



Medicine  
UNIVERSITY OF TORONTO

# SELF-STUDY REPORT

External Review 2013–2018  
Volume 1: Sections 1 to 9





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# Glossary of Abbreviations

<b>AACU</b>	Acute Ambulatory Care Unit	<b>COPD</b>	chronic obstructive pulmonary disease	<b>GEMINI</b>	General Medicine Inpatient Initiative
<b>AFP</b>	Alternate Funding Plan	<b>CPA</b>	creative professional activities	<b>GI</b>	Gastroenterology
<b>APD</b>	academic position description	<b>CPD</b>	Continuing Professional Development	<b>GIM</b>	General Internal Medicine
<b>BBDC</b>	Banting and Best Diabetes Centre	<b>CP&amp;T</b>	Clinical Pharmacology and Toxicology	<b>HSF</b>	Heart and Stroke Foundation
<b>BMJ</b>	BMJ (formerly British Medical Journal)	<b>C-QuIPs</b>	Centre for Quality Improvement and Patient Safety	<b>HSRLCE</b>	Heart and Stroke/ Richard Lewar Centre of Excellence
<b>CaRMS</b>	Canadian Resident Matching Service	<b>CREMS</b>	Comprehensive Research Experience for Medical Students	<b>ICES</b>	Institute for Clinical and Evaluative Sciences
<b>CBD</b>	Competence by Design	<b>CREOD</b>	Centre of Research Expertise in Occupational Disease	<b>ICU</b>	Intensive Care Unit
<b>CBME</b>	competency-based medical education	<b>CSTP</b>	Clinician Scientist Training Program	<b>ID</b>	Infectious Diseases
<b>CCO</b>	Cancer Care Ontario	<b>CTU</b>	Clinical Teaching Unit	<b>IDCCM</b>	Interdepartmental Division of Critical Care Medicine
<b>CDA</b>	Diabetes Canada (formerly Canadian Diabetes Association)	<b>CWC</b>	Choosing Wisely Canada	<b>JAMA</b>	Journal of the American Medical Association
<b>CFAR</b>	Continuing Faculty Appointment Review	<b>DDD</b>	Departmental Division Director	<b>JDRF</b>	formerly Junior Diabetes Research Foundation
<b>CGS</b>	Canadian Geriatrics Society	<b>DFCM</b>	Department of Family and Community Medicine	<b>KT</b>	knowledge translation
<b>CIA</b>	Clinical Immunology and Allergy	<b>DoM</b>	Department of Medicine	<b>MAM</b>	Mississauga Academy of Medicine
<b>CIHI</b>	Canadian Institute of Health Information	<b>EM</b>	Emergency Medicine	<b>MD</b>	Medical Doctor
<b>CIHR</b>	Canadian Institutes of Health Research	<b>EPA</b>	entrustable professional activities	<b>MED</b>	Membership, Equity and Diversity
<b>CISEPO</b>	Canada International Scientific Exchange Program	<b>FoM</b>	Faculty of Medicine	<b>MERS</b>	Medical Education Research & Scholarship
<b>CME</b>	continuing medical education			<b>MOHLTC</b>	Ministry of Health and Long-Term Care (in Ontario)





<b>MOTP</b>	Medical Oncology Training Program
<b>MSc</b>	Master of Science
<b>MScCH</b>	Master of Science in Community Health
<b>MSB</b>	Medical Sciences Building (at U of T)
<b>MSH</b>	Mount Sinai Hospital
<b>NIH</b>	National Institutes of Health
<b>OSCE</b>	objective structured clinical examination
<b>OTN</b>	Ontario Telemedicine Network
<b>PARO</b>	Professional Association of Residents of Ontario
<b>PBL</b>	problem-based learning
<b>PCC</b>	person-centred care
<b>PD</b>	Program Director
<b>PGME</b>	Postgraduate Medical Education
<b>PGY</b>	postgraduate year
<b>PhD</b>	Doctor of Philosophy
<b>PHO</b>	Public Health Ontario
<b>PI</b>	Principal Investigator
<b>PIC</b>	Physician-in-Chief
<b>PMCC</b>	Princess Margaret Cancer Centre
<b>PM&amp;R</b>	Physical Medicine and Rehabilitation

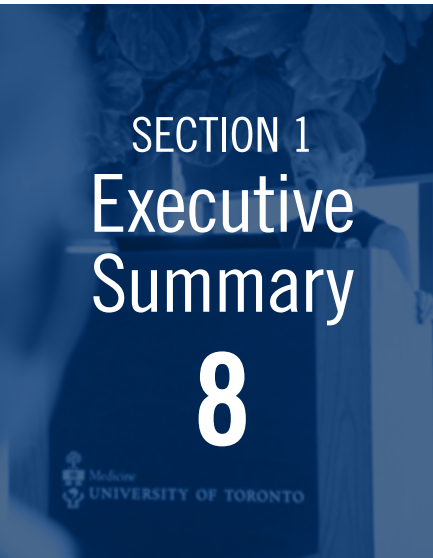
<b>RCPSC</b>	Royal College of Physicians and Surgeons of Canada
<b>RPC</b>	Residency Program Committee
<b>SCOPE</b>	Seamless Care Optimizing the Patient Experience
<b>SHS</b>	Sinai Health System
<b>SMH</b>	St. Michael's Hospital
<b>SMPA</b>	St. Michael's Hospital Physicians Association
<b>SPOR</b>	Strategy for Patient-Oriented Research
<b>TAAAC</b>	Toronto Addis Ababa Academic Collaboration
<b>TAHSN</b>	Toronto Academic Health Science Network
<b>TARRN</b>	Toronto Antibiotic Resistance Research Network
<b>TES</b>	teaching effectiveness scores
<b>TGH</b>	Toronto General Hospital
<b>TRI</b>	Toronto Rehabilitation Institute
<b>TWH</b>	Toronto Western Hospital
<b>UGME</b>	Undergraduate Medical Education
<b>UHN</b>	University Health Network

<b>UME</b>	Undergraduate Medical Education
<b>U of T</b>	University of Toronto
<b>VC</b>	Vice Chair
<b>WCH</b>	Women's College Hospital
<b>WCRI</b>	Women's College Research Institute
<b>WIHV</b>	WCH Institute for Health Systems Solutions and Virtual Care



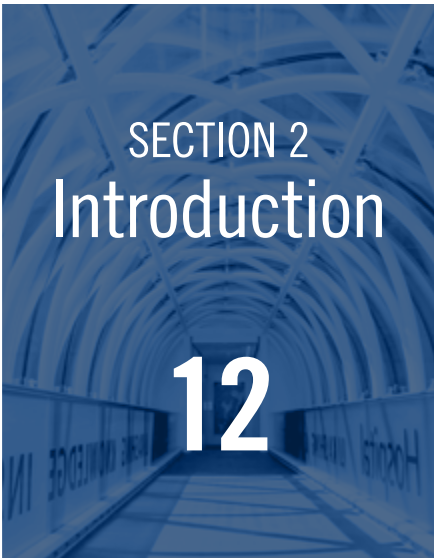


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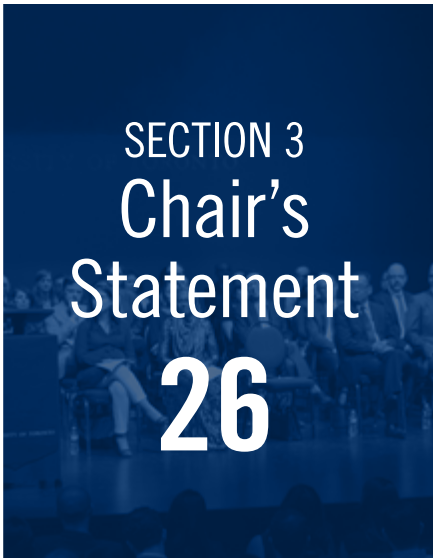
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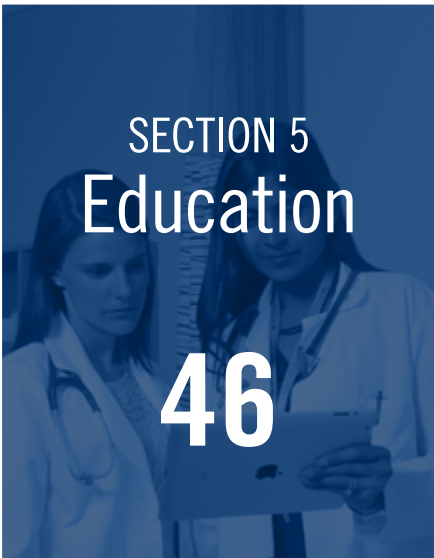
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# SECTION 1: EXECUTIVE SUMMARY



Medicine  
UNIVERSITY OF TORONTO





The Department of Medicine (DoM) at the University of Toronto is one of the oldest and largest in North America, dating back to the founding of the School of Medicine in 1843. A historic milestone in the Department's history was the establishment of the Sir John and Lady Eaton endowment in 1919. The endowment subsequently led to the appointment of the first full-time Chair of Medicine in what was then the British Empire, and the Chair of the Department has held the Sir John and Lady Eaton Chair in Medicine title since that time. What is special about this endowment is that it was established to protect physicians' time for research and teaching; in effect, these funds (\$375 thousand in 1919, approximately equivalent to \$5.4 million in 2018) laid the foundation for the principle of pooling clinical income to support academic activities through departmental practice plans. In 2019, we will celebrate this important milestone.

Our mission is to prepare future physician leaders, contribute to our communities and improve the health and health-care experiences of individuals and populations through the discovery, application, translation and communication of knowledge.

Our vision is to meaningfully impact health through international leadership in education, research and the translation of new knowledge into better care and health outcomes.

In 2015, the Department identified the following eight strategic priorities toward achieving this vision: <https://www.deptmedicine.utoronto.ca/values-guiding-principles>

1. Ensure the perspectives and experiences of our patients and their families guide our work.
2. Promote equity, diversity and professionalism.
3. Be socially accountable and steward health-care resources.
4. Align future physician training to meet future population needs.
5. Promote the generation and translation of new knowledge with the potential to impact patient care and outcomes.
6. Recognize and value the contributions of all (diverse teams, teachers and researchers, etc.).
7. Enhance mentorship across the academic lifespan.
8. Raise funds to meet our goals.

On January 30, 2018, the Department leadership reaffirmed its commitment to these priorities. Progress and growth of these strategic priorities is outlined in this report.

Today the Department has 1,474<sup>1</sup> faculty members, of whom 789 are full-time (including 15 PhD scientists) and 652 part-time or adjunct; the Department comprises approximately 27 per cent of the Faculty of Medicine's full-time faculty members.

Of the full-time faculty members, 15 are research scientists, 197 are clinician scientists, 178 are clinician investigators, 45 are clinicians in quality and innovation, 57 are clinician educators, 286 are clinician teachers and 26 are clinician administrators. Faculty members are distributed primarily in six major hospitals and health systems: (i) St. Michael's Hospital, which now incorporates St. Joseph's Health Centre and Providence Healthcare; (ii) University Health Network (UHN), which includes Princess Margaret Cancer Centre, Toronto General Hospital, Toronto Western Hospital, and Toronto Rehabilitation Institute; (iii) Sinai Health System, which includes Mount Sinai Hospital and Bridgepoint Active Healthcare; (iv) Sunnybrook Health Sciences Centre, which includes St. John's Rehabilitation Hospital; (v) Women's College Hospital, a fully ambulatory hospital; and (vi) Baycrest, a geriatric hospital. All hospital sites used by the Department of Medicine are full affiliates or community affiliates of the University of Toronto <https://medicine.utoronto.ca/about-faculty-medicine/university-affiliated-hospitals>.

The Chair works closely with the fully affiliated hospital Physicians-in-Chief (PICs) and Chief of Emergency Medicine, who report both to the Chair and to their respective hospital CEOs, and with the departmental division directors (DDD). Hospital division heads similarly have dual reporting responsibilities to their PIC and DDD.

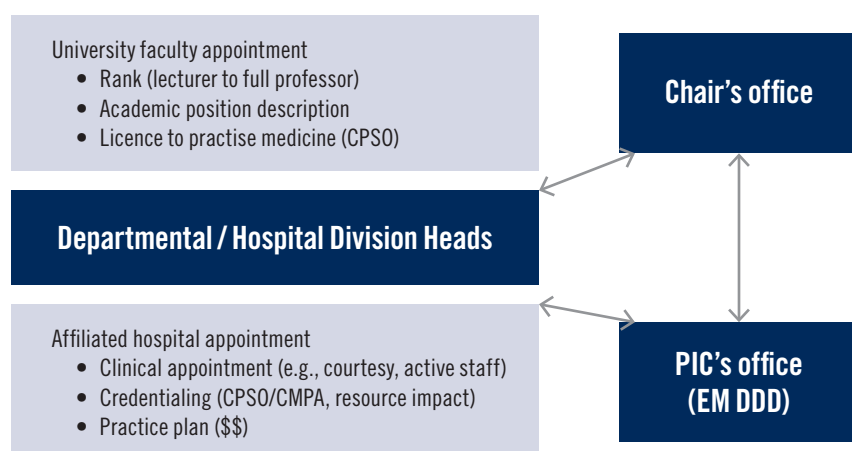
The Department's faculty is not only large, but also deeply committed to academic endeavours. The Department provides an extremely rich environment in which to teach and conduct scholarly work and is particularly research intensive. Our research spans the full spectrum: fundamental science; clinical translational research; clinical trials; clinical epidemiology and health-services research; global health; and scholarship in quality improvement, innovation and education. Research is conducted on campus, in the hospital-affiliated research institutes in the hospitals themselves. In 2017 (the most recent year for which data are available), Department research funding totalled \$185.448 million, an increase from \$160.613 million five years ago. These are primarily operating funds since the Canadian Institutes of Health Research does not allow funding of scientists' salaries. In the last five years, the DoM has generated 23,607 peer-reviewed publications (articles, editorials, proceeding papers and reviews) and 245,770 citations (see appendix).

### Merit Review of Clinician Scientists

The impact of our research is broad. It includes: basic discoveries; patents for novel devices and methodologies; drug development; clinical guidelines; public and health policy; and social advocacy. Our faculty are leaders in their fields, both nationally and internationally.

The Department is also a major contributor to undergraduate education, postgraduate education, faculty development and continuing education. At present there are 259 undergraduate medical students. In 2017–18, 1,004 postgraduate trainees were registered in our programs (compared to 740 in 2013) including 250 in Internal Medicine (PGY1–4), 142 in our PGY1 entry programs

(Dermatology; Physical Medicine and Rehabilitation; Emergency Medicine; and Neurology), 152 PGY4–PGY6 subspecialty trainees, and 460 fellows (441 clinical and



<sup>1</sup> The Faculty of Medicine has a total 6,074 clinical faculty.





19 research). We train roughly one in every two internal medicine specialists practising in Ontario and one in three practising in Canada. In addition, the Department supports and runs several advanced programs to train future faculty members, including the Eliot Phillipson Clinician Scientist and Clinician Educator Training Programs and the Master Teacher Program. Members of the Department also lead residency and continuing education programs in Quality Improvement and Patient Safety. These programs are described in detail in sections 5 and 7 of this report.

Department members are actively engaged in graduate training, principally through the Institute for Medical Sciences (IMS) within the Faculty of Medicine and the Institute for Health Policy, Management and Evaluation (IHPME) at the Dalla Lana School of Public Health (DLSPH). Members of our faculty lead these graduate training programs: IMS (Osborne and Horner); IHPME–Clinical Epidemiology (Fowler and Tinmouth), and the Centre for Quality Improvement and Patient Safety (Shojania and Wong). Faculty member Linn Holness leads a graduate training program in Occupational Medicine in the DLSPH, while several others provide teaching and graduate supervision in our extra-departmental units, for example, the Wilson Centre; Centre for Ambulatory Care and Education; Lewar Centre; Banting and Best Diabetes Centre; and others.

Sixty-three faculty members hold cross-appointments to the Department; the majority have primary appointments in other clinical or basic science departments in the Faculty of Medicine.

Funding for the academic enterprise is from multiple sources, including the Department’s operating budget,

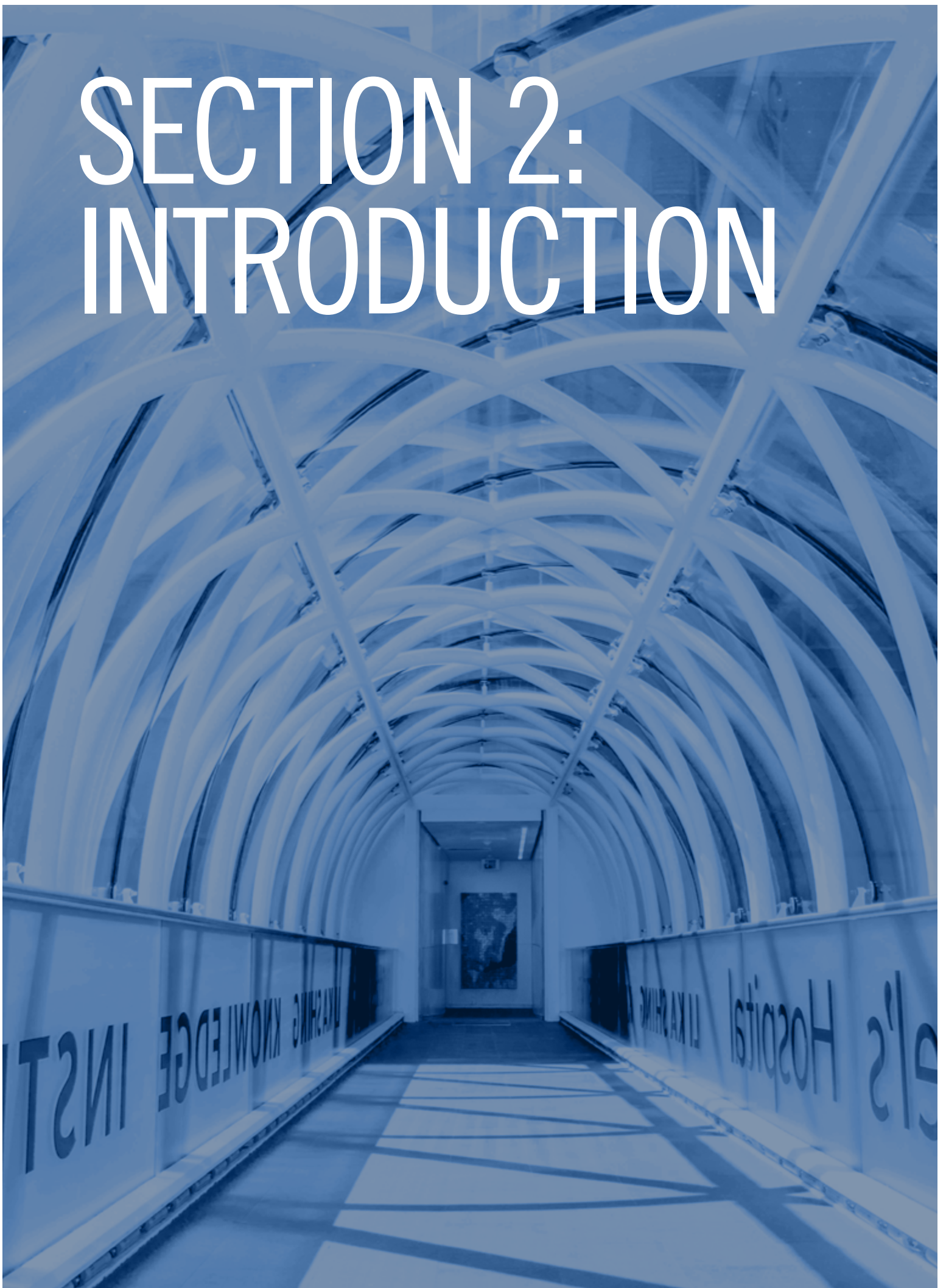
philanthropy, the hospital practice plans where clinical revenue flows, research funding organizations, and funding from the Ontario Ministry of Health and Long-Term Care (MOHLTC).

Over the past five years the Department has been focused on reassessment and renewal with a spotlight on enhancing diversity, equity and professionalism; the value the Department adds to its faculty and the hospitals; divisional support, particularly for residency training; cross-departmental communication and branding; and transparency of our processes and decision making.

In 2015, the expectations of DDDs were revised and agreed upon and leadership terms clarified (five years, renewable upon successful review). Ten external divisional reviews have been completed (Cardiology, Dermatology, Gastroenterology, Geriatric Medicine, Medical Oncology, Nephrology, Neurology, Occupational Medicine, Respiriology, and Rheumatology) with a number planned for the upcoming academic year (Hematology, Infectious Diseases, Physical Medicine and Rehabilitation, Clinical Immunology and Allergy, Emergency Medicine, and Critical Care). Two divisions (General Internal Medicine and Endocrinology) have undergone leadership renewal without review; strategic planning with external input is ongoing. A new division, Palliative Medicine, has been established to support a new Royal College residency training program in this discipline. Consideration is being given to creation of an inter-departmental division of Medical Genetics. International searches have been completed or are ongoing for 11 DDDs. We have been successful in attracting top talent at early and later career stages.

It has truly taken a village to achieve these successes. The DoM leadership team—faculty and staff—is collaborative, engaged and unafraid to take risks to achieve goals. Notably, I feel the relationship between the PICs and the Department has been strengthened considerably through a focus on common goals. Almost 400 faculty members are now participating in one or more divisional or departmental committees. Their contributions of time and energy have been stupendous. Our trainees are curious, intelligent and inspiring, while our patients drive us and keep us focused on what really matters. This collective engagement and enthusiasm has been integral to moving our strategic objectives forward. It has been a genuine pleasure to lead this group of talented people over the past four years.

# SECTION 2: INTRODUCTION



# THE DEPARTMENT & ITS PROGRAMS

Key to understanding the Department of Medicine (DoM) at the University of Toronto is understanding the close working relationships with the hospitals, practice plans and research institutes. While in many departments across North America, a Chair of Medicine would control clinical as well as academic operations, this is not the case at the University of Toronto. Rather, our success depends on close collaboration between the hospitals and the University.

Department of Medicine faculty members are organized into hospital departments, each led by a physician-in-chief (PIC), who is appointed jointly by the hospital and the University and who is responsible for the delivery of academic and clinical programs within the hospital. The PICs report both to the Chair of Medicine and to the hospital CEO. Emergency Medicine (EM) and, in some cases, Critical Care do not report to the PIC but rather to programmatic leads outside the Department of Medicine.

Faculty are also organized into 20 Department-wide specialty or subspecialty divisions led by a department division director (DDD), who reports to the Chair. The hospital PICs and Department Chair rely on the DDDs to help build and maintain a thriving academic enterprise. The DDDs are essential in supporting community, purpose, leadership, mentorship and communication within our academic community.

All full-time clinical faculty members must hold an appointment at the University to qualify for a hospital appointment. They are accountable to their University DDD and the Department Chair (through the PIC or chief) for their academic activities, and to their hospital division head and PIC/chief for their clinical activities; they must abide by the policies governing clinical faculty: <http://www.governingcouncil.utoronto.ca/Assets/Governing+Council+Digital+Assets/Policies/PDF/ppjul012005.pdf>.





All faculty members are expected to demonstrate teaching effectiveness and to engage in scholarly activities. However, the scope and intensity of teaching and scholarship will vary by faculty member's academic position description. Every full-time faculty member is assigned an academic position description (or academic job description; <http://www.deptmedicine.utoronto.ca/academic-position-descriptions>): clinician scientist; clinician investigator; clinician educator; clinician teacher; clinician in quality and innovation; research scientist; or clinician administrator. Faculty members' academic job descriptions are determined jointly by the PIC, DDD, Department Chair and the faculty members themselves. These are Department-specific and intended to clarify the amount of time the individual will devote to scholarship (all types), teaching (formal and informal clinically based), clinical activities and administrative service and identify the focus of the individual's scholarly work.

Aligned with our strategic priorities and core values, sustained demonstration of professionalism is now a requirement for full-time faculty members to pass their [Continuing Faculty Appointment Review](#) and for promotion through the ranks. The Department is committed to ensuring a culture of inclusion and professionalism and, as such, has been working hard to ensure faculty, staff and trainees are aware of the expectations for professionalism and the consequences of repeated or egregious demonstrations of unprofessionalism (i.e., creation of a hostile work environment; harassment; intimidation; discrimination; failure to disclose and manage conflicts of interest; inappropriate relationships with industry; violations of boundaries; failure to fulfill professional duties; bias; and research misconduct).

Full-time faculty members must be enrolled in a University-approved practice plan at one of the host hospitals. All income to practice plan members flows to their practice plan, which has policies and principles used to ensure the support of academic activities. Most income that goes to the practice plans comes from clinical earnings. The University contributes stipends for leadership roles, divisional discretionary funds and salary support for clinician scientists; these monies also flow through

the hospital practice plans. Thus, PICs must work closely with the Department of Medicine and vice versa.

Although the practice plans vary in their structures and governance, all provide financial support for members who play major roles in teaching and research and thus have less time to generate clinical income. The practice plans allocate approximately \$26.75 million, including MOHLTC Alternate Funding Plan (AFP) dollars, to support the academic activities of the faculty. The AFP dollars were negotiated with the Ontario MOHLTC to help offset income discrepancies between community-practising physicians and those in academia; 70 per cent of the funding is based on income differentials, and 30 per cent is based on academic productivity in terms of federally funded grants and "teaching days." The level of financial support provided by the hospital practice plans and by the Department to individual faculty members is determined by their academic job description.

Each hospital has its own foundation, which is highly effective at fundraising for hospital-based activities. There is little incentive for the hospital foundations to work together on University-wide fundraising activities. However, of late, the Department has been successful at partnering with individual hospitals to advance local hospital interests and those of the Department (e.g., Neurology and Dermatology recruitment of DDDs; establishment of endowed chairs for the PICs at Sunnybrook and St. Michael's).

Each of the fully affiliated teaching hospitals—and increasingly, some of the community-affiliated hospitals—has a research institute. Recruitment of a clinician scientist requires input and agreement from

the hospital practice plan, research institute and Department of Medicine; thus, close collaboration is required. Recruitment of PhD scientists requires agreement of the hospital research institute and the Department of Medicine. Increasingly, city-wide, multi-hospital searches are being conducted to reduce duplication of efforts and enhance the ability to get the best candidate to the right hospital.

The responsibility for pre-clerkship (Years 1 and 2) Undergraduate Medical Education (UGME) largely resides with the Faculty of Medicine. The Department is responsible for medicine clerkship rotations in UGME (Years 3 and 4) and for its postgraduate residencies and fellowships, reporting to the Undergraduate and Postgraduate Medical Education offices at the Faculty, respectively. While all clinical faculty members are expected to be effective teachers, the scope and quantity of teaching varies by position description.

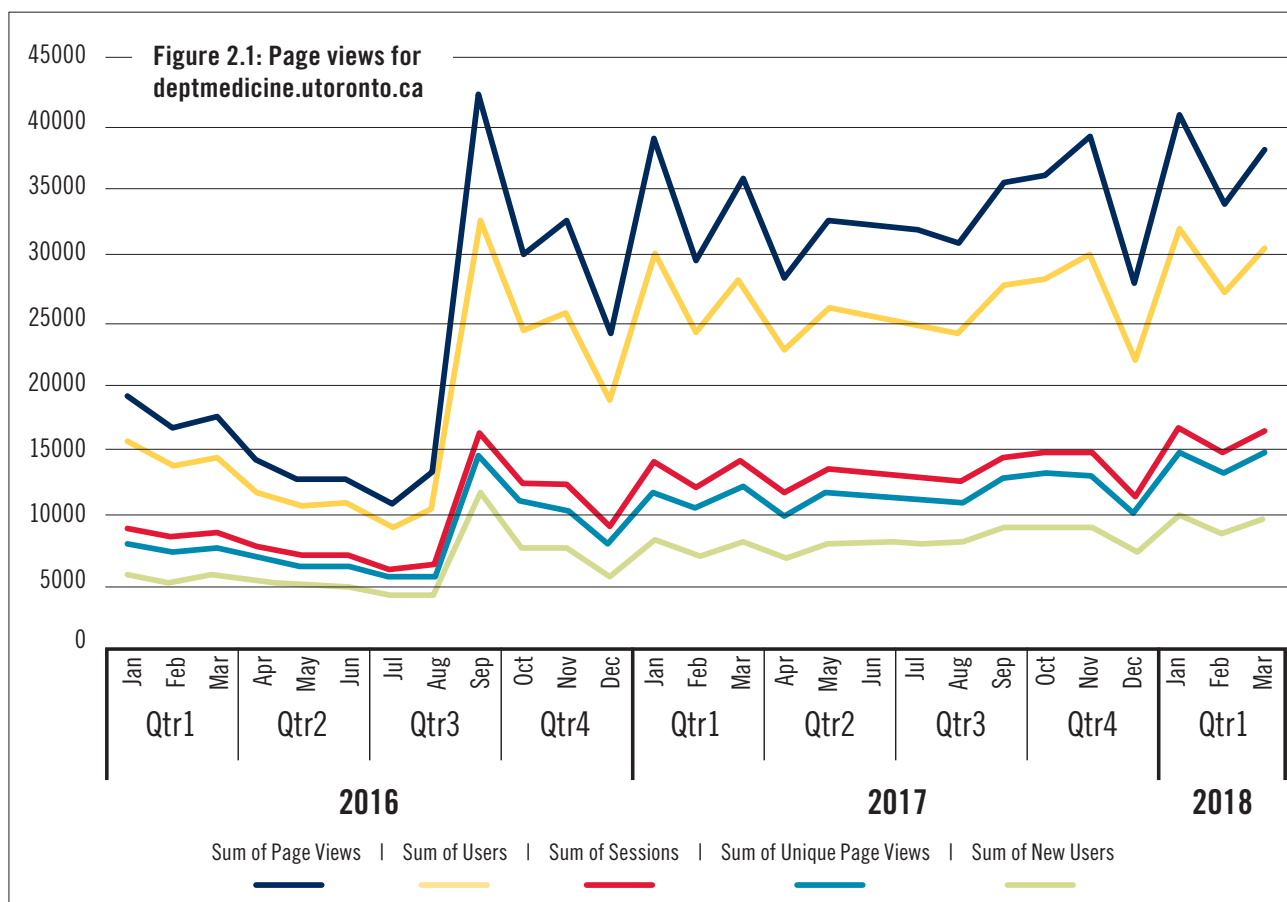
The Department has core staff who provide support to the faculty and hospitals with respect to the following:

- undergraduate and postgraduate education;
- research;
- finances;

- continuing education;
- quality and innovation;
- communication;
- mentorship, equity and diversity;
- events;
- strategic planning;
- recruitment;
- appointments;
- promotion; and
- Continuing Faculty Appointment Review (CFAR).

Currently, the departmental staff are working in rented space at the Toronto General Hospital site of the University Health Network (UHN) and on campus within the Naylor Building, beside the Medical Sciences Building. Plans are underway to locate all Department staff as well as the Chair's and Vice Chair's offices within the Naylor Building by the end of 2018.

Communication across a department of our size is challenging at its best. In the past five years, the Department's website has been completely redesigned to be more interactive, engaging and outwardly focused. The figure below shows website page views before (January–September 2016) and after the launch of the



new website. On average, we receive more than 30,000 page views per month.

Divisional websites can now be accessed via the Department website, and most divisions host a monthly newsletter. The Chair, the Department and divisions are also active on Twitter. The monthly departmental newsletter (DoM Matters) focuses on key issues in the Department. A weekly departmental e-blast (DoM Digest) provides a list of events, job postings and other relevant notices. Photographs of events are posted on our website and in a Flickr account. Standardized branded templates are used for all newsletters and have been provided for presentations (PowerPoint). All materials are circulated via email and online via our website. Monthly statistics about the uptake for these communiqués are collected and reviewed. Finally, the Chair presents an annual report to the Department at the end-of-year City-Wide Medical Grand Rounds.

## SIGNIFICANT DEVELOPMENTAL MILESTONES

- The senior leadership team is truly outstanding. They have enabled the Department to position itself as a catalyst, multiplier and facilitator of the incredible work our faculty members and trainees accomplish every day.
- We are well on our way to having established a platform for effective communication across a large, dispersed faculty, both at the departmental level (appointment of a communications lead, new and revamped website and monthly newsletter, Twitter feed, etc.) and divisionally, across sites.
- Through improved branding and celebration of our faculty and trainees (e.g., communication templates that highlight Department of Medicine affiliations; redeveloped Department of

Medicine graduation ceremony; and creation of an Associate Professors' Day), we are building a much-needed sense of "pride of place" in the University of Toronto and the Department.

- A major overhaul of our policies and procedures, or lack thereof, including allocation of salary support, recruitment and leadership appointments, has resulted in a greater sense of fairness and transparency, which has improved faculty engagement in departmental efforts (e.g., merit review of clinician scientists; formal search process for all new recruits and leadership roles).
- Simplification of complex processes (e.g., CFAR and senior promotion) is enabling improved mentorship and sponsorship of our faculty.
- The Department has fostered increased city-wide collaboration on recruitment and fundraising.
- Hospital vice presidents of research are now active participants in departmental reviews and recruitment and retention of our clinician scientist faculty.
- Finally, outstanding efforts have been made by our leadership team to work together to promote collegial culture, equity, diversity, inclusiveness and professionalism. It is not just talk, but action, and a tangible shift in culture is occurring with demonstrable impact on the trainee/work environment and faculty career satisfaction. Professionalism is now baked into recruitment, renewal, award allocation, leadership appointment and senior promotion. Other departments at the University of Toronto and elsewhere are following our lead. About this we are most proud.





# DEPARTMENTAL STRENGTHS, CHALLENGES, OPPORTUNITIES & THREATS



## Strengths

The Department's faculty are highly motivated and deeply committed to academic endeavours; we are able to recruit the best and the brightest at all career stages. The University of Toronto and Toronto itself provide an extremely rich environment in which to provide clinical care, teach and conduct scholarly work. Beyond the Faculty of Medicine, the University of Toronto has outstanding minds in computer science, engineering, global health, public health and the fundamental sciences. There is a thriving ecosystem for entrepreneurship; we have incredible opportunities for “entrepreneurship in medicine.” The diversity of the population in which we live and work provides an unequalled opportunity to lead the way in advancing equity, diversity and inclusiveness in academic medicine. People are drawn to Toronto and to the University of Toronto, specifically, by its international reputation and growing visibility in the artificial intelligence and big data realms. Finally, the current Dean has been an outstanding supporter of the Department, championing the culture shift and values that our Department holds.

As a clinical department, we have many strengths: first-rate trainees, teachers and educators across all levels; outstanding scholars with bench strength across all pillars of scholarship (our faculty members do not require “push” to aim high); rich clinical experiences across multiple sites, with focused centres of excellence; and city-wide engagement in advancing our vision and mission, which is growing with investment in people and processes to ensure fairness, equity and inclusion.

## Challenges

The Department's size makes effective communication challenging—awareness of changes in policies and practices is slow to diffuse through the ranks. As a result, faculty members may be “out of date,” which may impact effective mentorship and allow long-standing beliefs and misperceptions of the Department to remain strong. Our size also means that faculty members' alliance to their hospital is generally stronger than to the University or Department.

Each of the fully affiliated teaching hospitals—and increasingly, some of the community-affiliated hospitals—has a research institute. Recruitment of a senior scientist requires input and agreement from the hospital practice plan, research institute and Department of Medicine; thus, close collaboration is required. The research institutes tend to favour appointment of PhD scientists and clinician scientists who have the majority of their time protected for research. Given that the Department has as many clinician investigators as scientists, this disadvantages the former, who often are without access to research infrastructure and other resources.

All clinical income, as well as MOHLTC AFP dollars to offset lost income from teaching and research, flows into the hospital practice plans. Annual revenues to the hospital practice plans dwarf the annual operating budget of the University Department. This imbalance underlies the perception that the Department and its leaders, particularly the DDDs, have little more than moral suasion to do their

work. Money is seen as the most important influencer in academic medicine.

Each hospital has its own foundation, which raises funds for hospital-based activities. There is little incentive for the hospital foundations to work together on University-wide fundraising. The Department has access to a full-time Senior Development Officer, Chris Adamson, but does not have the benefit of “grateful patients” as prospective donors to solicit.

The hospital research institutes have traditionally prioritized and valued PhD scientists over clinician scientists. Although this has improved over time, physicians with less protected time for research (e.g., the clinician investigators in our Department) are still generally not given appointments in their research institutes. As a result, they are not able to access research administration and other resources at the hospital level, making their ability to conduct research increasingly challenging.

We are a research-intensive Department with a long history of celebrating research. We have fallen short in celebrating the front-line master clinicians and teachers who make it possible for research to be conducted. There is concerted effort underway to right this imbalance.

Despite the fact that women have comprised at least half the enrolment of medical school classes in Canada for several decades, and I am the second woman to Chair the Department of Medicine at the University of Toronto, women continue to be under-represented among our residents, faculty members and leadership positions in the Department. This is likely influenced by unconscious bias and institutional reproduction. As noted elsewhere, I believe we have made major strides toward addressing these issues.

Until recently, there has been a reluctance to discipline faculty members whose behaviour is uncivil or disrespectful or downright unprofessional, especially those who have gained acclaim for their academic contributions. (We have called these the “untouchables”). This reluctance to discipline has had a negative impact on the culture within the Department, affecting career satisfaction and wellness. By changing our policies and procedures about professionalism, we are tackling these issues as well.

Finally, our affiliated hospitals have a long-standing reliance on medical trainees, particularly residents, to provide clinical care in the inpatient setting. Thus, there is tremendous reluctance to “give up” residents on the wards, and it has been challenging to expand resident exposure to the management of complex medical patients in the ambulatory environment and to develop the new skills that will be required for future internists (e.g., competency with e-consultations).

## Opportunities

The University of Toronto brand is strong and could be better leveraged for philanthropy. For example, graduates of residency programs have only recently been considered as “alumni” by the Faculty of Medicine. In 2019, we will be celebrating the 100th anniversary of the establishment of the legacy Eaton family endowment at the University of Toronto. The original donation from Sir John and Lady Eaton was \$375 thousand Canadian in 1919—this equates to approximately \$5.4 million today. We are aspiring to raise funds in honour of this momentous occasion and plan to focus on working with our alumni and asking them to “pay it forward” for the next hundred years. At our recent Annual Day celebration in June, we formally launched this initiative with the announcement that Mr. John Craig Eaton (one of the grandchildren of the original donors) had pledged the first \$1 million. The divisions will be fundraising individually to support their University-wide activities, including support for residents, research and other education-related initiatives such as lectureships, fellowships and the clinician-scientist training program. In 2021, together with the Department of Physiology, we will be celebrating the 100th anniversary of the discovery of insulin at the University of Toronto, which revolutionized the treatment of diabetes. We anticipate that this will also provide an opportunity for fundraising to support specifically translational research across our departments and the broader University landscape. A Celebration Committee has been struck and a scientific meeting is being planned along with other additional events throughout the year.

The growing reputation of the University of Toronto and the Toronto-Waterloo corridor for entrepreneurship, particularly in the fields of big data, artificial intelligence (AI) and biotechnologies, has led to an influx of talent; tremendous opportunities present themselves to our Department. We have formally partnered with the Department of Computer Science in the recruitment



Dr. Marzyeh Ghassemi

of a recent PhD graduate from MIT in AI, Marzyeh Ghassemi, who will be working 51 per cent in Computer Science and 49 per cent in Medicine. Ghassemi was named among the top 35 under 35 in her graduating class at MIT, and we are very excited that she has joined us. She will be working with our General Medicine Inpatient Initiative—or GEMINI—group, a collection of young faculty members in General Internal Medicine (GIM) led by Fahad Razak and Amol Verma. They have created a GIM inpatient registry to conduct quality improvement initiatives. More about this can be found in the report on Quality and Innovation in section 7.

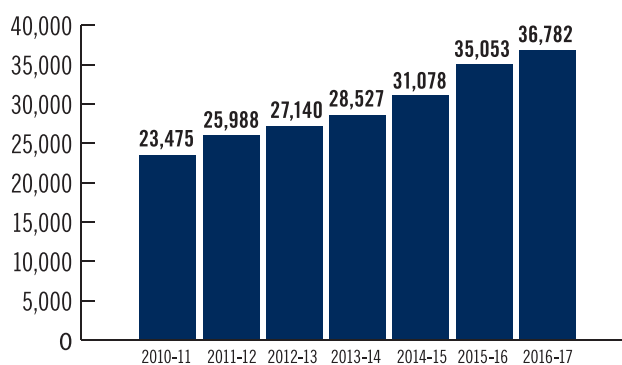
Finally, this past year has seen many new faces in the CEO positions at our University-affiliated teaching hospitals. Of the six fully affiliated teaching hospitals where adult medicine is based, four have recruited new CEOs in the past year, and one has recently launched a search. The new leaders—two of whom are members of our Department—seem truly interested in collaborative problem solving; each has reached out to me in my capacity as Chair of Medicine for my perspective and advice. I take it as a good sign. This bodes well for the future.

## Threats

There are some threats to the Department and its mission that cannot be ignored. First, we have witnessed a remarkable decline in the number of physicians in internal medicine and its specialties who are seeking academic careers in the basic sciences. Explanations include low grant-funding success rates, long training requirements, large debts incurred while training, the high cost of living and the desire for greater work-life balance. As the largest training site in Canada, we feel a responsibility to ensure the pipeline of physicians into the biomedical sciences is replete. We are working hard to address this problem.

Second, while overall career satisfaction is high among our faculty members, the number of physicians and trainees expressing symptoms of burnout is on the rise. The system has insufficient redundancy to manage when a physician or learner must take a planned or unplanned leave. The number, complexity and acuity of patients we care for has increased steadily, as have the expectations from and level of accountability to the provincial government that funds us (see figure 2.2). Our fee-for-service physician payment system is outdated, disproportionately rewarding provision of procedures and tests over cognitive activities and services provided in the inpatient versus outpatient environment. Physicians demand a better work-life balance, without a reduction in income; it's at odds with clinical needs and the fiscal realities in which we are working. These same factors make it difficult for our training programs to shift the focus of training from hospital-based management of acute illness in otherwise healthy people to ambulatory management of chronic illnesses in patients with multi-morbidity to reduce need for hospitalization.

**Figure 2.2: GIM admission volume – SMH, TGH, TWH, Sunnybrook, MSH, and Trillium Health Partners (C and M sites)**





In August 2018, the situation substantially worsened when a diplomatic disagreement between the Canadian government and the Kingdom of Saudi Arabia resulted in the immediate recall of all Saudi trainees from Canadian training programs. There are 76 residents and fellows funded by Saudi Arabia who train here. This political action is devastating to the trainees and represents a major loss of clinical care person power and an approximately \$1 million reduction in annual revenues to the Department. While I am hopeful that our new hospital CEOs will be willing to band together to address these issues; it is not readily apparent how this situation will be remedied without a substantial restructuring of how we work and are paid. Ontario's new provincial government is unlikely to be a partner in such renewal. We want to help our faculty and learners deal with the pressures that are upon them and achieve work-life satisfaction, so we will post for a new faculty leadership position—Wellness Lead.

## ENVIRONMENT

Faculty-wide surveys have been conducted every two years (2015, 2017) to take the pulse of the Department—what is working and what is not. The results are analyzed and fed back to key stakeholders (e.g., PICs receive a copy of their hospital's results, which are compared with other hospitals' results in aggregate) and Department members via our monthly newsletter. Findings and recommendations from the 2017 faculty survey (which received a 52 per cent response rate) have been published through the monthly chairs' columns.<sup>1</sup> Results are also



<sup>1</sup> See <https://www.deptmedicine.utoronto.ca/newsletter>.

posted on the website for review and feedback. These surveys have been critical to informing the work of the Department. For example, analysis of the results found that clinician investigators (CIs) and clinicians in quality and innovation (CQIs) were less satisfied than others with the amount of time they had to fulfill their scholarly obligations. (Thirty-one per cent of CIs and 42 per cent of CQIs were dissatisfied; about 20 per cent of the other APDs were dissatisfied.) Further, irrespective of the position description, female respondents were more likely than their male counterparts to report dissatisfaction in meeting scholarly obligations (34 per cent versus 18 per cent overall). There may be institutional barriers that contribute to these findings, which we are working on.

An initial review of the demographics of our Department in 2014 indicated that, despite the fact that our Canadian medical schools have been graduating at least as many women as men for more than two decades, representation of women among our residencies and faculty varied widely. We noted a low of 16 per cent in Cardiology and a high of 63 per cent in Rheumatology. Women were well represented among the assistant professors (49 per cent) but less so higher up the ranks (only 25 per cent of full professors were women). Overall, only 36 per cent of our faculty were women. To better understand these gaps, we conducted qualitative and quantitative studies (refs) and, in 2017, we held an inaugural *Summit on Women in Academic Medicine*, with a second summit held in February 2018. The first focused on storytelling, building trust and community. A number of strategies were subsequently put in place. The second summit focused on solutions, including allyship. Although not invited, faculty members in other clinical departments at U of T and faculty members from departments of medicine outside Toronto also attended these events. The impact of these initiatives has been large, as highlighted in the report of the Vice Chair, Mentorship, Equity and Diversity, in section 8.

Information regarding the makeup of our Department, both trainees and faculty, beyond gender is limited. The 2017 faculty survey was the first attempt to determine the extent to which we reflect the population we serve. Thirty per cent of faculty respondents indicated they were a person of colour or other visible minority, 15 per cent had been raised in a low-income or low-middle-income country, and 4 per cent reported a disability (largely non-visible, e.g., mental health problem); 92 per cent self-identified as male or female. To address the under-representation of

Indigenous peoples and Black people specifically, we are revising and standardizing our residency selection processes and have mandated implicit bias training for all members of search or selection committees.

This self-study has been prepared by the Department leadership team (faculty and staff) based on considerable input from key stakeholders as follows:

- 2015 and 2017 faculty surveys;
- faculty teaching evaluations (undergraduate, postgraduate);
- external divisional reviews;
- leadership reviews;
- fellowship reviews/program reviews;
- departmental executive retreats (2015 and 2018); and
- informal and formal feedback received to the monthly “Chair’s column” and annual City-Wide Medical Grand Rounds on the “State of the Department.”

## KEY FINDINGS FROM PRIOR EXTERNAL REVIEW & RESPONSES

The last external review of the DoM was conducted in 2013, covering the preceding five years of DoM activities under the direction of Dr. Wendy Levinson as Chair. The Review Committee consisted of Dr. Jeffrey Turnbull, Chief of Staff, Ottawa Hospital, and Talmadge E. King, Jr., Chair, Department of Medicine, University of California, San Francisco. The review was very positive. However, several useful recommendations were made.

### 1. Mississauga Campus

In 2011, the medical school was expanded with a cohort based at the Mississauga Academy of Medicine (MAM) campus of the University of Toronto. With this expansion

came the expectations of physicians in the Mississauga hospitals and community practices to provide clinical supervision and teaching to undergraduate medical trainees. To assist with this transition, several hundred new faculty members were hired as adjunct and part-time clinical faculty, and new residency rotations at the Mississauga hospitals were created to assist with the workload. Early challenges for our residents included travel time to the hospitals and relative lack of supervision by experienced clinician teachers. With regard to the new educational program for both clinical clerks and postgraduate trainees at the Mississauga campus, the reviewers pointed out that “concerns were raised that this was taking residents away from core educational programs.” They also recognized that resident duty hours and potential declines in resident numbers will increase challenges.

**Response:** A number of factors have reduced anxiety over the MAM campus since the 2011 review.

- Trillium Health Partners has recruited a Senior Academic Leader in Education, Dr. Allison Freeland, who has developed a very positive collaborative relationship with the Department and our Vice Chair, Education; efforts have been made at MAM-affiliated hospitals to improve the quality of the educational experience, demonstrated by improvements in teaching evaluations by our trainees who rotate there. Many of our top residents have elected to take positions at Trillium upon graduation and are now serving as faculty in these teaching programs.
- The prior position of Integrated Medical Education within the Department, held by Dr. Brian Murray, was disbanded in favour of a more fulsome formal relationship between the Department and leaders at the community teaching sites, including Trillium. Twice-per-year teleconferences ensure effective communication about appointment and annual reappointment requirements. The DDDs are now included in the process of community appointments; many are reaching out to their community faculty members and including them in rounds and events.



- In 2015, the Department implemented a new requirement for part-time clinical faculty: to obtain advanced training in health professions education within three years of the initial appointment. There has been strong support among the community hospital leaders for this requirement, and they have agreed to ensure that appropriate faculty development opportunities are available locally.
- Resident numbers have declined across all services largely due to the decline in off-service trainees (e.g., surgery, anesthesia, on-medicine inpatient rotations). As a result, the Department made the decision to prioritize teaching at the fully affiliated sites over community-affiliated partners, provided the educational experience was equivalent or better. Currently, four residents rotate per block (13 blocks per year) at Trillium hospitals in their clinical teaching units (CTUs).
- On our 2015 and 2017 faculty surveys, the issue of residents being allocated to the Mississauga campus was not identified as an issue.

## 2. Alignment of Research Efforts Across the Sites

The reviewers wrote, “The individual hospitals retain substantial administrative and financial control over the research efforts of the hospital and DoM faculty. Consequently, there is considerable duplication of effort and costs across the entire enterprise. Further, the Chair has limited influence over the coordination and development of research plans, or the recruitment/retention of faculty. The University needs to continue efforts to better coordinate the research efforts of the faculty across sites.”



**Response:** Under the leadership of our Vice Chair, Research, Dr. Michael Farkouh, the Department has forged strong partnerships across the hospitals and University campus. A new Research Committee has been established, with representation of all hospitals and research institutes, to ensure strong communication and input of key stakeholders into Department research plans. The Vice Presidents of Research at the hospitals have been invited to meet with all divisional external review teams. Dr. Farkouh participates on all search committees for senior leaders and works closely with the hospitals on the review and renewal of all University-Hospital Research Chairs. Efforts continue to streamline research ethics review and other processes and procedures that serve as barriers to cross-city research collaborations. A full-time research administrator, Joanna King, was hired to work alongside Dr. Farkouh to promote city-wide research efforts. They have established a highly successful initiative, the “network of networks,” to facilitate and grow interdisciplinary city-wide research. Finally, working closely with the hospitals, the Department has enabled the recruitment of international leaders in their fields through our DDD positions. For example, an international leader in multiple sclerosis had turned down an offer of recruitment to a specific hospital, but was subsequently attracted to Toronto as the DDD for Neurology due to the prestige of the role and the University. Thus, while our structure continues to be challenging, we have made substantial gains in the past five years.

## 3. Clinician Investigators

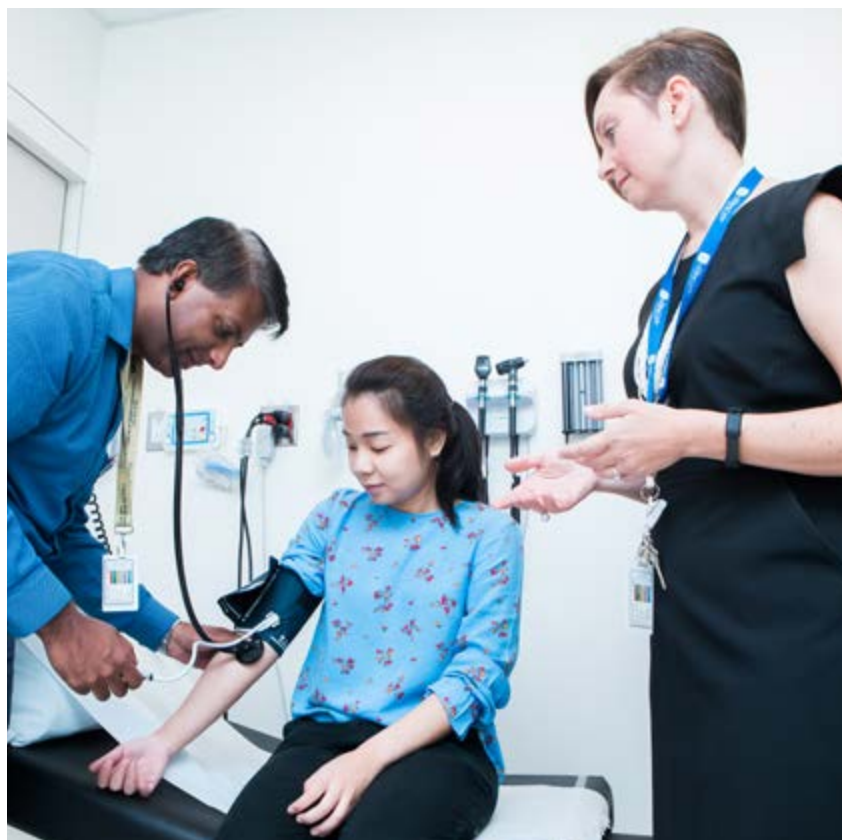
The reviewers noted, “There is concern that the clinician investigators track (50 per cent effort devoted to research) is not a viable option for the majority of individuals in this track. It takes considerable time and effort to excel at both clinical work and investigation. Therefore, faculty members in this track may end up frustrated or ineffective. Other academic medical centres have similar experiences with this track and have largely decided to eliminate it.”

**Response:** Before I took over as Chair, the Department had struck a task force to address the issue and make recommendations. The recommendation from this review was that this designation only be used in highly selective situations (where clinical work and research overlap substantially). In each of these cases, the PIC and the Chair have a specific conversation to consider whether a clinician investigator position is appropriate and to set up mechanisms to support these individuals. Disbanding this



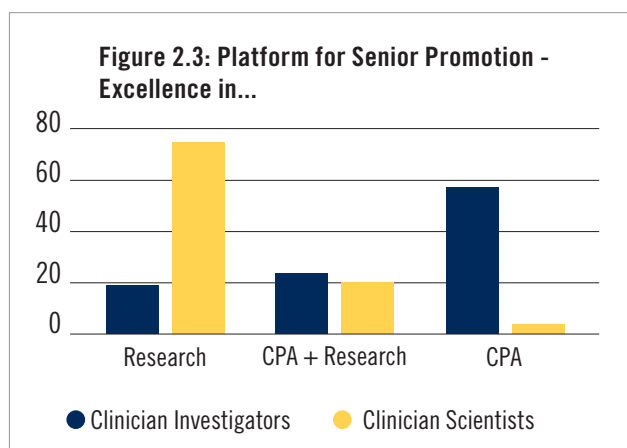
job description was also considered. However, discussions with current clinician investigators (CIs) indicated that, while the positions were indeed challenging, the CIs were not interested in changing their time allocation for clinical work or scholarship. Furthermore, analysis of our promotions data indicated that most CIs had been promoted for their excellence in creative professional activities (CPA) and not for their excellence in research. (See appendix: “Chair’s Column.”)

These findings suggested that the inherent problem with the CI position description was that it was being evaluated with the same research metrics as the position description of clinician scientists (CSs) (grants and publications). If instead we use criteria for excellence in CPA, we clearly see that these are many of the most talented and “successful” individuals in our Department. So revision of the expectations of the CI job description were undertaken to better align them with what CIs really do. Specifically, we removed the expectations for a peer-reviewed grant as principle investigator and shifted expectations to emphasize collaborative research and CPA. (See appendix: “Chair’s Column.”) However, many mentors and leaders



remain steadfast to prior expectations, and many CIs also seem unaware of the changes.

The most recent faculty survey, conducted in 2017, found that our CI faculty members were more likely than others to report dissatisfaction with institutional support and the amount of time they had protected for scholarly work. Their comments indicated that they had a sense of being “orphaned” from the research infrastructure of their hospital/institution, that they were less valued for their work than their CS peers and that they were under far greater pressure than CS faculty to pitch in when clinical needs are high. Considering these recent results, we have instituted a departmental “check in” for all CI faculty recruits after 1.5 years from their initial appointment to solve problems and reiterate expectations. We will also conduct focus groups of our CI faculty to learn how we can better support them. This will be a focus of the coming year.



## 4. Relationships

The reviewers noted that “For the Department of Medicine to move up to the next level, it must build upon the relationships, not only with the departments and the hospitals, but also with the research institutes, community



and industry. In the future, there will need to be a better sense of professional identity within the University. The DoM should continue to play a major role in the Toronto Academic Health Science Network (TAHSN).”

**Response:** This has been a major focus of the past four years. Stakeholder interviews conducted in 2014 indicated that a successful partnership between the Department and hospitals/hospital research institutes required the Department to increase its “skin in the game.” We needed to establish our value add to the enterprise. In brief, I believe we have made great strides in this direction through the following activities:

- enhanced administrative and financial support of faculty and trainees;
- increased transparency and fairness in processes and decisions;
- attention to the tensions between clinical service and academic productivity; working closely with the PICs to assist in city-wide planning and facilitating recruitment;
- enhanced engagement in divisional fund raising; and
- initiatives to address equity, diversity and professionalism, which have had positive repercussions across all sites and programs.

I have also assumed the role of Co-Chair of the TAHSN Medicine Committee; this committee of chief medical officers from across the teaching hospitals deals with all major issues affecting physicians.

## 5. Diversity

The reviewers commented on the need for the development of a plan to increase the diversity of students and faculty, and they also commented on the aging of some clinicians.

**Response:** “Equity, diversity and professionalism” was identified as a priority in our 2015 strategic plan. Dr. Sharon Straus was subsequently appointed the inaugural Vice Chair, Mentorship, Equity and Diversity. (Please see section 8 for details of progress.) Please also note the section on our Patient Centred Care Initiative in undergraduate and postgraduate education under Education.

The comment about the “aging of some clinicians” has been very much on the Department’s radar. Between 2000 and 2015, the mean age at recruitment to the Department, irrespective of rank, increased from 34 to 36 years, and the mean age of full-time faculty members

increased from 45 to 51 years. Consistent with these figures, the proportion of our full-time DoM members who had been on faculty for more than a decade increased from 47 per cent to 58 per cent. Potential explanations for this growth likely include sustained recruitment of physicians—perhaps necessary to meet the needs of an aging population with complex health-care needs—as well as the end of mandatory retirement at age 65 years in Ontario in 2006. In our 2015 faculty survey, we explored faculty members’ perceptions of retirement. In brief, only half of the respondents saw retirement as good, and one in five had no plans to retire at all. Availability of formal mentorship about retirement and academic roles that could capitalize on the wealth of experience and wisdom of senior faculty during and after retirement were seen as unmet needs.

Concerns regarding the “aging” of our faculty largely centre on two points: (i) Lack of retirement planning often resulted in a precipitous transition (e.g., illness, death, medical malpractice suit), which was bad for all; and (ii) many older physicians were no longer contributing fully to clinical activities, including on-call responsibilities, but they continued to receive full financial and other support (e.g., endoscopy time or clinic space), resulting in difficulty recruiting to meet clinical needs.

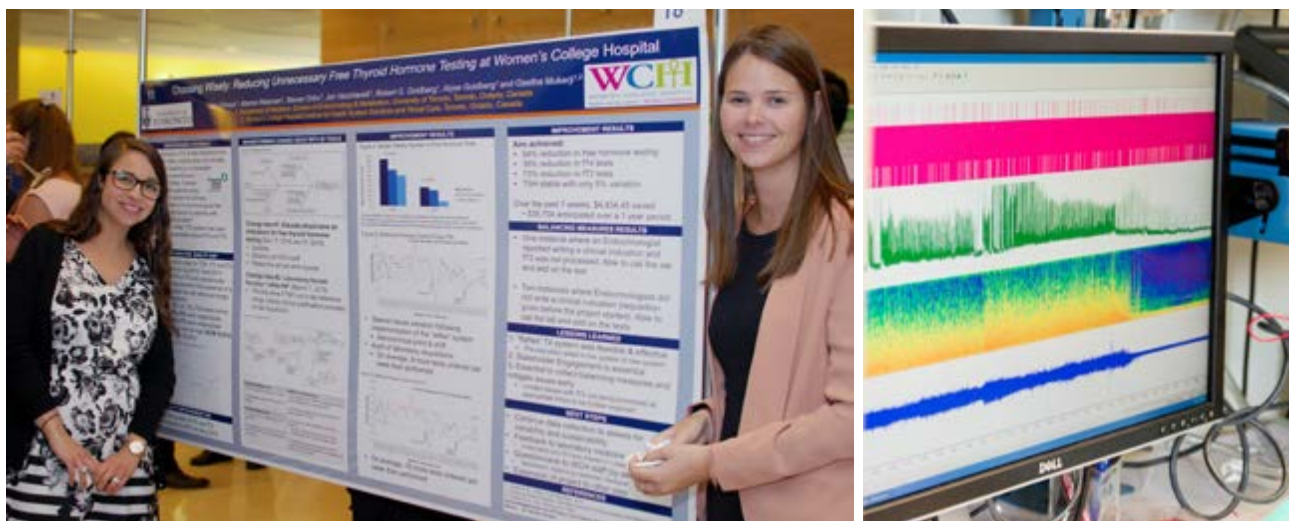
Under the leadership of our Vice Chair, Mentorship, Equity and Diversity, a task force was struck to develop and present strategies to address these concerns. We value equity and fairness and reject ageism, so we have decided to focus on accountability. We have developed an over-arching welcome letter for new recruits, cosigned by the PIC and Chair, that clearly outlines our clinical

and academic expectations of faculty members. This letter states: “All Department of Medicine full-time clinical faculty members are expected to make a full contribution to the clinical and academic mission of their Division and Department. These activities include clinical work, such as on-call duties and coverage of inpatient and consult services, as appropriate for the Hospital and Division, as well as teaching and scholarship according to one’s academic position description.” An annual review checklist has been developed and will be implemented this year; the checklist includes an inquiry of all physicians about their anticipated career transitions, irrespective of age or rank. Finally, we are considering implementing “retirement coaches” who can be accessed confidentially by faculty members who are contemplating retirement but wish to better understand the options open to them. Under the Faculty of Medicine, a policy on late career transition has also been developed and approved. Work continues to improve mentorship of faculty in late-career transition.

## 6. Research

The reviewers noted, “The Department of Medicine is uniquely positioned to play a role as a catalyst between basic sciences and clinician sciences and between the University, hospitals and research institutes.”

**Response:** We fully agree with this comment. This goal has been the impetus behind the above-noted research networks, the recruitment of a computer scientist, working jointly with Computer Science and myriad other ongoing initiatives. Please also see the report of the Vice Chairs for Research and for Quality and Innovation for additional information.





# SECTION 3: CHAIR'S STATEMENT



*Since 2014,* I have had the utmost pleasure of being the Sir John and Lady Eaton Professor and Chair of Medicine at the University of Toronto. By training, I am a clinician scientist and rheumatologist, having completed all my medical training at the University of Toronto. My research, which is based at Women's College Hospital (WCH), focuses on clinical epidemiologist and health-services research in the field of osteoarthritis. I am a passionate advocate for improving the diagnosis and management of osteoarthritis. As Chair, I am a passionate advocate for advancing the careers of women in academic medicine.

Before assuming the role of Chair of the Department of Medicine, I was the Physician-in-Chief (PIC) at WCH (interim PIC 2005–06; PIC 2006–14). I had the opportunity to oversee the de-amalgamation of WCH from Sunnybrook Health Sciences Centre to become the first fully ambulatory teaching hospital in Toronto. This was a formative time in my development as a leader; it allowed me to demonstrate my capacity for innovation and change management. There were only seven full-time faculty members in the WCH Department of Medicine in 2006. But, excited by the opportunity to work in a different kind of hospital, we were able to recruit outstanding faculty members, and our numbers grew quickly.

My experiences as PIC at WCH afforded me an excellent understanding of the affiliated hospital structure and its challenges. I gained a first-hand understanding of the critical role of internal medicine and its subspecialties while partnering with primary care providers to improve the experiences and outcomes of people living with multiple chronic conditions. I also gained an understanding of the need for education, implementation science and novel models of care to ensure that our trainees and faculty can meet these patients' needs and keep them out of hospital. This was a clear motivation for my interest in the role of Department Chair.

But there were two other key motivators. First, I was bothered by the lack of allegiance of faculty members to the University relative to their hospital. Most people were unclear what value-add the University served. I believed that greater cohesion was possible and that it would strengthen us academically and improve faculty and trainee wellness. Second, as a woman in medicine—a trainee and faculty member—I had experiences that were unacceptable with respect to civility and professionalism. I wanted to ensure that other women did not share these experiences.

In my role as Chair, I have been keen to participate in, and help guide, a cultural evolution in partnership with the affiliated hospitals and other departments within the Faculty of Medicine. From making departmental cohesion and community a priority to advancing the voices of women in medicine through such initiatives as the annual Summit for Women in Academic Medicine, I am hopeful that the results after four-and-a-half years are tangible.



# ORGANIZATION & FINANCIAL STRUCTURE

## Governance

The Department Chair is supported in her role by four Vice Chairs: Dr. Arno Kumagai, Education; Dr. Michael Farkouh, Research; Dr. Kaveh Shojania, Quality and Innovation (QI); and Dr. Sharon Straus, Mentorship, Equity and Diversity (MED). The latter two Vice Chairs were established by the current Chair in 2015. In addition, Dr. Charles Chan serves as Senior Advisor to the Chair on Finance. The Department is governed by an Executive Committee that includes the Chair, Vice Chairs (VCs), Physicians-in-Chief (PICs), Departmental Division Directors (DDD), leaders of key educational programs, and two “young faculty” representatives. Additional support is provided by members of senior administration, including: Advancement, Communications, Operations and Strategic Planning. The Committee meets monthly and is ultimately responsible for approving major policies and procedures for the Department. There are also quarterly meetings of the DDDs that are focused on divisional matters and of the Senior Executive (VCs, PICs and Senior Advisor, Finance) to monitor progress, discuss barriers and make decisions about priorities and use of resources. Standing committees are led by the VCs and education program leaders. Since the close relationship of the Chair and PICs is critical, this group also meets monthly to coordinate efforts.

Parallel to the Department Executive Committee, each division has an executive committee structure. The Executive of a division is led by the DDD and includes the hospital division heads in that specialty, the residency training program director, and selected other members as determined by the DDD (e.g., Fellowship Director, leads for quality and research). As described below, these Executive Committees are critical to decision making about the recruitment of new faculty members across the city and to management of Department programming being translated across divisional sites. Over the past five years, all divisions have been required to have a Mentorship Facilitator and Fellowship Director; many

have also appointed leads in preparation for Competence by Design, the new Royal College curriculum for residency training. <http://www.royalcollege.ca/rcsite/cbd/competence-by-design-cbd-e>

Since 2014, all senior leadership role descriptions have been updated and terms articulated. (Terms are five years, renewable once following satisfactory review.) This includes an expanded description for the role of DDD. From DDD leadership reviews, four themes emerged that helped us reshape the DDD role:

- i. the value of a clearly articulated, inspirational vision for the division and the role of the DDD in setting this direction;
- ii. the importance of strong, frequent and balanced communication by the DDD with divisional members, key stakeholders and trainees;
- iii. the role of DDD to put what’s best for the whole ahead of personal or site-based priorities; and
- iv. the need for leadership that can achieve consensus but also move forward when consensus is not achievable.

This feedback was used to establish the key attributes of a successful DDD and revise the DDD job description. The DDDs were surveyed to identify their top priorities for funding. There was consensus that funding should be provided for divisional leadership stipends and administrative support (DDD and residency program director) and a discretionary fund to support division-specific initiatives, such as networking events, programming and seed-funding competitions. Based on this feedback, divisional budgets were established, proportionate to the size of the division and training program.

## Administrative Staff

At present the office has 35 full-time administrative staff, led by Clare Mitchell, Director of Business and Administration. Administrative staff work in rented space at the Toronto General Hospital (education, MED, QI, Business Administration) along with the senior physician leaders, and in the Naylor Building on campus (communications, finance, research, advancement).

During the last five years, there has been major reorganization of administrative responsibilities reflecting changes in our program priorities, retirement of a number



Figure 3.1: University of Toronto, Department of Medicine Organization Structure

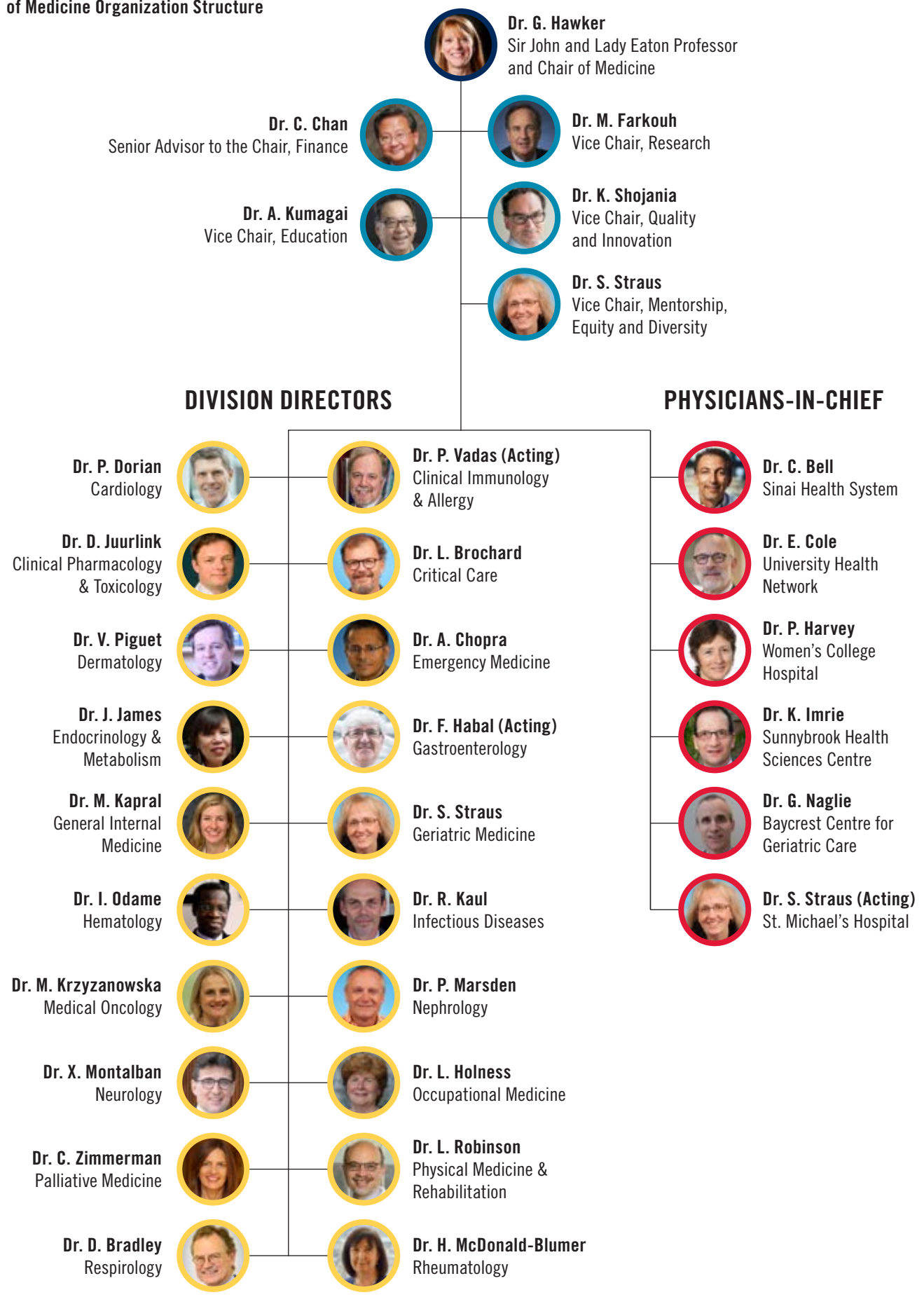
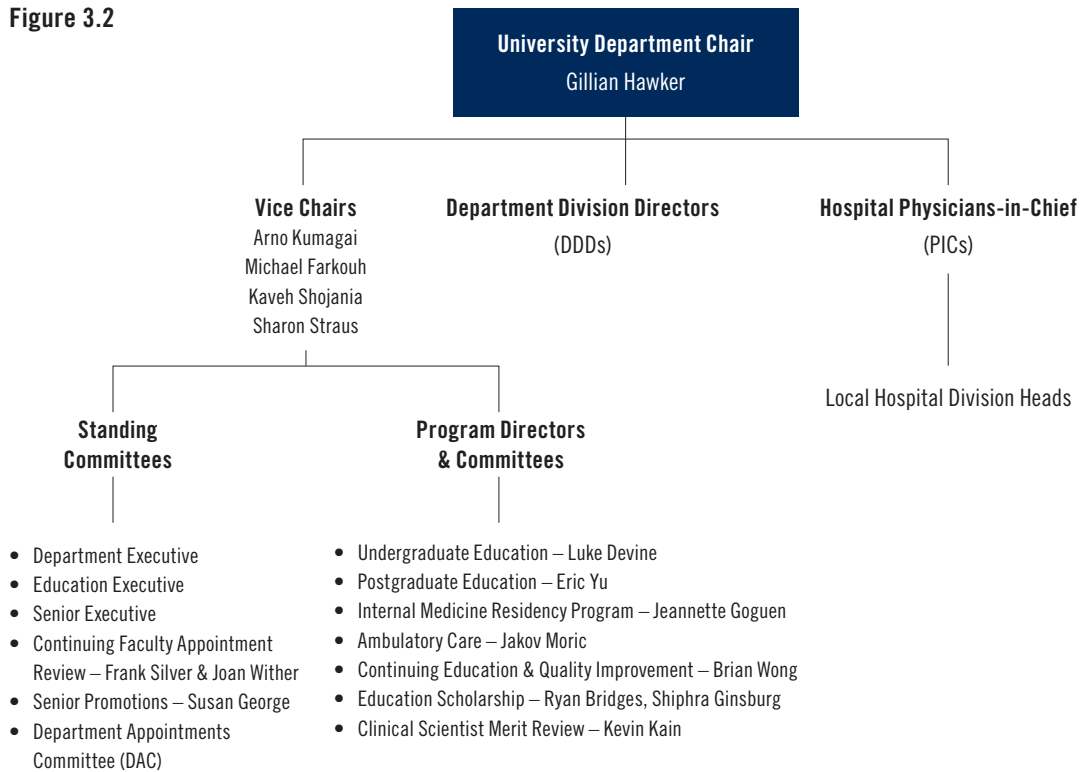


Figure 3.2



of long-standing senior staff members and an increase in the overall staff complement from 22 to 35 positions.

Important additions to the administrative staff of the Department include a Communications Lead, Research Administrator and two dedicated Academic Appointment Coordinators. Additional positions have been hired to support the divisions and residency programs within the Department. The Department has increased the administrative support to the divisions and residency programs. The funding for these staffing increases comes from the University operating budget allocated to the Department as well as the Department's share of funding from the foreign-trained residents and fellows. This

funding may now be in jeopardy because of the withdrawal of Saudi trainees at the time of writing.

In addition, the DoM purchases annual salary support from the host hospital payrolls in the sum of \$428 thousand. These funds are used to protect the time of the support staff for academic division heads and program directors.

## Faculty Appointments

Full-time faculty members are recruited jointly by the hospital departments and University through a formal search process. The DDD sits on all search committees as the University's representative. A search may be



conducted at a local level, national level (Canadian residents) or international level. To address unconscious bias/institutional reproduction and promote equity and diversity, the Department has established formal best practice guidelines and provided training resources to search committees (<https://www.deptmedicine.utoronto.ca/gender-equity-guidelines-department-medicine-search-committees>). Increasingly, searches are being conducted collaboratively by multiple hospitals where similar types of recruits are desired across sites. This reduces the workload for the hospital and division and helps to ensure a fair and transparent process for all.

To be eligible for full-time faculty positions at the assistant professor rank, candidates must have completed advanced training and have demonstrated scholarly productivity relevant to their career focus. Advanced training may be in the form of post-residency fellowship or graduate training in research, education, or quality and innovation or another relevant field. Previously, recruitment at the rank of lecturer was uncommon in the Department. However, due to increasing clinical demands and competition with the community for our recruits, we will now recruit at the lecturer rank individuals who are engaged in advanced training.

The Department supports advanced training in research, quality improvement and patient safety, and health professionals education. Research training is provided through the Eliot Phillipson Clinician Scientist Training Program (established in 1994) and the Eliot Phillipson Clinician Education Training Program (established in 2002). Quality improvement and patient safety training is provided through three programs: a Certificate Program in Quality Improvement and Patient Safety led by Dr. Brian Wong; the Veterans Affairs Quality Scholars Advanced Fellowship led by Dr. Chaim Bell (Toronto is the only non-American site of the VAQS program); and an MSc in Quality Improvement and Patient Safety through the Institute for Health Policy, Management and Evaluation in the Dalla Lana School of Public Health, led by Dr. Kaveh Shojania. Finally, health professional education training is provided through the Master Teacher Program (established in 2002), led by Drs. Danny Panisko and Umberin Najeeb. Details of these programs are recorded elsewhere in this report.

Recruitment open houses are held annually for interested trainees; requirements for appointment are posted online on our website. All posted positions are also now

available on the University career website and linked to from the departmental website. The requirements for each academic position description at appointment and at continuing faculty (three-year) review are also posted on our website.

All appointments are processed by our Academic Appointments Office and reviewed by the Department Appointments Committee (DAC). Between 2014 and 2015, the academic appointments process and procedures were reviewed and revised to streamline and standardize. DAC, which advises the Chair, was fully renewed to ensure that it is representative in terms of academic position description, gender, rank, full-time/part-time/adjunct faculty status and site (academic and community). Terms of reference for the committee were also revised.

Full-time faculty appointment requests incorporate an academic plan (signed off by the hospital PIC, the DDD and the designated formal mentor), a proposed academic position description and an updated CV. (<https://www.deptmedicine.utoronto.ca/clinical-faculty-academic-appointments>)

All new full-time faculty members are required to participate in an orientation “boot camp” designed to help them succeed at U of T. In addition, new full-time faculty members are paired with a mentor and supported by formal mentoring (described elsewhere). Initial appointments are probationary for a period of up to five years, pending successful Continuing Faculty Appointment Review (CFAR).

## EVALUATION OF FACULTY PERFORMANCE

### Annual Faculty Review

All members of the Department are expected to undergo annual review and performance assessment by the PIC (or, in the case of the PhD scientists, by the Department Chair or VC Research). The review requires the submission of a standardized annual activity report. In some hospitals this review is closely tied to an annual



merit payment while in others it is used to modify job descriptions and give feedback. Based on faculty survey responses, however, there is substantial variability across sites with respect to the rigour of the review; specifically, ensuring that an individual's activities are aligned with the expectations of their APD, late-career transition plans, industry relationships and professionalism/citizenship are recognized as essential elements of the annual review, yet these are not always adequately addressed. Further, the outcome of the review is not uniformly shared with key stakeholders. Work is underway to standardize the review process (timing, components, communication of outcome, etc.) across all sites.

## Merit Review of Clinician Scientists

[Http://www.deptmedicine.utoronto.ca/clinician-scientist-merit-review](http://www.deptmedicine.utoronto.ca/clinician-scientist-merit-review)

A merit review, led by Dr. Kevin Kain, was implemented in the Department in 2012. It targeted clinician scientists (CSs) receiving start-up or bridge support following the end of their career grants. The review determined eligibility for ongoing Department funding and identified those needing assistance and those excelling who were eligible for additional support. Successful CSs received \$25 thousand per annum of salary support from the Department for three years. In 2014, the merit review was revisited by the departmental leadership team. The amount of funding was felt to be low and, as a result, was not seen by the hospitals as “skin in the game.” There was agreement that support of the CS track in the Department was a priority—that departmental funds for salary support should be limited to stipends for leadership roles and CS start-up and Merit Awards. The amount was subsequently increased to \$40 thousand per annum for five years as



Dr. Kevin Kain

start-up for newly recruited CS faculty and \$40 thousand per annum for three years, renewable on re-review, for those mid- or late-career. The review process was revised to simulate that of the Canadian Institutes of Health Research (CIHR) Salary Support Awards (scale 0–5 when 4+ scores indicate excellent to outstanding); faculty are deemed eligible for Merit if they achieve a score of 4 or higher. Those holding salary support from other sources (e.g., a Chair), are not eligible to compete for Merit. Those whose scores are below 4 are given individualized feedback and mentorship to ensure future success. Altogether, the merit review has been seen as a definitive success—fair, transparent and formative.



## Continuing Faculty Appointment Review

<http://www.deptmedicine.utoronto.ca/continuing-faculty-appointment-review-cfar>

After three years on faculty, full-time faculty members are reviewed formally in a peer-review process. Academic appointments in the Faculty of Medicine remain “provisional” until this review is passed. In 1995, the Department established a formal Three-Year Review Committee, now called the Continuing Faculty Appointment Review Committee. This Committee, led by two senior faculty members, conducts reviews using a



Dean Trevor Young (second from left) at Annual Day with DoM faculty members promoted to full professor in 2017: Drs. Robert Fowler, Lori Albert, Mary Bell, Donald Branch, Shahid Husain, Geoffrey Liu, and Ramesh Prasad.

peer-review process similar to a promotion committee. Documentation for the review includes a faculty statement of progress and goals, letters from faculty's DDD and PIC, a CV and teaching dossier.

In the past four years, the process of this review has undergone major revision. PDF templates are now used to simplify, streamline and standardize the dossiers; expectations of faculty are posted online by APD and are covered at orientation, at annual reviews and in a CFAR workshop held annually. The CFAR Committee recommendations to the Chair are now shared with the candidate. Committee membership has been expanded to ensure representation of a growing number of clinicians in quality and innovation. In 2016, the Department added a professionalism requirement for successful CFAR. Candidates must have consistently demonstrated behaviours aligned with the code of conduct of the Faculty of Medicine. In 2018, we further revised our processes by no longer waiving the CFAR requirement for senior faculty recruits; we recognize that only during a probationary period would it be possible to address unprofessionalism if it occurred.

The CFAR Committee makes recommendations to the Chair for either a pass, a deferral requiring resubmission in one to two years, or a failure. Since 2013, 203 faculty members have undergone this review process. Although the vast majority pass, some reviews lead to reconsideration by the Chair, PIC and DDD. Reconsideration most often occurs when a job

description does not match the distribution of time that the individual devotes to the work; occasionally, the issue is professionalism or teaching effectiveness. Of 192 who underwent their first review in this time period, six (3 per cent) had their probationary periods extended, but the proportion requiring extended probation was disproportionately higher for CIs and CSs. It is increasingly difficult to successfully launch an independent research career, including obtaining peer-review grants and demonstrating productivity, in only three years. As a result, beginning in 2019, we will institute a 1.5-year interim meeting with early faculty recruits to ensure clarity about expectations and to proactively address issues before CFAR.

### Senior Promotion

<http://www.deptmedicine.utoronto.ca/senior-promotion>

The Department promotions process, which follows the policies and procedures set down by the University and Faculty of Medicine (FoM), involves a detailed independent assessment of each candidate in three sequential steps: (i) in a Department Promotions Committee at the hospital, (ii) at the DoM; and (iii) at the FoM. The DoM also has a Teaching Effectiveness Committee (TEC) that independently reviews the teaching dossiers of each faculty member since evidence of teaching effectiveness is required for all faculty members to be promoted. The TEC report is given to the DoM Promotions Committee and becomes a record in the promotion file.



Since 2014, there have been major changes made to the Department's promotion process to simplify, streamline and standardize. We ask candidates to focus on perfecting their CVs to ensure all relevant information is reflected in a single document, and we no longer request documents such as the CPA Report that were found to be redundant. Previous appendices of largely unnecessary materials are no longer accepted; all documentation is online. (It's paper free.) Candidates are expected, instead, to provide web links embedded in the CV to supporting materials, and additional documentation is only requested following the committee review if it is deemed necessary. As for CFAR, workshops are held annually for promotion candidates and support administrative staff. We succeeded in modifying the FoM policy whereby, for all candidates who provide and do not waive their external review, internal referee letters are now optional. We have substantially reduced the Department's workload. Finally, to provide greater support to the hospitals, the Department's senior promotion administrator does all referee solicitation.

Between 2014 and 2018, the Department conducted 192 reviews of 190 unique candidates for promotion (63.7 per cent for associate professor and 36.3 per cent for full professor). Reviews were of one clinician administrator, 16 clinician educators, 55 clinician investigators, nine clinicians in quality and innovation, 67 clinician scientists, 39 clinician teachers, and five

research scientists; 75 of the 190 candidates were women (39.5 per cent). Only 17 out of 193 applications (8.8 per cent) were not sent forward to the Decanal Committee (two individuals were not sent forward twice). All but one candidate (an adjunct professor in community practice) were recommended for promotion by the Decanal Committee. Ten men and four women have been declined by the Department, of which two and two, respectively, have subsequently been successfully promoted. The primary basis for promotions was research (92), creative professional activity (74) and sustained excellence in teaching (27).

## Senior Leadership Review

Increasingly, our leaders are being evaluated through hospital-based 360s. In 2014, the Department conducted 360 evaluations of all members of the Executive Committee (PICs, DDDs, VCs, and the Department Chair) and of our educational leadership (Residency Program Directors). The review template was customized to align with the defined attributes of a departmental leader, and reviews were conducted anonymously by a third party. Results were provided to participants and reviewed with the Chair. Open-ended comments were used to revise the DDD job description. As new leaders are recruited, this process has been implemented at one to two years into the role. All DDDs are on five-year terms, with formal external reviews at five and ten years. Nine external divisional reviews have been conducted (Cardiology, Dermatology, Gastroenterology, Medical Oncology, Nephrology, Neurology, Occupational Medicine, Respiriology and Rheumatology) with a number planned for the upcoming academic year (Infectious Diseases; Physiatry; Immunology and Allergy; Emergency Medicine; and Critical Care). Two Divisions (General Internal Medicine and Endocrinology) have



undergone leadership renewal without review; strategic planning with external input is ongoing.

The Department Chair is reviewed annually by the Dean.

## FINANCE

The DoM's annual operating budget amounts to approximately \$16.7 million per annum. These funds are composed of funding from the University operating budget (\$10 million), a share of central Postgraduate Medical Education (PGME) tuition revenues (\$3.7 million) and advancement endowment income of \$3 million (assuming a rate of return of 4 per cent). The DoM does not receive any revenues from the practice plans.

Before 2014, the DoM was in a significant positive financial position: it had an operating carry forward of \$16.7 million. Over the past five years, the Faculty of Medicine reduced operating funding by a million dollars, but it has also clawed back approximately \$6.7 million of the carry forward.

At the time of writing, the Saudi government has notified the Canadian government that Saudi trainees will be removed from Canada, effective September 22, 2018. The result will be a decrease in Department revenue of approximately \$1 million per annum from the PGME annual revenue. These funds are used solely to support education, via programmatic funding, staffing and stipends for faculty postgraduate education roles. This will have a significant negative impact on the Department. The Department continues to invest effort in increasing advancement fundraising, as this remains a viable source of long-term funding for the DoM.

\$11.6 million (70 per cent) of the annual operating budget is allocated to the practice plans or directly to academic salaries and fringe benefits; \$2.3 million (14 per cent) goes to administrative salaries and fringe benefits for our staff; and the rest (16 per cent) goes to specific programs in education and research.

Approximately \$5 million each is allocated to education and research portfolios. This includes stipends to faculty members, as well as programming funds and staffing support. Approximately \$5 million is allocated to senior

leadership stipends, including the Division Directors, Physicians-in-Chiefs and the Chair. \$1.5 million is allocated to general administration, including programming for events such as grand rounds, departmental celebratory events and central staffing, such as divisional staff, communications, finance and advancement.

Through strategic management of cash flow and funding, the DoM has been able to allow for significant one-time projects. These include, but are not limited to, the Challenge Team Grants (\$1 million was awarded in 2014–16) and strategic fundraising partnerships (\$2 million dollars has been segregated into endowments to support hospital PIC-endowed chairs). Segregated funds have been established to support quality and innovation, patient-centred care as well as a key faculty recruit in partnership with Computer Science. Two million dollars has been set aside for the renovation of the new office space for the Department at the Naylor Building.

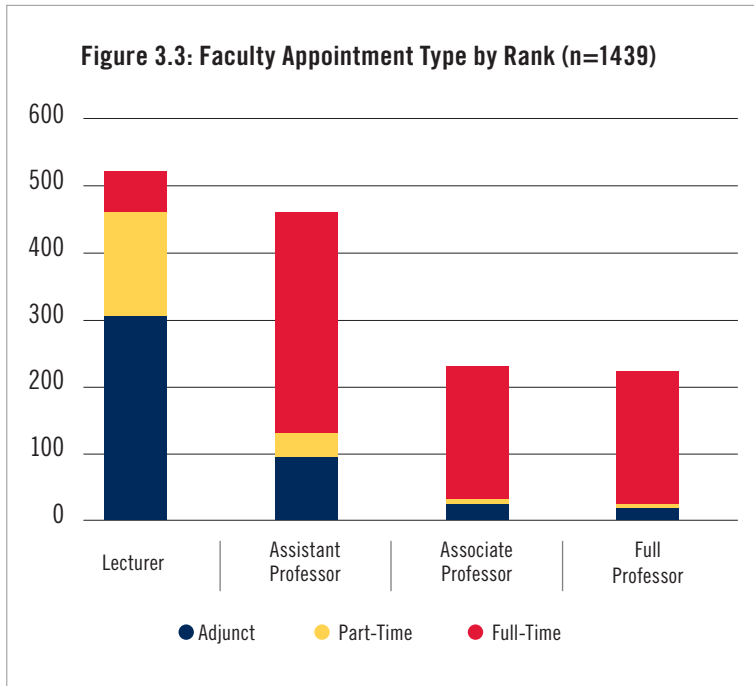
## RESOURCES & INFRASTRUCTURE

The DoM has complex resource and infrastructure needs, partly because of its vast size as well as the vast scope of the programs and activities of the Department's faculty members.

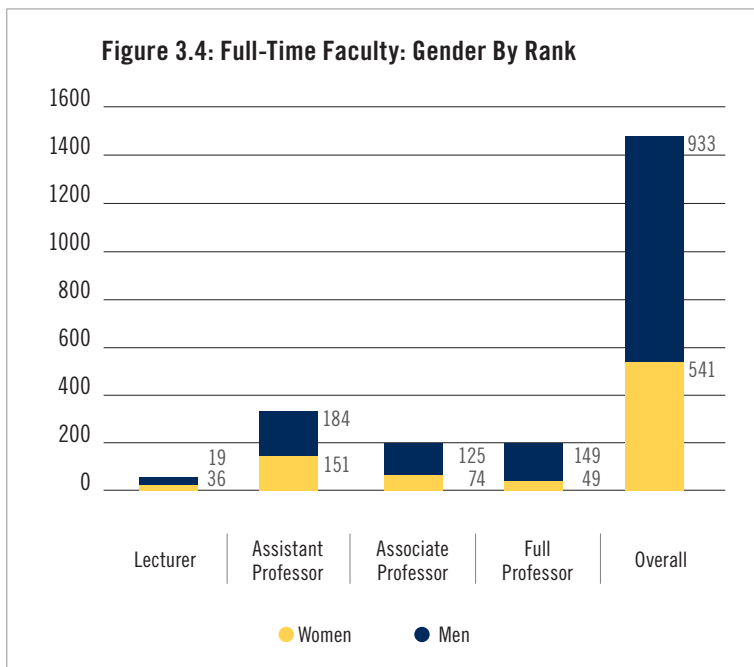
The Department continues to be challenged by securing sufficient space for staff, faculty collaboration and teaching activities. To that end, the Department has set aside \$2 million to renovate and refurbish the space it has been allocated on the University's St. George campus. The anticipated move date is late 2018 to early 2019, and all the staff and Faculty senior leadership will be in one consolidated location with expanded meeting and collaboration space.

In addition, the Department also faces challenges to IT infrastructure. Due to its size and scope, the Department must look at IT solutions. To date we cannot reliably count on IT services from the central University or the Faculty of Medicine. Many of the issues we face, such as scheduling a very large number of residents and fellows, are unique to our Department, and we cannot gain economies of scale by working with the Faculty of Medicine IT.

# STRATEGIC PLAN & LONG-RANGE PLANNING CHALLENGES



In 2014, the Department engaged in a major strategic planning effort with input from all DoM faculty members; trainees and key stakeholders in the hospitals; the Faculty of Medicine and University; and beyond. The process was designed to engage the faculty in creating a shared vision that they were invested in achieving, and establishing goals that were common to all and overarching across all shared hospital values.



As a new Chair, I was more interested in achieving consensus on the direction we should take and less on the explicit steps required to get there. Given the strength of the leadership team, it made sense to empower the DDDs and VCs to work with their constituencies to bring these priorities to life with clear and measurable deliverables. We revised our vision statement in this process to place greater emphasis on the importance of our work having meaningful impact—for our patients, their families, the health-care system, and ourselves as health professionals—on health care and health outcomes.

Eight strategic priorities emerged from this work that will move us toward achieving this vision:

1. Ensure the perspectives and experiences of our patients and their families guide our work.
2. Promote equity, diversity and professionalism.
3. Be socially accountable and steward health-care resources.
4. Align future physician training to meet future population needs.
5. Promote the generation and translation of new knowledge with the potential to impact patient care and outcomes.
6. Recognize and value the contributions of all (diverse teams, teachers and researchers, etc.).
7. Enhance mentorship across the academic lifespan.
8. Raise funds to meet our goals.

The priorities were communicated broadly and adjusted based on feedback. Departmental leaders were then tasked with aligning their work with these priorities, reporting on success annually. At the end of each academic year, I present City-Wide Medical Grand Rounds; at these rounds, progress on each priority is outlined and discussed. On January 30, 2018, the Department leadership held a retreat to review these priorities and look at what we'd achieved. As a result, these priorities were reconfirmed.

We have made significant progress in realizing these goals, as outlined in this report. Below, I have provided a brief summary of key accomplishments. Please see sections on Education; Research; Mentorship, Equity and Diversity; and Quality and Innovation for additional details.



Dr. Maria Jogova shares a story about her patient care experiences at the DoM Story Slam

#### Ensure Patient Perspectives Guide Our Work

- Patient-centred care initiative in undergraduate and postgraduate education (see Education)
- Introduction of “Story Slam” in 2017 and again in 2018 for trainees and faculty to use narrative to share

stories of their patient care experiences (led by Dr. Allan Detsky; published in *Annals of Internal Medicine*)

- Review of progress on this priority in January 2018 indicated consensus that, while this priority continued to have meaning for the leadership team, more attention was needed. We appointed Dr. Andreas Laupacis as the Lead for Patient Involvement in 2018 to guide us on how best to engage patients in our work to ensure patient-centred care.

#### Equity, Diversity and Professionalism

- Created a new portfolio—Vice Chair Mentorship, Equity and Diversity, which is held by Dr. Sharon Straus
- Established clear and transparent processes and procedures within the DoM (e.g., with respect to appointments, senior promotion, etc.)
- Mandated a formal search for all recruitment and appointments, with standardized requirements for the Selection Committee constituency
- Conducted faculty surveys in 2015 and 2017 to take the pulse of the Department on these issues
- Held an Inaugural Summit for Women in Academic Medicine in 2017, and a second summit in 2018
- Presented on sex and gender gaps in academic medicine locally and nationally, including advocating for change at the annual meeting of the Canadian Association of Professors of Medicine (CAPM)
- Conducted research to better understand barriers to women in academic medicine and perceptions regarding professionalism, which have been published in peer-reviewed journals
- Developed and implemented policies and procedures to address unconscious bias, professionalism/civility
- Incorporated professionalism in reviews for promotion, CFAR, awards
- Played integral role in the Faculty of Medicine's development and implementation of policy and procedures regarding disclosure, management of relationships with industry, and research integrity
- Further details in reports on Education; Research; and Mentorship, Equity and Diversity

#### Stewardship of Health-Care Resources

- Major success in training, recruitment and career development of clinicians in quality improvement (now 45 faculty; 100 per cent success to date at three-year review)
- Establishment of formal faculty mentors across the hospitals for CQI faculty





- Incorporation of QI expertise on departmental committees
- CQUIPS ten-year review highly successful
- Further details in report on Quality and Innovation

#### **Training to Meet Population Needs**

- Recruited Dr. Arno Kumagai as Vice Chair, Education, from the University of Michigan—international expert in humanism in medicine
- Implemented competency-based medical education (CBME)
- Increased trainee exposure to integrated models of primary-specialist care, ambulatory care and e-technologies in patient care
- Established the first ever Director of Fellowships, Dr. Cheryl Jaigobin; have undertaken review of all fellowship programs to ensure quality of the educational experiences
- Further details in report on Education

#### **Generating Knowledge to Affect Health Outcomes**

- Appointed a full-time administrative lead for research (Joanna King), which has substantially increased our capacity to support city-wide research initiatives
- Building on the highly successful Challenge Grants, implemented a transformational model of interdisciplinary, cross-university collaboration—

a network of networks; goals include creating opportunities for national and international collaboration

- Adjusted recruitment, probationary review and senior promotion such that faculty are required to “tell their stories”—describe how their work is important and its impact, or potential impact, on the health of Canadians
- Successfully recruited, with the Department of Computer Science, a PhD in Artificial Intelligence, Dr. Marzyeh Ghassemi

#### **Valuing All**

- “All” includes our faculty members, inter-professional colleagues, hospital and university identities
- We were instrumental in the Dean establishing a task force on Valuing the Clinician Teacher (co-led by our VC, Education, Dr. Arno Kumagai & Dr. Allison Freeland)
- Our Vice Chair, QI, Dr. Kaveh Shojania, successfully advocated for differential consideration of QI scholarship in the context of faculty evaluation for senior promotion
- Major emphasis of communications is now on celebrating our successes, highlighting faculty across sites, stage of career and position descriptions

- Introduction of annual Associate Professors' Day to celebrate those faculty who were successful in promotion to associate professor
- Establishment in 2018 of a new award for Humanism in Medicine—inaugural presentation to Dr. Adrienne Chan at Annual Day 2018
- Ongoing work to establish an Academy of Master Clinicians to recognize the importance of superb clinical skills and care
- Proactive identification of retiring faculty members who meet criteria for professor emeritus status—celebration of these individuals at Annual Day

### Mentorship

- Introduction in 2015 of a departmental orientation of trainees (PGY1, PGY4, Fellows) to the University and the DoM
- Launch of divisional mentorship facilitators
- Career Transitions Task Force, led by Dr. Liesley Lee, to guide and enhance the experience of late career transitions
- Clarification of academic position descriptions and expectations, including requirements at probationary review
- Enhanced attention to faculty and resident wellness—DoM Wellness Lead to be appointed fall 2018
- Further details in report on Mentorship, Equity and Diversity

### Fundraising to Achieve Our Goals

- Substantial increase in attention paid to stewardship of existing donors, including clear expectations of recipients of donor funds (annual reports, meetings, etc.)

- Planning for celebration of 100th anniversary for establishment of the Sir John and Lady Eaton legacy endowment in 2019 and for the discovery of insulin in 2021
- Development of business case for support of clinician scientist training and career support
- Engagement of all departmental leaders in advancement activities; advancement is now formally incorporated into the DDD role description

## ALUMNI & ADVANCEMENT PROGRAMS

Since beginning my tenure on July 1, 2014, I have worked with our full-time major gifts fundraiser (Senior Development Officer) to secure \$14 million of new philanthropic gifts and an additional \$6 million in sponsorship support for continuing professional development. The major gift portfolio has grown from an average of 2.5 major gifts closed per year in the two years preceding my arrival to an average of more than 11 major gifts closed per year, and 14 proposals submitted over the last three fiscal years, representing a 350% increase.

Equally as impressive has been embedding fundraising and advancement as a key strategic priority for the department. We have instituted a process where our Director of Business Administration and Senior Development Officer meet annually with all DDDs and



Dr. Adrienne Chan (right) receives the inaugural Award for Humanism in Medicine at the 2018 Annual Day



Dr. Gillian Hawker (left) with Professors Emeriti Drs. Andrew Simor, Linn Holness, George Fantus and Ian Quirt

endowed chair holders to review funds, ensure alignment with gift agreements and discuss new prospective donors. Faculty participation in advancement-related activities, such as donor cultivation and stewardship meetings, and new prospect referrals are also at an all-time high.

Further integration with hospital partners has been a focus of our efforts and has led to significant philanthropic gifts. Working in partnership with University Health Network–Toronto General Hospital, the DoM secured a \$5 million gift to enhance the newly created Division of Palliative Medicine and provide much needed support for fellowships in palliative care. Working collaboratively with St. Michael’s Hospital, the DoM was able to close a seven-figure gift that created a city-wide research and education program in multiple sclerosis at U of T. This development led to the recruitment of an internationally-renowned multiple sclerosis researcher who also became the DDD for the Division of Neurology.

2019 marks the 100th anniversary of the Eaton family gift that established the Sir John and Lady Eaton Professor of Medicine. To commemorate this milestone, the department is embarking on a fundraising campaign aimed at alumni from all 20 divisions, current faculty and prospective donors. The Eaton family, in honour of this occasion, recently made a new seven-figure gift that will support clinician scientists and the Eliot Phillipson Clinician Scientist Training Program. Other philanthropic successes include the creation of a Fund for the Advancement of Women in Academic Medicine, a Benign Hematology Fellowship Program Fund and new funding partnerships with industry in multiple divisions.

At present, department faculty members hold over 70 hospital-university named chairs and professorships. The sum of all endowed funds in the Department of Medicine is currently more than \$50 million.

## FUTURE DIRECTIONS

On the whole, I am extremely pleased with the current status of the Department. We have a truly outstanding leadership team, and it is an honour to serve such an exceptional group of physicians, scientists, educators, innovators, staff and trainees. Given our size and strengths, we recognize that we can play a pivotal role in shaping policy and setting direction, not only for ourselves but also more broadly in the Faculty of Medicine. At the U of T, the Chair does not need to push faculty or learners to aim high—the individuals we attract are inherently highly motivated to be the best they can be and to contribute meaningfully through scholarly work. As a result, I believe the most important role of the Chair and the leadership team is to break down barriers to the success of these individuals—to serve as catalysts, champions and facilitators. I believe that our collective work over the past five years to address unprofessionalism and inequities/lack of diversity in the workplace is doing just this. We will continue to break down the silos and biases that prevent us from being the best we can be. Increased attention to individual faculty wellness under the direction of a new wellness lead will further this goal.

Following this review, the leadership team will be given an opportunity to reflect on the recommendations of the reviewers. We will then meet with key stakeholders and as a team to set our direction (priorities and specific deliverables for each) for the next five years.





# SECTION 4: PEOPLE



## FACULTY MEMBERS

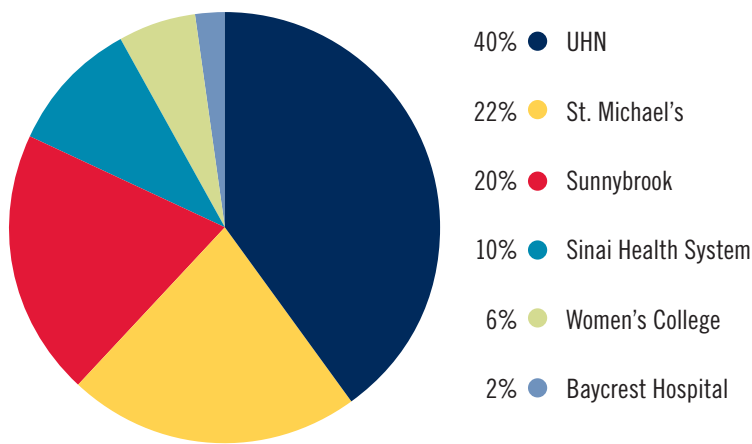
The Department comprises 1,474 faculty members (789 full-time; 652 part-time or adjunct), or roughly 27 per cent of the Faculty of Medicine (FoM). In addition, 63 faculty members who have primary appointments elsewhere at the University of Toronto hold cross-appointments to the Department of Medicine (DoM) in recognition of meaningful collaboration.

Department members are appointed to a primary hospital and University departmental division. Full-time faculty members are distributed primarily in six major hospitals and health systems: (i) St. Michael's Hospital, which now incorporates St. Joseph's Health Centre and Providence Healthcare; (ii) University Health Network, which includes Princess Margaret Cancer Centre, Toronto General Hospital, Toronto Western Hospital, and Toronto Rehabilitation Institute; (iii) Sinai Health System, which includes Mount Sinai Hospital and Bridgepoint Active Healthcare; (iv) Sunnybrook Health Sciences Centre, which includes St. John's Rehabilitation Hospital; (v) Women's College Hospital, a fully ambulatory hospital, and (vi) Baycrest, a geriatric hospital. All hospital sites used by the DoM are full or community affiliates of U of T.

Part-time and adjunct clinical faculty members are predominantly based at our community-affiliated hospitals or in private practice in the community. Traditionally, there were few part-time clinical faculty in our Department (members were either full-time or adjunct), but with the growth and academic development of the four community affiliates (St. Joseph's—now part of St. Michael's; Trillium; Toronto East; and North York General) this is changing.



**Figure 4.1 Distribution of Full-Time Faculty by Hospital**

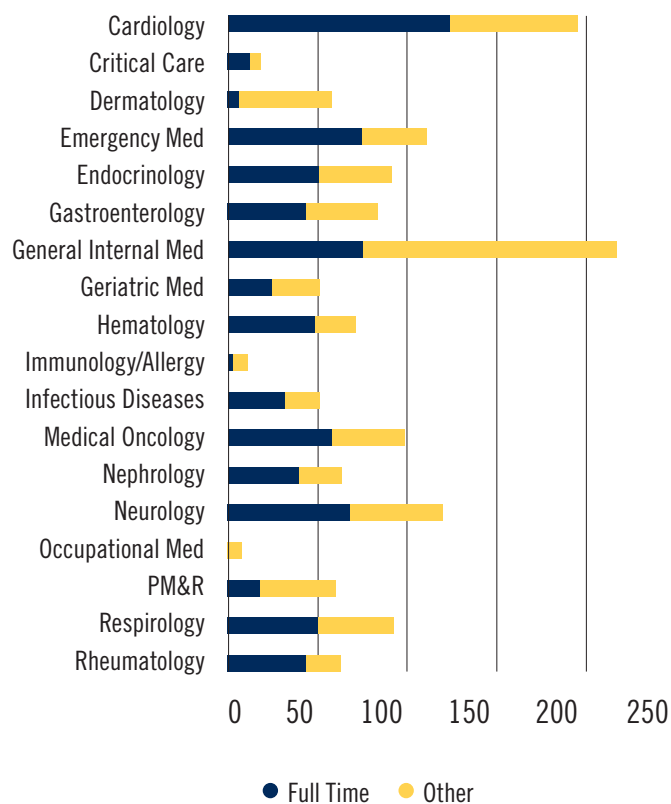


There are 20 departmental divisions, which vary in size from fewer than five full-time faculty in each of Occupational Medicine; Allergy and Immunology; and Clinical Pharmacology and Toxicology, to 127 full-time faculty in Cardiology. (See figure 4.2.)

Of the full-time faculty members 15 are research scientists, 197 are clinician scientists, 178 are clinician investigators, 45 are clinicians in quality and innovation, 57 are clinician educators, 286 are clinician teachers and 26 are clinician administrators. (See figure 4.3.)

**Figure 4.2 Department of Medicine Faculty by Division**

(does not include faculty members in no division (n=13))



The proportion of women in each academic position description (APD) declines from 44.8 per cent of clinician teachers and 48.9 per cent of clinicians in quality and innovation to 40.4 per cent of clinician educators and 37.1 per cent of clinician investigators, to 33.5 per cent of clinician scientists and only 19.2 per cent of clinician administrators.

The distribution of faculty members by rank is shown in figure 4.1 for full-time, part-time and adjunct faculty. Among full-time faculty, 7 per cent are lecturers, 43 per cent assistant professors, 25 per cent associate professors and 25 per cent full professors. Among part-time and adjunct faculty, 72 per cent are lecturers, 20 per cent assistant professors, 5 per cent associate professors and 4 per cent full professors.

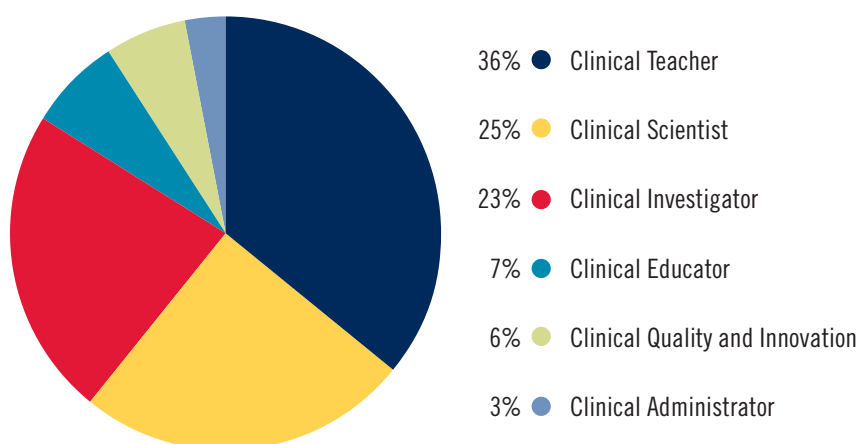
Currently, 39.3 per cent of the full-time faculty members are women. This has increased from 36 per cent in 2013. Women are disproportionately represented among the lecturers (63.2 per cent) and assistant professors (45.1 per cent) compared with associate (37.2 per cent) and full professors (24.8 per cent). By academic position description, women are disproportionately represented among clinician teachers (44.8 per cent), clinicians in quality and innovation (44.8 per cent) and clinician educators (40.35 per cent), but relatively less well represented among clinician investigators (37.1 per cent), clinician scientists (33.5 per cent) and clinician administrators (19.2 per cent).

The proportion of women by division also varies widely, from a low of 17.5 per cent in Cardiology to a high of 63.2 per cent in Rheumatology. (See figure 4.4.)

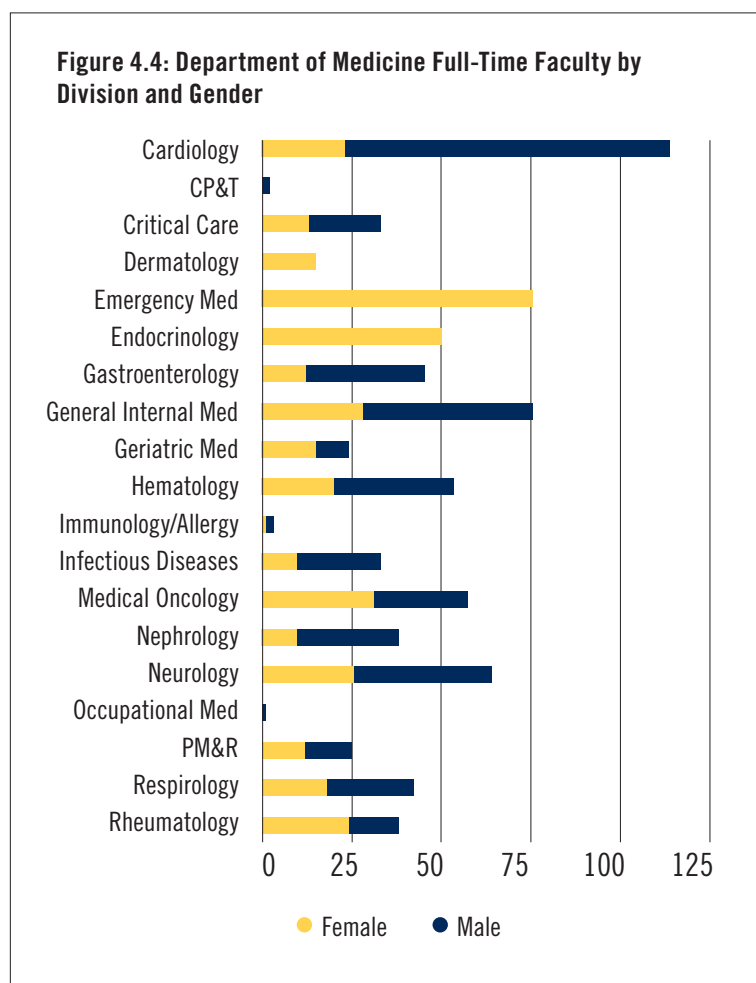
Less is known regarding the makeup of our Department faculty by race/ethnicity, gender identity and religion. The 2017 faculty survey asked respondents to provide anonymous responses to a series of sociodemographic questions. Of 414 respondents (52.5 per cent response rate), 119 (28.4 per cent) identified as women, 184 (43.9 per cent) as men, 3 (0.6 per cent) as transgender, and the remainder declined to answer. Over half (60.5 per cent) self-identified as Caucasian/White.

<http://www.deptmedicine.utoronto.ca/characteristics-2017-faculty-survey-respondents>

**Figure 4.3: Percentage of Full-Time Faculty in Each Academic Position Description**



**Figure 4.4: Department of Medicine Full-Time Faculty by Division and Gender**



# SECTION 5: EDUCATION





## Education in the Department of Medicine

Arno K. Kumagai, Vice Chair for Education



# GOVERNANCE

The overall educational enterprise is directed by the Vice Chair Education, with the assistance of the Education Executive Committee (EEC). The EEC meets monthly from September to June and consists of the Vice Chair, the Directors of Undergraduate and Postgraduate Programs (residencies and fellowships), the Director of Continuing Faculty Development and Quality Improvement, the Co-Directors of Medical Education Research and Scholarship (MERS), the Co-Directors of the Department’s Master Teacher Program, the Faculty Leads for the Department’s Person-Centred Care Educational Initiative, the Faculty Lead for Planning and Implementation of Competence by Design, a senior educational advisor (the former Director of the Internal Medicine Program) and senior support staff. All directors and faculty leads report directly to the Vice Chair, Education.

The DoM’s educational leaders are listed below.

Faculty	Leadership Position	Division
Arno K. Kumagai, MD	Vice Chair for Education	Endocrinology
Luke Devine, MD, FRCPC	Director, MD Program	General Internal Medicine
Jeannette Goguen, MD, FRCPC	Director, PGY1 Entry Programs	Endocrinology
Eric Yu, MD, FRCPC	Director, PGY4 Entry Programs	Cardiology
Cheryl Jaigobin, MD, FRCPC	Director, Fellowship Programs	Neurology
Ayelet Kuper, MD, DPhil, FRCPC Lisa Richardson, MD, FRCPC	Faculty Co-Leads, Person-Centred Care Educational Initiative	General Internal Medicine
Brian Wong, MD, FRCPC	Director, Continuing Professional Development and Quality Improvement	General Internal Medicine
Scott Berry, MD, FRCPC	Faculty Lead, Planning & Implementation, Competence by Design	Medical Oncology
Shiphra Ginsburg, MD, PhD, FRCPC Ryan Brydges, PhD	Co-Directors, Medical Education Research & Scholarship (MERS)	Respiratory Medicine (Shiphra Ginsburg) DoM (Ryan Brydges)
Danny Panisko, MD, FRCPC Umberin Najeeb, MD, FRCPC	Co-Directors, Master Teacher Program	General Internal Medicine

# UNDERGRADUATE EDUCATION

The MD Program in the Faculty of Medicine (FoM) at the University of Toronto (U of T) is one of the largest programs in North America. The program has approximately 270 students in each class over four years. It holds a pre-eminent place among faculties of medicine in Canada and the United States and is ranked seventh by different surveys among faculties of medicine worldwide. The MD Program is divided into two years of preclinical education and two years of clinical clerkships. Although the faculty of the DoM has a major presence in teaching during the first two years, the DoM does not have primary responsibility over the curriculum until the clerkship years, which start in the third year. During the third and fourth years, the DoM supervises the Internal Medicine Clerkship, the Emergency Medicine Clerkship and the Dermatology Curriculum. Together, the Department members' preclinical and clinical teaching activities represent the largest such contribution of any department at U of T.

**Preclinical.** In 2015, a new preclinical Foundations Curriculum was launched. Instead of offering traditional didactic lectures, the Foundations Curriculum has three major cross-cutting curricular dimensions: longitudinal courses, organizational components and interdisciplinary themes. The overall goal of the Foundations Curriculum is the integration of preclinical knowledge with clinical activities and the development of physician leaders who can effectively contribute to the health and well-being of individuals and communities. The design, implementation and assessment of the students and of the Foundations Curriculum itself have been informed by continual collaboration with internationally known educational scholars, including many who are members of the DoM.

**Clinical.** The Medicine Clerkship is an eight-week rotation that is nested in the 51 weeks of third-year clerkship. During the rotation, each

clerk is assigned to a single Internal Medicine Inpatient Clinical Teaching Unit (CTU). In addition, clerks are given six half-day ambulatory clinics. Formal didactic teaching consists of a two-half-days, case-based seminar series, along with weekly seminars for the remainder of the rotation.

Dr. Luke Devine succeeded Dr. Danny Panisko as Director of the MD Program for the DoM on July 1, 2017. Dr. Panisko had served as Clerkship Director for 12 years. Dr. Devine was specifically appointed to expand the scope of the program and to enhance coordination of participation of DoM faculty members in the new Foundations Curriculum and integration of the new curriculum with third-year clerkships.

## Major Accomplishments

1. **Person-Centred Care Curriculum.** An innovative person-centred care (PCC) curriculum, which is consistent with the Strategic Priorities of the DoM, was designed and implemented during the Medicine Clerkship. The curriculum is part of the larger initiative undertaken at the postgraduate level. The PCC Clerkship Curriculum has three interrelated components: a framework for providing culturally safe, equitable care to patients from structurally marginalized groups; evidence-based social-science-informed education related to the non-Medical Expert CanMEDS Roles; and an



educational approach that fosters compassionate person-centredness through dialogue. Clerks are provided with academic material to help them learn. It includes a one-hour didactic component aimed at reviewing and reinforcing concepts in equity, diversity and the PCC learned in Years 1 and 2 of the Foundation Curriculum (including cultural safety and education in equity and social-justice issues applied to health-care access and delivery) and outlines the expectations about PCC during their clerkship rotation. The clerks receive a specific assignment for their new clerkship curriculum component. Part of their task is presenting a patient's experience, either in the form of a written reflection or a verbal presentation, to their ward team once during their rotation.

2. **Student Assessments.** Historically, the assessment in the third-year medicine clerkship course was a paper-based test. The Medicine Clerkship is now computer-based. So existing exam questions were reviewed to enhance their validity and eliminate poorly constructed questions. The questions were then entered into ExamSoft, the online assessment program used by U of T, and “tagged” to allow for ease of blueprinting and interpretation of results. The computer-administered tests will allow for the review and revision of the usefulness of test questions and provide students with more rapid and in-depth feedback about their performance.
3. **Faculty Teaching Evaluations.** Faculty members receive teaching evaluations via MedSIS. Historically, the process of receiving timely, quality feedback has been challenging. Over the past year, the DoM has undertaken a major review and restructured the delivery of MedSIS data to faculty teachers and hospital and departmental leaders. This change will assist in achieving the goal of recognizing the work of clinician teachers and enhancing faculty mentorship. All faculty members seeking a Continuing Faculty Appointment Review (CFAR) now receive the teaching effectiveness scores (TES) scores that the DoM will submit on their behalf to ensure that faculty members will have an opportunity to review and comment on them. To improve faculty access to their TES, Dr. Devine and DoM staff have worked with the FoM to streamline reporting time and to allow creation of specific reports for physicians-in-

chief (PICs) and departmental division directors (DDD). Improved communication to faculty about accessing MedSIS and answering frequently asked questions has been developed. This review and enhancement is continuous.

## Upcoming Challenges and Plans— Undergraduate Medical Education

1. **The Longitudinal Integrated Clerkship (LInC).** In this longitudinal clinical experience, a medical student follows a panel of 50–75 patients. To smoothly integrate this experience with the new Foundations Curriculum, the LInC program will be discontinued at the end of the 2017–18 academic year. Successful components of the LInC will be integrated into the core clerkships in upcoming years, and faculty participating in LInC will need to be retrained to provide educational support in the newly designed clerkship.
2. **Clerkship Renewal.** The Foundations Curriculum features an integrated curriculum that exposes students early to clinical content and an assessment program that encourages self-directed learning. The existing medicine and overall clerkship courses will need to be modified to ensure that students from MD Foundations move easily into clerkship. The clerkship redesign must also consider that graduating students will enter residency programs redesigned to fit the requirements of the Competence by Design (CBD) framework. This framework is being implemented in all Royal College-accredited postgraduate training programs in Canada. This significant undertaking will require substantial faculty and administrative efforts. In the years to come, the implementation of related competency-based medical education (CBME) assessment frameworks in undergraduate education will require more effort.
3. **Valuing Clinician Teachers.** Closely related to the challenges described above is the need to find ways to acknowledge and value the work of the clinician teachers who shoulder the responsibility for most teaching activities. Clinician teachers sacrifice time, pay and opportunities for research, scholarship and professional advancement to teach. It is incumbent upon the DoM and FoM to align the contribution of these teachers with effective means of recognition,



professional development and promotion. To these ends, Trevor Young, the Dean of U of T's FoM, commissioned a task force, co-chaired by Dr. Arno Kumagai and Dr. Alison Freeland, the Associate Dean for Medical Education, Regional, to study this issue in depth and recommend action. Relevant action plans will be integrated into the DoM's educational plans in upcoming years. Please see the appendix for a summary.

## POSTGRADUATE EDUCATION

### Overview

The DoM has 20 postgraduate residency training programs with more than 1,000 learners. The programs are divided into five PGY1 entry programs—Internal Medicine, Emergency Medicine, Dermatology, Physical Medicine and Rehabilitation, and Neurology—and 15 PGY4 entry programs. There are two directors: one for PGY1 entry programs, Dr. Jeannette Goguen, who is also the Director of the Internal Medicine Residency Program, and the other, Dr. Eric Yu, who is also the Director of the Cardiology Training Program. In addition, Dr. Cheryl Jaigobin is Director of Fellowship Programs for the DoM. Residency programs directors are listed below. PGY1 program directors report to Dr. Goguen, while PGY4 program directors report to Dr. Yu.

#### PGY4 Entry Programs: Eric Yu, MD, FRCPC, Director

Program Name	Residency Program Director	No. of Residents	Duration (Years)
Adult Cardiology	Dr. Eric Yu	30	3
Adult Clinical Immunology & Allergy	Dr. Christine Song	3	2
Adult Endocrinology & Metabolism	Dr. Jeremy Gilbert	11	2
Adult Gastroenterology	Dr. Samir Grover	12	2
Adult Hematology	Dr. Martina Trinkaus	10	2
Adult Infectious Disease	Dr. Wayne Gold	7	2
Adult Nephrology	Dr. Jeffrey Schiff	6	2
Adult Respiratory Medicine	Dr. Christopher Li	13	2
Adult Rheumatology	Dr. Dana Jerome	13	2
Clinical Pharmacology & Toxicology	Dr. Chris Lazongas	4	2
General Internal Medicine	Dr. Tara O'Brien	14	2
Geriatric Medicine	Dr. Barbara Liu	13	2
Occupational Medicine	Dr. Aaron Thompson	2	2
Palliative Medicine	Dr. James Downar	4	2

#### PGY1 Entry Programs: Jeanette Goguen, MD, FRCPC, Director

Program Name	Residency Program Director	No. of Residents	Duration (Years)
Adult Neurology	Dr. David Tang-Wai Dr. David Chan (PD-Elect)	42	5
Dermatology	Dr. Scott Walsh	35	5
Emergency Medicine	Dr. Nazanin Meshkat	52	5
Internal Medicine	Dr. Jeannette Goguen, MD	225	3 (PGY1-3)
Internal Medicine (PGY4 Program)		16	1 (PGY4)
Internal Medicine (Chief Medical Residents)		6	1 (PGY4)
Physical Medicine & Rehabilitation	Dr. Lisa Becker	20	5

# MAJOR ACCOMPLISHMENTS

## Leadership Renewal

In the past three years, we have recruited new directors for Undergraduate Medical Education (MD Program) and Postgraduate Medical Education (PGME), including Directors for the PGY1 and PGY4 Entry Programs as well as the first-ever Director of Fellowships. In addition, we have had a scheduled turnover of the program director positions for three of four PGY1 Entry Programs and for eight of 15 PGY4 Entry Programs, including Internal Medicine. We have also recruited and appointed faculty leads for two major new initiatives: (i) Competence by Design Planning and Implementation and (ii) Person-Centred Care. In keeping with the DoM strategic priorities, all leadership positions have been selected by formal selection committee. Appointments were previously made by the divisional executive committees, and they didn't post. The new positions are in line with the DoM's Strategic Plan.

Key new faculty leads include the following people.

Year	Faculty Lead	Position and Program
2017	Dr. Lisa A. Richardson Dr. Ayelet Kuper, DPhil	Faculty Co-Leads, Person-Centred Care Curriculum
2017	Dr. Jakov Moric	Ambulatory Curriculum
2018	Dr. Scott Berry	Competence by Design
2018	Umberin Najeeb	Co-Director, Master Teacher Program

## Resident Selection Processes

Substantial variability in resident selection processes across programs and the paucity of Black and Indigenous residents have prompted the establishment of a DoM Canadian Residency Matching System (CaRMS) Working Group on Equity and a review and redesign of procedures for recruitment, interviews and ranking in CaRMS for individuals from historically under-represented groups. To address these issues, the Working Group is conducting an environmental scan of residency program selection practices. This will

inform the development of best-practice guidelines for the selection and rank-ordering of candidates. They will then be pilot tested in the Internal Medicine Residency Program and refined before they are implemented in all programs. Faculty development on the importance of equity in selection and of addressing implicit bias has been conducted for all residency program directors. All members of selection committees are now required to take the Harvard Implicit Association Test and will be required to take the e-learning module on unconscious bias developed by the Association of American Medical Colleges.

## Faculty-Resident Co-Learning Curriculum in Quality Improvement and Patient Safety.

In this unique and innovative program directed by Dr. Brian Wong, residents and faculty co-learn the principles of quality and innovation (QI) and patient safety (PS) while completing a QI project. This program is discussed in greater detail in the Continuing Faculty Development section below and in the report of the Vice Chair for Quality and Innovation.

Competence by Design (CBD) is the Royal College-mandated competence-based PGME system that is undergoing a phased rollout in all Royal College-accredited postgraduate residency programs throughout Canada. A major change in the culture of education, CBD shifts from time-based stages of training and summative evaluations to multiple-learner observations, formative feedback and fulfillment of entrustable professional activities (EPAs) that are organized according to educational developmental milestones. CBD aims to ensure clinical competency and teaching excellence for graduates of all PGME programs nationwide. CBD has required a rethinking of educational activities (particularly the incorporation of more frequent, direct observation of learners and low-stakes formative feedback), a redesign of assessment processes, reporting, and documentation, development of new methods of data acquisition, analysis, and organization of large volumes of data, faculty development and learner training. The CBD Lead, Dr. Scott Berry, served as former Chair of the Royal College's Medical Hematology Subspecialty Committee and has played a leadership role in national CBD implementation.

Planning and implementation of CBD has unique features in each of the 20 residency programs in the DoM and is especially challenging in a Department of our size. Subcommittees have been established in assessment and faculty development and are working closely with the Office of Postgraduate Medical Education and other departments and educational centres in U of T (e.g., the Wilson Centre and the Centre for Faculty Development). These efforts aim to develop CBD to fit the range, academic calibre and size of U of T programs. The DoM has provided administrative and project management assistance through the appointment of a Project Coordinator (Ms. Pavi Chandrasegaram); there are immediate plans to appoint another mid-level full-time administrative lead. Faculty development in assessment and feedback is led by Dr. Danny Panisko, the Gladstone and Maise Chair in Teaching of Internal Medicine and Co-Director of the DoM's Master Teacher Program, and Dr. Martin Schreiber, a highly decorated master teacher in the DoM. Two DoM faculty members have been consulted for assessment of learner progress: Dr. Lynfa Stroud, a nationally recognized expert on assessment, and Dr. Rodrigo Calvacanti, who is leading the design of analytics for high through-put data and who has a national reputation in assessment and evaluation.



provider communication, equity, diversity and inclusion, and cultural safety. As of 2017–18, these sessions have been implemented in academic half-days throughout all three years of the program.

This curriculum is also integrated with the Core Program's parallel Wellness Curriculum (which Dr. Richardson has directed) and has shared half-day sessions. The Co-Leads have also designed and held sessions in several subspecialty programs across the Department. The Co-Leads discussed the idea with subspecialty program directors of having a PCC education lead in each training program who can work with Drs. Kuper and Richardson to tailor the curriculum to the PCC leads' respective program's needs and deliver content to their trainees. They deliberately designed the postgraduate sessions with the idea of a "spiral curriculum" of increasing complexity and with built-in reviews and introductions (through supplemental online sessions) to assist residents who did not attend medical school in Toronto. Faculty development workshops have been conducted to develop and disseminate methods of dialogical teaching in the clinical environments where health care occurs and professional identities form.

The overall idea behind these efforts is to identify moments during daily clinical activities on the wards, in clinics, in intensive care units or in emergency departments where short on-the-fly dialogues between faculty and trainees can stimulate reflection about the human, social and societal dimensions of illness and health care. In this approach, the faculty preceptor raises questions or problems or relates brief stories without endings to stimulate meaningful but brief exchanges.

## Person-Centred Care (PCC) Educational Initiative

As noted above, this major innovation addresses the Department's Strategic Priorities, established in 2016 under the co-leadership of Drs. Ayelet Kuper and Lisa Richardson. Dr. Richardson is also the faculty Co-Lead for the Indigenous Health Curriculum and the Medicine Core Clerkship for third-year students.

A retreat to launch the PCC Educational Initiative was held. As a result, participants created a working definition of PCC that embraced both the idea of humanistic care and issues of equity and social justice in health care. Drs. Kuper and Richardson created a series of seven linked sessions for all Internal Medicine Core Program trainees related to PCC, including sessions related to patient-



Trainees also receive “homework”, which challenges them to spend time away from the clinical environment and think of ways to handle specific daily encounters with compassion, equity and understanding. Brief follow-up dialogues follow this clinical version of the “flipped classroom” and reinforce lessons about the human dimensions of illness and care.

The concept of the PCC Educational Initiative has been described in published articles by the faculty Co-Leads and the Vice Chair for Education, and the articles have been presented to national and international audiences. A manuscript describing the specific dialogical concepts and methods used in the initiative is in press in *Academic Medicine*, the top-tier journal in international medical education.<sup>1</sup>

## Ambulatory Curriculum

Traditionally, training in internal medicine in Canada has focused on inpatient medicine largely because, unlike their counterparts in the United States, most general internists in Canada work as hospitalists. However, given the demographic shift toward older adults as well as the increasing importance of training physicians to care for patients with complex chronic illnesses, the DoM has made a major long-term commitment to reshaping medical education to provide more emphasis on training in the ambulatory environment.

There are two continual collaborative efforts. The first, led by Dr. Graham Slaughter, assesses the state of ambulatory teaching in General Internal Medicine (GIM) throughout the U of T system to enhance the strength of its offerings. GIM ambulatory experiences vary substantially across teaching sites. In the past five years, new initiatives have been developed with great success. Sunnybrook Health Sciences Centre offers a Rapid Referral Clinic (RCC) that handles expedited referrals predominantly from the Emergency Department (95 per cent) and about 2,200 visits annually. Its GIM Ambulatory Clinic runs three half-days per week and handles

about 1,700 visits per year. PGY3 Internal Medicine (IM) and Emergency Medicine (EM) residents and PGY2 Family Medicine residents, as well as third-year clinical clerks and residents from other institutions on elective, rotate through both clinics.

University Health Network/Toronto Western Hospital now has a robust ambulatory experience. Developed by Drs. Lindsay Melvin and Rupal Shah, it incorporates Rapid Referral and Follow-up Clinics that allow residents to see patients referred from the Emergency Department and subsequently in close follow-up, a Post-Discharge Clinic that offers residents an opportunity to assist patients’ shift from inpatient to outpatient care, and an ambulatory Hypertension Clinic that is staffed by DoM faculty. St. Michael’s Hospital similarly has Rapid Referral and Post-Discharge Clinics and a separate GIM Clinic (whose referral base is local primary care physicians) and a thrombosis outpatient clinic through which residents rotate.

The second initiative, led by Dr. Jakov Moric, uses Women’s College Hospital (WCH) as a learning lab to develop and test model programs in ambulatory care. Since 2003, WCH has served as a unique fully ambulatory hospital. Dr. Moric takes advantage of the resources of WCH to establish ambulatory rotations in Core Internal Medicine and the GIM Subspecialty Residency Program to

- expose residents to a wide variety of ambulatory care experiences;
- foster important collaborations between Family Medicine and Internal Medicine and train IM Residents to act as effective consultants for primary care providers; and
- enhance resident education in providing care to underserved populations and communities.



<sup>1</sup> A.K. Kumagai, L. Richardson, S. Khan, and A. Kuper. "Dialogues on the Threshold: Dialogical Learning for Humanism and Justice." *Academic Medicine*. (forthcoming).



Dr. Tara O'Brien (left) with the Women's College Hospital Acute Ambulatory Care Unit team

At WCH, several unique programs exist. These include, but are not limited to, the following:

- the Acute Ambulatory Care Unit (AACU), directed by Dr. Tara O'Brien, where acutely ill patients referred from community-based primary care physicians are assessed to see whether close, specialized outpatient care is possible and hospitalization can be avoided;
- the Young Adult Transition Clinic for Type 1 Diabetes;
- clinics—such as the After Cancer Treatment Transition Clinic (for treatment of patients after cancer treatment), the Addictions Clinic and an HIV Clinic—where residents work in multidisciplinary teams to address the health-care needs of specific underserved groups; and
- a unique clinical learning experience in which internal medicine residents accompany an endocrinologist, Dr. Shoba Sujana Kumar, as she works side by side with primary care physicians in a combined WCH Family Medicine/Endocrine Clinic each week.

Dr. Kumar provides rapid referral visits and “curbside consulting” to family physicians in their practice and teaches the art of consultation to Internal Medicine and Endocrine residents. These initiatives, combined with the ambulatory rotations in GIM, enrich the ambulatory care experience for residents and better prepare them for working with individuals with chronic complex medical conditions in practice.

## Learner Climate

Fostering a climate of support, collegiality and professionalism for all members of the DoM is a Department priority. A Learner Climate Committee was established in 2017 to review and enhance the learners' reporting process for incidents of unprofessionalism, bullying and harassment and the Department's ability to investigate and adjudicate such reports. This extensive review addressed formalizing and streamlining processes of reporting unprofessionalism and learner mistreatment, protecting reporting parties and ensuring transparency and fairness in adjudicating reports. A Faculty Code of Conduct has been developed and broadly disseminated.

Responding to reports of unprofessional behaviour or bullying by isolated faculty members, the DoM established a working group. It is chaired by the Vice Chair for Education and consists of education leaders, current and former chief medical residents, and interested PGY1–3 residents. The working group developed a protocol for postgraduate learners in the DoM to report incidents of unprofessional behaviour by faculty, staff or other learners. The DoM's approach is founded on important principles: protection of learners from retaliation throughout the reporting, investigation and adjudication process; ensuring a fair and transparent process for both faculty and learners; and close collaboration with departmental and hospital division directors and physicians-in-chief during investigation

and adjudication. The protocol and an accompanying flowsheet are in the final stages of preparation.

Once approved by the Education Executive and Departmental Executive Committees, they will be distributed to all learners and faculty of the DoM and posted on the DoM website.

## Medical Education Research and Scholarship (MERS)

Over the past decade, U of T and the DoM have been at the international forefront in medical education research and scholarship. In particular, they have made significant contributions to the literature of assessment, simulation-based education, professionalism, social science and cultural safety, and quality improvement and patient safety. The recruitment of the Vice Chair (Dr. Arno Kumagai) from the University of Michigan in 2016 added to this bench strength in humanism, medical humanities, physician-patient relationships and social justice in medicine. Over the past two years, significant growth has occurred in these areas. Highlights follow:

- Competency-Based Medical Education (CBME) Research Network. Under the directorship of Drs. Shiphra Ginsburg and Ryan Brydges, Co-Directors of MERS in the DoM and scientists at the Wilson Centre for Research in Education (UHN), the CBME Research Network was launched in 2017 to develop rigorous research questions, methods and projects to address fundamental issues of CBME, including most importantly Competence by Design. Thirty-five faculty and residents from across divisions and hospital sites attended the Network's launch.
- The Collaboration of Researchers, Educators, Scholars and Teachers (CREST) was established in 2011 as a series of monthly Friday seminars for DoM faculty and trainees interested in MERS. Given strong interest by members of other educational groups and departments within the U of T system, CREST was modified and adapted to form the Cross-Unit Education Scholarship (CUES) group under the direction of Dr. Brydges. CUES aims to consolidate and optimize the support and resources for education scholarship across education units affiliated with U of T.
- A Resident MERS Interest Group was co-created by Dr. Jeannette Goguen, Internal

Medicine Residency Program Director, and Dr. Ginsburg to engage residents interested in medical education practice and scholarship. The interest group meets one evening per month; facilitators co-lead discussions with residents or mentor residents about writing MERS abstracts and presenting their work. After achieving great success with the initial meetings and receiving requests from other residents, the group opened to residents of all subspecialty programs in the DoM. Between two and five faculty and 10 and 15 residents attend each meeting.

- Residents as Participants in Research Guidelines. Drs. Ginsburg and Brydges collaborated with a senior educator, Dr. Heather McDonald-Blumer, to develop a document to guide investigators who wish to enrol residents as participants in their research. The document aims to both encourage and standardize approaches to research involving residents as research subjects in the interests of ethics and equity in scholarship. Both Co-Directors are also available to assist in the submission of Research Ethics Board applications. There is now an established process and application form, which work well, for the DoM.

## U of T DoM Graduation

To enhance the unity of health-care centres and units that make up the DoM, the DoM designed and held a graduation ceremony for all 20 divisions. The first occurred in 2015. The event is held in a historic theatre on the University campus, and all graduating residents and fellows, along with their families, are invited to attend. The event, which is hosted by the Department Chair and faculty, including vice chairs, departmental division directors and residency program directors, features a keynote, a valedictorian speech and a post-ceremony reception. Over the past three years, the event has grown in popularity and attendance. This past June, more than 150 graduates, along with an estimated 350 family members, faculty and staff, attended.







# MAJOR CHALLENGES AND FUTURE PLANS FOR POSTGRADUATE MEDICINE

## Competence by Design (CBD)

Even in a planned rollout, CBD poses a major challenge to the Department. The scale of human resources (faculty and administrative time), financial support, logistics, informatics and coordination is daunting. The total costs of CBD will be approximately \$500 thousand per year after 2021 when all programs have implemented CBD. Although the DoM is fully committed to accomplishing this nationwide initiative, the resources necessary to fully launch and maintain CBD risks compromising our ability to support other initiatives. The efficient and accurate processing of large volumes of assessment data for postgraduate learners in the DoM will be challenging. Most critically, the information that comes from dozens of separate observations and different faculty members for one learner must be organized to allow meaningful summative assessment and feedback. Replacing the CBD data-entry system in Medsquares with a more robust IT program known as Elantra will require additional IT support—some of which is available through the Office of Postgraduate Medical Education—and additional faculty development. Replacement will occur in 2019.

## Equity and Inclusion in Postgraduate Education

The task of reviewing and standardizing selection processes for residency programs while preserving unique features of each of the 20 divisions in the DoM is a challenge. The Person-Centred Care Education Initiative is an exciting postgraduate curriculum development in the DoM, but the number of faculty members able to deliver the curriculum remains limited. We are addressing this challenge through faculty development sessions to identify DoM faculty members who have the specific skills to multiply the effects of the program.

## Physician Scientist Training

The identification and nurturing of potential physician scientists early in their training is a major priority. A Dean's Committee has been struck to explore ways to identify and support potential physician scientists from the time they enter residency through subspecialty and/or graduate training to the time of faculty appointment. Several DoM members are serving on this committee.

## Ambulatory Care

The greatest challenges to expanding ambulatory care education in residency programs are an educational system that traditionally and almost exclusively focuses on inpatient care and hospitals that rely on residents to provide inpatient care. We address these challenges in several ways: they include establishing new models for care and education and working with

the physicians-in-chief to develop alternative models for care provision. Use of “physician extenders” is highly variable within the U of T system and may off-load work from clinical faculty and residents. This practice would help free up residents for non-CTU learning experiences, such as in ambulatory care clinics or ER diversion programs.

## PGY1 ENTRY PROGRAMS

There are currently five PGY1 Entry Programs in the DoM: Internal Medicine, Dermatology, Emergency Medicine, Neurology and Physical Medicine and Rehabilitation. Of the five, all except for the Internal Medicine Residency Program are administered through the individual divisions. Therefore, this part of the report will discuss the Internal Medicine Residency Program in detail and will refer to the reports from the individual divisions for detailed descriptions of the other PGY1 programs.

The Internal Medicine Residency Program consists of a traditional PGY1–3 program; an additional single-year PGY4 program is run under its direction. Among the largest residency programs in North America, the program is directed by Dr. Jeannette Goguen, who has been in this role since 2016. Dr. Goguen receives a 0.8 salary support from the DoM and the support of six faculty site program directors at the main teaching hospitals, 3.0 full-time equivalent (FTE) administrative assistants and five site-based education coordinators (total of 4.7 FTE). A full-time postgraduate officer supervises staff.

Salary supports for the program director (PD) and administration were both increased after the publication of the previous external review of the program. A Residency Program Committee (RPC) is responsible for program governance. The committee consists of

- the Program Director,
- the Site Program Directors,
- the Chief Medical Residents,
- two elected representatives for each of the PGY1–3 years, and
- Faculty Leads for
  - » Remediation (Dr. Wayne Gold, who also serves this role for the whole DoM),
  - » Wellness (Dr. Lisa Richardson),
  - » Academic Half-Days (Dr. Shoba Kumar),
  - » Simulation (Dr. Luke Devine),
  - » Research and Scholarship (Dr. Shiphra Ginsburg) and
  - » the Faculty Lead for the PGY4 Medicine Program (Dr. Kenneth Locke, who recently succeeded the founding Faculty Lead, Dr. Umberin Najeeb).



In addition, residents are represented by the four chief medical residents as well as elected representatives from each of the three cohorts (PGY1, PGY2 and PGY3). The overall purpose of the Internal Medicine RPC is to assist the PD in planning, organizing and supervising the residency program. The RPC meets every two months between October and June and has additional meetings when required to deal with urgent issues.

## Overall Structure

Most of the training in the Core Internal Medicine Program occurs at the five main medical centres of the U of T system. Residents also rotate through our community-affiliated sites. About four weeks of ambulatory care education is offered during the residency program; additional ambulatory weeks are offered for subspecialty services. Each year of the program is divided into 13 four-week blocks. Educational offerings are designed to fulfill Royal College accreditation requirements. For PGY1, five blocks are devoted to inpatient clinical teaching units (CTUs). For PGY2, two blocks are devoted to CTU, and for PGY3, one block is devoted. Intensive Care Unit (ICU) and Coronary Care Unit (CCU) experiences occur chiefly during PGY2 (two ICU blocks, one CCU block) and PGY3 (one ICU or CCU block). The CTU experience in PGY1 is intended for the junior resident. In PGY2 and PGY3, the CTU experience is intended for the senior resident who has greater responsibility. Additional inpatient rotations are devoted to cardiology, respiratory or nephrology ward teams or other subspecialty consultation services.

## The PGY4 Internal Medicine Program

This program is three years long. However, because a fourth year is required to qualify for independent practice, residents who

- decline to enter the CaRMS match,
- require additional time due to leave of absence or remediation, or
- unsuccessfully match in a PGY4 subspecialty entry program

are guaranteed a fourth year of Ministry of Health-funded training. Consequently, a PGY4 Internal Medicine Program has been dedicated to addressing the learning needs of these groups. (Please note that this program differs from the Royal College-accredited PGY4–5 General Internal Medicine Subspecialty Program.) This program was initially led by Dr. Umberin

Najeeb; she recently handed the job to Dr. Kenneth Locke to become the Co-Director of the Master Teacher Program. The PGY4 program emphasizes the practical aspects of transition to practice and is especially popular among residents who intend to work in the community.

# INTERNAL MEDICINE RESIDENCY PROGRAM: MAJOR ACCOMPLISHMENTS, CHALLENGES AND OPPORTUNITIES

## Competence by Design

The IM Residency Program, which is scheduled to launch in July 2019, has been conducting a pilot of CBD implementation with the 75 members of the PGY1 class since June 2017. Working groups have developed assessment forms and templates to assess entrustable professional activities (EPAs) as well as an analytics dashboard to handle the massive amounts of data for each learner. More than 1,700 individual EPA assessments and feedback sessions have been done as of June 2018, and 36 academic advisors have been identified. Their task will be to meet residents regularly to review data from individual feedback sessions and report to the Competency Committee on each resident's progress toward completion of EPAs.

The successful implementation of CBD poses numerous challenges. They include the sheer size of the IM Residency Program and the need

- for sufficient faculty members to observe and provide feedback and to serve on competence committees or as academic advisors,
- to incorporate ways of teaching and learning into busy clinical schedules,
- for increased administrative support for faculty and committees,
- for new and different ways of assessing data and





Drs. Ryan Brydges, Aleyet Kuper, Lisa Richardson, Umberin Najeeb, Alireza Jalali, Amol Verma, and Shiphra Ginsburg

- to address resistance to change among both faculty and learners.

But, as noted above, the DoM is making a major investment in dedicated faculty and administrative time to achieve CBD.

## Growth of the PGY4 Internal Medicine Program

In 2010, the Royal College of Physicians and Surgeons of Canada officially approved a two-year subspecialty program in General Internal Medicine. The first cohort began in 2014. As only four years of specialty training are required for independent practice, many graduates of the Core Internal Medicine (PGY1–3) Program have opted to forgo the CaRMS subspecialty matches and complete a PGY4 instead. In addition, the PGY4 program and its former Faculty Lead, Dr. Umberin Najeeb, received outstanding evaluations, and obtaining matches in other subspecialty programs (e.g., cardiology, gastroenterology) became more difficult. These factors contributed to a major increase in residents in this program from only four in 2013–14 to 19 in 2017–18. To accommodate the learning needs of this increased number of residents, the

Faculty Lead collaborated with community health-care centres to design and develop unique community-based rotations for the program’s residents to expose the trainees to a variety of practice settings and service delivery models and to prepare them for community-based practice.

While we are delighted with the success of the PGY4 GIM Program, an unintended consequence has been competition for residency positions with our subspecialty programs. The Ontario Ministry of Health and Long-Term Care (MHLTC) funds a fixed number of PGY4 residency positions each year; positions taken by PGY4 GIM Program residents are subtracted from the total number of positions allocated for a given year. The problem is exacerbated by two additional requirements. First, the Royal College has mandated that all residents must be offered a fourth year of training to qualify for the Royal College Internal Medicine Exam; therefore, it is not possible to “cap” the number of PGY4 residents in the program. Second, institutions may not roll over any savings from MHLTC funding of residency programs from year to year. Thus, the DoM may not use the remaining years of residency positions taken by first-year

programs for additional residents nor transfer credit for these years to other programs.

Because there are employment opportunities for graduates of the PGY4 GIM Program throughout the province, it is unlikely that the PGY4 Program will decrease in size anytime soon. These combined factors will exert pressure on other PGY4 programs in the years ahead. However, the DoM is exploring transparent and equitable processes to allocate residency positions to its 15 PGY4 programs. In allocation plans, the DoM is considering societal need, the availability of jobs within Ontario and across Canada, and the size and sustainability of the programs.

## Education/Patient Care Balance

With its numerous hospitals and health-care centres, its wealth of world-class expertise in virtually all areas of internal medicine and its rich and diverse patient base, U of T's DoM offers truly unique training. Therein lies one of its greatest challenges. The balance between educational opportunities and need to care for an increasing number of very complex, multi-morbidity patients places a strain on all of the DoM's educational programs. This situation is complicated further by the disproportionate growth of the PGY4 GIM Program, mentioned above, and the need to equitably provide residents to clinical teaching units at affiliated sites. To address this issue, many hospital leaders have made efforts to increase the presence and responsibilities of hospitalists who will deliver inpatient care independent of residents and increase the participation of allied health-care personnel, such as physician assistants, advance nurse practitioners or clinical pharmacists.

## Person-Centred Care (PCC) Educational Initiative

As of 2017–18, approximately 36 DoM faculty teachers have been trained and are participating in this initiative. However, our capacity to expand to the subspecialty programs requires additional faculty and administrative support. We are working to develop them.

## Learner Wellness

Responding to reports of difficulties experienced by residents who were pregnant during training, the IM Residency Program initiated a review of policies and procedures for pregnancy and parental leave and developed a *Handbook on Pregnancy and Parental Leave* for residents. It is based on the guidelines of the Professional Association of Residents of Ontario (PARO). Procedures regarding time off for clinic appointments, a “no-overnight call” rule starting in the 28th week of pregnancy, rotation scheduling during pregnancy and parental leave have been clarified and disseminated to all trainees and faculty in the DoM and applied to all training programs of the DoM. A copy of the *Handbook* is available on the DoM's website. Policies are covered during orientation for all residents.

The Internal Medicine Program Wellness Subcommittee was formed in 2016. Chaired by Dr. Lisa Richardson, the subcommittee is comprised of 10–20 resident representative volunteers. The Program Director, Dr. Goguen, comes for part of each meeting to support change. The Wellness Office at PGME has also been a tremendous resource and support for the subcommittee and the program. Dr. Richardson's work on this subcommittee has set the right tone and helped the residents recognize and set the right priorities. The subcommittee's work has resulted in important changes. For example, resident wellness has been incorporated into the role of the chief medical residents, a Resident Wellness Survey has been designed and is about to be launched and a Learner Climate Working Group has been struck to address the reporting of lapses in professionalism.

## Equity and Diversity in Selection Process and Programs

Please see “Equity and Inclusion in Postgraduate Education” above. For descriptions, accomplishments, challenges and plans of the other four PGY1 Entry Programs (Dermatology, Emergency Medicine, Physical Medicine and Rehabilitation, and Neurology), please see the reports from the individual divisions.

# CONTINUING PROFESSIONAL DEVELOPMENT

Continuing professional development in the DoM has four major streams:

- the CPD activities built around the City-Wide Medical Grand Rounds and the DoM's Annual Day,
- the DoM's Master Teacher Program,
- the Person-Centred Care (PCC) Educational Initiative, and
- the Quality Innovation Co-Learning Project.

The last-named stream is a central part of the work in the portfolio of the Vice Chair for Quality and Innovation, so we will discuss the first three in more detail.

City-Wide Medical Grand Rounds are held once a month to introduce impactful, internationally recognized work done within the DoM by senior faculty and to present up-and-coming junior faculty and their research. Two of the rounds are devoted to endowed lectureships (the F.M. Hill and Wightman Berris lectureships) or recipients of the annual Canada Gairdner Award for Biomedical Research. At the end

of each academic year, the DoM Chair, Gillian Hawker, gives a State of the Department address in which she discusses the accomplishments of the DoM over the past year and the directions and challenges facing the DoM and its faculty in the year ahead.

The Master Teacher Program of the Department of Medicine (MTP). Launched in 2002, the MTP was created to develop the clinical teaching skills of faculty members, particularly as they worked toward their initial appointment as clinician teachers in the Department. The MTP is anchored by a modified and expanded version of the eight-session Clinical Teacher Seminar Series developed by Drs. Kelley Skeff and Georgette Stratos of the Faculty Development Center of the Stanford University School of Medicine. The central goal of the MTP is to provide intense training for a small cadre of clinician teachers



Participants in the DoM Master Teacher Program



to enhance their clinical teaching skills and augment their understanding of medical education principles. The curricular framework allows participants to engage in critical reflection and analysis of medical and health profession teaching—either their own individual teaching or the teaching of others.

**Dr. Danny Panisko** has directed the program since 2003. **Dr. Tina Borschel** served as Co-Director from 2010 to 2017; she was recently succeeded by **Dr. Umberin Najeeb**. Drs. Panisko and Borschel completed the Clinician Teacher Facilitator Course in Palo Alto, California; Dr. Najeeb is scheduled to attend the course in the fall of 2018. The MTP runs as a half-day per week longitudinal instructional development program over a two-year period from September to May. First-year and second-year cohorts run simultaneously. Participants who successfully complete the course receive a departmental certificate.

The MTP's curriculum undergoes continual review and renewal. An annual visiting professorship is co-sponsored with the Centre for Faculty Development and the Centre for Excellence of Educational Practice at the University Health Network. Invitees have included Dr. Eric Holmboe from the American Board of Internal Medicine, Drs. Karen Mann and Blye Frank from Dalhousie University and Dr. Yvonne Steinert from McGill University.

The Department funds the activities of the program and provides access to the course for departmental members tuition-free. Entry to the MTP is competitive: because demand exceeded available space, the original plan of training a single cohort every two years yielded to training yearly cohorts while having two simultaneous courses running at all times. More than 180 participants will have completed the program, and it has become a major avenue through which clinician teachers obtain their faculty appointments.

## MTP Challenges and Future Directions

The Master Teacher Program will always face the challenge of providing a relevant and dynamic curriculum that meets the needs of its participants. Expansion of curricular content always occurs to account for and satisfy temporal trends in medical teaching and education. We constantly explore new and expanded ways to link and cooperate with the Faculty's Centre for Faculty Development to acquire curriculum content and provide continual meaningful teaching and scholarly activity for program alumni. The program must continually adapt to provide skills training for medical teachers who need to teach in the challenging new environments of health-care delivery.

## Continuing Professional Development in Quality Improvement and Patient Safety

This unique and successful program is directed by Dr. Brian Wong under the auspices of the DoM and the Center for Quality Improvement and Patient Safety (CQuIPS) in Maryland. The Faculty-Resident Co-Learning Curriculum allows residents alongside faculty supervisors to learn QI skills through the conception and completion of a project. The program has expanded from three subspecialty programs in 2011 to more than 30 programs across eight departments at U of T and beyond. Aspects of this work as well as individual projects arising from the Co-Learning Curriculum have been published in top academic medical journals, including *Academic Medicine* and the *Journal of Graduate Medical Education*, and have been presented to national and international audiences. Faculty development and the Faculty-Resident Co-Learning Curriculum are described in detail in the report from the Vice Chair for Quality and Innovation.

# REPORT OF STUDENTS

August 18, 2018

To Whom It May Concern:

## **RE: University of Toronto Internal Medicine Postgraduate Training Program**

It is our pleasure to write this letter detailing our experience as residents in the Internal Medicine training program at the University of Toronto. The three of us—Michael Kuhlmann, Maria Jogova and Abi Vijenthira—entered the program in 2014. We completed three years in the core internal medicine program and a fourth year as chief medical residents at Women’s College Hospital, St. Michael’s Hospital and Mount Sinai Hospital, respectively.

Currently, Michael is in the General Internal Medicine subspecialty program, Maria is in the Critical Care subspecialty program and Abi is in the Hematology subspecialty program at the University of Toronto. Our comments will speak to our experience during the first four years of core internal medicine training.

### **Overall Comments**

The University of Toronto internal medicine program prepares residents exceptionally well to excel as physicians in both academic and community practice. This is related to a multitude of factors including volume of patient care, depth and breadth of diagnoses seen, scholarly training and exposure, and support and mentorship of faculty staff.

### **Strengths of the Program**

The strengths of the program can be divided into clinical exposure and training, education and curriculum, leadership, site-level support, research training, and commitment to expanding diversity and improving the learner climate.

**Clinical Exposure:** There is a great variety and uniqueness of patient care experiences at each hospital site. This includes exposure to socioeconomically and multiculturally diverse populations who present with a range of symptoms and diagnoses. Residents therefore have the opportunity to manage both commonly encountered “bread and butter” conditions as well as rare diagnoses. Seeing unusual conditions and understanding indications for workup and/or referral is supplemented by exposure to subspecialty clinics, some of which specialize in the management of specific and rare conditions (pulmonary hypertension, tuberculosis and HHT clinics, just to name a few). Residents are also exposed to community and ambulatory medicine in their third year of training, through two blocks assigned to each of these rotations.

**Education and Curriculum:** The Internal Medicine program ensures that resident teaching and education is a priority rather than an afterthought throughout the three years of the core training program. Informal and formal teaching is encouraged through preceptor and rotation evaluations that specifically inquire about the educational efforts of each clinical rotation. Formal education also takes place through the Academic Half Day, which provides residents with didactic, case-based and simulation teaching. The curriculum is set by a committee that ensures that Royal College training objectives are met.

**Leadership:** The current Program Director, Dr. Goguen, has been an incredible leader for the program. Her approachability, high degree of resident advocacy and diligent responses to resident concerns make her an ideal program director. Her focus on resident wellness has led to marked improvement in residents' sense of belonging in the program. She has done a tremendous job in the face of unprecedented challenges to program structure, including the introduction of the CBME curriculum and growing patient care volumes.

**Site-Level Support:** A common weakness of larger residency programs is the inability to create a more intimate resident-centric learning environment. Despite the University of Toronto Internal Medicine having over 70 residents per year, this potential weakness is overcome with the creation of base-hospital sites, allowing smaller groups of residents within each year to learn in the aforementioned intimate, resident-centric environment. Each site orients its residents separately and creates a mini-community within the larger program. This includes site-led initiatives, education committees and social events. The site director and chief medical resident at each site is a direct point of contact and support for individual residents at that site and meets with each resident formally twice per year, making it easier to bring forward concerns or questions.

**Research and Academic Training:** There are experts and mentors in every academic field available to work with in the city, from research to medical education to the humanities to any other interest one could imagine. Although it takes initiative for residents to reach out to them, this is another strength of the program and enables people to find mentors for any interest they may have. For those interested in further research training, the Clinician Scientist Program, Clinical Investigator Program and Clinician Educator Programs are readily available. Interest groups have also been created for those residents interested in pursuing a career in Medical Education or Humanities in Medicine.

**Mentorship:** Mentorship is an important part of the program. The creation of a Near-Peer Mentorship program several years ago has allowed interested residents to find or become mentors through a formal, organized process. More informally, residents are frequently connected to academic or clinical mentors by their site directors or CMRs based on their interests. Finally, informal mentoring relationships form during clinical rotations. Faculty are generally quite willing to become mentors, often devoting substantial amounts of their time to guide residents along their career paths.

**Commitment to Expanding Diversity and Improving Learner Climate: See comments below.**

#### **Challenges/Areas for Improvement**

The current major challenge of the program is related to the volume of patient care that has increased over the past few years, likely due in part to the aging population and also to the rapidly expanding population of downtown Toronto. This has unfortunately coincided with fewer residents rotating on Clinical Teaching Units (CTUs) and subspecialty teams, leading to lower staffing numbers and higher patient-to-resident ratios. The implementation of the CBME curriculum is also a factor. This unfortunately creates a higher-stress environment for learners and at a certain threshold takes away from the educational experience.

Although seeing a large volume of patients is vital to improving one's capabilities as a physician, we note that a delicate balance needs to be struck at the training level for patient care and safety. It is hard to learn and thoroughly and thoughtfully manage a patient's issues when trying



to rush through the day. There is less time for discussion of patient cases as a team, teaching or rounding on patients as a team for bedside learning and physical examination. During the overnight call period, volumes of consults combined with managing patients on the ward is also a challenge.

Other external factors contribute to inefficiencies of care. They include patients being geographically dispersed throughout the hospital on different wards, multiple interruptions during the day for team rounds, multidisciplinary rounds, teaching rounds and interruptions related to non-urgent pages and calls.

These issues are being addressed by a committee dedicated to restructuring the CTU experience by reorganizing housestaff (i.e., clerks, residents and attendings). Other possible solutions could include hospitalist teams that can offload CTU teams with high patient numbers. Another potential contribution to a solution could be the addition of nocturnists to help with patient volumes overnight where needed (an effort recently initiated by Toronto General Hospital).

#### **Learning Climate**

Dr. Gillian Hawker has made it clear to residents that she is committed to improving diversity in the program and has a zero tolerance policy for learner mistreatment and unprofessional faculty behaviour. Sectors of the program still struggle with this behaviour in faculty members, but there are now formal and transparent processes in place to challenge the previous norm.

In sum, the program has been exceptional for our growth and training as physicians, and we are exceptionally grateful for the opportunity to train here.

With kind regards,

Michael Kuhlmann, MB BCh BaO, FRCPC  
PGY5 GIM, University of Toronto

Maria Jogova, MD, FRCPC  
PGY5 Critical Care, University of Toronto

Abi Vijenthira, MD, FRCPC  
PGY5 Hematology, University of Toronto

# SECTION 6: RESEARCH & SCHOLARSHIP



## Research in the Department of Medicine

Michael Farkouh, Vice Chair for Research



## Overview

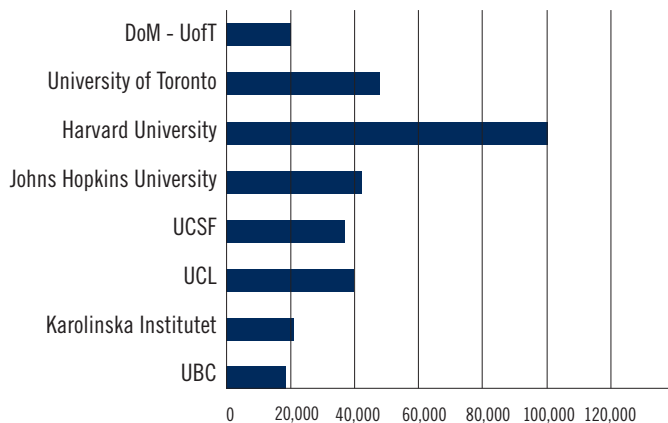
The Department of Medicine (DoM) at the University of Toronto (U of T) is research intensive. The research program spans the spectrum of biomedical investigation. Research in the DoM is conducted on the U of T campus in the Medical Sciences Building (MSB), at the research institutes of our fully affiliated hospitals and at the hospitals themselves. At present, there are 200 clinician scientists (75 per cent research, 25 per cent clinical) and approximately 185 clinician investigators (50 per cent research, 50 per cent clinical) in the DoM. In our most recent survey, the DoM held approximately \$185.448 million in funded research across our university-wide enterprise. This involved more than 1,900 individual awards in total, including 20 Canada Research Chairs held between 2012–17 and 19 CIHR foundation grants since the inception of the program.

Department faculty members are internationally renowned for numerous key research platforms. Our faculty collaborates extensively with universities across Canada, North America and internationally.

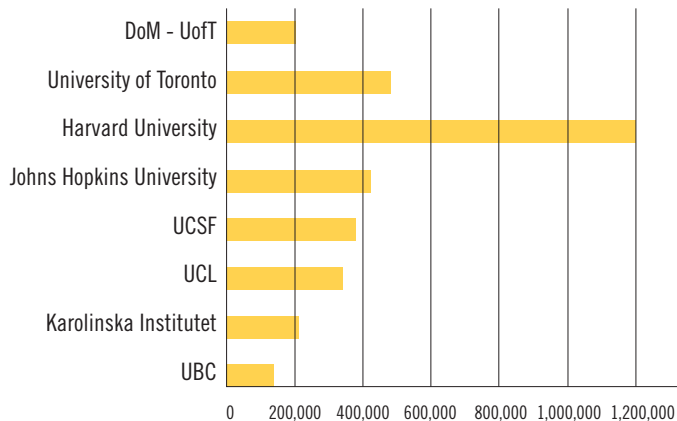
Research productivity measured by publications for the years 2012–17 is summarized for the DoM and compared with the totals for other universities below. U of T's DoM compares favourably with other public and private institutions, including Harvard University, the University of British Columbia, the University of California San Francisco and University College London.

Name	Web of Science	Times Cited	Documents Cited	Category Normalized Citation Impact
DoM - UofT	23,607	245,770	13,643	2.36
University of Toronto	52,838	502,635	32,080	1.96
Harvard University, Boston, US	106,231	1,234,968	66,915	2.21
Johns Hopkins University, Baltimore, US	47,778	535,251	30,002	2.13
University of California San Francisco, San Francisco, US	36,055	415,084	21,806	2.17
University College London, London, UK	42,175	394,698	25,407	1.85
Karolinska Institutet, Stockholm, Sweden	26,754	285,326	17,755	1.72
University of British Columbia, Vancouver, Canada	19,266	176,263	11,812	1.67

**Figure 6.1: Web of Science Documents**



**Figure 6.2: Times Cited**



The Vice Chair, Research, oversees all research initiatives in the DoM, promotes equity and diversity in the research training programs and faculty, and provides support to the research community. This support includes promoting collaboration with the Faculty of Medicine (FoM) and the hospital research institutes. The Vice Chair, Research, chairs the DoM Research Committee.

We are developing strategies to address both the lack of diversity in our clinician scientist faculty at the DoM and the absolute reductions in the number of women applying to the Clinician Scientist Training Program. Recognizing meritorious trainees and faculties for their support through salary support and nomination for key research awards is a critical component of this portfolio.

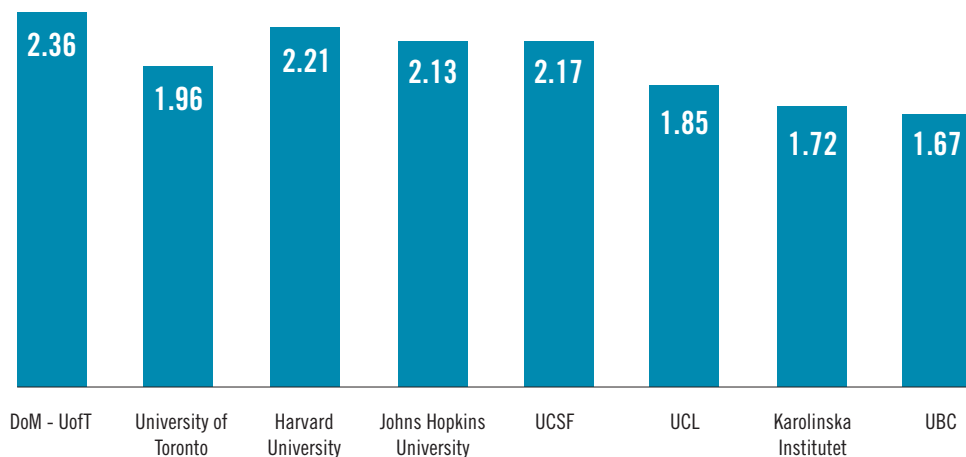
## Administration and Committees

Research in the DoM is overseen by a comprehensive Research Committee comprised of senior, mid-career and early-career investigators and representatives



**Figure 6.3: Category Normalized Citation Impact**

CNCI provides a single measure that reaches across subject areas and takes publication into account. It is a ratio of actual citation performance compared to what is expected and normalized to make a score of 1 the average.



from the hospital research institutes as well as all our 20 divisions.

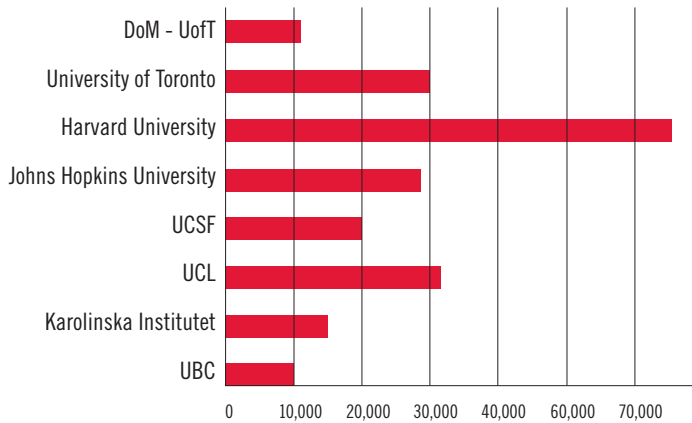
The Committee meets quarterly; sub-group meetings occur when required. In the past five years, we have implemented and maintained important initiatives.

In 2015, we initiated a plan that each division appoint a research lead to serve on the DoM Research Committee. In some cases, particularly for smaller divisions, this representation comes from the division chair. These individuals helped create the network model of collaborative research across the Department.

## Integrative Challenge Grants

From 2012 to 2015, the DoM held an annual funding initiative known as the Integrative Challenge Grants. These grants were designed to catalyze the formation of new research collaborations and the growth of pre-existing teams across

**Figure 6.4: Number of Documents Cited**

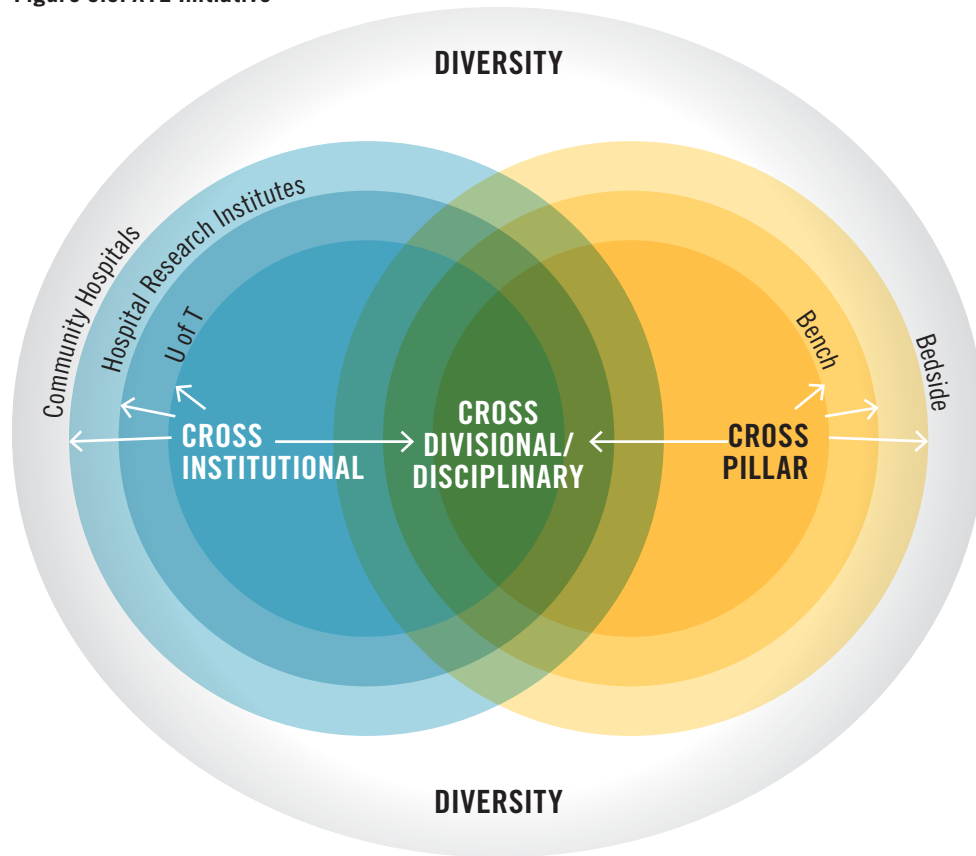


institutions and departments. Each team was provided up to \$250 thousand for its proposal. Proposals were vetted by faculty members, including the Vice Dean, Research, across the FoM. Funded challenge grants for 2013–15 are listed below.

## Implementation of DoM Research Networks

In 2016, the DoM decided to shift gears and instead use these resources to support novel network grant proposals to invigorate and promote collaboration not only across research institutes and pillars of research, but also across the health disciplines and divisions. This model was informed

Figure 6.5: XYZ Initiative



Year of Award	PI Name	PI Division	Project Title
2013	Richard Horner	Respirology	Sleep and Sedation: Translational Science to Public Health
2013	Heather Reich	Nephrology	IgA Nephropathy Immunopathogenesis Study Network
2013	Rupert Kaul	Infectious Diseases	A Small Animal Model of Human HIV-1 Infection to Accelerate the Pre-clinical Development of Novel Therapeutics and Vaccines
2013	Robert Fowler	General Internal Medicine	Shining a Light on End-of-Life Care: Investigating Barriers, Testing Interventions, and Disseminating Integrated Solutions for Patients, Families and Healthcare Professionals
2014	Kathy Siminovitch	Rheumatology	From Biomarker Discovery to Clinical Practice: Transforming the Clinical Management of Granulomatosis with Polyangiitis
2015	Shiphra Ginsburg	Respirology	Towards the Development of Best Practices for the Assessment of Competence in Medical Education
2015	Margaret Herridge	Respiratory and Critical Care Medicine	The RECOVER Program: An International Model of Post-ICU Care for Patients and Caregivers
2015	Susy Hota	Infectious Diseases	Creating a Multidisciplinary Fecal Microbiota Transplantation Program at the University of Toronto

by the ground-breaking Toronto Dementia Research Alliance that was created under the visionary leadership of Dr. Sandra Black from the Division of Neurology. We term this the XYZ/D Initiative. (See figure 6.5.) With this model, we have been able to create collaborative research networks that are well poised to promote cross-University multidisciplinary research and create platforms for competitive federal funding.

Since 2015, we have created the following research networks.

- **TARRN.** The Toronto Antimicrobial Resistance Research Network responded to the World Health Organization's declaration of an urgent public health threat from antimicrobial resistance. This complex multi-sectorial problem can be solved only through innovative multidisciplinary research collaboration. The TARRN harnesses the talent and expertise that exists across the University to tackle important issues such as skin testing to optimize antimicrobial use and antimicrobial de-escalation when appropriate.
- **The General Medicine Inpatient Initiative (GEMINI).** This initiative was created through a consortium of seven hospitals across the University to address the administrative data for patients with chronic disease who were admitted to general medicine wards. This initiative aims to improve



scientific understanding and improve care by describing variations and processes of patient care outcomes and costs at the patient and hospital level. (Further details about GEMINI can be found in section 7: Quality and Innovation.)

- **Critical Care Network.** This network features an interdisciplinary approach to understanding the life cycle of survivors of intensive care unit admissions.
- **Educational Research Network.** This network is novel and unique to U of T since it combines the expertise and educational research from network centres across the city. The main focus of this group is to evaluate competency-based education as it is introduced into our Department within the next two years.
- **The HIV Network.** The goal of the HIV Network is to improve the health and lives of people living with and at risk of HIV by generating new evidence and using these findings to drive changes in practice.
- **Infectious Global Health Threats.** This network has a focus on human migration, international air travel and the globalization of newly emerging and re-emerging infectious diseases.
- **Medical Oncology/Personalized Medicine.** The precision medicine oncology program is a multidisciplinary and multi-institutional program. It aims at improving the prevention, early recognition and management of systemic toxicity from cancer treatment. There is a special emphasis on breast cancer.
- **Stroke Network.** Through collaboration, education and innovation, the Stroke Network aims to collaborate with all major stakeholders within U of T to ensure leadership in cutting-edge research and quality stroke care to improve the outcomes and experiences of persons with stroke and their families.
- **CARDIA.** This network examines the cardiac assessment of rheumatic disease and inflammatory arthritis. The network combines three of our institutions and a multidisciplinary clinic to evaluate cardiovascular risk in patients with inflammatory arthritis and, particularly, rheumatoid arthritis.

## Merit Review

In 2012, a merit review was established to vet applications for salary support for clinician scientists five years or more after their first faculty appointment. Researchers are eligible if they do not hold external salary support and are deemed meritorious in a competition directed by the Merit Review Committee, which is chaired by Dr. Kevin Kain. The Merit Review Committee meets annually to review approximately 15–20 proposals from scientists across the spectrum of biomedical research in the DoM.

The merit review scores applications with the traditional Canadian Institutes of Health Research (CIHR) scale from one to five. (Five is exceptional.) Awardees receive \$40 thousand per year for three years. In 2018, 12 awards were granted to scientists across nine divisions. The Merit Review Committee is comprised of senior scientists across the DoM who represent the various research institutes and hospitals. The Vice Chair, Research, meets with all unsuccessful applicants to review critiques and design a corrective action plan before the next merit review.

## Support of Early-Career Clinician Scientist

Clinician scientists appointed at the rank of assistant professor or higher are supported at the level of \$40 thousand per year for their first five years on faculty provided they do not hold a career investigator award. Currently, we support 32 clinician scientists through this program. After the first five years, individuals are eligible for merit as long as they

do not hold a salary award or research chair position. The Vice Chair, Research, provides an overview of departmental research initiatives and opportunities during the new faculty orientation every fall. At the orientation, new faculty meet with established colleagues with similar job descriptions and types of research.

## Industry Relations Committee

Because of perceived challenges in getting industry to support research, we have formed an Industry Relations Committee. This initiative aims to allow our scientists and investigators to evaluate new compounds and devices in accordance with University policy and engage increasingly in multicentre international clinical trials. This committee has commissioned a meeting for the fall of 2018 to gather all the important stakeholders, including representatives from industry.

## Oversight of Endowed Chairs

There are several Endowed Research Chairs in the DoM. They include the Heart and Stroke Polo Chair, the Rose Chair in Palliative Care, the Hunt and Trimmer Chairs in Geriatric Medicine and the Ontario HIV Treatment Network Chair in Infectious Diseases and HIV. The Vice Chair, Research, is responsible for the five-year and end-of-term reviews of the chairs as well as the Search Committee for subsequent incumbents.







Dr. Michael Farkouh (left) and Dr. Eliot Philipson (centre) with trainees and recent graduates of the Eliot Phillipson Clinician-Scientist Training Program

Several of the chair holders in the DoM opt to use additional funds connected with their held chair to provide seed funding for other researchers in their division. Examples include the Heart and Stroke Foundation/U of T Polo Chair in Cardiology Young Investigator Award, the Respiriology Pettit Block Term Grant and the Pfizer Chair in Rheumatology Research Competition. Award amounts range from \$9 thousand to \$20 thousand for a one-to-two-year term grant. These internal grant competitions are a valuable source of seed funding for junior and mid-career researchers and promote collaboration and innovation. While these funding competitions are organized, adjudicated and awarded by the chair holder, the Vice Chair, Research portfolio creates award records, arranges for the approval of the Department Chair and releases the funding. Since 2015, nearly 50 of these internal grants have been awarded within the Department.

## Medical Sciences Building (MSB) Oversight Committee

The DoM has 10 laboratories in the MSB on campus and is responsible for their oversight and management. Drs. Richard Horner and Rupert Kaul serve as MSB on-site liaisons and are members of the Research Committee. In the past two years, significant renovations to laboratories occurred to make them comply with

advanced regulations. There has been centralization of glass washing, autoclaving and freezer farms to support Department-wide, faculty-wide collaboration. We have received a Canadian Foundation for Innovation (CFI) grant to support equipment/supplies for the lab of Dr. Vincent Piguet, who was recently recruited to lead the Division of Dermatology.

## The DoM Research Awards Committee

In 2016, the DoM's Research Awards Committee was established to determine how to better encourage and recognize meritorious scientists with external awards. The Committee is comprised of DoM scientists, many of whom have received international research awards, and Chairs of the DoM Promotions Committee and Toronto Academic Health Science Network Research (TAHSN-R) Committee. This initiative has been well received

and written up by colleagues from St. Michael's Hospital in "The Awards and Honours: Tricks of the Trade."

Several notable awards were won by DOM faculty members in the last year.<sup>1</sup>

#### **Gairdner Foundation**

- **Frances Shepherd**, 2018 Canada Gairdner Wightman Award
- This award recognizes outstanding career leadership in medicine and medical science.

#### **Order of Canada**

- **Kathleen Pritchard**, Member of the Order of Canada

#### **Governor General of Canada**

- **Kamran Khan**, Governor General's Innovation Award
- This award celebrates excellence in innovation across all sectors of Canadian society, inspires Canadians, particularly youth, to be entrepreneurial innovators and fosters an active culture of innovation that has a meaningful impact on our lives.

#### **American Thoracic Society**

- **Susan M. Tarlo**, ATS Assembly on Environmental, Occupational and Population Health John Peters Award
- This award recognizes outstanding contributions to occupational or environmental medicine through leadership in research, education or public health.
- **Margaret Herridge**, ATS Assembly on Critical Care Lifetime Achievement Award
- This award recognizes a career devoted to research and the teaching of the science and practice of critical-care medicine as well as outstanding service to the Assembly on Critical Care.

#### **Canadian Medical Association**

- **Andreas Laupacis**, F.N.G. Starr Award
- The Frederic Newton Gisborne Starr Award is the highest award that the Canadian Medical Association bestows upon one of its members. Achievement is the prime requisite in determining the recipient of this award.

#### **CAHR-CANFAR**

- **Darrel Tan**, Excellence in Research Award
- The award highlights the achievements of researchers who actively contribute to HIV research in their respective disciplines.

#### **Canadian Hematology Society**

- **Armand Keating**, Lifetime Achievement Award
- This award honours those who are internationally recognized for their work and impact in the field of hematology.

#### **University of Toronto**

- **Andreas Laupacis**, President's Impact Awards and the 2017 Carolyn Tuohy Impact on Public Policy Award
- The President's Impact Award recognizes and celebrates U of T faculty members whose research has had a significant impact beyond academia. The Carolyn Tuohy Impact on Public Policy Awards is presented annually to a member of the U of T teaching faculty who holds a continuing appointment and whose scholarship has had a significant impact on public policy.

The primary responsibility of the Committee is to identify candidates for the major DoM annual awards, including the Eaton Scholar Clinical Researcher of the Year, the Eaton Scholar Basic Science Researcher of the Year and the William Goldie Prize (which is awarded to an early-career scientist within 10 years of his or her first faculty appointment). The Committee provides oversight for other honours through a subcommittee's nominations to the American Society of Clinical Investigation, the American Association of Professors of Medicine, the Royal Society and the Canadian Academy of Health Sciences, to name a few.

The Committee aims to achieve equity and diversity among nominees. We believe this approach will lead to even greater success and recognition on the national and international fronts. Previous recipients of the Eaton Scholar Researcher of the Year and the William Goldie Prize are listed below.

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<sup>1</sup> See <http://www.deptmedicine.utoronto.ca/node/1363>.

**Eaton Scholar Researcher of the Year**

- 2018 Aaron Schimmer (Basic Science)\*
- 2018 Murray Krahn (Clinical)\*
- 2017 Daniel Cattran
- 2016 Lillian Siu
- 2015 Jack Tu
- 2014 Andreas Laupacis
- 2013 Sandra Black
- 2012 Paul Dorian

\* In 2018, the award was divided into two separate awards.

**The William Goldie Prize and Travel Award in Research**

- 2018 Andrea Gershon
- 2017 David Cherney
- 2016 Geoffrey Liu
- 2015 Douglas Lee and Lorraine Lipscombe
- 2014 Dennis Ko
- 2013 David Juurlink
- 2012 Rupert Kaul

**Clinician Educator and Clinician Scientist (Phillipson Scholars) Training Programs**

For the past 25 years, the Clinician Educator and Clinician Scientist Training Programs have been accepting clinical trainees to pursue graduate research training at U of T or select international universities. To date, these programs have trained more than 100 individuals; approximately 70 per cent go on to assume academic research positions as clinician scientists or clinician educators, primarily in Canada. Many of these trainees are eligible for, and are accepted into, the Royal College of Physicians and Surgeons of Canada’s Clinician Investigator Program at U of T. The calibre of the trainees selected to be part of the CSTP and CETP is demonstrated by the number of prestigious scholarships and grants awarded to them, including 12 CIHR fellowships and three Vanier awards, during their time in the program.





The CSTP is designed specifically for individuals interested in academic careers in clinical or basic science research; the CETP is for individuals who have an academic interest in education research. To maintain a robust pipeline filled with future academicians, these programs are essential; however, budgetary restrictions have limited the DoM's ability to support all promising candidates. Keeping these programs in place is a major DoM educational priority; expansion will depend partly on donor recruitment and development.

Over the past five years, a noticeable decline has occurred in the number of applicants pursuing the basic sciences; most applicants pursue training in clinical epidemiology and the health services research disciplines. There is also a noticeable paucity of female candidates. We are concerned about this paucity. The Vice Chair, Research, is working with the Vice Chair, Mentorship, Equity and Diversity, to encourage all eligible trainees to apply for this advanced training. The Clinician Scientist Training Program (CSTP) involves quarterly meetings to review the work of fellow Phillipson Scholars and has instituted a grant-writing seminar series to foster success in peer review funding early in the career cycle.

## Internal Medicine Research Proposal Scholarly Activity Committee

Scholarly activity is mandated by the Royal College of Physicians and Surgeons of Canada. In 2018, these electives will be evenly distributed over one or two

research blocks, supervised by a faculty member. At the end of their research block, residents are expected to present their research findings at a local or national meeting. Our Committee reviews the proposals for originality, feasibility and relevance to the field of study. Supervisors are required to complete resident assessments and provide the resources necessary for successful completion of the project.

This program identifies future clinician scientists who can then be mentored and provided with continual research opportunities as their clinical training progresses. During the PGY1 and PGY4 orientations, the Vice Chair, Research, meets with new trainees to introduce them to the full range of programs designed to promote opportunities for research during residency.

## Queen Elizabeth II Graduate Scholarships in Science and Technology

Designed to encourage excellence in graduate studies in science and technology, the QEII Graduate Scholarships in Science and Technology (QEII-GSST) program is supported through funds provided by the Province of Ontario and the private sector. The Vice Chair, Research, and members of the DoM Research Committee review and approve the applications. These awards are used to offset the cost of student stipends to their supervisors. There are four different types of QEII's adjudicated in the DoM; approximately 15–20 awards are given out each year, depending on available funds.





## Challenges

We face challenges in the next five years. They include these five:

- **Sustainability of Funding for Research Training, Start-Up Salary Support and Clinician Scientist Merit.** With finite resources, we prioritize funding opportunities. We give the highest priority to providing salary support to our clinician scientist faculty members through the merit review. We work closely with our Senior Development Officer, Chris Adamson, to identify philanthropic funding for our research training programs.
- **Pipeline of Biomedical Researchers.** We are creating a mentoring group to help address the relative lack of trainees interested in pursuing careers in the basic sciences. We have appointed Dr. Raymond Kim to oversee and mentor graduates of the MD-PhD program at U of T who enrol in residency training in the DoM.
- **Support for Clinician Investigators.** Because of finite resources, we can only provide salary support for clinician scientists, who dedicate roughly 75 per cent of their time to research. However, we have comparable numbers of individuals who commit 50 per cent of their time to research as clinician investigators. These latter individuals are also highly productive scholars. Thus we would like to identify means to help support and recognize this group of faculty members. The network initiative is helpful in this respect.
- **Engagement of the Hospital Research Institutes.** Our research team has worked very hard to engage all major stakeholders in our research committees. These relationships are critical, as is our relationship with the Toronto Academic Health Science Network (TAHSN) Research Committee, which is chaired by one of our Department members, Paula Rochon. We believe that integrating on all fronts at the Faculty level will help us better engage the respective research institutes to support meritorious investigators and scientists.
- **Laboratory Facilities at the Medical Sciences Building.** While the upgrading of laboratory space and improved centralized services in the MSB have been important advances, DoM researchers were slowed down by several infrastructure failures and delays in project completion. Continual collaboration with the Vice Dean, Research, will be critical to ensure that our basic science community at the MSB receives daily support.

# SECTION 7: QUALITY & INNOVATION (QI)



## Quality and Innovation in the Department of Medicine

Kaveh Shojania, Vice Chair for Quality and Innovation



The Department of Medicine's (DoM) recognition of Quality Improvement and Patient Safety as a critical piece of its academic mandate reflects a broader evolution in the relationship between the Department and its affiliated hospitals over the past decade. As clinical care has historically fallen under the purview of the hospitals, health-care quality was not a primary academic focus of the Department. The origins of this shift in perception can be attributed to a number of individual faculty members who made distinguished contributions to measuring and improving health-care quality. For instance, Dr. David Naylor, a member of the Department and later both Dean of the Faculty of Medicine and President of the University of Toronto, founded the Institute for Clinical and Evaluative Sciences (ICES) in 1989. The current Chair, Dr. Gillian Hawker, also has a long track record of research on health-care quality, as do other senior faculty members, including Dr. Sharon Straus (Vice Chair, Mentorship, Equity and Diversity and Division Director for Geriatric Medicine) and Dr. Chaim Bell (Physician-in-Chief at Mount Sinai). Dr. Jack Tu, Senior Scientist at ICES, led numerous high-profile studies (e.g., in the *New England Journal of Medicine* and *Journal of the American Medical Association*), and projects related to measuring and improving performance in cardiac care before his untimely death earlier this year.

Building on the foundation laid by these individual faculty members, over the past 10 years the Department has more systematically invested in supporting work in quality improvement and innovation. This includes initiatives in specific areas, as well as several very successful training programs directed at both residents and faculty. Following a commentary in the *Journal of the American Medical Association (JAMA)* by the current Vice Chair, Quality and Innovation (QI) and the previous DoM Chair,<sup>1</sup> the Department formalized its commitment to QI in July 2012, when it became one of the first academic departments in North America to introduce the clinician in quality and innovation (CQI) academic position description.

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<sup>1</sup> K.G. Shojania and W. Levinson. "Clinicians in Quality Improvement: A New Career Pathway in Academic Medicine." *Journal of the American Medical Association* (2009).





## Faculty Development in Quality Improvement

Since formally recognizing the contributions of its faculty members in quality improvement with the creation of the CQI position, the number of faculty members has grown from four to 44 over the review period, and now stands at 50 departmental faculty. All 23 faculty members have been successful at Continuing Faculty Appointment Review (CFAR). Over the reporting period, seven CQI faculty members have been promoted to associate professor.

The CQI position category serves to broadly include members whose primary academic interest is engaging in quality improvement, patient safety, knowledge translation (KT) or other forms of health-care innovation (e.g., advancing health informatics, developing new models of care). Many faculty members in this job description will demonstrate their impact through the creative professional activities (CPA) framework defined by the University of Toronto.

To support the development of faculty in quality improvement, the DoM provides project and research mentorship to faculty and trainees. Dr. Edward Etchells,

senior faculty quality improvement advisor, and Drs. Jerome Leis and Geetha Mukerji, faculty quality improvement advisors, provide free consultative advice and mentorship on the design, implementation and evaluation of QI projects to any departmental members working on such projects (similar to providing biostatistical support for clinical research). Drs. Kaveh Shojania and Brian Wong facilitate additional support to Department members through the Centre for Quality Improvement and Patient Safety (C-QuIPS).

Dr. Wong also receives support to oversee the Department's Continuing Education activities in general, but with an explicit mandate to make these synergistic with QI activities. A signature program developed by Dr. Wong in this role is the Faculty-Resident Co-Learning Curriculum in Quality Improvement, described below.



## Synergies Between Faculty Development and Resident Education

The Co-Learning Curriculum in QI began as a pilot program in the DoM in 2011–12 with three subspecialty programs.<sup>2</sup> The novel approach of bringing faculty and residents together to learn about QI addressed the dual goals of supporting resident QI project efforts while ensuring that faculty develop the necessary skills to supervise and teach QI effectively. It has since grown to more than 35 training programs and more than 200 participating residents each year across the Departments of Medicine: Paediatrics, Surgery, Laboratory Medicine and Pathobiology, and, as of 2018, Anesthesia.

Projects arising from this curriculum have been presented as abstracts at provincial (n=6), national (n=19) and international (n=14) meetings. Six projects have received conference awards, including the President's Award at the Endocrine Society meeting; top QI award at the Canadian Hematology Society meeting; first place in the resident research competition at the Canadian Association of Physical Medicine and Rehabilitation; best QI poster award at the Canadian Society of Hospital Medicine; the Garner King award for best QI project at the Canadian Critical Care Forum; and the best QI poster at the Intensive Care Society scientific meeting.

One of the first projects to generate a peer-reviewed publication, undertaken by the faculty and trainees in infectious diseases,<sup>3</sup> appeared in the highest-impact journal, *Infectious Diseases*, accompanied by an editorial highlighting that the publication represented the outcome of a quality-improvement project by trainees.<sup>4</sup> This project generated a subsequent publication<sup>5</sup> and led

to a sustained change in local practice. Antimicrobial stewardship programs at the three participating hospitals now routinely carry out point-of-care beta-lactam allergy skin testing to ensure that patients are not prescribed suboptimal antibiotics due to questionable allergy histories.

Dr. Wong has also helped two other Canadian universities (McMaster and Western) replicate the program in their Departments of Medicine, and Virginia Tech decided to implement after reading a second publication describing the more mature version of the program.<sup>6</sup> In addition to the obvious impact and recognition of the program in terms of its dissemination to other FoM departments, and to departments at universities in Canada and the United States, the Co-Learning Curriculum received the University of Toronto Helen P. Batty Faculty Development Award for innovation in program development and design in 2016. Dr. Wong has also delivered invited presentations to national (e.g., Royal College of Physicians and Surgeons of Canada) and international audiences (e.g., Association of American Medical Colleges) on the Co-Learning faculty development model.

While the Department has created a framework for quality and innovation through the Vice Chair portfolio, the CQI position, and the Co-Learning Curriculum, many of the projects and initiatives of departmental faculty consist of internal and external partnerships, as further described below.

### The Centre for Quality Improvement and Patient Safety (C-QuIPS)

[www.cquips.ca](http://www.cquips.ca)

Housed within the Faculty of Medicine, in partnership with Sunnybrook Health Sciences Centre and the Hospital for Sick Children, the Centre for Quality Improvement and Patient Safety (C-QuIPS) is an extra-departmental unit led since its inception by Dr. Shojania, the DoM's Vice Chair, Quality and Innovation. DoM faculty account for much of its leadership and core members. Dr. Etchells (General Internal Medicine, Sunnybrook) served as an Associate Director for an inaugural five-year term, and was followed in this role by Dr. Brian Wong.

<sup>2</sup> B.M. Wong, J. Goguen and K.G. Shojania. "Building Capacity for Quality: A Pilot Co-Learning Curriculum in Quality Improvement for Faculty and Resident Learners." *The Journal of Graduate Medical Education* (2013).

<sup>3</sup> D.R. MacFadden, A. LaDelfa, J. Leen, W.L. Gold, N. Daneman et al. "Impact of Reported Beta-Lactam Allergy on Inpatient Outcomes: A Multicenter Prospective Cohort Study." *Clinical Infectious Diseases* (2016).

<sup>4</sup> K.G. Blumenthal and E.S. Shenoy. "Fortune Favors the Bold: Give a Beta-lactam!" *Clinical Infectious Diseases* (2016).

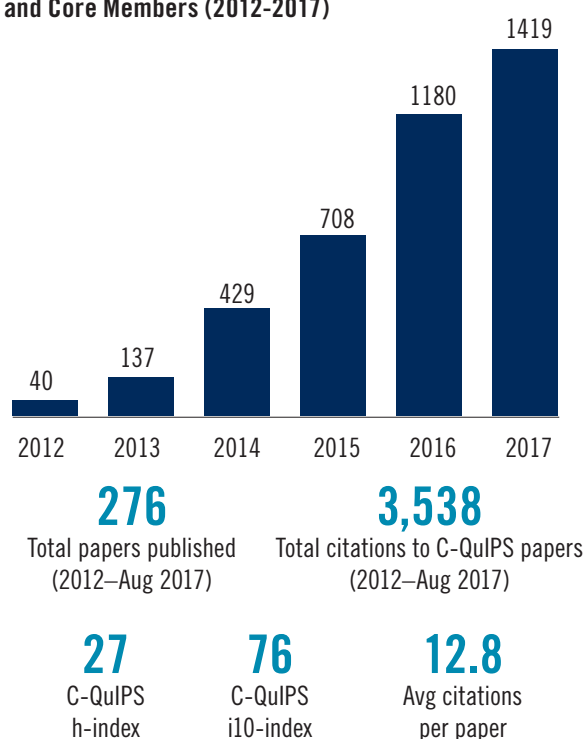
<sup>5</sup> J. Leis et al. "Point-of-Care Beta-lactam Allergy Skin Testing by Antimicrobial Stewardship Programs: A Pragmatic Multicenter Prospective Evaluation." *Clinical Infectious Diseases* (2017).

<sup>6</sup> B.M. Wong et al. "Faculty-Resident 'Co-learning': A Longitudinal Exploration of an Innovative Model for Faculty Development in Quality Improvement." *Academic Medicine* (2017).

Other core C-QuIPS members from the Department include: Dr. Chaim Bell (Physician-in-Chief, Mount Sinai Hospital), Drs. Christine Soong and Janice Kwan (both at Mount Sinai in General Internal Medicine), Dr. Rory McQuillan (Nephrology, UHN), Dr. Jerome Leis (Infectious Diseases, Sunnybrook), Dr. Alex Lo (UHN/Toronto Rehabilitation Institute), and Dr. Geetha Mukerji (Endocrinology, Women's College Hospital).

C-QuIPS recently underwent its second successful five-year external review. The report, prepared by Dr. Jennifer Myers (University of Pennsylvania) and Dr. Lisa Calder (University of Ottawa and Director of Research at the Canadian Medical Protective Association) highlighted the notable national and international reputation of the centre, as well as the impact of its work and the strong leadership of Dr. Shojania and Dr. Wong.

**Figures 7.1: Citations of Publications by C-QuIPS Staff and Core Members (2012-2017)**



- C-QuIPS has grown to 28 staff and core members committed to advancing QI/PS practice and research.
- From 2012 to August 2017, 25 C-QuIPS members published 276 peer-reviewed articles related to patient safety or quality improvement. Google Scholar identifies 3,538 citations to these, for a group h-index of 27 and an average of 12 citations per publication.
- Individual C-QuIPS members have participated as principal or co-investigators on grants totalling more than \$50 million.

- Two C-QuIPS team grants were received, with multiple members collaborating on projects central to C-QuIPS's activities.
- Under the editorial leadership of Dr. Shojania, BMJ Quality and Safety has risen from an Impact Factor of 1.683 in 2011 (the year he became editor) to 7.226, making it the highest-impact journal in a category of 94 journals. This category includes all peer journals in the field of health-care quality, as well as all journals in cognate fields such as health-services research, clinical epidemiology, health policy, informatics, and medical education. Other Department faculty who have played roles at the journal include Dr. Christine Soong (currently an associate editor) and Dr. Chaim Bell (a past associate editor).

## Choosing Wisely Canada

<http://choosingwiselycanada.org>



Choosing Wisely Canada (CWC) was initiated in the Department of Medicine in 2014 under the leadership of Dr. Wendy Levinson, who was Chair of the Department at that time. Since 2014, the campaign has flourished and many Department members play a leadership role on the CWC team or contribute significantly to the campaign. DoM members' roles in some of the accomplishments are highlighted below.

CWC is a campaign designed to stimulate conversations between clinicians and patients about the use of potentially unnecessary tests and treatments in order to help patients make informed decisions. The central tenet of the campaign is in creating a forum for national physician societies to identify tests, treatments or procedures in their discipline for which there is strong scientific evidence of overuse or harm to patients. The campaign in Canada started with physician societies but now includes lists of recommendations from national societies of nursing, pharmacy, nurse practitioners and dentists. Over 300 recommendations have been released to date.

## Key Accomplishments

1. **Campaign Recognition.** Physician recognition of CWC is very high in Canada with over 88 per cent of physicians reporting familiarity with the campaign, and 44 per cent reporting use of the campaign in their daily practice. In the four years since it began, it has become a recognized brand and has stimulated conversation about overuse in many settings—between clinicians, in medical education, and policy settings.
2. **National Society Engagement.** The national societies have been active in engaging members in activities related to CWC. For example, the Canadian Society of Internal Medicine runs a stream at its annual national meeting on the topic (Dr. Adina Weinerman and Dr. Christine Soong lead). There are more than 15 DoM members who have participated in list development.
3. **Student Engagement.** The campaign engages medical students across Canada through its Students and Trainees Advocating for Resource Stewardship (STARS) program, led by Dr. Brian Wong, a core CWC team member.
4. **Measurement of Overuse.** Measurement of overuse in Canada has been developed by CWC and the Canadian Institute of Health Information (CIHI). In April 2017 a major report was published demonstrating that up to 30 per cent of medical tests or treatments are potentially unnecessary.<sup>7</sup> The measurement and evaluation effort is led by Dr. Sacha Bhatia, a core CWC team member and DoM faculty member.
5. **Implementation of CWC Recommendations.** The most important activity is the grassroots effort across hospitals and family medicine to implement campaign recommendations as part of quality improvement and patient safety activities. CWC works with leaders who have successfully implemented recommendations to develop tool kits to disseminate the learnings. Many of these successful projects are led by DoM faculty members including Drs. Jerome Leis, Christine Soong, Lisa Hicks, Yulia Lin, Julie Gilmour, Geetha Mukherji, Aaron Mocon, Barbara Liu, Yuna Lee, Samuel Vaillancourt, Kieran McIntyre, Camilla Wong, Reena Pattani, Larissa Matukas, Alun Ackery, Michelle Sholzberg, Shirley Chow, Andre Amaral, and Rory McQuillan.

6. **Annual Meeting.** The CWC annual meeting has been held three times. The most recent, in April 2018 in Toronto, drew an oversold attendance of 330 participants. The Federal Minister of Health, the Honourable Ginette Petitpas Taylor, opened the meeting. The keynote, entitled “Implementing Choosing Wisely Targets: Suggestions from a Sympathetic Observer” was delivered by Dr. Kaveh Shojania and highly rated by participants.
7. **International Efforts.** The CWC team leads a consortium of more than 20 countries that are developing, or have started, Choosing Wisely campaigns in their own countries. The Organization for Economic Cooperation and Development (OECD) is collaborating with this group and has incorporated measures of overuse into its annual report on quality measures. Dr. Wendy Levinson is the leader of this international work.
8. **Using Antibiotics Wisely.** A sub-campaign aimed at decreasing the overuse of antibiotics is led by Dr. Jerome Leis. This is focused on treatment of upper respiratory tract infection in family medicine and urinary tract infection in long-term care facilities.

Overall Dr. Levinson and members of the DoM have led a national and international campaign with high visibility and increasing evidence of impact.

## General Medicine Inpatient Initiative (GEMINI)

<https://www.geminimedicine.org>

The General Medicine Inpatient Initiative (GEMINI) is a physician-led collaboration focused on studying and improving care for general medicine patients in hospital, primarily using electronic clinical data. Six of the seven team members, and one of the two senior advisors are DoM faculty.

General Internal Medicine (GIM) patients represent up to 50 per cent of patients admitted to hospital from the Emergency Department, and the number of GIM patients has increased by 32 per cent in the last five years. GEMINI is working to improve the research and quality improvement efforts around GIM patients through standardized methods for collecting and reporting data. GEMINI has developed infrastructure to extract and standardize electronic clinical data from hospital IT systems (laboratory, imaging, pharmacy, etc.) at seven University of Toronto hospitals. The project has analyzed

<sup>7</sup> See <https://www.cihi.ca/en/unnecessary-care-in-canada>.



data on all GIM hospitalizations over five years in these hospitals (150 thousand admissions) and developed quality indicators covering i) health outcomes, ii) resource utilization, and iii) hospital-acquired complications. Substantial variations in processes of care and clinical outcomes between and within hospitals have been identified, representing important opportunities to improve patient care and reduce costs.

For example, average length of stay (LOS) and readmission vary significantly among physicians. At one GEMINI hospital, the median LOS in GIM was 4.9 days, but LOS was 3.7 days for the 10th percentile physician versus 6.0 days for the 90th percentile physician. At the same hospital, the overall rate of 30-day readmission to GIM was 8.6 per cent, with 7.7 per cent among the 10th percentile and 12.0 per cent for the 90th percentile. Interestingly, there was no correlation between LOS and readmission rate, counteracting the argument that some physicians keep patients in hospital longer to achieve fewer readmissions. If physicians with longer LOS could achieve average performance, GEMINI hospitals could achieve a 5 per cent annual reduction of LOS (3,375 bed days) and readmissions (153 hospitalizations).

Having identified substantial opportunities to improve GIM care, GEMINI has started working with Health Quality Ontario to develop a provincial network for quality improvement in GIM. Beginning with the seven University of Toronto hospitals, clinical data will be used to provide “audit-and-feedback” practice reports to front-line physicians and clinical care teams. This will inform local quality improvement efforts and will also support the development of a provincial community

of practice dedicated to quality improvement. Over the next three years, we will be working toward spreading GEMINI to 30 hospitals across Ontario.

GEMINI’s rich dataset contains more than 150 million data points about 150 thousand patients and is projected to increase by 35 thousand patients per year. In its first year of active research, GEMINI has developed collaborations with 30 researchers, including those in psychiatry, infectious disease, hematology, and a close collaboration with Choosing Wisely Canada. More than 20 medical students and residents have been involved with GEMINI projects, and they have won local and national research competitions for their work. Project research has been published in *JAMA Internal Medicine*<sup>8</sup> and *Canadian Medical Association Journal (CMAJ) Open*.<sup>9</sup>

## Women’s College Hospital Institute for Health Systems Solutions and Virtual Care (WIHV)

<http://www.wchwihv.ca>

The Women’s College Hospital (WCH) Institute for Health Systems Solutions and Virtual Care (WIHV) was established in 2013 to transform

<sup>8</sup> A.A. Verma, H. Masoom, S. Rawal, Y. Guo, F. Razak. “Pulmonary Embolism and Deep Venous Thrombosis in Patients Hospitalized With Syncope: A Multicenter Cross-sectional Study in Toronto, Ontario, Canada.” *JAMA Internal Medicine*. July 1, 2017. 1046-48. doi: 10.1001/jamainternmed.2017.1246.

<sup>9</sup> A.A. Verma, Y. Guo, J.L. Kwan et al. “Patient Characteristics, Resource Use and Outcomes Associated with General Internal Medicine Hospital Care: The General Medicine Inpatient Initiative (GEMINI) Retrospective Cohort Study.” *CMAJ Open*. Dec. 11, 2017. E842-E849.



the way that patients experience their care, to create better long-term health outcomes, and to lower the cost of managing chronic illness in the system. DoM faculty member Dr. Sacha Bhatia co-founded WIHV and serves as the Director.

WIHV was founded to address health-care delivery, recognizing that for the most chronic users in the system, care is largely haphazard and disconnected and exacerbated by antiquated technology. WIHV's mandate is to

- develop, implement and evaluate new models of care, particularly those that use novel mobile and digital technology, that improve quality and that reduce costs in the health-care system; and
- work with government, industry, clinicians and patients to determine how to scale successful models of care across country.

WIHV consults on a wide array of projects, from evaluating apps that aim to help patients manage and monitor their diabetes, to new ways of communicating with patients to see if health-care providers can help patients continue with medications and rehab after a heart attack. These are some recent highlights:

- **Centre of Excellence in Digital Health Benefits Evaluation.** WIHV is coordinating the newly appointed Centre of Excellence in Digital Health Benefits Evaluation with nine core partners and more than 20 supporting partners.
- **Ontario Telemedicine Network.** WIHV is the preferred evaluator for the demonstration projects conducted by the Ontario Telemedicine Network (OTN). Over the past three years, WIHV conducted three large-scale randomized controlled trials on digital tools in the areas of diabetes, mental health, and chronic kidney disease. Current evaluation projects include i) enhanced access to primary care, ii) telewound care models, and iii) telepalliative care models. The first is a mixed-methods evaluation of the workflow challenges and potential care models that use virtual primary care visits (e.g., secure messaging, video, or phone). The latter two projects are qualitative investigations into understanding the necessary aspects of care models that use digital solutions in managing wound healing and palliative care, respectively.

- **Practical Apps.** Practical Apps is a project developed in partnership with the OTN and WIHV, to assess the quality of mobile health applications for chronic disease management. The results of this work can support both clinicians and health systems decisions makers in identifying and supporting high-quality apps for patient use. The aim is to leverage a comprehensive framework to develop set of credible reviews that identify high-quality, patient-facing health apps that have the potential to improve chronic disease outcomes across the health system.

### OpenLab

[www.uhnopenlab.ca](http://www.uhnopenlab.ca)

OpenLab is an inter-professional collaborative design and innovation shop based at the University Health Network/Toronto General Hospital. OpenLab is dedicated to finding creative solutions that transform the way health care is delivered and experienced. OpenLab work falls into three conceptual but overlapping “Labs”:

1. **The Complex Care Lab.** System redesign for patients with multiple co-morbidities
2. **The Experience Lab.** Focused on improving the experience of care for patients and their informal and formal caregivers
3. **The “X” Lab.** A playground for trying new, more transformative ideas

OpenLab maintains 15–20 ongoing projects at any given time, across its three labs. These are some of the current projects:

- **Hospital at Home.** A program designed to provide acute, hospital-level care at home for patients with heart failure (HF), chronic obstructive pulmonary disease (COPD), or community-acquired pneumonia (CAP).
- **PODS: The Patient-Oriented Discharge Summary.** Based on patient input regarding desired discharge information, now being implemented across Ontario.
- **VRx: Prescribing Virtual Reality.** A series of studies examining the use of VR for people with cognitive impairment and other medical conditions.

## Looking Forward

On April 1, 2018, the Department announced Dr. Andreas Laupacis as its first Lead, Patient Involvement. In alignment with the DoM's first guiding principle to "ensure that the perspectives and experiences of our patients and their families drive our work," the appointment of Dr. Laupacis reflects a commitment by Dr. Hawker and the Department to expand its leadership in this area.

Dr. Laupacis is currently engaged in a consultative process with departmental colleagues and potential partners to better define the parameters of "patient involvement." In exploring this mandate, Dr. Laupacis is considering the following:

- **Governance.** Should the Department have a Patient and Family Advisory directly advising the Chair? Should patients be on key recruitment/appointment committees? Should a patient lead the patient involvement activities of the Department and sit on its Executive Committee?
- **Education.** Should patients be involved in the resident selection process? (The Department of Psychiatry at the University of Toronto has some initial experience that the DoM can learn from.) Should the Department establish a cadre of carefully selected and trained patients who are involved in the education of medical students and residents? (The University of Montreal has experience in this regard that the DoM can learn from.)
- **Research.** Should the Department collate and develop tools to help Department members meaningfully involve patients in research (priority setting; research design and conduct; knowledge



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unbiased facts. informed opinions.

translation)? Should patients be partners in determining the Department's research priorities?

- **Quality Improvement.** Should patients be fully integrated in all QI activities in an effort to ensure that QI initiatives focus on topics that matter to patients and collect outcome data that matter to patients? How should patients be integrated into the teaching of QI?

While weighing the many challenges these questions present, including the resistance to change, the resources required (including payment to patients), and the need to ensure diversity in the pool of patient partners, there is also a great opportunity for the Department to take a leadership role in patient partnership in academia.

Dr. Laupacis is a general internist and health-services researcher who currently practices palliative care. For seven years he has held a Canada Research Chair in Health Policy and Citizen Engagement. While holding the chair he has been the Canadian leader in using the approach developed by the James Lind Alliance in the UK for involving patients and caregivers in research priority setting (<http://www.jla.nihr.ac.uk/about-the-james-lind-alliance/>) and has been involved in approximately a dozen such projects in dialysis; kidney cancer; head and neck cancer; paediatric inflammatory bowel disease; fibromyalgia; dementia; and others.

Dr. Laupacis is also the Founding Editor of Healthy Debate ([www.healthydebate.ca](http://www.healthydebate.ca)), a website focused on health policy issues. One of its target audiences is patients and the public. Healthy Debate has about 100 thousand readers a month. As part of his new role in the Department, Dr. Laupacis and Healthy Debate is offering four-week electives for residents who wish to learn how to write or produce multimedia pieces about health care for the public. The first resident started in late July 2018.

## Partnership with the Department of Computer Science

In a first for the Department, we have partnered with Computer Science to recruit Dr. Ghassemi, who completed her PhD in Computer Science at MIT and a post-doctoral fellowship at Google. Dr. Ghassemi arrived August 1, 2018, and holds joint appointments in the Departments of Medicine and Computer Science, as well as at the Vector Institute. Dr. Ghassemi was named one of the Top 35 innovators under 35 by MIT. Her research

focuses on using artificial intelligence to leverage health-care data to make better clinical decisions. Locally, she will be doing this work through her Machine Learning for Health (ML4H) lab, and she has already started collaborating with some of our clinical research- and quality improvement-oriented faculty to test and refine her ideas.

Dr. Ghassemi's position is the result of a growing formal partnership between Computer Science and Medicine over the past three years. Through this relationship, we have created a local Digital Health Advisory Committee, chaired by Drs. Kaveh Shojania and Trevor Jamieson. This group has coordinated two successful symposia aimed at charting a course for the University in the rapidly growing and increasingly recognized Toronto innovation ecosystem. Our most recent event, in March 2018, welcomed Dr. Michael Blum, the Executive Director of the Center for Digital Health Innovation at the University of California, San Francisco, as our special guest to share what he had learned in their past five years of academic innovation. Though still based at Google at the time, Dr. Ghassemi also made the trip from California for the event and presented an exciting and well received overview of her work.

This growing collaboration between Medicine and Computer Science provided part of the context for bringing together a consortium of partners who successfully bid for the \$2 million Centre of Excellence in Digital Health Benefits Evaluation in February 2018. Dr. Ghassemi will play a valuable role in this work as we attempt to understand how best to apply machine-learning techniques to large datasets for research purposes, as well as many other potential applications to health-care decision making.

A group of diverse people, including men and women of various ethnicities, are smiling and looking towards the camera. The image is overlaid with a semi-transparent blue filter. The text is white and positioned on the left side of the image.

# SECTION 8: FACULTY (MENTORSHIP, EQUITY & DIVERSITY)



## Mentorship, Equity and Diversity in the Department of Medicine

Sharon Straus, Vice Chair for Mentorship, Equity and Diversity



# OVERVIEW

The Mentorship, Equity and Diversity (MED) portfolio was established in November 2015 to build on the Department's commitment to faculty and trainee wellness and to develop policies and practices to increase fairness, transparency, equity and diversity. Dr. Sharon Straus was appointed as the inaugural Vice Chair, Mentorship, Equity and Diversity. She is supported by the MED Committee, described below.

Strong evidence shows that mentorship and a safe, collegial and professional work environment are associated with greater physician satisfaction, retention and wellness. The MED portfolio was created to respond to three factors:

- a review of departmental data by gender,
- findings from the 2015 DoM faculty survey, and
- stakeholder interviews conducted by the Chair during the first few months of her first term.

These factors identified a lack of sex/gender diversity in the Department, particularly among the higher academic ranks and leaders. Although 50 per cent or more of the graduating MD classes across Canada have been female for at least two decades, in 2014 only 36 per cent of DoM faculty members overall, and 25 per cent of full professors, were female. (See figures 8.1 and 8.2.)

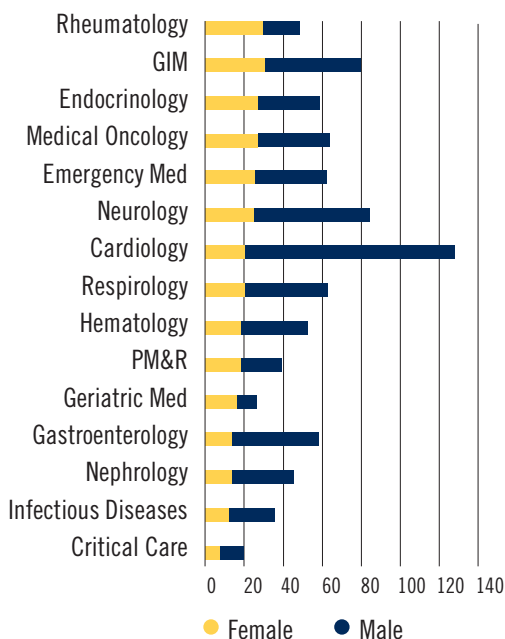
Further, we noted substantial variability across the divisions. Some (e.g., Cardiology and Nephrology) have few women faculty, while others have large proportions (e.g., Rheumatology). Only 31 per cent of the DoM's leadership roles were held by women. Looking at job descriptions over 15 years, from 2000 to 2015 (figure 8.3), while women and men were equally likely to have been recruited as clinician teachers, women were much less likely than their male counterparts to have been recruited as clinician scientists. These findings—although not disparate from those reported nationally by the American Association of Medical Colleges (AAMC)—raised concern about potential bias in recruitment and promotion within the DoM.

Stakeholder interviews identified a general perception that the Department lacked fairness and transparency in its processes and procedures, including recruitment and promotion. For example, recruitment was opportunistic

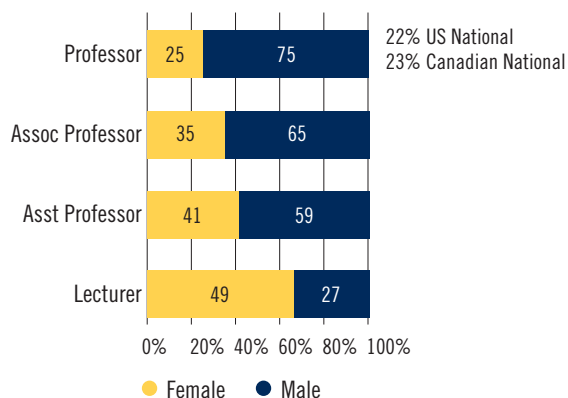
with no requirement for a formal job posting or application and interview. Finally, the 2015 faculty survey identified that a substantial proportion of faculty respondents had either witnessed or personally experienced unprofessional behaviour in the workplace. Mentorship was felt to be inadequate; less than 50 per cent reported having a formal mentor.

Since 2015, the MED Committee has developed initiatives that align with the Department's strategic plan to ensure that faculty members thrive personally and professionally.

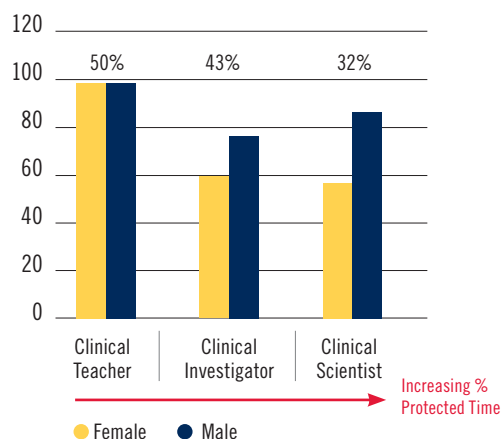
**Figure 8.1: Distribution of Full-Time Faculty Members by Division and Sex (36 Per Cent Female Overall) in 2015**



**Figure 8.2: % Full-Time Faculty Distribution by Rank & Gender 2015; n=711**



**Figure 8.3: Full-Time Faculty Recruited 2000–15 by Sex and Position Description**



## MED Committee: Structure and Governance

The Committee advises the Vice Chair, Mentorship, Equity and Diversity, and is expected to support the Vice Chair in all aspects of the role. Its responsibilities include, but are not limited to, the following:

- Manage the DoM mentorship program, associated events, awards and leadership development (faculty networking, women in academic medicine, support for leadership training); assist mentorship across the faculty member lifecycle.
- Promote faculty equity and diversity (accreditation standard; recruitment and promotion).
- Promote quality of life (civility and professionalism).
- Develop and implement meaningful benchmarks to measure the success of the overall portfolio; focus on equity and mentorship.
- Facilitate the selection of the annual Robert Hyland Excellence in Mentorship Award recipient.
- Oversee the administration of the biennial DoM faculty survey.
- Oversee special recognition events for newly appointed professors, associate professors and professors emeriti.

Committee membership is expected to reflect the diversity of the Department faculty: gender balance; representation of all job descriptions, divisions, hospitals; and equal membership from junior, intermediate and senior level faculty members as well as trainees. The

Diversity Strategist from the Faculty of Medicine (FoM), who was appointed in 2016, sits on this Committee to ensure cross-fertilization and coordination of activities. Membership and terms of reference for the MED Committee are available on the DoM website (<http://www.deptmedicine.utoronto.ca/mentorship-equity-diversity-committee>) and are included in the appendix.



Dr. Reena Pattani (right) speaks at the 2017 Summit for Women in Academic Medicine

## MED Initiatives 2015–18

To address MED concerns, the Committee has undertaken initiatives. They include the following:

- the completion of a qualitative study to gain greater understanding of the identified gender gap; the study explored the perceptions and experiences of our faculty members;
- conducting a qualitative study to explore the perceptions and experiences of our faculty members about professionalism and devise strategies to address incivility;
- the establishment of mentorship facilitators and workshops to optimize mentorship;
- the establishment of the Women in Academic Medicine (WAM) Summit to promote women in academic medicine; and
- conducting the 2017 faculty survey to gather additional information about these issues.

These and other projects are documented in more detail below.

## Program Initiatives

**Gender Gap Study.** In response to departmental data analyses, the 2015 survey data and a mixed-methods study done at one of the affiliated hospital research institutes,<sup>1</sup> the MED Committee completed a qualitative interview study to explore the perspectives of DoM faculty on the impact of the existing gender gap on

organizational effectiveness and workplace culture and to identify systems-based strategies to mitigate the gap. Forty-three full-time faculty members participated in the survey (29 of whom self-identified as female) and included representation across all job descriptions and university ranks and from all six affiliated hospitals. Participants outlined social exclusion, reinforced stereotypes and unprofessional behaviours as consequences of the gender gap. They suggested improvements for recruitment, hiring and promotion; inclusiveness of the work environment; structures for mentorship; and continual monitoring of the gender gap. This study was published in *BMC Medicine*<sup>2</sup> and has had more than 1,500 views. Its Almetric score shows it to be in the top 5 per cent of all research outputs scored. The results of this study were used to inform DoM activities, described below.

**Grand Rounds.** A completed study looked at the proportion of grand rounds that include a female presenter. The study showed a lack of diversity among our speakers and compared rounds between U of T and the University of Calgary. This project was led by a medicine resident, Dr. Danielle Buell, and results were published in 2017.<sup>3</sup>

<sup>1</sup> A. Mascarenhas, J.E. Moore, A.C. Tricco, J. Hamid, S.E. Straus et al. "Perceptions and Experiences of a Gender Gap at a Canadian Research Institute and Potential Strategies to Mitigate This Gap: A Sequential Mixed-Methods Study." *Canadian Medical Association Journal Open*. Feb. 23, 2017. E144–E151.

<sup>2</sup> R. Pattani, C. Marquez, C. Dinvarian, S.E. Straus et al. "The Perceived Organizational Impact of the Gender Gap across a Canadian Department of Medicine and Proposed Strategies to Combat It: A Qualitative Study." *BMC Medicine*. Apr. 10, 2018. doi:10.1186/s12916-018-1032-8.

<sup>3</sup> D. Buell, B.R. Hemmelgarn and S.E. Straus. "Proportion of Women Presenters at Medical Grand Rounds at Major Academic Centres in Canada: A Retrospective Observational Study." *BMJ Open*. Jan. 18, 2018. e019796.



**Incivility Study.** A qualitative study was conducted to explore organizational factors that may contribute to incivility in academic medicine and potential systems-level solutions to address it. Interviews were completed with 49 full-time faculty from six affiliated hospitals within the DoM. Physicians came from all university ranks and job descriptions. While all participants had collegial relationships with colleagues, each observed, heard of or had been personally affected by uncivil behaviour. Organizational factors perceived to contribute to incivility included silos within the DoM, poor leadership, a culture of silence and the existence of “power cliques.” Participants identified systems-level solutions to combat incivility, including improved reporting and clearer consequences.

This paper has been accepted for publication by *Academic Medicine* in 2018.<sup>4</sup> The results of this study were used to further develop DoM activities, including the 2017 faculty survey.

**2017 Faculty Survey.** The DoM has conducted a biennial faculty survey since 2009 to monitor academic culture and physician satisfaction. For the 2017 survey, the MED Committee formed a working group led by Dr. Karen Burns and Dr. Reena Pattani to evaluate and re-write the questions to ensure the receipt of clear and useful data and to provide data about issues that had

been raised in the above-described qualitative interview studies. The survey included questions related to career satisfaction, teaching, research, civility/professionalism, mentorship, and burnout and work-life integration. The survey response rate was 52 per cent, an improvement on previous surveys, and showed good representation across university rank and job descriptions.

Survey results have been analyzed and distributed to all faculty through the DoM newsletter and presented at DoM executive meetings. The results will inform various initiatives

in the future. See newsletter reports at <https://mailchi.mp/utoronto/departement-of-medicine-matters-may2018> and <https://mailchi.mp/utoronto/departement-of-medicine-matters-apr2018>.

The 2017 survey showed that, overall, faculty members were satisfied with their careers: 88 per cent of female and 84 per cent of male faculty expressed being somewhat or strongly satisfied with their careers; in 2015, 83 per cent and 86 per cent, respectively, expressed satisfaction. The survey highlighted areas that require more work, which the MED Committee and DoM have committed to undertake. For example, 83 per cent of women and 90 per cent of men indicated a sense of belonging to their hospital division, but the percentage was lower—50 per cent for men and women—at the level of the University DoM.

Almost 50 per cent of faculty members indicated that their work-life integration does not allow for enough personal or family time. The MED Committee is developing a proposal to complete a scoping review of approaches for flexible work hours and/or job descriptions to address this challenge.

Overall, the proportion of respondents reporting burnout was low: 64 per cent indicated having never or only infrequently experienced feelings of burnout. However, female faculty, when compared with male faculty, were twice as likely to report symptoms of burnout. Qualitative comments on the survey identified faculty concerns such as the need for transparency about financial

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<sup>4</sup> R. Pattani, S. Ginsburg, J.E. Moore and S.E. Straus et al. “Organizational Factors Contributing to Incivility at an Academic Medical Center and Systems-Based Solutions: A Qualitative Study.” *Academic Medicine*. June 12, 2018. doi:10.1097/ACM.0000000000002310. (Epub ahead of print.)



information, promotions and awards. We are addressing the concern by creating a data dashboard. (Dr. Ayelet Kuper and Dr. Larry Robinson lead.)

**Search Committee Guidelines.** The gender gap study identified lack of transparency in recruitment, so guidelines were created for search committees that must use the guidelines to fill all DoM positions. The guidelines, which were put into effect in 2016, seek to ensure that the search processes for the DoM are transparent and equitable. We believe that a diverse faculty benefits the Department, the University, our learners and our patients.

As part of this approach to recruitment, all Search Committee members must complete the Harvard Implicit Association Test (for gender and race) and the AAMC module on unconscious bias. The results of the Search Committee are monitored by the DoM. While we cannot claim cause and effect, the proportion of women recruited in the Department since the establishment of these standardized requirements has increased from 38 per cent to 56 per cent. The result is promising.

**Civility and Professionalism.** We implemented several strategies, which are based on the survey and interview study, within the DoM to address concerns. We have attempted to promote a culture shift that prioritizes equity, fairness and the collective instead of the individual. Persistent or recurrent incivility is not tolerated. For example, any concerns about a trainee or faculty member are to be brought to the attention of the appropriate leader and/or Chair or Vice Chair, Education. The concern will be addressed and investigated. An investigation into faculty-resident concerns will ensure procedural fairness.

As of 2016, professionalism is now part of the assessment for faculty members who undergo their Continuing Faculty Appointment Review (CFAR). As of 2017, all physicians recruited to the DoM, regardless of university rank, have a probationary period of three years. Consistent demonstration of professional conduct is expected

of them throughout this period. Similarly, consistent demonstration of professionalism is now a requirement for senior promotion in our Department and nomination for Departmental and Faculty awards.

Leadership evaluations are conducted routinely at the level of the University Department and in hospitals, and feedback from these evaluations is used to provide coaching when needed. Finally, lack of physician wellness may manifest itself as unprofessional behaviour. Appropriate support (such as through the Ontario Medical Association Physician Health Portfolio) must be provided for these individuals.

**Mentorship.** To optimize mentorship within the DoM, we have modified our mentorship program. Introduced in 2007 and officially named in 2010, the Robert Hyland Award for Excellence in Mentorship is designed to recognize faculty who have shown sustained excellence in mentoring other members of the Department, including helping them to develop their professional careers while balancing the competing challenges of the mentees' personal lives. A commemorative certificate is presented at the Department of Medicine Annual Day.

In 2016, the MED Committee formed a working group to increase the transparency of award selection. Under the leadership of Dr. Robert Wu, the working group designed criteria and transparent nomination. These changes were in effect for the 2017 and 2018 award cycles.



Dr. Kaveh Shojanian (centre), recipient of the 2018 Robert Hyland Award for Excellence in Mentorship



In 2016, the DoM created the position of Divisional Mentorship Facilitator; the MED Committee helped with the hiring. The mentorship facilitator is a senior, impartial and trusted individual who assists the mentee-mentor relationship within the division. The mentorship facilitator assists physicians-in-chief and department division directors in recommending and maintaining mentoring relationships for faculty members. The mentorship facilitator is the first point of contact for the establishment of new mentor-mentee pairings and is also the go-to person should any challenges arise within these relationships. The facilitators meet quarterly to share experiences and discuss best practices. Guest speakers are invited to discuss relevant topics.



We have also identified the need to find people to coach faculty about career and personal transitions. For example, we have identified faculty who are parents at each of the university-affiliated hospitals; they coach junior faculty through parental leaves. We have similarly identified successful retirees who can coach other faculty members who are approaching this career transition. The 2017 faculty survey showed an increase in the proportion of faculty who had mentors and were satisfied with mentorship. Since the 2015 survey, the number rose from 55 per cent to 75 per cent.

**Mentorship Workshops.** Over the past two years, mentorship workshops have been held for mentors

and mentees across the Department. These workshops are based on evidence from systematic reviews and primary studies conducted by Dr. Straus with Dr. David Sackett.<sup>5,6,7</sup> Sessions are held as part of the new faculty orientation and at the request of the divisional leadership. (There have been more than 10 workshops to date). Moreover, the DoM has been a resource for other departments and institutions. For example, Dr. Straus has conducted workshops for the Departments of Paediatrics, Surgery and Family and Community Medicine.

### Summit for Women in Academic Medicine

In March 2017, the DoM hosted the First Annual Summit for Women in Academic Medicine. It was designed to



offer a forum and skill building for the DoM's female faculty and trainees. On the first day, approximately 100 attendees participated, including representatives from the Departments of Family and Community Medicine, Surgery, Psychiatry and Paediatrics. The second day presented a condensed version of the same program to

female trainees. Approximately 70 women attended, including residents, fellows and undergraduates.

In 2018, we hosted a Second Annual Summit, which was a collaboration with all other clinical departments in the FoM. The one-day event hosted approximately 300 faculty from all departments. Women were invited for the full day, and men were also invited to attend the afternoon panel, which focused on creating allies. Representatives from four other departments of medicine across Canada also attended. The FoM's Chief Diversity Officer (Dr. Lisa Robinson) attended, and she highlighted the leadership role that the DoM has played in addressing equity and diversity.

We have established a fund to attract philanthropic donors who wish to support these activities.

### Faculty Seminars

Beginning in January 2017, the DoM has presented seminars for faculty on topics including citizenship, research integrity, time management, documenting teaching impact and crafting a CPA (creative professional activities) story. More workshops about financial planning, allyship, leadership and others are being planned.

Working with survey results, we attempt to secure seminar times that allow as many faculty members as possible to attend. In particular, we attempt to host events to allow faculty to meet personal and family obligations.

### Retirement Working Group

In 2016, a working group was formed under the leadership of Dr. Liesly Lee to discuss retirement transitions. The group has developed a document that

- describes a practical approach for faculty members nearing retirement; it includes an overview of the process;
- suggests opportunities for retirees to remain involved with the Department, such as mentorship, teaching or committee work; and
- summarizes benefits for retirees.

<sup>5</sup> D. Sambunjak, **S.E. Straus** and A. Marusic. "A Systematic Review of Qualitative Research on the Meaning and Characteristics of Mentoring in Academic Medicine." *Journal of General Internal Medicine*. January 2010. 72-78. doi:10.1007/s11606-009-1165-8. Epub Nov. 19, 2009.

<sup>6</sup> D. Sambunjak, **S.E. Straus** and A. Marusic. "Mentoring in Academic Medicine: A Systematic Review." *Journal of the American Medical Association*. Sept. 6, 2006. 1103-15.

<sup>7</sup> **S.E. Straus**, M.O. Johnson, C. Marquez and M.D. Feldman. "Characteristics of Successful and Failed Mentoring Relationships: A Qualitative Study across Two Academic Health Centers." *Academic Medicine*. January 2013. 82-89. doi:10.1097/ACM.0b013e31827647a0.



Financial implications and practical options are being explored at the departmental and University level as well.

### **Impact**

The work done by the MED portfolio has made our Department a leader locally, nationally and internationally.

Nationally, colleagues from seven departments of medicine have requested to use our 2017 survey in their departments. We have been approached by some of these colleagues to distribute the survey to their departments and analyze the results. The U of T FoM used our survey items to inform the development of its survey, which was conducted in 2018.

Our search guidelines for DoM recruitment have been adapted by three other academic departments of medicine across Canada, and we have also shared them with all clinical chairs within the FoM and the FoM's Chief Diversity Office. Research institutes (e.g., at St. Michael's Hospital) have also adapted our search guidelines. (The fact was noted in a *Globe and Mail* commentary.)

Locally, other clinical departments have used our summit approach; for example, Psychiatry hosted a summit for its trainees, which followed our 2018 summit. Nationally, the University of Calgary (led by Dr. Bev Adams, newly appointed Associate Dean, Professionalism, Equity, and Diversity) held a summit for women in academic medicine, which was modelled on our 2018 summit, in April 2018. Dr. Straus was the keynote speaker.

Dr. Straus and Dr. Hawker have led grand rounds and seminars on the work of the MED portfolio at nine departments of medicine across Canada over the past two years. They also presented during the annual meeting of the Canadian Association of Professors of Medicine in 2017.

Based on our approach, other university medical departments—in the University of Calgary, the University of Alberta, the University of Manitoba, McMaster University, Dalhousie University and other locations—have created or are creating similar portfolios. Our scholarly work has also led to other collaborations, including work on projects targeting undergraduates and postgraduates as well as other clinical departments including critical care in Calgary.

Internationally, Dr. Straus has presented on mentorship to colleagues in the United States (e.g., the Association of

Professors of Medicine), the United Kingdom (e.g., the University of Surrey) and Australia (e.g., Bond University) among others.

In 2017, Dr. Straus was appointed to the Tri-Agency Advisory Committee on Equity, Diversity and Inclusion Policy, which reports to the Canada Research Chair Secretariat and provides recommendations about university policies on institutional equity, diversity and inclusion action plans. This Committee was initiated after Minister Kirsty Duncan, federal Minister of Science and Sport, requested that universities address the lack of diversity among holders of the Canada Research Chair. Dr. Straus is the only representative from U of T and the only physician serving on this Committee.

### **Education**

The summits were highly successful and have affected our training programs. Indeed, the summit for trainees led to the identification of professionalism issues that the Vice Chair, Education, promptly addressed. We have also become partners with trainees: activities include informal networking events with faculty (to enhance opportunities for interaction and career development discussions). We have become partners with medical students who are creating a summit for undergraduates in August 2018. Dr. Hawker is their keynote speaker.

### **Research**

The MED Committee has been active in research over the past two years. For example, committee members have led the publication of six research articles





on gender bias and incivility.<sup>8,9</sup> We are working on four other collaborative research projects on equity and professionalism with colleagues across Canada and the world. The review conducted by Dr. Straus and her research team on gender bias in peer review was commissioned by the Canadian Institutes of Health Research and informed the development of educational modules on gender bias. It is now required for all grant peer reviewers; this example indicates the national impact of the DoM.

### Looking Ahead

Overall, the MED Committee is grateful for Dr. Hawker's support and especially for her leadership in addressing challenges such as unprofessionalism and inequity. Future goals of the Committee include achieving further data collection and a commitment to data transparency, increasing equity initiatives for minority and other vulnerable populations and building opportunities for successful work-life integration, including assistance with family challenges and flexible work schedules. Our current initiatives include the following:

- establishing a DoM Lead for Faculty Wellness (to be posted fall 2018);
- developing a data dashboard (with a working group led by Dr. Ayelet Kuper and Dr. Larry Robinson) to provide data on finances, promotions, recruitment, etc.;
- developing a data stewardship approach (Dr. Lisa Richardson leads);
- submitting a research proposal to complete a scoping review of flexible work hours and job sharing; we are doing this in partnership with Dr. Tanya Horsley from the Royal College of Physicians and Surgeons of Canada;
- developing a Diversity Working Group (led by Dr. Sam Sabbeh) within the MED portfolio to address lack of representation of racialized and disabled physicians within our DoM;
- preparing mentorship workshops for senior faculty as their careers change;
- preparing a series of faculty workshops on creating allies; and
- identifying future leaders early (i.e., at CFAR) and developing and offering workshops on leadership skills (pathway to leadership).

<sup>8</sup> A.C. Tricco, S.M. Thomas, J. Antony, **S.E. Straus** et al. "Strategies to Prevent or Reduce Gender Bias in Peer Review of Research Grants: A Rapid Scoping Review." *Public Library of Science One*. Jan. 6, 2017. e0169718.

<sup>9</sup> A.C. Tricco, S.M. Thomas, **S.E. Straus** et al. "Strategies for Addressing Unprofessional Behaviour: Scoping Review." (under review).

# SECTION 9: HOSPITAL REPORTS







# BAYCREST HEALTH SCIENCES

Prepared by Dr. Gary Naglie, Physician-in-Chief,  
Baycrest Health Sciences

## Hospital Overview

Baycrest Health Sciences is an academic geriatric health-care delivery system, fully affiliated with the University of Toronto (U of T), that is committed to providing state-of-the-art care to older adults including those with neurodegenerative illnesses. It plays an important role in training future professionals who will care for our aging population. Baycrest provides care to thousands of people each year through a unique spectrum of services including wellness programs and residential housing, ambulatory and community outreach services, adult day programs, a day treatment centre (day hospital) and a 472-bed nursing home.

The 262-bed hospital offers rehabilitation services, palliative care, a behavioural neurology unit, an inpatient geriatric psychiatry unit and a transitional care unit. In addition, the hospital's Complex Continuing Care Program provides assessment, treatment and care for older individuals who have multiple chronic complex medical conditions. Outpatient services include specialty clinics that focus on comprehensive geriatric assessment, memory, movement disorders, wounds, audiology and mental health, as well as subspecialty clinics (cardiology, neurology, dermatology, rheumatology,

physiatry, ophthalmology, otolaryngology, urology and urogynecology). Baycrest provides community outreach services that focus on comprehensive geriatric assessment, mental health and behaviour support for individuals with dementia.

Baycrest's research enterprise includes the acclaimed Rotman Research Institute (RRI), considered one of the top five cognitive neuroscience institutes in the world, and the Kunin-Lunenfeld Centre for Applied Research and Evaluation (KL-CARE), a unit that supports clinical research, program evaluation and the application of research findings directly to patient care.

Primary focuses include the maintenance of mobility, function and brain health and treatment of physical frailty and neurological

dysfunction from disorders associated with aging. By virtue of its care models, research and education, Baycrest is a world-class leader in innovation in aging. It is also the home base of the Centre for Aging and Brain Health Innovation (CABHI), which accelerates the development and testing of technologies and services from around the world to reduce the challenges of aging and has an emphasis on mobility, falls and dementia.

## Baycrest Department of Medicine

### Overview

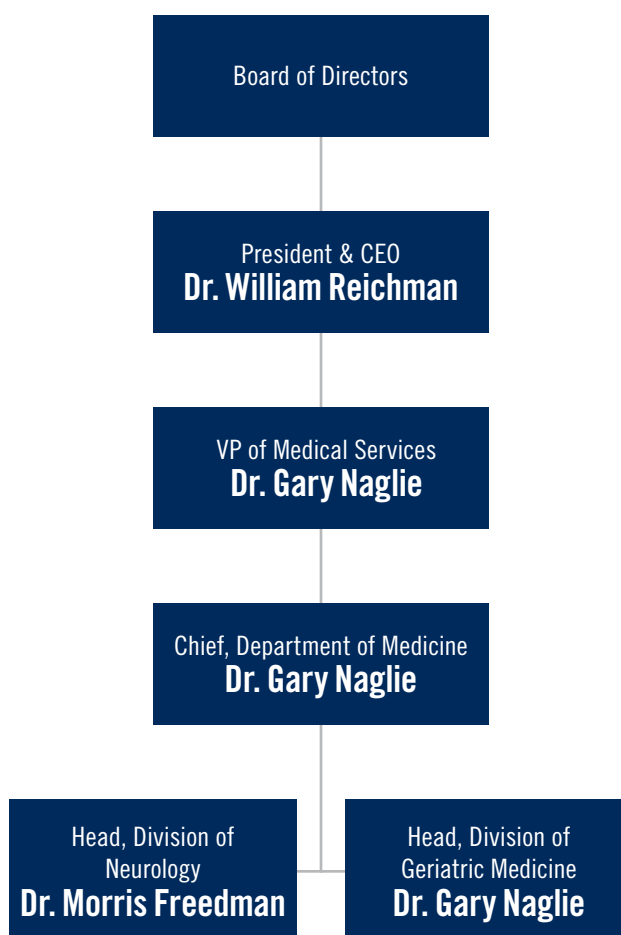
Baycrest’s Department of Medicine consists primarily of two divisions: Geriatric Medicine and Neurology. The Division of Geriatric Medicine has six full-time and three part-time members of the U of T Department of Medicine (DoM). The Division of Neurology has three full-time members. In addition, Baycrest’s Department of Medicine has a part-time member in the Division of Physical Medicine and Rehabilitation. Of the full-time members of the Department of Medicine, four are full professors, and five are assistant professors. The University job descriptions for the full-time members include two clinician scientists and one clinician investigator, all of whom have appointments with Baycrest’s RRI, and six clinician teachers. The Chief of the Department of Medicine has held a U of T Chair in Geriatric Medicine since 2002; the Mary Trimmer Chair in Geriatric Medicine Research from 2002 to 2012; and the George, Margaret and Gary Hunt Family Chair in Geriatric Medicine since 2012.

The Baycrest Department of Medicine has recently recruited Dr. Howard Chertkow, an internationally recognized cognitive neurologist who is the Scientific Director of the Canadian Consortium on Neurodegeneration in Aging (CCNA), which is funded by the Canadian Institutes of Health Research (CIHR). The CCNA is the national research hub for all aspects of research involving neurodegenerative diseases that affect cognition in aging, including Alzheimer’s disease, and has brought together 400 leading dementia researchers in Canada. He has been recruited as a full professor with a clinician scientist job description and started at Baycrest in September 2018. With his move to Baycrest, Baycrest will become the Research Network Centre of the CCNA. Dr. Chertkow holds a Chair in Cognitive Neurology and Innovation at Baycrest, is the Director of Baycrest’s new Kimel Family Centre for Brain Health and

Wellness, and is a Senior Scientist at Baycrest’s Rotman Research Institute.

### Governance and Leadership

The Chief of the Department of Medicine, Gary Naglie, is also the Vice President (VP) of Medical Services. The VP Medical Services reports to the President and Chief Executive Officer who, in turn, reports to the Board. (See Department of Medicine organizational chart.) The Head of the Baycrest Division of Neurology, Morris Freedman, reports to the Chief of the Department of Medicine. The Chief of the Baycrest Department of Medicine is also the Head of the Division of Geriatric Medicine.



Members of the Department of Medicine play a key role in leadership positions at Baycrest. Gary Naglie, the Head of our Division of Geriatric Medicine in the Department of Medicine, is also the VP of Medical Services and is the Co-Chair of the Clinical Leadership Strategy Forum and the Chair of the Medical Advisory Committee. The Chief of the Department of Medicine is a member of Baycrest’s Executive Leadership Team and the Leadership Advisory Forum. Michael Gordon, geriatrician, is the



Co-Director of Ethics at Baycrest. Shelley Veinish, geriatrician, is the Medical Director of Specialized Geriatric Care. Thiru Yogaparan, geriatrician, is the Executive Medical Director of the Baycrest Hospital. Morris Freedman, Head of the Division of Neurology, is the Medical Director of Cognition and Behaviour.

Members of our Department of Medicine also play significant leadership roles at U of T. The Chief of Medicine is a member of U of T's DoM Executive Committee. He is also a member of the Division of Geriatric Medicine's Executive Committee and Residency Program Committee, and he is the Chair of the Research Committee. Thiru Yogaparan is U of T's FoM lead for the Care of the Elderly/Geriatrics undergraduate education. Thiru Yogaparan is also the University's Division of Geriatric Medicine postgraduate and undergraduate education representative for the Baycrest Hospital site and is a member of the Division of Geriatric Medicine's Residency Program Committee. Terumi Izukawa is the Site Coordinator for the Baycrest/U of T Geriatric Medicine Fellowship. She is Co-Lead for the Royal College's Competence by Design implementation for the Division. Morris Freedman serves as the Director of the Behavioural Neurology section and is a member of the Research Committee of the University's Division of Neurology. He is also the University's Division of Neurology continuing education representative.

## Practice Plan Overview

The Department of Medicine practice plan was instituted to support the academic and clinical goals of its members. When the Alternate Funding Plan (AFP) was formulated, all the academic practice plans, including Baycrest's, were reviewed, and the structure of Baycrest's practice plan was found to meet U of T standards. Membership in the practice plan is limited to those members of the Department who have a full-time academic appointment in the DoM at U of T and are on Baycrest's active medical staff. Practice plan funds are committed to support research and education (e.g., supporting junior staff to protect time for scholarly pursuits; augmenting research awards; and providing travel funds to support medical students, residents, fellows and staff who attend and present at academic conferences). In addition, the practice plan receives Ontario Ministry of Health and Long-Term Care (MOHLTC) AFP funding to support academic work as an agent and distributes these funds to the members as a monthly stipend. The apportioning of

these allocated funds to individual members of the practice plan is determined by a point system for participation in research, education and creative professional activities.

## Department of Medicine Strategic Directions

The institutional strategic plan has recently been finalized, so the process for refreshing the Department of Medicine's strategic directions will commence shortly. The Department of Medicine has five strategic goals:

1. to provide high quality effective clinical care to our patients;
2. to strengthen and promote opportunities for research activities;
3. to strengthen and promote opportunities for creative professional activities;
4. to educate in the realm of care for the elderly; and
5. to strengthen and build the capacity of the Department of Medicine within Baycrest and the community.

Moving forward, the Department of Medicine would like to provide leadership in several key areas: increasing the institutional integration of clinical care, education, research and innovation; innovating the educational experience for medical-student and resident electives and rotations in geriatric medicine; developing and evaluating new, innovative and scalable models of care for frail, complex older adults living in their own homes, supportive housing or long-term care; embracing technology to improve efficiencies of care and patient/family-centredness, including evaluating new roles for Telemedicine; prioritizing the

focus on quality care and patient safety with repeated PDSA (plan–do–study–act) cycles for continuous quality improvement; creating an environment that routinely makes use of process and outcomes data along with best evidence to influence clinical practice; developing a novel curriculum for physician practice in the nursing home based on best evidence and creating metrics for monitoring the quality of nursing home medical care; and developing closer ties with the Departments of Family and Community Medicine and Psychiatry to identify synergies for improving the care, education and research pertaining to older adults with complex medical and psychosocial issues.

## Innovations and Major Accomplishments

In the past five years, members of the Baycrest Department of Medicine have been funded as principal investigators, co-principal investigators or site principal investigators

- for numerous research studies by several peer-reviewed funding organizations totalling over \$32 million; and
- for 12 innovation projects funded by the MOHLTC’s AFP Innovation Fund totalling \$410,331.

We have published or have in press 42 peer-reviewed publications by a principal or senior author and 74 by co-authors. Our authors have also written two books and contributed to seven book chapters. (See table.)

## Peer-Reviewed Funding

	Funding Agency	Amount Funded
<b>PI or CO-PI</b>	Canadian Institutes for Health Research (CIHR)	\$ 2,623,140
	Canadian Centre for Aging Brain Health Innovation (CABHI)	\$ 450,000
	Ontario Brain Institute (site PI)	\$ 28,500,000
	MOHLTC (CO-PI)	\$ 274,862
	Council of Academic Hospitals of Ontario (CAHO) (site PI)	\$ 552,528
	Canadian Cancer Society (site PI)	\$ 192,240
	Allergan Pharmaceutical Inc.	\$ 100,000
	Post-Grad Innovation Fund, Department of Medicine, U of T (site PI)	\$ 5,000
	<b>Co-I</b>	Canadian Institutes for Health Research (CIHR)
Westin Brain Institute		\$ 170,010
Brain Canada		\$ 2,999,950
Alzheimer's Society of Canada		\$ 150,000
Weston Brain Institute		\$ 1,499,998
Parkinson's Society of Canada		\$ 90,000
Heart & Stroke Foundation Canada		\$ 114,684
Retired Teachers of Ontario		\$ 25,000
The Alzheimer's Association		\$ 98,707
The Drumond Foundation		\$ 145,000
Ontario Stroke Network		\$ 99,750
Ontario Ministry of Transportation		\$ 50,000
Baycrest Department of Psychiatry		\$ 15,000
<b>Collaborator</b>	Canadian Institutes for Health Research (CIHR)	\$ 171,464
	Canadian Centre for Aging Brain Health Innovation (CABHI)	\$ 1,197,912
<b>Totals</b>		<b>\$ 47,243,426</b>

## Ministry of Health and Long-Term Care Alternate Funding Program Innovation Funding

Year	Project Lead	Title/Project	Year	Amount Funded
2017–18	Gary Naglie	An Innovative Intervention Framework and Toolkit to Ease the Decision-Making and Transition to Non-Driving for Persons with Dementia and Their Caregivers: Translating Knowledge to Action	1	\$25,000
2015–16	Terumi Izukawa	Motivation to Ambulate Using Pedometers and Partnered Education in Dementia (MAPPED) Years 1 & 2	1-2	\$50,000
2015–16	Thiru Yogaparan	Geriatrics Hub	1	\$25,000
2015–16	Gary Naglie	Implementation of the Activity Measure—Post Acute Care Assessment Tool in Geriatric Rehabilitation Units	1	\$25,000
2014–15	Gary Naglie, Sid Feldman	A Mixed-Methods Formative Evaluation of the Integrated Community Care Team (ICCT)	1-2	\$50,000
2014–15	Galit Kleiner-Fisman	The “PD Portfolio”: Creation of Comprehensive Educational Resources for People with Parkinsonism in Ontario	1	\$25,000
2013–14	Morris Freedman	Comprehensive Care Transition: Randomized Control Trial (Dementia)	1	\$22,831
2013–14	Gary Naglie	Evaluating Baycrest’s Capacity Building... INTERACT Years 1 & 2	1-2	\$50,000
2013–14	Galit Kleiner-Fisman	Standard Treatment Algorithms Against Non-Dopaminergic Symptoms of Parkinson’s Disease: STAANDS-PD	1	\$25,000
2012–13	Terumi Izukawa Thiru Yogaparan	Evaluating the Impact of a Knowledge Translation Intervention on the Use of Neuroleptics in the CCC Setting: An Interrupted Time Series Study	1	\$20,000
2011–13	Galit Kleiner-Fisman	Development of an Innovative, Educational and Therapeutic Program Model for PD	1-2	\$45,000
2011–13	Gary Naglie	Program Evaluation to Facilitate Innovation through Program Replication	1-2	\$47,500
<b>Total Amount of Innovation Funds to Baycrest Department of Medicine</b>				<b>\$410,331</b>

Gary Naglie, the Chief of Medicine, has had a major role in leading the innovation of a new integrated model of care for frail, complex older adults living in the community. He is also a Co-Lead of the Driving and Dementia Team of the CCNA, which is funded by CIHR. Morris Freedman, the Head of Neurology, is an affiliate member of the Toronto Dementia Research Alliance, as well as the co-recipient of a grant from Brain Canada that will launch Canada’s first cross-institutional memory clinic.

In the past five years, we have made important teaching contributions. Our geriatricians have trained 46 geriatric medicine subspecialty residents, 171 family medicine residents, two family medicine fellows and 60 elective medical students. We have also taught the Geriatrics block of the Art and Science of Clinical Medicine to 113 medical students.

No. of Publications	Principal/Senior Author		Co-Author	
	Published	In Press	Published	In Press
Peer Reviewed Articles	41	1	65	9
Books	2			
Chapters	5		1	1
Non-Peer Reviewed	27		1	

Program	Medical Residents (PGYs)	Medical Fellows	Medical Students	Total
Geriatric Medicine	46	0	30	76
Family Medicine	171	2	10	183
Medical Clerkship	-	-	113	113
Neurology	16	6	20	42
Psychiatry	57	-		57
<b>Total</b>	<b>290</b>	<b>8</b>	<b>173</b>	<b>471</b>

Over the past five years, our neurologists have trained 16 neurology residents and six behaviour neurology fellows, as well as 57 psychiatry subspecialty residents and numerous family medicine residents and medical students.

One of our geriatricians, Thiru Yogaparan, has made and continues to make substantial contributions to revisions of the geriatric medicine undergraduate education curriculum in her role as U of T's FoM lead for the Care of the Elderly/Geriatrics undergraduate education. Terumi Izukawa was awarded the Baycrest Annual Teaching Award for Outstanding Medical Education in 2016.

Since 2010, Baycrest has hosted bimonthly Geriatric Medicine Rounds that are shared by video conference across Ontario and nationally.

Since 2005 our Chief of Neurology, Morris Freedman, has led an initiative to sponsor monthly International Video Conference Behavioural Neurology Rounds. American, Argentinean, Brazilian, Canadian, Chilean, Cuban, Israeli, Jordanian, Palestinian, Russian, South African, Spanish and Swiss hospitals have participated. These rounds link countries across the world in an academic activity under the auspices of the Peter A. Silverman Global e-Health Program, the Canada International Scientific Exchange Program (CISEPO) and the Canadian Neurological Sciences Federation. He also facilitates the weekly Behavioural Neurology Rounds that are shared by video conference through the Ontario Telehealth Network.

In 2017, the Chief of the Department of Medicine, Gary Naglie, completed a five-year term as the holder of the University of Toronto's George, Margaret and Gary Hunt Family Chair in Geriatric Medicine. After a review, the chair was renewed for another five-year term.





# ST. MICHAEL'S HOSPITAL

Prepared by **Dr. Sharon Straus, Physician-in-Chief (Acting),**  
St. Michael's Hospital

## Overview

St. Michael's Hospital (SMH) is a Catholic teaching and research hospital founded by the Sisters of St. Joseph in 1892 to care for the sick and poor of Toronto's inner city. St. Michael's is renowned for providing exceptional patient care. As downtown Toronto's adult trauma centre, the Hospital is a hub for neurosurgery, complex cardiac and cardiovascular care, diabetes and osteoporosis care, minimally invasive surgery, and care of the homeless and disadvantaged. St. Michael's is also one of the province's major sites of care for critically ill patients.

Fully affiliated with the University of Toronto (U of T), St. Michael's provides outstanding medical education to health-care professionals in 29 academic disciplines. Home to the Li Ka Shing Knowledge Institute, made up of the Keenan Research Centre and the Li Ka Shing International Healthcare Education Centre, the Hospital is among the first in the world to bring

together researchers, educators and clinicians to take best practices and research discoveries to patients faster. The Hospital's total revenue for 2017–18 was \$685.9 million. It provides 460 acute adult inpatient beds and has 77,152 emergency visits annually.

SMH with Providence Healthcare and St. Joseph's Health Centre now operate under one corporate entity as of August 1, 2017. United, the three organizations serve patients, residents and clients across the full spectrum of care while investing in world-class research and education. Their services span primary care, secondary community care, tertiary and quaternary care services, post-acute through rehabilitation, palliative care and long-term care.

## Overview of the SMH Department of Medicine

Interim PIC Dr. Sharon Straus chairs the departmental Executive Committee, which also includes the following members.

### Division Heads

<i>Allergy and Immunology</i>	Dr. Peter Vadas
<i>Cardiology</i>	Dr. Howard Leong-Poi
<i>Dermatology</i>	Dr. Paul Adam
<i>Endocrinology</i>	Dr. Richard Gilbert
<i>Gastroenterology</i>	Dr. Gary May
<i>General Internal Medicine</i>	Dr. Rob Sargeant
<i>Geriatrics</i>	Dr. Marisa Zorzitto
<i>Hematology/Oncology</i>	Dr. Christine Brezden-Masley
<i>Infectious Diseases</i>	Dr. Kevin Gough
<i>Nephrology</i>	Dr. Jeff Zaltzman
<i>Neurology</i>	Dr. Dan Selchen; Dr. Gyl Midroni is interim Division Head, effective July 1, 2018
<i>Occupational Medicine</i>	Dr. Linn Holness
<i>Respirology</i>	Dr. Liz Tullis
<i>Rheumatology</i>	Dr. Louise Perlin
<i>Critical Care</i>	Dr. Jan Friedrich
<i>Postgraduate Education Program Director</i>	Dr. Natalie Wong
<i>St. Michael's Hospital Physician Association (SMPA) (Practice Plan) Chair</i>	Dr. Juan Carlos Monge

## Education

Postgraduate Education Program Director Dr. Natalie Wong chairs the departmental Education Committee that also includes divisional education directors.

<i>Allergy/Clinical Immunology</i>	Dr. Christine Song
<i>Cardiology</i>	
<i>Undergraduate</i>	Dr. Victoria Korley
<i>Postgraduate (Cardio)</i>	Dr. Jeremy Edwards
<i>Postgraduate (CCU)</i>	Dr. Neil Fam
<i>Dermatology</i>	Dr. Paul Adam
<i>Endocrinology</i>	Dr. Maria Wolfs
<i>Gastroenterology</i>	
<i>Undergraduate</i>	Dr. Gary May
<i>Postgraduate</i>	Dr. Samir Grover
<i>General Internal Medicine</i>	Dr. Rob Sargeant
<i>Geriatrics</i>	Dr. Marisa Zorzitto
<i>Hematology</i>	Dr. Tina Trinkaus
<i>Infectious Diseases</i>	Dr. Kevin Gough
<i>Nephrology</i>	
<i>Undergraduate</i>	Dr. Martin Schreiber
<i>Postgraduate</i>	Dr. Jordan Weinstein / Dr. Martin Schreiber (ITERs)
<i>Neurology</i>	Dr. David Chan
<i>Occupational Medicine</i>	Dr. Aaron Thompson
<i>Oncology</i>	Dr. Ronita Lee
<i>Respirology</i>	Dr. Anju Anand
<i>Rheumatology</i>	Dr. Louise Perlin
<i>Critical Care</i>	Dr. David Hall
<i>General Internal Medicine Program Director</i>	Dr. Ophyr Mourad
<i>General Internal Medicine Ward Chief</i>	Dr. Yuna Lee

### Undergraduate Education at St. Michael's Hospital

<i>FitzGerald Academy Director</i>	Dr. Molly Zirkle
<i>Clinical Skills 1</i>	Dr. Bruce McGoveran
<i>Clinical Skills 2</i>	Dr. Jonathan Ailon
<i>Clerkship Co-Directors</i>	Dr. Reena Pattani and Dr. Vera Dounaevskaia

## Research

SMH's Department of Medicine consists of approximately 160 full-time clinicians and scientists and another 110 part-time physicians and clinical associates. All full-time physicians hold faculty appointments in the U of T DoM, as do the majority of part-time physicians. All full-time members receive academic base support, which depends on their job descriptions, to compensate for the time spent on non-remunerative activities such as teaching and research. Base support is funded by the SMPA through a tithe on all partners' net income.

## Overview of the St. Michael's Hospital Physicians Association

The SMPA, the Department's practice plan, changed to a cost-sharing association in 2018 called the SMPA Admin Agent Inc. All full-time active members of SMH's Department of Medicine must be associates of the SMPA, which handles the revenues and expenses of the Department's members. The practice plan is a fair and transparent cost-sharing association in which all associates are treated equitably. The cost-sharing agreement requires that all revenue received from the practice of medicine be included. Almost all such income arises from billings to the Ministry of Health and Long-Term Care (MOHLTC), but the definition includes alternative funding plans and non-MOHLTC sources such as institutional salaries or stipends from the hospital, the research institute, the University or granting agencies.

Clinical practice revenue is the major source of income for the cost-sharing association, comprising about 67 per cent of all revenue. Funding from U of T comprises approximately 2.6 per cent of total revenues; 10.4 per cent comes from other external and internal sources; 3.3 per cent comes from personal support grants; 3.2 per cent comes from the Hospital and the research institute; and 13.5 per cent comes from the alternate funding plan.

The SMPA is governed by an elected board of directors, who in turn elect a chair, vice chair and deputy vice chair. These offices are held for two-year terms. The PIC is an ex officio non-voting member. The SMPA provides support for the academic activities of Department of Medicine members:

- Approximately \$6.75 million of total practice plan revenue funds academic base support.
- 60 per cent of academic base support supports clinician scientists and investigators; 40 per cent supports clinician educators and teachers.
- Individual ranges of academic base support by job description are as follows:
  - » clinician teacher (CT): \$20 thousand to \$55 thousand
  - » clinician educator (CE): \$35 thousand - \$55 thousand
  - » clinician investigator (CI): \$40 thousand - \$75 thousand
  - » clinician in quality and innovation (CQI): \$30 thousand - \$65 thousand
  - » clinician scientist (CS): \$40 thousand - \$104 thousand
- \$400 thousand is provided for stipends for specific academic roles.
- \$200 thousand is provided in short-term research operating support.

## Faculty 2012–2017

Between April 1, 2012 and March 30, 2017, St. Michael's Hospital had 201 faculty members with a primary appointment at the U of T Department of Medicine (DoM). An additional 12 faculty members were cross-appointed with other U of T departments.

168 of these faculty members had full-time appointments. Three faculty had part-time appointments, 27 were adjunct, and 5 were PhD researchers.

Among full-time faculty, the distribution according to academic position description was well distributed.

- Clinician Administrator . . . . . 8
- Clinician Educator . . . . . 13
- Clinician Investigator . . . . . 29
- Clinician Scientist . . . . . 40
- Clinician Teacher . . . . . 69
- Clinician in Quality & Innovation . . . . . 9

## Strategic Plan: *Innovation for a New Era*

Since developing our strategic plan for 2011–16, *Innovation for a New Era*, we have achieved significant progress across three strategic areas. (See executive summary and plan, attached.)

## 1. Clinical Care

- Development of the General Internal Medicine (GIM) RAPID Assessment Clinic to enhance patient flow from the Emergency Department and avoid hospital admission
- Initiation of geriatric medicine consultation and teaching clinics within Family Practice Unit/Family Health Team, as well as modifying the Acute Care of the Elderly Unit
- Promotion of Quality programs across the Department including focus on Choosing Wisely campaigns, reflected in the increasing number of Quality presentations at our annual Higgins Day
- Participation in the city-wide approach to restructuring GIM Clinical Teaching Units (CTUs)

## 2. Education

- An Education Committee led by Dr. Natalie Wong
- Availability of outpatient experiences for trainees across all departmental programs
- Financial support provided for formal training in education to enhance educational scholarship
- Participation in the city-wide restructuring of the resident night and weekend on-call system
- Informal networking events for women residents and faculty to enhance diversity in academic medicine and optimize mentorship opportunities
- Support provided for faculty and trainees to attend the First Summit for Women in Academic Medicine in 2017

## 3. Research

- Research recruitment to areas of clinical strength have included clinician scientists and investigators to programs in GIM
- Leadership in development of General Medicine Inpatient Initiative (GEMINI) to provide data that will be used to optimize patient care

A departmental online community was developed at [www.smhdom.com](http://www.smhdom.com). This now serves as a resource for trainee scheduling and rotation information. It also provides information about departmental activities and the minutes of departmental meetings. A departmental e-newsletter has also been created; it publishes Hospital and University news and events and celebrates departmental members.

## Analysis of Strengths, Challenges, Opportunities and Threats

### Strengths

- Department is viewed as being collegial and supportive with a strong tradition of mentorship
- People feel valued and are loyal to the institution and Department
- High-quality clinical care is delivered and recognized across the Hospital
- Recruitment that has grown and enhanced the research and quality improvement expertise; the need to enhance recruitment in educational scholarship has been recognized
- Excellent track record in teaching, mentorship and research

### Challenges

- Rollout of Competence by Design with few resources to optimize its implementation
- Increasing patient volumes and complexity without additional resources
- Increasing competition for peer-reviewed grants; limited salary support for clinician scientists
- Modest support from the University for various administrative initiatives including undergraduate, postgraduate activities
- Need to increase faculty diversity

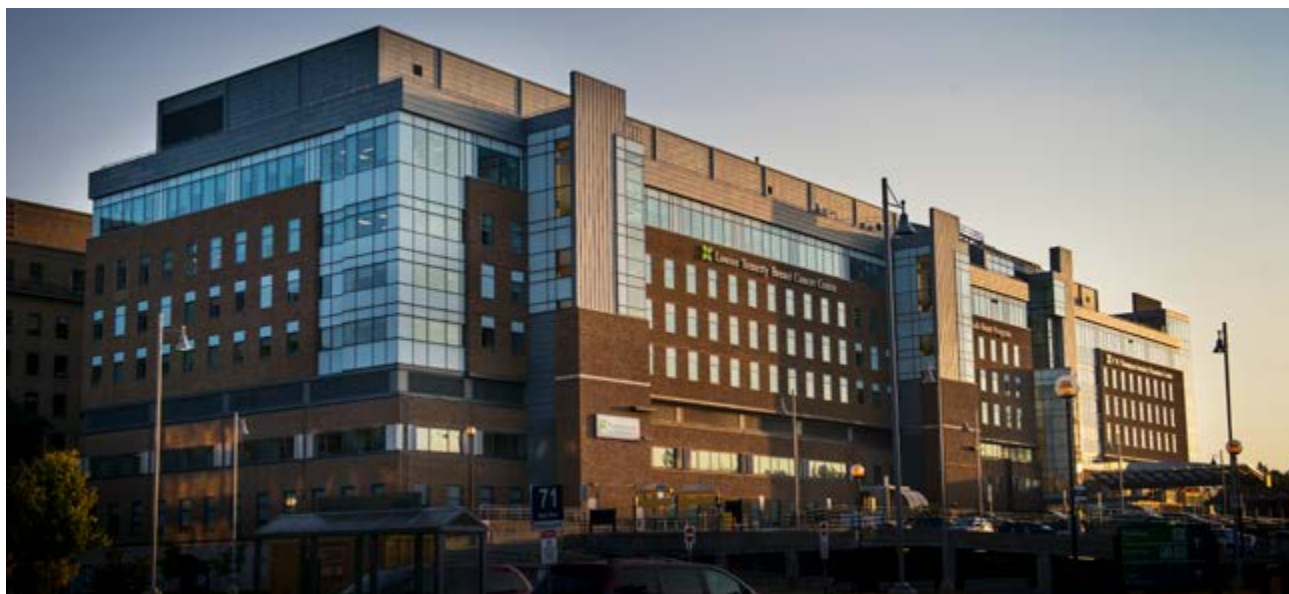
### Opportunities

- Ability to develop partnerships across SMH (e.g., Family and Community Medicine, Critical Care), the network, the University DoM and affiliated academic hospitals to enhance clinical care, research and education
- Recruitment of individuals focused on educational scholarship and quality improvement

### Threats

- Resident shortages, which are anticipated to continue
- Increased clinical and educational demands on faculty could affect retention and physician wellness
- Recruitment in some areas depends on successful career transition of senior members





# SUNNYBROOK HEALTH SCIENCES CENTRE

Prepared by Dr. Kevin Imrie, Physician-in-Chief,  
Sunnybrook Health Sciences Centre

## Overview

Sunnybrook Health Sciences Centre is a member of the Toronto Academic Health Sciences Network (TAHSN) and a core teaching site for the Department of Medicine (DoM) at the University of Toronto (U of T). The Hospital has three principal sites—Bayview Campus, Holland Orthopaedic and Arthritic Centre and St. John’s Rehab—as well as an ambulatory dialysis satellite at the Canadian National Institute for the Blind at 1929 Bayview Avenue.

Sunnybrook is a 1,325-bed tertiary care centre with 627 acute care beds currently in service. The Hospital spends about \$900 million to run its operations and conducts more than \$100 million in research. Sunnybrook activities are shaped by its mission to care for patients and families “when it matters most.” And it does this job by focusing its educational, research and clinical activities in five strategic priority areas: cancer, heart and vascular, high-risk maternal and newborn health, trauma, and image-guided brain therapies. Our clinical and academic programs are organized in eight programs: Brain Sciences, Holland Musculoskeletal, Odette Cancer, Schulich Heart, St. John’s Rehab, Trauma Emergency and Critical Care (TECC), Veterans and Community, and Women and Babies. The programs are multidisciplinary and multi-professional in nature. The DoM plays a major role in all programs but Holland and TECC. A new realignment of the programmatic structure is underway to promote integrated and innovative care with our local partners in our corridor of care.

Sunnybrook is well along in the development of its strategic plan for 2018–21. The strategic directions, as ratified by the board in May 2018, are the following:

- personalized and precise treatments,
- integrated and sustainable models of care,
- quality and creating a better care experience, and
- high-performing teams.

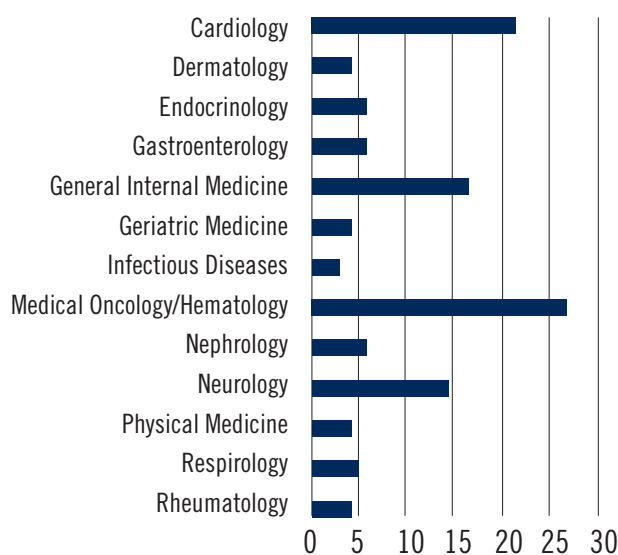
## Sunnybrook Department of Medicine

The Sunnybrook Department of Medicine has all of the divisions and services that you would expect of a tertiary care academic science centre. Although Emergency Medicine and Critical Care Medicine, which are divisions within the University DoM, are separate departments at Sunnybrook, we maintain a close collegial relationship with these departments and interact in a supporting role with them in University processes such as the Continuing Faculty Appointment Review (CFAR) and promotion.

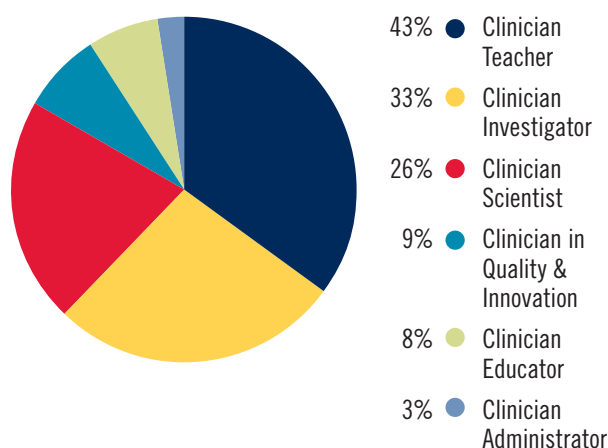
### Faculty

Our Department has grown over the last five years. Our total full-time staff in 2012 was 103. We have recruited 35 new members of staff since that time. As of April 30, 2018, we now have 122 full-time members (an 18 per cent increase) in the Department along with more than 200 part-time members. The charts below and at right summarize staff by division, rank and job description. *The Clinical Pharmacology and Obstetrical Medicine Divisions are not included, as members in both divisions are cross-appointed from one of the other 13 divisions.*

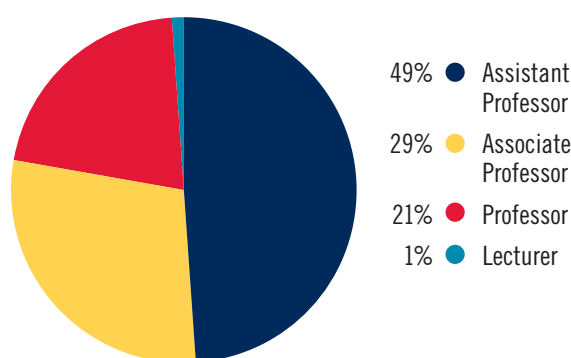
**Figure 9.1: Full-Time Faculty by Division as of April 30, 2018**



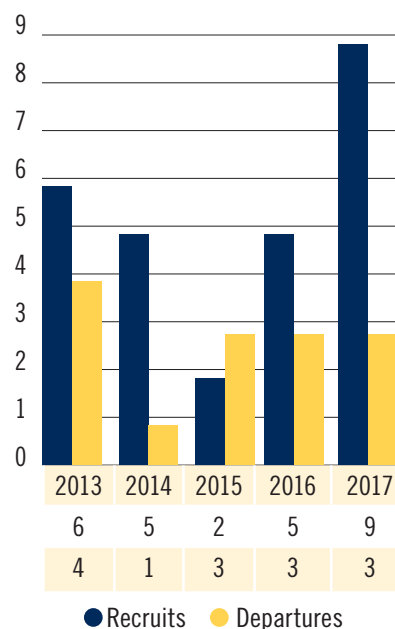
**Figure 9.2: Full-Time Faculty by Job Description as of April 30, 2018**



**Figure 9.3: Full-Time Faculty by Rank as of April 30, 2018**



**Figure 9.4: Recruitment and Departures: 2013–2017 Calendar Year**



## Department Governance

The Department has a well-developed organizational structure. I am ably assisted by Dr. Steven Shadowitz, the Deputy Physician-in-Chief, who has primary oversight for clinical care and operations. Each division is led by a division head. (See below.) The heads, along with the chairs of our four standing committees (Education, Research, Finance, and Faculty Well-Being), form the Department’s Executive Committee. The Executive Committee meets monthly and advises me on all major clinical and academic policies. The Department’s full-time members are members in one of our two practice plans. (See below.) Each committee now has formal and updated terms of reference to guide their activities, and each lead has a written position description.

### Leadership

- Dr. Kevin Imrie: Physician-in Chief
- Dr. Steven Shadowitz: Deputy Physician-in-Chief

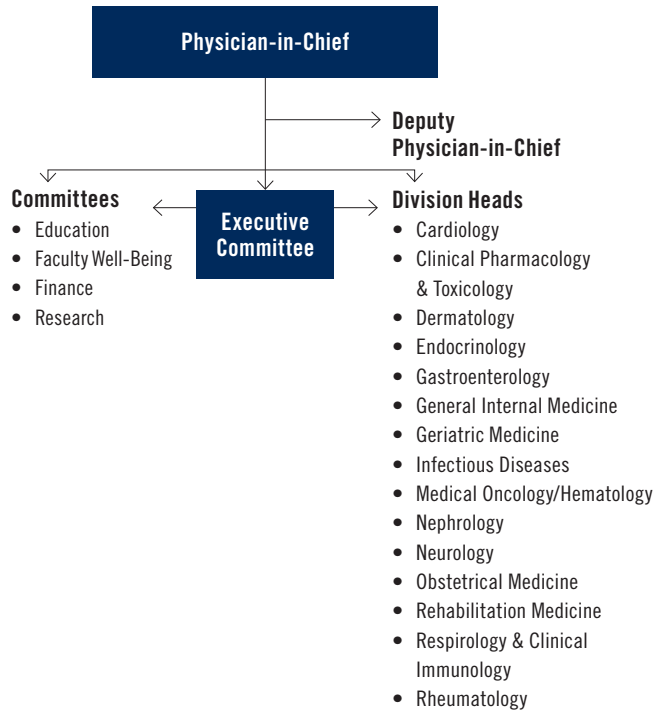
### Division Heads

- Dr. Bradley Strauss: Cardiology
- Dr. David Juurlink: Clinical Pharmacology and Toxicology
- Dr. Neil Shear: Dermatology
- Dr. Baiju Shah: Endocrinology
- Dr. Elaine Yong: Gastroenterology
- Dr. Steven Shadowitz: General Internal Medicine
- Dr. Rajin Mehta: Geriatric Medicine
- Dr. Nick Daneman: Infectious Diseases
- Dr. Helen McKay: Medical Oncology/Hematology
- Dr. Michelle Hladunewich: Nephrology and Obstetrical Medicine
- Dr. Lawrence Robinson: Rehabilitation Medicine
- Dr. Anu Tandon: Respiriology and Clinical Immunology
- Dr. Greg Choy: Rheumatology

### Committee Chairs

- Dr. Gemini Tanna: Education
- Drs. Ivy Fettes and Liesly Lee (Co-chairs): Faculty Well-Being
- Dr. Matthew Oliver/Dr. Georg Bjarnason: Finance
- Dr. Robert Fowler: Research

## Governance Chart



## Strategic Planning

The DoM updated our strategic plan—*Intensifying Our Focus*—in 2015. In May 2018, the hospital board endorsed a new hospital-wide strategic plan *Planning Our Future Together*. We are reviewing the Department’s plan to ensure complete alignment.

The DoM strategic plan has four clearly defined strategic priority areas: quality clinical care, research, education, and sustainability and accountability.



Each area has short-term goals that provide a roadmap to guide our activities for the upcoming academic years. The following chart highlights the progress that has been made over the last two years. We are finalizing our goals and action plans to guide us through the next two years of the plan.

## Tracking Our Year 1 Progress

1. Quality Clinical Care			
Priorities	Short-term Goals (Years 1+2)	Progress	
1.1 Continue implementing innovative inpatient and ambulatory models of acute care to improve access, quality and efficient use of hospital resources.	a. Deploy Gastroenterology, Respirology and Outpatient Parenteral Antibiotic Therapy (OPAT) rapid referral clinics.	Achieved	
	b. Develop and implement division-specific coordinated patient triage and referral management.	In progress	
	1.2 Improve alignment with Sunnybrook's strategic priorities and programs.	c. Ensure all divisions implement processes that support timely access to primary and secondary care for patients in Sunnybrook's catchment area.	In progress
		d. Explore innovative ways of providing primary and secondary care, including eConsultation, and visiting (sessional) care to family health teams.	Achieved
	1.3 Increase collaborations with other Sunnybrook departments.	e. Ensure all divisions make outpatient notes accessible in Sunnycare.	Achieved
		f. Identify and implement collaborative initiatives with Anesthesia, Surgery and other Sunnybrook departments.	In progress

2. Research			
Priorities	Short-term Goals (Years 1+2)	Progress	
2.1 Continue to improve support for clinical researchers within the DoM.	a. Increase the maximum support for researchers in the Department through the partnership and other sources.	Achieved	
	2.2 Continue to strategically recruit clinician scientists and investigators who focus on (i) health services research; (ii) quality and patient safety; (iii) educational research and scholarship; and (iv) specific academic foci within clinical programs.	b. Establish an endowed chair for the DoM PIC to support research in the Department.	Achieved
		c. Partner with the Sunnybrook Foundation to support additional research chairs and/or professorships for clinician scientists.	In progress
		d. Explore opportunities for commercial ventures and inventions.	In progress
2.3 Continue to strengthen the relationship of the DoM to Sunnybrook Research Institute in support of mutual priorities.			
2.4 Promote commercialization of innovations.			



3. Education		
Priorities	Short-term Goals (Years 1+2)	Progress
3.1 Improve the experience of our learners.  3.2 Advance educational leadership, research and scholarship.  3.3 Lead in the teaching of quality and patient safety.	a. Increase support for clinician teachers and educators through the partnership and other sources.	Achieved
	b. Nominate at least four DoM members for external awards each year.	Achieved
	c. Increase the volume of education research and scholarship grants, presentations and publications by 25%.	Achieved
	d. Continue to grow education in quality and safety in partnership with the U of T DoM.	Achieved
	e. Create departmental education rounds to promote interaction and collaboration among teachers and educators.	Achieved
	f. Partner with Sunnybrook to improve physical infrastructure for teaching within the Department.	Achieved
	g. Improve the education presence on the DoM website.	In progress

4. Sustainability and Accountability		
Priorities	Short-term Goals (Years 1+2)	Progress
4.1 Continue to evolve and strengthen the financial management model.  4.2 Continue to evolve and strengthen the DoM recruitment plan.  4.3 Continue to improve faculty workplace satisfaction.  4.4 Develop performance metrics for clinical care, research and education.	Sustainability	
	a. Develop and implement a global budgeting model for the academic budgets.	Achieved
	b. Advocate for financial support for DoM administrative roles and those with oversight for hospital resources.	Achieved
	c. Develop a budget to support work in quality and patient safety.	Achieved
	d. Develop and implement at least two new/enhanced initiatives per year to support faculty development, workplace satisfaction and wellness.	Achieved
	Accountability	
	e. Continue to develop and report one measure of access and one measure of outcome for each division.	Achieved
	f. Improve the system of measuring and reporting productivity for clinician teachers and educators.	Achieved
	g. Implement a rigorous annual review process for all part-time faculty.	Achieved
	h. Improve physician hand-hygiene compliance to >90% and maintain gains.	Achieved
	i. Develop and implement individual physician reports that include length of stay and eDischarge completion rate.	Achieved
	j. Incorporate multisource feedback into annual activity reporting.	Achieved

## Clinical Services

The Sunnybrook DoM has unique clinical services including Thromboembolism, the Division of Obstetrical Medicine, Clinical Pharmacology and Medical Dermatology. Clinically, our efforts continue to focus on growing our specialized activity while providing excellent general specialty support for our local community. We continue to focus on expanding our QUICK rapid-referral clinics. This initiative, which began in General Internal Medicine, has expanded to Neurology, Cardiology, Endocrinology, Gastroenterology and Infectious Diseases. In keeping with Sunnybrook's strategic plan, we continue to focus on increasing our specialized tertiary and quaternary services to be a regional and provincial resource while we focus our primary and secondary care activities on our local community. To accomplish this dual role, we are expanding our partnerships with our Academic Health Science Centres and community partner institutions.

Departmental initiatives have aligned with the integrated and sustainable models of care direction that the Hospital espouses. The push over the last year has been to provide timely discharge summaries and, more recently, to ensure medication reconciliation on admission, transfer and discharge from the hospital to facilitate the integration of care with our primary care colleagues. We have been successful: 90 per cent of our patients have discharge summaries completed within 48 hours, and more than 85 per cent have medication reconciliation (MedRec) performed on admission.

## Research

The Department's clinician investigators and scientists have a strong focus on our three crosscutting themes: health services research, quality and patient safety, and educational research and scholarship. Our scientists support hundreds of trainees' research activities at all levels from high school, undergraduate, medical school, graduate to postdoctoral.

Although our researchers operate in a climate of reduced national and international research funding and support, they have continued to perform at the highest levels of research scholarship over the years. In fact, this past year our principal investigators received over \$45 million in research funding, and members authored over 650 peer-reviewed publications and filed six patents.

Over the last year as well, members received more than 100 individual research-related awards. They include the following individuals:

- **Robert Fowler** (Royal College of Physicians and Surgeons of Canada Teasdale-Corti Humanitarian Award, American Thoracic Society Mid-Career Achievement Award),
- **Andrea Gershon** (American Thoracic Society Elizabeth A. Rich Award, Canadian Institutes of Health Research Emerging Research Leaders Initiative Award and the Gold Leaf Prize for Outstanding Achievements by an Early Career Investigator),
- **Michelle Hladunewich** (Cancer Care Ontario and the Ontario Renal Network Human Touch Award),
- **Don Redelmeier** (Canadian Medical Association Bruce Squires Award of Excellence),
- **Harindra Wijeyesundera** (Cardiovascular Research Technologies Young Leadership Award),
- **Brian Courtney** and **Idan Roifman** (Heart and Stroke Foundation Richard Lewar Centre of Excellence Research Awards),
- **David Juurlink** (Dalhousie Medical Alumni Association Alumnus of the Year),
- **Larry Robinson** (Lifetime Achievement Award from the American Association of Neuromuscular and Electrodiagnostic Medicine),
- **Adrienne Chan** (U of T Postgraduate Medical Education Social Responsibility Award) and
- **Brad Strauss** (China Innovation in Cardiology Best Clinical Application Award).

Many members of the Department also received external salary support for their research success. They include the following individuals:

- Canada Research Chair holders **Jack Tu** and **Don Redelmeier**;
- **Nick Daneman**, CIHR Phase II Clinician Scientist;
- **Ayelet Kuper**, **Andrew Lim**, CIHR New Investigators;
- **David Gladstone**, Heart and Stroke Foundation of Canada Mid-Career Investigator Award;
- **Jill Tinmouth**, a CIHR Embedded Scientist Award;
- **Dennis Ko**, **Harindra Wijeyesundera**, **Rick Swartz** and **Rob Fowler**, Heart and Stroke Foundation Career Scientist Awards;
- **Sandra Black**, the Deborah Ivy Christiani Brill Chair in Neurology;

- **Lawrence Robinson**, John and Sally Eaton Chair in Rehabilitation Science;
- **Andrea Gershon**, Physicians' Services Incorporated Translational Fellowship Award and a CIHR New Investigator Award;
- **Sheldon Tobe**, Heart and Stroke Foundation and Northern Ontario School of Medicine Chair; and
- **Michelle Hladunewich**, U.S. National Institutes of Health and Patient-Centered Outcomes Research Institute.

## Education

The Department of Medicine at Sunnybrook continues to have outstanding successes in our medical education mission and have shown excellence in both education scholarship/research and excellence in academic teaching activities.

**Education Scholarship and Research.** We continue to be a primary centre and recognized leader in education scholarship and medical education research at local, national as well as international levels. Several of our Department of Medicine members are principal or co-investigators in several grants, including external (RCPSC Medical Education Research grants/ABIM Foundation/Medical Council of Canada) and internal grants [GIM Research Awards/Sunnybrook Education Advisory Committee (SEAC)/Alternate Funding Plan (AFP)]. In the last academic year, members of our Department have had more than 14 publications (seven as first author and seven as senior author) in high-impact medical education journals such as *Academic Medicine* and *Medical Education*. As well, Sunnybrook medical educators and clinician teachers have had many oral presentations and abstract presentations at major forums for medical education research. Finally, we held our eighth Annual Education Symposium on September 28, 2017. The topic was Mentorship in Medical Education; Drs. Sharon Straus, Ed Etchells and Umberin Najeeb facilitated excellent sessions.

**Teaching.** We are especially proud of our clinician teachers. The changes in the Faculty of Medicine's undergraduate curriculum have increased our teaching requirements, and I am proud to say that our teachers have unstintingly risen to this challenge. Over the past five years, our clinician teachers and educators have garnered awards across the entire spectrum of academic teaching endeavours ranging from the international

and national to the regional-provincial and local stages. Special commendations go to

- **Kevin Imrie** (Canadian Association for Medical Education (CAME) Ian Hart Award and Charles Mickle Fellowship),
- **Ayelet Kuper** (CAME Meredith Marks New Educator Award),
- **Steve Shadowitz** (Faculty of Medicine Postgraduate Education Award),
- **Anita Rachlis** (SEAC, Allan Knight Lifetime Education Achievement Award),
- **Lynfa Stroud** (PGY Excellence in Development and Innovation),
- **Brian Wong** (Helen P. Batty Award for Excellence and Achievement in Faculty Development),
- **Scott Walsh** (DoM Teacher of the Year),
- **Lynfa Stroud** (Top Research in Residency Education Paper, International Conference of Residency Education (ICRE) and William Goldie Prize and Travel Award in Education),
- **Umberin Najeeb** (Sarita Verma Award for Advocacy and Mentorship), and
- **Piero Tartaro** (Helen P. Batty Award for Excellence and Achievement in Faculty Development).

**Education Leadership.** Sunnybrook continues to play a major education leadership role at the University and Faculty of Medicine level. A few senior academic leaders deserve mention. **Ayelet Kuper** is the Faculty Co-Lead in Person-Centred Care Education, and **Umberin Najeeb** is a Faculty Lead for the Master Teacher Program and the IMG Mentorship Program. **Brian Wong** is Director of Continuing Education and Quality Improvement, and **Eugenia Piliotis** is the Director of the Peters Boyd Academy.

## Finance

### Overview of the Sunnybrook Department of Medicine Practice Plans

All full-time members of Sunnybrook's Department of Medicine must be a member of a conforming practice plan according to U of T faculty policy. The Sunnybrook Department of Medicine has two such conforming practice plans: the Sunnybrook Medical Oncology Alternate Payment Plan (SMOAPP) for the Division of Medical Oncology and the Sunnybrook Department of Medicine Association (SDMA) for all other Department members.

## **Sunnybrook Department of Medicine Association (SDMA)**

The SDMA has 97 members. The Association is governed by an association agreement that explicitly addresses issues such as eligibility, admission, withdrawal and expulsion, transparency, confidentiality, conduct of the association business and conflict resolution. The association agreement has been reviewed and complies with both the University faculty agreement as well as the Ontario Ministry of Health and Long-Term Care (MOHLTC) AFP agreement. The plan explicitly requires that all income related to the practice of medicine regardless of source is tithable according to processes outlined in the agreement. This includes not only clinical revenue, but also income from the MOHLTC AFP as well as University stipends and revenue from medico-legal work and/or consulting. Clinical practice revenue is the major source of revenue, comprising 57.1 per cent of all revenue. Other sources include the MOHLTC AFP (11.8 per cent), hospital support, including the Hospital On-Call Coverage Program (HOCC), clinical support and education (13.1 per cent) and non-association revenue (6.6 per cent).

An elected management committee governs the SDMA. The associates elect members to a two-year term and directly elect the Chair of the Committee. The Committee then selects a Vice Chair; the Physician-in-Chief is a non-voting ex-officio member. The Association supports the academic mandate of the Department in keeping with the strategic priorities of the Department. The association agreement explicitly states that the “Physician-in-Chief of the Hospital shall have exclusive and absolute discretion and authority with respect to the development and implementation of all academic policies and programs.”

## **Sunnybrook Medical Oncology Alternate Payment Plan (SMOAPP)**

The medical oncologists are funded through the alternate payment plan (APP) from the Ontario MOHLTC. This plan includes dedicated funding to protect time for academic activities. The medical oncologists as a group have formed a legal partnership and tithed their APP revenue to support recruitment of members without APP salaries and to support educational programs. Each year, the Division prepares a report outlining the academic

productivity of its members and the investments made to support the academic mission. This data is presented to the Department of Medicine executive to ensure it is aligned with the principles of the Sunnybrook Department of Medicine Partnership (SDMP) agreement.

## **Quality and Patient Safety**

Clearly, quality of care and patient safety have become essential components of current health-care delivery and education. Over the past five years, the Sunnybrook Department of Medicine has strongly supported the academic area of quality and patient safety through (i) official recognition of it as a career stream, (ii) prominent inclusion of quality and safety in our strategic plan, (iii) recruitment of new faculty with a Clinician in Quality and Innovation designation, (iv) development of an annual budget process to provide financial support from the practice plan for individuals who demonstrate exceptional commitment, academic activities and leadership in quality and safety, and (v) major contributions to the University’s focus in this area.

Currently, nine full-time faculty have a primary job description as Clinician in Quality and Innovation. Each Division has identified an individual to lead in quality and safety, and most divisions have ongoing QI initiatives.

Kaveh Shojania is Vice Chair for Quality and Innovation in the University DoM, leads the U of T Centre for Quality Improvement and Patient Safety and is the Editor-in-Chief of the premiere quality and safety journal in the world, *BMJ Quality and Safety*. Because of his expertise in education and quality improvement, Brian Wong is the University DoM Director of Continuing Education and Quality Improvement as well as Associate Director, Centre for Quality Improvement and Patient Safety. Ed Etchells, now the Medical Director for Information Services, is the former Director of Patient Safety at Sunnybrook. He leads the development and implementation of a comprehensive Sunnybrook electronic medical record and order entry initiative.

Several Sunnybrook faculty members help lead the University education activities in quality improvement and patient safety. More recent recruits have established leadership roles. For example, Jerome Leis, a national and international expert in the prevention of health-care-associated infections, is Medical Director of



Infection Prevention and Control. Other Department faculty who have major commitments to quality and safety include Michael Bernstein (Gastroenterology), Shirley Chow (Rheumatology), Sonal Gandhi (Medical Oncology), Dov Gandell (Geriatrics), Bill Geerts (Thromboembolism), Ilana Halperin (Endocrinology), Amanda Mayo (Physical Medicine and Rehabilitation), Christine McDonald (Respirology), Sara Mitchell (Neurology), Matt Oliver (Nephrology), Stephanie Poon (Cardiology), Simron Singh (Medical Oncology), Sheldon Tobe (Nephrology) and Adina Weinerman (General Internal Medicine). Over the past five years, Sunnybrook Department of Medicine quality and safety faculty have obtained peer-reviewed grants, published extensively and received awards for their academic work.

## Wellness

The Faculty Well-Being Committee continues to engage Sunnybrook Department of Medicine members to develop and foster the working environment and a sense of belonging. A previous University-wide faculty survey shows that Sunnybrook physicians describe a strong sense of identity and belonging as one of the unique features of working at Sunnybrook. We have continued to foster this unique sense of family through social events such as the luncheons held every two months during the academic year. They cycle through the different divisions, continue to be a tremendous success and have good turnouts. We host the spring/summer evening social. We also hold unique workshops—in different years to address the faculty's needs—such as the workshop on the nuts and bolts of shifting from practice into retirement. Another seminar, which focused on practical mindfulness training, reflected the diverse nature of these endeavours.

The Faculty Well-Being Committee continues to expand its role and address physician burnout. Fostering interdepartmental collegiality within the hospital is a unique undertaking. Guest lecturers are invited annually; we hope to go beyond the Department of Medicine to bring the diverse departments at Sunnybrook together. Novel approaches to reduce physician workload and stressors while fostering healthy relationships at Sunnybrook continue to be the Committee's main agenda. We seek to enhance networking and collegiality amongst the faculty from different disciplines and academic job descriptions.

## Key Accomplishments of the Past Five Years

1. **Strengthening of the Practice Plan.** Historically, the Sunnybrook Department of Medicine did not invest as much as our peers in the TAHSN in supporting academic activities. In addition, the structure of the practice plan, which had been in place for decades, was not onside with changes to taxation, incorporation and business processes. Beginning in 2009, we created a new practice plan structure with new processes. The result not only is more efficient financial structures and risk mitigation, but also facilitates significant investments that support the academic mission. For example, the Department's planned academic budgets increased 17.4 per cent from \$4.119 million in 2012 to \$4.981 million in 2018. The increase in the academic budget has made a material difference in the support we can provide to our researchers and educators. In addition, this new process has facilitated applications for scientific research and development tax credits (SREDS) which enable further investments that support academic activities. The 2017 median tithe rate is at 8.1 per cent on practice plan revenue of \$49.891 million.
2. **Recruitment.** I am particularly proud of the volume and high calibre of our recruitment over the past five years. When I began my term as PIC in 2009, some of our divisions did not have the critical mass of personnel to sustainably provide clinical care. The situation limited the ability to engage fully in academic pursuits. But I am pleased to say this is no longer the case. We have established a robust recruitment process, which features mandated searches for all positions, regardless of job description. We have implemented a structured process to ensure broad input into recruitment and encourage diversity in our recruitment. I am pleased by the significant interest our positions have attracted, including the interest of international candidates. I am proud that 48 per cent of the faculty who joined us in the past five years are women and that half of the division heads I have recruited are women.

3. **Leadership in Quality and Patient Safety.** Sunnybrook Hospital houses the U of T Centre for Quality and Patient Safety, and the U of T Vice Chair of Quality for the DoM is based in our Department. Over the past five years, we have recruited a cadre of nine clinicians in quality and patient safety to lead quality improvement initiatives and teaching in quality and safety. We now have identified leads in quality for each of our divisions. Many of our faculty lead city-wide and regional quality initiatives.
4. **Annual Review.** I am proud of the robust process that we have implemented for the annual review of our full-time and part-time faculty. We have developed a standard template for the reports and have incorporated physician practice data, including formal multisource feedback reporting, as well as practice-specific data such as length of stay and discharge completion reporting. We look to further incorporate practice-specific data into the review process and improve the review process for part-time members. Our process is viewed as exemplary for other departments at the Hospital and in the University Department.
5. **Ambulatory Acute Care.** We have developed a robust ambulatory acute care strategy for the Department. This began with a General Internal Rapid Referral Clinic, which aims to provide an alternative to admission for patients with medical problems who present themselves to the Emergency Department. This clinic is complemented by clinics in other divisions, including transient ischemic attack (TIA) and stroke prevention, gastroenterology, and Outpatient Parenteral Antibiotic Therapy. The GIM Rapid Referral Clinic has become a very popular rotation for residents, and the clinic is a model for other TAHSN centres.

new technology, including videoconferencing, to offer patient visits not only to far-flung parts of the province, but also to support patients transferred from Sunnybrook to the new Pine Villa supportive housing site, as well as patients in their homes or workplaces using the Ontario Telemedicine Network's personal videoconferencing service.

2. **Precise and Personalized Therapeutics.** Sunnybrook's new strategic plan puts renewed emphasis on targeted therapies. This includes building on world-class infrastructure in imaging not only for diagnosis but also for targeted therapeutics such as high-frequency ultrasound. It also includes increased emphasis on molecular and genomic medicine.
3. **Leadership in Physical Medicine and Rehabilitation.** The recent merger of Sunnybrook with St. John's Rehab offers great potential for expanded academic leadership in psychiatry and rehab medicine. While we have very good clinical programs in this area, we will need to develop a strong nucleus of researchers and educators to capitalize on this opportunity. Under the leadership of Larry Robinson, we have initiated the recruitment of a cadre of excellent new academic recruits to serve this mandate.
4. **Increased Investment in Research.** I am immensely proud of the significant progress we have made in increasing support for our researchers; however, a gap remains between Sunnybrook and many of our TAHSN peers. This gap applies not only to practice plan investment, but also to support in the form of endowed chairs. In this area, we lag far behind our peers. Addressing this gap needs to remain a major area of emphasis.
5. **Leadership in Complex Malignant Hematology.** Sunnybrook is embarking upon a significant two-stage expansion of complex malignant hematology. The first stage, which involves the expansion of acute leukemia treatment, is already underway with the creation of the new Complex Malignant Hematology Unit. Renovations to several pharmacies and an outpatient clinic will occur in phases over the next 6-to-12 months. We have begun recruiting new faculty members, not only in Hematology, but also in other key subspecialties. We have begun recruiting from

## Future Opportunities

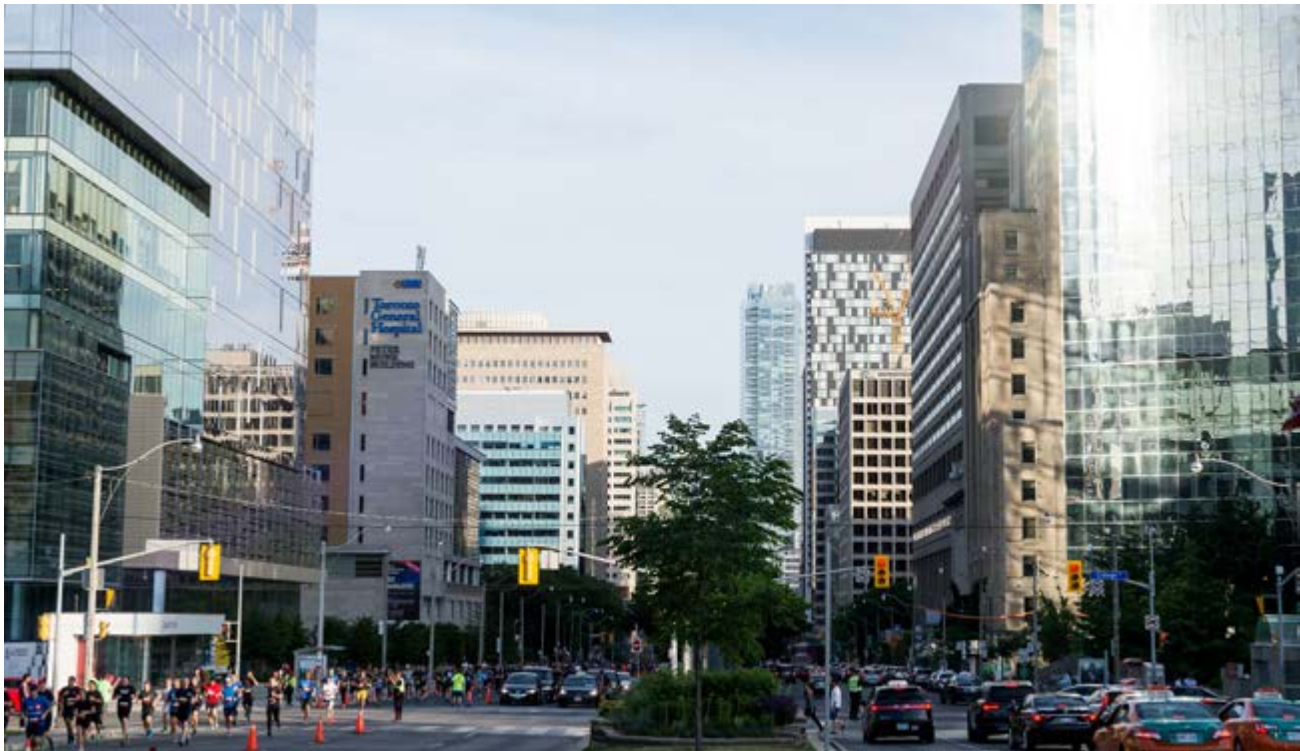
The following areas represent opportunities for the Department's future development.

1. The recently approved strategic plan puts renewed emphasis on our role within our local community. We will take advantage of this opportunity to work with our system partners to provide such care in a more thoughtful and integrated way. We will leverage

other health professions to provide the complex interdisciplinary and interprofessional care these patients will require. The second, even more ambitious, stage will see us perform both autologous and allogeneic stem cell transplantation in addition to CAR-T cell therapy and other immunotherapies. This stage will depend on the planned construction of a new building and the commitment of more government and philanthropic funds. It is likely a few years off. This expansion will make us the second-largest acute leukemia centre in the Greater Toronto Area and will allow us to build upon our national academic and clinical leadership in stem cell disorders, including myelodysplasia and aplastic anemia.

## Conclusion

The past five years have been a time of major growth and maturation for the Department of Medicine at Sunnybrook. We have grown, become more cohesive and intensified our commitment to research and education while becoming a leader in the growing academic patient quality movement. The next five years will see a continued emphasis on our “when it matters most” business of acute, highly specialized episodic care. At the same time, we’ll become a stronger partner in providing integrated and innovative care for patients living in our corridor of care. Our research activities will continue to focus on our established strengths in health services research, quality and patient safety, and education scholarship.



# UNIVERSITY HEALTH NETWORK

Prepared by Dr. Edward Cole, Physician-in-Chief,  
University Health Network

## Introduction

The Department of Medicine at University Health Network is one of the largest hospital departments in Canada. It has 278 full-time members. The size of the Department creates both opportunities and potential limitations. (See below.) Having said that, I feel privileged to lead this outstanding group of highly committed academic physicians. Most of the activity of members of the Department of Medicine occurs at the Toronto General Hospital (TGH), the Toronto Western Hospital (TWH) and Princess Margaret Cancer Centre (PMCC). Members of our Division of Geriatric Medicine play a significant role in managing patients at the Toronto Rehabilitation Institute (TRI), one of the University Health Network hospitals. However, Psychiatry at UHN is a separate Department; the Psychiatrist-in-Chief is Dr. Gaetan Tardif. The Emergency Department, which is under the leadership of Dr. Anil Chopra, is also separate.

I am just completing the third year of my second term as Physician-in-Chief at University Health Network, and I am pleased to say that several outstanding individuals in the Department are fully capable of leading the Department as the next Physician-in-Chief. Although we share a single practice plan and divisional leadership with Sinai Health System, as requested, I will focus on University Health Network in this document.

## Strengths

Our practice plan supports many highly successful scientists, investigators, educators and teachers. There are 168 clinician scientists and clinician investigators who receive about \$120 million dollars per year in total grant support. They do highly impactful research in multiple divisions. An external assessment of research productivity from 2012 to 2016 (for both UHN and Sinai Health System) shows a mean number of publications per Department member of 18. The mean impact factor was 6.2. Thirteen per cent of publications by UHN faculty appeared in top journals, and an average of 30 per cent of papers by UHN faculty appeared in the top 10 per cent of cited papers across their respective disciplines.



We have a large group of outstanding committed educators and teachers who provide a substantial amount of undergraduate and postgraduate teaching and continuing professional development. In one year, we are responsible for the education of 75 clinical clerks, and 868 residents rotate through our core internal medicine and subspecialty services. We have 192 clinical and research fellows. Dr. Danny Panisko, a member of our Department, is the founding and current Co-Director of the Master-Teacher Program; he is responsible for educating our future clinician teachers. Dr. Rodrigo Cavalcanti is the Director of the Ho Ping Kong Centre for Excellence in Education and Practice at TWH. Our teachers and educators have documented impact; they are recognized by local and national awards. Many of our educators have hospital and university educational and leadership positions.

We have two highly effective foundations: Toronto General & Western Hospital Foundation and Princess Margaret Cancer Foundation. They are very successful at raising funds (each over \$100 million per year) to support our clinical and research endeavours. Members of our Department collaborate with the Toronto General & Western Hospital Foundation in raising about \$40 million per year. Our medical oncologists also have important collaborations with Princess Margaret Cancer Foundation, but no figure is available which quantitates the Department of Medicine's role versus other departments, such as Radiation Oncology or Surgical Oncology (a division of the Department of Surgery). Members of our Department currently hold 42 hospital and University chairs.

We have two very large and busy Emergency Departments that provide many consultations and admissions for many of our services. A large amount of quaternary care occurs at UHN, so we also see many unusually complex cases in cancer, multiorgan transplantation, cardiology, critical care, neurology, rheumatology, lung disease, liver disease, red blood cell disorders, thrombosis and glomerulonephritis. We have unique specialized services such as our Infectious Disease Program, which focuses on infections in our immunosuppressed patients in cancer and multiorgan transplantation, and we have national expertise and leadership in tropical medicine. We have large unique clinics in interstitial lung disease, pulmonary hypertension, lupus, scleroderma and psoriatic arthritis, as

well as spondylitis. There are also multidisciplinary clinics in diabetic renal disease, lupus nephritis, antiphospholipid antibody syndrome, scleroderma and neurofibromatosis.

## Weaknesses

As UHN is a large, multiple-site hospital, the culture can be viewed as less communal and friendly than others. This culture can be difficult for new staff members, although people generally find a peer-support group within their divisions. Perhaps as a consequence of our size and possibly because of a more competitive culture, we have had substantial problems with collegiality, bullying and harassment. According to a recent survey done by the University Department of Medicine, this problem seems to be more pervasive at UHN than in the departments of medicine at other teaching hospitals. Although I have appointed two ombudspersons to hear concerns about inappropriate behaviour, most people have not been willing to bring their specific concerns forward because of fear of retaliation. This is a serious institutional problem that I have brought to senior leadership, and I am awaiting more definitive action.

While the load of quaternary cases is a strength in many ways, some of our core trainees, particularly in some of the subspecialties, feel they do not get enough exposure to more standard cases.

Because we have a quaternary care referral centre and busy Emergency Departments serving our community, the patient load is heavy, and there are not enough beds to support the number of inpatient admissions. This situation is particularly true in General Internal Medicine. The results include a lack of efficiency in managing cases dispersed over the hospital and quality and safety concerns, especially with patients waiting for beds in the Emergency Department. As the success rates of cancer treatment improve and the stem-cell marrow transplantation program subsequently expands, PMCC does not have enough beds to manage all of its patients. As a consequence, the Emergency Department and General Internal Medicine service at the TGH jointly provide inpatient care to patients who face the complications of cancer and its treatment.

Clinical research is an essential part of our hospital's mission, but unfortunately both contract services and research financial services have not functioned optimally

to best facilitate the work of our researchers. In some cases, we have lost opportunities to participate in important trials because of contract delays.

Several concerns—the recent strategy of top-down management, the lack of a single electronic health record, the lack of available beds, stresses associated with the focus on quality and safety of care and increasing patient demands associated with our patient portal (which all agree is a good thing)—have contributed significantly to burnout. It is an important problem not only for physicians, but for all hospital staff. Our administration will turn its attention to this problem in the very near future.

As our CEO recently left after only two-and-a-half years, a new CEO is starting. This CEO will be the third since I became Physician-in-Chief. These leadership changes have consequences: we do not have a hospital-wide strategic plan, so it is not yet appropriate for my colleagues and I to revisit the previous Department of Medicine's strategic plan which was drafted in 2011.

We lack a single electronic medical record for inpatient and outpatient care, and in both cases a combination of paper and electronic systems is used. This situation hampers efficiency and causes quality and safety problems. We also have little if any real-time business intelligence to guide our activities.

There have been concerns about our practice plan's lack of transparency, which the leadership has attempted to address. However, since we believe that the practice plan needs to be able to reward meritorious activities, total transparency is impossible. Nevertheless, we have made substantial advances toward improving the principles of transparency. I believe that we, relative to other teaching hospitals, have many scientists and investigators, who come at a substantial cost to the practice plan. We also provide base support for educational leadership roles and teaching. Inevitably, this situation affects the take-home income of our members, and I suspect that we will have to make some difficult decisions about which areas to prioritize.

As a consequence of the previous hospital strategic plan, the Hospital has higher and lower priority areas. Related causes include government funding and the philanthropic success of particular areas. Thus cancer, cardiovascular disease, neuroscience and multiorgan transplantation

have been our high priority areas. However, many other divisions within the Department of Medicine feel poorly resourced and unloved. One of my most important jobs is to highlight the importance and successes of members of these divisions. I am also working with our foundations to broaden the philanthropic focus, notwithstanding the above paragraph.

As the largest single teaching hospital in Canada, UHN for many years has developed a culture that lacks humility. While I believe this culture has improved over the last couple of decades, it still can be somewhat alienating for our partners at other hospitals. Individuals at UHN are often considered to be less than optimally collaborative. I believe that important cultural changes are required.

While I am very satisfied with the current system of separate hospital practice plans and leadership, the lack of University financial resources has sometimes made it difficult for optimal collaboration to occur between the University and its teaching hospitals. The effectiveness of the University Division Director's role is highly variable and depends on the individual appointed. Dr. Hawker is making a serious effort to standardize the job description and to enhance collaboration between the Departmental Division Directors and Physicians-in-Chief as well as hospital divisions.

## Opportunities

Our new Chief Executive Officer, who has recently started, is a highly experienced health-care leader who seems to have great understanding of our system and in particular of the unique role of physicians. I believe that his personality will improve inclusiveness at UHN, and he is committed to selecting an appropriate electronic medical record. He is also committed to soon developing a hospital strategic plan, which will enable us to develop one for the Department.

We have recruited young clinicians who have expertise in quality improvement. I therefore strongly hope that our Department is able to develop a more advanced program to assess the quality of care we provide in the non-procedural areas. The University group of general internists, including some from UHN, has developed the GEMINI project, which should improve the assessment of quality of care in General Internal Medicine. It might be used in other areas too.

Some of my colleagues and I have spoken to the Ontario Deputy Ministry of Health about the possibility of creating a broader alternate funding plan. It would allow us to focus on health-care system needs and protect academic time much better than our current system, where most income is based on fee generation from patient care. The Ontario Ministry of Health and Long-term Care (MOHLTC) indicated interest but is unable to discuss this issue further until the completion of the fee-schedule negotiations with the Ontario Medical Association (OMA).

We have many experts in health services research at UHN who can act as an important resource for the institution and the Province to enhance evidence-based care and the use of technology.

To reduce inpatient length of stay and re-admission rates, we will clearly require enhanced ambulatory care, particularly in General Internal Medicine, and collaboration with family physicians in the community. The development and expansion of ambulatory care in General Internal Medicine is an important first step. The SCOPE Program, which links family physicians to UHN, is another important early step in this process. Because Women's College Hospital (WCH) is very close to TGH, and WCH focuses on ambulatory care, I believe that collaboration between the two institutions could be significantly enhanced to the benefit of both.

UHN is involved in a bed-mapping exercise; the focus is at TGH. At this site, a clear mismatch exists between the beds available and the beds needed, particularly in General Internal Medicine. Twelve beds have been reassigned to General Internal Medicine, and over the next six months we expect a greater number to be assigned. Bed reassignment will reduce crowding, improve access to the Emergency Department and lead to fewer patients being admitted to off-service beds. The exercise should enhance the General Internal Medicine team's efficient provision of care.

I believe that Dr. Hawker's efforts to standardize the Departmental Division Director's job description have the potential to improve collaboration between hospital divisions across the city.

The Hospital has provided us extra support to provide care for the many patients with oncologic illnesses, both at PMCC and TGH.

While some of our divisions have collaborated extremely well with our foundations and have been highly successful at philanthropy, others have been less so. I look forward to Toronto General & Western Hospital Foundation's efforts in the next academic year to engage and train our faculty to optimally collaborate for philanthropy.

Our General Internal Medicine and Geriatric Medicine Division have not been well-supported philanthropically. I believe the problem relates partly to the lack of ambulatory care and the development of long-term relationships with patients who receive this service. I hope the situation might improve with the increase in ambulatory care. We also do not have an effective brand for General Internal Medicine. Thus I am engaging a branding company to develop one and hope that it might allow us to be more successful in the future.

## Threats

Trainee reduction is perhaps the biggest threat to our Department. Staff physicians have had to spend more time in patient care and reduce their academic time. There is a threat to recruitment and retention. Furthermore, because of the increased number of cancer patients, trainee reduction has the potential to compromise patient safety on nights and weekends.

Burnout poses a huge threat to all physicians, including those in the Department of Medicine, unless we deal with burnout at the institutional level.

Research funding is becoming harder to attract, so our research enterprise is threatened. This is particularly true of our younger researchers in the early phases of their careers. I suspect that, in the future, only large and highly successful groups may have sufficient funds to succeed. This change in grant funding, and limited Hospital and departmental resources, may well limit the amount of research that we can support.

The provincial fee schedule rewards procedural work and inpatient work much more than ambulatory care, but ambulatory care may well be more important if we want to improve the health of our populations. While our institution deals with exceedingly complex cases, the Ontario Medical Association, which plays a major role in determining the fee schedule, focuses much more on more routine cases, which take far less time. Attempts to provide an extra fee code for dealing with time-consuming,

complex cases were rejected by the MOHLTC as they were being used to treat all cases in the community. This issue remains to be satisfactorily addressed.

The continuing growth of the population at PMCC, while a tribute to improved success in treating this disease, continues to stress the limited resources at the TGH. More MOHLTC funding is required.

After the removal of mandatory retirement laws and while changes to the economy continue, fewer people are retiring. I strongly believe that new recruitment is an essential part of keeping our Department vibrant and maintaining our innovative culture. However, unless more people develop retirement plans, our ability to recruit is seriously threatened, especially in these economic times when physician reimbursement has been significantly reduced.

The Hospital focus on quality and safety is clearly essential, but without proper resources it may simply add to stress and burnout.

Competence by Design (CBD) was recently introduced by the University, based on Royal College edict, and in my opinion, without optimal evaluation or planning. CBD will require more time commitment from our teachers, further reducing their ability to perform other activities, and without offering significant incremental compensation.

## Strategic Priorities

- a) Update our departmental strategic plan once the hospital plan is available.
- b) Focus scientist and investigator recruitment on Hospital priorities and groups that have sufficient depth and breadth to succeed.
- c) Enhance ambulatory care access, especially in General Internal Medicine.
- d) Enhance linkages with the community, family practice and WCH.
- e) Stabilize needed substitute clinicians for trainees and the provision of inpatient care and consultations despite trainee reductions.
- f) Broaden the alternate funding plan to support our Department.
- g) Improve quality assessment of care by members of our Department.
- h) Work with the University Department of Medicine to improve recognition (e.g., promotion) of the importance of the provision of outstanding clinical care and of our teachers.
- i) Reduce time of recruitment and the associated bureaucracy.
- j) Review the job description and base support of all members of the Department to assure that all are performing appropriately for their job description and protected time.
- k) Review the teaching responsibilities of all members of the Department to ensure the responsibilities are distributed equitably. Take job description into account.
- l) Further identify and educate the future leaders of our Department.
- m) Develop a better plan to encourage retirement and departmental renewal.
- n) Enhance the ability of our physicians to collaborate with our philanthropic foundations.
- o) Optimize General Internal Medicine resources and collaboration with the administration.
- p) Work with the Hospital to optimize quality and safety, especially in General Internal Medicine and the Emergency Department.
- q) Optimize provision of dermatology consultations on University Avenue in Toronto.





## SINAI HEALTH SYSTEM

Prepared by Dr. Chaim Bell, Physician-in-Chief, Sinai Health System

### Hospital Overview

In 2015, Mount Sinai Hospital amalgamated with Bridgepoint Active Healthcare (a rehabilitation and chronic continuing-care facility) and, together with Circle of Care (a home-care organization) and the Lunenfeld-Tanenbaum Research Institute, formed Sinai Health System (SHS). SHS has an operating budget of more than \$600 million. Its vision is to be “Canada’s leading integrated health system, pushing the boundaries to realize the best health and care from healthy beginnings to healthy aging for people with complex health needs.”

SHS has six core values: (i) person-centred care; (ii) excellence; (iii) accountability; (iv) equity; (v) collaboration; and (vi) innovation. SHS is renowned for its Women and Infants Program, which includes a Level 3 Neonatal Intensive Care Unit, and one of the largest high-risk obstetrical programs in North America. Other hospital priorities include complex orthopedics, cancer care, diabetes care, inflammatory arthritis, emergency care, geriatrics, chronic complex conditions and inflammatory bowel disease. There are four strategic priorities: (i) clinical excellence; (ii) operational effectiveness; (iii) growth and investment; and (iv) research and education.

Bridgepoint Active Healthcare has nearly 440 beds split between complex continuing care, rehabilitation and palliative care. For the most part, these are staffed by family doctor hospitalists as most responsible physicians. There are a few individuals providing general medicine, geriatric and endocrine consultations. There is also a 32-bed hemodialysis unit; it has up to 10 beds designated for inpatients receiving peritoneal dialysis.

The Department of Medicine largely resides within the Mount Sinai Hospital campus and is the largest department at Sinai. It is an acute care academic health sciences centre, located on University Avenue. It has over 450 inpatient beds (including bassinets), and almost 29 thousand admissions. For the most part, the

activities of the Department of Medicine will be the focus of the report. Under the leadership of Dr. David Dushenski, the Emergency Department is a separate Department, which attends to nearly 63 thousand annual Emergency Room visits.

The Departments of Medicine at SHS and University Health Network (UHN) are, strictly speaking, two separate departments in two separate hospitals. However, de facto, the two separate Departments of Medicine function for education, research and clinical purposes as if they were a single Department of Medicine under the combined leadership of the SHS and UHN Physicians-in-Chief.

Virtually all members of the Department have staff appointments at both SHS and UHN. All members of the Department of Medicine are members of the same practice plan, and the subspecialty divisions are merged with single leadership. There is a unitary committee structure—Economics, Gender and Diversity Issues (mandate under current review), Senior Advisory, Executive—and a single business office. Our education programs are merged under a Deputy Physician-in-Chief for Education. The current practice plan has been operating successfully since 1990 and has more than 350 full-time members. There are approximately 75–80 individuals whose primary practice is at SHS. The number of part-time physicians and clinical associates exceeds the number of full-time faculty. All full-time physicians hold a faculty appointment in the University of Toronto (U of T) Department of Medicine (DoM), as do the majority of the part-time physicians. All full-time members receive an academic base support dependent on their job description to compensate for the time spent on non-remunerative activities such as teaching and research. Base support is funded by the practice plan through a tithe on all members’ net income.

SHS is divided into programmatic themes or “centres of excellence.” (The terminology will be changed soon.) Each centre is led by a program director and a medical director. They report to the various corporate vice presidents. The Department’s Divisions are divided within these themes as appropriate; however, all Department of Medicine members fall under the jurisdiction of, and are the responsibility of, the Physician-in-Chief (PIC). On February 1, 2017, Dr. Chaim Bell was appointed PIC of SHS; he was previously appointed interim PIC in October 2016, when Dr. Gary Newton became the CEO of SHS.

## Overview of the Sinai Health System’s Department of Medicine

*Physician-in-Chief* Dr. Chaim Bell

### Division Heads

<i>Cardiology</i>	Dr. Anna Woo (interim)
<i>Dermatology</i>	Dr. Cheryl Rosen
<i>Endocrinology</i>	Dr. Minna Woo
<i>Gastroenterology</i>	Dr. Louis Liu
<i>General Internal Medicine</i>	Dr. Peter Cram
<i>Geriatrics</i>	Dr. Samir Sinha
<i>Hematology/Oncology</i>	Dr. Amit Oza
<i>Infectious Diseases</i>	Dr. Rupert Kaul
<i>Nephrology</i>	Dr. Chris Chan
<i>Neurology</i>	Dr. Vera Brill
<i>Physiatry</i>	Dr. Chris Fortin
<i>Respirology</i>	Dr. John Granton
<i>Rheumatology</i>	Dr. Jorge Sanchez Guerrero
<i>Critical Care</i>	Dr. Niall Ferguson
<i>Postgraduate Education Program Director</i>	Dr. Andrea Page
<i>Practice Plan Chair</i>	Dr. Chris Chan

### Education

Dr. Andrea Page is the Postgraduate Education Program Director, and she chairs the Departmental Education Committee that also includes Divisional Education Directors.

<i>Cardiology</i>	Dr. Jeremy Kobulnik
<i>General Internal Medicine</i>	Dr. Luke Devine
<i>Critical Care</i>	Dr. Christie Lee
<i>General Internal Medicine Program Director</i>	Dr. Andrea Page
<i>General Internal Medicine Ward Chief</i>	Dr. Luke Devine

Undergraduate education occurs at SHS’s Wightman-Berris Academy.

<i>Director</i>	Dr. Zareen Ahmad
<i>Director</i>	Dr. Dan Liberman

## Research

SHS is fortunate to have several clinician scientists and clinician investigators at all stages of seniority. Overall our researchers are quite successful: they include particularly prominent and world-class groups in diabetes, inflammatory bowel disease and rheumatology. An external assessment of research productivity from 2012 to 2016 (for both UHN and SHS) shows a mean number of publications per Department member of 18 and a mean impact factor of 6.2. Thirteen per cent appear in top journals, and 30 per cent appear in the top 10 per cent of cited papers.

## Strategic Directions

The Department has not had a formal strategic plan since the 2009–14 document. In August 2017, the PIC initiated development of a strategic plan for SHS's Department of Medicine. Although SHS and UHN have a merged Department of Medicine—with joint Division heads and medical faculty cross appointed to both organizations—this strategic plan focuses uniquely on SHS's Department of Medicine. The plan will include goals, priorities and actions for the next five years that will strengthen SHS's medical faculty and enable them to help meet the strategic goals of the organization.

Extensive consultations to identify goals and priorities have been conducted with more than 50 internal and external stakeholders. These include meetings with individuals as well as with the Education and Research Committees. The reflection and feedback continue, and an updated draft will be disseminated to senior executives in September 2018. Some draft guiding principles include the following:

- The Department of Medicine will evolve strategically by leveraging SHS's unprecedented growth and its focus on exceptional care, integrated health systems and academic excellence.
- The Department of Medicine's strategic goals will advance quality practices and outcomes in all areas of endeavour.
- The Department of Medicine's strategic goals will align with the priorities of SHS, U of T's DoM, and UHN's Department of Medicine.

- The Department of Medicine will partner with the Sinai Health Foundation to engage donors and invite their philanthropic support for the Department of Medicine's initiatives.

Following further feedback with Department members, we should have a final version of the document ready in autumn 2018.

## Strengths, Challenges, Opportunities and Threats Analysis

### Strengths

- Department is highly collegial
- Strong feeling of loyalty and identity toward the institution and Department
- High-quality clinical care delivered and recognized across the Hospital
- General hospital with some highly specialized programs (e.g., obstetrical medicine, certain cancer programs, inflammatory bowel disease)
- Excellent reputation in clinical care, teaching and research
- Separate research and education academic fund provides resources for various competitive projects and programs
- Excellent renewed senior leadership team, many of whom are Department members

### Challenges

Some are germane to all Toronto institutions:

- Rollout of Competence by Design with few resources to optimize its implementation
- Increasing patient volumes and complexity without additional resources
- Increasing competition for peer-reviewed grants and limited salary support for clinician scientists
- Modest support from the University for various administrative initiatives including undergraduate, postgraduate activities
- Need to increase faculty diversity

Others are unique to Sinai:

- Staff renewal with many senior faculty still on staff
- Maintaining identity with respect to UHN
- Relationship with basic scientist-dominated Lunenfeld-Tanenbaum Research Institute
- Electronic patient record and communication with other hospital sites and outpatient electronic record

- Ambulatory care strategy needs for Department and Sinai-provided resources
- Improving transparency within practice plan—have already standardized academic base support
- Feeling of “haves” and “have-nots” dependent on priority program

## Opportunities

- Partnerships across Sinai include psychiatry, palliative care and family medicine
- Integrating clinical care at the Bridgepoint site into the greater Department of Medicine
- Recruitment of properly trained clinician scientists and clinician teachers
- Alignment of recruitment with SHS's overarching priorities, including obstetrical medicine, complexity medicine, and oncology
- Cadre of people trained in quality and safety who can work toward a strong departmental emphasis on measurement and improvement
- Special relationship with Princess Margaret Cancer Centre (next door) for cardiology and critical care, including consults, resuscitation and rapid response team

## Threats

Some are germane to all Toronto institutions:

- Continued resident shortages—largest threat to academic mission
- Increased clinical and educational demands on faculty affects recruitment and wellness (e.g., Competence by Design from Royal College)
- Government fee negotiations and dilution of Alternate Funding Plan

Others are unique to Sinai:

- Resident shortages requiring cutbacks in resident allocations to many teaching services mean resident-independent services
- Lack of succession planning with some highly successful individuals
- Government fee negotiations and dilution of Alternate Funding Plan
- Dependence on UHN for certain clinical consultation





# WOMEN'S COLLEGE HOSPITAL

Prepared by Dr. Paula Harvey, Physician-in-Chief,  
Women's College Hospital

## Overview of the Hospital

For more than 100 years, Women's College Hospital (WCH) has been developing revolutionary advances in health care. In 2006, after eight years of amalgamation with two other hospitals, WCH was directed (by provincial decree) to de-amalgamate and given the specific mandate to rebuild as the first fully ambulatory academic hospital in Ontario. Twelve years later, WCH is a successful and innovative academic hospital that keeps people out of hospital. WCH is also a leader in health for women, health equity and health system solutions designed to improve the patient experience and reduce system costs. The Hospital has significant and intersecting local, national and global roles as health-care partner, academic leader, system innovator, capacity builder and advocate.

WCH has two distinct and unique multidisciplinary research institutes and is ranked among Canada's top 40 research hospitals by Research Infosource. WCH outperformed many larger academic institutions, and in 2017 was in the top 10 for research spending growth. The Women's College Research Institute (WCRI) was established in 2006 and is one of only a few hospital-based institutes worldwide that has a significant focus on women's health and

where the majority of scientists are women. WCRI brings a sex and gender lens into health research so that the known gaps in diagnoses and clinical treatments for women can be solved through discoveries that transform knowledge and practice. The WCH Institute for Health System Solutions and Virtual Care (WIHV) was established in 2013 with mandates to develop, implement and evaluate new models of care and policy solutions and to scale successful solutions provincially and beyond. Since its inception, WIHV has grown rapidly and is now one of the leading applied research centres in Canada. WIHV faculty include health services researchers, quality improvement specialists, implementation science experts and experts in public policy, all working collaboratively with academic organizations, government agencies and industry to develop innovative

approaches and virtual care solutions to improve critical issues such as wait times, variation in quality of care and optimization of services.

In June 2018, after a comprehensive consultation that included partners across the spectrum of academic medicine, community medicine and health agencies and government, WCH launched a new strategy for 2018–22. The four specific strategic goals for the next five years are as follows:

1. Revolutionize health for women and pursue equity for all.
2. Revolutionize care and care experience.
3. Revolutionize health systems.
4. Undertake sustainable, world-class research, innovation and education.

## Overview of the WCH Department of Medicine

The WCH Department of Medicine (WCH DoM) has been through many changes over the past five years, including relocation to new facilities in a two-stage process. (Stage one occurred in 2013, and the second and final stage occurred in 2015.) Concurrent with stage one of the move, a transition from a private office-based system to a centralized shared-care model occurred. The new model is designed and engineered to connect providers around the patient to improve effectiveness and efficiency of care. The multidisciplinary model includes shared space, administrative support and technical staff with clinic processes governed by common standards and procedures. The shared clinic space is co-located with laboratory testing where appropriate (e.g., cardiology programs are co-located with non-invasive cardiac testing; respirology programs are co-located with pulmonary function testing). In 2015, the electronic medical record (Epic EMR) was implemented in waves across all subspecialties of medicine. This implementation was completed in 2016.

Further, after the transition to the shared-care model, faculty no longer have personal administrative assistants, but each division is assigned an academic coordinator. The academic coordinator's responsibilities include learner scheduling within and across subspecialty programs, supervising learner evaluations and supporting faculty who are preparing academic CVs (currently WebCV), annual activity reports for annual reviews and merit allocation, the Continuing Faculty Appointment Review (CFAR) and the senior promotions process.

Although the WCH DoM has undergone major clinical and administrative reorganization, the subspecialties fall within traditional academic divisions. While the WCH DoM focuses on new opportunities for collaboration and innovation, much of the clinical care is still provided through overarching multispecialty medical programs. The WCH DoM has grown substantially over the past five years: it has a total of eight new faculty recruits in multiple subspecialties and job descriptions. The WCH DoM focused on recruiting faculty clinicians in quality and innovation (CQI) to place at least one CQI faculty member in each subspecialty division. The WCH DoM has 47 full-time academic faculty plus seven active secondary, 45 courtesy and 24 clinical associates (a total of 123 physicians) credentialed within the Department. The regeneration of the WCH DoM in the decade after de-amalgamation has produced a preponderance of early- and mid-career faculty, all of whom align with the focus on innovation and multi-faceted, multidisciplinary collaborations.

## Leadership

In the past five years, following formal search processes, new Division heads have been appointed to Respirology (Dr. Jakov Moric), Rheumatology (Dr. Dana Jerome), Endocrinology (Dr. Lorraine Lipscombe) and Dermatology (Dr. Vincent Piguët). Dr. Piguët is also Departmental Division Director (DDD), Dermatology, at the University of Toronto. There are two interim Division heads: Dr. Sacha Bhatia in Cardiology and Dr. Tara O'Brien in General Internal Medicine (GIM). Searches will occur within the next academic year to secure permanent leadership for the interim positions.

## Mentorship, Advocacy and Equity

Since its inception more than 100 years ago, WCH has embraced values of equity, diversity and collaboration. WCH's value of equity is rooted in the Hospital's history of advancing health for women and women in leadership. WCH continues to build on this rich legacy: the organization reflects the diversity of the world we live in and provides and advocates for excellent health care for all. These values, embedded within the culture of the WCH DoM, are reflected in the composition of our faculty, the leadership positions held, the awards received combined with the programs developed, and the education and research conducted by our faculty.

The WCH DoM has two specific and unique endowed chairs that reflect these values: the F.M. Hill Chair in Humanism Education held by Dr. Arno Kumagai and the F.M. Hill Chair in Academic Women’s Medicine held by our Physician-in-Chief (PIC) Dr. Paula Harvey. The mandate of the latter chair is to create academic opportunities for women in medicine, promote academic and educational activities in women’s health and offer support and mentorship to staff (particularly women) in developing and managing their careers. The F.M. Hill Lecture is presented by an invited woman physician in academic medicine in November of each year. Humanitarian and mentoring awards for resident staff who have been nominated for their outstanding humanism and mentorship qualities and contributions are presented annually at the F.M. Hill Lecture.

WCH DoM faculty have been acknowledged nationally for mentorship and advocacy contributions. Notable awards and advocacy achievements include

- the Inaugural Canadian Women’s Heart Health Advocacy Award (Dr. Len Sternberg and Dr. Jennifer Price, 2016);
- Canadian Medical Association May Cohen Award for Women Mentors (Dr. Gillian Hawker, 2017);
- Chair of the Board of Directors of the Kids’ Brain Health Network and recipient of the Gerald (Gerry) Bloomfield Award of Autism Ontario (Dr. Sheila Laredo, 2016 and 2018); and

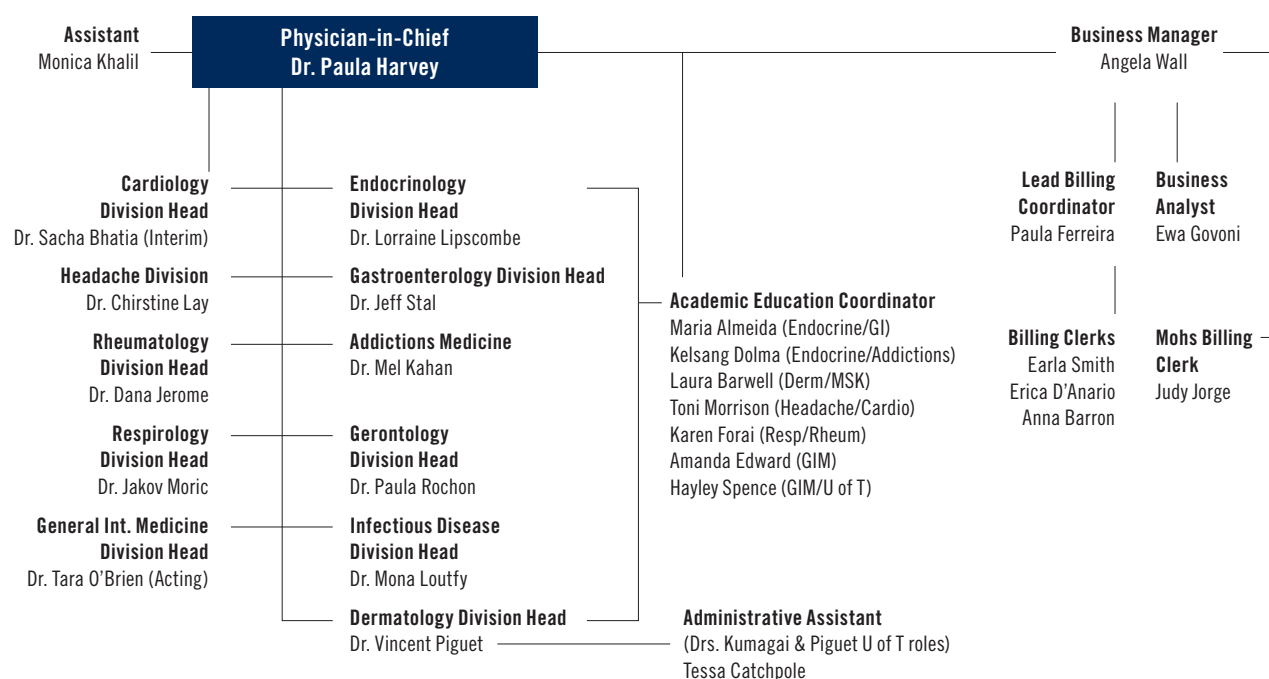
- the Robert Hyland Award for Excellence in Mentorship, University of Toronto (Dr. Hawker, 2013, and Dr. Loutfy, 2017).

## Governance

The WCH DoM is led by the PIC, Dr. Paula Harvey. Financial activities of the Department, including the practice plan, are supervised by Business Manager Angela Wall and a part-time assistant. Billing services are centralized within the Department of Medicine billing office. (See organizational chart.)

The PIC represents the WCH DoM as a member on many Hospital-wide committees such as the Medical Advisory Council (MAC), Executive Search Committees (currently the CEO and Chief of Psychiatry), Medical Assistance in Dying (MAiD), Seamless Care Optimizing the Patient Experience (SCOPE), WCRI Executive Council, Quality Operations as well as the Resource Utilization, and Epic EMR Steering Committees. The PIC is the Dean’s representative on the WCH Academic and Medical Services Management Group (WCHAMSG). The PIC works closely with the WCH Foundation and meets frequently with potential donors to speak about the WCH DoM clinical programs in general as well as her own cardiology-related clinical and research initiatives.

**Figure 9.5: Women's College Hospital Department of Medicine Organization Chart (July 2018)**



Of note, the WCH DoM has strong representation across the Hospital in key leadership positions. Dr. Sheila Laredo (endocrinology) is the WCH Chief of Staff; Dr. Paula Rochon (gerontology) is the VP, Research; Dr. Sacha Bhatia (cardiology) is Director, WIHV; Dr. An-Wen Chan is Vice Chair (VC), Research Ethics Board; and Dr. Jeff Stal (gastroenterology) is WCH Epic EMR lead, a post previously held by Dr. Afshan Zahedi (endocrinology).

For a list of WCH DoM committees, please see appendix.

## Overview of the Women's College Hospital Department of Medicine Practice Plan

All full-time active members of the WCH DoM who hold full-time faculty appointments in the DoM of the Faculty of Medicine (FoM) at the University of Toronto (U of T) are required to be members of the WCH DoM practice plan. The WCH DoM practice plan is a formal association in which members agree to pool their income and share expenses. The PIC represents the WCH in all financial dealings with either the group or any member. The economic policy document (see appendix) outlines the practice plan in greater detail. As of this writing, the Economics Committee is renewing the Association Agreement in consultation with a financial lawyer who has extensive expertise in academic practice plan agreements.

Practice plan members are encouraged to serve on Hospital and departmental committees, such as the Research Ethics Board, Economics Committee, Merit Committee and Education Committee, as required. Members who wish to take pregnancy or parental leave are strongly supported. They are permitted to hire a locum to cover clinical work, and they may spread their annual income at a reduced rate over the term of their leave to provide financial security.

The practice plan year aligns with the July 1 to June 30 academic year. Members each receive an annual contract from the PIC outlining their projected income and expenses and including their monthly draw, which is determined according to university rank. Members do not receive “base funding” as such, but Alternate Funding Plan (AFP) funds are divided equally among faculty, and additional financial support is provided, based on job description, for leadership roles and other related academic activities of the Department. Practice plan

members are required to deposit all professional income earned in each academic year into a WCH-administered account, including all earnings from OHIP and non-OHIP sources related to the practice of medicine, such as salary support from funding agencies or U of T, honoraria for talks, contract work with pharmaceutical companies, royalties, etc. Expenses include an academic tax (to support the academic and leadership activities of faculty), fee for administrative services (academic coordinators, WCH DoM finance office) and billing expenses, which are charged as a percentage of total OHIP payments. All expenses related to clinical work—including clinical secretaries, clinic room and testing facilities, and administrative offices—are covered by the Hospital.

In addition to a monthly draw, members receive “overage” either quarterly or at the year-end depending on their balance. At year-end, each member contributes a percentage of her or his overage balance to the practice plan, which is used to support a merit scheme. Merit is awarded annually upon completion of an annual activity report submitted to the Merit Committee for review. The purpose of the merit award is to recognize accomplishments from the previous 12 months and to encourage and promote accomplishments in the next year. Merit is awarded based on academic and administrative activities such as research, creative professional activity, teaching [which is weighted in categories of clinical teaching and formal (e.g., lectures and seminars) undergraduate, graduate and postgraduate teaching hours], quality improvement, academic administration or any other work that may be deemed meritorious. A detailed merit document outlining the composition of the Merit Committee (which includes representation across all job descriptions), eligibility for merit and merit award distribution is included in the economic policy document. (See appendix.)

Clinical practice revenue is the major source of income of the practice plan. Clinical practice revenue comprises about 62 per cent; the AFP follows at 11 per cent. Funding from U of T accounts for about 6 per cent of total revenue; 5 per cent comes from taxing of members, 2 per cent comes from WCH Foundation, 3 per cent comes from personal support grants, 6 per cent comes from WCH, 1 per cent comes from research institutes, and 4 per cent comes from other sources within the Hospital.



## Innovations and Major Accomplishments

Over the past five years, the WCH DoM has focused on the following:

- i) growing the Department across all medical subspecialties to support the mandate and priorities of the Hospital as an academic centre of excellence and innovation in ambulatory models of clinical care, education and related research;
- ii) recruiting, supporting and mentoring early and mid-career faculty to build leadership and impact locally, nationally and internationally across the spectrum of ambulatory clinical care, education and quality improvement (QI);
- iii) continuing to build capacity in quality improvement and innovation to achieve CQI faculty representation in all subspecialty programs with a collective vision and Department-wide QI collaboration to advance QI and best practices in innovative ambulatory care; and
- iv) building and consolidating internal and external collaborations with the University community, partner hospitals and community organizations to successfully spread and scale innovations and new knowledge to affect policy and models of care beyond WCH.

WCH has had many successes achieving these goals. Of note, two international faculty have been recruited to substantial leadership positions within the Hospital and University. Dr. Kumagai, an internationally recognized scholar in medical education, was appointed F.M. Hill Chair in Humanism Education (established in 2016) and is VC, Education, in the U of T DoM. Dr. Piguet, Division Head, Dermatology, at WCH is city-wide DDD of Dermatology at U of T. He is a basic researcher who has expertise in virology, immunology and inflammation in the context of dermatology. We have successfully grown leadership within the organization with mid-career faculty appointed to leadership positions at U of T that include Program Directors (PDs) for rheumatology (Dr. Jerome) and the GIM subspecialty (Dr. O'Brien) and Associate PD for gastroenterology (Dr. Talia Zenlea). The WCH DoM also holds major leadership positions in the recently established WCH Peter Gilgan Centre for Women's Cancers (2018); Dr. Narod is the lead for the Familial Breast Cancer Research Unit, and Dr. Zahedi was appointed thyroid cancer lead. Dr. Zahedi was also recently appointed Endocrine Oncology Program Lead,

U of T Division of Endocrinology and Metabolism (2018). Faculty also hold major internal leadership roles in WCH including VP, Research, and Retired Teachers of Ontario Chair in Geriatric Medicine (Dr. Rochon); Chief of Staff (Dr. Laredo); and Director of WIHV (Dr. Bhatia). Dr. Bhatia was also recently appointed F.M. Hill Chair in Health System Solutions.

**Education.** The WCH DoM is fully invested in and committed to leading the U of T DoM in the development, implementation and evaluation of education curriculums designed specifically for ambulatory medicine and infused with an equity and humanism lens. Of note, the U of T Centre for Ambulatory Care Education is based at WCH and is integral to the design and evaluation of ambulatory education initiatives at WCH.

Faculty have been recognized by prestigious teaching awards that include the:

- William Goldie Prize and Travel Award in Education (Dr. O'Brien, 2016);
- Division of Respiriology Annual Teaching Award (Dr. Mintz, 2016);
- Clinical Teacher of the Year, Dermatology (Dr. Doiron, 2017);
- Excellence in Clinical Teaching Award, Canadian Dermatology Association (Dr. Doiron, 2017);
- American Board of Internal Medicine Foundation Professionalism Article Award (Dr. Kumagai, 2017);
- Peters-Boyd Academy of Medicine Teaching Award (Dr. Moric, 2018; Dr. Laredo, 2016; Dr. Joseph, 2015); and
- Daniel C. Tosteson Visiting Professorship in Medical Education at Harvard Medical School and Beth Israel Deaconess Hospital (Dr. Kumagai, 2018).

Recent innovations in education in the WCH DoM include the following:

- establishment of the unique F.M. Hill Chair in Humanism Education (2016)
- Quality of Care Medical Grand Rounds, a model of morbidity and mortality ("M&M") rounds specially adapted to the ambulatory setting
- unique ambulatory rotations for learners at all levels that include
  - » a comprehensive Acute Ambulatory Care Unit (AACU) elective, through which residents can gain experience in the care of acute, high acuity ambulatory patients that includes

initial consultation and subsequent short-term follow-up of these patients to prevent inpatient hospitalization and to support the patient's primary care provider and services within the community; and

- » ambulatory rotations specifically designed for residents to attend a variety of subspecialty and general medical clinics, along with attendance at didactic teaching sessions to complement the ambulatory experience. Additional unique opportunities beyond traditional subspecialty clinic attendance include the After Cancer Treatment Transition (ACTT) Clinic, a clinic specifically devoted to post-cancer treatment of patients; the Substance Use Service that includes the Rapid Access Clinic; and the Virtual Ward. Finally, a new initiative establishes a rotation in which internal medicine trainees (under the supervision of an internal medicine staff physician) are embedded within the WCH family health team; the rotation thus allows for a model of one-stop collaborative and patient-centred care, and primary care is informed by internal medicine expertise.
- an incremental increase in unique post-residency fellowships within the subspecialty divisions specifically tailored for advanced training in ambulatory medicine and relevant research training. We have recently appointed in 2018 a WCH DoM Fellowship Director (Dr. Owen Lyons) to represent the WCH DoM at U of T; and
- appointment of an inaugural Chief Medical Resident (CMR) in the new fully ambulatory hospital in 2013. CMR is an important leadership role within academic hospitals. Appointment to this position is now highly competitive, and we continue to attract outstanding candidates for this role.

**Research.** Over the past five years, WCH has focused on strategic recruitment of clinician scientists and investigators to strengthen its unique research programs and collaborations. WCH DoM faculty comprise approximately 50 per cent of all full-time scientists appointed to WCRI and 66 per cent of all MD scientists. Over the last six AFP Innovation Fund competitions, WCH DoM secured 41 per cent of funds available to WCHAMSG (\$547,555 out of \$1,323,011). Researchers' expertise spans health services research, clinical epidemiology, clinical trials (design, ethics and outcomes), integrative physiology, QI and basic science. Their work

is deeply enmeshed within the clinical programs at WCH. WCH has world-renowned expertise in hereditary breast and ovarian cancers, diabetes, osteoporosis, osteoarthritis, psoriatic arthritis, HIV, health services analysis, cardiovascular diseases, and mechanisms and complications of inflammatory skin diseases.

Research faculty have received many prestigious awards and accolades that recognize their work and impact. Several senior faculty hold the highest academic honours in Canada, including fellowship in the Royal Society of Canada and the Canadian Academy of Health Sciences. A selection of additional highlights of WCH DoM research achievements over the past five years include the following:

- Dr. Steven Narod, one of the most often cited cancer researchers in the world, has been the recipient of many awards recognizing his career contributions to breast and ovarian cancer research. These include the Killam Prize for Health Sciences, Canada Council for the Arts (2016), Basser Global Prize (2016), Karen Campbell Award, Ovarian Cancer Canada (2014), and Queen Elizabeth II Jubilee Medal (2013).
- Dr. Paula Rochon has been recognized with a Career Award from Canadian Institutes of Health Research (CIHR) for her contributions to health services research, which focus on aging and complex chronic disease.
- Dr. Gillian Hawker, an international leader in osteoarthritis research, received the Queen Elizabeth II Diamond Jubilee Medal (2013). For her outstanding contributions to mentorship, Dr. Hawker received the May Cohen Award (2017) and the Robert Hyland Award for Excellence in Mentorship, University of Toronto (2013).
- Dr. Vincent Piguet, an international leader in basic and clinical research in the discipline of dermatology, was appointed to Academia Europaea (2017). He is also President-Elect of the European Dermatology Forum.
- Dr. An-Wen Chen, a recipient of the Rising Star Award, University of Toronto, FoM (2014), chairs the international Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT) initiative to improve the quality of clinical trial protocols. He helped develop the World Health Organization's International Clinical Trials Registry Platform and continues to serve on its advisory board.
- Dr. Mona Loutfy received the Canadian Association for HIV Research and the Canadian Foundation for

AIDS Research (CAHR-CANFAR) Excellence in HIV Research Award in Clinical Science (2017) for her work in HIV in women. She also received the Robert Hyland Award for Excellence in Mentorship, University of Toronto (2017).

- Dr. Lorraine Lipscombe was recognized with the Goldie Award for Research, Department of Medicine, University of Toronto (2015) for her excellence in diabetes research.
- Dr. Jacob Udell received the CIHR Institute of Health Services and Policy Rising Star Award (2014), the CP Has Heart Cardiovascular Award (2015), the Ontario Ministry of Research and Innovation Early Researcher Award (2016) and the Canadian Cardiovascular Society Young Investigator Award—Clinical Science (2017) for his work in health services and clinical trials in cardiovascular sciences.
- Dr. Lihi Eder received the Early Researcher Award, Ontario Ministry of Research Innovation and Science (2018) for her work in cardiovascular complications of inflammatory rheumatologic conditions.
- Dr. Husam Abdel-Qadir received the European Society of Cardiology Young Investigator Award (2017) and the Young Investigator Award, Global Cardiology Oncology (2017), recognizing his work in cardio-oncology.

**Summer Students.** The WCH DoM supports the WCRI summer student program, which is designed to introduce undergraduate students to the world of scientific and medical research. The program is uniquely tailored to give students practical research experience to help prepare them for the next step in their education and careers. The WCH DoM usually provides funding for up to five summer students per year. In the past, students have worked on ongoing research projects and special projects related to clinical programs and innovation endeavours.

**Quality Improvement and Innovation.** WCH is proud of program innovations and accomplishments in quality, innovation, and virtual care as well as collaborations to support patients with complex diseases, as outlined here.

- **Quality Improvement Research Committee.** Quality improvement and innovation are core and critical to the success of the goals, mission and vision of WCH. The Quality Improvement Research Committee (QuIRC) was designed to improve data infrastructure and scholarly output

in QI by encouraging peer support, collaboration and professional development among WCH DoM faculty. The Committee comprises representatives from all major subspecialty divisions and is supported by the Hospital through a dedicated member of the Information Technology (IT) Department. The F.M. Hill Chair in Health System Solutions and Director of WIHV, Dr. Sacha Bhatia, provides mentorship and guidance to the QuIRC Chair and faculty membership of the Committee. QuIRC's current initiatives include the following:

- » EMR optimization for the purpose of QI data collection, improved clinical documentation, program development and learner and patient education;
- » development of quality indicators for evaluation of physician and program performance and improvement; to create, implement and evaluate models that decrease inappropriate treatment and care while increasing quality of care and improving value and costs;
- » two QuIRC \$10 thousand grants per year supported by the WCH DoM (established 2017). Applications are peer-reviewed by a committee of QI researchers independent of the grant application process. The competition is open to all WCH DoM faculty, and statistical expertise is available through a WCRI statistician paid in part by the WCH DoM;
- » QuIRC Medical Resident Research Awards (established 2017), awarded annually based on faculty nominations; and
- » a Transitions of Care Committee co-chaired by two QI faculty. This Committee is a collaboration with broad subspecialty membership. Its vision and mission are to develop a centralized transition program to fulfill the needs of patients, their families and paediatric and adult health-care providers. Committee membership has extended beyond the WCH DoM to other WCH departments and disciplines (including psychiatry and chronic pain management) and to engagement of our partners at Hospital for Sick Children. All are united by a common interest in the development and evaluation of transitions of care.

- **Quality Awards:** Faculty have been recognized for their outstanding achievements in QI. They include Ontario Osteoporosis Strategy in collaboration with Osteoporosis Canada (Dr. Kim, 2018); Canadian Rheumatology Association Practice Reflection Gold Award (Dr. Gakhal, 2018); Joan Lesmond Quality

Excellence Award (Dr. O'Brien, 2017); Excellence in Collaborative Ambulatory Care Practice Award (Young Adult Diabetes Quality Improvement Team, 2017); and Accreditation Canada Leading Practice Award [Atrial Fibrillation Quality Care Program (AFQCP), 2015].

- **Virtual Care:** Across all subspecialties of medicine, clinicians and researchers have demonstrated an increased focus on designing, implementing and evaluating new models of virtual care that leverage digital technologies. One model is the Virtual Ward. First established in 2012, this program is undergoing re-evaluation to address the needs of all stakeholders (patients, health-care providers within WCH and our partners within inpatient hospital facilities and out in the community). Resource costs and use receive special consideration. WCH has recently recruited (June 2018) a new faculty member in GIM, appointed Medical Director, Virtual Ward, to provide oversight and clinical consultation for this program. In addition to the Virtual Ward, the WCH DoM has established many models of virtual clinics, which have virtual consultations formally built in to the program's infrastructure. For example, digital technology is employed to support virtual clinics in osteoporosis, cardiac rehabilitation, dermatology and the headache program. Further, Gastroenterology is developing and evaluating a virtual program for patients with inflammatory bowel disease (IBD). The addition of virtual clinics to Cardiology and Respiriology are planned for the next year.

#### **Subspecialty Programs and Collaborations.**

For more information on subspecialty programs and collaborations in the divisions of GIM, Oncology, Endocrinology, Dermatology, Rheumatology, Neurology, Infectious Diseases, Cardiology, Gastroenterology, Geriatric Medicine, and Respiriology, please see the appendix.

## **Analysis of Strengths, Challenges, Opportunities and Threats**

### **Strengths**

- As WCH rebuilds, the Hospital has the unique opportunity to strategically recruit faculty who collaborate and invest in innovations in clinical care, ambulatory education, QI, and research with a sex and gender lens.
- Despite growth, the DoM and the Hospital remain small enough to be nimble, adaptive and highly collaborative. These strengths lead to unique multidisciplinary partnerships in clinical care and research that extend beyond the Hospital to the community partners and inpatient organizations.
- Ambulatory care and virtual care are the core mandate of the Hospital and are arguably integral to the future of health care. WCH is unique in this mandate as we are the only academic fully ambulatory hospital in Ontario.
- U of T DoM fully supports and promotes innovations in ambulatory education and supports WCH DoM in developing leadership in this area.
- All faculty, no matter the job description, are invested in WCH as a living laboratory for innovation and evaluation.
- The new model, with a centralized clinical program and academic coordinators to support faculty in academic activities, has been a great asset to the WCH DoM.

### **Challenges**

- Significant issues with resources and financial constraints (e.g., effective decreases in hospital operating funds over recent years) exist; operating dollars are limited for program development and support. Furthermore, until approximately two years ago, the WCH Foundation was constrained by the need to cover the hospital capital development costs for the new facilities and thus provided little financial support for the research institute and/or individual scientists' research programs/opportunities for chairs, etc. The practice plan has covered the shortfall, but this tactic is not sustainable in a fee-for-service model. The renewed focus of the Foundation on fundraising, supported by a new CEO Foundation (August 2018),



is critical to the support of our academic faculty and their education/research endeavours.

- We need to strengthen expertise in ambulatory education with recruitment of mid-career faculty to enable strong mentorship. However, ambulatory care is a new focus in medical education, making recruitment of mid-career faculty more difficult and competitive.
- While having primarily early- and mid-career faculty can be advantageous, it does limit the opportunities for effective and broad faculty mentorship and for impact in leadership at U of T and beyond.
- As we do not have an inpatient service income, opportunities in the fee-for-service model are reduced and could affect the practice plan. A lack of inpatient access may also affect maintenance of clinical skills in the more inpatient-focused specialties. These factors may impede recruitment for these specialties; however, to date we have been able to forge partnerships with inpatient hospitals to allow access to inpatient service opportunities. This model has been very successful thus far but is dependent, to some extent, on good will.
- Although we have excellent teaching evaluations for both individual teachers and the programs, the ambulatory environment is disadvantaged at the University. Centralized evaluations of most POWER (Postgraduate Web Evaluation and Registration) and MedSIS scores focus on inpatient CTUs. This disadvantage affects our faculty for CFAR and senior promotions and the strengthening and elevating of faculty profiles within the University for leadership roles and awards.
- Faculty transition to retirement influences the opportunities for recruitment of new faculty who have the latest training and expertise.

## Opportunities

- We have already leveraged opportunities for creative partnerships with U of T inpatient hospitals with many collaborations and cross appointments to allow clinics and ward service contributions (e.g., cardiology, respirology, GIM, gastroenterology, dermatology and neurology). In two of these subspecialties, cross appointments to Hospital for Sick Children (paediatrics—neurology and dermatology) have been established, allowing for creative clinical models of patient-centred care. In one further

instance, a joint recruitment process occurred: stakeholders from both WCH and University Health Network (cardio-oncology) participated in the Search Committee and the appointment process/provision of resources and operating funds.

- We are in a unique space (i.e., intermediate care—the conduit between the community resources and inpatient hospitals). We have the room to innovate and have an impact not covered by our inpatient or community partners.
- With the ambulatory and innovation mandate, WCH has the opportunity to reduce duplication of services, reduce Emergency Department (ED) visits and prove more cost efficient than the inpatient organizations.
- Virtual Care is leading innovation in ambulatory care, and WCH's mandate includes virtual care as a priority.
- A CEO search is in progress. The anticipated date of appointment is in early 2019. This search provides opportunities for re-invigoration of the senior team of the Hospital and new energy and vision.
- The equity lens in all WCH endeavours provides the opportunity to lead in humanist education and equity for all, including underserved populations.

## Threats

- We are small and surrounded by multiple amalgamated hospitals; therefore, we are under constant threat of re-amalgamation even though this has been attempted twice in the past. One attempt was successfully resisted, and one was ultimately unsuccessful and led to de-amalgamation.
- The recent change in provincial government may be a threat to the organization if the need for ambulatory care and innovation, and our successes in these areas, are not effectively communicated or understood. Pressure could be added to an already financially stressed system or put us at risk of amalgamation.
- Many resources are already scarce. Scarcity is reflected in the Quality-Based Procedure (QBP), which favours economy of scale. We may need to be creative with partnerships to maintain access to services. For example, endoscopy services were closed at WCH and the organization partnered with Mount Sinai Hospital to pool our volumes and create efficiencies to cope with QBP-based funding. In this partnership, WCH has been disadvantaged with reduced access to urgent endoscopy and exclusion from management decisions. This situation is

being rectified by full WCH representation (the Division Head of GI at WCH plus management representation) on a new Endoscopy Management Committee. It was established to review the partnership and joint decision making in the future.

- The branding of our organization remains an issue. The public and, in particular, potential donors do not necessarily clearly understand the meaning of “ambulatory hospital” and “complex chronic conditions.” So we need to continue to strengthen branding and our profile to attract and maintain funding and support.





2015 graduation ceremony for postgraduates held at Hart House at U of T







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