PGME COMMITTEE MEETING MINUTES

	Date:	Time:	Location:
	Wednesday, Nov. 9, 2022	07:00 – 08:00	Virtual
MEETING CALLED BY	L. Champion, Associate Dean, Postgraduate Medical Education		
ATTENDEES	C. Anderson, P. Basharat, P. Bere, M. Bhaduri, J. Borger, P. Cameron, M. Chin, G. Eastabrook, S. Elsayed, A. Florendo-Cumbermack, K. Fung, C. Hsia, A. Huitema, Y. Iordanous, H. Iyer, S. Jeimy, T. Khan, D. Laidley, J. Landau, J. Laba, Y. Leong, A. Lum, S. Macaluso, K. MacDougall, M. Marlborough, B. McCauley, D. Morrison, C. Newnham, M. Ngo, M. Qiabi, K. Qumosani, P. Rasoulinejad, J. Ross, P. Stewart, P. Teefy, L. Van Bussel, J. Van Koughnett, J. Vergel de Dios, J. Walsh, P. Wang, M. Weir, C. Yamashita, Q. Zhang **Hospital Rep**: R. Caraman, S. Taylor, **PARO Reps:** R. Barnfield, V. Turnbull, R. Woodhouse, **PA Exec:** C. Kinsman, **Guests:** S. Dave, B. Ferreira, S. Ibdah, M. Williams, S. Henderson, S. Dave, A. Edwards, S. Bains		
REGRETS	B. Rotenberg, S. Venance		
NOTE TAKER	Andrea Good, andrea.good@schulich.uwo.ca		

CALL TO ORDER (7:00 AM) & APPROVAL OF AGENDA/MINUTES

DISCUSSION

- Three announcements were added to the agenda: Dates for 2024 CaRMS Match, CMPA Patient Safety Primer, newly accredited Area of Focused Competence (AFC) programs.
- The agenda and previous meeting minutes were approved. Motion to approve: P. Wang, seconded by K. Qumosani.

ANNOUNCEMENTS (AGENDA ADDITION) — L. CHAMPION

DISCUSSION

- **Dates for PGY1 CaRMS match announced:**
  - Nov. 17, 2023 – MSPR transcript submission
  - Dec. 1, 2023 – Application deadline
  - Dec. 1, 2023 – Jan. 15, 2024 – File review (six weeks but over holiday break)
  - Jan. 15 – Feb. 4, 2024 – Interview period (three weeks)
  - Mar. 19, 2024 – Match Day
  - Apr. 25, 2024 – Second iteration match day
  - March Break: March 11-15, 2024
  - Dates are available on the AFMC website.
- **CMPA Patient Safety Primer:**
  - Name change for the course (previously “Prepped for Practice”).
  - Interactive virtual workshop includes: medico-legal issues, informed consent, documentation and disclosure of patient safety incidents. One-hour of pre-workshop material.
  - Multiple dates and times available for registration. Encourage any Program Directors with second year residents who have not yet taken this workshop to have their trainees register. The seminar receives a lot of positive feedback and has useful material.
- **Congratulations to newly accredited AFC programs:**
  - Prehospital and Transport Medicine (PTM) in the Division of Emergency Medicine. Led by Drs. Sean Doran and Matthew Davis.

	▪ Adult Echocardiography in the Division of Cardiology. Led by Dr. Sabe De.
MOH MEDICAL EDUCATION EXPANSION	**L. CHAMPION**
DISCUSSION	▪ Ministry of Health (MOH) has received allocation requests from all schools. No school is able to provide the requested 60% allocation to Family Medicine for the 2023 match. ▪ In addition, a budget proposal was provided with requirements for additional accommodation/travel funding for distributed electives, increase in funding adjusted for inflation proportionate to 2022 dollars, new site start up costs, etc. ▪ Ontario Postgraduate Deans have requested, and are expecting confirmation of, the 2023 allocation on Nov. 17, 2022. ▪ Allocation proposal: 2 Family Medicine spaces, 1 Family Medicine Enhanced Skills, 1 Internal Medicine, 1 Anesthesiology, 1 Emergency Medicine, 3 Psychiatry (2 London, 1 Windsor), 1 Physical Medicine & Rehabilitation
MEDICAL RECONCILIATION UPDATES	**S. HENDERSON**

DISCUSSION	▪ Part of the Hospital Accreditation Requirements from Accreditation Canada.
	▪ Medication Reconciliation (LHSC Policy) identifies the following responsibilities:
	  ▪ Best Possible Medication History (BPMH) to be completed by designated staff member (usually medical resident or nurse). ED and Cardiology have provided funding for pharmacy technician support to do BPMH.
	  ▪ Medical Reconciliation: Inpatients must be done at admission, transfer of service, and upon discharge by the ordering provider. Outpatients must be done in high risk areas in accordance with LHSC policy (i.e., urgent medicine clinics at both sites; Cardiology Clinic at UH).
	▪ Current State:
	  ▪ Admission med rec rates have high rates of compliance across most inpatient services.
	  ▪ Discharge med rec rates: lower rates of compliance
	  ▪ Transfer med rec rates: very low rates of compliance
	  ▪ Ambulatory med rec: very low rates of compliance (10% or less) across most areas.
	▪ Identified Barriers: knowledge of policy/process; resources on how to complete med rec; workflow in Cerner (time consuming, too many clicks)
	▪ Resources:
	  ▪ LearnNow Library: https://wiki.cerner.com/display/LRHEE/Home
	  ▪ Can also access on the navigation toolbar within PowerChart, SurgiNet, and FirstNet – watch for the LearnNow Icon.
	▪ Existing Cerner functionality to support med rec:
	  ▪ “Do Not Continue Remaining Orders”: button available in the inpatient setting for med rec.
	  ▪ “Acknowledge Remaining Home Medications”: button currently available for use in the ambulatory setting for med rec.
	▪ Upcoming Functionality:
	  ▪ “Continue Remaining Home Medications” button – not currently available for use in the inpatient setting for discharge med rec.
	  ▪ This is a single click button that can be made available within the *Discharge Medication Reconciliation* window to improve provider workflow.
	  ▪ Similar idea to the “Do Not Continue Remaining Orders” button that is currently available.
	  ▪ Intent is to support by adding a tool that can be used or not used at the provider’s discretion, and one that does not remove the requirement for appropriate med rec to be done.
	▪ Next steps: “Continue Remaining Home Medications” button will be activated for use at LHSC on Nov. 22. LearnNow resources will be available.

	▪ Question from S. Macaluso: Does this apply to SJHC as well? S. Henderson: It could be available at SJHC as it is functionality that can be turned on by site. SJHC had concerns about turning the button on, and we are unsure where they landed on their decision. It will be available at LHSC. ▪ A. Lum: Where are we at with hospital accreditation status? Specifically on this ROP? M. Williams: Discharge med rec in Q2 was 73.1% and was 73.3% in Q1 so not moving upwards and still in the red. A. Lum: Hospital accreditation is very important and will be looking at this ROP. Implication to postgrad – if the hospital does not get accredited, Royal College and CFPC programs are not able to train.
PARO UPDATE	**V. TURNBULL**

DISCUSSION	▪ Western took part in their first provincial PARO event this year: the Halloween trivia night on Oct. 27.
	▪ Western PARO will be hosting two in-person events in the coming months, please share with residents:
	  ▪ Board Game Night at SAGA Board Games & Coffee on Nov. 24. Free food and drinks will be served.
	  ▪ Pottery making event at Crock A Doodle on Dec. 3
	▪ Next PARO site meeting is Dec. 1 and will be discussing ways to increase PARO visibility. Please contact V. Turnbull with any ideas or concerns you would like brought forward.

CBME UPDATE	**J. VERGEL DE DIOS & P. MORRIS**

DISCUSSION	▪ Elentra Update:
	  ▪ Resident dashboard filtering options will be expanded based on feedback from the RAC-CBME:
	  ▪ Filter out achieved EPAs so only in-progress EPAs are displayed
	  ▪ Adding completed EPA count to scatterplot date ranges
	  ▪ Features will likely be helpful to Competence Committees as well. Hoping that the features will be available in November and more details will be communicated at that time.
	  ▪ Current focus: implementation of rotation schedule and non-EPA forms. A working group made up of PGME staff and Program Administrators is being established to provide input and advice on functionality and ease of use. Call for PA volunteers for this working group will go out in the next few days.
	  ▪ Programs should consider reviewing existing evaluation and assessment forms (non-urgent) as the forms will eventually be rebuilt in Elentra so it is a good opportunity for programs to make revisions and remove outdated material. Programs who would like assistance with form review can contact the PGME CBME team.
	  ▪ Working to improve support and training materials for Elentra and one45 to address commonly asked questions. P. Morris will be meeting with the PA Exec on Nov. 10 to discuss the initiative and ask how we can ensure PAs specifically are aware of the resources available to support themselves and their program.
	  ▪ L. Champion: We have seen so many updates and improvements to the Elentra platform and thank you very much to P. Morris and the CBME team for all of their work.
	▪ CBME Steering Committee meeting took place on Nov. 3. Welcome to the new PA representatives: Carrie Kinsman (Neonatal-Perinatal Medicine), Sheryl Jones (Orthopedic Surgery), Jen Whytock (Geriatric Medicine)
	▪ Resident Advisory Committee (RAC-CBME) meeting took place on Nov. 7. Resident Co-Chairs led a resident-only portion (Leo Calderon, Internal Medicine; Mais Nuaaman, Internal Medicine). PGME joined for the second half of the meeting. Focus of meeting: Resident Pulse Check Report.

	▪ Royal College put out a one-pager on Best Practices in CBD assessment data security.
	  ▪ Four areas covered: Who can access the data? How can they access the data? What about sharing? Keeping residents informed?
	  ▪ Update of current Elentra Reports portal access policy will be done by PGME to reflect new best practices.
	▪ Resident Pulse Check Report (Schulich is Institution F):
	  ▪ Report developed by RDoC and the Royal College, based on a survey open for one month in the fall of 2021. Feedback from all residents in programs that have officially launched CBD between 2017-2020 with the exception of Quebec (34/41, 82% of launched CBD programs).
	  ▪ 649/4302 residents responded (15.1% response rate). Western: 39/362 residents responded.
	  ▪ Must consider: COVID-19; time-based comparators that we do not have pre-CBD; program-specific wins and challenges; local, regional and provincial factors. For example, in Quebec CBD has been garnering a lot of media attention that has taken a political slant. Independent analysis in Quebec that has taken a very critical look at CBD and the effect on resident wellness.
	  ▪ Royal College report infographic: 37% of resident physicians agree or strongly agree that CBD is going well for their program.
	  ▪ Good CBD implementation components: Competence Committees and electronic portfolios. Implementation that has not gone as well: EPA assessments.
	  ▪ Transition to CBD is in the “messy middle”. 73% of residents indicate that the transition to CBD has had a negative impact on their health and wellness. We know some programs are affected more than others.
	  ▪ Impacting resident health and wellness: stress of chasing staff for EPAs, concern about achieving requirements, administrative burden, etc.
	  ▪ Change in leadership at the Royal College: CEO leaving, Susan Moffatt-Bruce, MD, FRCSC, PhD; Office of Specialty Education (OSE) replaced with the Office of Standards and Assessment, led by Dr. Glen Bandiera, MD, FRCPC; Director, Standards and Accreditation, moving to Dr. Damon Dagnone, MD, FRCPC, in Jan. 2023.
	  ▪ CBD is at a turning point and the pulse check report is a good way to bring everything together and think about what the next phase of CBD should look like.
	▪ This will be J. Vergel de Dios’s last meeting as her term as PGME CBME Director comes to an end. She thanks the PGME team and Dr. Champion for the support.
	  ▪ L. Champion: Thank you, J. Vergel de Dios, on behalf of PGME and all the Royal College CBD programs, for your leadership, energy, commitment, enthusiasm, advocacy, and all that you have done and worked on over your five-year term. It is astounding and inspiring. Thank you. Thanks were echoed by many Program Directors in the Zoom comment box.
	  ▪ The CBD Director role description is being revised and will be put forward for anyone interested in taking up the role in the future.

INTERVIEW ACCOMMODATIONS AND BEST PRACTICES	**L. CHAMPION**

DISCUSSION	▪ Draft Selection Guidelines to promote equity, diversity and inclusion were circulated in advance of the meeting. L. Champion is seeking feedback, and it will also go to the Policy Subcommittee.
	  ▪ Includes: structured file review process with a standardized and weighted rubric (ideally, minimum of two separate reviewers); standardized language regarding accommodations; interviews (mitigation of implicit bias).
	  ▪ Consider: providing a standardized background for applicants; blinded/semi-blinded interviews (files not provided); pronoun pins; closed captioning; avoiding halo

	effects and contrasting applicants during the interview process (do not discuss among interviewers); using initials for rank order discussions. ▪ Provided as appendices: information regarding validity/reliability, implicit bias resources, and information about interview questions. ▪ Next steps: feedback and suggestions provided to L. Champion by Nov. 25. Finalized at Policy Subcommittee and have ready for approval for the Dec. 14 PGME Committee meeting. ▪ V. Turnbull: Is there a reason that the language around implicit bias training is not stronger in the policy? Why is the school not offering some version of their own implicit bias training or someone else's to do? L. Champion: It is currently a guideline and not a policy so that is why the language is not stronger; however, it can be made stronger. In addition, training was provided in the appendices resources as a Qualtrics survey because then it could be determined who has done it. L. Champion strongly encourages all programs to incorporate implicit bias training for both the file reviewers and all the interviewers. ▪ V. Turnbull: Will interview questions be evaluated against the guideline? L. Champion: standards of accreditation require a fair, transparent and equitable selection policy. The next iteration of CanMEDS (CanMEDS 2025) will include EDI-D and will absolutely be required but not currently. ▪ Note: Recent Zoom updates do not allow MacBooks to update zoom backgrounds. Please keep that in mind.
EDID SELECTION PROCESS – CYTOPATHOLOGY EXAMPLE	**M. WEIR**
DISCUSSION	▪ An Area of Focused Competence (AFC) is an advanced training program accredited by the Royal College, and has been around since about 2010. These programs were the first competency-based training programs at the Royal College. ▪ The Cytopathology program knew they needed to change their process for trainee selection and wanted to strive for a fair interview process by leveling the playing field, reducing implicit bias impact on candidate selection, and practice EDI-DI principles. ▪ Note: did not say "remove" bias as it is subconscious and we all bring it to the table and have to live with biases but be aware of them. However, we knew we needed to reduce the impact of those biases on the selection process. ▪ Process: ▪ Had the EDI-DI lead come into the AFC Committee (equivalent to CC) and discuss implicit bias and educate each other on it. ▪ Reviewed resources: Project Implicit (Harvard); CIHR Implicit Bias; Article on Breaking Down Bias in Admissions by Kyra Talent. Each person on the AFC Committee committed to completing/reviewing 1-2 of the resources listed. ▪ Types of implicit bias: ▪ Many types out there but opted to focus on the following: groupthink, halo effect, recency, ingroup, status quo, stereotype, confirmation, conservatism ▪ Standardized interview questions, had a scoring rubric and determined attributes of an ideal candidate and terminology definitions so everyone was on the same page. ▪ Rubric was the same as what was used before but the questions, attributes and terminology were new. Interview questions were behavioral and future-facing rather than looking back at past activities. Used many HR questions from LHSC and modified them to suit the needs of the program. ▪ This addressed the following biases: groupthink, ingroup, status quo, confirmation and conservatism. ▪ Groupthink: is a phenomenon where people tend to conform with group decisions to avoid feeling outcast, leading to errors in decision-making. ▪ To reduce group think, there was no discussion of the candidates amongst interview panel members before, during or after the interview process. A standardized interview rubric that was independently gathered, and scores were

	pooled and anonymized by the Program Administrator. A summary sheet then came to the PD.
	▪ Halo Effect: a positive impression really shines over everything else in the candidate.
	  ▪ To reduce the halo effect: rethought achievements and contributions. Considered electives and academic endeavors in light of COVID-19 restrictions and inequitable opportunities.
	▪ Ingroup Bias: humans intrinsically categorize people into groups like ourselves (ingroup) and those who differ from ourselves (outgroups). Confirmation Bias: tendency to search for, interpret and recall information in a way that supports what we already believe.
	  ▪ To address these biases: had the same core diverse interviewer panel. More than three interviewers on the panel, and standardized interview questions.
	▪ Strategies to support EDI-DI practices:
	  ▪ Diverse panel of interviewers with balanced diversity (learners, gender, visual identities)
	  ▪ Met with other learners outside of the interview where candidates could ask questions in a safe and open environment.
	  ▪ Used initials of candidates, not names, at Competence Committee when in the process of reviewing candidates and setting up interviews.
	  ▪ Closed captioning was made available, phone or zoom.
	  ▪ Used our pronouns where comfortable doing so.
	▪ Please contact M. Weir (Michele.weir@lhsc.on.ca) for any questions or if you want to see rubrics, documents, questions.
	▪ L. Champion: Thank you M. Weir, and to other programs doing great work in EDI-D.
	▪ J. Walsh: Excited to see your questions and rubric! Wondering if there are guidelines on how to score/assess applicant files, knowing that med school grades do not predict performance in residency and that there is so much inequity in terms of ability to be involved in research, etc.? M. Weir: Yes, there are for UME especially, but certainly for other programs. I think there is some movement away from only grades, but more on other skills, behaviours, and contributions from applicants.
	▪ S. Elsayed: Great presentation, very informative. Did you look at inter-rater reliability for using this framework? M. Weir: we did not but I would be interested in anyone who does especially given our small number of panel members.

SCHULICH EDID	**S. BAINS**
DISCUSSION	▪ Dr. Sukhi Bains is the Associate Dean, EDID, at Schulich. ▪ The scope and vision of the Schulich Office of EDID is large. The only way to be successful is to allow each area to prioritize their visions and strategies in a decentralized hub and spoke model. However, feedback was recently provided that it is also an opportunity for collaboration within groups. Dr. Bains' priority is for groups to be able to implement what makes sense for their Department, Division or program. ▪ The overall purpose of the Office of EDID is to provide support, connections, resources, and guidance for the many areas within Schulich, so that they can meet the needs of their specific contexts and groups. The goal is to empower our many constituents so that they can best actualize their objectives and priorities. This will take time as ultimately what we are talking about is systemic and cultural change. However, with intentionality we can move toward inclusivity and equity by creating a culturally safe space for all in our diverse community (both present and potential) and challenging the structures that got us here. ▪ A good way to look at this work: Not about what extra work you need to do, but rather what you need to remove (i.e., assumptions that you have, etc.). ▪ We have organizational challenges but also a public-facing responsibility to the communities that we serve. Both things are true with regard to EDID, as clinicians, educators, and as an organization. ▪ Where are we now? A lot of work done already:

	▪ Council on Reforming Equity, Diversity, and Inclusion for Trainees (CREDIT) module developed by graduate students ▪ Equity, Diversity, and Inclusivity (EDI) Curriculum Report ▪ EDI Survey Report, 2021, from CREDIT ▪ Equity, Diversity, Inclusion and Decolonization in Surgery ▪ Equity, Diversity, Inclusion and Decolonization (EDI-D) in Academia: Medical Sciences module, by CREDIT ▪ Western Research: Knowledge Exchange @ Western – Bringing in an EDI-D specialist who is pre-award in research. ▪ Office of Indigenous Initiatives: Dr. Bains encourages faculty and learners to be aware of this Office and how much work has been done to develop the immense about of resources and educational opportunities available through their office. ▪ Please complete the Western Equity Census and encourage others to do so. We will not know where we are going unless we know who we are. Cannot be blinded to sociodemographic data as we have been in the past in Canada. ▪ Existing module on building inclusivity through anti-racism (employee) that was developed by the EDI office. It is foundational and applicable to everyone, and includes information that we often rely on faculty from equity seeking groups to be teaching us about (when it should not be their burden to do so). ▪ Contact EDID@schulich.uwo.ca for questions and resources.
ADJOURNMENT (8:03 AM) AND NEXT MEETING	
	Next Meeting: Wednesday, December 14, 2022, 7:00 – 8:00 a.m., Virtual