Breaking Through the Boundaries

2004-2009 Strategic Plan
Department of Surgery
University of Toronto
July 2004

TECHNICAL APPENDIX
Summary Notes
Department of Surgery – Strategic Planning Retreat
March 26, 2004

Contents

Summary of Synthesis of Issues Arising from the Strategic Planning Process

Summary of Proceedings from the Department of Surgery Retreat
## Summary of Synthesis of Issues

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<th>Theme</th>
<th>Findings and Issues</th>
<th>Key Strategic Issues/Tensions</th>
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<tr>
<td><strong>External Environment</strong></td>
<td><strong>Technology</strong></td>
<td>Advances in technology will necessitate rethinking training and practice of surgery</td>
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<td>• Accelerating change technologically, primarily driven by molecular engineering, genetics, technology; implications for realignment of skills and resources; information technology and communication</td>
<td>Need to consider the type of people to be trained for what type of system and optimal sites for this new training</td>
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<td>• Major advances in diagnostics, medical imaging and interventional radiology</td>
<td>Cross-discipline dialogue will become increasingly important</td>
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<td>• Changes in practice that are blurring the lines between surgery and other disciplines</td>
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<td>• Emerging <em>halfway technologies</em>—molecular and tissue transplant and repair, robotics, imaging control, fundamental change in the management of specific disease problem</td>
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<td>• Moving from maximally to minimally invasive surgical techniques and procedures</td>
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<td>• Moving upstream to new diagnostic techniques and sideways to new techniques of intervention; new orientation will need to be the problem to be solved—rather than the technique</td>
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<td>• (i.e. cancer)</td>
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<td>• Services will no longer be trained by the well-trained sole practitioner; will operate in a system of well-trained support systems</td>
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<td>• Increasingly the practice of surgery will require the work of interdisciplinary teams, changing the workload and current pressures on surgery</td>
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<th>Theme</th>
<th>Findings and Issues</th>
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<td><strong>Organization of Surgery</strong></td>
<td>• Fragmentation into subspecialties threatens critical mass, increases silo mentality</td>
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<td>• Teaching hospitals will continue to change the way they are organized bringing multiple disciplines together, forcing the reorganization of traditional departments</td>
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<td>• Supporting infrastructure—trend for more and sophisticated technology practice inside teaching hospital, yet same structure has responsibility for training students where this level of supporting infrastructure is not available</td>
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<td>• Department will need to explore various collaborative arrangements, with other surgical specialties and Faculties, i.e. Biomedical Engineering</td>
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<tr>
<td>External Environment</td>
<td><strong>Political Environment and Changes to Health Care System</strong></td>
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| Key Trends – Implications for Organization and Practice of Surgery | • Federal government will need to revisit sustainability of the system and how it is financed; current provincial environment not receptive to privatization  
  • Increasing accountability to government, to public  
  • Three new provincial health priorities: decrease waiting times (including some surgical procedures); increase access to family physicians and primary care; increased attention on health promotion and prevention  
  • Increasing trends towards co-ordination and integration, shared services “regionalization”, care transformation (Electronic Health Record), registries  
  **Research Environment**  
  • Funding environment continues to be favourable for grant funding, ongoing challenges with securing sufficient infrastructure funding |                                                                                             |
| Alternate Funding Plans           | • Alternate funding plan is seen as the single most important mechanism for bringing stability to clinical faculty across the Department  
  • Strong Department and Faculty preference for a “horizontal alternate funding plan” although some divisions still favour the notion of addressing “hot spots” first  
  • Fee for service income is no longer sustainable in a high-end tertiary/quaternary teaching hospital environment  
  • Surgeons need a stable personal income and need protected time to do teaching and research  
  • Highly competitive environment where surgeons are being “spirited away” to the United States and across Canada to Alberta, British Columbia and Halifax where very competitive alternate funding plans are in place |                                                                                             |
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| Hospital University Relationships | • Increasingly strong role of teaching hospital in research, teaching and setting clinical priorities that have implications for academic medicine  
• Department goals not well enough aligned with hospital goals (i.e. “No overall master plan for surgery. Hospitals have the resources, but we have the human resources”)  
• Hierarchical structure of Faculty of Medicine and Department of Surgery works at cross-purposes with programs. Need more alignment in structure. “Need to shift thinking to program, rather than discipline”  
• Shrinking university budget has had impact on influence and authority of academic department; need reaffirmation from Surgeons-in-Chief and CEOs that they will continue to support the Department and its academic mission  
• Affiliation agreements under revision, changing from bilateral to multilateral agreements  
• Voluntary discussions under way with hospitals and university departments re: streamlining and consolidation of some specialty services’ - strong recognition that “we need to find a regional approach to everything we do”  
• (CEO perspective) “Surgery is seen as a way of differentiating from other hospitals, including community hospitals”. (Surgery is so resource intensive, always is on the CEO’s radar screen”)  
• Hospitals supportive of alternate funding plan to support academic mission, however, need to ensure clinical productivity is also maintained  
• Surgery needs stability in the hospital sector. Surgery is much more dependent than Medicine on our teaching hospitals, therefore stable funding bases and sufficient hospital resources are critical to Surgery achieving its mandate | Departmental strategic planning needs to actively involve the teaching hospitals  
Need city-wide joint AHSC and academic Department approach to setting program priorities, with a view to strengthening clinical and academic components  
Teaching hospitals must reaffirm support of Department and of Surgeons-in-Chief; need clear process for joint senior hospital/university appointments  
Investing in seamless information system between hospital and university will strengthen working relationships among all parties – need common database and common performance measures |
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| **University of Toronto, Faculty of Medicine and Relationship to Other Clinical Departments** | • Continuing successive years of budget cuts, increasing the proportion of support that comes from teaching hospitals  
• Eroding funding base is seen as a major threat to sustaining excellence in teaching and research  
• Aggressive efforts needed to explore funding strategies to support and reinforce the resource base  
• Continued emphasis on research, with renewed focus on teaching and valuing clinical teachers; strong emphasis on interdisciplinarity and diversity  
• Faculty supportive of horizontal alternate funding plan, with Departmental Chair linked to governance  
• Renewing affiliation agreement with fully affiliated hospitals and reviewing agreements and relationships with partially affiliated teaching hospitals  
• Faculty priorities remain consistent with 2000 Strategic Plan, midcourse review currently underway  
• Chairs have less input into hospital priority setting and decision-making; need more collaboration amongst the Chairs – requires different organizational structure to leverage collective strength (i.e. surgical and related specialties department)  
• Clinical faculty questioning the relevance of the University in today’s medical economy | Growing constraints being placed on departments as a result of University resource limitations and cutbacks  
Greater collaboration and consolidation of surgical related specialties is seen as one way of strengthening the resource base and reinforcing influence of surgery  
Be more strategic about aligning with key partners and leveraging the strength of the Department to attract greater autonomy/control |
| **Education** | **Strengths**  
• Individual teachers  
• Strong program leadership  
• Reputation of Chair  
• Foreign residents  
• Breadth of University resources  
• Patient base  
• Education research and scholarship  
• Department’s research strength and links to teaching  
• Trainee base (CARMS Match) | Balancing teaching role with clinical workload is becoming increasingly difficult. Changing and increasing expectations from University in terms of teaching, appointments and promotions. More demanding clinical environment, with more complex patients  
Growing funding requirements to address pressures in teaching and research  
National issue with undergraduate medical students dislike/lack of interest in surgery clerkship. Need focused strategies and objectives to enhance clerkship |
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<td>Education</td>
<td><strong>Weaknesses</strong>&lt;br&gt;• Faculty “burnout”&lt;br&gt;• Perception that residency and life of surgeon is terrible&lt;br&gt;• Diminishing numbers of clinical role models because of rising academic and research expectations of faculty (“every division should have a cutter, clinician role model for teaching in the OR”)&lt;br&gt;• Limited recognition and remuneration for clinical teachers&lt;br&gt;• Ranking of surgical undergraduate education has declined to national mean&lt;br&gt;• Fellowship enterprise needs reorganization&lt;br&gt;• Limited resources and administrative support to support Program Directors&lt;br&gt;• Lack of formal implementation plans for achieving mandates in various training programs</td>
<td>Advances in technology, particularly changes in diagnostics and imaging, create opportunities in joint training program and challenge current training models</td>
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<td><strong>Opportunities</strong>&lt;br&gt;• Collaborative program with medical imaging and surgery&lt;br&gt;• Coordinate IT/MIS technology – MIS is a major area of opportunity&lt;br&gt;• Expand offerings of Surgical Skills Centre&lt;br&gt;• Cancer care for is an area of growing educational opportunity&lt;br&gt;• Increase attention on service/delivery activities not currently receiving appropriate attention; in particular, ambulatory/outpatient caseload and needs of research fellows&lt;br&gt;• Explore new training models to address problems that have arisen with respect to ‘fragmented’ training (i.e. pre-op, surgery, post-op continuum)&lt;br&gt;• Simulation (Department could be leading centre in simulation)&lt;br&gt;• Web-based, more computer driven, with new curriculum available on the web&lt;br&gt;• Greater emphasis on evaluation&lt;br&gt;• Rethink and revitalize postgraduate education; implement recommendations from postgraduate education retreat&lt;br&gt;• Consider placements outside Toronto (international exchanges)&lt;br&gt;• Surgical training for non-physicians, i.e. nurse practitioner, physician extenders&lt;br&gt;• Continuing education can be expanded – provides revenue generating option</td>
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| Education  | - Faculty burnout, lack of remuneration for clinical teachers, “at the wall of what they can do”  
- Balancing clinical and academic pressures, in an environment where there are both greater academic and clinical pressures  
- Providing appropriate training for undergraduate medical students in a highly complex environment of increasing acuity – changing mix and number of patients available to teach fundamental surgical skills  
- Increasing competition for clerkship time by other disciplines  
- Resident attrition in a number of specialties  
- Clarification of clinical fellow role |
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<td><strong>Strengths</strong></td>
<td>Incredible momentum in surgical research; need to capture the opportunity for increased research funding in Canada</td>
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<td>• Bright, energetic faculty, “enlightened leaders who sustain environment for research”</td>
<td>Department should have focused areas of research with recruitment practice aligned to priorities; this requires further alignment with hospital research institute priorities</td>
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<td>• Surgeon Scientist Program, internationally recognized</td>
<td>Need to secure alternate funding plan to enable recruitment and retention and to secure protected time for research.</td>
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<td>• Ten year Johnson &amp; Johnson commitment to support Surgeon Scientist Program</td>
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<td>• Strong clinical research</td>
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<td>• Royal College Clinical Investigator Program</td>
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<td>• Excellent collaboration with hospital- based research institutes</td>
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<td>• Impressive growth in research funding</td>
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<td></td>
<td><strong>Weaknesses</strong></td>
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<td>• Fee for service model incompatible with recruiting and retaining faculty</td>
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<td>• Department-wide research priorities have not been set because hospitals tend to provide infrastructure and resources, therefore research tends to be aligned to hospital priorities</td>
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<td>• Need enhanced research role of “non-clinician scientist”</td>
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<td>• Length of clinician scientist training program – need alternatives to engage others in research</td>
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<td><strong>Opportunities</strong></td>
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<td>• Strength of University is basic research, Department can facilitate interhospital translational biology</td>
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<td>• Leverage strength in translational research, with industry partners to raise funds for Department</td>
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<td>• Department can play a role in city-wide initiatives, i.e. personalized diagnosis and treatment, clinical information and database, image guided therapy and interface with surgery; tumor banks, facilitate clinical trials, ethics</td>
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<td></td>
<td>• “Capture every case in a database”</td>
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<td>• $8 million in research space</td>
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<td>• Canada Research Chairs and endowments</td>
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<tr>
<td><strong>Research</strong></td>
<td><strong>Challenges/Priorities</strong>&lt;br&gt;- Recruit and retain excellent individuals – need to secure alternate funding plan that is competitive nationally and with United States&lt;br&gt;- Balancing clinical and research mission, increasingly difficult with rising acuity of patients&lt;br&gt;- Promotion of surgeon scientist training (role modeling; funding mechanisms during training)&lt;br&gt;- Support of interdisciplinary research (basic science to the bedside)&lt;br&gt;- Continued recognition of importance of research through all levels of training&lt;br&gt;- Ongoing and continued university/hospital research institute interaction and collaboration</td>
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<td><strong>Faculty Recruitment, Retention, and Renewal</strong>&lt;br&gt;- Residency work hour cutbacks and increasing service requirements&lt;br&gt;- Ongoing global competition attracting top caliber candidates to senior clinical, educational and research positions&lt;br&gt;- Delays in finalizing alternate funding plan agreements contributing to growing concerns about staff recruitment and retention being felt by a number of departments within teaching hospitals&lt;br&gt;- Mentoring, role modeling and faculty development are required&lt;br&gt;- Place greater emphasis on better managing and nurturing current staff resources more effectively&lt;br&gt;- Changing work patterns of new surgeons requires rethinking traditional staffing patterns&lt;br&gt;- Age of workforce; increasing risks (changes in PAIRO contracts and residents service, medical legal constraints and burnout)</td>
<td>Must secure alternate funding plan for all surgical divisions; must be horizontal to strengthen the university/hospital partnership&lt;br&gt;Must develop strategies to attract young doctors (particularly women) into surgery as a specialty</td>
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<td><strong>Diversity</strong>&lt;br&gt;- “No question of the necessary ethnic diversity of a population is an important contributor of success”; way of harnessing the potential of a community&lt;br&gt;- Requires role models; should look for people with diversity of experience as well as gender and ethnic diversity&lt;br&gt;- Difficulties attracting women into the discipline: 50% of undergraduate medical students are women; 20% surgical residents; 5% faculty</td>
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<td><strong>Interdisciplinarity/Interdisciplinary Collaboration</strong></td>
<td>• Reach out to other disciplines outside the faculty (Dentistry, Engineering, Physical Sciences)</td>
<td>Need better process or ground rules for working with University and hospital foundations around fundraising initiatives to avoid conflicts and competition</td>
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<td>• Explore new partnerships, i.e. joint residency in surgery and interventional radiology</td>
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<td>• Appoint surgeon scientists from outside the discipline</td>
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<td>• Diverse faculty within surgery in terms of intelligence should be leveraged</td>
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<td><strong>Alternative Funding Strategies</strong></td>
<td>• Declining University budget makes looking for alternative sources of revenue a necessity</td>
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<td><strong>Government Compensation</strong></td>
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<td>• All divisions need to be funded through alternate funding plans; need to press on with negotiations</td>
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<td><strong>Fundraising</strong></td>
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<td>• Surgery has gone from 3 to 20 chairs since 1992</td>
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<td>• Department has its own Development Officer who works with the Faculty, has brought in incremental dollars to Department</td>
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<td>• Need to manage hospital/university conflict and competition</td>
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<td>• Best collaborative venture, large program or centre where both University and hospital can promote a piece</td>
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<td>• Surgical Skill Centre should be leveraged</td>
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<td><strong>Surgicentre</strong></td>
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<td>• Innovative clinical, teaching and research model that has potential to generate additional revenues; need to develop business plan to assess feasibility</td>
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<td><strong>Industry Partnerships</strong> (see more below)</td>
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<td></td>
<td>• Surgical robotics</td>
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<td>• Alpha development site for new technologies</td>
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<td><strong>Educational Models</strong></td>
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<td>• Training courses, continuing medical education offerings</td>
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<td>• Simulation, web-based programs</td>
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<td>• Rogers TV – educational capital; market for certain products “stuff already on the shelf”</td>
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<td>• Surgical physician assistant training, physician extenders</td>
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| **Industry – Department Partnerships**    | • Need careful management and at arm’s length, under increasing scrutiny; process and principles of engagement must be clear  
  • Potential partners, pharmaceutical, biotechnology, | Partnerships with industry should be explored, but terms of engagement and expected outcomes must be clear from the outset |
| **Envisioned Future**                     | • “Internationally recognized leader in the field of surgery and in clinical care”  
  • Department of Surgery could be an umbrella department for more diverse disciplines  
  • Needs to prioritize and focus. Needs greater alignment with teaching hospitals in establishing these priorities. “Work closely with hospitals to develop a master plan”.  
  • The future is “minimally invasive and interventional” | Department needs to reconfirm its mission and articulate a new vision for the future |
Strategic Planning Retreat

Presentation Highlights and Summary of Discussion

Date: Friday, March 26, 2004
Place: Vaughan Estates, Toronto

Opening Remarks/Context for Strategic Planning

Richard Reznick, Chair

- The day provides an opportunity for members of the Department to think boldly, to shed traditional ways, and adapt to a new reality.
- Need to remember that this is not being done in isolation but in intricate partnership with the Faculty of Medicine and the teaching hospitals.
- Theme of the day is “pulling together” and determining how to harness the energy within the Department.

Context/Considerations Impacting on Surgery in the Future

- AFP planning/agreements
- Ramped up technology
- Outcome = high volumes
- Strategic development of business partnerships
- Interdisciplinarity
- Diversity within the Department

Accomplishments/Achievements in Recent Years

- Fundraising
- Research (external funding increased from $19 to $27 million in recent years)
- Political activity
- Centres of global excellence
- Education – last year had two education retreats (residency retreat; exam writing workshop)
- Surgical Skills Centre
Process for Development of a Strategic Plan for the Department
Michael Jewett, Chair Strategic Planning

The essence of strategy is about choice, trade-offs and fit”.
- Michael Porter

Purpose of the Session
• Share the planning process and progress that has been made to date
• Share feedback from the consultation process
• Confirm emerging priorities
• Develop bold goals and innovative actions to support these priorities
• Provide input to the strategic directions for the Department of Surgery for the next five years

Review of Strategic Planning Process: A Four-Phased Approach
Phase 1: Project start-up
Phase 2: Identify key issues, opportunities and challenges
Phase 3: Test strategic priorities, develop goals and actions
Phase 4: Prepare strategic plan

Inputs to Process
• Department of Surgery External Review, summary report and preparation documents
• Postgraduate education retreat
• Departmental Plan 2000
• Stepping Up, Framework for Academic Planning and Faculty of Medicine Guidelines to Departments
• Strategic issues and priorities identified through interviews and focus groups

Environmental Scan Sought Input from Internal and External Sources
• Over sixty contacts and inputs from interviews and focus groups
• Stakeholder groups included: Senior Advisory Committee; Research Committee; educational leaders; “Wise men from industry”; CEO, TAHSC Chair; clinical sector Chairs; development/fundraising; surgicentre leaders; targeted individuals (internal/external)

Key Issues and Themes Emerging
• The changing external environment – accelerating change technologically; changes in practice that are blurring the lines between surgery and other disciplines
• The changing political environment – enhanced emphasis on accountability; limited support for privatization; renewed interest in regionalization
• Increased urgency for alternate funding plan to help balance clinical and academic mission
• Changing hospital-university relationships and increasing dependency on teaching hospitals and their priorities
• Declining interest in surgery as a choice for young doctors, particularly women
• Changes needed in all levels of training programs
• University funds continue to decline, alternative sources of revenue required, included alternate service delivery models

Emerging Strategic Priorities
• Secure alternate funding plan across the Department
• Exploit impacts of advancing technology on changing practice and organization of surgery, including all training programs
• Promote interdisciplinary in teaching and research
• Attract young doctors, particularly women, to the discipline
• Maximize hospital-university relationships, including joint planning and priority setting
• Establish alternative sources of revenue
### SWOT Analysis

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<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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| • Department recognized as top in Canada; top 10% in the world  
• Impressive research productivity, over $21 million in grant funding  
• Outstanding, well-funded Surgeon Scientist Program  
• Large, diverse accomplished faculty  
• Strong educational research and scholarship  
• Affiliated teaching hospitals with well-established hospital-based research units  
• Academic leadership in teaching, research and clinical portfolios  
• Solid trainee base and leader in CARMS match  
• Innovative Surgical Skills Centre, emergency skills centre | • Successive cuts to University budget, eroding resource base  
• Inability to achieve Department-wide alternate funding plan  
• Faculty burnout  
• Low morale of clinical teachers  
• Age of workforce  
• Decreasing numbers of clinical role models  
• Undergraduate program slipping in rankings  
• Clinical fellowship program needs reorganizing  
• Surgery decreasing in popularity as choice for young doctors, especially women |

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<th>OPPORTUNITIES</th>
<th>THREATS/CHALLENGES</th>
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| • Leveraging advances in technology  
• Simulation  
• Web-based technology for teaching  
• Leveraging Surgical Skills Centre  
• Academic freestanding surgicentre  
• Teaching and research in cancer care  
• Joint training programs with Imaging and Interventional Radiology  
• Minimally invasive surgery  
• Opportunity to rethink and revitalize postgraduate education  
• Continuing medical education  
• Training for non-physicians (i.e. physician extenders)  
• Mentoring, role modeling and faculty development  
• Collaboration with other surgical specialties and disciplines, within and outside surgery  
• City-wide collaboration in tumor banks, clinical databases, clinical research and ethics  
• Industry partnerships  
• Rich research funding environment at federal and provincial levels  
• Enhanced role of non-clinician scientist | • Difficulties in balancing clinical and academic missions  
• Maintaining influence with hospitals with diminished resource base  
• Retaining and recruiting staff in a highly competitive environment  
• Establishing city-wide joint process with TAHSC to set clinical priorities that strengthen academic and research programs  
• University departmental structure versus hospital programmatic structure  
• Blurring lines between surgery and other disciplines  
• Creating alternative sources of revenue  
• Increasing the diversity of the Department, particularly women faculty  
• New provincial government that is opposed to privatization  
• Lack of financial stability in the hospital sector which translates to uncertainty for surgical programs |

**Today’s Challenge**
- Think big – think bold
- Identify major goals and actions that the Department of Surgery should undertake to achieve its vision of: *International leadership in health research, education and surgical practice.*
GO WEST YOUNG SURGEON, GO WEST...SECURING ALTERNATE FUNDING PLANS AND OTHER POLITICAL REALITIES FOR SURGERY

Moderator: Zane Cohen, Surgeon-in-Chief, Mount Sinai Hospital/University Division Chair, General Surgery

Panelist – David McCutcheon, Assistant Deputy Minister, Ministry of Health and Long-Term Care

- The 2000 Ontario Medical Association agreement theoretically expires on March 31, 2004 but is expected to be extended.
- Phase 1 negotiations, agreements, implementation discussions were undertaken between 2001-2004.

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<th>Rationale for AHSC Alternate Funding Plan</th>
<th>Goals for an Alternate Funding Plan in an AHSC</th>
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<td>Recognize academic activity of physicians</td>
<td>Recognize the full contribution of academic physicians to the academic mission</td>
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<tr>
<td>Recognize innovative role of physicians in clinical care and need for greater flexibility</td>
<td>Offer AHSC physicians increased flexibility through a global funding mechanism – begin to address the fee-for-service treadmill</td>
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<tr>
<td>Recognize the need for better co-ordinating of the missions for academic physician with the teaching hospitals and the University</td>
<td>Enhance or maximize the deployment of physician services in an AHSC</td>
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<tr>
<td>Alternate funding plans as an alternative to move away from fee-for-service environment</td>
<td>Redress the voluntary or self-funded clinical education conundrum</td>
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<td>Enhance/improve collaboration between the parties i.e. align the goals and incentives of the AHSC medical staff, teaching hospitals, universities</td>
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<td>Maintain and enhance clinical care</td>
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<td>Stabilize the medical staff complement at AHSCs</td>
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<table>
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<tr>
<th>Essential components of an AHSC Alternate Funding Plan</th>
<th>Current Status: AHSC Alternate Funding Plan Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance structures</td>
<td>Total number of participating physicians in newly negotiated alternate funding plans is 2,678</td>
</tr>
<tr>
<td>Funding</td>
<td>All phase 1 agreements are scheduled to expire September 30, 2004</td>
</tr>
<tr>
<td>Measurable deliverables</td>
<td>Total new funding: $75 million AHSC alternate funding plan annualized funding from 2000 Ministry of Health and Long-Term Care/Ontario Medical Association agreement</td>
</tr>
<tr>
<td>Methodology for payment</td>
<td>$23 million in new funding (annualized) from 4th Ontario Medical Association/Ministry of Health and Long-Term Care agreement re-opener, was approved for implementation of five specialty areas</td>
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<tr>
<td>Human resources plan</td>
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<td>Provisions for change</td>
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<tr>
<td>Broad participation</td>
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Feedback and Next Steps

- Ministry hosted a workshop session in January 2004 to better understand expectations regarding the next phase of negotiations
- Surgery proposal being reviewed at AHSC side table at Ontario Medical Association negotiations
- Next steps dependent on outcome of Ontario Medical Association/Ministry of Health and Long-Term Care negotiations
COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

Department should consider adding the following “priorities” to their agenda:

• Research work related to health services research to their agenda; need to look at cost-benefit and cost-effectiveness analysis [i.e. quality of work-life issues; patient safety; variations in surgical practice]
• Development of mechanisms for better co-ordination across strategic plans of all Academic Health Sciences Centres [i.e. mechanisms to streamline work here]
• Development of a good recruitment plan for the Department and provincial needs/requirements overall
• Addressing issues related to vascular surgery

Panelist – David Pattendon, Executive Director, Ontario Medical Association

• Changing technology is impacting on surgery.
• Political environment is also becoming an increasingly important consideration.
• Changing professional environment – huge difference in opinions and attitudes within specialties; gender groups; age groups. Current graduates not interested in being on the fee-for-service – do not want to operate a business, want pensions and benefits. 55–60 year age group had different expectations, etc.
• The differences illustrate the diversity and challenge in trying to come up with any kind of a plan. Other considerations: fee-for-service basis; practice plans; alternate funding plans (some within specialty groups; some attempts to have Faculty-wide plans; some provincial issues; some national issues); trying to establish ‘equity’ in remuneration rates; foundations (to what extent do you stabilize versus allowing flexibility); the community centres; gender issues; government objectives.

COMMENTS ON FUTURE DIRECTIONS/PRIORITIES FOR THE DEPARTMENT

• Important to position yourself as a resource to government
• Need to recognize differences across teaching sites
• Importance of having local input from physicians that relate to particular sites

Panelist – Robin Richards, Surgeon in Chief, Sunnybrook and Women’s College Health Sciences Centre

• The system in terms of demand has been under-funded for years.
• Cost containment has had a tremendous impact on surgery.
• Other changes impacting on surgery include: the relative value review; generational change; ongoing reforms; and a number of “hot spots” across the system that have made academic surgery itself a hot spot.
COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

There are five questions that should be asked and addressed by the Department as part of the strategic planning process:

1. Would you sign your Memorandum of Agreement if starting out now?
2. Is the current environment sustainable?
3. What are merits of addressing hot spots versus adapting a more integrated approach to develop strategies for the medium to longer-term future?
4. What are critical elements required to sustain academic surgery/academic productivity?
5. If there is a need for a new paradigm, how can it be achieved?

DISCUSSION/QUESTIONS ARISING

- What about perceived inequity that exists between Ontario and other provinces in terms of remuneration rates?
- What about the distress being created by the current approach to addressing “hot spots”? What impact will addressing the hot spots have on the potential to develop a horizontal alternate funding plan (i.e., the whole process)?
- What is the official position of the Ontario Medical Association with respect to alternate funding plans?
- When are we going to get to Phase 3 (implementation of full alternate funding plan)? What are the timelines?
- Why does government focus on clinical volumes versus research/academic contributions?
- What about pensions?
- What about vertical versus horizontal governance structures?

One of big problems in developing alternate funding plans is being able to compare current physician incomes given the many different arrangements in place.
- Should the objective be to equalize incomes across the country?
- “Hot spots” addressed because of significant recruitment issues identified in these areas. Important to remember that this is a transitional time and in the absence of a lot of money, it was decided to begin by focusing on a few “high pressure” areas.
- Ontario Medical Association is “hugely supportive” of alternate funding plans. The model being used is to work with individual sites within a general framework.
- It may be time for the Department to rethink its position on alternate funding plans. Although health care is administered provincially, there is a very real national and international marketplace for physicians.
- Need to make sure that Phase 3 is what we want and need. There is a general lack of trust that if physicians move entirely to a complete conversion to alternate funding plans then the province will “get what they want” (i.e. restrict money given to physicians within Ontario).
- It will be important to consider all of the options before finalizing plans for Phase 3 (i.e. Kaiser Permanante model based on 70% of income being fixed and 30% flexible).
- Different views in different parts of the province (i.e. Toronto more willing to move to Phase 3; other regions want to move more cautiously).
- Government not taking into consideration the academic work and accomplishments (i.e. Toronto recently received 30 percent of funding from Canadian Institutes of Health Research).
- A key challenge is figuring out how to measure research outcome/output.
- There have been discussions about pensions. However, the issues are complicated i.e. do physicians want to give up their status as independent contractors; how do you develop effective pension plans for 50+ group.
### OUR CHANGING ENVIRONMENT
### TAKING THE LONG VIEW – SURGERY IN A CHANGING WORLD

*Presenter: Alan Hudson, President, Cancer Care Ontario*

- It is important to do a little diagnostic and find out where you are in terms of standing and competitiveness: *Is this a company that has done well but is going to shortly fall flat on its face?*

<table>
<thead>
<tr>
<th>Heading for a fall</th>
<th>What kind of change?</th>
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<tbody>
<tr>
<td>• Self congratulatory</td>
<td>• Incremental change (incremental but no real change in direction)</td>
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<tr>
<td>• Inwardly focussed</td>
<td>• Evolutionary</td>
</tr>
<tr>
<td>• Not watching the marketplace</td>
<td>• Revolutionary</td>
</tr>
<tr>
<td>• Unethical behaviour</td>
<td>• First to market (we should be a lot more in this position; this is a risk taking kind of change; we were the first doing double lung transplant, etc.) – need to get vision and timeline straight and then implement. Did it by “chunk it” method.</td>
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Examples: EATONS versus WALMART

<table>
<thead>
<tr>
<th>Principles underlying significant change</th>
<th>It’s the right people, stupid</th>
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<tbody>
<tr>
<td>• Discontent (how much do you have? If you do not have it, create discontent)</td>
<td>• Agreement, disagreement, black holes</td>
</tr>
<tr>
<td>• Vision, strategy, tactics</td>
<td>• Leadership, strategy and execution</td>
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<tr>
<td>• Speed (crucial; need to do something before voices of discontent emerge; will get criticized; once you decide what you want to do get on with it)</td>
<td>• The changing team, a measure of reality.</td>
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<tr>
<td>• Novel approaches</td>
<td>• Planning part is easy. Execution is the difficult part.</td>
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</table>

Examples: Cancer Care Ontario, Princess Margaret Hospital merger, University Health Network rebuilding

- It’s the right people, stupid
  - Agreement, disagreement, black holes
  - Leadership, strategy and execution
  - The changing team, a measure of reality.
  - Planning part is easy. Execution is the difficult part.
  - The plane is leaving. If they are not ready, leave them behind.
  - This is about success and failure.
COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

- Information management and information technology important
- Technology: trends in technology assessment; trends in emerging/changing technologies
- Communications absolutely critical. Need to meet personally and individually with those affected by chance. Get professional help on how to do this.
- Important to include the concept of safety in anything you do; this is paramount (a “hook” for “quality”); incentivize (Surgery way behind here).
- *What can be done to position the Department in the international context/environment?*
- *What can be done to position the Department in the Greater Toronto Area context/environment?*
- Cancer should be a key priority: vision could be to be the world leader in cancer research, teaching, clinical practice, etc. – take on cancer as an entire Department. The laboratory for this theme should be the entire Greater Toronto Area.
- **Other advice:** Set out where you are going and get on with the job. Expect the unexpected. There will be some painful consequences.
- Plan on making a significant change, but not a huge change.
- The Medical University of Toronto (International Network)
- Consider establishing the Greater Toronto Area Network of Health Services and Intellectual Resources – this would have a single Board, single CEO with authority and scope of department/hospitals well defined (needs to be decided by hospitals).
- “Bet half the company”: combine revolution, evolution and incremental change.
WHERE HAVE ALL THE SURGEONS GONE? Addressing the issues of recruitment to the discipline, diversity and career development

Moderator: Robin McLeod, Head, Division of General Surgery, Mount Sinai Hospital

What will it take to recruit more women into surgery?

Panelist: Andy Smith, Head, Division of General Surgery, Sunnybrook and Women’s College Health Sciences Centre

- Recruitment and retention is a challenge across the Department. Some issues relate specifically to women, others are relevant to women and men. Generally speaking, the issue of lifestyle has become an increasing concern for those contemplating a future in surgery.

<table>
<thead>
<tr>
<th>Reasons for concern</th>
<th>Solutions</th>
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<tr>
<td>Women comprise about 50% of the medical school class</td>
<td>Attitudes about surgery – change in the way we do things is possible; parenting policy (not “maternity”) – accessible child care</td>
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<td>There is no gender difference among final year medical students that consider a surgical career</td>
<td>Larger call groups, etc.</td>
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<tr>
<td>Significantly fewer women choose surgery as a profession</td>
<td>Create a mentoring culture: experienced surgeons are encouraged and expected to mentor; mentoring counts towards promotion</td>
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<tr>
<td>Applicants for surgery are down overall. Each year 7-28% of recruits are women</td>
<td>Mentoring opportunities</td>
</tr>
<tr>
<td>Attrition is increasing – slightly less than half of those who leave are women</td>
<td>Female recruitment not optimal presently; changes needed to improve recruitment and retention; essential to meet the needs of the population in the present and future</td>
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<td>What do female recruits see when they look at us? Fewer women than student body; men “running the show”; paucity of female role models</td>
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<td>Nepotism and sexism – dreadful under-representation of women at higher levels of academic surgery</td>
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<tr>
<td>Mentorship issues for women: female students feel that surgery not compatible with rewarding family life, happy marriage, raising children; women choosing surgery more likely to come from schools with higher percentage of female teachers</td>
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<tr>
<td>Parental wall: men and women involved in parenting; female MDs spend more time on family care responsibilities than their male counterparts; can derail professional progress</td>
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Gender diversity with a twist

Panelist: Jenny Blake, Associate Chair, Department of Obstetrics and Gynaecology

- Fewer men choosing obstetrics and gynaecology. General agreement that this is a problem: impacts on patient choice; practice patterns
- How did we get here? Gender appropriate role models (may not make a big difference); discrimination; comfort zone; malpractice premiums; lifestyle concerns; socio-cultural shift; College of Physicians and Surgeons of Ontario task force on physician abuse; peer pressure
- What have we done? Talked about at national meetings; clerkship – make sure men get clinical experience; electives – introduce to specialty; “audition”; Career night – male resident; interview process (gender mix)
- What have not done? Imposed quotas; given preferential treatment
- Implications for obstetrics and gynaecology? Potential human resources crisis

What do our junior faculty need?

Panelist: Carol Swallow, Program Director, General Surgical Oncology Fellowship Program

- Reported on results of a survey of recently hired faculty (time period: 1996-2002). Survey focused on clinician academics.

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<tr>
<th>Method of survey</th>
<th>Results/Suggestions for Improvement</th>
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<tr>
<td>• Questionnaire developed, field tested; list of new faculty provided by Department; request for interview made by mail or fax; 20 minute personal interview; responses coded</td>
<td>• Selection of mentor – less than half of new hires had/knew a mentor was specifically identified; 10/12 times mentor acted in role; 6/10 said the mentor relationship was successful</td>
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<tr>
<td>• 31 contacted; 27 responded; 26 agreed to be interviewed</td>
<td>• Planned regular interaction; a more structured, formal, and objective format</td>
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**Success and mentorship:** 11/26 had mentors that did not live up to their expectations: poor support; no mentoring provided; no impact on career; inconsistency, selfishness

**Gender and mentorship:** 9/26 of protégé had a mentor of the opposite sex

- 20/26 support a formal mentoring program in the Department of Surgery

**DISCUSSION/QUESTIONS ARISING**

- Message needs to be that women are just as capable; this cannot be a “tokenism” program
- Take issue that “lifestyle issue” is a female issue. This is a lifestyle issue for both males and females. Let’s call it lifestyle and parenting issues that impact on male and female both. Lifestyle issues are generational not gender issues. “Get a life” generation. This is a matter of what it takes to recruit and retain surgeons and look at this as a generational issue
- How do we solve under-representation of women? Need to step back and change the culture. Creation of a culture of “making it work”
COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

- Department should develop a mentoring program. How to do this effectively is an issue? Are we going to tweak at the edges or do something bold?
- Department should develop a human resources leader position. The Department has established clinical, academic and research programs, but there is no human resources leader. This is a huge gap [strategic issue].

THE IMPACT OF FUTURE DIRECTIONS OF OUR TORONTO ACADEMIC HEALTH SCIENCE CENTRES ON SURGERY

Moderator: Michael Jewett

Panelist: Jeff Lozon, President, St. Michael’s Hospital

Integrative planning work being undertaken by TAHSC

The scope and diversity of initiatives under way by TAHSC and the Ministry are reflected in 14 different planning activities currently in progress:

1. vascular surgery review
2. neurosciences review
3. joint replacement review
4. emergency mental health review
5. developmental pediatrics review
6. critical care review
7. cancer care - regional planning effort
8. ophthalmology review
9. cardiovascular review
10. pediatrics/obstetric/gynaecology review
11. laboratory services review
12. review of information technology led by TAHSCs
13. back office review
14. materials handling review

- Bottom line: “Potential for change is beginning to look like a modestly busy airport.”
- The purpose of all of these initiatives is to create centres of excellence – focus on teaching, research, and clinical excellence.
- The move to “fewer” hospitals doing certain procedures will require good transitional planning. It will be important to deal with very real human resource coverage issues/low critical mass issues that will emerge. If we begin to aggregate services, we will need to talk about what will happen at the other sites? Also need to acknowledge that creating centres of excellence will require an investment. Need to find a way to deal with services in hospitals that are ‘vacated’. Need to evolve beyond “win and lose” mentality. Need to evolve to determining how best to implement plan.
Panelist: Alan Gayer, President, The Hospital for Sick Children

Is Canada’s health care system hopeless?

- Difficult part of today’s environment is the lack of money. The Hospital for Sick Children renewal of the alternate funding plan agreement reached through agreement that the Foundation will pay 25% of the bill. Dealing with major economic pressures – need to think of health care as a cost that needs to be minimized.
- Rising expenditures are the result of the fact that we are increasingly able to do more “good” things in health care. Politicians have yet to grapple with this. Tendency to “demonize” the hospitals. System in a bit of a logjam right now. The way the pressures come out is in the form of wait lists.
- The concept of a “health care guarantee” (as proposed by Kirby) is on the horizon. The issue of wait lists has forced this onto the political agenda. Timely access to first-rate care will continue to be a very important issue.
- The system is not without hope.

COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

- The issue of access creates an opportunity for the Department to use its leverage as a platform for moving forward: How can the Department lead in offering timely access to world class care?
- The platform of the government is about access. Important to collect “wait time” information and participate in these processes.
- Think about publicizing research/data on how long people wait and develop research to show the impact of waiting.

RELATIONSHIP BETWEEN TEACHING HOSPITALS AND FACULTY OF MEDICINE

Panelist: Tom Closson, President, University Health Network

- University mission: education and research
- Teaching hospitals mission: education and research and clinical work
- Dean has been reluctant to get involved in clinical aspect unless it impacts on teaching and research
- The power base for research has changed: University Health Network now does more research on its site(s) than the Faculty of Medicine. Hospital putting more money into research than Faculty
- Developing research information systems that enable data to be readily accessible
- Foundation kicking in huge amounts of money to support growth in research
- Cannot separate hospitals/University yet
COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES
FOR THE DEPARTMENT

What do we need to do?

• Nine teaching hospitals and one University – need to establish a broader network
• Need to consolidate services on fewer sites for purposes of being “more excellent”
• Need combined research facilities; need research collaborations
• 30% of published papers involve co-authors with those outside the country
• Need to think in terms of developing educational centres of excellence
• Need integration of information systems; better collaboration across organizations
• Need horizontal alternate funding plans
• Need a multi-lateral agreement with the University – all hospitals and Faculty to decide what
goals and priorities are and reach agreement on who will lead what
• Hospitals are in this together…. The challenge is not to separate but instead to collaborate”.
  We need to remember that with the resources we have, we are the best academic centre in the
country with one of the best university in North America
• Potential threats are tertiary community hospitals and other jurisdictions

DISCUSSION/QUESTIONS ARISING

• Total research budget of hospitals and University significant
• Need a different mindset. Need to see consolidation not as a loss but a win. If programs consolidate then the
challenge will be to make sure, for example, that “the third site is well covered.” This will demand more
  collaboration. Will require a different view (i.e. being able to work at more than one hospital)
• Some believe that the CEOs of the big hospitals have contributed to many of the current problems with respect
to non-collaboration
• Reality is that now we have three big academic sites – a little easier now that there are fewer
• The term “centres of excellence” has a lot of implications”. Perhaps we are really talking about “centres of
resource intensity.”
• Is there enough money in the system now? There is a limit to how much can be spent on health care? It may be
time to think about having a dedicated tax to pay for increases in health care expenditures/costs
• Is involvement of foundations in alternate funding plan agreements a good strategy? Are we not really saying
that the alternate funding plan at The Hospital for Sick Children is 25% under funded? Mistake at The Hospital
for Sick Children was that the agreement should have clearly stated that the strategy “was transitional”.
Strategically the idea was a “good plan given the circumstance” but may not have been the “right plan”
• Challenge on a going forward basis – how will hospitals keep up with the need to make growing investments to
physicians?
DEBATE: IS IT TIME FOR A FEDERATION OF SURGERY WITHIN THE FACULTY OF MEDICINE

Panelist: John Wedge, Associate Dean, Clinical Affairs

- If designing, a Faculty of Medicine would probably have 8 or 9 departments. What exists today is purely the result of historical “happenstance”. Current situation creates a need for inter-professional positions (i.e. Associate Deans).
- Growth in surgery has been significant but has been outstripped by medicine.
- Provost’s white paper calls for strategies to collaborate to make more effective use of scarce resources. The challenge ahead is for Department Chairs to collaborate and find ways to streamline activities that will help to garner support from each other.

Panelist: Bryce Taylor, Associate Chair, Department of Surgery

- A federation of surgical services in the Faculty? Definitely not.
- Different ‘cutting specialities’ have different concerns (one voice may compromise minority groups, i.e. part-time issue ophthalmology). More voices at Dean’s table good for surgical specialities, rather than a hindrance. Chairs are advisory to Dean – therefore, number of voices is important.
- If there were a federation, how would leadership issues be resolved (i.e. rotating Chairs, who rules?)
- Any proposed administrative savings can be achieved in other ways.
- What about blossoming “cutting” specialities e.g., medical imaging, cardiology, gastroenterology “Canadian association of cutters, probers, drainers and pokers”.
- Any revenue initiatives (surgical centres) could be accomplished “ad hoc” without a federation.
- Final verdict: Why bother? We are fighting for crumbs anyway given the planned cutbacks.
- Suggestion: What about a coalition? Would achieve administrative cost savings as desired; individual specialty interests would be protected; would be easier to “sell” to the smaller cutting groups; would not result in a loss in influence at the Dean’s table if there is appropriate communication among members prior to decision-making.

Panelist: Walter Kucharczyk, Chair, Medical Imaging

- Propose that a federation for the Department of Surgery for all departments would be a good idea.
- Propose provincial units be the hospital with the federation being a Toronto-wide program.
- The current problem is that most of us can plan, but we cannot execute. A major difficulty standing in the way is the lack of cohesiveness resulting from discordant planning. Decisions made at hospitals sometimes do not align with departmental goals. Departments are competing with each other. Therefore, multiple processes that are not aligned – educational planning probably works better than the other parts.
- **What do we do?** Money for systems most important resource – the clinicians – the money should flow to the department.
- Need to look at a horizontal alternate funding plan. We cannot plan if we have no resources to implement. Hospitals provide physical infrastructure. We have a federal system but lacks resources on federal side to make it work.
- **Final verdict:** Unless we have the resources we will not be able to execute our plans and have a significant change/influence over anything.
DISCUSSION/QUESTIONS ARISING

- At a hospital level having a federation can work very well. Horizontal alternate funding plans are a must to make this work.
- Why would we want to establish a federation? Very little to gain; really only talking about crumbs. Perhaps a better alternative would be to get organized as a surgical domain. Programmatic/grouping/matrix organizational design could help integrate services. The key is to find ways to improve co-ordination to ensure that fiscal resources support agreed upon goals, i.e. maximize effectiveness of resource use.
- Would there be efficiencies gained if we could agree on common vision/ themes/ priorities? It is possible to achieve common objectives without destroying the current departmental structure?

COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

- The role of the federal government has not come up, but it is an important consideration. Pushing the development of a ‘federation’ of surgery working with engineering, etc. may well be a way to leverage opportunities to tap into significant money to support clinical work and research.
- Need to do something or will see the downfall of Department within the Faculty as budget cuts of 13% over next five years are implemented.
### Faculty of Medicine: Past, Present and Future

- **Raising our Sights** – 2000
- **Stepping Up** – 2004
- Faculty of Medicine impacted by key pressures in past 10-15 years: mission (building research institutions); annual operating budget cuts from MTCU (in 1996, budget cut by 15%); hospital/research institute partnership has “saved” the University – this is what has happened and it is where we need to be headed; successful fundraising for research.
- CFI and OIT funding has been excellent; but the Faculty is “cash poor”.
- Present vision: *International leadership in health research and education* (Faculty of Medicine Strategic Plan 2000)

### Research Success

- Faculty of Medicine – 70% of researchers are MDs
- Research success in North America: out of 156 research universities, University of Toronto ranked second after Harvard in publication rate, mainly due to higher number in clinical health sciences (in terms of Canadian standing, the University of British Columbia ranked next at #13)
- Some significant research success in Canada: Surgeon Scientist Program; leadership in research through hospital partnerships; this program has become the model for other departments; this is a program to be infinitely proud of; clearly doing some things very right

### Education Mission

- Undergraduate medicine – decoupling from Departmental governance (not head and shoulders above others….work needed here); postgraduate medicine – enhanced educational experience (best in Canada); major increase in graduate programs – 66% in hospitals/research institutes
- New revenue for enrolment expansion: Dean’s Excellence Fund; Education “Achievement Day; contribution to academy infrastructure; Centre for Faculty Development (St. Michael’s Hospital); offset clinical department budget cut 2002
- Education mission - surgery: research in health education (Wilson Centre) ; Surgical Skills Centre; major contributions to graduate education – these are major successes quoted by Faculty of Medicine
- Faculty of Medicine’s biggest partner is the Hospital/Faculty of Medicine partnership

### Present Challenges

- **STABILIZE AND ENHANCE THE INFRASTRUCTURE AND RESOURCE BASE OF THE FACULTY** – medical education funded by Ministry of Health and Long-Term Care; medical school enrolment expansion – new revenue; alternate funding plan supporting clinical faculty contribution to teaching and research
- **RECRUIT AND RETAIN OUTSTANDING FACULTY**: attract the best trainees; provide outstanding academic training; recruit with competitive packages; mentor faculty and protect academic time; facilitate innovative collaborations across institutions and beyond departments.
COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT

- Need new ideas on how to change budget management, etc.
- International leadership in research: build on established success.
- Need to ask the question: “Where have we over-performed?” Maybe need to focus on strengths; identify critical mass of collaborators and work across institutions.
- Need to identify new collaborations across disciplines – what are the unique opportunities at the University of Toronto? Translational research in biomaterials, robotics, diagnostics imaging, early cancer detection – there are opportunities but we need a process in leadership to connect people better.
- International leadership in education: build education on a research platform; what are the unique opportunities at the University of Toronto? Inter-professional education, knowledge translation, professional skills evaluation. Need to take seriously support and promotion of education careers – developing new graduate opportunities (joint medicine with Ontario Institute for Studies in Education); faculty development (Centre for Faculty Development) – reward and recognize teaching more.
- Need to understand where partners are and how we can fulfill our mission (hospitals more important at this point than the University of Toronto)

IMPLEMENTATION PRINCIPLES TO THINK ABOUT

- Value all faculty members – you are an academic team
- Balance roles of educators, researchers, administrators (hospital and university)
- Align strategic priorities among hospitals/research institutes and clinical department
- Enhance partnerships among clinical departments and hospitals/research institutes

DISCUSSION/QUESTIONS ARISING

- Need to work on an understanding of how clinical scientists can benefit research institutes.
- Need to work on creative solutions to funding new investigators.
- Need to change culture.
- Major funding agencies have put a lot of their emphasis on basic research (two thirds are basic research). This is a challenge in terms of where funding agencies are putting their priorities; basic problem in terms of the way basic funding agencies are set-up.

BREAK OUT GROUPS: PRESCRIPTIONS FOR ACTION SYNERGIES WITH FACULTY AND UNIVERSITY PRIORITIES

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<tr>
<th>BREAK OUT GROUPS</th>
<th>DESCRIPTION OF THEME</th>
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<tr>
<td>Research</td>
<td>Emerging impact, productivity and interdisciplinarity in research</td>
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<tr>
<td>Education</td>
<td>Strengthening our teaching and enriching our student experience</td>
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<tr>
<td>Faculty Renewal</td>
<td>Supporting faculty renewal, retention and surgery recruitment</td>
</tr>
<tr>
<td>Infrastructure/Enhancing Resource Base</td>
<td>Building our infrastructure and resource base – exploring new models</td>
</tr>
<tr>
<td>University/Teaching Hospital Relationships</td>
<td>Maximizing our hospital/university relationships</td>
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</tbody>
</table>
A summary of the key issues and strategies arising from each of the break out group discussions is summarized below.

### RESEARCH

**Emerging impact, productivity and interdisciplinarity in research**

<table>
<thead>
<tr>
<th>Key Themes/Highlights of Discussion</th>
<th>Proposed Priorities/Ideas for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Department is recognized nationally and internationally for its quality and productivity in research.</td>
<td>Strategies for Sustaining Leadership Role in Research</td>
</tr>
<tr>
<td>• Concerns raised about appeal of surgical science for next generations. This may parallel the reduction in the appeal of surgery in general. Should lectures about surgery and surgical science be re-introduced in the early years of medical school? Is it harder for surgeons to do good research in the modern era given the demands of surgery as a profession?</td>
<td>• Surgeon Scientist Program identified as a key element that must be nurtured. Must attract bright students into the program, and facilitate their becoming independent investigators when they graduate.</td>
</tr>
<tr>
<td>• Concerns raised about the lack of nurturing of residents into scientists. Nurturing – number one concern is about job security for clinician scientists given their significant time commitment to science.</td>
<td>• Provide role models to nurture appeal and continued interest in surgery.</td>
</tr>
<tr>
<td>• We’re requiring our residents to think out of the box but with little guidance.</td>
<td>• Enhance the research component in the residency research program.</td>
</tr>
<tr>
<td>• A strength of being in Canada is that it is one of the few places in the word where clinician scientists can be fostered.</td>
<td>• Surgeon Scientist Program should position itself to become a national co-ordinating centre for surgical science in Canada. This may also help to attract candidates into surgery in Toronto.</td>
</tr>
<tr>
<td>• The Department has not established department-wide research priorities.</td>
<td>• Establish a program similar to the Alberta Heritage Fund Clinician-Scientist Program, and ideally make it national. This may help with the issue of concerns about job security.</td>
</tr>
<tr>
<td>• The Provost has identified interdisciplinarity in research and teaching as a major goal for the future.</td>
<td>• Modify the training program for clinician scientists so that the total amount of time it takes to train for both is not as long? Is this amount of time the same for every type of surgeon scientist (i.e. surgeon-epidemiologist versus surgeon-molecular biologist).</td>
</tr>
<tr>
<td>• Enormous opportunities exist within the University and at the Research Institutes for interdisciplinary research.</td>
<td>• Focus on a small number of individuals up front in order to channel them into surgical science. How would we identify such individuals and at what stage of their training? One suggestion is to incorporate research electives in the PGY1 phase. This would expose the residents to surgical science at the University of Toronto, and would help them focus their views about surgical science.</td>
</tr>
<tr>
<td>• A concern was raised that there are still impediments to interdisciplinary research, including institutional rivalry, disparate information systems, etc.</td>
<td>• Develop Department-wide research priorities/city- wide approaches for research in key target areas including: tumor banks; clinical information and databanks; ethics; facilitating clinical trials</td>
</tr>
<tr>
<td>• The hospitals have developed research institutes that frequently provide the majority of research resources for the surgeon-investigator/scientist. Is this model working, do the institutes plan adequately in a co-ordinated way?</td>
<td>Interdisciplinary Opportunities in Research for Department of Surgery</td>
</tr>
<tr>
<td>• What are the barriers to surgeons doing research at present at the University of Toronto and its affiliated hospitals? Are we adequately training and mentoring our researchers?</td>
<td>• Interdisciplinary research can be enhanced/advanced through several means including:</td>
</tr>
</tbody>
</table>

- Tapping opportunities available through peer-review agencies
- Bringing money to the table as a catalyst for partnerships,
- Sharing graduate students
- Providing incentives for cross-appointments in other university departments.

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*Summary Notes*

*Department of Surgery – Strategic Planning Retreat*

*March 26, 2004*
• Go back to hospital-based programs whereby each program is, by nature, multidisciplinary (i.e. thematic programs where a priority brings together people from different backgrounds).
• Develop mechanisms to make the faculty and students aware of the multidisciplinary opportunities at the University (i.e. mechanisms to link people and demonstrate opportunities – common website; common resource; symposium)
• Develop an administrative infrastructure and a management infrastructure necessary to facilitate interdisciplinarity in research.
• Link the centres within the Faculty, put together the annual reports, establish a common web-based site as a resource for advancing research partnerships across disciplines.

EDUCATION

Strengthening our teaching and enriching our student experience

Key Themes/Highlights of Discussion

- General thoughts: Learner centred approach; less patient or teacher centred; look at things through student’s eyes first
- Education must be flexible or have different streams – some students do not want to be surgeons
- Fellowship training needs more regulation
- Need more of a departmental role in continuing medical education as professional development i.e. supported sabbatical for faculty to regularly update skills and knowledge
- Interdisciplinary education: sounds good but difficult to implement; some areas better suited (already going on): cardiac surgery and cardiology, neurosurgery and neurology, orthopaedics and rehabilitation, supervision of graduate students; is “the future of everything”

Proposed Priorities/Ideas for Change

**Undergraduate Training Goals**

- Start the thinking about lifestyle issue early
- Provide early introduction to radiology within surgery
- Allow more time before making residency decisions (bring back the internship)
- Improve the introduction to surgery pre and during clerkship – capture interest, clarify scope of job
- Develop a roster of surgeons to act as mentors to foster student interest

**Postgraduate Training Goals**

- Maximize education and minimize superfluous service
- Facilitate ways for hospitals to help fill some of the service gaps that residents take care of, without eliminating the “useful” components of service
- Develop two streams: academic and non-academic
- Provide resident training anywhere, based on where best resources are (i.e. send out of University if needed)

**Fellowship Training Goals**

- Improve co-ordination of program centrally; help ensure quality of fellow; ensure the quality of teaching of fellow; ensure that residents are not short-changed
- Facilitate ways for fellows and residents to work together
### FACULTY RENEWAL

**Supporting faculty renewal, retention and surgery recruitment**

<table>
<thead>
<tr>
<th>Key Themes/Highlights of Discussion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Consider merits of other benefits: pensions, retirement benefits, life and disability benefits (of interest to women in particular)</td>
<td><strong>Strategies to Advance AFP Support</strong></td>
</tr>
<tr>
<td>• Accept that some will leave (this is a positive reflection of our program)</td>
<td>• Promote development of a medical economic index to compensate for living costs based on location (could be addressed in a province-wide alternate funding plan)</td>
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<tr>
<td>• Follow up with close evaluation of reasons for leaving</td>
<td>• Better to negotiate alternate funding plan as a large group: differential for Toronto; flexibility to distribute money; well-defined deliverables</td>
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<tr>
<td>• Other human resource issues</td>
<td>• More teaching in community hospitals as teaching hospitals develop a more complex case mix</td>
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<tr>
<td>• Perks: childcare; fitness; social interactions cafeteria; MD’s lounge</td>
<td><strong>Recruitment Strategies</strong></td>
</tr>
<tr>
<td>• Diversity: recruit the best; cultivate individuals; more support for existing surgeons; set an example</td>
<td>• Programmatic</td>
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<td></td>
<td>• Tuition scholarships</td>
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<td>• Shorten training (undergraduate and graduate)</td>
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<td></td>
<td>• Recruit entire family: follow-up; human touch; financial support; alternate funding plan; other supports: housing, etc.</td>
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<td></td>
<td>• “In common” year to allow flexibility in career choice</td>
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<td>• Look at more successful programs re: recruitment</td>
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<td>• Comprehensive information</td>
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<td>• Focus on students</td>
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<td></td>
<td>• Make individuals feel wanted</td>
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<td></td>
<td><strong>Retention Strategies</strong></td>
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<tr>
<td></td>
<td>• Funds</td>
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<td></td>
<td>• Provide recognition for teaching: junior faculty filling in for workload adjustment for trainees</td>
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<td></td>
<td>• Provide mid-late career support and development</td>
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<td>• Career shift</td>
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<td>• Individual goals</td>
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<td></td>
<td>• Culture change (“what can we do for you?”)</td>
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<td></td>
<td>• Sabbaticals</td>
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<td></td>
<td>• Vacation</td>
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<td></td>
<td>• Family time valued</td>
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</table>
### Key Themes/Highlights of Discussion

- The continuous shrinking of the University budget has necessitated an innovative look at alternative sources of revenue. Need to build actual business case that defines where we want to go in the future – believe there is money out there to sustain the future. **Challenges** – The “patient” is normally regarded as the “right” of the Hospital Foundation and not the surgeon. We need to transform the relationships to be more partnership focused. **Consider** – How do we approach other industry (non healthcare)?

- Development of a University of Toronto Surgicentre – **Goal**: efficient (high volume, high quality), resource for education, and a resource for clinical research. How could it be accomplished and what would be the effect on the hospitals? **Challenges** – diverts from the teaching hospitals those procedures that residents can participate in since the focus will be on efficiency. Infrastructure already exists in institutions (currently mothballed). Hard to make money in these centres. Creates a dysfunctional dynamic due to the fee-for-service and volume generating ability in non-teaching centre. **Positives** – Difficult to justify doing less complex cases (gall bladder, cataracts, etc.) in “expensive” tertiary centres. Now we are shifting them elsewhere. Enables a higher volume of procedures in surgicentre. Would enable tertiary centre to focus on truly complex teaching procedures. Can be done in a decentralized manner within hospitals.

- Industrial Partnerships/Other collaborations **Goal**: How can we think bigger regarding what the Department can do with industry that will enable the Department to gain access to additional resources? **Existing models** – Entrepreneurial sourced, usually specific to a product/clinician. Some degree of technology transfer, usually with the University commercializing. **Challenges** – Limited pool of resources to develop the idea. We are underestimating the intellectual capital in our Department. Today the relationship is somewhat unidirectional. Moves us away from a “pure” academic model and closer to a “profit” focus. How do you find the middle ground. **Execution** – Define needs to industry. Identify intersections of academic and industry priorities. Consider industry – not just healthcare industry. We must understand the intersections of University of Toronto and Canadian healthcare. We must mutually create the future – find examples and then let it spread. Collaborative effort of U of T and Research Institutes.

### Proposed Priorities/Ideas for Change

<table>
<thead>
<tr>
<th>Strategies for Attracting Alternative Sources of Revenue</th>
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<tbody>
<tr>
<td><strong>Fundraising (endowments, chairs, etc)</strong></td>
</tr>
<tr>
<td>- Identify those opportunities/priorities for the future and have a plan available to create energy</td>
</tr>
<tr>
<td>- Department also needs to increase its presence in the eyes of the Foundation (recruitment for example) and among other industries to fund the future on an ongoing basis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Development of a University of Toronto Surgicentre</th>
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<tbody>
<tr>
<td>- There are efficiencies to removing low intensity procedures from the tertiary operating room, but there are risks to education</td>
</tr>
<tr>
<td>- Consider moving forward with the “concept” within the existing infrastructure, but do not build a free-standing centre</td>
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<tr>
<td>- Call to arms for the hospital infrastructure. Perhaps incorporated into the “centre for excellence” concept.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Industrial Partnerships/Other Collaborations</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consider approaching others (broader than industry) to fund/create a position in the Department of Surgery to explore the opportunities between industry, foundations, etc. and the Department.</td>
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</table>
### UNIVERSITY/TEACHING HOSPITAL RELATIONSHIPS

#### Maximizing our hospital-university relationships

<table>
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</table>
| • The Department’s partnership with the TAHSC hospitals is our most important relationship. Hospitals are under severe budgetary pressure and surgery is expensive. Planning occurs locally and is not always co-ordinated with other teaching hospitals. | **Priority areas for collaboration between the Department of Surgery and teaching hospitals**  
  • Clinical, education, research  
  • Recruitment and retention  
  • Linkage of surgery department with research institutes (MD may be at a disadvantage in the hospital research institute)  
  • Identification of and involvement in setting programs (vascular surgery an example of a problem)  
  • Fundraising: hospital and university Chairs – important to recognize; foundation collaboration and communication  
  • Turf areas – head and neck, back surgery, endovascular technology |
| **Who needs to be involved? What processes should we be putting in place to optimize that relationship?**  
  • Who? Department of surgery individuals.  
  • Involvement of partially affiliated hospitals  
  • **Process**  
    - CEOs meet with Surgeons-in-Chief and Chairs regularly to look at gaps at individual AHSC  
    - Chairs and Surgeons-in-Chief meet with CEOs to discuss problems in surgical disciplines  
    - Dean present at second meeting  
    - Involvement of partially affiliated hospitals. | **Opportunities for innovation and change**  
  • Horizontal alternate funding plan introduction  
  • Commercialization of intellectual property (MARS)  
  • New technology (PET scanners; robotics; endovascular)  
  • Rethinking of current healthcare funding mechanisms (regionalization as an example) |
| **What major goals should we be establishing between the Department of Surgery and the teaching hospitals for the next five years?**  
  • Development of communication strategies between hospitals and Department of surgery  
  • Engagement of people  
  • Surgeon researchers better supported within hospital structure  
  • Strategic involvement of University in redistribution of clinical resources | |

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*Summary Notes*

*Department of Surgery – Strategic Planning Retreat*

*March 26, 2004*
A REVIEW FROM OUTSIDE THE ACADEMIC LOOKING GLASS

Speaker: Martin Barkin, President, Draxis

- Lessons from the private sector
- Theme of discussion: Difference between controlling change and being controlled by change.
- The landscape: Five areas which are changing face of surgery

| POLITICAL ENVIRONMENT       | • All political parties subscribe to principle of single tier health care. |
|                            | • None can resolve ‘sustainability’ issue.                          |
|                            | • Wariness of the role of private sector in delivery; in funding delivery; in funding of R&D; clinical trial sponsorship |
|                            | • However, private sector welcomed in areas of philanthropy; management; support services |
|                            | • Emergence of patient power |
|                            | • Access to information (GOOGLE)                                  |

| TECHNOLOGIC ENVIRONMENT     | • Application technology – combining molecular biology and physics and engineering |
|                            | • Information technology – patient information; outcome analysis; remote telemedicine; research |
|                            | • Performance indicators                                          |

| ACADEMIC/UNIVERSITY ENVIRONMENT | • University dichotomy: staying on leading edges of discovery and application versus training practitioners for community |

| ECONOMIC ENVIRONMENT          | • Length of training for academic surgery – fundamental economic problem when training completed. |
|                               | • Traditional fee-for-service model – unable to fund academic units; excellent for data collection. |
|                               | • Economic inequities/injustices within surgery: academic surgery versus community surgery; hospital versus free standing; cosmetic versus neuro; surgery versus other specialties; surgery versus other careers |

| CHANGING FACE OF SURGERY       | • Traditional delineation between surgery and medicine is being broken down in hospital settings characterized by shift to program management and cross-disciplinary institutes. |
|                               | • There is also manual/technical skill requirements versus technological skill (i.e. interventional radiology versus traditional vascular and neurosurgery techniques) |
|                               | • Need for widening support in system for the academic surgeon |
|                               | • Aging and diversity on staffing and recruitment |
|                               | • Medical advances that obviate surgical procedures |
SURGEON AS LEADER
- Taught to be individuals/individualism
- Admired for depth of knowledge/skill applied to that (“knowing more and more about less and less is the hallmark for success”)
- Financial accounting
- Much loved by families, colleagues – need to be loved is a powerful driving force for everyone but especially surgeons

HOW ARE THESE CHARACTERISTICS “OFF”
- Leaders need collective decision making
- Leaders need breadth of knowledge
- Leaders need managerial accounting – forward looking management of funds and resources – surgeon relies on others to do this
- Leaders – if lucky – will be respected

COMMENTS ON FUTURE DIRECTIONS/THEMES/PRIORITIES FOR THE DEPARTMENT
- Surgery does have some external levers that need to be leveraged: i.e. surgery is an essential service in under-supply - there are no alternatives
- Usual retreat responses tend to be tactical in nature: i.e. promote closer interaction with hospitals; advance establishment of co-management role of essential infrastructure and resources; promote alternate funding; develop alliances with other disciplines; strengthen bonding with advocacy organizations; become more visible
- Need to look at some of the lessons from the private sector:
  - Taking control of the change process
  - Cultivating leaders – academia does not do this well
  - Take control of organizational dynamics – organizations do what they are organized to do; if not organized to do what you want won’t. This demands attention to governance; to organizing for effectiveness; to developing indicators of effectiveness to know whether or not you are making a difference

- Strategies for reform to consider:
  - Strategy 1: Bring/expand surgeon and Surgeon-in-Chief and CEO of affected hospital to the table. Look at resources; programs; institutes as well as teaching
  - Strategy 2: Add governing body to your organizational structure i.e. departmental governing council – depending on membership you will have credibility; strategic guidance; authority; leverage; advocacy
  - Strategy 3: Develop key performance investigators (KPIs)– all great enterprises do this. (You can’t manage what you don’t measure.) The most successful pick the right KPIs. Once you do this then people will behave accordingly
  - Collect data; determine which indicators need to improve (i.e. select your KPI); publish and publicize it.
- Final advice: Remember that the Departmental Chair has two streams to focus on: academic stream and hospital stream. Manage with the use of data – data driven management important.
- Role of Board would be to keep you in touch with external environment.
- Cultivate leadership qualities in internal people. Organize yourself to achieve results – i.e. bring in hospital resources to your structure/draw them into your work.
- Managing by data driven decision-making means picking the right performance indicators.
- Final caution: Be careful what you ask for….you just might get it.
The four goals that have been articulated as the basis for this work being undertaken by TAHSC are: To provide an integrated system that enhances the quality of care for those who need it; To realize savings through integration of support services so that money may be reinvested in patient care; To enhance our ability to deliver on our research and teaching mandates; and to develop Centres of Excellence in specific clinical areas. The six (6) clinical areas being looked at will focus on the process and merits of developing Centres of Excellence in each of the following areas—Neurosurgery; Vascular Surgery; Ophthalmology; Orthopaedics; Emergency Mental Health; Child Development.