From the Chair and Vice-Chair

Welcome new residents!

You have been accepted into one of the most sought-after programs on the planet, and joined an incredible group of residents, faculty, teachers, researchers and other colleagues in Surgery. We are in an exciting era of knowledge expansion, technology explosion and deepening commitment to the humanistic and psychological aspects of training and practice. You could not have arrived at a better time...welcome! I look forward to meeting all of you individually over the coming year.

James T. Rutka, MD, PhD
R.S. McLaughlin Professor and Chair

Welcome to Surgery PGY1's; welcome to Toronto newcomers, and welcome back to PGY2's! Congratulations PG1Y's on becoming doctors, and for joining us in the Gallie Program.

Dr. William Edward Gallie initiated residency training in Surgery at U of T in July 1931. That year, each trainee had completed a year of Pathology, and would spend a year in General Surgery followed by a final year rotating through any two of Urology, Neurosurgery and Paediatric Surgery. Though training in our department has evolved considerably since then, Professor Gallie’s vision for teaching clinical excellence and surgical investigation continues to thrive in 2012-2013. Along the way, the department has fostered diversity, humanistic attributes, and strong collegial bonds. You belong to one of the finest residency programs anywhere.

Core Surgery refers to the first two years of Royal College of Physicians and Surgeons of Canada (RCPSC) accredited training in Surgery. All Surgery trainees must learn the fundamentals of wound repair, transplantation, airway management, effective communication and operating room skills to name a few. This orientation booklet provides information on the Core Surgery training program, including lists of training objectives from the RCPSC and Department of Surgery. The appendices contain material taken from the RCPSC website, which are cited at several points along the way. Please familiarize yourselves with the contents of this orientation package, and don’t hesitate to speak with us about it. Can we make it better?

Ronald H. Levine, MDCM, FRCSC
Director, Postgraduate Education
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**POSTGRADUATE EDUCATION OFFICE, DEPARTMENT OF SURGERY**

Hello from the Postgraduate Surgical Education office!

Dear Core Surgery Residents:

We at the Postgraduate Surgical Education office are here to help you. Our functions include administering the online evaluation system called "POWER"; dealing with RCPSC requirements; organizing your rotations and helping you get paid. Some of our responsibilities intersect with those of your program administrators – don’t worry – between your program and our office, we can sort out who should do what.

We keep documents related to your training at our central site. These include your evaluations, applications, and any correspondence related to your residency. For example, any time you apply for a position later in your career, the recipients of your application will ask us for verification and possibly evaluations of your training.

We are happy to answer your queries about anything related to your training (if we don’t know, we’ll point you in the right direction). Be sure to keep your e-mail address (and other coordinates) current with our office, and check the Department of Surgery Newsletter for seminar schedules, exam dates and other important information.

We look forward to working with you!

Tess Weber  
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CORE SURGERY AND THE SPECIALTY PROGRAMS

Each first and second year Surgery resident, though accepted into a RCPSC specialty program, belongs, in parallel, to Core Surgery. Core Surgery training culminates in achievement of knowledge, skills and attitudes basic to all surgery, and success in the RCSPC Principles of Surgery examination. Educationally, the core and divisional programs function in tandem, i.e. residents attend both Core and divisional didactic sessions at separate times.

The next section lists the objectives of Core Surgery training. The curriculum that supports those objectives, described in the following section, complements and overlaps with the training within each specialty.

Core Surgery Educational Objectives

The educational objectives for Core Surgery, described below, cover the RCPSC CanMEDS competencies – medical expert, communicator, collaborator, manager, health advocate, scholar and professional. Those objectives are available (along with material covered by the Principles of Surgery exam, described later) on the RCPSC website (“Objectives of Core Training in Surgery”): (http://rcpsc.medical.org/residency/certification/training/corsur_e.html), and appear in APPENDIX A – of this orientation package.

(There is no separate category for Core Surgery objectives in the RCPSC website – they appear in each of 6 Surgery specialty’s sections and, above, we have cited the General Surgery URL)

In Core Surgery, the resident will achieve the following competencies:

**Medical Expert**

1. Acquire the knowledge, skills and attitudes in the Medical Expert role described in the RCPSC Objectives of Core Training in Surgery (Appendix A Preamble and Sections 1-8 and 11 – 14). These include medical problems in the surgical patient and preparation for surgery; conduct of a surgical procedure; postoperative care; wound management and healing; hemostasis and use of blood products; fluid management and acid-base problems; hemodynamics, oxygen transport and shock; metabolic and nutritional care; trauma and burns; sepsis and surgical infections; transplantation and implantation; and cancer.

2. Obtain a relevant and accurate history and physical examination.

3. Develop an appropriate differential diagnosis.

4. Order appropriate laboratory, imaging and other diagnostic procedures demonstrating knowledge in the interpretation of these investigations.
6. Develop appropriate management plans, including prevention, demonstrating knowledge and skill in operative and nonoperative management of disease processes.

7. Master technical skills taught in the Surgical Skills Centre.

8. Manage ambulatory patients, demonstrating knowledge and skills in procedures including wound debridement, incision and drainage, suturing and local anesthesia.

9. Manage the patient throughout the entire in-hospital course, demonstrating knowledge of and being able to treat potential complications of disease processes and therapeutic interventions.

10. Provide a plan for patient follow up.

**Communicator**

1. Acquire Communicator knowledge, skills and attitudes associated with the RCPSC objectives of Core Training in Surgery described in the Preamble and section 15.

2. Communicate effectively with the patients and their families and friends, explaining disease process and the benefits, risks, complications and alternatives of management recommendations in terms they understand.

3. Communicate and relate effectively with members of the health care team, consultants and referring caregivers.

4. Convey medical information succinctly and accurately in the patient record.

**Collaborator**

1. Demonstrate the ability and willingness to work in a cooperative manner with other health care personnel, being sensitive to their roles and abilities, and giving and receiving advice in a manner consistent with harmonious operation of a team.

2. Seek appropriate consultation, including establishing rapport, and relationships with other providers.

3. Work effectively with other providers, patients and families to prevent, negotiate and resolve inter-professional conflicts.

**Manager**

1. Contribute to the effectiveness of health care organizations and systems.

2. Manage one's practice, training and career effectively.
3. Allocate finite health care resources appropriately.

4. Serve in administrative and leadership roles.

**Health Advocate**
1. Understand and manage effectively psychological, social, and cultural influences and needs in planning, communicating with, and treating individual patients and patient populations.

2. Understand and apply the principles and practices of prevention, screening, and early detection of cancer and other diseases.

**Scholar**
1. Obtain information on clinical management using textbooks, advice from other health professionals, and search technology.

2. Evaluate critically, and apply to clinical care, information and its sources.

3. Develop a system for ongoing, life-long learning.

4. Teach and facilitate learning of surgical concepts and techniques to medical students, other health professionals, patients, families and the public.

5. Create, disseminate, apply and translate new medical knowledge and practices.

**Professional**
1. Demonstrate appropriate professional behaviour including honesty, commitment, compassion, respect, punctuality and altruism towards patients, profession and society.

2. Understand and act by the legal, ethical, and professional codes by which physicians are expected to behave.

3. Participate in profession-led regulation.

4. Strive for personal health and sustainable practice.
CORE SURGERY CURRICULUM

The following educational offerings comprise the Core Surgery curriculum, which complements the sessions provided by each specialty. Attendance for these sessions is mandatory and for some, the setting is informal. The feedback from attendees is strongly positive. We serve food!

Principles of Surgery (POS) Lectures and Practice Exam
Core Surgery residents attend POS lectures at Mount Sinai Hospital, 18th Floor Auditorium on Tuesday mornings 7:30 – 9:00am, coordinated by Dr. Robert Mustard. In February, residents write a practice POS examination, followed by a session with Dr. Mustard to go through the answers.

Dr. Mustard selects the best lecturers, whom he advises about content to ensure that the course meets the needs of Core Surgery residents. Attendance is mandatory for Surgery PG1s and PG2s. Residents in Otolaryngology, Maxillofacial Surgery, as well as Obstetrics and Gynaecology also attend.

Be sure to keep your e-mail address current with the Postgraduate Surgery Education Office and check the Department of Surgery Newsletter or the web page http://surgery.utoronto.ca/events/Principles_of_Surgery.htm for final schedules and date of the POS practice examination. For lectures on line please check: http://surgery.utoronto.ca/events/Principles_of_Surgery/lecture_notes.htm

See Appendix D for a tentative schedule.

Surgical Skills Centre
The Surgical Skills Centre at Mount Sinai Hospital Skills Lab (Level 2, Room 250) provides a 28-week skills training program for PGY 1 Core Surgery residents, following the POS lectures Tuesday mornings. Each resident gets a CD ROM syllabus that outlines the objectives and assumptions for each weekly session. The curriculum is completed each year with an OSCE exam. The lab is outfitted with high and low fidelity simulation models, cadavers, and animal labs.

Advanced Trauma Life Support (ATLS) Training
The ATLS courses, coordinated by Dr. Jameel Ali, are provided at St. Michael’s Hospital, and paid for by the specialty programs. The Office of Surgical Education coordinates these events and assures residents and faculty are informed so residents are freed from clinical duties.

Teaching Residents to Teach
Each year, the first year residents attend “Resident as Teacher Day” to gain knowledge and skills in teaching medical students. This full-day program is a chance to relax, eat, and learn important skills to teach and attract future colleagues. The “Resident as Teacher” day is coordinated by Drs. John Murnaghan and Nikki Woods.
Surgeon in Society
Early in July, Core Surgery residents join Drs. Ron Levine and John Bohnen and other faculty in the “Surgeon in Society” symposium. These sessions focus on general themes such as adapting to change, medicolegal risk and information technology.

SPECIALTY OBJECTIVES AND CURRICULA WITHIN CORE SURGERY

Specialty educational objectives for Core Surgery residents

Besides learning within their own programs, Core Surgery residents take rotations outside their specialties, in and outside of Surgery. At the start of each of those rotations, you should receive the specific goals and objectives for your stay on that rotation (please let Dr. Levine know immediately if you do not). Appendix B - describes generally the goals and objectives for most specialties in which Core Surgery residents will train, which might help you plan your training with your Program Director. These specialty-specific goals and objectives are not rotation-specific.

Specialty Curricula for Core Surgery Residents

Appendix C describes the curricula for Core Surgery residents in each of our six (6) programs, consisting of mandatory and elective clinical rotations available for training.
EVALUATION OF TRAINEES, TEACHERS AND PROGRAMS

Evaluation of Trainees

Faculty surgeons evaluate residents continually, from the start to the end of each rotation. Though all surgeons whom you contact usually will contribute to your evaluation, one surgeon, who acts as rotation co-coordinator, will record the evaluation and discuss it with the resident. Often the rotation co-coordinator is the division head. Residents should receive an interim evaluation, usually an informal discussion, somewhere near the midpoint of each rotation. If you do not, please remind your staff – it is important to know what you are doing well and what to work on. At the end of the rotation you must have a formal discussion (usually with the rotation co-coordinator) around your In Training Evaluation Report (ITER).

Evaluations are recorded through an on-line system, POWER, which is managed centrally in the department and by your program. If you have a problem with POWER, contact your Program Director’s office (or ours) immediately. Usually it’s a quick fix.

The ITER parallels the learning objectives, covering the CanMEDS competencies. Therefore, you will be evaluated as medical expert, which includes knowledge and technical skills; collaborator; professional etc.

What should you conclude from your ITERs? If you score 3s, 4s and 5s out of 5, you are doing well. Don’t be disappointed if you get "3s" in all domains (having scored at the top as a student); “3s" indicated a solid performance rating, so be proud and work on your weaknesses. If you receive one or more 2s or 1s, you may need help. Don’t get discouraged if this happens – many former residents (including your professors) had learning challenges early in their training – that’s what your teachers are there for. Many types of counseling and extra training are available and may be offered to you. It’s smart to take advantage of these opportunities early in your training.

Knowledge and technical skills are important, but the most challenging difficulties early on may arise in communication, collaboration and professionalism. Surgery provides a rewarding but intense environment. You might be perceived by others as high-maintenance and selfish if you ask for special attention, leave work for others, have troubles with collegial relationships or do not respect others’ views and actions. If you think you have difficulty in this regard, or your ITERs say so, engage your teachers in helping you. Sometimes achieving excellence in these attributes takes more work than learning to diagnose and dissect.

To demonstrate competency in Core Surgery training each resident must, besides passing the clinical rotations, pass the RCPSC POS exam, which is described in APPENDIX A – (general contents) and Appendix D (the exam process). The POS lecture series helps in exam preparation, as does the U of T POS practice exam and exam review. Besides the POS exams the residents of each divisional program take a variety of training exams specific to the specialties.
Some of you will run into serious difficulties, especially in one or a combination of expert, communicator, collaborator or manager roles. Your Program Director, in consultation with your Residency Program Committee, might consider you a candidate for remediation or probation. This is covered in Appendix E (Guidelines for the Evaluation of Postgraduate Trainees of the Faculty of Medicine at the University of Toronto), which describes important processes related to the evaluation of all residents in the faculty. The majority of residents who enter remediation or probation complete their training successfully, but this anxiety-filled situation consumes considerable time, effort and emotion on the part of trainees and teachers.

**Evaluations of Teachers, Rotations and Programs**

At the end of each rotation, residents are prompted by email to evaluate their teachers and rotations through "POWER", an on-line confidential evaluation system, Only the Program Directors, Dr. Levine and Dr. Woods (Director, Education Evaluation) see the individual anonymous evaluations. Based on this resident feedback, each teacher receives a yearly cumulative report consisting of a teaching score; and each hospital division gets rotation scores and qualitative feedback on improvement needs. Your teachers take this seriously – please provide this information accurately and fairly. The Teaching Effectiveness Score (TES) is also important for promotion of faculty in the department.

Each educational offering of the Core Surgery Program (POS, Skills Centre sessions, Surgeon in Society etc) is evaluated by residents, with results fed back to the teachers/providers. The logistics and data generally are covered and maintained by those in charge of these programs, and reported in various formats to the Core Surgery Coordinator.
CORE SURGERY COMMITTEE

In Parallel with each divisional program’s Residency Program Committee, the Core Surgery Committee meets 4 times yearly to oversee the Core Surgery Program, review its educational offerings, take feedback from the residents and consider improvements. Informal, *ad hoc* working groups sometimes meet to consider specific proposals such as new training ideas or orientation strategies. Please see below, the member list, which includes residents.

- Core Surgery Coordinator and administrative coordinator
- Program Directors, CaRMS-entry Surgery programs
  - General Surgery
  - Cardiac Surgery
  - Urology
  - Plastic Surgery
  - Neurosurgery
  - Orthopaedic Surgery
  - Vascular Surgery
- Program Director, Otolaryngology
- Director, Surgical Skills Centre (or delegate)
-Coordinator, ATLS program
- Coordinator POS lecture series and practice exam
- Director, Education Evaluation, Department of Surgery
- Resident representative from each CaRMS entry specialty
STRESS MANAGEMENT AND RESIDENT WELLNESS

The surgery residency poses many stressful situations that you may have trouble handling solo. We encourage you to seek help. And offer access to private counselling in a number of formats. You will find mentors from among your division's staff surgeons, your Program Director, Division Chair, Postgraduate Education Director, or Department Chair. All of these individuals are available to offer assistance.

In addition, the following individuals have volunteered confidential assistance to trainees in need, and can be contacted at any time at these phone numbers.

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<tr>
<th>Department</th>
<th>Name</th>
<th>Phone</th>
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<tbody>
<tr>
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<tr>
<td></td>
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In addition, several of the divisions have established a mentor system in which one member of the faculty will be assigned to each trainee to act as a counsellor and provide support where necessary during the residency period.

No stigma or reprisal will arise from a resident seeking the help of the faculty in dealing with stressful situations. You need not approach a faculty member of your own division for assistance. The faculty member chosen is entirely at your discretion.

Dr. Ron Levine, Director of Postgraduate Education is also available to meet with residents at any time. He can be contacted at Ronald.levine@utoronto.ca

Outside the department, Dr. Susan Edwards, Director, Resident Wellness, Postgraduate Medical Education, 416 946 4015 susan.edwards@utoronto.ca and her staff provide residents access to individuals and programs such as the Ontario Medical
Association’s Physician Health Program, PAIRO and other partners. This important resource serves residents of all programs. Besides seeking help yourself, you may help a resident colleague by recommending a consultation.

CONCLUSION

Our residents and programs succeed by all indicators – low attrition, success on POS and fellowship exams, commendations at RCPSC accreditation, resident returns to faculty positions, and the strong sense on collegiality within our programs. This attests to the large number of enthusiastic, talented and humane faculty, residents, administrative assistants, and collaborators in the clinical, education and research communities. We are glad you have joined our family!
PART II- APPENDICES
APPENDIX A – RCPSC OBJECTIVES OF SURGICAL FOUNDATION TRAINING
This document applies to those who begin training on or after July 1st, 2010.
(Please see also the “Policies and Procedures.”)

DEFINITION
Surgical Foundations encompasses the core foundational surgical competencies that are required for the following surgical specialties:

• Cardiac Surgery
• General Surgery
• Neurosurgery
• Orthopedic Surgery
• Otolaryngology – Head and Neck Surgery
• Plastic Surgery
• Urology
• Vascular Surgery

Surgical Foundations is that initial period of postgraduate training required to acquire the knowledge, skills and attitudes underlying the basics to the practice of surgery in general and preparatory to further training in a surgical specialty or sub-specialty. For the purpose of clarity, the junior surgical resident refers to any surgical resident in postgraduate year (PGY) 1 and PGY 2. These objectives refer to exit competencies for which a junior surgical resident must be evaluated by the end of PGY 2.

NOTE:
At the discretion of the surgical foundations and home program director, residents who fail to meet these objectives at the end of PGY2 may continue training, however, a remediation plan must be put in place. These objectives of training must be achieved by the end of the third year of training. Successful completion of the Principles of Surgery examination has been designated as one of the means to evaluate the attainment of the objectives of Surgical Foundations, however, if all other objectives are met, but if a candidate fails the POS exam, he/she may be allowed to continue in their home specialty.

GOALS
Upon completion of the Surgical Foundations training period, a junior surgical resident is expected to demonstrate competence in the management of the surgical patient as outlined in this document.

Residents must demonstrate the requisite knowledge, skills, and attitudes for effective patient-centered care and service to a diverse population. In all aspects of specialist practice, the resident must be able to address issues of gender, sexual orientation, age, culture, ethnicity and ethics in a professional manner.

Surgical Foundations must provide opportunities for residents to achieve the competencies outlined in these objectives. Training must provide the resident with graduated responsibility for the management of surgical patients under appropriate supervision.

SURGICAL FOUNDATIONS COMPETENCIES
At the completion of Surgical Foundations training, the resident will have acquired the following competencies and will function effectively as a:
Medical Expert

Definition:
As Medical Experts, the junior surgical resident will integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care. Medical Expert is the central physician Role in the CanMEDS framework.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Demonstrate the ability to perform a consultation, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centered medical care
   1.1. Perform a consultation, including:
      1.1.1. Conduct and present well-documented assessments
      1.1.2. Prepare recommendations in written and/or verbal form in response to a request from another health care professional
   1.2. Demonstrate compassionate and patient-centered care

2. Establish and maintain clinical knowledge, skills and attitudes appropriate to surgical practice
   2.1. Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to surgical practice during assessment of a patient including:
      2.1.1. Anatomy
      2.1.1.1. Relevant anatomy to all basic surgical approaches
      2.1.2. Physiology
      2.1.2.1. Impact of age on specific organ systems as it relates to surgical management
      2.1.2.2. Impact of pregnancy on specific organ systems as it relates to surgical management
      2.1.2.3. Obesity and the impact of obesity on organ systems
      2.1.2.4. Respiratory system
      2.1.2.4.1. Lung volumes - flow rates - pressures
      2.1.2.4.2. Oxygen transport
      2.1.2.5. Hemostasis
      2.1.2.5.1. Physiology of coagulation
      2.1.2.6. Fluid and electrolyte physiology
      2.1.2.6.1. Fluid compartments and body water component
      2.1.2.6.2. Osmotic and volume regulation
      2.1.2.6.3. Sodium (Na), Potassium (K), Calcium (Ca), Phosphorus (P) and Magnesium (Mg) metabolism
      2.1.2.6.4. Regulation of acid-base
      2.1.2.7. Circulatory system
      2.1.2.7.1. Hemodynamics of cardiovascular system
      2.1.2.8. Immunology of sepsis and transplantation
      2.1.2.9. Nutrition
      2.1.2.9.1. Metabolic needs
      2.1.2.9.2. Caloric-protein-lipid requirements, fluids and micronutrients
2.1.2.9.3. Adaptation to starvation as compared to response to surgical stress
2.1.3. Body response to surgical stress
2.1.3.1. Metabolic responses including catabolic response, the need for metabolic support and endocrine changes not mediated by the neuroendocrine axis
2.1.3.2. Mediators, cells
2.1.3.3. Neuroendocrine axis
2.1.4. Sepsis and the inflammatory response
2.1.4.1. Metabolic and hemodynamic patterns
2.1.4.2. Mediators, cells
2.1.4.3. Impact on organ systems
2.1.5. Disease states in organ systems and their impact on the surgical patient:
2.1.5.1. Cardiac
2.1.5.1.1. Coronary Artery Disease (CAD)
2.1.5.1.2. Valvular disease
2.1.5.1.3. Cardiomyopathy
2.1.5.1.4. Cardiac arrest, arrhythmias as per ACLS protocols
2.1.5.2. Pulmonary
2.1.5.2.1. Chronic Obstructive Lung Disease (COLD)
2.1.5.3. Renal
2.1.5.3.1. Renal failure
2.1.5.4. Endocrine
2.1.5.4.1. Diabetes
2.1.5.4.1.1. Physiological complications
2.1.5.4.1.2. Management of glycemia
2.1.5.4.2. Thyroid pathophysiology
2.1.5.4.3. Parathyroid pathophysiology
2.1.5.4.4. Adrenal pathophysiology
2.1.5.5. Hepatic
2.1.5.5.1. Cirrhosis
2.1.5.5.2. Liver failure
2.1.5.6. Hematologic:
2.1.5.6.1. Screening for diatheses
2.1.5.6.2. Hypocoagulable states
2.1.5.6.3. Hypercoagulable states
2.1.6. Indications, complications and benefits for nutritional support, including enteral and parenteral feeding
2.1.7. Risk assessment strategies and scores
2.1.7.1. Anesthetic risks
2.1.7.2. Cardiac risk assessment
2.1.7.3. ICU risk assessment
2.1.7.4. Trauma assessment including Glasgow Coma scale
2.1.7.5. Nutritional assessment
2.1.7.6. Preoperative screening tests and their limitations
2.1.8. Diagnostic modalities including their technology and limitations
2.1.8.1. Plain radiography
2.1.8.2. Ultrasound
2.1.8.3. CT scan
2.1.8.4. MRI technology
2.1.8.5. Fluoroscopy
2.1.8.6. Nuclear Medicine
2.1.8.6.1. PET scan
2.1.8.7. Emerging technologies
2.1.9. Radiation safety principles as they apply to patient and practitioners
2.1.10. Medical treatments and their impact on the surgical management of a patient
2.1.10.1. Immunosuppression
2.1.10.2. Chemotherapy
2.1.10.3. Radiotherapy
2.1.10.4. Common drugs with impact on hemostatic function and how to correct their impact
2.1.10.5. Alternative medicine
2.1.11. Blood products and derivatives, including types, indications and adverse reactions
2.1.12. Oncology:
2.1.12.1. Purpose and basis of staging
2.1.12.2. Basic principles of neoplastic transformation including tumor growth and spread
2.1.12.2.1. Pathology requirements for appropriate assessments:
2.1.12.2.2. Definition of common pathological terms such as but not limited to neoplasia, malignancy, dysplasia, metaplasia and atypia
2.1.12.3. Genetics of neoplasia
2.1.12.4. Genetics of families at risk
2.1.12.5. Role of environmental carcinogens
2.1.12.6. Paraneoplastic syndromes
2.1.12.7. Principles of multi-modality therapy
2.1.13. Trauma:
2.1.13.1. Principles of advanced trauma life support (ATLS) or principles of trauma care including initial management
2.1.14. Common infection
2.1.14.1. Community and hospital acquired bacteria, fungi and viruses
2.1.14.2. Impact of blood borne pathogens, including HIV, Hepatitis B and Hepatitis C
2.1.15. Transplantation/implantation
2.1.15.1. Description of autograft, xenograft, and allograft
2.1.15.2. Graft rejection - mechanisms and types
2.1.15.3. Implants
2.1.15.3.1. Principles of compatibility
2.1.15.3.2. Biological reaction/rejection
2.2. Demonstrate an understanding of the conduct of a surgical procedure
2.2.1. Principles of patient safety
2.2.2. Principles of management of patient and surgical team with respect to blood borne pathogens
2.2.2.1. Needle stick injury
2.2.2.2. Mucosal exposure
2.2.2.3. Smoke plume inhalation
2.2.3. Wound healing
2.2.3.1. Classification of wounds
2.2.3.2. Normal wound healing
2.2.3.3. Abnormal wound healing
2.2.3.4. Factors that alter wound healing
2.2.4. Principles of energy sources
2.2.4.1. Electro-cautery
2.2.4.2. Laser
2.2.4.3. Emerging energy source modalities
2.2.5. Principles of prophylaxis
2.2.5.1. Wound and systemic infection
2.2.5.2. Thromboembolism
2.2.5.3. Tetanus
2.2.6. Principles of anesthesia, analgesia and sedation:
2.2.6.1. Local anesthetic agents, indications, contra-indications and administration
2.2.6.2. Regional anesthetics
2.2.6.3. General anesthetics
2.2.6.4. Procedural sedation, indications, contra-indications and administration
2.2.6.5. Complications arising from the administration of anesthesia
2.3. Demonstrate an understanding of routine post-operative patient care
2.3.1. Fluid management
2.3.2. Wound care
2.3.3. Pain management:
2.3.3.1. Pathophysiology and types of pain
2.3.3.2. Common analgesic medications
2.3.3.3. Patient controlled analgesia
2.3.3.4. Regional analgesia, including epidural
2.4. Demonstrate an understanding of the pathophysiology and complications in the surgical patient
2.4.1. Cardiac
2.4.1.1. Principles of advanced cardiac life support
2.4.1.2. Failure
2.4.1.3. Ischemia
2.4.1.4. Arrhythmia
2.4.2. Circulatory shock
2.4.2.1. Distributive
2.4.2.2. Cardiogenic
2.4.2.3. Hypovolemic
2.4.2.4. Obstructive
2.4.3. Multiple organ dysfunction syndrome
2.4.4. Pulmonary
2.4.4.1. Respiratory failure
2.4.4.1.1. Indications, contra-indications and complications of mechanical ventilation
2.4.4.2. Pulmonary embolism
2.4.4.3. Fat embolism
2.4.5. Genito-urinary
2.4.6. Hemostasis
2.4.7. Vascular
2.4.7.1. Deep Venous Thrombosis (DVT)
2.4.7.2. Arterial ischemia
2.4.8. Endocrine
2.4.8.1. Glycemic control
2.4.8.2. Thyroid storm
2.4.8.3. Adrenal insufficiency
2.4.8.4. Syndrome of Inappropriate ADH
2.4.9. Skin
2.4.9.1. Pressure sores
2.4.10. Neurologic
2.4.10.1. Delirium and altered mental status
2.4.10.2. Transient Ischemic Attack (TIA) and stroke
2.4.10.3. Principles of brain death assessment
2.4.11. Psychiatric
2.4.12. Gastrointestinal:
2.4.12.1. Stress gastritis
2.4.12.2. Post-operative Ileus
2.4.13. Common postsurgical infections:
2.4.13.1. Pulmonary
2.4.13.2. Vascular catheter
2.4.13.3. Urinary
2.4.13.4. Parotitis
2.4.13.5. Surgical site infection, including incisional and organ/space
2.4.13.6. Spreading and necrotizing infections
2.4.13.7. Hematogenous infections
2.4.13.8. Types of bacteria:
2.4.13.8.1. Clostridium difficile
2.4.13.8.2. Multi antibiotic-resistant pathogens
2.4.13.8.2.1. Methicillin-resistant *Staphylococcus aureus*
2.4.13.8.2.2. Multi-resistant gram negative bacilli
2.4.13.8.2.3. Vancomycin Resistant Enterococci
2.4.13.8.3. Common pathogens in the specific surgical site
2.4.14. Compartment syndromes
2.4.14.1. Abdominal
2.4.14.2. Limb
2.4.15. Delayed wound healing

3. Perform a complete and appropriate assessment of a surgical patient

3.1. Elicit a history and perform a physical examination that is relevant, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis and/or management

3.1.1. Identify risk factors for disease or diagnoses
3.1.2. Identify aspects that may affect surgical management of the patient
3.1.3. Identify issues that may impact post-operative care
3.1.4. Identify opportunities for risk management and prevention
3.2. Select medically appropriate investigative methods in a resource-effective and ethical manner including but not limited to the:

3.2.1. Preoperative screening tests
3.2.2. Laboratory tests and imaging

3.3. Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating the information to generate differential diagnoses and management plans

4. Use preventive and therapeutic interventions effectively

4.1. Formulate and implement a comprehensive management plan in collaboration with patients and their families for the following clinical situations

4.1.1. Preoperative evaluation and optimization of the patient with the following conditions:

4.1.1.1. Cardiac disease
4.1.1.1.1. Arrhythmias
4.1.1.1.2. Ischemic heart disease
4.1.1.1.3. Valvular heart disease
4.1.1.1.4. Heart failure
4.1.1.1.4.1. Myopathy
4.1.1.1.2. Pulmonary disease
4.1.1.1.2.1. Respiratory failure
4.1.1.1.2.2. Chronic lung disease (CLD)
4.1.1.1.3. Kidney disease
4.1.1.1.3.1. Acid base disorders
4.1.1.1.3.2. Electrolytes disorders (sodium, potassium, calcium, phosphorus, magnesium)
4.1.1.1.3.3. Renal insufficiency
4.1.1.1.4. Liver disease:
4.1.1.1.4.1. Cirrhosis and its complications
4.1.1.1.4.2. Liver failure
4.1.1.1.5. Endocrine disease:
4.1.1.1.5.1. Diabetes
4.1.1.1.5.2. Thyroid disease
4.1.1.1.5.3. Adrenal disorders
4.1.1.1.6. Disorders of hemostasis
4.1.1.1.7. Pregnancy
4.1.1.1.8. Morbid obesity
4.1.1.1.9. Malnutrition
4.1.1.1.10. Patient with immunosuppression:
4.1.1.1.10.1. HIV
4.1.1.1.10.2. Secondary to drugs
4.1.1.1.10.3. Chronic disease states
4.1.1.1.10.4. Post transplant
4.1.1.1.11. Trauma
4.1.1.1.12. Thermal injury
4.1.1.1.13. Shock of all types
4.1.1.1.14. Infections
4.1.2. Unexpected perioperative bleeding both surgical and nonsurgical
4.1.3. Prophylaxis:
4.1.3.1. Antibiotic
4.1.3.2. Thromboembolic
4.1.3.3. Immunization, including tetanus
4.2. Demonstrate effective, appropriate and timely application of preventive and therapeutic interventions for post-operative management of patients with:
4.2.1. Uneventful postoperative course
4.2.2. Complicated post-operative course:
4.2.2.1. Approach to a patient with fever
4.2.2.2. Cardiac disorders:
4.2.2.2.1. Ischemia
4.2.2.2.2. Arrhythmias
4.2.2.2.3. Heart failure
4.2.2.3. Pulmonary disease
4.2.2.3.1. Aspiration pneumonia
4.2.2.3.2. Hospital-acquired pneumonia
4.2.2.3.3. Pulmonary embolus
4.2.2.3.4. Respiratory insufficiencies
4.2.2.3.5. Pneumothorax
4.2.2.4. Kidney disease:
4.2.2.4.1. Oliguria – anuria
4.2.2.4.2. Renal failure
4.2.2.4.3. Electrolyte and acid-base disorders
4.2.2.5. Vascular disease:
4.2.2.5.1. Deep venous thrombosis
4.2.2.6. Gastro-intestinal disease:
4.2.2.6.1. GI bleeding
4.2.2.6.2. Ileus
4.2.2.7. Sepsis
4.2.2.7.1. Catheter sepsis
4.2.2.7.2. Superficial surgical site infection
4.2.2.7.3. Deep surgical site infection
4.2.2.8. Compartment syndromes:
4.2.2.8.1. Abdominal
4.2.2.8.2. Limb
4.2.2.9. Fat embolism
4.2.2.10. Pressure sores
4.2.2.11. Recognition of complications from operative positioning
4.3. Ensure appropriate informed consent is obtained for therapies
4.4. Ensure patients receive appropriate end-of-life care

5. Demonstrate proficient and appropriate use of procedural skills

5.1. Ensure appropriate informed consent is obtained for procedures including the discussion of appropriate postoperative care and issues with patients and families
5.2. Pre-procedural skills
5.2.1. Appropriate usage of imaging
5.2.1.1. Demonstrate proficiency in ordering appropriate imaging with sufficient attention to clinical details.
5.2.1.2. Demonstrate an approach to the interpretation of common and simple imaging modalities including:
5.2.1.2.1. Plain chest X-ray
5.2.1.2.2. Plain views of the abdomen
5.2.1.2.3. Common cross-sectional imaging
5.2.1.2.4. Routine trauma imaging
5.2.1.2.5. Ultrasound
5.2.2. Demonstrate effective, appropriate and timely performance of a surgical procedure while maintaining patient and team safety
5.2.2.1. Apply the concept of aseptic technique as it is used for all procedures
5.2.2.2. Gather and manage the availability of appropriate instruments and materials for minor procedures
5.2.2.3. Obtain appropriate assistance
5.2.2.4. Maintain universal precautions
5.2.2.4.1. Demonstrate understanding of the steps to take when there has been a break in universal precautions or a potential contamination
5.2.2.5. Demonstrate appropriate patient positioning
5.2.2.6. Prepare the operative site
5.2.2.7. Cleanse the operative site
5.2.2.8. Appropriately hand-cleanse, gown and glove
5.2.2.9. Demonstrate appropriate draping
5.2.2.10. Deliver pre-procedural anesthesia if appropriate
5.3. Procedural skills
5.3.1. Demonstrate the application of anatomic knowledge as it relates to the surgical procedure in which they are participating.
5.3.2. Demonstrate appropriate use of operative assistance
5.3.2.1. Recognize when to use operative assistance as necessary for the safe and effective performance of operative procedures
5.3.2.2. Demonstrate understanding of personal technical limitations
5.3.2.3. Direct assistants
5.3.3. Demonstrate effective operative assistance
5.3.3.1. Demonstrate how to provide operative assistance as necessary for the safe and effective performance of operative procedures
5.3.3.2. Take direction from a lead surgeon
5.3.4. Demonstrate the appropriate use of common surgical instruments such as but not limited to needle drivers, retractors, forceps, clamps, electrocautery, scalpel and scissors.
5.3.5. Demonstrate the appropriate choice and use of suture materials
5.3.6. Perform the following surgical skills
5.3.6.1. Incision using sharp and energy-based instruments
5.3.6.2. Knot tying
5.3.6.3. Suturing
5.3.6.4. Appropriate tissue handling during surgical procedures paying attention to the preservation of tissue vitality
5.3.6.5. Blunt and sharp dissection without injury to adjacent structures
5.3.6.6. Vascular control in elective and critical situations
5.3.6.7. Closure of simple wounds
5.3.6.8. Appropriate use of drains
5.3.6.9. Application of appropriate wound dressing
5.3.6.10. Urethral catheter insertion
5.3.6.11. Insertion of a nasogastric tube
5.3.6.12. Tourniquet application
5.3.6.13. Splint for bony injury or soft tissue injury
5.3.6.14. Remove a superficial skin lesion
5.3.6.15. Drain a superficial abscess
5.3.6.16. Biopsy (the specifics of tissue type and anatomic locations can be designated as appropriate to the surgical specialty and will be outlined in that OTR)
5.3.6.17. Secure arterial and venous vascular access in critical and non-critical situations
5.3.7. Demonstrate the ability to perform the following procedures in critical situations:
   5.3.7.1. Needle thoracostomy
   5.3.7.2. Tube thoracostomy
   5.3.7.3. Needle Cricothyroidotomy
   5.3.7.4. Cricothyroidotomy or tracheostomy
5.4. Post-procedural skills
   5.4.1. Preparation and handling of specimen for presentation to a pathologist
   5.4.2. Perform appropriate wound surveillance and dressing care
5.5. Document and disseminate information related to procedures performed and their outcomes including operative reports and other records
5.6. Ensure adequate follow-up is arranged for procedures performed
   5.6.1. Plan and discuss appropriate postoperative care and issues with patients and families
   5.6.2. Discuss immediate and long-term follow-up issues with family members or medical power-of-attorney as appropriate
5.6.3. Arrange for appropriate postoperative resources

Communicator
Definition:
As Communicators, the junior surgical resident will effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Develop rapport, trust, and ethical therapeutic relationships with patients and Families

   1.1. Identify and explore issues to be addressed in a surgical patient encounter effectively, including but not limited to the patient’s context and preferences which include items to be addressed such as age, ethnicity, gender, family, and religious beliefs.
   1.2. Recognize that being a good communicator is a core clinical skill for surgeons, and that effective physician-patient communication can foster patient adherence to treatment regimens, improved clinical outcomes, patient satisfaction and physician satisfaction.
1.3. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
1.3.1. Encourage discussion, questions, and interaction in the encounter
1.3.2. Engage patients, families, and relevant health care professionals to develop a plan of care using shared decision-making
1.4. Respect patient confidentiality, privacy and autonomy
1.4.1. Demonstrate an understanding of the risk of breaching patient confidentiality as a result of new technologies such as telehealth, internet or digital storage and transmission devices
1.5. Listen effectively
1.6. Be aware of and responsive to nonverbal cues
1.7. Facilitate a structured clinical encounter effectively

2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals

2.1. Gather information about a disease and about a patient's beliefs, concerns, expectations and illness experience
2.2. Seek out and synthesize relevant information from other sources, such as a patient's family, caregivers and other professionals

3. Convey relevant information and explanations accurately to patients and families, colleagues and other professionals

3.1. Deliver information to a patient and family, colleagues and other professionals in a humane manner and in such a way that it is understandable, encourages discussion and participation in decision-making
3.2. Plan and discuss appropriate peroperative care and issues with patients and families preoperatively
3.3. Perform informed discharge as it relates to the procedures being done
3.4. Discuss follow-up issues with family members or medical power-of-attorney as appropriate
3.5. Educate the patient and family concerning alternatives for surgical and non-surgical care
3.6. Demonstrate an awareness of effective communication using newer technologies

4. Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care

4.1. Respect diversity and difference on decision-making, including but not limited to the impact of:
4.1.1. Gender
4.1.2. Religion
4.1.3. Cultural beliefs
4.1.4. Age
4.1.5. Sexual orientation
4.1.6. Socioeconomic status
4.2. Address challenging communication issues effectively, including:
4.2.1. Obtaining informed consent
4.2.2. Delivering bad news
4.2.3. Disclosing adverse events
4.2.4. Discussing end-of-life care
4.2.5. Discussing organ donation
4.2.6. Addressing anger, confusion and misunderstanding
4.2.7. Language barriers
4.2.8. Cultural differences

5. Convey effective oral and written information about a medical encounter

5.1. Maintain clear, concise, accurate and appropriate records (e.g., written or electronic) of clinical encounters and plans
5.2. Present verbal reports of clinical encounters and plans

Collaborator

Definition:
As Collaborators, the junior surgical resident will effectively work within a health care team to achieve optimal patient care.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Participate effectively and appropriately in an interprofessional and interdisciplinary health care team

1.1. Describe the surgeon's roles and responsibilities to other professionals
1.1.1. Describe the elements of a good consultation
1.1.2. Recognize one's own limitations and when help is needed from others
1.2. Describe the roles and responsibilities of other professionals within the health care team
1.3. Recognize and respect the diversity of roles, responsibilities and competencies of other professionals in relation to their own
1.4. Work with others to assess, plan, provide and integrate care for individual patients (or groups of patients)
1.4.1. Arrange for the appropriate postoperative resources to be available
1.4.2. Arrange for appropriate postoperative allied health care assistance as necessary
1.5. Work with others to assess, plan, provide and review other tasks, such as research problems, educational work, educational program review or administrative responsibilities
1.6. Participate effectively in interprofessional team meetings
1.7. Enter into interdependent relationships with other professions for the provision of quality care
1.8. Describe the principles of team dynamics in the operative and non-operative environments
1.9. Respect team ethics, including confidentiality, resource allocation and professionalism
1.10. Demonstrate leadership in a health care team, as appropriate
1.11. Describe the use of a pre-operative team checklist and how it improves patient safety

2. Work with other health professionals effectively to prevent, negotiate, and resolve conflict

2.1. Demonstrate a respectful attitude towards other colleagues and members of a team
2.2. Work with other professionals to prevent conflicts
2.3. Employ collaborative negotiation to resolve conflicts
2.4. Respect differences and address misunderstandings and limitations in other professionals
2.5. Recognize one’s own differences, misunderstandings and limitations that may contribute to interprofessional tension

Manager

Definition:

As Managers, junior surgical residents will take part in health care organizations, making decisions about allocating resources, and contributing to the effectiveness of the health care system.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Demonstrate an understanding of the influences that affect the workings of the health care system at various levels, including an understanding of:

1.1. The Canada Health Act
1.2. Pertinent provincial and federal health legislation
1.3. Provincial regulatory bodies
1.4. Hospital governance
1.5. Operating room governance
1.6. Worker’s Compensation organizations
1.7. The role of the Coroner’s Office/Medical Examiners
1.8. Public Health as it relates to mandatory reporting of disease

2. Participate in activities that contribute to the effectiveness of their health care organizations and systems

2.1. Participate in systemic quality process evaluation and improvement, such as patient safety initiatives
2.2. Describe the structure and function of the health care system as it relates to their surgical practice, including the roles of physicians
2.3. Describe principles of health care financing

3. Manage their practice and career effectively
3.1. Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
3.2. Employ information technology appropriately for patient care
3.3. Demonstrate an understanding of the introduction of new technologies and the need for:
   3.3.1. Health technology assessment
   3.3.2. Education
   3.3.3. Credentialing

4. Allocate finite health care resources appropriately

4.1. Recognize the importance of just allocation of health care resources, balancing effectiveness, efficiency and access with optimal patient care

Health Advocate

Definition:

As Health Advocates, the junior surgical resident will responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Respond to individual patient health needs and issues as part of patient care
   1.1. Identify the health needs of an individual patient
   1.2. Recognize opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care, such as identifying:
       1.2.1. Child abuse
       1.2.2. Elder abuse
       1.2.3. Domestic violence
       1.2.4. Smoking cessation
       1.2.5. Substance abuse
       1.2.6. Patient behaviours that place them at risk for injury or disease
       1.2.7. Disadvantaged populations
   1.3. Recognize the importance of organ transplantation
       1.3.1. Identification of potential donors
   1.4. Identify opportunities to advocate for appropriate screening

2. Describe and respond to the health needs of the communities that they serve
   2.1. Demonstrate an understanding of how they may affect surgical disease prevalence

3. Promote the health of individual patients, communities, and populations
3.1. Describe an approach to implementing a change in a determinant of health of the populations they serve
3.2. Describe how public policy impacts on the health of the populations served
3.3. Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism
3.4. Appreciate the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper
3.5. Describe the role of the medical profession in advocating collectively for health and patient safety

4. Promote and participate in patient safety
4.1. Describe ways to prevent injury
4.1.1. Appropriate safety equipment for work and leisure pursuits
4.1.2. Error prevention system in operating room

Scholar

Definition:

As Scholars, the junior surgical resident will demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Maintain and enhance professional activities through ongoing learning
1.1. Describe the principles of lifelong learning
1.2. Describe the principles and strategies for implementing a personal knowledge management system
1.3. Pose an appropriate learning question
1.4. Access and interpret the relevant evidence including appropriate literature search
1.5. Integrate new learning into practice
1.6. Evaluate the impact of any change in practice
1.7. Document the learning process using methods such as:
1.7.1. Surgical logs
1.7.2. Learning portfolios

2. Critically evaluate medical information and its sources, and apply this appropriately to practice decisions
2.1. Describe the principles of critical appraisal including statistics and epidemiology
2.2. Critically appraise retrieved evidence in order to address a clinical question
2.3. Discuss ways to integrate critical appraisal conclusions into clinical care
3. Facilitate the learning of patients, families, students, residents, other health professionals, the public and others

3.1. Describe principles of learning relevant to medical education
3.1.1. Develop the skills to educate medical students
3.2. Identify collaboratively the learning needs and desired learning outcomes of others
3.3. Select effective teaching strategies and content to facilitate others’ learning
3.4. Demonstrate an effective lecture or presentation
3.5. Assess and reflect on a teaching encounter
3.6. Provide effective feedback
3.7. Describe the principles of ethics with respect to teaching

4. Demonstrate an understanding of the principles of dissemination of new knowledge

4.1. Demonstrate appropriate presentation skills including formal, informal and written Presentations

5. Demonstrate an understanding of the use of information technology to enhance surgical practice, including:

5.1. Computers
5.2. Presentation software
5.3. Personal digital assistant (PDAs)
5.4. Simulation and other technologies

Professional

Definition:
As Professionals, the junior surgical residents are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

Key and Enabling Competencies: by the end of Surgical Foundations training, the junior surgical resident is able to...

1. Demonstrate a commitment to their patients, profession, and society through ethical practice

1.1. Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism
1.1.1. Demonstrate the ability to be objective in treating patients regardless of their socioeconomic status or other factors
1.2. Demonstrate and maintain a commitment to delivering the highest quality care
1.3. Recognize and appropriately respond to ethical issues encountered in practice
1.4. Manage conflicts of interest
1.4.1. Demonstrate an awareness of the influence of industry on practice and training
1.5. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law
1.6. Maintain appropriate relations with patients
1.7. Recognize the duality of being a learner as well as a practitioner
1.7.1. Demonstrate an understanding of the role of appropriate supervision

2. Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation

2.1. Demonstrate knowledge and an understanding of the professional, legal and ethical codes of practice
2.2. Fulfill the regulatory and legal obligations required of current practice
2.3. Demonstrate accountability to professional regulatory bodies
2.4. Recognize and respond to others' unprofessional behaviours in practice
2.5. Participate in peer review

3. Demonstrate a commitment to physician health and sustainable practice

3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
3.2. Strive to heighten personal and professional awareness and insight
3.3. Recognize other professionals in need and respond appropriately
3.4. Demonstrate an awareness of the risks associated with the high stress environments in which surgeons work
3.5. Demonstrate an understanding of occupational risks and their management
3.6. Promote a healthy lifestyle and demonstrate awareness of personal at risk behaviours
3.6.1. Substance abuse
3.6.2. Exposure to infection
3.6.3. Sleep deprivation
3.7. Demonstrate an understanding of techniques for stress reduction
APPENDIX B - EDUCATIONAL OBJECTIVES FOR CORE SURGERY RESIDENTS ON ROTATIONS IN SURGERY AND OTHER SPECIALTIES

Anaesthesia
Cardiac Surgery
Emergency Department
General Surgery
Intensive Care Unit
Neurosurgery
Orthopaedic Surgery
Plastic Surgery
Thoracic Surgery
Urology
Vascular Surgery
ANAESTHESIA

A. GENERAL AIMS

1. To stabilize and to care for critically ill patients.

2. To improve the depth of knowledge, technical skills, and decision-making capacity in the anaesthetized patient.

3. To improve ability to care for patients recovering from surgery and anaesthesia.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

Given a patient to be anaesthetized or in the post-operative situation, the core surgery resident will be able to carry out the following to the satisfaction of his/her supervisor(s).

In addition to the skills noted on page 8 - Core Surgery Educational Objectives

Manage the patient throughout the anaesthetic experience including potential complications.

(II) COGNITIVE KNOWLEDGE

Given a preoperative or postoperative patient, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2(a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A & B) General Areas and Specific Disease Entities

1. Cardiac Arrest.

2. Cardiac crises - e.g. arrhythmias, diminished organ perfusion, pulmonary edema, myocardial infarction and severe hypertension.

3. Shock.

4. Respiratory failure.

5. Coma, status epilepticus, and acute neuromuscular diseases.
7. Acid-base disorders.
8. Fluid and electrolyte disorders.
9. Renal preservation and support.
10. The acute abdomen, gastrointestinal haemorrhage, hollow viscus dysfunction, and hepatobiliary disease.
12. Endocrine disturbances in the critically ill related to water and/or glucose metabolism and adrenal, parathyroid, thyroid and pituitary dysfunction.
13. Coagulation disturbances and blood replacement therapy.
15. Drugs - general pharmacology of commonly used drugs in the critically ill.
17. Trauma.
18. Burns.
19. Perioperative high-risk conditions.
20. Pain, anxiety, and sleep.
21. Intoxications.
22. Transportation of the critically ill.
23. Anaesthetic agents, including their physiologic action and complications.
(III) TECHNICAL SKILLS

At the end of a rotation on anaesthesia, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Establishment and maintenance of the airway, including orotracheal and nasotracheal intubation, cricothyroidotomy and tracheostomy.

2. Emergency bronchoscopy.

3. Techniques used in advanced cardiac and trauma life support.

4. Techniques of arterial and venous access, including arterial lines, CVP lines, and venous cut-downs.

5. Insertion of venous flow-directed catheters.

6. Regional anaesthesia (optional).

7. Epidural anaesthesia (optional).

8. Physiologic monitoring techniques, including O2 saturation, cardiac outputs.

9. Other - e.g. Foley catheter insertion, Nasogastric tube insertion, Silastic feeding-tube insertion.
A. GENERAL AIMS
   1. To gain knowledge of cardiovascular physiology and pathophysiology.
   2. To gain an understanding of the current practice of cardiac surgery.
   3. To acquire technical skills as they apply to cardiac surgery.
   4. To gain knowledge in the principles of surgery.
   5. To develop a professional attitude as it relates to cardiac surgery practice.

B. EDUCATIONAL OBJECTIVES

   (I) CLINICAL SKILLS

   See Core Surgery, Clinical Skills, page 8 Core Surgery Educational Objectives

   (II) COGNITIVE KNOWLEDGE

   The core surgical resident must have a basic understanding of the following areas:

   1. Anatomy, physiology and pathology of the pericardium, heart and great vessels.
   2. The pharmacology, indications for and the complications of drugs commonly used in the specialty.
   3. The natural history of treated and untreated diseases of the cardiovascular organs.
   4. The general principles of preoperative assessment, anaesthetic management and postoperative management of cardiovascular surgical patients.
   5. Surgical diseases of the pericardium, heart and great vessels.
(III) TECHNICAL SKILLS

At the end of the rotation, the core surgical resident on a cardiac surgical rotation must show technical competence in the following:

1. Assisting in the operating room either as second or first assistant and demonstrate an ability to anticipate surgical manoeuvres, to take direction well, to make reasonable suggestions, and to contribute to a positive operating room atmosphere.

2. Handling tissues and surgical instruments in an appropriate manner.

3. Assisting in the removal of the long saphenous vein and leg wound closure.

4. Assisting with sternotomy and cannulation.

5. Demonstrating adherence to sterile technique.

6. Inserting and removing chest tubes and pacer wires.

7. Managing cardiac dysrhythmias.
A. GENERAL AIMS

1. To stabilize and to care for the undifferentiated patient.

2. To develop triage skills appropriate to the management of patients presenting to emergency.

3. To rapidly recognize the acutely ill/injured patient and to develop a systematic approach to his/her assessment and management.

4. To improve depth of knowledge, technical skills and decision-making capacity regarding the critically ill.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See Core Surgery, Clinical Skills, page 8 - Core Surgery Educational Objectives

(II)COGNITIVE KNOWLEDGE

Given a patient in the emergency department, the core surgical resident must be able to perform the clinical skills listed in the section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment.

(A & B) General Areas and Specific Disease Entities

1. Cardiac Arrest.

2. Cardiac crises - e.g. arrhythmias, diminished organ perfusion, pulmonary edema, myocardial infarction and severe hypertension.

3. Shock.

4. Respiratory failure.

5. Coma, status epilepticus, and acute neuromuscular diseases.


7. Acid-base disorders.

8. Fluid and electrolyte disorders.
9. Renal preservation and support.

10. The acute abdomen, gastrointestinal hemorrhage, hollow viscus dysfunction, and hepatobiliary disease.


12. Endocrine disturbances in the critically ill related to water and/or glucose metabolism and adrenal, parathyroid, thyroid and pituitary dysfunction.

13. Coagulation disturbances and blood replacement therapy.


15. Drugs - general pharmacology of commonly used drugs in the emergency department.


17. Trauma.

18. Burns.

19. Perioperative high-risk conditions.

20. Pain, anxiety, and sleep.

21. Intoxications.

22. Pre-hospital care including paramedics, ambulance, first-aid providers, poison control, disaster planning.

23. X-ray interpretation.

(III) TECHNICAL SKILLS

At the end of a rotation in an emergency department, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Establishment and maintenance of the airway, including orotracheal and nasotracheal intubation, bag valve mask ventilation, bronchoscopy.

2. Techniques used in advanced cardiac and trauma life support, including defibrillation and cardioversion, and EKG interpretation.

3. Techniques of arterial and venous access, including arterial lines, CVP lines, venous cutdowns, and blood gas sampling.

4. Thoracentesis, paracentesis, pericardiocentesis.
5. Tube Thoracostomy.
6. Lumbar puncture.
7. Physiologic monitoring techniques, including O2 saturation, cardiac outputs.
8. Foley catheter insertion, Nasogastric tube insertion, gastric lavage.
10. Wound management, including cleaning, use of local anaesthetics and techniques of wound closure.
11. Fracture care, including splinting and casting.
12. Slit lamp examination.
13. Use of Schiotz tonometer.
14. Use of external pacemakers.
15. Epistaxis care, cauterization and nasal packing.
GENERAL SURGERY

A. GENERAL AIMS

1. To investigate and manage general surgical patients with acute and chronic illness.

2. To improve depth of knowledge, technical skills and decision-making capacity with respect to the general surgical patient.

3. To gain knowledge and management skills in the Principles of Surgery.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

Given a patient with general surgical disease, the core surgery resident will be able to do the following to the satisfaction of his/her supervisor(s):

1. In addition to the skills noted on page:

2. To formulate an initial hypothesis in light of conflicting data or events.

3. To identify conditions that requires urgent treatment.

4. To supervise the management of the critically ill or traumatized patient.

PGY I & II

Given a patient with one of the disease entities listed in Section 2, the core surgery resident will be able to perform the clinical skills listed in this section. It is expected that the data-gathering process will be accomplished by the PGYI resident completely. It is expected that the core surgery resident will consistently arrive at a correct diagnosis for common surgical problems. It is expected that the core surgery resident will formulate management strategies based on fundamentally sound surgical principles, but that treatment plans will often require corroboration or alteration by more senior individuals. It is expected that the core surgery resident will recognize the need for surgical intervention in critically ill patients, and in most elective situations.

(II) COGNITIVE KNOWLEDGE

Given a patient with a general surgical disease, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s) a fundamental knowledge and understanding of the general areas in 2(a) and a practical working knowledge of the specific disease processes listed in section 2(b); the expectations of depth of knowledge will vary with the level of training.
A. General Areas

**Principles of Surgery and Post-operative Problems**

1. Fluid and electrolyte disorders
2. Acid base disturbances
3. Cardiogenic shock
4. Hypovolemic shock
5. Septic shock
6. Neurogenic shock
7. Wound infection, dehiscence, and evisceration
8. Thromboembolic disorders
9. Atelectasis and pneumonia
10. Pressure palsy and pressure
11. Bladder retention

**Trauma**

1. Airway obstruction
2. Pneumothorax
3. Cardiac tamponade
4. Fractured cervical spine
5. Major vascular injury
6. Head injury
7. Spinal, paraspinal, and Syndrome, cord injuries
8. Face and neck injuries that are life threatening
9. Myocardial contusion
10. Pulmonary contusion
11. Aortic rupture
12. Tracheobronchial tree injury
13. Diaphragmatic rupture
14. Esophageal rupture
15. Blunt or penetrating abdominal
16. Fractures, joint injuries, open wounds, compartment & fracture accompanied by neurovascular compromise
17. Urologic injuries
18. Burns

B. Specific Disease Entities/Clinical Syndromes

1. The Acute Abdomen
   a) cholecystitis
   b) appendicitis
   c) diverticulitis
   d) pancreatitis
   e) perforated ulcer
   f) intestinal ischemia
2. Upper and lower GI bleeding
3. Gastric Outlet Obstruction
4. Bowel Obstruction
5. Hernias- Inguinal
   - Femoral
   - Umbilical
   - Incisional
6. Acute Anorectal Disease
   - abscess
   - fistula
   - hemorrhoids
7. Breast Lumps
   - benign
   - malignant
8. The Neck Lump
9. Hiatus Hernia & Esophageal Cancer
10. Carcinoma of Stomach, Periampullary region, Colorectum
11. Peptic Ulcer Disease of Stomach and Duodenum
12. The Jaundiced Patient
13. Inflammatory Bowel Disease
14. Abdominal Abscess and Fistula
(III) TECHNICAL SKILLS

Residents at all levels must master:

ASSISTING (both first and second) in the operating room, developing a facility for anticipation of surgical manoeuvres, gentle traction on tissues, ability to take direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.

Preamble

PGYI: Given a patient requiring one of the surgical procedures listed below, the PGYI resident will participate in the patient's care as a member of the operating team. It is expected that the PGYI resident will initiate the process of technical skill development by assisting in both simple and complex operations, and by performing, under supervision, simple procedures. It is expected that the PGYI resident will be familiar with surgical instruments and suture materials. It is expected that the PGYI resident will be able to position and drape patients for general surgical operations. It is expected that the PGYI resident will be able to open and close surgical wounds, control bleeding, and demonstrate knowledge of fundamental principles of tissue handling.

At the end of a rotation in general surgery, the PGYI resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s). Designation is listed as to expectation of "Surgeon" (S) or "Assistant" (A).

A. The PGYI resident may act as surgeon or assistant in those procedures marked (SA) depending on various factors at the time of surgery.

B. General diagnostic and therapeutic procedures

1. Arterial puncture
2. Venipuncture
3. Naso-gastric intubation
4. Insertion and removal of permanent feeding line
5. Insertion and removal of venous access reservoir
6. Proctoscopy & sigmoidoscopy
7. Insertion and removal peritoneal dialysis catheter
8. Skin suturing & stapling, knot tying
9. Selection of abdominal incisions
10. Laparotomy & closure of abdominal wall
11. Peritoneal tap
12. Electrocardiogram
13. Foley catheter insertion
14. Tracheostomy
C. Specific Procedures

Integumentary System
1. Incision and drainage of a subcutaneous abscess
2. Foreign body removal
3. Excision skin and subcutaneous abscess
4. Suture of lacerations

Breast
1. Aspiration breast cyst
2. Excision benign breast tumor

Haemic Lymphatic System
1. Splenectomy
2. Biopsy of enlarged nodes: (cervical, axillary, inguinal, scalene, submandibular)

Digestive System

Endoscopy
1. Esophago-gastro-duodenoscopy

Gastric
1. Pyloroplasty
2. Gastroenterostomy
3. Closure perforated ulcer

Intestinal
1. Rigid sigmoidoscopy
2. Flexible sigmoidoscopy
3. Insertion feeding enterostomy
4. Colostomy
5. Entero-enterostomy
6. Resection and anastomosis of small bowel
7. Resection and anastomosis of large bowel
8. Proctectomy (AP Resection)
9. Lysis of Adhesions
10. Appendectomy

Anorectal
1. Anoscopy
2. Excision thrombosed haemorrhoid

Liver
1. Incisional liver biopsy
2. Local excision liver lesion
**Biliary Tract**
1. Cholecystostomy, open  
2. Cholecystostomy, laparoscopic  
3. Exploration common bile duct  

**Pancreatic**
1. Drainage pancreatic abscess  
2. Whipple procedure  
3. Distal pancreatic excision  
4. Puestow procedure  

**Trauma**
1. Laparotomy for acute trauma  
   - splenectomy  
   - repair liver laceration  
   - repair ruptured diaphragm  
   - repair ruptured bladder  
   - nephrectomy  

**Abdominal Sepsis**
1. Drainage intra-abdominal abscess  
   - abdominal  
   - subphrenic  
   - pelvic  

**Hernia & Abdominal Wall**
1. Insertion peritoneovenous shunt  
2. Laparoscopy  
3. Repair inguinal hernia  
4. Repair femoral hernia  
5. Repair ventral hernia  
6. Excision hydrocele  
7. Closure evisceration
A. GENERAL AIMS

1. To stabilize and to care for critically ill patients.

2. To improve depth of knowledge, technical skills and decision-making capacity in the critically ill.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

(II) COGNITIVE KNOWLEDGE

Given a patient in the intensive care unit, the core surgical resident must be able to perform the clinical skills listed in section (I), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease:

(A & B) General Areas and Specific Disease Entities

1. Cardiac Arrest.

2. Cardiac crises - e.g. arrhythmias, diminished organ perfusion, pulmonary edema, myocardial infarction and severe hypertension.

3. Shock.

4. Respiratory failure.

5. Coma, status epilepticus, and acute neuromuscular diseases.


7. Acid-base disorders.

8. Fluid and electrolyte disorders.

9. Renal preservation and support.

10. The acute abdomen, gastrointestinal haemorrhage, hollow viscus dysfunction, and hepatobiliary disease.

12. Endocrine disturbances in the critically ill related to water and/or glucose metabolism and adrenal, parathyroid, thyroid and pituitary dysfunction.

13. Coagulation disturbances and blood replacement therapy.


15. Drugs - general pharmacology of commonly used drugs in the critically ill.


17. Trauma.

18. Burns.

19. Perioperative high-risk conditions.

20. Pain, anxiety, and sleep.

21. Intoxications.

22. Transportation of the critically ill.

(III) TECHNICAL SKILLS

At the end of a rotation in the SICU setting, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Establishment and maintenance of the airway, including orotracheal and nasotracheal intubation, cricothyroidotomy and tracheostomy.

2. Emergency bronchoscopy.

3. Techniques used in advanced cardiac and trauma life support.

4. Techniques of arterial and venous access, including arterial lines, CVP lines, and venous cut-downs.

5. Insertion of venous flow-directed catheters.

6. Thoracentesis, paracentesis.

7. Tube thoracostomy.

8. Lumbar puncture.

9. Physiologic monitoring techniques, including O2 saturation, cardiac outputs.

10. Other - e.g. Foley catheter insertion, Nasogastric tube insertion, Silastic feeding-tube insertion.
INTERNAL MEDICINE

A. GENERAL AIMS

1. To investigate and manage internal medicine patients with acute or chronic illness.

2. To improve depth of knowledge, technical skills and decision-making capacity in the internal medicine patient.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient on a medical ward, the core surgical resident must be able to perform the clinical skills listed in the section (I), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2, including:

1. Cardiology: hypertension, cardiac arrhythmias, congestive heart failure, chest pain of unknown etiology, coronary artery disease.

2. Respiratory: asthma, chronic obstructive pulmonary disease, pulmonary embolism, the assessment of haemoptysis and lung infiltrates, and the assessment of masses of unknown etiology.

3. Gastroenterology: acute gastrointestinal bleeding, diarrhea, abdominal pain of unknown etiology, inflammatory bowel disease, malabsorption syndrome, hepatitis, obstructive jaundice, peptic ulcer disease, alcoholism and alcoholic liver disease, nutritional disorders.


7. Infectious Diseases: community acquired infection, hospital acquired infection, rational use of antibiotics, pneumonia and bronchiectasis, septic shock, endocarditis, urinary tract infections, meningitis, cellulitis, pyrexia of unknown origin.


(III) TECHNICAL SKILLS

At the end of a rotation in internal medicine, the core surgical resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Techniques used in advanced cardiac life support, including EKG interpretation.

2. Techniques of arterial and venous access, including arterial lines, CVP lines, and venous cut-downs.

3. Thoracentesis, paracentesis.

4. Lumbar puncture.

5. Bone marrow aspiration.

6. Physiologic monitoring techniques, including O2 saturation, cardiac outputs.

7. Other - e.g. Foley catheter insertion, Nasogastric tube insertion.

8. Sigmoidoscopy.


11. Interpretation of imaging techniques, including X-rays and nuclear scans.

(IV) OVERALL

Clearly the PGYI or PGYII taking one or two months of Medicine will not have the opportunity of achieving all the goals and objectives listed above. However those identified in sections 1 and 4, some technical skills in section 3, and many of the general areas in section 2 should be achieved.

During the clinical teaching unit experience, where possible, one half-day should ideally be identified for an ambulatory care experience. Where this does not exist for the General Internal Medicine clinical teaching units, it should be provided through one of the subspecialties.
A. GENERAL AIMS

1. To gain knowledge of central and peripheral nervous system physiology and pathophysiology pertinent to the practice of neurological surgery.

2. To gain a working knowledge of central and peripheral nervous system surgery, as currently practised.

3. To gain technical expertise helpful to the developing surgeon in any specialty.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient with a neurosurgical condition, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A) General Areas

1. Anatomy and physiology of the central and peripheral nervous system.

2. Pharmacology as related to diseases of the central and peripheral nervous system.

3. Resuscitation and care of the neurosurgery patient in the critical care setting.

(B) Specific Disease Entities

1. Assessment and acute resuscitation of the trauma patient with head or spinal injuries, or injury to the peripheral nervous system.

2. Assessment and treatment of a patient with raised intracranial pressure.

3. Assessment and treatment of a patient with spinal cord or cauda equina compression.
4. Assessment and investigation of a patient with haemorrhagic or ischemic cerebrovascular disease.

5. Management of patients with acute or chronic seizure disorders.


(III) TECHNICAL SKILLS

At the end of a rotation on a neurosurgery service, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Assisting (both first and second) in the operating room, developing a facility for anticipation of surgical manoeuvres, gentle traction on tissues, an ability to take direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.

2. Lumbar puncture.

3. Insertion of lumbar subarachnoid catheter for the treatment of cerebrospinal fluid fistulae.

4. Insertion of at least one type of intracranial pressure monitoring device.

5. Application of a halo ring and institution of traction by pulley weights or vest for the treatment of spinal instability.


7. Evacuation of chronic subdural collection by burr holes and subdural drain insertion.

8. Assisting at one or more operations using the operating microscope to appreciate the potential of this technology.

9. Positioning of patients for cranial and spinal neurosurgical procedures.

10. Application of at least one type of pin fixation headrest used in cranial neurosurgery.
ORTHOPAEDIC SURGERY

A. GENERAL AIMS

1. To gain knowledge of musculoskeletal physiology and pathophysiology pertinent to the practice of Orthopaedic surgery.

2. To gain a working knowledge of Orthopaedic surgery as currently practiced.

3. To gain technical expertise helpful to the developing surgeon.

B. RESOURCES

There are presently six orthopaedic hospital divisions through which trainees rotate. The hospital divisions comprise the University Division of Orthopaedic Surgery. As a trainee you will not rotate through every hospital division. The divisions and their faculty strengths are listed below:

- The Hospital for Sick Children (paediatric orthopaedics, regional trauma centre)
- Mount Sinai Hospital (reconstructive surgery, oncology)
- St. Michael's Hospital (reconstructive surgery, trauma, upper extremity, spine)
- Sunnybrook Health Sciences Centre
- Women's College Hospital (trauma, reconstructive surgery, spine, upper extremity)
- Toronto Western Hospital (reconstructive surgery, spine, arthroscopy, sports medicine)
- Toronto East General (community orthopaedics, trauma, reconstructive surgery)

C. CURRICULUM

The University of Toronto Orthopaedic Training Program has as its major objective not only clinical excellence but also academic development and as such it offers in addition to the mandatory requirements of the Royal College a mandatory six months experience in research. This training may be extended beyond six months if the trainee should desire to pursue participation in the Surgical Scientist Program. The Surgical Scientist Program requires a commitment of a minimum of two years research, leads to a postgraduate degree and has been designed for those trainees who are interested in an academic surgical career with a significant research interest. It is available to the trainees upon completion of their residency. The six months research experience will be biological, biomechanical, educational or epidemiological areas, under the supervision
of one of the members of the Orthopaedic Faculty. Contact with the research supervisor should be established during the PGY-1 year. The actual six months of research will be done either during PGY-2 or PGY-3 years.

A. PGY 1 & 2

These two years of training are "core years". Trainees serve as assistant residents on a variety of services. These services may include rotations on general surgery, plastic surgery, neurosurgery, surgical intensive care or other surgical services. During these two years the residents will do twelve months of orthopaedic surgery at a junior level.

B. PGY 3 TO 5 [PROBABLY DELETE]

During these years the resident completes his/her senior orthopaedic training and will spend six-month periods at four of the six adult teaching hospitals and six months at the Hospital for Sick Children. Between PGY3 to PGY5 the residents are exposed to 24 months of adult orthopaedics and six months of paediatric orthopaedics at The Hospital for Sick Children. An intensive exposure to trauma is offered during the penultimate year of training at St. Michael's Hospital and Sunnybrook Health Science Centre, which are the Regional Trauma Centres.

D. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient with a musculoskeletal problem, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A) General Areas

1. Anatomy and physiology of the locomotor system.

2. Pharmacology as related to diseases of bones and joints.

3. Resuscitation and care of the multiply injured patient in the critical care setting.

4. Principles of treatment of fractures, including open fractures.

(B) Specific Disease Entities
1. Upper and lower extremity fractures (classification, treatment, complications & results).
2. Spinal fractures (diagnosis, treatment, complications and prognosis).
3. Ligamentous and tendinous injuries.
4. Vascular and nervous complications.
5. Compartment syndrome.
6. Principles of reconstruction of arthritic joints.

E. TECHNICAL SKILLS
At the end of a rotation on an orthopaedic surgery service, the core surgical resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Assisting (both first and second) in the operating room, developing a facility for anticipation of surgical manoeuvres, gentle traction on tissues, ability to accept direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.

2. Surgical approaches to upper and lower extremities and spine.

3. Closed reduction of fractures and cast application techniques.

4. Open reduction of fractures and application of internal fixation devices including plates and IM nails.

5. Repair of ligamentous injuries of the knee.


7. Measurement of compartment pressures.
A. GENERAL AIMS

1. To improve an understanding of lesions of the skin, benign and malignant, wound creation and closure, and other fundamental problems in plastic surgery.

2. To gain technical experience in optimal incisions, suturing techniques, and the handling of wounds.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient with a plastic surgical condition, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A) General Areas

1. Pathophysiology of trauma, general and specific to the plastic surgery service.

2. Pathophysiology of burns.

3. Wound healing in aseptic and septic conditions.

4. Options for wound closure.

5. Reconstructive surgery options for head and neck, hand, and trunk.

6. Aesthetic surgery options.

(B) Specific Disease Entities

1. Trauma - polytraumatized patient, head and neck trauma, facial features, facial soft tissue injury.

   - hand trauma including skin loss, tendon injury, closed and open hand
fractures.
- burn patient (including frostbite and hypothermia)

2. Wound healing problems - especially in difficult circumstances such as diabetes, immunosuppressed patients, and paraplegic patients.

3. Hand lesions - malformations, deficiencies, other diseases.


5. Soft tissue infections - spontaneous, post-traumatic and postoperative
   - principles of tetanus prophylaxis, antibiotic usage.

6. Principles of techniques of skin surgery
   - skin grafting, Z-plasty, rotation flaps, myocutaneous flaps, microvascular techniques.

7. Skin ulcers - principles of management of vascular and diabetic and decubitus ulcers.

(III) TECHNICAL SKILLS

At the end of a rotation on a plastic surgery service, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Assisting (both first and second) in the operating room, developing a facility for anticipation of surgical manoeuvres, gentle traction on tissues, ability to take direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.

2. Excision of skin tumours.

3. Vermilionectomy and wedge excision of the lip.

4. Proper topical care and preparation for wound closure.

5. Variety of wound closures (including design incision, Z-plasty, flaps).

6. Split-thickness skin graft.

7. Minor maneuvers in facial fractures (e.g. zygoma elevation, jaw wiring).

8. Tendon repair.

9. Stabilization of hand and finger fractures (closed and open techniques).
10. Debridement of wounds; handling the infected wound and the soft tissue infection requiring debridement as part of treatment.

11. Local treatment and dressing of minor burns.

THORACIC SURGERY

A. GENERAL AIMS

1. To gain knowledge of cardiopulmonary physiology and pathophysiology pertinent to the practice of surgery.

2. To gain a working knowledge of thoracic surgery practised in the 1990's.

3. To gain technical expertise helpful to the developing surgeon.

B. EDUCATION OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient with thoracic disease, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A) General Areas

1. Anatomy and physiology of the heart, lungs, chest wall and mediastinum.

2. Pharmacology as related to diseases of the heart and lungs.

3. Resuscitation and care of the thoracic surgery patient in the critical care setting.


5. Pulmonary reserve and the measurements thereof.

6. Principles of esophageal manometry and pH testing.


(B) Specific Disease Entities

1. Carcinoma of the lung, including staging, pathology and management.
2. Chronic obstructive pulmonary disease.
3. Pneumothorax.
4. Haemothorax.
5. Chest trauma, blunt and penetrating, including rib fractures, bronchotracheal disruption.
7. Esophageal carcinoma.
8. Esophageal motility disorders including achalasia, esophageal spasm.
9. Gastroesophageal reflux.

(III) TECHNICAL SKILLS

At the end of a rotation on a thoracic surgery service, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Assisting (both first and second) in the operating room, developing a facility for anticipation of surgical maneuvers, gentle traction on tissues, an ability to take direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.
2. To insert and remove chest tubes with minimal physical and emotional discomfort for the patient.
3. Emergency treatment of tension pneumothorax.
4. Opening and closing of a thoracotomy incision.
5. Intercostal nerve block.
6. Arterial blood stab.
8. Mediastinoscopy.
10. Minor chest wall procedures.
A. GENERAL AIMS

1. To gain knowledge of genitourinary physiology and pathophysiology pertinent to the practice of surgery.
2. To gain a working knowledge of urologic surgery, as currently practised.
3. To gain technical expertise helpful to the developing surgeon, in any specialty.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient with a urologic disease, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2 (a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A) General Areas

1. Anatomy and physiology of the genitourinary tract in males and females.
2. Pharmacology as related to diseases of the kidney, ureter and bladder.
4. Investigation of genitourinary problems (i.e. urinalysis, urography, nephrotomography, retrograde pyelography, cystography, cystoureterography, CT scan, MRI scan, angiography, lymphangiography, vasography).
5. Ultrasonography of the urinary tract and male genitalia.

(B) Specific Disease Entities

1. Urologic oncology (kidney, ureter, pelvis, bladder, prostate, penis, testis, urethra).
2. Obstructive uropathy (BPH, prostate carcinoma, strictures).
3. Calculous disease (kidney, ureter, bladder, urethra, prostate)
4. Trauma - blunt and penetrating to all organs related to urology.
5. Renovascular hypertension.
6. Renal transplant and transplant immunology.
7. Sexuality and psychic disorders of the urinary tract (impotence, priapism).
10. Genitourinary infection.

(III) TECHNICAL SKILLS

At the end of a rotation on a urology service, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Assisting (both first and second) in the operating room, developing a facility for anticipation of surgical manoeuvres, gentle traction on tissues, ability to take direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.

2. Difficult catheterization.

3. Cystoscopy and urethroscopy.

4. Urethral dilatation.

5. Vesical and urethral biopsy and fulgurations.

6. Internal urethrotomy (blind and visual).

7. Lithoplasty.

8. Urethral meatotomy.

9. Suprapubic cystostomy.

10. Circumcision.

11. Excision and fulguration of venereal warts.
12. Open renal biopsy.
13. Penile biopsy
14. Testicular biopsy.
15. Prostatic biopsy.
17. Vasotomy and vasography.
18. Cystolithotomy.
20. Drainage of perivesical abscess.
22. Orchietomy (scrotal or inguinal)
23. Epididymectomy.
24. Ligation of spermatic veins.
25. Hydrocele, spermatocele.
26. Testicular prosthesis.
27. Excision kidney cyst.
28. Urethrotomy.
A. GENERAL AIMS

1. To develop an understanding of radiologic and non-invasive assessment of arterial, venous, and lymphatic disease.

2. To develop an ability to localize the level of obstruction in exercise-induced leg ischemia by history and clinical examination.

3. To gain technical expertise with arteries and veins pertinent to the practice of a general surgeon.

B. EDUCATIONAL OBJECTIVES

(I) CLINICAL SKILLS

See page 8.

(II) COGNITIVE KNOWLEDGE

Given a patient with vascular disease, the core surgical resident must be able to perform the clinical skills listed in section (1), and be able to demonstrate to the satisfaction of his/her supervisor(s), a fundamental knowledge and understanding of the general areas in section 2(a), and a practical working knowledge of the specific disease processes listed in section 2(b); the core surgical resident's knowledge must be adequate to allow appropriate assessment, investigation, diagnosis, and treatment; the senior resident's knowledge of the same areas must be detailed, and include the incidence, etiology, pathophysiology, natural history, clinical diagnosis, investigation, treatment, prognosis, and complications in each disease.

(A) General Areas

1. Anatomy and physiology of the arterial, venous and lymphatic systems, with emphasis on the arteries to the leg, the arterial and venous relationships at the inguinal region, the carotid bifurcation, the subclavian artery and vein, and the abdominal aorta and vena cava.

2. Non-invasive and radiologic assessment of the arterial, venous and lymphatic systems.

3. Pharmacology as related to diseases of arteries and veins, especially chronic and acute arterial disease, deep venous thrombosis and pulmonary embolism.

4. Natural history of arterial disease processes and outcome of a variety of vascular procedures.
(B) Specific Disease Entities

1. Arterial insufficiency of the legs, acute and chronic.
2. Abdominal aortic aneurysm-asymptomatic and leaking.
3. Peripheral aneurysms.
4. Extracranial vascular disease (carotid)
5. Renal hypertension.
6. Associated diseases e.g. diabetes
7. Varicose veins.

(III) TECHNICAL SKILLS

At the end of a three-month rotation on a vascular service, the resident must be able to show technical competence in the following procedures to the satisfaction of his/her supervisor(s).

1. Assisting (both first and second) in the operating room, developing a facility for anticipation of surgical maneuvers, gentle traction on tissues, ability to take direction well, to make reasonable suggestions and enquiry, and to contribute to a positive operating room atmosphere.

2. Control of haemorrhage in emergency situations.

3. Femoral arterial embolectomy.

4. Exposure of arterial pathology at various sites without injury to the artery or surrounding structures.

5. Repair of traumatized artery.


7. Vascular anastomosis of a large vessel.

8. Fasciotomy.
APPENDIX C – SPECIALTY CURRICULA FOR CORE SURGERY RESIDENTS

*Rotations and Seminar Programs for*

i) Cardiac Surgery  
ii) General Surgery  
iii) Neurosurgery  
iv) Orthopaedic Surgery  
v) Plastic Surgery  
vi) Urology  
vii) Vascular Surgery
CURRICULUM FOR CARDIAC SURGERY RESIDENTS

I.

A. ROTATIONS – JULY 2012

PGY I

3 months - Cardiac Surgery
1 month - Emergency
3 months - General Surgery
1 month - Internal Medicine
1 month - Elective
1 month - Cardiac Consults
1 month - Perfusion/PTCA

PGY II

2 months - Cardiology
1 month - CVICU
1 month - Cardiac Pathology
2 months - SICU
2 months - Thoracic Surgery
2 months - Vascular Surgery
1 month - Surgical echocardiography
1 month - Pacemaker/EPS

NB: Elective can be in any of the above rotations or in any of the following:

- Cardiac Transplantation
- Cardiac Pathology
- CVICU, Anaesthesia and Perfusion
- Paediatric Cardiac Surgery
- Paediatric General Surgery

B. STUDY

7. Seminar Program in Principles of Surgery
8. Seminar Program in Cardiac Surgery

Dr. C. Caldarone, Chair of Cardiac Surgery, University of Toronto and Dr. G. Cohen, Program Director, have approved this curriculum.
CURRICULUM FOR GENERAL SURGERY RESIDENTS

II.

A. ROTATIONS - JULY 2012

PGY I

6 months - Adult General Surgery
1 month - Emergency Medicine
1 month - Thoracic Surgery
1 month - Transplantation
2 months - Paediatric General Surgery
1 month - Anaesthesia

PGY II

5 months - Adult General Surgery
2 months - Gastroenterology/Endoscopy
3 months - SICU
2 months - Surgical Elective*

* The Surgical Elective may consist of any one of:

a. Burn Unit
b. Community General Surgery
c. Neurosurgery
d. Orthopaedic Surgery
e. Plastic Surgery
f. Radiology
g. Critical Care
h. Thoracic Surgery
i. Urology
j. Vascular Surgery
k. Breast Service

B. STUDY

1. Seminar program in Principles of Surgery
2. Seminar program in General Surgery

Dr. A. Smith, Chair of General Surgery, University of Toronto and Dr. N. Ahmed, Program Director of General Surgery have approved this curriculum.
CURRICULUM FOR NEUROSURGERY RESIDENTS

III.

A. ROTATIONS - JULY 2012

PGY I

3 months - Adult Neurosurgery
2 months - Emergency Medicine (or 3mo EM & 1mo general medicine)
3 months - General Surgery
4 months - Surgical Elective* (2months each)


PGY II

9 months - Adult Neurosurgery
3 months - SICU

B. STUDY

1. Seminar Program in Principles of Surgery

2. Seminar Program in Neurosurgery
   (see website for study notes for last 3 years of curriculum)

   http://www.surg.med.utoronto.ca/NEURO/curriculum.html
   http://ots.utoronto.ca/users/howardg/

Dr. A. Lozano, Chair of Neurosurgery, University of Toronto, and Dr. A. Kulkarni, Program Director, Division of Neurosurgery have approved this curriculum.
A. ROTATIONS - JULY 2012

PGY I

1 month - Surgical Skills Lab
1 month - Adult General Surgery
6 months - Adult Orthopaedics
1 month - Emergency
1 month - Internal Medicine
2 months - Vascular Surgery or Neurosurgery

PGY II

3 months - Adult Orthopaedics
3 months - Paediatric Orthopaedic Surgery at Hospital for Sick Children
2 months - Surgical Intensive Care Unit

AND

4 months off service to be chosen from:

a. Neurosurgery
b. Plastic Surgery
c. Vascular Surgery
d. Hand Surgery
e. Radiology
f. Anatomy

B. STUDY

1. Seminar Program in Principles of Surgery
2. Seminar Program in Orthopaedic Surgery

Dr. B. Alman, Chair of Orthopaedic Surgery, University of Toronto, and Dr. P. Ferguson, Program Director, Division of Orthopaedic Surgery have approved this curriculum.
CURRICULUM FOR PLASTIC SURGERY RESIDENTS

A. ROTATIONS - JULY 2012

PGY I

1 month - Emergency
4 months - General Surgery
1 months - Medicine
3 months - Plastic Surgery
2 months - ICU
1 month - Oral Surgery

PGY II

3 months - Burn Unit
3 months - Plastic Surgery
2 months - Orthopaedic Surgery
2 months - ENT
1 month - Dermatology
1 month - Dermatological Pathology

B. STUDY

1. Seminar program in Principles of Surgery
2. Seminar Program in Plastic Surgery

Dr. C. Forrest, Chair of Plastic Surgery, University of Toronto and Dr. M. Brown, Program Director of Plastic Surgery have approved this curriculum.
A. ROTATIONS - JULY 2012

PGY I

6 months - General Surgery
2 months - Adult Urology
2 months - Vascular Surgery
2 months - Selective*

* Selective – May include 1 or 2 months of any of the following, alone or in combination: Gynaecologic Oncology, Radiology, Pathology, Medical Oncology, Radiation Oncology (others to be approved by Program Director)

PGY II

6 months - Adult Urology
2 months - Paediatric Urology
2 months - ICU
2 months - Nephrology/Tx

B. STUDY (YEARS I AND II)

I. Postgraduate Seminar Program in Urology (Friday AM)

II. Principles of Surgery Seminar Program (Tuesday AM)

This curriculum has been approved by Dr. S. Herschorn, Division Chair, and Dr. R. Stewart, Residency Program Director of Urology
C. ROTATIONS - JULY 2012

PGY I

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PGY II

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This curriculum has been approved by Dr. T. Lindsay, Division Chair, and Dr. G. Oreopoulos, Residency Program Director of Vascular Surgery
APPENDIX D – PRINCIPLES OF SURGERY
EXAMINATION
POS Practice Examination – University of Toronto

The University of Toronto Principles of Surgery Practice Examination will be held in the early spring – please see schedule for exact date for exam and follow-up session.

POS Examination – Royal College of Physicians and Surgeons of Canada

Residents who are completing their second year of core surgery are eligible to sit the Royal College of Physicians and Surgeons of Canada, Principles of Surgery examination.

Please note that if you wish to sit the exam in the spring of 2013, you should apply to the Royal College by April 30, 2012 to obtain a preliminary assessment of your training.

For complete information, please visit:


The Principles of Surgery (POS) examination is offered annually at all centres where Royal College examinations are written.

This examination, developed by an inter-specialty test committee, allows the other components of the examination process to be made more specific to the specialty concerned, and since it may be written after two years of surgical training, and since "feedback" will be provided, candidates will be helped in assessing their in-training progress. In order to assist program directors in improving their training programs, candidates will be asked to indicate their willingness to have their program director given information about their performance.

The six-hour examination contains 300 multiple choice questions covering the categories listed in the outline of contents for the POS examination.

Candidates in cardiovascular and thoracic surgery, general surgery, neurosurgery, orthopaedic surgery, plastic surgery and urology must pass the POS examination.

Candidates must pass the POS examination, the final examinations, and satisfactorily complete the required residency training to obtain Certification by the Royal College.

At the present time, the POS examination is voluntary for candidates in other surgical specialties. Candidates who pass the POS examination will receive credit and will not be required to repeat the examination if it has become mandatory in their specialty by the time they come to their final examinations.
Applications

Assessment-of-training forms may be obtained from the College in Ottawa. They must be returned by April 30 of the year prior to the year of the examination. Those assessed in the past need only bring their training histories up to date by means of a letter. For complete information, please visit:

Eligibility

The examination is open to all surgical residents who have satisfactorily completed at least two years of specialty training in an approved training program in cardiovascular and thoracic surgery, general surgery, neurosurgery, obstetrics and gynaecology, ophthalmology, orthopaedic surgery, otolaryngology, plastic surgery or urology. The Specialty Committees in obstetrics and gynaecology, in ophthalmology and in otolaryngology have decided not to make the POS examination mandatory.
**Principles of Surgery Lecture Series 2010-2011**

*PLEASE PROCEED TO THE SKILLS LAB IMMEDIATELY FOLLOWING THE LECTURE*

This is tentative so expect changes. Please see [www.surgery.utoronto.ca](http://www.surgery.utoronto.ca) for the most up-to-date schedule.

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<td>The Resident and the Law</td>
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<td>Diabetes for Surgery Residents</td>
<td>R. Silver</td>
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Flowchart of SF Training

Remediation (A)

SF Competency Evaluation

Fail

PGY1

PGY2

PGY3

PGY4

PGY5

PGY6

Remediation (B)

Pass

Must pass by PGY3

POS Examination

Fail

Pass

Must pass prior to Fellowship exam

Fellowship Exam

(A) The SF and home program directors will collaboratively design a remediation program for the resident who does not pass SF, and decide whether that will mean that the resident repeats previous rotations or has new, PGY2 rotations, or whether the resident proceeds to clinical PGY3 rotations during that remediation. (B) The SF and home program directors will collaboratively design a remediation program for the resident who does not pass the POS examination. The resident will have 2 attempts to write the POS examination prior to the Fellowship Examination. After 2 attempts, the resident will need to reapply to the RCPSC to write the examination for a third and final time.
APPENDIX E – BOARD OF EXAMINERS GUIDELINES FOR THE EVALUATION OF POSTGRADUATE TRAINEES OF THE FACULTY OF MEDICINE AT THE UNIVERSITY OF TORONTO
GUIDELINES FOR THE EVALUATION OF
POSTGRADUATE TRAINEES
OF THE FACULTY OF MEDICINE
AT THE UNIVERSITY OF TORONTO

February 2007
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1. INTRODUCTION

These Guidelines for the Evaluation of Postgraduate Trainees at the Faculty of Medicine at the University of Toronto (the "Guidelines") contain the rules governing the evaluation and promotion of all residents in postgraduate training programs at the University of Toronto. For the purposes of this document, a resident is a physician registered in a program subject to certification by the RCPSC or CFPC. It is the responsibility of each resident to read the Guidelines and to be familiar with their content.

The Guidelines have been developed to be in compliance with the accreditation standards of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The Guidelines are also designed to be consistent with the following University of Toronto academic policies, and policies of the following medical organizations:

(a) the University of Toronto Grading Practices Policy;
(b) the University of Toronto Code of Behaviour on Academic Matters;
(c) the Standards of Professional Behaviour for Medical Undergraduate and Postgraduate Students; and
(d) the University of Toronto Code of Student Conduct
(e) the College of Physicians and Surgeons of Ontario Policy on Professional Responsibilities in Postgraduate Medical Education; and
(f) the Canadian Medical Association Code of Ethics

The Guidelines set out the procedures for the assessment of Trainees (as defined below). The Guidelines also establish the processes for remediation when a Trainee has failed to meet the performance standards of the Residency Program (as defined below), or where a problem in respect of the behaviour or performance of a Trainee has been identified.

In these guidelines the word “must” is used to denote something necessary and the word “should” is used to denote something highly desirable.
2. DEFINITIONS

The following definitions are used in this document:

2.1 "Board of Examiners – PG" means the Board of Examiners – Postgraduate Programs, which is the committee of the University Faculty Council responsible as set out in the Terms of Reference by Faculty Council.

2.2 "CFPC" means the College of Family Physicians of Canada.

2.3 "CPSO" means the College of Physicians and Surgeons of Ontario.

2.4 "Dean" means the Dean of the Faculty of Medicine of the University.

2.5 "Dismissal" shall have the meaning set out in 7.1.

2.6 "End of Rotation Evaluation" shall have the meaning set out in 4.5.

2.7 "Final Assessment" see definition for "End of Rotation Evaluation"

2.8 "Standards of Accreditation" means the standards of accreditation of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, as applicable.

2.9 "Head of Department" means administrative head of the University department.

2.10 "Improper Conduct" shall have the meaning set out in 6.2.

2.11 "ITER" means in-training evaluation report.

2.12 "Mid-way Evaluation" shall have the meaning set out in 4.4.

2.13 PGMEAC" means the Post-Graduate Medical Education Advisory Committee, which is the committee which, as stated in the Standards of Accreditation, is responsible for the development and review of all aspects of postgraduate medical education within the Faculty. The PGMEAC is chaired by the Vice Dean.

2.14 "Probation" shall have the meaning set out in 5.11.

2.15 "Program Director" is the officer responsible for the overall conduct of the integrated residency program in a discipline, and responsible to the head of the department concerned and to the Vice Dean.

2.16 "RCPSC" means the Royal College of Physicians and Surgeons of Canada.

2.17 "Remedial Period" means any of Remediation, Remediation with Probation, and Probation, all as defined in the Guidelines.
2.18 "Remedial Plan" shall have the meaning set out in 5.5.

2.19 "Remediation" shall have the meaning set out in 5.9.

2.20 "Remediation with Probation" shall have the meaning set out in 5.10.

2.21 "Residency Program" means a RCPSC or CFPC postgraduate medical training program;

2.22 "RPC" means the Residency Program Committee is the committee that assists the Program Director in the planning, organization, and supervision of the residency training program, (and) must include representation from the trainees in the program.

2.23 "Signature" means actual signature or electronic acknowledgement.

2.24 "Supervisor" means a staff physician directly responsible for a period or segment of the Trainee's professional training, teaching and instruction.

2.25 "Suspension" shall have the meaning set out in 6.1.

2.26 "Postgraduate Trainee/ Resident" means a physician registered in a training program accredited by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada who is registered in the Faculty of Medicine of the University.

2.27 "University" means the University of Toronto.

2.28 "Vice Dean" means the Vice Dean of Postgraduate Medical Education of the Faculty of Medicine of the University.

3. PGMEAC – MAINTAINING STANDARDS OF EVALUATION

3.1 It is the responsibility of the PGMEAC to establish standards for the evaluation, promotion, and dismissal of Trainees in all Residency Programs by:

3.1.1 Reviewing the evaluation process of each Residency Program on a periodic basis;
3.1.2 Ensuring that evaluation processes and practices are consistent with the Guidelines, and the minimum standards set by the University and related professional organizations, including the CPSO, CFPC and RCPSC;
3.1.3 Ensuring that clinical and field supervisors, as well as trainees, are properly informed about evaluation and related processes as required by the University Grading Practices Policy; and
3.1.4 Responding appropriately to the annual report of the Board of Examiners – PG.
4. TRAINEE EVALUATION

4.1 Evaluation: Mid-way and Final Assessment

As students of the University and trainees in either an RCPSC or CFPC Residency Program, Trainees are routinely evaluated on an ongoing basis, both formally and informally. This evaluation may be formative or summative. This evaluation must be conducted in accordance with the policies of the University, the RCPSC, and the CFPC.

The University Grading Practices Policy provides at section II.4:

“Divisions may make reasonable exemptions to the classroom procedures... in circumstances such as field or clinical courses where adherence to these procedures is not possible. Nevertheless, it is obligatory that the assessment of the performance of students in clinical or field settings should be fair, humane, valid, reliable and in accordance with the principles enunciated in the University Grading Practices Policy. Accordingly, where a student's performance in a clinical or field setting is to be assessed for credit, the evaluation must encompass as a minimum:

(a) A formal statement describing the evaluation process, including the criteria to be used in assessing the performance of students and the appeal mechanisms available. This statement should be available to all students before or at the beginning of the clinical or field experience;

(b) A mid-way performance evaluation with feedback to the student;

(c) Written documentation of the final assessment.

In addition, for such clinical and field experiences, divisions must ensure that:

(d) Clinical and field assessors are fully informed regarding University, divisional and course policies concerning evaluation procedures, including the specific assessment procedures to be applied in any particular field or clinical setting.

The minimum standards set by the University Grading Practices Policy for Clinical and Field Settings include a Mid-way Evaluation and a written Final Assessment. In this document, the term End of Rotation Evaluation is used to refer to the Final Assessment under the University Policy.
4.2 Evaluation: the ITER

4.2.1 Purpose

The ITER form to be used by a Residency Program should be designed or adopted by the RPC of that program. The purpose of the ITER is as follows:

4.2.1.1 to provide a framework for the assessment of the Trainee’s knowledge, skills and attitudes by a Supervisor;

4.2.2.2 to facilitate feedback to the Trainee by a Supervisor or the Program Director;

4.2.1.3 to serve as a record of the strengths and weaknesses of the Trainee for the Program Director;

4.2.1.4 to enable the Program Director to assist future Supervisors in ongoing supervision;

4.2.1.5 to assist the Program Director in providing a final in-training evaluation of the Trainee for the RCPSC, the CFPC, or the CPSO; and

4.2.1.6 to establish the basis for progress and promotion.

4.2.2 Marking

4.2.2.1 The ITER must contain or be accompanied by guidelines for the rating scale to assist the Supervisor(s) in marking individual evaluation items and should relate to level-specific learning goals and objectives. Comments should be made on any specific areas of performance which contribute significantly to the evaluation, especially in areas of weakness.

4.2.2.2 For the purpose of completing the ITER, appropriate medical and non-medical personnel should be consulted about the Trainee’s performance.

4.3 Evaluation: Process

4.3.1 As required by the University Grading Practices Policy, a Trainee must be provided with:

4.3.1.1 a copy of Residency Program Goals and Objectives

4.3.1.2 a statement describing the evaluation process used by the particular Residency Program;

4.3.1.3 a copy of the ITER form; and
4.3.1.4 a copy of these Guidelines.

4.3.2 During a Residency Program, Supervisors should make every effort to provide ongoing, informal, verbal feedback to all Trainees, in addition to the formal feedback and evaluation required by the Guidelines.

4.3.3 If a problem is identified at any point during the rotation, a Supervisor must bring this problem to the attention of the Trainee promptly. This must be documented by the Supervisor.

4.4 Mid-way Evaluation

4.4.1 At the midpoint of any rotation of 6 weeks or longer, a Supervisor should provide the Trainee with a Mid-way Evaluation, orally or in writing. The Supervisor should meet with the Trainee to discuss the Trainee’s progress to date, identifying any specific strengths or weaknesses.

4.4.2 The Mid-way Evaluation should serve as an opportunity for discussion and feedback about the Trainee’s performance. The ITER form should be used as a guide for the Mid-way Evaluation, but it does not need to be completed. If the ITER is completed as part of the Mid-way Evaluation, this ITER will be treated in a manner consistent with the treatment of ITERs completed as part of a Final Assessment.

4.5 End of Rotation Evaluation

4.5.1 At the end of each rotation, and at least every 180 days, an End of Rotation Evaluation, in the form of a written evaluation must be completed, using the ITER form, by the Supervisor(s), or by the Program Director or delegate. The End of Rotation Evaluation should outline the progress that has been made by the Trainee in addressing any problems identified at the Mid-way Evaluation. A Supervisor, or the Program Director, must discuss the written evaluation with the Trainee. This discussion should occur in a timely fashion, preferably in person and preferably before the end of the rotation or as soon thereafter as possible.

4.5.2 The Trainee must be asked to provide their signature on the ITER to confirm that it has been seen and discussed with the Supervisor or Program Director. This confirmation does not signify that the Trainee agrees with the evaluation. Failure of the Trainee to sign the form does not invalidate the evaluation. The Trainee should be given a reasonable period of time in which to consider the evaluation and be encouraged to provide comments regarding this evaluation in a space provided. If subsequent comments are added by the Supervisor, they must be shared and discussed. A copy of the evaluation must be provided to the Trainee upon request.

4.5.3 An ITER is a confidential document and must only be disclosed as strictly
necessary. A Trainee's ITER must only be provided to the Trainee, to the Trainee's Supervisor, to the Program Director and RPC, and where appropriate, the Vice Dean, the Board of Examiners – PG and any Faculty or appeal committee considering the Trainee's performance.

5. REMEDIAL PERIODS

5.1 If an End of Rotation Evaluation is below the standards expected for the level of training of the Trainee, the RPC must decide whether to recommend that the Trainee be required to enter one of the following Remedial Periods:

5.1.1 Remediation;
5.1.2 Remediation with Probation; or
5.1.3 Probation.

5.2 These Remedial Periods are intended to deal with problems which are not expected to be readily corrected in the normal course of the Residency Program.

5.3 Any recommendation of a Remedial Period must be subject to the approval of the Board of Examiners – PG. Prior to consideration by the Board of Examiners – PG, the Trainee must be given the opportunity to meet with the RPC to discuss the recommendation.

5.4 Where a Remedial Period is being considered, for the purposes of presenting to the Board of Examiners – PG, the Program Director, in consultation with the RPC, must develop a written Remedial Plan for the Trainee.

5.5 The written Remedial Plan should:

5.5.1 Include Trainee background Information;
5.5.2 Identify the aspects of the Trainee's performance or behaviour that require remedial attention;
5.5.3 Describe the proposed remedial education and the resources available to the Trainee;
5.5.4 State the specific duration of Remedial Period;
5.5.5 Define the expected outcomes of the Remedial Period and how they will be evaluated; and,
5.5.6 State the consequences of a successful or unsuccessful outcome of the Remedial Period.

5.6 The Trainee should have input into the Remedial Plan through interaction with the Program Director and must be provided with a copy of the Remedial Plan.

5.7 If the Trainee indicates acceptance of Remedial Plan the Trainee may
commence the Remedial Period prior to the approval of the Board of Examiners – PG. If the Trainee does not accept the recommendation, the Remedial Period may not commence until it is approved by the Board of Examiners – PG.

5.8 At the end of a Remedial Period, the Program Director, on the basis of the final evaluation and on the advice of the RPC, must inform the Trainee and the Board of Examiners – PG of the outcome, which may be that:

5.8.1 The Remedial Period has been successful and the Trainee will continue in the Residency Program at a level determined by the Program Director, on the advice of the RPC; or,

5.8.2 If the remedial period has been unsuccessful, the Program Director, on the advice of the RPC, may recommend outcomes as outlined in 5.9, 5.10, and 5.11.

5.9 Remedial Period: Remediation

5.9.1 Remediation is a formal program of individualized training aimed at assisting a Trainee to correct identified weaknesses, where it is anticipated those weaknesses can be successfully addressed to allow the Trainee to meet the standards of training.

5.9.2 Where the Remediation is unsuccessful, the RPC may recommend to the Board of Examiners – PG that the Trainee enters a further period of Remediation or Remediation with Probation.

5.10 Remedial Period: Remediation with Probation

5.10.1 Remediation with Probation is a Remedial Period similar to Remediation, but provides that if the outcome of Remediation with Probation is unsuccessful, the Trainee may be dismissed.

5.10.2 Remediation with Probation may be recommended and approved:

5.10.2.1 after an unsuccessful Remediation; or

5.10.2.2 following an End of Rotation Evaluation, where the Trainee's overall performance or the performance in a critical area is sufficiently below expectations that there is serious concern about the Trainee's ability to meet the Residency Program's required standards within a reasonable time.

5.10.3 Where the Remediation with Probation has been successful, the Trainee may continue in the regular Residency Program at an appropriate level, as determined by the Program Director on the advice of the RPC.

5.10.4 Where the Remediation with Probation has been only partially successful, the
Program Director, on the advice of the RPC, may recommend to the Board of Examiners – PG that the Trainee enter a further Remedial Period.

5.10.5 Where the Remediation with Probation has been unsuccessful, the Program Director, on the advice of the RPC, may recommend to the Board of Examiners – PG that the Trainee be dismissed from the Residency Program.

5.11 Remedial Period: Probation

5.11.1 A Trainee will be placed on Probation in circumstances where the Trainee is expected to correct identified serious problems which are not subject to usual remedial training including, but not limited to, attitudinal deficiencies, behavioural disorders or chemical dependence, which are assessed to jeopardize successful completion of the Residency Program.

5.11.2 The Program Director, on the advice of the RPC, may recommend that a Trainee be placed on Probation. The Probation itself may not be able to provide the intervention required to address the identified serious problems, but may permit assessment of any further intervention required, if appropriate.

5.11.3 Where the Probation has been successful and the problem identified has been corrected the Trainee may continue in the regular Residency Program at an appropriate level, as determined by the Program Director, on the advice of the RPC:

5.11.4 Where the Probation has been only partially successful, the Program Director, on the advice of the RPC may recommend to the Board of Examiners – PG that the Trainee is required to enter Probation.

5.10.5 Where the Probation has been unsuccessful the Program Director, on the advice of the RPC, may recommend to the Board of Examiners – PG that the Trainee be dismissed from the Residency Program.

6. SUSPENSION

6.1 Suspension is the temporary interruption of a Trainee's participation in the Residency Program, and includes the interruption of clinical and educational activities.

6.2 Improper Conduct

Because they are both physicians and students of the University, the conduct of the Trainees is governed by the policies of professional bodies, such as the CPSO, the Canadian Medical Association (Code of Ethics) and others, and by policies of the Faculty of Medicine, including the Standards of Professional Behaviour for Medical Undergraduate and Postgraduate Students, and of the
University of Toronto, including the University of Toronto Code of Behaviour on Academic Matters and the University of Toronto Code of Student Conduct. Violation of any of these standards or policies may constitute improper conduct.

6.3 Suspension from the Training Program

A Program Director may, pending consideration by the Board of Examiners - PG, and after consultation with the Vice Dean, suspend a Trainee for Improper Conduct if the conduct is of such a nature that the continued presence of the Trainee in the clinical setting would pose a threat to the safety of persons (i.e. patients, staff and students, or the public that uses the clinical setting), or to the academic function of the training program or the ability of other trainees to continue their program of study. The Trainee, as well as the Head of the Department and the Vice Dean, must be notified in writing of a Suspension, and the notification must include the reasons for and duration of the Suspension. The trainee will continue to be paid during the Suspension, pending formal review, but may be denied access to hospitals and other clinical or laboratory facilities.

6.4 Evaluation Following Suspension

A decision to suspend a Trainee must be reviewed by the RPC and followed by either full reinstatement or any of the processes described in sections 5 and 7, subject to approval by the Board of Examiners – PG.

7. DISMISSAL

7.1 Dismissal of a Trainee involves the termination of the Trainee from the Residency Program. Dismissal may occur:

7.1.1 following an unsuccessful Remediation with Probation;

7.1.2 following an unsuccessful Probation;

7.1.3 following Suspension; or

7.1.4 for Improper Conduct.

7.2 The recommendation to dismiss a Trainee may be made by the Program Director on the advice of the RPC to the Board of Examiners – PG. The Trainee must be informed of the decision in writing. The written statement must include the reason(s) for dismissal.

8. DECISIONS OF THE BOARD OF EXAMINERS – PG

8.1 All decisions of the Board of Examiners – PG must be communicated in writing by the Chair to the Vice Dean and copied to the Program Director and the Trainee.
8.2 The Trainee’s copy of the decision should include a copy of the procedures of the Faculty of Medicine Appeals Committee.

9. APPEALS

9.1 A Trainee may appeal a decision of the Board of Examiners – PG.

9.2 If the Trainee wishes to appeal the decision of the Board of Examiners – PG, notice should be given in writing, within 30 business days, to the Faculty Secretary. Appeals will be heard by the Faculty of Medicine Appeals Committee following the procedures of that Committee.

10. FINAL EVALUATION

When a Trainee is assessed by the RPC at the end of the Residency Program as having met the prerequisites for certification by the RCPSC or the CFPC, the Vice Dean will notify the RCPSC or the CFPC of this in the required manner.
APPENDIX F – GUIDELINES FOR APPROPRIATE USE OF THE INTERNET, ELECTRONIC NETWORKING AND OTHER MEDIA
Guidelines for Appropriate Use of the Internet, Electronic Networking and Other Media

These Guidelines apply to all postgraduate trainees registered at the Faculty of Medicine at the University of Toronto, including postgraduate students, fellows, clinical research fellows, or equivalent. Use of the Internet includes posting on blogs, instant messaging [IM], social networking sites, e-mail, posting to public media sites, mailing lists and video-sites.

The capacity to record, store and transmit information in electronic format brings new responsibilities to those working in healthcare with respect to privacy of patient information and ensuring public trust in our hospitals, institutions and practices. Significant educational benefits can be derived from this technology but trainees need to be aware that there are also potential problems and liabilities associated with its use. Material that identifies patients, institutions or colleagues and is intentionally or unintentionally placed in the public domain may constitute a breach of standards of professionalism and confidentiality that damages the profession and our institutions. Guidance for postgraduate trainees and the profession in the appropriate use of the Internet and electronic publication is necessary to avoid problems while maintaining freedom of expression. The University of Toronto is committed to maintaining respect for the core values of freedom of speech and academic freedom.

Postgraduate trainees are reminded that they must meet multiple obligations in their capacity as university students, as members of the profession and College of Physicians and Surgeons of Ontario, and as employees of hospitals and other institutions. These obligations extend to the use of the Internet at any time – whether in a private or public forum.

These Guidelines were developed by reference to existing standards and policies as set out in the Regulated Health Professions Act, the Medicine Act and Regulations, CPSO The Practice Guide: Medical Professionalism and College Policies, September 2007, the Standards of Professional Practice Behaviour for all Health Professional Students [the Standards] and the Policy on Appropriate Use of Information and Communication Technology.

Postgraduate trainees are also subject to the Personal Health Information and Privacy Act as "health information custodians" of "personal health information" about individuals.

**General Guidelines for Safe Internet Use:**

These Guidelines are based on several foundational principles as follows:

- The importance of privacy and confidentiality to the development of trust between physician and patient,
- Respect for colleagues and co-workers in an inter-professional environment,
- The tone and content of electronic conversations should remain professional.
- Individual responsibility for the content of blogs.
- The permanency of published material on the Web, and
- That all involved in health care have an obligation to maintain the privacy and security of patient records under *The Personal Health Information Protection Act (PHIPA)*, which defines a record as: “information in any form or any medium, whether in written, printed, photographic or electronic form or otherwise.”

**a) Posting Information about Patients**

Never post personal health information about an individual patient. Personal health information has been defined in the PHIPA as any information about an individual in oral or recorded form, where the information “identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.”

These guidelines apply even if the individual patient is the only person who may be able to identify him or herself on the basis of the posted description. Trainees should ensure that anonymised descriptions do not contain information that will enable any person, including people who have access to other sources of information about a patient, to identify the individuals described.

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² *Personal Health Information Protection Act*, S.O. 2004 C. 3 s. 2.
³ *Personal Health Information Protection Act*, S.O. 2004 C. 3 s. 4.
Exceptions that would be considered appropriate use of the Internet:
It is appropriate to post:
1. With the express consent of the patient or substitute decision-maker.
2. Within secure internal hospital networks if expressly approved by the hospital or
   institution. Please refer to the specific internal policies of your hospital or institution. 4
3. Within specific secure course-based environments that have been set up by the
   University of Toronto and that are password-protected or have otherwise been made
   secure.
   Even within these course-based environments, participants should
   a. adopt practices to “anonymise” individuals;
   b. ensure there are no patient identifiers associated with presentation materials;
   and
   c. use objective rather than subjective language to describe patient behaviour.
   For these purposes, all events involving an individual patient should be
   described as objectively as possible, i.e., describe a hostile person by simply
   stating the facts, such as what the person said or did and surrounding
   circumstances or response of staff, without using derogatory or judgmental
   language.
4. Entirely fictionalized accounts that are so labelled.

b) Posting Information About Colleagues and Co-Workers
Respect for the privacy rights of colleagues and coworkers is important in an
interprofessional working environment. If you are in doubt about whether it is appropriate to
post any information about colleagues and co-workers, ask for their explicit permission –
preferably in writing. Making demeaning or insulting comments about colleagues and co-
workers to third parties is unprofessional behaviour.
Such comments may also breach the University’s codes of behaviour regarding
harassment, including the Code of Student Conduct, the Sexual Harassment Policy, and the
Statement on Prohibited Discrimination and Discriminatory Harassment.

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4 Faculty, instructors and postgraduate trainees are reminded that portable devices are not necessarily secure, and that
   confidential patient information should not be removed from the hospital.
5 Faculty and instructors are reminded that they must use a secure environment provided by the University.
6 See University of Toronto, http://www.governingcouncil.utoronto.ca/Assets/Policies/PDF/studentc.pdf;
   http://www.governingcouncil.utoronto.ca/Assets/Policies/PDF/sexual.pdf;
   http://www.governingcouncil.utoronto.ca/Assets/Policies/PDF/Statement+on+Prohibited+Discrimination+and+Discriminatory+Har
   assment.pdf
c) Professional Communication with Colleagues and Co-Workers
Respect for colleagues and co-workers is important in an inter-professional working environment. Addressing colleagues and co-workers in a manner that is insulting, abusive or demeaning is unprofessional behaviour. Such communication may also breach the University’s codes of behaviour regarding harassment, including the Code of Student Conduct, the Sexual Harassment Policy, and the Statement on Prohibited Discrimination and Discriminatory Harassment.

d) Posting Information Concerning Hospitals or other Institutions
Comply with the current hospital or institutional policies with respect to the conditions of use of technology and of any proprietary information such as logos or mastheads. Postgraduate trainees must not represent or imply that they are expressing the opinion of the organization. Be aware of the need for a hospital, other institution and the university to maintain the public trust. Consult with the appropriate resources such as the Public Relations Department of the hospital, Postgraduate Medical Education Office, or institution who can provide advice in reference to material posted on the Web that might identify the institution.

e) Offering Medical Advice
Do not misrepresent your qualifications. Postgraduate trainees are reminded that the terms of their registration with the College of Physicians and Surgeons of Ontario limits the provision of medical advice within the context of the teaching environment. Provision of medical advice by postgraduate medical trainees outside of this context is inconsistent with the terms of educational registration.

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f) Academic Integrity extends to the appropriate use of the Internet
The University of Toronto's Code of Behaviour on Academic Matters contains provisions on academic dishonesty and misconduct. These provisions may be breached by sharing examination questions, attributing work of others to oneself, collaborating on work where specifically instructed not to do so, etc.

Penalties for inappropriate use of the Internet
The penalties for inappropriate use of the Internet include:
- Remediation, dismissal or failure to promote by the Faculty of Medicine, University of Toronto.
- Discipline for breach of hospital or institutional policy.
- Prosecution or a lawsuit for damages for a contravention of the PHIPA.
- A finding of professional misconduct by the College of Physicians and Surgeons of Ontario.

Enforcement
All professionals have a collective professional duty to assure appropriate behaviour, particularly in matters of privacy and confidentiality.
A person who has reason to believe that another person has contravened these guidelines should approach his/her immediate supervisor/program director for advice. If the issue is inadequately addressed, he/she may complain in writing to the Vice-Dean Postgraduate Medical Education or to the College of Physicians and Surgeons of Ontario through designated processes.
Complaints about breaches of privacy may be filed with the Information and Privacy Commissioner/Ontario.

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See Code s. 8i for the list of academic offences, Appendix A s. 2(d) for the definition of “academic work” and s. 2(p) for the definition of “plagiarism” for the purpose of the Code.
References:

College of Physician and Surgeons of Ontario:
   CPSO The Practice Guide: Medical Professionalism and College Policies,
   September 2007
   http://www cpso.on.ca/Policies/PracticeGuideSept07.pdf
   www.cps on.ca/Policies/behavior.htm
   CPSO Confidentiality of Personal Health Information #8-05, November 2005
   http://www.cps on.ca/Policies/confidentiality.htm

University of Toronto:
   University of Toronto Standards of Professional Practice Behaviour for Health
   Professional Students
   Policies on on-line harassment:
   http://www.enough.utoronto.ca/policies.htm
   Appropriate Use of Information and Communication Technology
   http://www.provost.utoronto.ca/policy/use.htm
   Code of Behavior on Academic Matters

Personal Health Information Protection Act
   http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm#BK3

Information and Privacy Commissioner/Ontario
   http://www.ipc.on.ca/
APPENDIX G – IMMUNIZATION REQUIREMENTS
IMMUNIZATION REQUIREMENTS

Documentary proof of current immunization against specific diseases must be submitted to the Postgraduate Medical Education Office with the trainees’ Letter of Appointment (LOA). Trainees cannot start clinical practice without completing the immunization requirements. The specific immunization requirements for all trainees are:

1. **Tuberculosis** – Students must have an initial baseline two-step Mantoux skin test, and an annual TB skin test thereafter if the results are negative. A chest x-ray is required if the TB skin test is positive.

2. **Hepatitis B** – Immunization is a series of 3 injections. Following vaccination, all students must be tested for anti-HBs antibodies, and the results must also be submitted to the Faculty Postgraduate Office. Individuals who are non-immune (i.e. do not have the antibodies against HBsAg or no prior history of immunization), must be screened for the surface antigen (HBsAg) prior to registration. If the HBsAg result is positive, a further screen for e-antigen (HBeAg) must be performed. Those who are non-immune and HBsAg negative must undergo a second series of HBV immunization, and subsequent lab evidence of immunity. *Registration status for HBV Carriers remains CONDITIONAL until the Expert Panel on Infection Control reviews their case.*
   - Procedures for Hepatitis B Carriers
   - Blood and Body Fluid Exposure Policy

3. **Measles, Mumps, Rubella (MMR)** – Proof of either immunization or positive titre results. Immunization against mumps is strongly recommended.

4. **Chicken Pox** – Details of history of infection, or VZV titre, or 2 varicella vaccines.

5. **Diphtheria, Tetanus and Polio** – Immunization against diphtheria, tetanus and polio is generally valid for ten years. Proof of up-to-date immunization status is recommended.

Trainees are expected to seek appropriate medical care when ill. In addition, trainees are expected to follow appropriate infection control practices and are expected to notify the Occupational Health Department of the hospital following needle stick injuries and following contact with patients with communicable diseases.

Completed **Full Immunization Form (with instructions)** and **TB Skin Test form** are to be returned the Postgraduate Medical Education Office.

Trainees may have the tests done at their training sites’ Occupational Health Offices.
APPENDIX H – TRANSFER OF RESIDENCY PROGRAMS
Transfer of Residency Programs from program to program or school to school

The University of Toronto Postgraduate Medical Education Office tries to provide opportunities for program transfer to its trainees. At the beginning of January each year, the Postgraduate Dean sends an email to PGY1 and PGY2 residents informing them of this opportunity and advising them of the principles and procedures of the transfer process, as follows:

A. GENERAL PRINCIPLES:

1. Wherever possible, transfers should not subvert the CaRMS match.
2. Resident must be released by their home program
3. Residents must be accepted by their requested program
4. Final approval of any internal transfer lies with the Postgraduate Dean.
5. The Postgraduate Deans at the respective Ontario schools will have the final approval regarding intra-provincial transfers, including funding availability.

B. SPECIFIC PRINCIPLES:

In addition to fulfilling the requirements of the general principles above, the following specific principles will apply to all transfer requests:

1. Residents must have at least 6 months of residency in the discipline from which they request transfer. PGY-1 transfer requests will be considered after January 1st each year.
2. Residents should have sufficient exposure to the discipline to which they are requesting transfer either in the last year of medical school or during their residency.
3. Residents matched through the second round of CaRMS are not eligible for transfer in the PGY1 year.
4. Residents must be of similar quality to successful candidates through the CaRMS match by the receiving program, utilizing similar selection methods and rating systems where they are used.
5. Transfer requests from the Family Medicine program will only be considered from residents at the PGY1 level.
6. Consideration of transfer requests from residents in specialty programs at the PGY2 level and above will be based on evidence of wrong career choice or demonstrated need, e.g. disability, health or family issues that prevent residents from completing their initial program, etc.
7. Transfers at the PGY2 or higher level will be dependent on availability of funding.

C. PROCESS:

1. Residents wishing to transfer programs will submit their names and preferred programs to the PGME Office in January of each year. For 2008-09, the deadline is Wednesday, January 21, 2009.
2. Requests will be compiled and reviewed by the PGME Office. The PGME office will immediately contact residents whose transfer requests are not approved by the Postgraduate Dean and therefore will not be forwarded to Program Directors.
3. The PGME office will send approved program transfer requests to the Program Director with the residents' name and contact information as well as the number of positions the program may potentially fill. All requests are sent at the same time to the Program Directors.
4. Program Directors are not obligated to accept trainees who do not meet admission requirements. Also, some Program Directors may not be able to increase their numbers even by one, if clinical training resources do not permit this.

5. Program Directors/Program Assistants will contact residents individually to request documentation for review and possible interview and prepare a rank list of its acceptable applicants and discuss with the PGME Office regarding funding availability.

6. After consultation with the PGME Office, the Program Director will inform the transfer applicant of acceptance/refusal verbally or by email. This process should be completed by the end of February.

7. The PGME Office will treat transfer requests as confidential and will not advise current Program Directors of the acceptance of residents to other programs -- this is the responsibility of the resident. An applicant who is accepted as a transfer resident must arrange a meeting or contact his/her current Program Director to request a release from the program as of July 1st or a date which is mutually acceptable to both Program Directors. Due to rotation and call schedule requirements, both program directors must agree on the start/release date if other than July 1st.

8. The PGME Office will issue a revised Letter of Appointment to successfully transferred residents after receipt of authorization letters from the new and former Program Directors.

9. An intra-provincial (within Ontario) transfer process will take place in March, following the internal University of Toronto transfer process. Transfer requests to programs in other Ontario schools will be considered during this period to accommodate residents who are requesting a transfer of medical school, or have been unsuccessful in the internal transfer process. However, as funding years are not transferable among schools, direct and equal swaps are usually sought during this process. Residents at each school who wish to be considered for the intra-provincial transfer process must "register" their transfer request with the PGME Office. The transfer requests are compiled centrally and reviewed by the Ontario Postgraduate Deans in March. For UofT, please contact loreta.muharuma@utoronto.ca by the end of February regarding your request to transfer to programs at other Ontario schools.

Approved PGMEAC, November 21, 2008
APPENDIX I – PG CORE ED
About PGCorEd™

The Postgraduate Medical Education Office (PGME) Core Curriculum Web Initiative – called PGCorEd™ is a set of web-based e-learning modules, which covers the foundational competencies for the University of Toronto postgraduate trainees. PGCorEd™ is designed to be responsive to the practical realities of residency training by being available when and where the resident needs the information.

Each PGCorEd™ module is about 4 hours in length and includes 6-8 units, which require half an hour to complete.

Effective July 1, 2008 all University of Toronto Residents entering PGY1 are required to complete the web based PGCorEd™ core competency modules as part of their residency program certification.

These modules are required for completion before the end of the PGY2 year. Failure to complete the modules required by their program will delay processing of their completion or Final In-Training Evaluations (i.e. FITERs) and may constitute professional misconduct.

These modules provide the foundation for the non-Medical Expert roles for the Royal College of Physician and Surgeons of Canada Specialty Programs and the 4-Principles for The College of Family Physicians of Canada Family Medicine program.

Upon entry to the program you will be provided with an ID and password to access the modules, which are located on the UofT Portal system (our online learning environment).

WHEN you register you will be given a 'login' for the UofT portal system.

There are currently 5 modules available to residents (End of life care, Resident as Manager, Communicator 1, Communicator 2, Resident as Learner & Teacher)

By the end of 2011-2012, there will be an additional 3 modules available (Patient Safety, Resident as Professional, Collaborator).
APPENDIX J – SPECIALTY TRAINING
REQUIREMENTS IN SURGICAL FOUNDATIONS
MINIMUM TRAINING REQUIREMENTS

1. Two (2) years of approved residency in foundational training, a maximum of one year of which may be undertaken in their parent specialty. This period must include the following training that will be counted as part of the parent specialty training if provided by that specialty:

   1.1. A minimum of one (1) block of critical care
   1.2. A minimum of one (1) block on a service that provides initial trauma management (such as Emergency Medicine, General Surgery, trauma team, Orthopedic Surgery, or Plastic Surgery)

NOTES:
It is expected that the core program director and the parent program director will collaboratively develop the series of rotations that will allow the trainee to meet the Objectives of Training in Surgical Foundations.
APPENDIX K – ADDRESSING INTIMIDATION AND HARASSMENT

NOTE: THIS POLICY IS UNDER REVIEW FOR 2012 AND WILL BE UPDATED.
Guidelines

Addressing Intimidation and Harassment
The Education and Learning Environment at UT-PGME
April 21, 2006

Preamble

We are committed to maintaining an environment in the PGME programs and offices that is free of harassment or intimidation based on race, creed, colour, ethnicity, sex, sexual orientation, national origin, age, marital and family status, and disability. We are committed to eradicating any conduct that unreasonably interferes with an individual’s work performance or creates an intimidating, hostile or offensive work environment. Such behaviour is in violation of policy and will not be tolerated. The policy defines harassment and intimidation and explains the procedures for responding to harassing behaviour by members of the hospital and university community.

Implicit in this University policy is the recognition that there are concurrent policies at each Affiliated Teaching Hospital and a procedural memorandum that specifically addresses sexual harassment cases involving university members that arise in clinical settings.

We are committed also to the fair and responsible management of ethical concerns and conflicts arising for healthcare professional trainees in clinical practice.

Relevant Documents for Reference:

University of Toronto: Sexual Harassment Policy
www.utoronto.ca/sho

University of Toronto: Statement on Prohibited Discrimination and Discriminatory Harassment

RCPSC-CMQ-CFPC: Accreditation and the Issues of Intimidation and Harassment in Postgraduate Medical Education Guidelines for Surveyors and Programs

Faculty's Guidelines in Ethics and Professionalism
Understanding Harassment and Intimidation

Harassment is defined in the Ontario Human Rights Code as "a course of vexatious conduct which the actor knows or ought reasonably to know is unwelcome". Harassment that is based on someone's race, creed, colour, ethnicity, sex, sexual orientation, national origin, age, marital status, family status, or disability, is explicitly prohibited under Ontario's human rights law as a form of discrimination.

Harassment is conduct that is annoying; that is unwelcome; that is based on personal characteristics of its target; and that the person engaging in it either knows, or should know, is unwelcome. It usually involves repeated conduct, but a single incident, if it is serious, may also constitute harassment. It can create an intimidating, hostile or offensive environment and can interfere with a person's work performance and adversely affect their employment opportunities.

Harassment may occur between faculty members and students; or among students; or between MDs and allied health professionals or employees of the University or Hospitals. Sexual harassment may likewise be engaged in by women and by men, and may be directed at both women and men.

Examples of harassing conduct include the following kinds of behaviour:

- racial epithets or slurs
- disrespectful jokes or banter about sex
- comments about someone's physical appearance or sexual attractiveness
- negative stereotypes about a particular ethnic group
- homophobic remarks
- disparagement of someone's religious devotions
- the circulation of insulting or demeaning written material and pictures
- unwelcome physical contact

Sexual harassment may also include making repeated unwelcome sexual advances, retaliating when someone ends a relationship or refuses a sexual advance, making professional decisions about someone or offering them job-related benefits based on their willingness to comply with sexual demands, or circulating intimate details of someone's life or private sexual behaviour.

Retaliation against someone because they make a complaint of harassment, or because they offer support or evidence in a complaint of harassment, is a violation of University policy and of Ontario law, and is treated in the same way as the substantive offence of harassment.

Intimidation and Abuse are forms of harassing conduct that involve the improper exercise of power. They may not be discriminatory in nature, but they will often have the same impact as discriminatory harassment, of interfering with people's work performance, affecting their employment opportunities, and creating a hostile work environment.

Intimidation is behaviour which instils fear. It may involve using one's authority to influence other people's behaviour, and can reduce the extent to which people are willing to exercise their rights. Abuse of power can involve the exploitation of trust and authority to improper ends. Sometimes abuse of power takes the form of apparently positive conduct, such as flattery that is intended to persuade someone to co-operate, or favouritism.
Examples of intimidation and abusive conduct include the following kinds of behaviour:

- shouting or raising one's voice
- constant interruption and refusing to listen
- public criticism
- ridicule
- singling someone out for grilling or interrogation
- unjust assignment of duties; overloading someone with work

Conflict of Interest

Faculty members who become romantically or sexually involved with a student they teach are in a conflict of interest. University policy on conflict of interest requires that in any circumstance where personal and professional interests overlap faculty must declare the conflict to their own supervisor, who will arrange for someone else to evaluate that student's work. This is to safeguard the right of all students to fair and unbiased treatment. Faculty members should also be aware that sexual invitations or suggestions to their students leave them open to allegations of sexual harassment. Members of faculty have authority over students, and thus any intimate overture can readily be interpreted as coercive.

Professional conduct

A faculty member's relation with students is a professional one and as such many personal comments or questions (about someone's appearance, personal life, sex life, etc.) are improper and potentially damaging. Remarks which focus on the sex or sexual orientation of individuals can constitute sexual harassment. Physical contact for any reason may be construed as sexual or threatening and should be considered carefully.

Processes for Trainees in Postgraduate Medical Education

Principles

1. Timely identification of a concern about intimidation and harassment should be the goal of all programs.
2. Trainees should be encouraged to inform their program director or university administration of problems.
3. The initial discussion must occur in a confidential setting.
4. There should be a process to clarify the facts concerning the allegation.
5. The process of clarification must occur in an atmosphere free of retribution.
6. Allegations should be addressed and resolved in a timely manner.

A. Preventing harassment: each Residency Program has a responsibility to maintain an educational environment free of any form of harassment, whether by a manager, supervisor, employee, or other person (including a patient or other learners).

B. Communicating the Policy: all medical students, residents and faculty should be aware that the University and the teaching hospitals will take appropriate action to prevent and correct any behaviour which constitutes harassment or sexual harassment as defined above, and that individuals who are found to have engaged in such behaviour are subject to discipline up to and including termination.

C. Deciding which procedure to use: the relevant hospital and/or University policies will be applied. When a complaint is brought forward to either the University or the teaching hospital, the institution that receives the complaint will immediately notify the other institution of the complaint, and the institutions will consult one another to determine which institution shall take responsibility for dealing with the complaint. The University and the teaching hospital may agree to share this responsibility. In any case, the institution taking carriage of the complaint will inform the other institution of the outcome.
D. Discussing and Reporting Incidents or Problems

1. Trainees have access to confidential resources in the University and may in particular contact the University's Sexual Harassment Office, its Anti-racism and Cultural Diversity Office, and its Community Safety Office, on an entirely confidential basis and without commencing a formal complaint process.

2. We urge anyone who believes he or she had been subject to harassment to bring a complaint forward.

3. Trainees should usually bring their concerns to their University Program Director, who will discuss the matter with the trainee, consult with University resources, and may attempt to resolve the matter. Discussions will be kept confidential to the extent possible and every reasonable effort shall be made to protect the privacy of all parties. However, residents should keep in mind that reporting the situation may result in an investigation, and that this will require that the person whose conduct is complained of be informed about the complaint. It may also require that witnesses be interviewed.

4. Trainees may elect to bring their complaint forward through another University office. In such a case that office will advise the University Program Director of the matter and keep the Program Director informed.

E. Jurisdiction

University: the University will normally have jurisdiction in the following situations:

- A complaint by a trainee about the behaviour of a member of the teaching faculty in an academic context.
- A complaint by a trainee about the behaviour of another trainee in an academic context.
- A complaint by a member of the teaching faculty about the behaviour of a trainee in an academic context.

Hospital: the teaching hospital will normally have jurisdiction in the following situations:

- A complaint by a trainee about the behaviour of a member of the hospital staff.
- A complaint by a hospital employee about a trainee.
- A complaint by a patient or member of the public about a trainee.

Joint: the University and the teaching hospital will normally share jurisdiction in the following situations:

- A complaint by a trainee about the behaviour of a member of the teaching faculty in the hospital context.
- A complaint by a trainee about the behaviour of another trainee in the hospital context.
- A complaint by a member of the teaching faculty about the behaviour of a trainee in the hospital context.
F. Procedure

Notification and Consultation:

When a trainee brings a complaint forward to the University Program Director, the Program director will consult with University resources: in the Dean's Office and, where relevant, in the Sexual Harassment Office and/or the Anti-racism and Cultural Diversity Office. The university and the hospital will discuss and decide upon the question about which institution has jurisdiction to deal with the complaint.

Where the hospital takes carriage of the complaint, the VP Education will be contacted, as will the University Program Director, the Dean's Office, the Vice-Provost, Relations with Health Care Institutions and, where appropriate, the CPSO. The hospital CEO and the VP Human Resources will also be notified. The University will co-operate with the hospital and will take appropriate steps to safeguard the interests of the trainee.

Where the University takes carriage of the complaint, the University Program Director, the Dean's Office, the Vice-Provost, Relations with Health Care Institutions and, where appropriate, the Sexual Harassment Office and/or the Anti-racism and Cultural Diversity Office, will be contacted. If necessary the Division Head or Department Chair will be notified.

Mediation: A trainee may choose to resolve a case within the University through mediation, calling on the resources offered by the Sexual Harassment Office and the Anti-racism and Cultural Diversity Office for alternative dispute resolution.

Investigation: Where a complaint requires investigation a committee will be established. Where appropriate this will be a joint committee with representatives of the hospital. The Dean's Office will determine membership of the committee from the University, and may draw members from PAIRO where appropriate.

G. Investigation

The committee will promptly conduct a thorough and objective investigation of the allegations, and will determine whether they can be substantiated.

1. The investigation will include, but may not be limited to, a meeting or meetings with the complainant, with the person accused of harassment (the respondent), and with people who have relevant evidence about the allegations (witnesses). It may also examine documents and communications such as e-mails and other relevant evidence.

2. The committee or designated members will meet with the respondent and
   a. inform them that there has been a complaint;
   b. provide details of the complaint;
   c. provide information about relevant policies;
   d. summarize the procedure that will be followed for investigating the complaint;
   e. inform them that the hospital and/or the University will handle the matter confidentially as far as possible and that it expects the respondent to do the same;
   f. advise them that any retaliation against or intimidation of the complainant or of anyone connected with the complaint will be treated as an offence.
3. The complainant will be informed:
   a. that the hospital and/or the University will handle the matter confidentially as far as possible and that it expects the complainant to do the same;
   b. that s/he should bring forward any complaint of further harassment or of retaliation.

Both the complainant and the respondent will be given a full opportunity to state their case and to present relevant evidence.

H. Resolution

1. If it is determined that harassment or retaliation has occurred, prompt and effective measures will be taken to remedy the harassment.

2. The decision about the measures necessary to remedy the harassment will be made within a reasonable time.

3. The committee will notify the complainant and the Associate Dean and appropriate VP Education of the results of the investigation, and of any action that will be taken to remedy the harassment.

4. Any resident, faculty or program director or other person who is found, after appropriate investigation, to have harassed any person will be subject to appropriate disciplinary action, up to and including termination.

Approved at PGMEAC
May 19, 2006
Postgraduate Medical Education Harassment Complaint Protocol

Managing Ethical Concerns
The Faculty of Medicine has developed guidelines on ethics and professionalism.

In the PGME program and offices we adhere to the following principles:

1. The expectation is that most ethical concerns or conflicts in the teaching institutions will be discussed in a collegial atmosphere and be satisfactorily resolved at the teaching or clinical interface.

2. The clinical faculty or supervising clinician must provide the healthcare professional trainee with an opportunity to discuss an ethical concern.

3. A healthcare professional trainee has the right to refuse to participate in patient care or clinical teaching if the trainee has ethical concerns about the activities, is concerned regarding their own competency, lack of knowledge, lack of understanding of the duties/tasks/responsibilities or believes there is a lack of explanation or supervision.

4. The clinical faculty or supervising clinician should normally accept the trainee’s refusal on ethical grounds to participate in patient care activities or clinical teaching.

5. There will be no repercussions for the trainee who expresses concern about ethical issues, refuses to participate in patient care activities or clinical teaching based on reasonable ethical grounds, or seeks consultation on an ethical issue.

6. Healthcare professional trainees and clinical faculty or supervising clinicians have the right to consultation with a bioethicist, clinical ethics consultant or other individual specifically trained in the management of ethical issues. Each institution should have policies and procedures to facilitate these consultations.

7. Procedures will be available for healthcare professional trainees and clinical faculty/supervising clinicians to report ethical concerns. Reports may be dealt with through the usual academic or hospital service routes for dispute resolution or through the institutional committee (described in paragraph 8 below).

8. Each affiliated institution will identify a committee to receive reports of unresolved ethical issues, adjudicate them as necessary and report to all parties involved. Committees will consist of an institutional bioethicist or his/her delegate, and institutional VP Education or his/her delegate, and at least one other member.

9. Information will be available to ensure that healthcare professional trainees and clinical faculty or supervising clinicians are aware of the procedures available to them to address ethical concerns and/or other issues by performing periodic audits of ethical issues brought forward for dispute resolution.
APPENDIX L – HEALTH AND SAFETY GUIDELINES
1. BACKGROUND

The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada have collaborated in developing national standards for evaluation of the University Postgraduate Medical Education function and the sites used for residency education. Standard A.2.5. states that:

"All participating sites must take reasonable measures to ensure resident safety at all times, particularly considering hazards such as environmental toxins, exposure to infectious agents transmitted through blood and fluid, radiation, and potential exposure to violence from patients or others."

The collective agreement between the Professional Association of Internes and Residents of Ontario (PAIRO) and the Council of Academic Hospitals of Ontario (CAHO) states that residents are postgraduate medical trainees registered in university programs as well as physicians employed by the hospitals. The agreement states that the trainees/employees must have secure and private rooms and secure access between call room facilities and the service area and access to and coverage for Occupational Health services.

Accreditation Canada standards indicate that member hospitals must have an operational safety and security program for staff and patients.

The Ontario Ministry of Labour’s Occupational Health and Safety Act (OHSA) outlines minimum standards for health and safety and establishes procedures for dealing with workplace hazards and protection against risks of workplace violence.

The University of Toronto Health and Safety Policy (Governing Council March 29, 2004) states that the University is committed to the promotion of the health, safety and well-being of all members of the University community, to the provision of a safe and healthy work and study environment, and to the prevention of occupational injuries and illnesses.

2. PURPOSE

- to minimize the risk of injury and promote a safe and healthy environment on the university campus and teaching sites

- to demonstrate the University of Toronto Faculty of Medicine’s commitment to the health, safety, and protection of its residents

- to provide a procedure to report hazardous or unsafe training conditions and a mechanism to take corrective action

3. SCOPE AND RESPONSIBILITY

The University, hospitals, and affiliated teaching sites are accountable for the environmental, occupational, and personal health and safety of their employees and have the right to make implementation decisions within their respective policies and resource allocations. Residents must adhere to the relevant health and safety policies and procedures of their rotation’s training site. In addition, all teaching sites must meet the requirements of the PAIRO-CAHO collective agreement.

These Resident Health and Safety guidelines provide a central faculty mechanism for residents to use...
when faced with a health and safety issue during the course of their training which cannot be resolved at the local training site level.

4. PROCEDURE

a) Environmental Health

Accidents, incidents and environmental illnesses occurring during a resident’s training will be reported and administered according to the reporting policies and procedures of the university, hospital or clinical teaching location.

b) Occupational Health

The Faculty of Medicine and the residency programs are each responsible for providing an introductory program to residents on body substance precautions, infection control, and occupational health procedures in the hospitals and teaching sites.

The faculty Postgraduate Medical Education Office collects the immunization data on the trainees on behalf of the hospitals and the hospitals may view each trainee’s immunization record on Postgraduate Web Evaluation and Registration (POWER) system. The Faculty’s Communicable Disease Policy meets all of the basic immunization and communicable disease requirements of the teaching hospitals.

Medical Residents not meeting the immunization requirements of the faculty are not permitted to complete their registration with the PGME Office and are not registered at the hospital. Communicable disease issues are reviewed by the Expert Panel on Infection Control and dealt with on a case-by-case basis prior to finalizing a trainee’s registration.

Resident Health and Safety Guidelines, March 2009

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c) Personal Health and Safety

The University of Toronto Faculty of Medicine strives for a safe and secure environment for medical residents in all training venues. All teaching sites, hospitals, and long-term care institutions are responsible for ensuring the safety and security of residents training in their facilities in compliance with their existing employee safety and security policies/procedures as well as the requirements outlined in the PAIRO-CAHO collective agreement.

During block time in community-based practices, residents may be required to attend patients in doctor’s offices or patient homes. Residents will not be required to see patients alone in the clinic, on house calls, or other settings that are not appropriately supervised. Locations without a formal health and safety policy or joint committee will be guided by the standards outlined in the Occupational Health and Safety Act.

d) Reporting/Follow-Up/Dispute Resolution

Residents in hospital/institutional settings identifying a personal safety or security breach must report it to their immediate supervisor at the training site and program director to allow a resolution of the issue at a local level, and comply with the site reporting requirements, such as completion of an Incident Report Form.

Residents in community-based practices or other non-institutional settings should discuss issues or concerns with the staff physician or community-based coordinator, or bring any safety concerns to the attention of their Program Director or the PGME Office Director, Resident Wellness.

Pending investigation and resolution of the identified concerns:

- The program director and/or director of resident wellness has the authority to remove residents from clinical placements if the risk is seen to be unacceptable. If a decision is taken to remove a resident, this
must be communicated promptly to the Chair, Residency Program Committee, the training site, as well as the Vice Dean, PGME.

- If the safety issue raised is not resolved at the local level, it must be reported to the Director, Resident Wellness who will investigate and may re-direct the issue to the relevant hospital or University office for resolution. The resident/faculty member bringing the incident forward will receive a response within 10 days outlining how the complaint was handled or if it will require further review.

- The Director, Resident Wellness may bring the issue to the hospital office responsible for safety and security, the University Community Safety Office, Faculty of Medicine Health and Safety Office, or the Director, Distributed Medical Education for resolution or further consultation, and will report the issue annually to the Postgraduate Medical Education Advisory Committee (PGMEAC) and the Hospital University Education Committee (HUEC) through the Vice-Dean, PGME.

Resident Health and Safety Guidelines, March 2009

annually to the Postgraduate Medical Education Advisory Committee (PGMEAC) and the Hospital University Education Committee (HUEC) through the Vice-Dean, PGME.

Urgent resident safety issues will be brought to the attention of the Vice-Dean, PGME as well as to the relevant hospital VP Education as appropriate.

Health and safety systems issues may also be brought to the attention of the Director, Resident Wellness at any time by various methods, including internal reviews, resident/faculty/staff reporting, or police/security intervention.

References: Sunnybrook Health Sciences Centre, Administrative Policy Manual, Section IV: Human Resources. Policy

No IV-A-1000, “Abuse of Staff or Volunteers”, July 2006; Workers Health and Safety Centre. Dupont Inquest: Coroner’s Jury Recommendations

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