty development, which this portfolio is incredibly committed to. The Sunnybrook Program to Access Research Knowledge (SPARK) for Black and Indigenous Medical Students is led by UofT DoM faculty (Dr Mireille Norris, Dr Jill Tinmouth, and Dr Nick Daneman) and supported by the hospital practice plan and Sunnybrook Foundation. This has been a highly successful program providing research mentorship, opportunities, and career sponsorship for Black and Indigenous medical students. This is clearly a program that should be scaled but is in need of human resource and financial support to do this.

2. Faculty

A. Equity, Diversity, Inclusion & Wellness

- **Please comment on steps taken to ensure fairness, equity, diversity, and transparency of faculty recruitment and appointments.**
- **Please comment on the overall commitment to physician wellness. What have been the challenges and what are the opportunities?**

The DoM has a very highly developed structure to promote equity, diversity, inclusion, and wellness across the Department. In fact, the DoM structure is a model that might be useful to other departments outside UofT and perhaps at UofT. The structure is led by the VC, Culture and Inclusion (currently Umberin Najeeb) and includes Faculty Leads in each of six areas: physician wellness, equity, mentorship, black and indigenous resident application and mentorship, late career transition, and valuing clinician teacher. The VC, Culture and Inclusion and the six Faculty Leads constitute an Executive Committee for Culture and Inclusion. The VC, Culture and Inclusion is also responsible for DoM programs to promote Wellness and Mentorship. This explicit and refined structure was designed in part in response to Recommendations 17-23 of the External Review 2018.

Overall, the DoM has focused on creating a culture that promotes each of the three domains: Equity, Diversity, and Inclusion; Wellness; and Mentorship, and the self-study and interviews both indicate that the Department has made great progress in advancing this culture. The leadership of Dr Hawker, her personal commitment to this culture, and resources she has committed through DoM are recognized and greatly appreciated by faculty. DoM has also made focused efforts to advance wellness such as support for the CTUs during COVID-19 and leadership of a TAHSN working group to standardize wellness initiatives across institutions. The DoM recognizes its limitations in diversity and conducted its first self-identification survey, which revealed that 2.3% of faculty identified as Black and 0.8% identified as Indigenous.

Specific efforts to increase representation in the faculty include the Annual Lecture in Black Health, development with TFOM of "Guidelines for Inclusivity," and support of the Black and Indigenous Resident Application and Mentorship Program, under the leadership of Dr Mirielle Norris. The culture of Mentorship has been advanced with several specific programs described in the self-study, including a formal mentorship program for junior faculty that assigns mentors both within and outside of the faculty member's division. The proportion of faculty who report one or more mentors increased to 76.3% in 2022, compared to 47% in 2017; mentorship satisfaction also improved over that time.

A systemic tension for UofT faculty, and potentially a threat to the future value of a UofT appointment is the development of new campuses in Mississauga and soon in Scarborough. The new campuses are perceived to dilute the resources on other campuses by requiring residency training programs that will be built by taking residency positions from the downtown campuses and by requiring resources to support a Clinical Teaching Unit for new medical students, apparently without additional financial support to DoM. Also, there is the perception that the value of the UofT faculty appointment is eroded when the same appointment is given to community physicians who do not contribute substantially to the DoM.

An Area of Concern

The external reviewers were informed that a pattern of microaggressions from leaders creates a "toxic culture as a norm" in one of the hospitals. It was reported that some physicians in leadership use their power to spread rumours and inaccurate data "to create a culture of hate for a division member." Also, it was reported that a physician leader used abusive language to interrogate and inappropriately escalate a situation. We were asked not to identify the hospital in which this happens because of fear of retribution and retaliation. The faculty believes that this information is unknown to Dr Hawker, who has promoted inclusive, positive leadership.

Another concern raised was that the clinical culture is to replace a clinical physician once every 5 years with new graduates.

The faculty suggested that these concerns can be addressed with humanistic leadership, which is modeled by the Chair, developed systematically across the DoM:

- a leader who values a physician as a person, reflects, acts and leads positive cultural changes
- a leader who sees things from the subordinate's lens and who permits unintentional tolerable mistakes/admits mistakes and sees others as human beings.
- a leader who creates a culture of growing mindset, equity, and inclusivity, instead of a blame/shame culture

B. Mentorship

- **Please comment on the appropriateness of steps taken to ensure mentorship within the faculty.**

The steps taken to ensure mentorship within the faculty are laudable – see comments above for details.

C. Faculty Development

- **Describe briefly opportunities for faculty development.**
- **Please comment on opportunities for leadership development and workshops.**

Faculty Development is clearly a priority for the DoM. The first Vice Chair with responsibility for Mentorship was appointed in 2015 and has been superseded by the Vice Chair, Culture and Inclusion, as described above. Faculty Development begins at appointment when each clinical faculty member is assigned an Academic Position Description that stipulates how much time is expected to be committed to clinical care, teaching, research, and administrative activities. Programs in the VC, Culture and Inclusion portfolio extend these initial efforts at faculty development – e.g., the programs in mentorship, valuing clinician teachers, and late career transitions. The DoM has developed exceptional programs described by clinical fellows, especially those in research-intensive programs.

3. Quality & Innovation

- **Please briefly describe (e.g., leadership, faculty development, capacity building / collaboration, and knowledge translation).**
- **Please comment on the level of scholarship in quality improvement (innovation).**

The DoM is highly supportive of Quality and Innovation (QI) and has appointed a Vice Chair, QI – Dr Kaveh Shojania. In 2009, the UofT Centre for Quality Improvement and Patient Safety (CQuIPS) was established followed by the creation of the Clinician in Quality and Innovation (CQI) academic position description. Over the past decade the number of faculty has grown from one to now 90 faculty, with 78 full-time and 11 part-time CQI faculty. They work in all the major teaching hospitals and 16 of the 20 Divisions have CQI faculty. Furthermore, other departments such as Anesthesia and Pain Medicine and Family and Community Medicine have CQI positions. Laboratory Medicine and Pathology, Medical Imaging, and Psychiatry also are appointing faculty members as CQIs. The QI work is dependent on hospital and wider health systems to provide most of the support. Attention to developing the governance and structure was initiated but was stalled due to the pandemic although there is an active Executive Committee comprised of faculty across sites and divisions. When this track was originally developed, it was envisioned that administrative positions in the hospital would buy out time to do the hospital quality work and the scholarship on top of it. This track has become very popular and there are not enough paid administrative positions for all CQI faculty resulting in insufficient base support. There is a mismatch of expectation and alignment of CQI faculty at the hospital and university level. The hospital focus is operational work and committees, and this does not typically result in scholarship. Of note, Continuing Faculty Appointment Review has not had difficulty promoting faculty who have been put forward from their sites, although there are CQI

faculty who are being told to wait because of the lack of output associated with traditional scholarship (publications and grants). It is notable CQI faculty have been critical to health care improvements including new models of care, overall care delivery during COVID-19, and clinical informatics. This portfolio has also made impressive strides in faculty development and residency education through the Co-Learning Curriculum in Quality Improvement, which has scaled to 35 training programs and more than 200 residents across the Departments of Medicine, Surgery, Pediatrics, Laboratory Medicine, and Anesthesia. This program has also been replicated at Western and McMaster University as well as Virginia Tech (US). There are numerous PGME offerings including the Master of Science in Quality Improvement and Patient Safety at the Institute of Health Policy, Management and Evaluation, the CQuIPS Certificate Course, the Excellence in Quality Improvement Certificate Program (EQUIP), and is an affiliate site of the VA Quality Scholars program. The scholarly output has been impressive with over 1200 refereed publications and increased collaborations among CQI faculty in publication. They have also taken on leadership roles in the teaching hospitals. The topics they address have powerful impacts on the health system such as the LTC+ program that involves six hospitals and 54 sites to improve the appropriateness of patients being transferred from long term care facilities. This important work has also been supported by CIHR funding. Other exciting initiatives include GEMINI, GeMQIN, and Choosing Wisely Canada.

Funding for Chairs, Vice Chairs, and CQuIPS could allow for redistribution to junior faculty. There is a low budget from the DoM to support QI work and there is a need for more awards and recognition. This funding could offset some of the cost for open access publication fees and provide scholarships for early career and learners to travel and allow for knowledge dissemination. It was noted that in-kind support from hospitals in supporting a project manager in hospital-related CQI projects is invaluable in terms of data access and analytics. The criteria for promotion need to be less traditionally focused on research scholarly outputs and instead value the CQI faculty engagement with health system work, which improves how care is delivered.

4. Research

- **Please comment on the scope, quality, and relevance of research activities.**
- **Are the research activities appropriate for the residents and fellows in the Clinical Department?**
- **Have opportunities for recruitment of young investigators been identified?**
- **Are the levels of research activities (e.g., funding and peer-reviewed publications) appropriate relative to national and international comparators?**
- **Please comment on the faculty complement plan and, specifically, on how the Clinical Department is increasing diversity among its faculty members at all levels, including among its senior leaders.**
- **Address the appropriateness and effectiveness of the Clinical Department's use of existing human resources.**
  [In making this assessment, reviewers must recognize the institution's autonomy in determining priorities for funding, space, and faculty allocation.]

It is truly remarkable to review the scope, quality, and relevance of research activities of the UofT DoM, especially in light of the multiple waves of the COVID-19 pandemic and the significant impact it had on faculty of the DoM who also provided frontline care to patients. The research areas span fundamental science, translational, clinical, population, and health system, and the DoM has 22 Canada Research Chairs. The DoM produced 32% of all UofT scholarly output in health sciences from 2017-22. In 2023, the journal Nature ranked the UofT as the second most prolific academic health science research institute in the world second to Harvard and ahead of Johns Hopkins, Yale, and Oxford. It is certainly the top research DoM in Canada. The research funding has been increasing year-over-year with a total of $1,229,465,220 (2017-22). The Vice Chair of Research Dr Jane Batt was appointed June 2023 and took over from Dr Michael Farkouh who held this role 2015-2023 and established the Network of Networks to support city-wide interdisciplinary research teams. Numerous research networks have developed across multiple hospital sites and divisions. The UofT DoM also provided start-up support to newly appointed Clinician Scientists (CS) of ~$40K per year for the first five years. The CS Salary Support Program was re-vamped in 2021 after an EDI-focused external review and the changes, which incorporate DORA in the assessment of research in addition to traditional research metrics has been well received by researchers. In terms of training programs, the Eliot Phillipson Clinician Scientist Training Program (CSTP) is impressive and was directed by Dr Robert Chen (2009-21) and is now led by Dr Mamata Bhat. The program provides a stipend of $75K + tuition and trainees were successful in external funding of $2.45 million in addition to $1.63 million of internal scholarships, (2018-22) reflecting the high quality of individuals in the programs. We were highly impressed with the trainees we met who had completed their subspecialty training and pursuing further research training with a Master's, PhD, or Post-doctoral Fellowship and research projects in their fields of interest. It was noted that fewer clinician scientist trainees are pursuing basic science and this is being reviewed by Dr Bhat. The graduates of this program apply for CS positions within the DoM and are competitive for positions in Canada and the US. The calibre of UofT DoM faculty who conduct research as CS and Clinician Investigators (CIs) creates a highly scholarly environment for both students and residents to pursue research projects and receive instrumental support. Dr Hawker has paid a great deal of attention to EDI issues in all aspects of the UofT DoM including research. Dr Jane Batt and Dr Mamata Bhat are both in positions of leadership in this portfolio and are committed to processes that are transparent and inclusive. As reviewers, we have determined that the UofT DoM has been very effective in its use of resources to optimize its research mission. That said, the support given to the CS has been stagnant for the past decade and with rising cost of living pressures it may be increasingly difficult to recruit and retain this category of faculty. Greater investment in the CS program would likely have excellent returns in terms of the development of research-intensive faculty and increase in excellent research programs. Also, DoM investment in CS affiliated with the Research Institutes (RIs) would strengthen the bonds between DOM and the RIs.

A substantial amount of extramurally funded research was reported by faculty to be done by Clinician Investigators, who seem not to receive financial support from DoM or from RIs. (Section 3, Appendix C indicates that CIs spend 30-50% effort in Research Scholarship, compared to 75-90% effort for CSs. It is not clear to the reviewers whether the research effort has a different focus in the two tracks (e.g., patient-based or data-based research vs. laboratory-based research) or whether the sources of support differ for the two tracks.

We heard comments that CI is a “hard job” because CIs are “torn in all directions” because of funding needs. It was reported that Dr Hawker has done a great deal to learn and speak to the needs and contributions of CIs. We believe that focused investment in CIs would likely have a great dividend in building the scientific community and building extramurally funded research.

The hospital RIs provide start-up and space for CS who are recruited to their site and over the years, there is a perception that the amount of support provided by the DoM has eroded over time. There is a desire for the UofT DoM to play an important role beyond the academic appointment and ideally recruitment is a potential partnership opportunity to best set up the candidate to be successful. This may be achieved by integrating UofT and hospital fundraising opportunities where possible. The overhead provided on research grants to the RIs does not cover the costs of doing research and collaboration between the RI and the UofT; addressing the question of how UofT and the RIs can achieve more mutual benefit is a priority. Inter-institutional collaborations continue to be a challenge and the barriers to inter-institutional collaborations are stifling research and innovation due to being bogged down by each institution’s REB and contracts office and this needs to be urgently addressed by the TAHSN-R. There is a rising clinical demand that also needs to be met as well as research needs, which requires strategic recruitment and potentially thinking city-wide to leverage and share resources and reduce duplication by building infrastructure that could be shared. Harmonization would be critical for this to be successful.

The rate of increase in extramural research funding has decreased from 19% growth from 2017-18 to 2018-19 to 13%, 5%, and 1% growth in each of the subsequent years. While this may reflect the effects of the COVID-19 pandemic to some degree, the trend may also indicate underinvestment by TFOM and the hospitals/RIs in sustaining and developing research.

5. Relationships

- **Please comment on the strength of the morale of the faculty, learners, and staff.**
- **Please comment on the initiatives undertaken to enhance a sense of an inclusive community in the Clinical Department.**
- **Please comment on the scope and nature of the Clinical Department’s relationships with cognate Departments/EDUs at the University of Toronto, affiliated hospitals, and external government, academic, and professional organizations.**
- **Address the extent to which the Clinical Department has developed or sustained fruitful partnerships with other universities and organizations in order to foster research, creative professional activities, and to deliver teaching programs.**
- **Please comment on the social impact of the Clinical Department in terms of outreach—locally, nationally, and internationally.**

Morale

The strength of the morale of the faculty is threatened by several recent developments even though faculty we met love their work and mission. Senior physicians spoke of a “crisis situation in academic medicine” that is perceived across Canada to have eroded the value of the University as dissemination of UofT faculty appointments to community physicians is felt to have devalued the meaning of an appointment to the traditional faculty. The required implementation of CBD is felt by many faculty to have added work without proportionate benefit to education. The accreditation review of the DoM residency demoralized many faculty when they were their most stressed during the COVID-19 pandemic. The work expectations for faculty are perceived to have increased with the unfunded workload of CBD, substantial teaching responsibilities, the sequelae of the accreditation review (including increased tension between faculty and trainees, and increasing clinical workloads. TFOM is perceived to have not supported DoM adequately by sweeping most of the funds in DoM reserves and not to have supported many faculty by not having adequate number of students’ complete evaluations. (We were told that only 37 faculty received UME evaluations.)

Sense of an Inclusive Community

The sheer size of the DoM and its decentralized structure in 6 practice plans and teaching hospitals provide challenges to creating the sense of a single, unified clinical department that fosters inclusive community. Nevertheless, several DoM programs make the DoM remarkably inclusive, including the following:

- The structure of the Department with Vice Chairs responsible for integration across the DoM in their domains;
- The Residency Program in general and the program to recruit and sustain Black and Indigenous residents in particular;
- Several specialized training programs available across the Department, including the Eliot Phillipson Clinician Scientist Training Program, the Master Teacher Program, and the program for advanced training in Quality Improvement and Patient Safety;
- The Vice Chair, Culture and Inclusion and the Culture and Inclusion Executive Committee with six specific domains of focus.

Despite these structures and the substantial investment of DoM in building an inclusive community, it is not clear how much sway the DoM has over the actual performance at each teaching hospital. In fact, the “Area of Concern” cited above in Section 2.A suggests that one of the teaching hospitals has permitted behaviors that do not build an inclusive community.

Relations with Cognate Departments/EDUs

The leaders of the cognate departments whom we met are deeply appreciative of DoM and of Dr Hawker’s efforts. Specific comments include “DoM is extraordinary,” “the Department makes great contributions to IHPME, one of UofT’s elite programs,” “great leadership,” and “Gillian is very collaborative and a great contributor.”

Cognate Department leaders recognize tensions in the DoM that result from its diversity and its hard-driving pursuit of excellence in research, education, and care. For example, in the past, there was concern that DoM overemphasized science, and now concern was expressed that DoM is not as bold as it might be in promoting research because of increased concern for learners and clinician-teachers; we emphasize that we did not conclude that DoM overemphasizes one activity over another, only that the Department navigates inevitable tensions in its pursuit of excellence, and that "holding" the tensions is part of a healthy department. Cognate Department leaders commented that the Dean's Office could do more to recognize Department leadership and to include Department leadership in key decisions. We did not learn greater specificity on this comment.

Concern was expressed about the future of Clinician Scientists, a concern that is shared across academic medicine. No department is better positioned to create a bright future for CS, given the needed resources and the ability to continue to focus on CS.

Partnerships with Other Universities and Organizations

Department leaders and faculty have extensive relationships with universities and organizations around the world, as illustrated by the Toronto Addis Ababa Academic Collaboration and a collaboration with UCSF to develop training for faculty in clinical informatics, remote patient monitoring, and AI. These collaborations address cutting edge issues such as managing the EHR inbox. We did not hear evidence that DoM has systematically built partnerships with other departments or organizations to address issues faced by many departments and across the field. Such issues might include the future of the physician-investigator, challenges to sustained well-being, and the effects of remote work. While the possibility of partnerships to develop these and other issues is intriguing, constraints on time and funding, especially in a world with increasing demands for clinical work and teaching, limit this possibility.

Outreach – Local, National, International

The Department has created and sustained a culture in which its faculty engage with local, national, and international communities, including Indigenous communities in Canada. In addition to leading efforts in science and education, faculty address issues such as homelessness, addiction, and climate change.

6. Organizational + Financial Structure

- **Please comment on the appropriateness and effectiveness of the Clinical Department's organizational and financial structure, and its use of existing human, physical, and financial resources in delivering its programs.**
  [In making this assessment, reviewers must recognize the institution's autonomy in determining priorities for funding, space, and faculty allocation.]
- **In the broadest sense, how well has the Clinical Department managed resource allocation, including space and infrastructure support?**
- **Please comment on opportunities for new revenue generation.**

The DoM's organizational structure is rational and effective in weaving together an exceptionally complex enterprise of six hospital-based departments of medicine with 20 department-wide divisions, each of which includes faculty in most of the hospital-based departments. This enterprise includes nearly 1000 faculty and over 1000 post-doctoral trainees. The Chair and the four Vice Chairs provide centripetal force and integration for the DoM. The fact that the center holds, and that the DoM has both an internal and external identity in the context of such complexity is a remarkable tribute to value-driven, spirited, and effective leadership.

Based on the understanding that we developed, noteworthy organizational characteristics of the DoM are that all clinical activities occur at the level of each hospital and its practice plan and that most research activity occurs at the level of each hospital, largely within hospital-based research institutes. The DoM has the following portfolios supported by its organizational structure:

- Education: Includes medical clerkships for MS3 and MS4, training of >1000 postgraduate trainees (more than half of whom are specialty fellows), advanced faculty development programs in research, teaching, and quality improvement/patient safety, and leadership of the Institutes for Medical Sciences and Health Policy, Management and Evaluation.
- Research: Roughly half of faculty spend >50% effort in research, with annual funding nearing $300,000,000. Management of the research portfolio is apparently largely the responsibility of the Research Institutes. The Department manages the Eliot Phillipson Clinician Scientist Training Program and supports the Program with up to ~$2M/year.
- Quality and Innovation: While most quality, innovation, and safety activities are hospital-based and funded, the Department provides training in this area and a community for 79 full-time clinical faculty.
- Culture and Inclusion (and Mentoring): DoM establishes and monitors mentoring programs across the Department, procedures for recruitment and selection of faculty and learners to promote diversity and assure equity, and expectations for professionalism.

The Department's financial structure is strained and it is remarkable that so much has been accomplished with such limited resources. Funds to DoM are derived from TFOM, payment for resident training, and endowment revenue. Total funds were essentially the same ($23M) from 2014 until 2022 when funding fell to $19M, in part because of decreases in funding from TFOM. In addition, TFOM swept much of the DoM reserves and limited the amount of reserves the DoM could carry forward from year to year, resulting in decreased capacity for new DoM investments. DoM has accomplished great things with limited resources, and further investment would likely have tremendous return in terms of the development of the next generation of physician-investigators and the expansion of clinical training. Funding from the practice plans and from the philanthropic community would benefit the Department's faculty and learners.

DoM delivers terrific programs with outstanding, committed people and limited physical and financial resources.

Potential sources of new revenue generation include:

- Philanthropy: This would require the commitment of TFOM and of the six hospitals to prioritize some giving to DoM. Funds might be raised for specific programs that would cross and integrate hospital-based programs and for training, especially research training. As a global leader in a wealthy city, UofT is well positioned.
- IP: Agreements with UofT and individual hospitals and RIs could provide DoM a portion of funding from IP developed by DoM faculty.
- Practice Plans: A tax, even a small tax, on practice plans for DoM-supported research and faculty development would provide funds that would have tremendous payback for the faculty.
- Graduate Education Programs: The UofT faculty and reputation would be very attractive to international students. Starting new programs will require investment, and DoM has been left with insufficient funds to make such investments.

7. Long-Range Planning Challenges

- **Please comment on the vision for the future of the Clinical Department.**
- **Has the Clinical Department clearly articulated a strategic academic plan that is consistent with the University's and Temerty Medicine's academic plans?**
- **Please comment on whether there is consistency with Temerty Medicine's commitment to EDIIA to attain Excellence Through Equity.**
- **Please comment on the planning for advancement and leadership in approaching alternative sources of revenue, and appropriateness of development/fundraising initiatives.**
- **Please address any space and infrastructure considerations.**
- **Please comment on the management, vision, and leadership challenges in the next 5 years.**

The DoM vision is aspirational and appropriate: to impact health through international leadership in education, research, and the translation of new knowledge into better care and health outcomes. The four-point strategic plan is congruent with the academic plans of UofT and Temerty Medicine. Most importantly, the Department's commitment to being a community that "promotes mutual respect, compassion, integrity and inclusion, and thus fosters the wellbeing of our faculty and learners" is congruent with Temerty Medicine's commitment to EDIIA, as described in Excellence Through Equity.

We had the impression that advancement is conducted primarily at the level of Temerty Medicine and that it is under-resourced to achieve the results needed in DoM. Moreover, there may be conflict with the individual hospitals and their faculty and programs. DoM leadership does not have the bandwidth to lead development efforts themselves, even though they would likely be very effective.

An important infrastructure constraint is a lack of research space for new faculty, and the fact that all research space is under the authority of hospital-based research institutes. While there are advantages to the hospital-based approach, would TFOM and a donor build new space for a program(s) that would be crown jewels?

The self-study eloquently describes on page 135 the substantial challenges facing an exceptional academic department such as this one. Continued efforts to develop new models of care and to provide environments that are healthy for faculty, staff, and learners will be critical. In every large academic medical centre, tension is growing between centralized approaches to management and reliance on the exceptional abilities and drive of individual leaders and faculty with autonomy. The DoM leadership and faculty will certainly deliver tremendous results in proportion to the resources and autonomy they are given to address critical issues in medicine.

8. National + International Comparators

- **Please assess the stature of the Clinical Department compared to others of similar size in national and international universities, including areas of strength and opportunities.**

This is the largest Department of Medicine in Canada and it has premiere stature nationally and its ranking is also comparable to top tier international universities. In fact, the journal Nature ranked the University of Toronto as the second most prolific academic health sciences research institute in the world and the scholarly output from the UofT DoM makes a substantial contribution to this. As mentioned earlier, the ranking is second to Harvard University and ahead of Johns Hopkins, Yale, and Oxford University. The current faculty have worked tirelessly for the academic mission, which is particularly powerful given that such output occurred during a devastating pandemic and societal upheaval. Overall, we believe the UofT DoM is a global leader in research, education and training, and clinical programs. The fact that DoM has achieved so much with only modest financial support available to the Department suggests that increased investment in DoM would have tremendous benefits for UofT and TFOM.

9. Conclusions

- **Provide an overall assessment of strengths and concerns, and recommendations for future directions.**

Strengths

1. Large, fully diversified Department with internationally prominent faculty and programs in research, training, and patient care.
2. The organizational structure works remarkably well to weave together faculty in 20 divisions across 6 hospital-based departments, with efficient use of quite limited resources for the DoM itself.
3. Dr Hawker has set the Department's North Star on mutual respect, compassion, integrity, inclusion, and wellbeing, while committing her effort and Department resources to the development of outstanding faculty.
4. While the Residency Accreditation Review was troubling to all in the Department, Dr Hawker led the Department positively and forthrightly in recognizing and addressing the important issues identified. (https://deptmedicine.utoronto.ca/news/departments-response-internal-medicine-residency-accreditation-review-taking-action-address)
5. DoM attracts and develops incredibly talented and committed trainees and junior faculty, and it supports them as much as possible to develop as leading faculty. (Few departments have this track record.)
6. DoM is deeply respected and appreciated by leaders of cognate departments.
7. Incredible thinking, policies and operational changes, and programs have started in Culture and Inclusion. Deep passion and commitment towards wellness, EDI and mentorship, despite limited resources.

Concerns

1. The fact that the Residency Accreditation Review seems to have caught faculty by surprise may indicate the degree to which the "old school" culture of training had hung on and how much Dr Hawker's North Star of mutual respect, compassion, integrity, inclusion, and wellbeing was needed. Steady attention to these issues from DoM leaders will be important, even with the formidable challenges of the health care environment.
2. DoM is severely financially constrained, and it is not clear to anyone in DoM why TFOM has limited funding so severely. For example, faculty ask, What proportion of visa trainee funds are transferred to the DoM? While DoM provides tremendous value for the money, far greater results are expected with increased funding.
3. The complexity of the DoM grows as new teaching sites are added with insufficient resources and transfer of residents and resources from core teaching hospitals.
4. The potential of the TAHSN-R is not realized because of inter-institutional barriers to collaboration such as lack of integrated/harmonized ethics approval and contracts.
5. The tension between resources and ambition (as represented by the many tremendous initiatives undertaken) may reflect lack of attention to prioritization in the context of resource constraints.
6. The future of CTs is challenged because of the amount of work expected of them and minimal investment in their development. This is critical because CTs are the engines of the hospital Practice Plans, and they play a critical role in medical education – UGME, PGME, and fellowship training.
7. CBD has increased workload without any value perceived by all faculty we met.
8. Recruitment and development of clinician scientists is threatened. Need a centralized resource to jump start early faculty positions and need to be partner in a cohesive strategy that is more city-wide with the hospitals. More transparent.
9. Faculty are severely strained, with the perception of increasing demands for clinical work and teaching.
10. Faculty perceive insufficient recognition by TFOM of contributions of DoM.
11. Faculty reported lack of access to TFOM resources, such as internal grant reviews.
12. There are needs for more research space, which has been controlled entirely by Research Institutes.
13. Staff reported insufficient resources for leadership recruitment.

Recommendations

1. Expand recognition of DoM leaders and faculty, with special attention to CTs.
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.
3. Expand efforts to promote well-being of faculty, staff, and learners, with appropriate resources.
4. TFOM increases transparency in how DoM funding is determined and which DoM investments are considered worthwhile.
5. TFOM and DoM design a funding strategy that will sustainably increase funding for DoM.
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.
7. Harmonized pre-award research procedures, such as IRB and contracting, across TAHSN.
8. Consider a formal review of priorities and initiatives by the Chair to inform allocation of resources and to clarify realistic expectations.

9. Review the role of CTs and the resources available to them, with the goal of sustaining them and their substantial contributions.
10. Insofar as possible, increase TFOM/DoM investment in attracting and developing the next generation of CS.
11. With TFOM, identify programs of little value, as some think CBD is, and work together to eliminate or modify such programs.
12. With TFOM, determine TFOM resources that might be valued by DoM faculty and develop strategies to make them available.
13. Assess needs for research space and explore whether those needs can be met with space other than that controlled by the Research Institutes.

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