Schulich MEDICINE & DENTISTRY

Children's Hospital London Health Sciences Centre

Western

THE PAEDIATRIC INSIDER

CONTINUING MEDICAL EDUCATION

ANNUAL REPORT 2017

Our mission is to promote medical education that is effective, ethical and evidence based, and strive for continuous quality improvement.

Our vision is to provide high quality knowledge, skills, and inter-professional learning opportunities in a variety of settings for Physicians and other health care providers in Southwestern Ontario.

Our Goals

Ensure regular assessment of delivered CME content and inclusion of unmet learning needs into programs developed and co-developed by CME Paediatrics.

Continue to organize a regional Paediatric conference on an annual basis.

Develop curriculum for the outreach education program. Supporting faculty education and development.

Utilise technology to improve program visibility.

Develop an informative, easily navigable CME Website.

Improving and updating the constructive presence on social media.

Supporting the educational development within the department and across southwestern Ontario.

Ensure operations are sustainable.

Continuing Medical Education Strategic Directions

Program planning and delivery

Leadership in education

Integrating technology to improve education & communication.

Foster collaboration within the hospital and regional partners.

CME program sustainability

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Message from Dr. Michael Rieder

Chair/Chief

I am proud and humbled by the scope and breadth of the activity of department members of Paediatrics in Continuing Medical Education (CME) and Maintenance of Competence. Given the speed of change in medical care, keeping up to date is difficult for many child health care providers. CME is a key enabler for this and a driver of ensuring best practice care for children in the region and world-wide. Congratulations to the Department members for their outreach and their commitment to better health for children everywhere.

Michael Rieder MD, PhD, FRCPC, FAAP, FRCP
Chief of Paediatrics, Children's Hospital
Chair, Department of Paediatrics
Distinguished University Professor
Schulich School of Medicine & Dentistry, Western University

"Given the speed of change in medical care, keeping up to date is very hard for many child health care providers."

Message from Dr. Rahul Ojha

Director of Continuing Medical Education

It is an amazing time to practise medicine as there are massive technological advances happening all around us. The technological advances are expanding scientific knowledge, improved education techniques and increased access to information. in the twenty-first century is mandated to be accountable in facilitating high quality scientific knowledge and demonstrating physician practice improvement.

In the fall of 2015, I assumed the role of Continuing Medical Education Director in Paediatrics and since then, it has been an eventful time for we have continued to grow, adapt and remain open to new ideas. We are in pursuit of a truly dynamic, learner–focused approach.

CME continues to evaluate, receive feedback and improve on an ongoing basis to ensure we are meeting and growing with the needs of the community. It is important for medical staff to continue to grow and expand their knowledge, that is why the CME is so detrimental.

The CME paediatric program is not only dedicated to providing education to Children's Hospital but also to Southwestern Ontario's medical community. The larger CME grows, the clearer it becomes that there is a need for more education in the smaller communities around the region. In 2017, the CME Committee started to travel to regional hospital's to provide educational days. This new initiative is something CME plans to grow and foster in the upcoming years.

"It's an amazing time to practise medicine..."

Rahul Ojha MBBS, DCH, MD, FRACP
Assistant Professor, Schulich School of Medicine & Dentistry, Western University. Paediatrician, Children's Hospital-LHSC.

Conferences In Focus

Children's Hospital Paediatric Update Conference

The Children's Hospital Paediatric Update is becoming an annual event. The conference started again in 2016 after many years without one. In 2017 the conference has continued to grow in the number of attendees and in the number of sessions. The conference gives medical professionals the opportunity to learn about common and important medical problems in children.

Drug Therapy Day

2017 was Drug Therapy Day's 38th year. Drug therapy day is a one-of-a-kind event in London. The planning committee membership includes individuals from different departments working together for a common goal. Drug Therapy Day allows attendees to learn about how to treat babies and geriatric patients and everyone in between.

Canadian Paediatric Emergency Medicine Review Course

The course is a national, annual course offering trainees and consultants from across Canada the opportunity to consolidate and update their knowledge in core topics in paediatric emergency medicine. The 2017 two day comprehensive course took place in Banff, Alberta and provided a case based approach, embedding up to date literature, for consultants and trainees requiring both practical and exam preparation knowledge for emergent illnesses in children.

Paediatric Emergency Medicine Refresher Course

The Paediatric Emergency Medicine Refresher Course presents an opportunity for health care providers to learn about the current standards of care in emergency medicine for children and youth. The conference this year focused on school aged children and covered a wide range of topics like pain, DKA, cardiac emergency, trauma, procedural sedation, infectious disease and much more.

More than 450 attendees and 60 speakers, four different conferences.

Dr. Aenean Posuere

International Impact

Where in the world have Continuing Medical Education activities happened?

North America

Countries: 5
Talks: 118
Divisions: 19

Academic Paediatrics, Cardiology, Clinical Pharmacology, Community Paediatrics, Dermatology, Developmental Paediatrics, Emergency, Endocrinology, Gastroenterology, Genetics, Haematology/Oncology, Infectious Disease, Neonatal/Perinatal, Neurology, Paediatric Clinical Care, Physiatry, Respirology, Rheumatology

South America

Countries: 3
Talks: 6
Divisions: 2

Developmental Paediatrics, Nephrology

Europe

Countries: 6
Talks: 7
Divisions: 5

Academic Paediatrics, Cardiology, Clinical Pharmacology, Emergency, Neurology

Africa

Countries: 1
Talks: 13
Divisions: 2

Emergency, Neonatal/Perinatal

Asia

Countries: 2
Talks: 4
Divisions: 1

Neurology

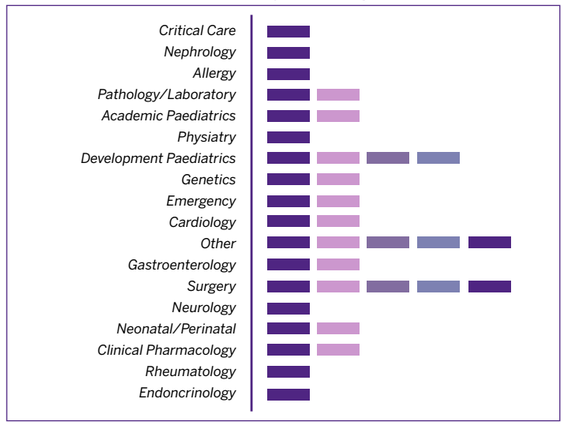
Educational Activities

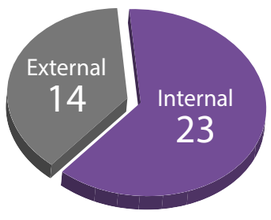
Spotlight on the Education Activities for Continuing Medical Education.

Grand Rounds

Paediatric Grand Rounds lectures take place weekly during the academic calendar year. The rounds are designed to discuss and evaluate cutting edge topics relevant to contemporary paediatric practice. Grand rounds is a forum for information exchange and to display excellence in paediatric research and education.

# of Grand Rounds Speakers by Division





In 2017, 37 Grand Rounds presentations consisting of 23 internal speakers and 14 external speakers were made. A wide variety of topics were presented at Grand Rounds by local and international guest speakers. Topics included The Dark side of Dialysis, Human Trafficking, Street Drugs in Adolescence, Big Changes in Food Allergy, The New Stethoscope in Family Medicine, Pot from Producer to Patient, and Building an Evidence Base for Rare Diseases. These Rounds are accredited by the Royal College as a Category 1 Continuing Professional Development activity.

Ethics Rounds

Department of Paediatrics Ethics Rounds take place quarterly. These rounds are designed to encourage a rich interactive discussion focusing on the ethical principles in question through discussion of a clinical case or case composite. It is a forum for information exchange and learning for all. The lectures are presented by faculty and trainees of the Department of Paediatrics at the Children's Hospital. Paediatric Ethics Rounds is accredited by the Royal College as a Category 1 Continuing Professional Development activity.

Dr. Amrita Sarpal
Ethics Rounds Chair

Dr. Dhandapani Ashok
Grand Rounds Chair

Outreach Education Program

In 2017, the Continuing Medical Education Committee worked in conjunction with the Paediatric Simulation Centre and the Maternal Newborn Child and Youth Network to launch the Paediatric Regional Education Program (PREP). PREP provides specific learning opportunities for physicians and other health care professionals in the region. We are proud to share the expertise of our physicians and educators in providing an OTN lecture series and outreach simulation days. Our overall goal is to share our collective knowledge base with our regional partners.

In 2017 two simulation days were hosted in the region. The Simulation days took place in the fall at Cambridge Memorial Hospital and Stratford General Hospital. The simulation days consists of three different simulation cases, a lunch time lecture and are accredited for attendees. The simulation days were attended by family physicians, emergency doctors, paediatricians, nurse practitioners, nurses, respiratory therapists and medical students who all worked together on simulated medical cases. With the Simulation Days it allows attendees the opportunity to practice procedures, enhance their communication skills and reflect in a debriefing session.

The second part of PREP is an OTN lecture series. In 2017 a need assessment survey was completed by many different facilities around the region to help determine the topics of the lecture series. Now that the topics have been determined, a list of objectives and potential speakers has been generated. The OTN lecture series will launch in early 2018.

Certified Courses (PALS, APLS, NRP)

Certified courses provided on regular basis

Simulation

The Michael Gunning Simulation Centre

High fidelity mannequins, new procedure rooms and a control room are just some of the new features of the Michael Gunning Simulation Centre. The new Centre opened its doors in 2017, immediately increasing the simulation learning opportunities for faculty, health care professionals and learners. In just seven months, more than 680 learners have participated in 80 sessions hosted at the Centre.

The Simulation Centre is used to provide simulation programs that span undergraduate, postgraduate, consultant level multi-disciplinary training and outreach education programs.

Many of these simulations include Paediatric Resident Simulation Sessions, Multi-disciplinary CTU Simulation, Multi-disciplinary Mock Codes, Procedural Skills Session, PEM Rotation Simulation, NICU Rotation Simulation, PALS or APLS training and the opportunity for much more.

The resident simulation provides the opportunity for Fellows with the Paediatric Emergency Department, the Paediatric Critical Care Unit and the Neonatal Intensive Care unit fellows use simulation training to enhance their medical skills and their communication skills.

> "The Simulation program also has the opportunity to travel to hospitals around the region to provide simulation education to a group of medical professionals from smaller hospitals in the community."

Each simulation program is dedicated and tailored to each learning group and their specific needs to ensure they receive the best simulation education possible.

For third year medical students, the Centre has become a place to learn and practise new skills and gain confidence for their work with human patients. They learn a variety of procedural skills including BMV, intubation, IO insertion, as well as neonatal resuscitation, status epilepticus, severe asthma, and septic shock

Paediatric residents will receive approximately 60-70 hours of dedicated simulation training during their core three years – depending on how many procedural skills and mock codes they attend. Through simulations, residents increase their knowledge, practice their procedures and enhance their communication skills.

Fellows can participate in multiple multi-disciplinary simulations in a year including how to transfer a patient from the Emergency Department to the Paediatric Critical Care Unit. They also have the opportunity to work with the residents in a leadership role to grow their leadership, teaching abilities and to expand their knowledge.

In-situ simulation is run in the Children's Hospital Emergency Department for consultants, nurses, respiratory therapists, social workers, unit clerks, residents and med students to improve the system and the team dynamics during a resuscitation in the Emergency Department.

Nurses and unit clerks participate in multi-disciplinary simulation activities, orientations, skills training simulations, unit training sessions and other educational simulation activities at the Michael Gunning Simulation Centre.

80 Simulations

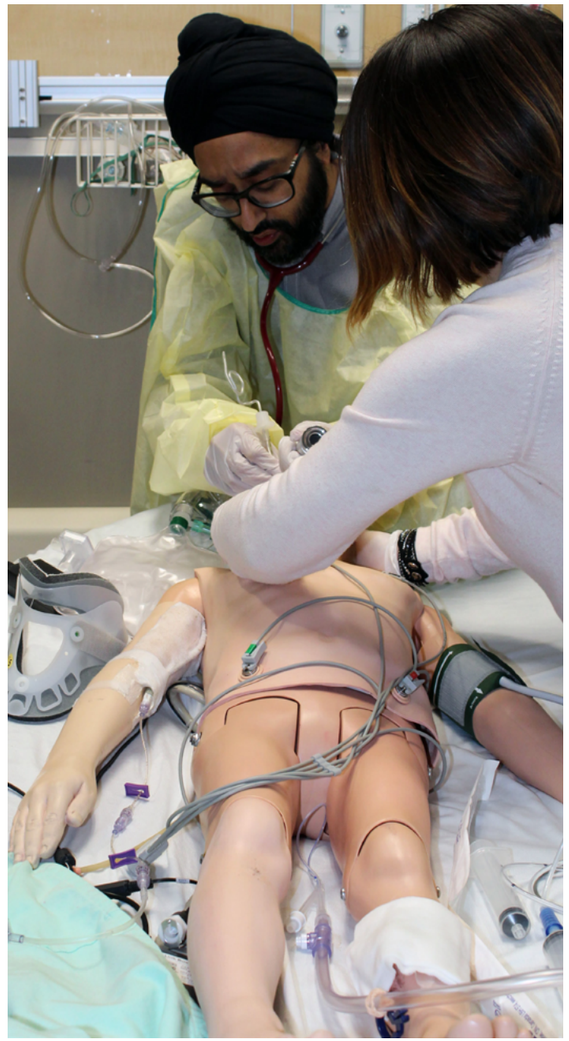
19 Specialities

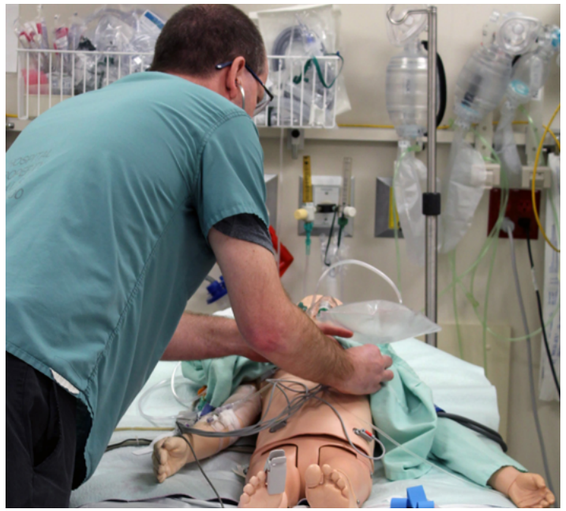
685 Learners

The Simulation Program also provided a faculty development opportunity by hosting a medical debriefing course. Medicine and nursing participants from a variety of specialities learned skills essential for simulation that could also be used after a medical emergency.

As the Centre continued to serve as a learning centre in the hospital, the Simulation program went on the road travelling to hospitals around the region to provide simulation education to medical professionals from smaller hospitals. By travelling to hospitals in the region, multi-disciplinary teams are able to increase their knowledge and enrich their communication skills for a real life medical emergency.

In the past four years, the Paediatric Department has gone from having no formal simulation training to having a formal education program for learners, a Simulation Centre and dedicated staff to help the program grow and prosper. 2017 was an excellent year for Simulation at the Children's Hospital and we cannot wait to see what is in store for the future.





Reducing Stigma through Implicit Bias Recognition and Management in Paediatrics

Dr. Javeed Sukhera, HBSc, MD, DABPN, FRCPC, Assistant Professor, Child Adolescent Psychiatrist

The headlines are everywhere. There is a mental health crisis in the community and youth are disproportionately affected due to lack of access to treatment and the stigma of mental illness. Increasing numbers of youth with mental illness are presenting in paediatric settings including ambulatory clinics, inpatient wards and the emergency department.

Think of this example, if two patients present to triage and one is in emotional distress and the other in physical distress, who does the physician go to first?

Part of understanding the problem involves taking a step back and remembering that all providers and staff are nothing but well intentioned. Unfortunately, with time and experience, hospital culture fosters biases that lead us to discriminate against patients with mental illness by avoiding and distancing ourselves from them. In most circumstances, these behaviours are displayed despite the best of intentions.

Initial research at London Health Sciences Centre's Children's Hospital reveals that stigma is a result of a complex interaction between processes that take place at individual and societal levels. Systemically, resources are scarce, leading patients to present to the emergency department on a recurring basis. This leads to providers feeling that patients with mental illness are time consuming or seen as a "problem you cannot fix." Despite their best intentions, these patients are often avoided leading to the perception of judgment and discrimination by patients and caregivers.

One of the physicians interviewed stated, "I will do my best to send someone else into that room, because I know that if I go in, I'm going to be there for an hour…and, at the end of that hour, I'm going to have no answer for this family. It's the most depressing, horrible thing to deal with, because you…like a broken arm, I can fix it. Whatever else, I can deal with it, I can refer them on. With mental illness there's no sense of satisfaction whatsoever because you emerge from that feeling despondent and feeling like you're making the family worse because we have nothing really good to offer them in the emergency department."

To address this challenge, our team has been conducting stigma reduction trainings for paediatric emergency and paediatric inpatients over the course of the past two years.

The training was designed to highlight biases at the unconscious level that lead to stigmatizing attitudes and behaviours. Significant effort went into providing a safe, non-threatening learning environment for participants. Emphasis was placed on the fact that removal of all stigma is impossible and that rather than foster guilt for our own stigmatizing attitudes or behaviours, we are there to take responsibility for our actions and work to become more empathic and compassionate with the patients and families we work with.

The training went on to discuss the psychology of bias and its relationship with mental illness stigma. We discussed internalized stigma, which happens when patients with mental illness feel blamed and shamed for their own illness. We discussed the destructive impact of stigma, which can be significant enough to lead to suicide and lower adherence to treatment. Participants engaged in participatory theatre, role plays and tackled core skills to reduce stigma and take a more empathic and non-judgmental stance. Feedback was almost entirely positive.

A recent evaluation of this work revealed that as education brings implicit bias to explicit awareness for individual learners, the resulting dissonance between the individual and their learning

> "With mental illness there's no sense of satisfaction whatsoever because you emerge from that feeling despondent.."

environment prompts critical reflection. As individuals adapt with new behaviours, observing and discussing with peers can decrease fear and improve confidence. Eventually, behaviours that are modelled through social influence are perceived to increase, and individuals describe the process of remaking their learning environment.

Despite some success, we still have a long way to go. Part of addressing stigma is recognizing that we will never eliminate it. Through conscious and critical reflection, we can take responsibility for the negative consequences of stigma and reflect on our roles as physicians to reduce stigmatizing experiences for our patients and provide more equitable care.

Learning to become advocates: The Resident Experience

Dr. Andrea Wallace. MD, BSc, Resident

In 1996, the Royal College of Physicians and Surgeons of Canada introduced the CanMEDS competencies, a new way of defining the essential values and roles that should be held by every Canadian physician.

In 2018, every Canadian medical resident knows the seven core roles off by heart, and each step of medical education aims to make us competent in these roles. Medical school training has prepared us well to become medical experts, communicators, collaborators, leaders, scholars, and professionals. But one of the most important roles of a physician, and the one that remains elusive to many residents, is our role as advocates.

Advocacy requires physicians to understand patients' needs beyond the healthcare setting and to work with patients and other community members to ensure that these needs are met in order to promote overall health and wellness. This is particularly important for paediatricians, as we work to protect the youngest and most vulnerable members of our population.

Research suggests that physicians who are involved in advocacy early in their training are more likely to use strategies to advocate for children's health at a population level in the future.

Despite this growing body of evidence, advocacy education in residency programs across the country remains inconsistent, and the responsibility is largely left up to the individual resident to incorporate advocacy work into their training.

> "Advocacy requires physicians to understand patients' needs beyond the health care setting… in order to promote overall health and wellness.."

into our residency education. A resident-driven advocacy project led by Dr. Dara Petel a second year resident, will have residents provide health education to at-risk youth in our local community. Programming will be developed by residents and will focus on a number of health-related topics, including nutrition, exercise, and mental health. This will also tie in to our new resident advocacy curriculum, a longitudinal experience which will have residents work on advocacy initiatives to promote children's health throughout their residency.

With the growing understanding that health needs extend beyond the healthcare setting, we hope that advocacy education will be prioritized both in residency education and Continuing Medical Education, so that residents and established paediatricians alike will be able to support Canadian children in meeting their needs in order to achieve optimal health and wellness.

The Canadian Paediatric Society has been instrumental in supporting paediatric resident advocacy activities nationwide. Since 2004, along with the Healthy Generations Foundation, they have supported resident-led advocacy projects through the Paediatric Resident Advocacy Grant. The yearly Canadian Paediatric Society conference also offers an opportunity for residents to present their advocacy project.

The residency program leadership, as well as the residents at the Schulich School of Medicine & Dentistry, are working hard to incorporate advocacy

The Modern Age of Transport Medicine

Dr. Anna Gunz, MD FRCPC, Paediatric Intensivist, Director of LHSC Neonatal Paediatric Transport Team

After initial assessment and stabilization, critically ill infants and children presenting to a non-tertiary care centre must undergo inter-facility transport to receive ongoing care in a neonatal or paediatric intensive care unit. During transport, they are managed in a resource limited environment with spatial and technical limitations to monitoring, assessment and ongoing intervention. In addition, they are exposed to environmental hazards not realized in the confines of a hospital. All of this puts patients at risk of experiencing adverse events; a well-described phenomenon.

Transport Medicine has emerged as a specialized discipline of medicine in recent decades. The goal of this discipline is to ensure safe, incident-free care for patients by skilled health care providers who continue active resuscitation and stabilization during transport. Essentially, Transport Medicine clinicians operate as a mobile extension of the intensive care unit.

It's well described in the neonatal and paediatric transport literature that patients who are transported by clinicians with specialization in paediatrics experience less adverse events during transport and have better outcomes than those transported by teams without specialization. For this reason, there are important provincial, national and international networks of transport providers who strive to advocate for the maintenance and expansion of neonatal and paediatric transport services.

The paediatric transport physicians at London Health Sciences Centre's Children's Hospital, are actively involved in advocating for the safe and efficient transport of critically ill neonates and children in north and southwestern Ontario and lead paediatric transport research and quality assurance initiatives.

The Neonatal Paediatric Transport team is uniquely positioned nationally. Founded in 1983, it was the first Neonatal Paediatric Transport Team in the country and remains the only team in Ontario that transports infants and youth of all ages, from the extremely premature to 18 years old. Initially, the team was staffed by paediatric critical care nurses, respiratory therapists and physicians with specialized Transport Medicine training who would assemble ad hoc to respond to the needs of the community.

As the service expanded and became more established, in 2004 the team became a dedicated team providing 24-7 coverage to our region. The transport team members are now termed Transport Clinicians, which reflects their expanded scope of practice. They receive specialized orientation and provincially-standardized testing in order to qualify for the team. Team members are held to a high standard of care with annual recertification and continual educational activities.

Historically, the LHSC Neonatal Paediatric Transport Team completes approximately 450 inter-facility and 100 intra-facility transports of neonatal and paediatric patients per year.

The team continues to expand services to patients in the region, including high-risk surgical patients and acutely ill ED-to-ED transfers. While also recruiting and orienting new transport clinicians to ensure regional coverage. In addition, we are active in provincial negotiations to improve transportation infrastructure to attain targeted retrieval times.

The paediatric intensivists at LHSC's Children's Hospital are specialized in Transport Medicine and are actively involved in facilitating the transport of paediatric patients to the Children's Hospital and around the province, beyond those admitted to the Paediatric Critical Care Unit. If regional partners are concerned about a high-risk transport, we welcome your consultation through CritiCall regarding the safest and most available transport service.

> "Transport Medicine has emerged as a specialized discipline of medicine in recent decades."

Patients admitted to the Neonatal Intensive Care Unit will have transportation facilitated by the neonatologist on call through our local and regional neonatal transport partners. We are committed to providing the highest quality of care and welcome your feedback. Please do not hesitate to contact us.

Anna Gunz MD, FRCPC Paediatric Intensivist, Director of the LHSC Neonatal Paediatric Transport Team

Henry Roukema MD, MSc FRCPC, Neonatologist, Co-Director of LHSC Neonatal Paediatric Transport Team
Medical Director, NiCU

Karyn Calwell RN Coordinator, Neonatal Paediatric Transport Team

Competence Based Medical Education: The Paediatrics Journey Begins

Dr. Tamara Van Hooren, MD, FRCPC, Academic Paediatric Medicine and Child Protection, Program Director, Postgraduate Paediatrics

Competence Based Medical Education (CBME) is already a reality of training in a small number of Schulich postgraduate training programs. For Paediatrics, the anticipated transition date to CBME had been set as July 2019, making the upcoming academic year pivotal in planning for success. Though our final move to CBME has now been delayed to 2020 on a national level, Schulich Paediatrics has no intention of standing still and waiting to institute change.

Competence based education represents a major paradigm shift in medical training, and one that most significantly effects not what our future trainees learn, but how their performance is measured. It forces both trainees and educators to ask the difficult question -- "where is the bar for a practicing paediatrician?". And it requires that they ask not monthly, but instead as part of a daily ritual.

CBME moves the focus of trainee evaluation from infrequent high stakes assessments to frequent low stakes assessments. Too often evaluators have a clear sense of a resident who is struggling, but pinpointing the exact area requiring support is a challenge. It is nearly impossible to pay attention to all aspects of an individual trainee's performance during a single encounter, and so CBME tells us to stop trying.

Instead, the focus of trainee assessment will now be on discipline specific observable tasks, known as Entrustable Professional Activities (EPAs). EPAs are the stepping stones which a resident must achieve to be promoted through the stages of a training program. Each EPA is accompanied by a list of associated Milestones, a list of individual skills that are needed to complete a task, or EPA, necessary to practice paediatrics. The stages of training are universal regardless of the discipline of training; Transition to Discipline, Foundations of Discipline, Core of Discipline, and Transition to Practice.

The above may sound like an unfortunate word soup brought to you by the Royal College of Physicians and Surgeons of Canada, and best not entertained before morning coffee! This is where getting started becomes so important. Discussing the principles of CBME without the technology to make it practical has been a challenge. Being in the fourth cohort to implement CBME lends at least a bit of a helping hand. Disciplines beginning in 2017 (Anesthesiology and Otolaryngology) started with paper assessment forms; for us an easily accessible mobile app may actually be a realistic expectation.

I have been asked why just competence; why not excellence? Because excellence at everything is a fallacy; and a good evaluation process acknowledges this. Competence based training is not about limiting a resident's potential, but about ensuring that even the weakest skill at the end of training still makes the cut. In the words of Schulich Postgraduate Dean Dr. Chris Watling, "CBME is medical education's response to honour our pact with society". In paediatrics, this is ultimately about ensuring that the paediatricians we graduate are ones we would allow to care for our own children.

Why the delay from 2019? In mapping EPAs for transition to discipline to a fourth-year in training curriculum, it became clear that the structure of paediatric training in Canada, one that allows subspeciality entrance after three years in training, seemed to contradict the training path that CBME aims to accomplish. If a period of Transition to Discipline is deemed important, why can one practice general paediatrics without completing this? The dialogue is ongoing, but the question is important enough to pause to make sure we get this right.

Education experts, including all Program Directors across the country have been working closely with the Royal College to create EPAs that incorporate the abilities needed to be a competent paediatrician. Those EPAs now drafted well enough for piloting, have been mapped into our own curriculum, with the help of our new Paediatrics Competence By Design (CBD) Lead, Dr. Anna Gunz. This has been achieved with little disruption to the way we do business. It is now time to introduce these assessments to the faculty and allied heath members who will be so key in making this process a success. Faculty will be trained to use a modified "O-score", which asks evaluators to rate how much the resident still requires their support. The goal is for the resident to perform at a level where you didn't' need to be there. Et voilà – independent practice.

Sounds seamless? Absolutely not. How do we add direct observation to the already stretched balance of clinical care and trainee supervision? How do we acknowledge that time in a way that is academically meaningful? The questions are not unique to paediatrics; many of the answers will not be either. As with the introduction of any new process one of the major challenges in the journey to competence based training will be acknowledging that our best efforts will need continual adjustment. However, this new process of resident assessment, even with its many challenges, will be better than what we were doing before.

> "This is where getting started becomes so important."

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This is particularly important for paediatricians, as we work to protect the youngest and most vulnerable members of our population.”

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