



FINAL REPORT WONCA ACCREDITATION VISIT

University of Toronto Department of Family and Community Medicine (DFCM)

June 3rd-5th 2018:

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Acknowledgements:

We acknowledge, and are grateful for, the detailed comprehensive preparation undertaken by the DCFM Faculty at the University of Toronto and the staff at the North York General; St Michael's and Royal Victoria Regional Health Training Sites. Throughout the visit we were made welcome, kept well informed and offered an open transparent environment for information gathering and discussion. This greatly aided the accreditation process. It also, we felt, reflected the overall transparent learner centred philosophy and caring, safe atmosphere of the training programme. We thank all staff and trainees for their time interest and understanding.

Glossary

CanMEDS	Can MEDS Physician Competency Framework
CaRMS	Canadian Resident Matching Service
CFPC	College of Family Physicians of Canada
DCFM	Department of Family and Community Medicine
EPA	Entrustable Professional Activity
FM	Family Medicine
ITER	In Training Evaluation Report
PG	Postgraduate
Triple-C	National Curriculum: Comprehensive; Continuous, Centred on FM
WBA	Workplace Based Assessment
WONCA	World Organization of Family Doctors

Executive summary:

Aim of visit: To appraise, against World Organization of Family Doctors (WONCA) Global Standards for Postgraduate (PG) Family Medicine Education, the two-year PG programme for Family Medicine (FM) doctors at the Department of Family and Community Medicine (DCFM) Department, University of Toronto. The aim was to assess the programme for WONCA accreditation and give feedback on areas for further development.

Methods: DCFM submitted fully comprehensive paperwork outlining and evaluating the programme prior to a three-day site visit from the WONCA team. Faculty, trainees and staff at three training sites were interviewed. Verbal feedback was given at the end of the visit.

Findings

The University of Toronto DCFM offers a well-established two-year training residency. Strong values and vision shine consistently across the programme. We witnessed, on the three sites visited, collaboration, respect, responsiveness and flexibility in all contexts. The competency based Canadian triple C curriculum is well established and impressively embedded in the CanMEDS Physician Competency Framework (CanMEDS). Faculty deliver close 1:1 supervision and have a robust remediation system to identify struggling trainees. There is a comprehensive assessment programme using a range of tools. Trainees reported feeling well trained for exit into unsupervised practice and perform well on The College of Family Physicians of Canada certification examination. . On all sites they expressed great satisfaction with their training and felt Faculty responded positively to their feedback. Governance and administration process is robust.

Internationally it is unusual to deliver FM training in two years. We judged the programme to be successful in achieving this. We attribute this to (i) residents being free to focus on self-directed learning in the clinical environment as they are not contracted to service delivery (ii) the trainees' relative maturity as graduate entries to undergraduate training;(iii) the close 1:1 supervision from Faculty.

Conclusion:

We recommend to the WONCA Executive that the DCFM is accredited for five years and congratulate the University of Toronto on their achievements. No programme should ever stand still. We offer recommendations for further development:

Recommendations for ongoing development:

1: Embrace the "patient voice" in the programme: Patients as stake holders were not clearly visible across the programme yet their voice can contribute positively to defining outcomes and standards for patient safety. Exploring lay representation within curriculum planning, teaching and assessment processes is recommended. (see 2:5)

2: Horizontal versus block curriculum structure: Given the changes in health care as patients' needs alter, longitudinal (horizontal) experiences may now be more advantageous. Critical evaluation of the two models is advised . (see 3:4)

3: Logging of clinical experience: Completion rates varied across trainees who find the process challenging to complete 100% comprehensively. Work to link contact records directly with the electronic medical records would significantly aid this important education process. (see 3:5)

4: Recording procedural skills competencies: Overall the records we saw were patchy, had significant gaps and did not reflect actual achievement. Given this is an important appraisal of skills competency, records need improvement especially in procedures performed in the hospital setting. Entrustable Professional Activities, if evidence emerges to confirm their validity and reliability, may help. (see 4:3)

5 Assessing professionalism: CanMeds values are well embedded across the programme. A move to explicitly appraise the trainees' development of reflective practice and application of these professional values through a personal portfolio is recommended. Current assessment tools, such as multi-professional feedback, are proving effective and could be introduced. (see 4:4)

6: Feedback: Faculty training on feedback is recommended. We suggest a critical look at the need to grade feedback, given evidence is emerging that words may be more effective than numbers. (see 6:3)

Full report against WONCA PG accreditation standards:

1: Accreditation process:

1:1 In 2017 The University of Toronto approached WONCA seeking accreditation of the DCFM training programme against WONCA Global Standards for Postgraduate Family Medicine Education.¹ The training programme is one of 82 PG programmes offered by the institution.

1:2 A team of three WONCA members with the appropriate expertise and availability was appointed to visit Toronto in June 2018: (i) Garth Manning (WONCA Chief Executive Officer) (ii) Viviana Martinez-Bianchi (FM Residency Program Director, Duke University, USA and WONCA member at Large (iii) Val Wass (Emeritus Professor of Medical Education, Keele University, UK and Chair WONCA Working Party on Education).

1:3 The DCFM programme follows the National Triple-C curriculum of the College of Family Physicians of Canada (CFPC).² It is well established.³ Regular national CFPC accreditation takes place every eight years against the Specific Standards for FM Residency Training Programme's Red Book.⁴

1:4 Trainee selection follows the Canadian Resident Matching Service (CaRMS) with allocation numbers determined by the provincial workforce needs. The DCFM residency is a popular programme, routinely over-subscribed, and attracting trainees of high calibre.

1:5 We received comprehensive information of the programme in advance. Over the three-day visit, meetings were held with DCFM University Faculty senior management and staff where presentations stimulated open discussion of issues raised. Three contrasting sites were selected for visits: St Michael's (central large teaching hospital) and the North York Hospital (leading community academic hospital) both in Toronto and the Royal Victoria Regional Health Centre in Barrie, approx. 50 miles north of Toronto. We saw a sample of trainee records and assessment documentation. Helpful meetings with staff and trainees at all sites furthered our information gathering for accreditation against the WONCA standards:

¹ http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Education/WONCA%20ME%20stds_edit%20for%20web_250714.pdf

² http://www.cfpc.ca/Triple_C/

³ http://www.cfpc.ca/uploadedFiles/Education/_PDFs/WGCR_TripleC_Report_English_Final_18Mar11.pdf

⁴ <http://www.cfpc.ca/uploadedFiles/Red%20Book%20English.pdf>

2: Standard 1: Mission and outcomes

2:1 The mission, vision and values for the programme and the video from Prof Michael Kidd outlining the future of Academic FM at DCFM⁵ impressed us.

2:2 We consistently noted across our visit a strong ethos of education and research scholarship and mature self-directed learning. Inclusivity, interprofessional collaboration, mutual respect, flexibility, responsiveness and caring support were values pervading the programme. Residents felt included and held a meaningful voice within the curriculum and its development.

2:3 The CanMEDS framework is impressively embedded in the triple C curriculum. We saw strong evidence of its application.

2:4 Embracing indigenous health issues and avoiding unconscious racial bias in an increasingly culturally diverse society challenges us all. The 30-minute Faculty and resident interviews might be worthy of review to ensure the interviews encourage wide cultural inclusivity⁶ and believe that University of Toronto has an important role to play in leading the process to facilitate indigenous student entry into residency.

2:5 The patient voice and an explicit culture of patient safety was not immediately tangible within the curriculum itself, although patient involvement was clearly part of health care delivery as witnessed on site visits. We suggest more explicit lay involvement in the curriculum development and implementation; this generally enhances rather than detracts.

Recommendation 1: Embrace the “patient voice” in the programme: Patients as stake holders were not clearly visible across the programme yet their voice can contribute positively to defining outcomes and standards for patient safety. Exploring lay representation within curriculum planning, teaching and assessment processes is recommended.

3: Standard 2: The training process:

3:1 Despite the limitation of the programme to two years, we conclude that the residents we saw are sufficiently prepared for independent practice and to meet the needs of local communities. The focus on learning on placements independent of any contractual commitment to service delivery appeared key to achieving this.

⁵ <https://www.dcfm.utoronto.ca/mission-vision-and-values>

⁶ McCambridge⁹J et al Systematic review of the Hawthorne effect: New concepts are needed to study research participation effects. <https://doi.org/10.1016/j.jclinepi.2013.08.015>

3:2 Learning is self-directed, encompassing and integrating reflective observations. We felt the strong, effective 1:1 support from a permanent family physician advisor was key to achieving this.

3:3 We would have liked to explore further whether residents have sufficient opportunity to learn how to manage their own practice within the various models of team-based health care in Ontario at this time.

3:4 Some sites followed the new horizontal delivery model; some the old block model. Although each has its pros and cons we heard concerns that half a day a week in the block model may not provide sufficient continuity of care to prepare them for practice. Given the increasing move to longitudinal attachments⁷ in medical education we recommend:

2: Horizontal versus block curriculum structure: Given the changes in health care as patients' needs alter, longitudinal (horizontal) experiences may now be more advantageous. Critical evaluation of the two models is advised . (see 3:4)

3:5 Residents reported feeling sufficiently empowered to hold the necessary autonomy to direct their own learning. One said, "patients are first in everything we do". We found some inconsistencies, variance and frustration in finding the time to log their daily encounters. Overall, we estimated 80% of daily contacts on average are recorded. We suggest:

Recommendation 3: Logging of clinical experience: Completion rates varied across trainees who find the process challenging to complete 100% comprehensively. Work to link contact records directly with the electronic medical records would significantly aid this important education process.

4 Standard 3: Assessment

4:1 Multiple assessment tools are used across the curriculum to measure progress towards independent practice. The ultimate summative assessment is the College of Family Physicians of Canada certification examination where residents' performance gives no cause for concern.

⁷ Ogur, B et al Academic Medicine: [2007; 82: 397-404](#)

4:2 We were impressed by the application of the field tools, In-Training Evaluation Reports (ITERS) and progress testing. These provided a good mechanism for early identification of struggling trainees and extension of training when necessary.

4:3 It was less clear how efficiently procedural skills were being assessed and recorded. The logs we saw were patchy, inconsistent and failed to document comprehensive cover of skills competencies; a cause for concern. We learnt that in FM logs are kept but not necessarily on hospital rotations. Fully comprehensive recording of skills achievement to highlight gaps would be reassuring to assure standards of patient safety. We recommend:

Recommendation 4: Recording procedural skills competencies: Overall the records we saw were patchy, had significant gaps and did not reflect actual achievement. Given this is an important appraisal of skills competency, records need improvement especially in procedures performed in hospital settings. Entrustable Professional Activities (EPAs), if evidence emerges to confirm their validity and reliability, may help.

4:4 Assessing professional behaviour against the CanMeds framework was less explicit. Given the current trend to use personal portfolios to assess and document the positive development of professionalism, and highlight where it is lacking⁸, we recommend:

Recommendation 5 Assessing professionalism: CanMeds values are well embedded across the programme. A move to explicitly appraise the trainees' development of reflective practice and application of these professional values through a personal portfolio is recommended. Current assessment tools, such as multi-professional feedback, are proving effective and could be introduced.

5 Standard 4: Trainees:

5:1 Residents were uniformly positive about their preparation for independent practice. They felt empowered, autonomous in self directing their learning, listened to, and effective in initiating change through good representation on committees. They were well supported and could work outside their comfort zone knowing faculty always provided a safety net.

⁸ Hodges BD et al 2010 Med Teach; 33: 354-363.

5:2 Opportunities within training for electives and taking an enhanced skills training year were valued. Leadership development is encouraged. There are ample opportunities to develop education and research scholarship.

5:3 There was clear evidence of immediate effective support to trainees in crisis through the PARO emergency help line and the web site red button. Other initiatives such as Balint groups, mindfulness training and wellness initiatives are offered. This is impressive support.

6: Standard 5: Staffing

6:1 As already intimated, the staff to trainee ratio is remarkably high and key to the success of the programme.

6:2 It is a large faculty. We learnt that circa 70% of the faculty members are ranked at the level of lecturer . We suggest provision of resources to support promotion.

6:3 Trainees reported receiving adequate verbal feedback from staff but less frequent written recording of ways to improve. The records we saw confirmed this. We noted trainers tended to consistently score trainees highly on workplace-based assessment (WBA) and offer limited constructive written feedback on areas to improve. Internationally there is a move to assess more formatively **for** learning rather than focus on assessment **of** learning.⁹ There is increasing recognition that in competency driven curricula trainees need nurturing to aspire for excellence beyond “a just good enough” perception of competency¹⁰.

Recommendation 6: Feedback: Faculty training on feedback is recommended. We suggest a critical look at the need to grade feedback, given evidence is emerging that words are more effective than numbers¹¹.

7: Standard 6: Training setting and resources.

7:1 Within the inevitable limits of the visit which restricted the range of sites seen, we concluded the setting, residency structure and allocation to training trusts and resources met the curriculum requirements.

⁹ Konopasek L et al. Academic Medicine 2016; 91:1492-7

¹⁰ Doctors in Society: Medical Professionalism in a Changing World

<https://shop.rcplondon.ac.uk/products/doctors-in-society-medical-professionalism-in-a-changing-world?variant=6337443013>

¹¹ Norcini J & Burch V Medical Teacher AMEE Guide 31 <http://www.informaworld.com/smpp/title-content=t713438241>

7:2 IT support should be enhanced to facilitate the ability to gather numbers of patients, diagnostic codes, demographics of patients seen, procedures, and other pertinent process data, to give an accurate assessment of what residents are doing. This would aid residents to more accurately document patient encounters and follow educational exposure and progress over time (see 3:5).

8: Standard 7: Evaluation of training process

8:1 We were satisfied that the programme followed a continuum of regular feedback, evaluation and change. Residents reported being actively engaged in the process (see 5:1).

9: Standard 8: Governance and Administration

9:1 Training is conducted in accordance with the University and national CFPC regulations for structure, content, process and outcome. Budgeting of training resources appeared to be appropriate.

10: Standard 9: Continuous renewal

9:1 As outlined in 1:3, the programme follows a standard national accreditation cycle led by the CFPC.

Conclusion:

We recommend to the WONCA Executive that the DCFM at the University of Toronto is accredited for five years and congratulate the University of Toronto on their achievements. No programme should ever stand still. We offer the above recommendations for further development:



Professor Val Wass



Dr Garth Manning



Dr Viviana Martinez Bianchi