2ND DRAFT

FIVE YEAR DEPARTMENTAL REVIEW

DEPARTMENT OF FAMILY MEDICINE

CHAIRMAN'S REPORT

AUGUST, 1990

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REPORT

REVIEW OF THE CHAIR OF THE DEPARTMENT OF FAMILY MEDICINE

DEPARTMENT OF FAMILY MEDICINE

JULY 1, 1986 - JULY 1, 1990

INTRODUCTION

During the four year period being reported on, the Department of Family Medicine had 35 geographical full time faculty members on July 1, 1986 and on July 1, 1990, had 33 full time faculty members. There were 85 part time members in the Department on July 1, 1986 and on July 1, 1990, there are 116 part time members.

Six full-time Department members working in the Emergency Room at McMaster University Medical Centre resigned their geographic full time positions on July 1, 1988, as part of a hospital/faculty organization of emergency services. During the four years, Dr. Elizabeth Latimer was granted a hard funded position in Palliative Care, Dr. Fionella Crombie was recruited to a clinical contract at First Place, Dr. Dave Davis was recruited to a faculty position at the North Hamilton Community Health Centre, Dr. Stephen Lloyd was assigned a full time clinical faculty position to be the leader of Academic Emergency Medicine, Dr. Phyllis Blumberg was recruited as full time Director of the Geriatric Educational Development Unit, Dr. Elizabeth Lindsay was granted a full time faculty position through the Educational Centre for Aging and Health, Dr. Andrew Oxman was granted a full time position in the Department of Family Medicine as a researcher, and Dr. John Swift was hired on a contract between Chedoke-McMaster Hospitals and the University to work in Family Medicine and Palliative Care.

Three senior faculty retired during the time period, namely, Dr. Vince Rudnick, Dr. John Premi, and Dr. Jack Marlow.

During the four year time period, ten research leaves totalling 99 months were granted to full time faculty members. There were five clinical scholars who worked in the Department during the four years

The postgraduate Educational REsidency Program remained constant in size with approximately 80 trainees; 35-37 in the first year, 35-37 in the second year, with approximately five

third year trainees in each of the four years. One hundred undergraduate students each year were provided with a Unit VI Clerkship in Family Medicine as well as a wide range of other support by clinical faculty.

Department of Family Medicine Organizational Structure

On July 1, 1986, the principle governing body of the Department was the Departmental Executive consisting of 13 members who represented the four family practice units and the leaders of each Department program as well as members at large.

On January 1, 1988, the Executive Committee was abandoned and a new Executive Committee structure was formed; consisting of one representative elected by each of the four family practice units and one representative elected at large from the Department. The Departmental Administrator and the Chairman made up the seven person Executive as of July 1, 1990. There are four family practice units, namely, the McMaster University Medical Centre with nine full time equivalent faculty, the North Hamilton Community Health Clinic with four full time equivalent faculty, First Place Family Practice Unit with five full time faculty and the Henderson Family Practice Unit with three full time faculty and another 1 1/2 full time equivalents.

3Y Ward at McMaster University Medical Centre, a 34 bed in-hospital service operated as a unit of the Department until May 1, 1990.

Since July 1, 1988, some residents have received the family medicine experience in what is known as the Pilot Project led by Dr. Don McLean, a community practitioner with six residents involved in the program during each year. The Chairman was responsible for developing the support system with the Northwestern Ontario Medical Residency Program now scheduled to register 12 first year family medicine residents on July 1, 1991.

Each family practice unit has a Unit Director appointed jointly by the Department Chairman and the hospital, as well as a number of committees or individuals who represent the unit in the various Departmental programs.

Structure of Departmental Programs

There are a number of programs in the Department, each with a departmentally appointed director. The undergraduate program coordinates all undergraduate activities in the six unit undergraduate curriculum. The postgraduate program with a postgraduate program director has a Residency Educational Committee which consists of a designated member of each of the four units and the Pilot Project as well as a resident representative from the four units and Pilot Project. The 3Y Director is also involved, and the Department Chairman is an ex-offio member of this group.

The research program traditionally had a director, but is undergoing reorganization at the present time, with the suggestion that a Deputy Chairperson might take on an advocacy role for education and research in the Department.

Although CME is not a designated program in the Department, members of the Department including Dave Davis and John Premi, have been involved in providing leadership for the Faculty's CME and CE development supported by a number of part time Department members.

The 17 nurses and nurse practitioners who were in the family practice units have traditionally met as a group with an elected leader who represents the nursing group in Departmental matters.

There is also a committee of Unit Administrators, under the chairmanship of the Department Administrator who attempt to integrate and coordinate the administrative structure.

Accountability

Each committee reports annually, or more frequently if necessary to the Executive Committee providing the Executive with information and requesting resource support for new directions. The Executive Committee from time to time has also appointed adhoc sub groups to address specific issues. Examples include an Adhoc Subcommittee to develop a paper on the faculty strategic plan, (appendix 1), an Adhoc Subcommittee to deal with the development of the strategy for the move of the Henderson Family Practice Unit (appendix 2), and an Adhoc Committee on the practice plan (appendix 3). These are usually specific task-oriented groups with limited time to report. There has also been a subcommittee on finance appointed by the executive which recently reported to the Department.

The finance committee's objective is to develop financial reporting mechanisms that are common amongst the four or five family practice units so that more proactive financial plans may occur (appendix 4).

There has also been a PC grant committee, chaired by Dr. Ron McAuley that administers the PC grant funds received annually. This committee is accountable to the Associate Dean for Education as well as the Chair of the Department. The Postgraduate Program Director is also accountable to the Director of Postgraduate Education as well as the Department Chairman for all postgraduate educational programs.

Intrafaculty Relationships

The Chairman has represented the Department on a number of intrafaculty committees that are important in the administrative structure of the Faculty as wall as the Department. The Chairman represents the Department on the Clinical Chairman's Committee, where major financial planning for the Faculty takes place, including policy development for the faculty practice plan, and remuneration policies for the faculty members. The Chair also represents the Department on the Faculty Executive Committee, Faculty Council, and the Educational Centre for Aging the Health Steering Committee. The Chairman was a member of the committee that developed the grant application for the Educational centre for Aging and Health and was the acting Chairman of the Health Priorities Analysis Unit Steering Committee after the ECAH grant was received.

The Chairman also sits on the District Health Council Committee on the Community Health Services Planning, and has been a member of the Hospital in the Home Committee of the Victorian Order of Nurses, which recently submitted a grant application to the Provincial Government. The Chairman is also a member of the Regional Palliative Care Program Committee.

External Faculty Relationships

The Chair has represented the Faculty on the Ontario Department of Chairman's Committee. This group has been very active during the past three years in the planning and lobbying for the expansion of Family Medicine. The Chairman has represented the Department at several national meetings of the College of Family Physicians on Educational Development; has represented the

Council of Faculties of Medicine on the Ontario Task Force on the implication of the two-year licensure requirement. The Chairman was appointed by the Minister of Health to the Ontario Task Force on the Use and Provision of Medical Services since it was formed in March of 1988. This commitment is demanding, requiring two one-day meetings per month on average.

NEW INITIATIVES

Since July 1, 1986

Move and Development of the North Hamilton Community Health Centre

By July 1, 1986, the decision had been made to move the General Hospital Family Practice Unit into a community health clinic in North Hamilton. A community needs assessment had been completed, and plans had been made for the East Hamilton Kiwanis Club to purchase and renovate a building in the community, suitable for the establishment of the community health clinic under the Ministry of Health's CHC program.

This initiative had broad support. A board was formed under the chairmanship Dr. George Woodward, CEO of the Hamilton General Hospital. The board consisted of three representatives from each of the Kiwanis Club of East Hamilton, the Hamilton Civic Hospitals, the Faculty of Health Sciences at McMaster University, the clinic Staff and the community. This 15 member board was established in 1987 and the Chairman was elected as the Vice-President of the board.

Since the move was completed during 1987, the Clinic has undergone dramatic developments with new programs established in preventive health, spanish speaking outreach, physiotherapy, nutrition, social work, chiropody, as well as extensive participation in community based groups.

The provincial government has supported the development of these new initiatives and has been receptive to other initiatives. Residents evaluations of the educational programs have improved from being strongly negative in 1986, to being positive and supportive in 1989. the clinic population has risen from about 3,000 registered patients in 1986 to more than 4,500 and the variety of clinical material has improved, with a major increase of pediatrics and obstetrics.

Plans continue to develop to enlarge the clinic and become more intensely involved in a number of community projects such as Occupational Health and Community Outreach (appendix 5).

Mission Statement - Goals and Objectives

During the initial review of the Department when the Chairman arrived in 1986, it was apparent that there was a need for a clear mission statement and a set of goals and objectives. A one-year process was commenced in 1987 including extensive consultation within the Department

and the Faculty of Health Sciences culminating in unanimous approval of the document in 1987 (appendix 6).

Climate

During the process of developing goals and objectives, it became apparent that the climate in the Department was not conducive to the type of collaboration and cooperation that the majority of the Department members felt would be appropriate. A retreat to develop strategies to improve the climate was held in April of 1987. Since that time, the Chairman and Executive have developed a number of strategies to improve communications amongst Department members (appendix 7).

Information System

In March of 1987, a grant of $500,000 was received from the Ministry of Health to develop a comprehensive information system in the four department units and four community Health Service Organizations.

A committee was organized under the Chairmanship of Dr. Ted Evans which developed a request for proposal to which was reviewed by 11 private companies who participated in a bidding process (appendix 8). The contract was given to On-Line Systems Ltd. of Kitchener and over the past three years, a very significant amount of effort has been expended by the committee with On-Line Systems developing a very sophisticated software package, and purchasing the hardware for all eight practices. As of July 1, 1990, the hardware and software has been installed in three practices with the fourth and fifth installation scheduled during the summer. The objectives of the grant will likely be fulfilled by the end of this calendar year.

The funding plus interest that accrued will have been used by September 1, 1990 but a mechanism of financing the ongoing development and maintenance of the system has been finalized by the Department Administrator and the Chairman (appendix 9). A committee has been organized by the executive to receive proposals for research or academic development of the system and to handle the high level of interest from both inside and outside the department. The progress of the system development is outlined in weekly committee meeting minutes which are available upon request.

Strategic Plan of the Department of Family Medicine

Subsequent to developing goals and objectives, the Dean's Advisory Group required a detailed strategic plan for the Department to justify recruitment of new faculty.

During 1988, a strategic plan was developed and approved by the Department (appendix 10). Difficulty experienced in convincing the Dean's Advisory Group of the need for new faculty resulted in further development of a strategic plan, rationalizing of major research and development goals for the 1990s (appendix 11).

Faculty Strategic Plan

During the years 88-89, the Faculty of Health Sciences embarked on a strategic planning process. Part of this process called upon all of the Departments to respond to a proposal for a faculty strategic plan. The Department of Family Medicine as a Department, considered the proposal and outlined how the Department could and should support the faculty strategic plan (appendix 1). The Department of Family Medicine feels that is has a central role to play in the development of the Faculty's strategic plan in the 1990s.

Postgraduate Program Decentralization and Development

After a prolonged search for a Director of Postgraduate Program in the Department of Family Medicine, in 1987 Dr. Ron McAuley graciously accepted the position. He, in collaboration with the Chair agreed that decentralizing the postgraduate program would be very important for the evolution and strengthening of education for residents. This involved placing more responsibility in each of the four units for the evaluation and management of the day to day operations of the postgraduate program.

The central function of the Program Director was to set minimum standards across the system and to conduct internal audits, two of which have been conducted in the past year to assure that standards are being met.

These strategies have given much more planning and operational control of the postgraduate program to each of the individual family practice units and has resulted in a clear strengthening of program in the units (appendix 12, 13).

Research Initiatives

Although the Department has had an excellent research record, there has been relatively little collaborative work between members of the Department. Most collaboration has been with persons outside of the Department. Many individuals research efforts are unknown within the Department, although they may have received national or international recognition.

To address this issue, a research and academic forum now occurs bimonthly, having commenced in 1988. Theses are sessions where members of the Department present research and academic work that they are involved in. Presentations can be at various stages, from early planning, initial conduct of study through to the final paper and product of the study (appendix 14). To recruit a new research director, a search committee was assembled which had membership from within and outside the Department. The advice of the committee in 1990 was to hold a retreat and gain a consensus from the Department as to what the future should be for the Department to develop research strategy (appendix 15). During the past four years, collaboration with the faculty committee on scientific development has resulted in a number of strategies to promote research including the support of the primary care research group, and several initiatives to obtain career awards for Department members.

Report on the Research Search Committee

The Department held a retreat in June of 1990 which developed a consensus on research directions and organizations in the Department for the 1990s (appendix 16). This report to the Executive of the Department will be reviewed by the Executive with recommendations made to the Department for their approval in the fall.

Practice Plan Implementation

A decision was made in 1985 by Faculty Executive to implement a decentralized faculty practice plan.

By 1987, the Faculty of Health Sciences' Clinical Chairs determined that each clinical department develop a practice plan and incentive plan. Previously, all clinical income generated at McMaster University was centrally pooled and then redistributed back to the Departments according to need. The practice plan initiative decentralized clinical income finances so that each department was entitled to the income it generated after central expenses were deducted.

The result of this process was that each department was required to develop both a practice plan and an incentive plan strategy. The Department of Family Medicine Executive embarked on developing an incentive program in the fall of 1987 culminating in presentation to the Department of a detailed practice and incentive plan in December of 1987.

The plan was rejected by the Department. The failure of this process prompted the chairman to restructure the Executive. Several other initiatives have taken place since to refine the practice plan. The Department has had great difficulty in developing cooperative financial arrangements (appendix 17) mostly because of the major differences in financial support and income generated in each of the four units. The Chairman has developed a method for calculating merit within the Department based on input from the original incentive plan committee and this has been used to distribute incentive plan funds since 1987 (appendix 18).

It has recently been stated by the faculty employment equity office that the practice plan, incentive plan distribution in the Department of Family Medicine is the most equitable within the clinical faculty.

Development of the Henderson Hospital Plan to Move to the Community

In 1987-88, projections for the future of the Henderson Family Practice Unit indicate that the unit would become educationally and economically nonviable in the 1990s. The site had not been modified or improved since its founding over twenty years ago. New construction at the Hospital would eliminate easy access to the facility. There were early discussion about moving to two sites south of Limeridge Mall on the Hamilton Mountain but they were not suitable.

A detailed planning process was then initiated in cooperation with the Executive, the Chairman, and the Unit Director. A number of options for the future have been considered during the planning process including exploratory discussion with the East End Health Centre through St. Joseph's Hospital. The Dean's Executive Group initiated a review of the educational objectives for the development of the new facility and struck a sub committee to review educational potential with he the Chairman. The Department, at a meeting in 1989 after considerable work by the Executive and the Director of the unit and unit members, endorsed the move of the Henderson Unit to the community on the Hamilton Mountain after considering a number of options (appendix 2). In January of 1990, the plan to move was accepted by the Dean's Advisory Group pending further development of a business plan and the move is planned for early in 1991 (appendix 19).

Faculty Development Initiatives

The Departmental strategic planning process and continuing concern over problems with the climate in the Department prompted the Executive to have the Chairman review every individual's role in the Department and to determine what they would prefer to do and what the obstacles blocking their aspirations were. After individual faculty review, the chairman produced a report that has resulted in a number of initiatives in each family practice unit to address identified problems (appendix 7).

Faculty Recruiting Effort

The Departmental Executive, after developing the strategic plan, began the process of recruiting one or two new faculty with specific academic interests. The faculty priorities for new appointments were influenced by the uncertainty of the future of the Henderson unit and faculty priorities that took precendence over Departmental concerns. One of the positions that resulted from retirement was assigned to Dr. Dave Davis with the full endorsement of the Executive and the Chairman and the Department. The other two positions were assigned to Dr. Elizabeth Latimer to fulfil the commitment to Palliative Care and to Dr. Stephen Lloyd to fulfil the commitment to developing Emergency Medicine with the endorsment of the Dean's Executive Group. Dr. Andy Oxman has been recruited as a full time researcher in the Department and Dr. John Swift was

recruited through a co-operative program between Chedoke-McMaster Hospitals and the Department to provide Palliative Care and Obstetrical Care expertise.

3Y Development

Ward 3Y is a Departmental resource where during the past year 24 residents from the Department received their two month internal medicine experience. The ward's position in McMaster University Medical Centre Hospital was put under significant threat in the summer of 1989 when summer bed closures and further plans to reduce the hospital's deficit suggested that the ward should be closed. A strategy was developed at that time which resulted in the ward being retained over the winter with fewer beds.

However, a decision made by the hospital for summer bed closures in 1990 resulted in the ward becoming a nonviable teaching facility with only ten active beds. The Executive of the Department after consultation and receiving advice from both the Hospital and the Director of Postgraduate Programs decided to withdraw the residents from the Ward on May 1, 1990. The result of this has been a very difficult situation which is ongoing at the present time (appendix 20) and will not likely see a family medicine teaching ward return to Chedoke-McMaster Hospital.

During the summer of 1990, a strategy is being proposed by the Department to develop a combined medicine/family medicine teaching ward on 3Y which is unacceptable to the Department of Medicine (appendix 21).

Financial Management

During discussions to develop the practice plan and the incentive plan, there was a feeling that the four units because of the complexities of their financial structure and the different ways in which they were funded were not receiving equitable treatment. In 1989, the Department struck a finance committee which worked during the past year to determine all the sources of financing for each unit and what this meant in terms of flexibility and working conditions for faculty in each unit. The committee reported to the Department in May of 1990 (appendix 4).

With clear evidence of inequalities in working conditions between the four units, the finance committee has been asked to identify strategies to overcome some of these inequalities. The move of the Henderson Unit will obviously address its inequitable position and now there has to be serious consideration given in how to assist the McMaster University Medical Centre Unit which may also be in a position requiring a move in the next years. Restructuring financial policies to gain more flexibility in the MUMC unit will be the short term goal.

Geriatrics

During the past four years, considerable development work has been carried out to improve teaching and stimulate research in care of the elderly. Appendix 22 outlines the present programs in the Department and the relationship of the Department with the Education Centre on Aging and Health. Dr. John Feightner recently received a $250,000 grant to study the benefits of a reactivation unit in an acute hospital which is a further boost to research and care of the elderly.

Emergency Program Development

The Emergency Department and six full time faculty positions were located at the McMaster University Medical Centre. These faculty were responsible for leading postgraduate educational programs in both Emergency Medicine, Family Medicine and the Royal College Emergency Medicine Programs. Both accreditation teams criticized the programs because of the cooperative and integrated program, clearly stating that the leadership of and each program must be distinct for accreditation by the two colleges. The directors of each independent program were subsequently appointed by the Chairman of the Department of Family Medicine. The emergency physicians expressed the opinion that they were not being adequately paid by the University and elected to leave the Faculty of Health Sciences and become part of an emergency system at Chedoke-McMaster Hospitals operated by the Hospital. This severance took place on July 1, 1988. The faculty carried out a full review of the emergency medicine programs role in the Department of Family Medicine and the faculty and made recommendations for the future (appendix 23). Denis Psutka who was on loan to the Ontario Government as Deputy Minister of Health returned to McMaster after a seven year leave and has assisted in developing an integrated emergency medicine program in the region.

Dr. Stephen Lloyd, after a search has been appointed as the Director of Academic Emergency Medicine and subsequently another individual will be appointed. Both of these will be in the Department of Family Medicine to set up a division of academic emergency medicine in the Department of Family Medicine, to provide the academic leadership in emergency medicine for the faculty.

NOMP Program Development

After two years of planning by the five chairs in Family Medicine in the province, a proposal was put forward to develop two norther programs. One based in Thunder Bay and one in Sudbury (appendix 24).

McMaster University's Department of Family Medicine will be responsible for the academic development of the Northwestern Ontario Medical Program's Residency Program. The structure and organization of this involvement are currently under development with the Chair being a member of the Executive Planning Committee and the planning committee of the NOMP residency program (appendix 25).

Expansion Plans

Part of this expansion plan for the Department will take place in July 1, 1991. The Pilot Project developed by Dr. Donald McLean under the postgraduate program is seen as the most effective way for McMaster to absorb the three or four extra residents in each of the two years that will be required for McMaster's full expansion in Hamilton. The evaluation of this program has been very successful (appendix 26). We are now committed to expanding by placing between four and six residents a year in the pilot project style of program. For postgraduate trainees applying to the program, we will offer five sites for their Family Medicine experience - one being the community (appendix 27).

SUMMARY

This is a summary of major program development in the past four years. There were many other unit or individual initiatives during the past four years.

PART II INTERNAL REVIEW DOCUMENT

Addressing Recommendations of the External Review of 1984

Recommendations

I. Organization and Communication

1. Recommendation: **The Department of Family Medicine should develop a mission statement to assist the search committee for a new Department Chairman.**

Comment:

Although some mission statements were developed prior to the process that commenced in 1987, the full process is outlined in appendix 6.

1.2 Recommendation: **The Policy and Priorities Committee and the Management Committee should be merged into one senior committee.**

Comment:

This in fact occurred and the Executive has evolved into its present format (described in Department Organization Structure).

1.3 Recommendation: **The monthly faculty meeting should be upgraded to consider major policy decisions in depth. Lesser issues of a housekeeping nature can be communicated by way of regular written reports and possibly a Department newsletter.**

Comment:

At the beginning of 1986 academic session, the Departmental meeting was increased from one to two hours. Although some housekeeping issues are reported upon in Departmental meetings, all of the major decision documents were discussed and voted on at departmental meetings. The departmental meeting concept as outlined the proposal for the new executive (appendix 28) is where final decisions are made and policies agreed upon by the department. The executives role is to prepare this material for appropriate presentation to the Department as a whole.

1.4 Recommendation: **A program of faculty develop giving direction to faculty members especially those who are new to the department would be desired. Academic cluster should be formed to bring together those faculty members who have like interests. A cross over exchange program where faculty could go to other units for brief periods of teaching and evaluation could improve communications among faculty in the four units.**

Comment:

A number of steps have been taken in this direction, although this area may need further development. There have been a number of recommendations and discussions around models of

teaching with sharing of information between units. (appendix 29). Presently First Place and North Hamilton Community Health Centre have an exchange program for faculty to accommodate the obstetrical problems in that unit. The academic forum is a method of sharing both educational and research ideas amongst the faculty (appendix 14). Although these steps have assisted in improving information exchange within the faculty combined with the production of an annual bibliography and the commencement of a Departmental newsletter (appendix 30). This area still needs to be further addressed.

1.5 Recommendation: **A more formal organization of the faculty of Family Medicine residents at McMaster should be considered with direct resident representation on key Departmental committees.**

Comment:

Residents play a very important role in the REC committee as it is now organized, and have major say in the development of their academic half-day program, and are also involved in educational committees with in each unit. Some faculty members would argue that there is excessive resident input to the curriculum and that the balance needs to be redirected. Residents are involved in a number of other important committees within the Department. They have been very involved in the internal review process at all levels and it is unlikely that lack of resident input is seen as a problem today.

1.6 Recommendation: **A committee should be formed to coordinate all the community teaching, undergraduate, and residency chaired by a community teacher with representation from the full time faculty, with responsibility for undergraduate and resident training. The community teacher chairing this committee should probably sit on the Senior Departmental Committee to represent the community teachers.**

Comment:

There are actually two community teachers that play an important role in the department, and have significant input at a number of levels. There is an Undergraduate Community Coordinator, Paul Steinberg, who is actively involved with the undergraduate program. The most active postgraduate level program is under the leadership of Dr. Don McLean, who coordinates the postgraduate teaching in the community and also the pilot project. Dr. McLean is very involved in the department on all the postgraduate committees, including the PC6 committee as well as being asked to come to the Departmental Executive on occasions to report on the activities in the program. He was honoured this year as the outstanding part time teacher in the whole Faculty of Health Sciences in recognition of the major contribution that he has been making over the past few years (appendix 31).

PART II EDUCATION

2.1 Undergraduate

2.1.1 Recommendation: **That Faculty of Health Sciences should ensure that the Department of Family Medicine has sufficient resources to maintain their heavy input into the undergraduate curriculum and this should be reviewed on a regular basis.**

Comment:

One of the objectives in the past two years has to be determined, what the expectations are of the Department of Family Medicine for input onto the undergraduate program. There are a variety of views, ranging from the perception that we are contributing excessively to the undergraduate program through to the perception that we are not contributing enough. A new information system known as the FEIS system has been developed by the faculty and we are currently reviewing the Department of Family Medicine's contribution in relation to other departments. The Chairman has been actively involved in soliciting members of the department to become more involved in tutoring and other undergraduate activity. It is hoped that within the next month or two we will be in a position to determine whether our contribution is approximately as it should be on the basis of this information (appendix 32)

2.1.2 Recommendation: **Family Medicine and Psychiatry should be separated in the clerkship and Family Medicine should try a one month uninterrupted block of teaching time.**

Comment:

Although this recommendation was made in 1985, it has not been implemented for a variety of reasons. Several adjustments have been made to the shared curriculum at the present time and the complaints of logistical and other difficulties with the shared curriculum have been reduced by these adjustments.

2.2.1 Recommendation: **Minimum standards for supervision of residents in all of the family practice units should be established. It is suggested that this should be the availability of the teacher at all times in a review of all patients charts with a resident at the end of each office session monitoring, teaching, and evaluation, using one-way glass and video tapes should be course occurrent at regular intervals also.**

Comment:

The internal review process has revealed unevenness in supervision, however, many steps have been taken to improve the levels of supervision in all of the centres, and minimum standards have been discussed, although not yet implemented (appendix 12 -13). This recommendation remains under review and consideration, and it is the belief of the post-graduate program director that at the present time, the level of supervision is adequate although possibly less than what some would desire in some centres.

2.2.2 Recommendation: **Some experimentation with different systems of teaching is recommended ~~comment~~.**

Comment:

As per appendix 29, both organization and supervision models have been experimented within recent years and major changes have taken place within two of the units with consideration of significant changed in the other two underway at the present time. The major adjustments in the curriculum and the way in which it is delivered have taken place in all of the units as a result of the change of requirements of the College of Family Physicians. This is brought to the consideration of teaching approaches and methods in all of the centres, and under the leadership of the Residency Education Committee (appendix 12, 13).

2.2.3 Recommendation: **McMaster could benefit from the experience of other universities and the experiment with the whole day release time or alternatively evening office hours to accommodate residents who have difficulties getting away from their rotations during the day.**

Comment:

Although this continues to be a problem as perceived by the specialty groups, especially the Department of Medicine, it is not as a significant a problem as it was in the past. The half-day back program is continuously under review, especially with internal medicine where fewer internal medicine residents are available to cover clinical teaching unit wards. The Department of Medicine has requested that the Department of Family Medicine discontinue the half-day back sessions. During the past year, Academic Half-day sessions, the Behavioral Science sessions, as well as the half-day releases for patient care have all been well reviewed by residents. The survey of our graduates conducted in 1988, indicated that these were considered very important parts of the program and therefore, we continue to support this approach to education (appendix 33), but will work with the Department of Medicine to reduce problem from the half-day back.

2.2.5 Recommendation: **The residency program in Family Medicine at McMaster should be encouraged to maintain as many of its third year positions as possible.**

Comment:

A great deal of effort has gone into not only retaining the positions, but allowing them to be used by more individuals. Many individuals have required less than one year to achieve their objectives for extra training, and therefore, the result has been that as many as eight residents have benefited from four positions over the past two or three years. A strong plea has been made by the Chairman of the five Departments for the expansion of our R3 positions. The appended proposal was recently approved by COFM. and we now await government approval of the proposal (appendix 34).

2.2.6 Recommendation: **Improve the opportunity for residents and faculty from First Place to follow their patients into hospital.**

Comment:

Residents are encouraged to follow their patients into the hospital from First Place Family Practice Unit and regular rounds are made. Palliative care teaching, Obstetrical teaching, Pediatric teaching, all take place at St. Joseph's Hospital for First Place residents. In recent years and in the internal review, this is not been perceived as a major deficiency in the program at First Place.

2.2.7 Recommendation: **The present effort to establish more training potential in the second year program either in Hamilton or in peripheral community hospitals should be encouraged. In recruiting new faculty, an effort should be made to ensure that there are family physicians faculty in each unit doing obstetrics.**

Comment:

This comment has been taken very seriously over the past four years. Faculty members and community groups have been organized at McMaster to provide delivery supervision for all residents, and all residents are encouraged to achieve the ten deliveries minimumally required. There are enough faculty both at First Place and the Henderson unit involved in the delivery of obstetrics to provide appropriate supervision of ongoing obstetrical care for residents in those two units. There are no faculty at the North Hamilton Community Health Centre involved in delivery obstetrics. An agreement made for two of the faculty at First Place exchange with faculty from North Hamilton to allow supervision and delivery of all obstetrical cases followed by residents at North Hamilton. This has also been an issue in the pilot project and in fact ongoing supervision and obstetrical deliveries have been provided for all the residents in the pilot project. This problem has therefore been addressed. At MUMC recruitment of a now faculty member with a strong interest in obstetrics combined with community physician support has addressed the problem.

2.2.8 Recommendation: **We recommend that the new pediatric walk in clinic be allowed to open as planned to satisfy the Royal College accreditation requirements but predict that it will eventually close for the lack of patients.**

Comment:

The clinic has opened and has been functioning for the past three years. It has not had any significant impact on pediatric care at McMaster University Medical Centre or in any other of the facilities in the community.

2.2.9 Recommendation: **The possibility of establishing a brief one or two month surgical experience should be explored. Emphasis should be placed on surgical diagnosis, the assessment of acute problems in the emergency department, out patient surgical clinics, and a limited exposure to operating room.**

Comment:

A surgical elective experience with appropriate objectives has been developed cooperatively between the Department of Surgery and Family Medicine. So far, very few residents have participated in this service (appendix 35)

2.2.10 Recommendation: **Efforts should be made to provide more cohesion to the training in psychiatry for the family practice residents. Additional opportunities should be provided for training and psychotherapy.**

Comment:

The Behavioral Science program under the direction of Dr. Allyn Walsh and Dr. Nick Kates of Psychiatry has been continually evaluated and upgraded in all of the family practice units. Elective opportunities still exist for residents taking extra experience in psychotherapy. Family principles are being introduced, family systems principles are being introduced into the Behavioral Science curriculum, and there is a family systems group with about six members at the present time working in the Department. The internal review revealed a number of problems in specific areas of behavioral science which have been addressed (appendix 36).

2.2.11 Recommendation: **The admission of inpatients from the First Place Family Practice Unit needs to be reviewed.**

Comment:

The internal review and other steps taken in the last year have not revealed the major problems in this area at First Place.

PART III RESEARCH AND SCHOLARSHIP

3.1 Recommendation: **There is room to develop a Departmental research strategy to provide some general direction without inhibiting individual enthusiasm. There is also a need to incorporate the needs of research into the service and teaching function within the Department. One way to accomplish this would be to form task oriented groups.**

Comment:

During the past four years, considerable thought and effort has gone into developing a research strategy. The conflict between individual interests and individuals efforts, which is strongly encouraged and some kind of a corporate or focused effort has been continuing and has not been resolved. The outcome of our research retreat in June of 1990, sets a reasonable direction. This combined with a strategic plan and the research focus on information systems and management approaches in Family Medicine have given focuses that encompass most of the activities in the Department (appendix 15).

3.2 Recommendation: **If possible, faculty with the interest and knowledge should be freed up from service and teaching responsibilities to pursue research and other scholarly activities.**

Comment:

The strategy has been followed through in a number of instances. One faculty member has now been freed up for two days a week for the year to produce a research effort that will help prepare this individuals CV to be well positioned to obtaining career award funding. A considerable effort was made to get career award funding for an other individual (appendix 37). Two other faculty members have been encouraged to take two week breaks in which to catch up on their writing to produce four or five papers that will improve their CV for both application for career award possibilities as well as for promotional possibilities. The objective in the Department will be to have three or four career award funded individuals in the next two to years. The hiring of Andy Oxman and involvement of individuals like Elizabeth Lindsay in the Department will further enhance the research effort.

3.3 Recommendation: **It is probably time to broaden the research interests of the Department.**

Comment:

The fact that not only has research been focused on clinical issues, but there have been six or eight papers in production now on educational issues is believe to have broadened the interests of the Department. A review of the four year publication list from the Department will reveal a very wide range of interests (Department Bibliography).

3.4 Recommendation: **The views of the full time faculty should be respected in a portioning time for research. As an alternative to an M.D. and a Ph.D. person could be appointed as designated funding research scientist.**

Comment:

One non-clinician has been hired full time in the Department, others are working part time. Two full time, one Ph.D and one M.D. who is not clinically involved or currently full time funded in the Department, and it is hoped that others will be appointed in the future.

PART IV SERVICE

4.1 Recommendation: **Effort should be made to increased the patient volume in the family practice units. Evening office hours and the provision of obstetrical care in all units are two suggestions for consideration**

Comments:

Volume at the McMaster University Medical Centre remains high and there is no particular need at this point and time to increase it. The volume at the North Hamilton Community Health Centre that was previous low has been substantially increased and is adequate to provide the educational milieu necessary. Although the volume has been stable at First Place, it has been considered by most of the faculty to be reasonably adequate, although efforts are being made to increase it. Henderson volume is still adequate to provide educational opportunities at the Henderson but is falling. It is anticipated that the move into the community within the next six to eight months will quite dramatically improve the volume at the Henderson unit and reduce any risk that there will be inadequate numbers for appropriate education. Volume in the pilot project has been perceived as a strength. Financially, the Department has operated with an excess of earnings over expenses and is able to provide start up costs for both the North Hamilton and Henderson move. This suggests adequate clinical work.

4.2 Recommendation: **The Department of Family Medicine should be increased to take a leading role in the provision of health care to the elderly and teaching and research in the field of gerontology. It is time that we developed strategy through doing this within the faculty of Health Sciences at McMaster.**

Comment:

The Department of Family Medicine has active involvement in a number of projects in cooperation with the educational centre and aging in Health (appendix 22). At the same time, a survey was conducted in the faculty to determine what the deficiencies with the faculty were and a faculty development program has taken place to improve the level of interest (appendix 38). The Department is sponsoring in the fall an international meeting to promote the leading edge developments and education in geriatric (appendix 39). There will be continuing development in the coming years, as well as more promotion of the available elective resources to residents in the program.

4.3 Recommendation: **Palliative care is a logical component of Family Medicine. They find in Hamilton as they did in Toronto that there are a large number of patients requiring palliative care and do not have family physician. This could prove to be a source of new patients for family practice units that have an excellent learning experience for the trainees.**

Comment:

Palliative care is an important component in the Department of Family Medicine. Dr. Latimer has been given a full-time appointment in the department in recognition of her efforts. A survey has been conducted of palliative care, and there is an individual who has taken a palliative care training program and is involved in palliative care in each of the four units (appendix 40). Again, on going development in this area will continue. Dr. John Swift's appointment on the faculty of McMaster University Medical Centre has also promoted palliative care teaching.

4.4 Recommendation: **It is important that trainees, especially family practice residents be included in the patient care activities of nurse practitioners and be taught by them where appropriate.**

Comment:

On going recognition of the role of nurse practitioners in the education of family practice residents has been increased over the past two or three years. The nursing group has produced an excellent document to outline their roles in the Department of Family Medicine (appendix 40). There has been considerable recognition of the nurse practitioners in the internal review of the last few months (appendix 13, 14).

4.5 Recommendation: **Allow the pediatric walk in clinic to come and probably go on its own.**

Comment:

This has been previously address and although it still exists, it has not provided any particular problem for the Department of Family Medicine and in fact in some occasions has provided excellent consultation back up when ill children are seen in the emergency room.

4.6 Recommendation: **Emphasising the management of gynaecological problems in the family practice units and in the community teaching practices and self training for family practice residents are in private office of staff gynaecologist is possible. Gynaecology rotation should include the assessment of acute gynaecological problems in the Emergency Department.**

Comments:

The establishment of the obstetrics and gynaecology rotation at St. Joseph's Hospital as the principle mode of training Family Medicine residents has recognized the importance of gynaecology. Attachment of physicians in private offices has occurred and involvement of Family Medicine residents in the acute emergency care has also been on a regular base. There is a considerable volume of gynecology in all the teaching practices.

5.0 Recommendation: **There should be a community teaching committee established under the chairmanship of the community physician with faculty representation for the persons responsible for the post-graduate and under-graduate teaching in the community. This committee should be responsible for supervising all community teaching both**

undergraduate and postgraduate. The chairman of this community should represent the community teachers on the faculty committees.

Comment:

This situation that was a problem in 1984 appears to be well in hand with Dr. McLeans involvement (appendix 42).

5.1 Recommendation: **Some of the money from the PC6 grant should be used to support the administrative function of the above mentioned teaching committee.**

Comment:

The Department has taken to support these activities quite extensively. There is an extremely capable Executive Secretary, Joyce Groves who is supervising the whole area of undergraduate support and activity. Also available to promote academic and write up a variety of activity in this area is the half time appointment by the Department of Pearl Dodd as a Research Assistant in Education. Dr. Phyllis Blumberg's appointment in the Department has been extremely valuable in providing educational back up in the development of these areas.

5.2 Recommendation: **The balance of clerk and resident teaching in community practice should be studied.**

Comment:

This has been studied quite extensively, and does not appear to be a major problem at this time.

VI EMERGENCY MEDICINE

6.0 Recommendation: **The attachment of the emergency physician in the Department of Family Medicine occurred all levels of the structure up to the level of Department Chairman. This resulted in being a division of Emergency Medicine within the Department of Family Medicine but all under the jurisdiction of one Chairman of the Department of Family Medicine.**

Comment:

This recommendation has been followed through and there has been a reorganization of the management of Emergency Medicine in the Faculty. A Division of Emergency Medicine has been formed and a Director of this division has been appointed. The division will operate on a regular basis with reporting mechanisms through the Department Chair.

6.1 Recommendation: **The need for full-time emergency physicians in Hamilton should be studied. The present staffing arrangements seem to be overloaded for the number of patients being seen. Consideration should be given to**

reintroduction of family physicians as part-time emergency room physicians in the Hamilton hospitals as was the case a number of years ago.

Comment:

This recommendation has not been followed through, but it is likely that there will be rationalization in emergency rooms in Hamilton. The actual numbers are considerably larger than they were in 1984, but it is likely that there will be a merger of at least one or two of the present emergency rooms in the near future and this will cause a further rationalization. The reintroduction of family physicians into providing emergency care in Hamilton is not likely to occur in emergency rooms, but may well occur in the east end facility in the future.

VII NURSING

7.0 Recommendation: **The Department of Family Medicine should take an ideal leading role in the integration of the various faculty within the various Health Science Group.**

Comment:

Family Medicine has continued to take a leading role in this area and in fact the integration of various disciplines at the North Hamilton Community Health Centre is regarded as a role model for the rest of the faculty in the integration of disciplines. The disciplines now involved at the North Hamilton Community Health Clinic include medicine, nursing, physiotherapy, occupational therapy, social work, community facilitator, dietitian, and nutritionist. To a lesser extent, these integrations are occurring in all of the other facilities (appendix 1 - Strategic plan document, Faculty of Health Sciences).

7.1 Recommendation: **Family Medicine practice nurses need to be supported in their educational activities by the Department of Family Medicine. Mechanisms should be developed to allow more nursing input to the decision making process within the Department.**

Comment:

The formation of a nursing group within the Department that reports in a similar fashion to the executive as do all other programs in the Department has facilitated this. The production of the nursing strategies document over the last two years has also further supported this effort (appendix 41).

VIII ROLE OF NEW CHAIRMAN

8.0 Recommendation: **Now is the time to develop a mission statement for the Department of Family Medicine using the internal review document as a starting point.**

Comment:

The mission statement has been developed (appendix 4).

8.1 Recommendation: **The new Chairman should be free floating representing the entire University Department not having responsibility for a specific hospital department.**

Comment:

The Chairman has no responsibilities for a section or unit in the Department. This situation at both the Civics and Chedoke-McMaster Hospital has been a source of considerable difficulty (see self-evaluation).1

1990 INTERNAL REVIEW

SELF EVALUATION

INTRODUCTION

The preceding documentation concerning the new major initiatives in the Department in the past four years, the response to the comments on the suggestions of the Internal Review of 1984, and the Departmental Bibliography are a positive statement of the activities in the Department. On assessing problems or lack of progress, the following four areas have been identified by the Chairman as the most significant areas where there was lack of progress. Since the Chairman is departing statements are developed as suggestions for the new Chairman.

I *The Chairman's Relationship with the Dean and the Leadership of the Faculty*

It is extremely important that the Chairman establish a good working relationship with the Dean of the Faculty of Health Sciences. The Dean's support is essential for developing new initiatives and programs. All plans for recruiting, developing new initiatives, or changing the nature of educational programs must be carefully reviewed by the Dean and the appropriate Associate Deans before any initiatives should be taken by the Chairman. Inadequate communication has resulted in problems with recruiting strategy, the move of the Henderson Family Practice Unit and the bed closures at Chedoke-McMaster Hospitals.

II *Climate*

When the new Chairman arrived in the Department, it was very clearly expressed to him that there were problems with the climate of the Department of Family Medicine. Each unit had operated somewhat independently and had been perceived by other units as not working to capacity. Although those initiatives have had some effect, the new chairman will need to continue to work diligently to create a climate that is supportive of new initiatives in research and education.

III *Relationships with the Hospitals*

It is very important for the new chairman to establish a good working relationship with the CEOs of the three hospitals. Lack of communication at this level in the past led to significant problems with the Henderson Hospital move and the loss of the teaching unit of 3Y (appendix 43).

IV ***Personal Academic Activity***

The Chairman, on arrival, understood that there was an expectation that to maintain credibility in the academic community, the Chairman should be personally involved in a number of academic initiatives. The Department membership does not support the Chairman being involved in many academic activities and expects the Chairman to be an administrator. Academic activities carried out by the Chairman that have caused these reactions include: participation in a number of international visiting professorships and lectures, as well as participation in the Ontario Task Force on the Use and Provision of Medical Services. This particular commitment has involved one or two days on average per month of absence from the Department to participate in these meetings. It is the present Chairman's opinion that the Department very significantly benefits from the profile obtained from activities. It may be important for the subsequent Chairman to clearly define the expectations of the Department in this area (appendix 44).

SUMMARY

The Department Chairman has been criticized for a number of other decisions taken during the past four to five years both inside and outside of the Department. The Chairman obviously has to accept responsibility for all of the decisions made by the Department and the interrelationships that developed between the Chairman both inside the Department and outside the Department. It is clear that no chairman can ever satisfy all of the demands and needs within the Department. The most important component of this activity is to keep open lines of communication between Department members and the clinics. The Chairman has made a sincere effort to do this within the past four years and the record will have to stand on its own merits.

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DEC 07 1990

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RESPONSE

Department of Family Medicine

to the Internal Review of September 19, 1990

The report of the Internal Review was extensively discussed at both the Departmental Executive and at a Departmental meeting held on November 27, 1990. The Department was pleased with the positive tone of the Review Committee's report. The members of the Department agree with the identified strengths.

Areas of identified weakness were difficult to interpret because of the general statements made in the review. However, members of the Department are aware of two major areas that need to be addressed within the Department. First, the relationship between the Department of Family Medicine and the Faculty of Health Sciences needs to be developed with much more effective communications than have occurred in the past.

Second, the relationship amongst the Faculty in the four Family Practice Units also needs to be substantially revised and enhanced. We have identified that there is a need for more coherence and collaboration between Faculty and Units. The Departmental Executive has been charged with responsibility for careful review of these areas. We anticipate that identification of specific problems in these two areas and careful development of a consensus on how to address identified problems will result in strengthening of the Department during the coming decade.

The above process has commenced and the Executive was charged by the Department on November 27, 1990 to report back to the Department by June 1991.

The Department had an important observation about the review process. We believe that the presence of one senior member of the Department on the review team would significantly facilitate the review.

OCT 04 1990

INTERNAL REVIEW — FAMILY MEDICINE

SEPTEMBER 24-25, 1991

Dr. J. Sorbie, Dr. P. B. Dent, Dr. S. Watt,
Dr. W. P. Cockshott (Chair)

The department of Family Medicine is considered by the review team to have a good academic program in keeping with its international high profile reputation.

The faculty has an experienced cadre of staff with well known academic leaders in the discipline who are probably more recognised as such outside this school than within.

They have provided good models of primary health care for education and service with H.S.O.'s, C.H.C., and involvement of community physician practices and N.O.M.P. This diversity of units is to be commended even though, paradoxically, within the department the lack of uniformity is perceived as a weakness.

Though there are some financial problems, in general the financial structure of the department is sound and a reasonable period of time without direct service commitment permits staff involvement in academic aspects of Family Medicine and university duties.

The post graduate educational endeavours are impressive with a high level of resident satisfaction. A wide variety of experience is available from the different clinical sites.

This department of Family Medicine is well known for its excellent track record in research. It is perceived to have become less active of late but is still healthy but it requires further

encouragement, development and leadership to raise its research profile. Researchers in the department are often unaware of what investigations are going on in other individual units which function in isolation.

Observations:

Though the overall evaluation is most favourable, nevertheless some problems and malaise were perceived. These are briefly mentioned (not in order of importance) as they indicate areas that require the attention of a new chairman to enhance the overall efficiency and morale of the Department of Family Medicine.

We were repeatedly made aware that the management of the department is dysfunctional despite considerable corrective efforts -- the unfavourable ratio of thoughtful input to productive output was noteworthy. Consequently, morale was low in some units (the fun has gone) and there was a sense that Family Medicine was held in low esteem by much of the Faculty. It was widely felt that primary care had only a few advocates and that there was a desire to have the Faculty reaffirm the role of primary care among the goals of the school.

This attitude is indicative of the need for strong leadership and more clearly articulated goals than are readily evident in the mission statement. A sense of unity and camaraderie though present at individual unit levels was conspicuously absent in the departmental sense as department policies were not clearly defined! Executive committee policy was at times questioned at unit level after decisions had been reached leading to delays and impasses and highlighting the need for improving management style and processes in the Department.

A gradual change has been occurring at McMaster in the setting in which Family Medicine is being practised. In the early days of the school units were related to teaching hospitals, but over the years the units at St. Joseph's, Hamilton General and now the Henderson General Hospitals have moved out into the community. This trend is consonant with increasing emphasis on community involvement outside the traditional secondary and tertiary care hospital. This has produced innovative and exciting settings providing care in underserviced areas of the city and underserviced parts of the province. The unit at MUMC is the only one now in a somewhat contrived setting. Based on the experience of the other three units a change to a community venue rather than being detrimental proved to be a positive challenge promoting togetherness. The role of the primary care physician in the hospital (emergency, palliative care and geriatrics) needs to be better defined and developed. The provision of some funded slots in these areas indicates a start has been made in palliative and geriatric care commitment.

Perceived mythological and real inequities in the funding of units were apparent and caused unnecessary tensions. Some of the imbalance is due to varying funding mechanisms in the system. The most acute difficulties lie with the components funded by hospitals (nursing and support staff) where flexibility is limited and recent constraints have resulted in inability to cover absences from sickness and vacation This is most acute at MUMC. Perhaps some excess earnings could be redistributed to ameliorate these hardships which create an adverse climate in units. Clearly directors of units must be kept well informed on finances and keep their unit staff aware of the facts to overcome unfounded claims of inequity.

The academic half day was about the only unifying feature

across the residency program and was excellent. By contrast the half day call back was a disruptive and impeded some educational experiences - this feature of the residency program requires reassessment despite CCFM views as its elimination would improve relationships with other departments.

Considerable energy and funds have been expended in developing a system wide computer data base. This could provide great research potential for monitoring health care delivery and audits. This has by no means reached its full potential and requires continued active support and encouragement by the chair. This project requires definition of its purpose.

The Community Teaching pilot project appears to be a successful venture and further growth in this area seems merited.

Undergraduate education focused mainly on clerkship with little involvement in tutoring, particularly re phase one and five where Family Medicine input would be valuable - logistics considerations due to continuity of patient care impeded greater participation. Approximately 60% of clerkship in Family Medicine took place in private part time faculty offices. These community physicians are an invaluable resource for the M.D. program.

Attributes of New Chair:

A primary care physician who has a broad vision of what Primary Care/Family Medicine needs are for the year 2000. The individual must be enthusiastic, energetic, insightful and articulate with considerable management skills to provide direction and unity to the department.

Innovative approaches to health care, bearing in mind the

limited recruitment options for new faculty (few staff retire until 1994) will demand people skills. The individual units require leadership to produce a more cohesive coordinated department operational plan.

The holder of the chair must foster good relations with the Dean and Faculty Executive, Hospital C.E.O's, Family Practices and Community leaders.

Family Medicine is charged with the responsibility of post graduate education for 40% of our graduates. The chair person must be able to communicate effectively the manpower implications of this educational commitment and promote an understanding of the special operational requirements that continuity of care in Family Medicine imposes on their Faculty.

An understanding of financial management and an ability to balance the needs of local unit autonomy with department objectives are important. At present the opportunity for shifting and sharing of all types of resources appears to be limited.

Finally, improved information transfer within the department needs to be nurtured. The newsletter (only a single issue to date) is the first step in that direction. Mechanisms must be developed to increase awareness of departmental achievements, objectives, problems and proposed solutions.

In conclusion, this large divèrse department requires strong leadership and direction.

W. Peter Cockshott