

## INTERNAL MEDICINE RESIDENCY TRAINING COMMITTEE MEETING MINUTES

Meeting held on Thursday, October 13  
Room D1-226 (Roney B) SJHC  
5:00 – 6:30 p.m.

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Attendance: B. Ballantyne, M. Bensette, A. Bhalla, J. Calvin, L. Chow, D. Durocher, F. Esmailbeigi, J. Gregor, S. Gryn, S. Kane, M. Lu, D. McCarty, S. Mioduszewski, D. Morrison, G. Mount, M. Mrkobrada, S. Ratner, H. Salim, A. Smaggus, L. Wang

Regrets: P. Basharat L. Ciprietti, A. Gob, S. Gottheil, J. Jackson, C. Kortas, M. Mahler, A. Malbrecht, F. Rehman, W. Saad, M. Schorr

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### 1 APPROVAL OF AGENDA AND MINUTES

The minutes were approved as distributed. A draft Resident Selection Policy document was circulated before the meeting to be discussed under 'New Business'.

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### 2 BUSINESS ARISING FROM MINUTES

#### 2.1 PGY2 CTU Role Description

The previous meeting had highlighted concerns that the R2 role was unclear in the R2 role description. Upon review, it was found that the role description was fairly accurate. The document included information about taking alternating lead roles in Emergency, triaging, communicating with other services, taking the lead for the team in the absence of the R3, weekly teaching and assisting juniors with meeting their objectives. It was mentioned that the problem could be that R2 residents are not thoroughly reading the document. The description did require a couple of changes – eliminating item 7 (attend the Team's post-discharge clinic - each team does not have a discharge clinic). It was also recommended that the description should note that the R2 would be expected to hold the pager until 1:00 pm. S. Kane asked the group to re-approve the role description, provided the aforementioned changes are made. The role description was approved. There was some concern about how R2s will function in the future when the R3s will be writing their Royal College exam in their PGY3 year. The issue was deferred to a future meeting.

*Action: DoM to revise R2 role description in CTU Goals & Objectives document*

*Action: Rotation schedule for PGY2s to be reviewed at future IMRTC Meeting*

## **2.2 SAMU Services at LHSC – Update**

S. Kane inquired if there had been any clarification about the requirement for a disposition plan from the SAMU service. J. Gregor to follow-up with SAMU Service

## **2.3 UpToDate- Update**

Residents were informed that Medical Affairs would be covering the Resident's portion of the UpToDate subscription.

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# **3 COMMITTEES/TASKFORCE REPORTS**

## **3.1 Education Liaison Committee**

No meetings have taken place yet.

## **3.2 Faculty PGE**

The Competency Committee Terms of Reference were discussed. The IMRTC was reminded about the importance of establishing a Competency Committee. It was clarified that the purpose of the committee is to review resident performance at each stage of training and determine whether the resident is prepared to move onto the next stage of training. Data on resident performance will be reviewed by the committee at a meeting. There will be a more formalized process than what is currently happening. S. Kane mentioned that the Program Director could not chair the committee but did need to be a part of the committee. S. Kane re-stated her goal of having the Competency Committee running and at the very least have current PGY1s assessed for readiness to move into the PGY2 role before July. This was recognized as an aggressive goal.

The residents were asked if they thought there should be resident representation on the committee. Two positions were offered on this:

- a) Yes – including residents would provide a sense of transparency. Two programs with operating competency committees have included residents
- b) No – it would be difficult for residents to be put in the position of judging their peers

Residents were asked to consider the amount of time commitment required for a competency committee. M. Mrkobrada asked if the current ERB position could be extended to the Competency Committee role. As the ERB representative, M. Lu mentioned that the current ERB role is to advocate for residents whereas the role of evaluating residents would be a different process. She thought that it would be difficult to decide if a resident should decide if a colleague should progress. There was further discussion about whether it was appropriate for the ERB resident to work on the committee. Residents agreed that if a resident were to be involved, it would have to be in a supportive, advocate role. It was also suggested that perhaps a sub-specialty resident could be involved to ensure confidentiality. Some faculty thought the committee should be restricted to faculty only with the opportunity for resident input if necessary. It was decided that input would be required from a large group of residents. Some options will be put together for future consideration.

The Recruitment and Selection document was discussed. It was stated the current model is that IMRTC delegates recruitment and selection to the Program Director and Assistant Program Director. S Kane

asked if anyone had an objection to delegating the selection process to the Program Director and Assistant Program Director. There were no objections.

*Action: Options for resident involvement in the Competency Committee will be drafted and distributed to residents for consideration*

### **3.3 Windsor Program**

No update provided.

### **3.4 IM/EM Working Group**

No further meetings have taken place.

### **3.5 Social Committee**

No update provided.

### **3.6 Resident Wellness Committee**

The Resident Wellness Committee has been meeting to discuss future events. They are hoping to set-up a debriefing/sharing session and are also preparing for a retreat later in the year. Residents were also reminded that there is someone available for support 24/7 and can be reached by pager.

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## **4 COORDINATORS' REPORTS**

### **4.1 Research Coordinator**

Nothing new to report.

### **4.2 Simulation Coordinator**

The procedure ultrasound course went well. There is a vascular access session scheduled for May. D. Morrison is continuing to encourage residents to use QPath software to document their procedural access. Alternate locations to CSTAR for simulation exercises are being considered due to lack of availability of the CSTAR facility.

D. Durocher mentioned that the medicine ultrasound machine at Victoria Hospital is not properly uploading to QPath. D. Morrison suggested that the IT person could likely resolve the issue.

*Action: D. Durocher to talk to IT support person to resolve ultrasound machine training*

### **4.3 Curriculum Coordinator**

H. Salim had recently met with DoM to discuss the Academic Half Day schedule. A draft schedule has been created. It was hoped that Patient Safety Modules created by the CMPA could be introduced. It was thought that one session a month could be reserved for this teaching either at noon rounds or at the end of a half day. S. Kane highlighted the importance of patient safety in internal reviews. The most appropriate format to deliver this information was discussed. A. Smaggus mentioned that patient safety training was included in his teaching at UH already. S. Kane reiterated the importance to demonstrate

that all residents have exposure to patient safety training material. After further discussion it was decided that the detriment could be at Victoria Hospital exclusively.

*Action: The CMRs are going to change their orientation at VH to the morning and teach patient safety in the former Orientation time.*

*Action: CMPA modules to be made available to residents to complete. Residents can complete the modules and then document their progress by sending the record of completion to the DoM for their resident file.*

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## 5 RESIDENT'S REPORT

### 5.1 Chief Residents

#### VH Chief (D. Durocher)

Overall things are going well. Residents have mentioned that they are really happy with simulation sessions. D. Durocher asked if the person covering the pager on Academic Half Day could do senior rounds. CMRs currently have difficulty to find someone to present every week so it was suggested that the person who is hired to cover the pager could fill that role. It would be positive for the PGY5s to gain teaching experience and helpful to the CMR to have someone set up to teach. If this is implemented, the PGY2 carrying the pager would have to carry the pager until 1 to allow the senior person to deliver the senior rounds. J. Gregor discussed changing the timing of Senior Rounds. Future consideration required. Alternatives for teachers for Senior Teaching were discussed.

*Action: Site Chiefs to look into the possibility of hiring a hospital Internist which might help with finding someone to do senior teaching.*

#### UH Chief (B. Ballantyne)

Attendance to Senior Rounds was further discussed. It is hoped that R4s can be involved more in Senior Rounds and it was recognized that it is important that rounds have teachers in place so that rounds are well-received by the PGY4s so that they attend sessions when they are able to.

It was reported that there have been some challenges with ICU Transfers where requests are coming in really late in the day and the patients are being cared for by clerks or junior residents. It would be preferable to have these patients earlier in the day so that the patients can be seen by the senior resident before he/she leaves. The need for clear communication was discussed and it was noted that it is reasonable to expect the EDC resident or the SMR to ensure the juniors are comfortable caring for the patients. The seniors need to communicate with the juniors as they are ultimately responsible for everyone on all three medicine teams. Seniors may have to step in to ensure patients are receiving adequate care. S. Kane stated that ICU Transfers cannot be turned away and should be accepted at all times throughout the day. There was also discussion that some nursing staff is trying to push patients onto the CTU teams. It was agreed that hand-overs from ICU to Medicine should be MD to MD to ensure patient safety.

*Action: B. Ballantyne to discuss transfer issues at ICU Transfer Committee and send out an email to all seniors to reinforce the importance of communication.*

## 5.2 Trainee Representatives

PGY1 - M. Mahler

Unavailable to report.

PGY2 – J. Jackson

Unavailable to report.

PGY3 – S. Ratner

No issues identified. R3 residents are looking forward to the CaRMS match.

PGY4 - L. Ciprietti

Unavailable to report.

ISR

No report provided.

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## 6 NEW BUSINESS

### 4.1 Competency Committee and Terms of Reference

See item 3.2

### 4.2 Resident Selection Policy

The policy was reviewed and approved.

*Action: Policy to be finalized*

### 4.3 Rotation Reviews:

#### Cardiology, CCU, Electrophysiology

Rotations were reviewed. A lot of feedback was provided which was very positive. It was also recognized that a lot of changes have been made to the Cardiology rotation but the strengths of the rotation have been highlighted in the rotation feedback – specifically around teaching, and exposure. Some issues around team rounding that could be looked at for learning purposes but overall the evaluation was strong. Some residents didn't feel that there was an opportunity for formal end of training feedback. There was a perceived lack of exposure to outpatient clinics. In addition, residents hoped for more simulation exposure and ECG teachings. Residents were reminded that a Cardiology Clinics rotation was dissolved when the EDC rotation was added and were also notified that an online ECG training module was available. Cardiology is continuing to work on improving their rotations.

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## **7 ANNOUNCEMENTS**

### **7.1 Fall Retreat**

The Fall retreat will be taking place October 22<sup>nd</sup>. Residents were reminded to respond to DoM's survey if they had not already done so.

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Meeting adjourned at 6:35 pm.