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Introduction to the McMaster University Geriatric Residency Training Program

Welcome!

The Geriatric Medicine Residency Program at McMaster University is designed to develop well-rounded expert clinicians in geriatric medicine. The core clinical rotations are structured to provide a balanced and diverse exposure to inpatient, outpatient and long term care populations. During the program residents will work closely with Geriatricians whose interests span, not only clinical geriatrics, but also medical education, research, program development and health advocacy.

The PGY-4 year allows the resident to develop clinical expertise in a variety of geriatric medicine services. Introductory rotations include inpatient geriatric assessment and rehabilitation, hospital-based consultation, and outpatient clinics. Experiences in community settings and geriatric psychiatry are also completed early in the program, to provide broad exposure to the variety of practice models possible in geriatric medicine. There are dedicated activities for trainees who will be sitting Royal College Exams in the spring. Twelve weeks, which may be taken in block or staggered form, are protected for a mandatory research project.

The PGY-5 year is flexible, typically individualized based on career interests and designed to foster graduated responsibility. There is a longitudinal chief’s clinic that prepares residents for independent practice in the ambulatory setting. Residents return to rotations in inpatient consults and inpatient geriatric assessment and rehabilitation, this time in the role of “junior attending”. This role is meant to simulate the experience of a consultant geriatrician, requires greater independence in clinical management, and increased responsibility. In addition, there is protected time and faculty support to focus on teaching skills and health advocacy activities. We offer ample time for elective experiences to accommodate the diverse career interests of trainees.

For those who are interested, the program offers specialized programs for the PGY-5 year that integrate clinical experiences with elements designed to develop expertise in education, leadership and administration, or research.

We are proud to be part of the Faculty of Health Sciences at McMaster: http://fhs.mcmaster.ca/main/facts.html

The guiding values for our faculty, our clinical and academic work, and our residency program are encapsulated in the mission statement of McMaster University.

At McMaster our purpose is the discovery, communication, and preservation of knowledge. In our teaching, research, and scholarship, we are committed to creativity, innovation, and excellence. We value integrity, quality, and teamwork in everything we do. We inspire critical thinking, personal growth, and a passion for learning. We serve the social, cultural, and economic needs of our community and our society.
Program Overview:

**PGY-4**

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Rehabilitation Unit (GRU)</td>
<td>8 weeks</td>
<td>Inpatient Ward providing interdisciplinary rehab post-acute care, and assessment of complex patients admitted directly from the community.</td>
</tr>
<tr>
<td>Inpatient Geriatric Consultations</td>
<td>8 weeks</td>
<td>Consultation to other inpatient services</td>
</tr>
<tr>
<td>Ambulatory Geriatric Medicine</td>
<td>12 weeks</td>
<td>Outpatient geriatrics clinics and associated services</td>
</tr>
<tr>
<td>Geriatric Psychiatry</td>
<td>8 weeks</td>
<td>Inpatient, outpatient, outreach, family health team experiences available</td>
</tr>
<tr>
<td>Block Selectives</td>
<td>8 weeks</td>
<td>e.g. Palliative Care, Neurology, Stroke Rehabilitation</td>
</tr>
<tr>
<td>Community Geriatrics</td>
<td>4 weeks</td>
<td>Mixture of inpatient and outpatient services with a community geriatrician</td>
</tr>
<tr>
<td>Research</td>
<td>4 weeks</td>
<td>May be taken in block or staggered form, and timing is flexible throughout the program</td>
</tr>
</tbody>
</table>

**PGY-5**

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
<td>8 weeks</td>
<td>May be taken in block or staggered form, and timing is flexible throughout the program</td>
</tr>
<tr>
<td>GRU – junior attending</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Inpatient Consults – junior attending</td>
<td>8 weeks</td>
<td>Primary and consultative care for complex nursing home patients. Home visits for frail, housebound seniors included in this rotation.</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Assorted Specialty Clinics (Horizontal Selectives)</td>
<td>12 weeks</td>
<td>Specialty Clinics: Neurology, movement disorders, stroke, rheumatology, osteoporosis, urology, urogynecology, physical medicine and rehabilitation, orthopedic surgery, chronic disease management (diabetes, heart failure, chronic lung disease) Other: geriatrics home visits, integrated long-term care experience, outreach telemedicine, administration / program development.</td>
</tr>
<tr>
<td>Electives</td>
<td>16 weeks</td>
<td></td>
</tr>
<tr>
<td>Chief’s clinic</td>
<td>Integrated</td>
<td>1 half day per week for 6-12 months</td>
</tr>
</tbody>
</table>
Training Sites

<table>
<thead>
<tr>
<th>Training Sites for Core Rotations in Hamilton</th>
<th>Additional Training Sites for Selectives and Electives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juravinski Hospital</td>
<td>Brantford</td>
</tr>
<tr>
<td>St. Joseph’s Hospital</td>
<td>Guelph</td>
</tr>
<tr>
<td>St. Peter’s Hospital</td>
<td>Brampton</td>
</tr>
<tr>
<td>St. Joseph’s Centre for Ambulatory Health Services</td>
<td>Kitchener-Waterloo</td>
</tr>
<tr>
<td>Hamilton General Hospital</td>
<td>Oakville</td>
</tr>
<tr>
<td>St. Joseph’s Centre for Mountain Health Services</td>
<td>Mississauga</td>
</tr>
</tbody>
</table>

On Call Responsibilities

Residents will participate in home call for coverage of the 18 bed GARU during completion of core geriatrics rotations. Call requirements are graded such that PGY5 residents do approximately half as much call as PGY4 residents. Since the focus for these patients is on rehabilitation, call is usually light (e.g. it would be unusual to need to come in at night). The full GRU call guidelines are posted in One45 under Handouts and Links.

Academic Curriculum

There is a weekly academic half-day which includes a seminar series of core geriatrics topics, a quarterly academic journal club, and additional topics of interest as selected by residents of the program. Residents from the Family Medicine Enhanced Skills Care of the Elderly program also attend these sessions.

There is also a collaborative workshop series that is planned jointly by the Program Directors of all medical subspecialty programs. These sessions focus on topics of shared interest, and are attended by all PGY4 and PGY5 residents in the medical subspecialty programs.

The full academic curriculum, with links to learning objectives and key articles, is posted in One45 under schedules.

Exam Preparation

Preparation for the Internal Medicine Royal College Examination

During the PGY-4 year, residents will have direct access to faculty who offer Royal College exam teaching sessions and practice scenarios. Our division places high value on preparing our residents for this event, and many participate in the annual Internal Medicine PGY2-4 practice OSCE. Several McMaster geriatricians have extensive experience as Royal College or LMCC examiners and exam board chairs.
Preparation for the Geriatric Royal College Examination

Our program also provides an annual practice short-answer written exam on geriatrics topics. This is to help residents gauge where learning gaps are, and guides preparation for their final Subspecialty Royal College Examinations.

Funding for Conferences
The program places a high priority on supporting residents to attend major geriatrics conferences. Upon entry to the program, each resident will be allocated a “professional development allowance,” which they can use to attend conferences, register for workshops and courses, and purchase books. Most trainees use this fund to attend the Annual Meeting of the Canadian Geriatrics Society, Canadian Conference on Dementia as well as one major American Geriatrics Conference or Review course (Boston or UCLA).

Resident Involvement in the Program
Residents are represented on the Residency Program Committee by the Chief Geriatric Resident(s). The Program Director also meets regularly with each resident individually. Resident feedback and suggestions are actively solicited. Residents complete anonymous faculty and rotation evaluation forms using a web-based system. As soon as sufficient evaluations are completed to maintain confidentiality, evaluations are compiled into a summary report that is forwarded to the Residency Program Committee, the Director of the Geriatric Residency Program, relevant site directors and supervisors. Each January, the Residency Program Committee has a meeting specially dedicated to formal review of the program (which is predominantly based on resident feedback), and goal-setting to make continual improvements in the resident learning experience.

People and Committees in the Geriatric Residency Program

Residency Program Director

Dr. Joye St. Onge (stongej@mcmaster.ca)  
905-522-1155 x33005

Residency Program Assistant

Meggan Armstrong (armstrom@stjosham.on.ca)  
905-522-1155 x33005

External Program Ombudsperson

The role of the Ombudsperson is to offer confidential, informal and independent information and advice; as well as, provide intervention and referrals. The Ombudsperson acts as an advocate for residents on equity and fairness. All matters dealt with are held in the strictest confidence.

Dr. Anne Woods (Geriatric Medicine Residency Program Ombudsperson)  
Palliative Care Team Fontbonne Building  
8th Floor St. Joseph’s Hospital, 50 Charlton Avenue East Hamilton, Ontario L8N 4A6  
Tel: 905-522-1155 ext. office 33529 ext. voice mail 33609  
email: awoods@stjoes.ca or awoods@mcmaster.ca
Residency Program Education Committee

The McMaster University Geriatric Residency Education Program is a collaborative effort, guided by the Program Director. The Committee assists the Program Director with the planning, organization and supervision of the Geriatric Residency Program. The Committee ensures that the program meets the standards of accreditation; reviews the program to assess the quality of the educational experience and adequacy of resources; fosters resident research; and evaluates the performance of teaching faculty. The Committee also participates in selecting candidates for admission to the program. The Committee meets quarterly and at the call of the Program Director. It provides input to and receives input from the Regional Geriatric Group. The Geriatric Residency Program Director sits on relevant external committees to ensure that potential impacts related to residency education are considered.

Site Coordinators
There are site coordinators at each hospital site that are responsible for the overall quality and process of resident rotations and clinical experiences at that site. Site coordinator duties include scheduling, orientation and ensuring adequate facilities, resources and opportunities for residents.

<table>
<thead>
<tr>
<th>Site</th>
<th>*Site Coordinator</th>
<th>*Administrative Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Joseph’s Hospital</td>
<td>Dr. Michelle Gagnon</td>
<td>Lena Pearlman</td>
</tr>
<tr>
<td>Juravinski Hospital</td>
<td>Dr. Brian Misiaszek</td>
<td>Karen Archer</td>
</tr>
<tr>
<td>St. Peter’s Hospital</td>
<td>Dr. Tricia Woo</td>
<td>Cindy Worrin</td>
</tr>
<tr>
<td>St. Joseph’s Center for Ambulatory Health Services (CAHS)</td>
<td>Dr. David Cowan</td>
<td>Natalie Hlacar</td>
</tr>
</tbody>
</table>

For questions or concerns related to your rotation at one of these sites, you should contact the pertinent site coordinator and/or administrative contact.
Adapting Your Program

A standard residency program will be organized for you according to the template outlined in the program overview. We are happy to tailor the program to suit individual interests and needs, and encourage residents to discuss potential interests early on with the Program Director. For those who are interested in developing more focused expertise in academic or community leadership, adapted programs are offered. At any point during the pgy4 year, residents may request a special stream program, though some courses and experiences may not be guaranteed if this decision is made after January.

Your current program plan can be accessed at the following link: http://www.medrez.net/view.php?a=ykzl49ih7
Password will be provided by the Program Director.

Clinician-Educator Stream

For residents who have demonstrated interest in pursuing an academic career as a clinician-educator, the program will facilitate the development of expertise in this area. It may, for example, include any of these elements:
- Protected time and tuition support to begin a MSc in Health Science Education
- Formal mentorship by a clinical educator
- Active involvement in educational initiatives being developed by faculty members
- Active involvement in teaching and tutoring activities
- Support to participate in local faculty development offerings
- Support to attend major conferences in Medical Education
- Research in medical education

Administrative-Leadership Stream

For those residents who wish to gain skills in leadership and administration, the program will facilitate the development of expertise in this area. Any of the following elements may be included:
- Protected time and tuition support to enroll in the Health Care Leadership & Management Program (http://www.leadershipandmanagement.ca/) at McMaster University.
- Mentorship by faculty members in administrative positions
- Involvement in administrative, service planning or political activities related to geriatric medicine
- Protected time for well-defined resident administrative projects
- Support to attend leadership workshops or conferences
- Research related to health care organization, evaluation and development

Clinician-Researcher Stream

For those interested in a career as a clinical-researcher, prospective residents may apply to the Health Research Methodology (HRM) program, and once accepted, may then apply for a Ministry-funded position in the Clinician Investigator Program (CIP) at McMaster. These are available on a competitive basis, and if successful, the resident’s program would be adapted to include up to 12 months dedicated time to research. Alternatively, residents have the opportunity to participate in the innovative Drug Safety and Effectiveness Cross-Disciplinary Training (DSECT) Program (http://safeandeffectiverx.com/).
SECTION 2
Research

Residents are expected to complete a research project during the program, and at a minimum, present the results at the Geriatric Medicine Research Day that rotates annually between Hamilton, London, Toronto and Waterloo. Twelve weeks, which may be taken in block or staggered form, are protected for this project. Residents are encouraged to discuss ideas with faculty and potential research mentors as soon as possible. The residency research director, Dr. David Cowan, will provide an overview session at the beginning of training.

We strongly encourage you to use the following timeline to organize this element of the program:

Recommended Timeline

PGY4 year:

October 1 – Deadline to inform Program Director if you wish to schedule any protected research days in the PGY 4 year

January/February – Progress meeting with Program Director - At this meeting you will review preferences for scheduling of your remaining research time in the PGY 5 year (i.e. staggered, block, which months)

PGY5 year:

July/August – Decide on your topic and conduct relevant literature reviews. By the end of the summer, or by the time you have started to use up research time (whichever is sooner), you must have a focused research question, and primary supervisor.

October – Interim evaluation – supervisor will be asked to comment on amount of progress to date, and whether project completion is expected by June.

November – Complete written research proposal, REB application, and data collection form.

January – Interim evaluation – supervisor will be asked to comment on amount of progress to date, and whether project completion is expected by June.

April – Most of Data Collection & Analysis should be done. Abstract submission deadline for Internal Medicine Resident’s Research Day.

May – Prepare abstract and presentation for Geriatric Medicine Research Day

Practical Tips

1. Choose a project design that is feasible to complete in 1 year, for example: quality assurance, survey, systematic review or cross-sectional study to characterize a certain population via chart review. Generally, an experimental study (e.g. RCT) will not be feasible to start and complete within a 2-year time span.

2. Try to apply for ethics review several months before your dedicated research block, so you can start collecting data when you actually have time to do so. Go to the REB website ([http://www.mcmaster.ca/ors/ethics/](http://www.mcmaster.ca/ors/ethics/)) to review guidelines, deadlines and download the relevant forms. If your study involves a chart review, there is an online course that you must take in order to be certified prior to applying for ethics approval. You should plan for the review process to take 4-6 weeks (less if your study is a chart review).

3. Prepare for meetings with research advisors by reading the relevant chapters in the Research Guide published by the Royal College of Physicians & Surgeons of Canada. This will help you make the best use of their support and advice, and have productive meetings. A copy of this handbook, and other resources may be borrowed from the Program Director’s office.

Funding

You are eligible for funding to help you conduct and disseminate your research project. The residency research director will be able to provide more details about eligible expenses and
amounts. For projects with a large scope, you may apply for operating grants from the following organizations:

- PSI Foundation- Awards- $20,000 per project for a 12 month period. (Maximum for all resident funding per year is $300,000) [www.psifoundation.org/resident research.htm](http://www.psifoundation.org/resident research.htm);

- R.M.A Scholarship Awards- R.M.A. scholars, $5000 maximum per year. (Apply by August 31st, application forms picked up Rm 3113 MDCL, Dr. Walton).

A number of other awards are also available, including:

- Canadian Society of Internal Medicine- Ted Giles Clinical Vignette- Deadline June 6th ([www.csim.medical.org](http://www.csim.medical.org)).

**Examples of Past Resident Research Projects**

All presented at Tri-City Resident Research Day

(* = first prize winner, resident category)

- Does the medical curriculum teach students and residents how to discuss code status? A systematic review (2013) *
- Audit of code status documentation in older cardiac inpatients (2012)
- Systematic review of rapidly progressive dementia (2012)
  *Presented at the 2013 Annual Scientific Meeting of the Canadian Geriatrics Society, Toronto, ON*
- Pilot RCT of nebulized opioids for dyspnea in advanced COPD (2011) *
- Vitamin D levels in Frail Hospitalized Geriatric Rehabilitation Patients (2010)
- Toxicity of digoxin in heart failure patients in long-term care (2009)
- A multifaceted intervention to improve osteoporosis diagnosis and treatment after non-hip fragility fractures. (2009)
- A survey of internal medicine residents’ attitudes towards geriatrics medicine as a career. (2007)
  *Presented at the 2008 Annual Scientific Meeting of the Canadian Geriatrics Society, Montreal, QC*
  *Presented at the 2004 Scientific Sessions of the American Heart Association, New Orleans, LA.*
Guidelines for Research Supervisors

The foundation of the relationship between residents and research supervisors may take 2 possible forms:

Option A: A resident approaches the supervisor with a feasible, reasonably defined research question that they would like to investigate.

Option B: A resident approaches the supervisor wishing to participate in one of their current research projects

Expectations of research supervisors are as follows:

Frequency of contact

At least 2 face-to-face meetings should be scheduled with the resident.

One should be soon after initiation of the relationship to outline expectations, explore the resident’s capabilities and support needs, and agree upon a plan of action and timeline.

The second should be approximately one month prior to abstract submission deadline of the venue where results will be presented. (April or May). The purpose of this meeting would be to review the results and prepare for the presentation.

These 2 meetings should be supplemented with regular contact to touch base on progress and address any problems that may be impeding this. This may be via email, phone or face-to-face depending on resident and supervisor preferences.

Role Expectations

Supervisors are expected to understand the content of the research project guide, and should facilitate learning, review resident work, provide constructive feedback, and direction when necessary. More specifically:

- Encourage residents to specify the research question on their own. Discuss the question, and help them refine it, and understand how it leads to a research design.

- Encourage residents to consider what search terms they will use and what databases they will use to perform the literature search; encourage them to talk to a librarian for help if needed.

- Be able to trouble shoot and assist, if necessary, during data collection.

- Be aware of funding support and awards available to residents, and encourage and support them to apply for these if appropriate. At a minimum, most residents would be eligible for the McMaster University Geriatric Medicine Research Award (description below). Resident research of particularly high quality and promise should be discussed early with the Research Director and/or Program Director.

- Be able to review data and results with resident, and encourage resident to bring forward his / her own conclusions and interpretation; Be prepared to discuss this and provide feedback.
- If resident selects OPTION B, then the resident and supervisor must clearly define what the resident’s contribution will be as part of the larger research project and discuss with the Program Director.

**Evaluation**

Supervisors will be asked to complete an interim and a final evaluation on the resident’s performance. If there are concerns about insufficient progress identified by the midway point, these must be documented and discussed with both the resident and the Program Director.

The resident will also be asked to complete an evaluation on the rotation and supervisor.
Teaching & Education

At each of the four core training sites, geriatrics residents can expect to work alongside medical students and other residents completing their geriatrics rotations. Our Geriatric Medicine rotations attract residents from a number of programs including core internal medicine, family medicine, psychiatry, physical medicine & rehabilitation, community medicine, and neurology. On the GRU, most months there are 2-3 clinical clerks completing a selective rotation in geriatric medicine. Our faculty members are very engaged in medical education at the undergraduate, postgraduate and CME levels. Many have won teaching awards, and are highly regarded clinical educators.

We encourage residents in the program to take advantage of these opportunities and resources to develop their own teaching skills. Participation in the teaching of junior housestaff is expected, particularly during the junior attending rotations.

There are many other roles in teaching and education that residents may choose to participate in, both for interest and resume building. These include but are not limited to:

- Co-tutor Undergraduate PBL Sessions
- Clinical Skills Preceptor
- Interdisciplinary Geriatrics Workshop Facilitator
- Contribution to Books or CME articles being produced by the Division
- Membership on the Division’s Education Committee
- Educational research

Involvement in these is as easy as letting the Program Director know.

Those interested in a clinician-educator career are encouraged to apply to McMaster’s MSc program in Health Science Education. Full details about this exciting new program are available on the website -  http://hsed.mcmaster.ca/
SECTION 4
Clinical Rotations & Electives

Rotation specific learning objectives are attached to your schedule in One45. Please review these documents prior to starting each rotation.

Core Rotations PGY-4 Year

Geriatric Rehabilitation Unit (GRU)

In this rotation, residents will look after patients admitted to the Complex Medical Rehabilitation Unit under the geriatric service. This 18-bed unit provides interdisciplinary assessment and rehabilitation following an acute hospital stay, to patients with complex geriatric issues. It also has a few assessment beds for direct admission of patients with complex issues from the community.

Training Site:

1. Juravinski Hospital:

Inpatient Geriatrics Consults

In this rotation, residents will work on the consultation teams, seeing referrals from other wards of the hospital. Common reasons for referral include: cognitive impairment, recurrent falls, help with discharge planning, functional decline, medication optimization, and suitability for rehabilitation.

Training Sites:

1. St. Joseph’s Hospital
2. Juravinski Hospital
3. Hamilton General Hospital

Ambulatory Geriatrics

During this rotation, residents will attend a variety of outpatient geriatric medicine clinics, and become familiar with other outpatient interdisciplinary programs for seniors.

Training Sites

1. St. Joseph’s Center for Ambulatory Health Services
2. St. Peter’s Hospital

Geriatric Psychiatry Rotation

In this rotation, residents will work with geriatric psychiatrists, seeing patients in a variety of settings including clinics, inpatient wards, homes and residential settings. Conditions that
Residents can expect to encounter include depression/mood disorders, dementia complicated by psychosis, behavioural disturbance or depression, and psychotic disorders.

Community Geriatrics

Residents will work with a geriatrician-supervisor who works in a site peripheral to Hamilton. Generally these rotations will provide exposure to a diverse practice model that is not seen in tertiary care centres, an interesting case mix, and a more integrated community care model. These sites usually have specific paperwork that residents need to complete to obtain appropriate hospital privileges.

Site: Kitchener-Waterloo  
Supervisors: Dr. Sadhana Prasad, Dr. Nicole Didyk, Dr. Gagan Sarkaria

Site: Cambridge  
Supervisor: Dr. John Yang

Site: Oakville  
Supervisors: Dr. Simona Abid, Dr. Aliya Khan

Site: Brampton  
Supervisor: Dr. Andrew Baker

Site: Guelph  
Supervisor: Dr. Amra Noor

Core Rotations PGY-5 Year

The senior year consists of rotations that allow residents to obtain clinical experience in diverse settings and related specialties. In addition, three clinical rotations are designed to develop the consultancy, administrative and educational skills that are expected at the end of core training:

1. Inpatient Rehab – Junior Attending  
2. Geriatrics Inpatient Consults – Junior Attending  
3. Longitudinal Chief’s Clinic

Residents must have demonstrated competency in the corresponding PGY4 rotations in order to progress to a JA rotation. This means predominantly scores of 4 or 5 on the end of rotation ITER, with no items below 3

Inpatient Rehab – Junior Attending

The role of the Junior Attending (JA) on the Inpatient Rehab rotation is to simulate the experience of the Rehab Attending Staff. This should not be a duplication of the PGY-4 experience and residents are expected to organize and manage the clinical duties, teaching and supervisory responsibilities approaching the level of a consultant. The JA is responsible for the care of all patients on the ward as well as the teaching, supervision, and administrative activities of an Attending. The JA is responsible for assigning ward patients to junior learners (if applicable).
The JA must review the goals and objectives of the rotation with the attending physicians.

JAs should follow the suggested guidelines for calling the attending:

- Notification of new admissions and discharges
- Concerns/questions regarding management
- Major changes in patient status
- Patients who are being transferred to another ward
- Bed management issues that are not easily handled
- Potential medical-legal issues
- Any CODE situation (missing patient, aggressive patient, fire, etc...)

At some point during the rotation, the Geriatrician attending should review the principles of OHIP billing as MRP on a geriatric unit.

Residents should have 2 team meeting STACERs completed during this rotation if they were not completed previously. This is also a good opportunity to complete family meeting STACERs.

**Available sites:**

1. **Juravinski Hospital – Geriatric Rehab Unit (GRU)**

Patients are admitted under the attending geriatrician, and managed collaboratively with a Geriatric Medicine Associate (Dr. Allaby). At the beginning of the rotation, it should be clearly outlined what the responsibilities are for the resident as JA, the attending geriatrician and the Geriatric Medicine Associate (Dr. Allaby).

The JA should lead interdisciplinary team rounds, communicate with allied health professionals regarding the care of the patients, and ensure that family physicians are contacted when their patients are discharged, in order to negotiate ongoing care.

The JA will take a very active role in the teaching and supervision of juniors. While the attending may provide bedside teaching, their main role is to observe and critique the performance of the JA in this role, and provide constructive feedback privately at an appropriate time. The JA is expected to provide one formal teaching session (1 hour) per week, on topics consistent with the learning objectives of the junior housestaff. The dates and topics should be planned in collaboration with Dr. Allaby at the beginning of the rotation.

The JA is responsible for assessing strengths and deficiencies of each individual housestaff and plays a major role in the evaluation. Mid-term verbal evaluations should be provided with suggested plans for improvement in clinical performance. The JA should seek feedback on learners from other members of the health care team. While the JA may be asked to complete the paper/on-line evaluations for the junior housestaff at the end of the month, the attending geriatrician should be present during the feedback sessions and cosign the evaluations. The JA should notify the attending immediately if there are significant issues with performance that may require remediation. Requests for time off by junior housestaff (e.g. doctor appointments, Carms sessions, etc...) should be directed to the attending geriatrician.

The JA will take 1st or 2nd call (as numbers allow), for a maximum of 9 days per block.
2. St. Joseph’s Hospital – General Rehab

The SJH general rehabilitation unit receives a mixed population, including orthopedic (post-hip fracture, hip & knee replacement), complex nephrology, and stroke patients. Patients are admitted under the attending internist and managed collaboratively with a nurse practitioner (Barb L’Ami). A physiatrist provides weekly consultation and bedside neuro/MSK for all admissions (Wed AM), and leads weekly interdisciplinary rounds (Thurs PM). The Geriatric Medicine consult service is involved with all hip fractures, performing an initial assessment during the perioperative period, and following up any identified geriatrics issues as needed once they are transferred to rehab. At the beginning of the rotation, it should be clearly outlined what the responsibilities are for the resident as JA, the attending, the physiatrist and the nurse practitioner. This rotation will be scheduled to ensure that at least 2 weeks of the block is with a geriatrician as attending. A high degree of autonomy will be given, and the JA will be expected and supported to “shadow bill” on behalf of the attending geriatrician.

Each day, the JA is generally expected to review new admissions, and see any patients flagged by the NP as potentially sick or with complicated presentations. During the block, the JA is expected to provide one teaching session for the CTU housestaff or residents rotating on geriatrics. This may be a prepared didactic or bedside clinical exam session. In contrast to the Juravinski site, junior learners are usually not present on the unit. An opportunity to lead the team meeting will occur at the end of the rotation, after the JA has become familiar with the usual process of the team. The JA will take 1st call for a maximum of 9 days per block.

Inpatient Consults – Junior Attending

The role of the Junior Attending (JA) on the inpatient consults rotation is to simulate the experience of the Consultant Geriatrician. This should not be a duplication of the PGY-4 experience. It is expected that residents will effectively use this opportunity to gain some experience in advocacy, service development and/or education. Residents are expected to integrate and organize clinical duties alongside educational and administrative activities, similar to practicing consultants.

At the beginning of the month, the JA must negotiate a clinical schedule with the supervisor that balances inpatient consultation coverage, and also allows some time to focus on other activities that geriatricians typically do when not providing direct clinical service.

For example, the JA may be encouraged to arrange and pursue other activities related to education (faculty development workshops, preparing and delivering teaching sessions to junior housestaff, co-tutoring, CTU teaching), administration (leadership workshops, meetings), or health advocacy (collaboration with a non-profit agency, public education) during this time. These additional activities should be tailored to personal interest.

During the JA rotation, the Consultant Geriatrician should spend some time discussing aspects of personal experiences with education, advocacy or administrative responsibilities that would be of learning value to the resident. OHIP billing principles for inpatient consults should also occur, and residents are strongly encouraged to practice by “shadow billing.”
Available sites:

1. St. Joseph’s Hospital

At this site, the JA will act as the first line clinical supervisor for junior housestaff, with the Consultant Geriatrician serving as support and backup. There are usually 2-3 residents from a variety of programs each block. The supervising Consultant Geriatrician will provide 1 hour of dedicated teaching/mock oral preparation for the junior residents each morning (usually from 8-9A). Immediately after this, the JA will review cases seen by the residents, provide teaching and feedback around the cases, and round with the team at the bedside. The Consultant Geriatrician will sit in on the case review and provide feedback initially, but will subsequently allow increased independence according to the ability of the JA. The Consultant Geriatrician will formally touch base with the JA daily and be available for support as needed. The Consultant Geriatrician will attend the case review at minimum one morning per week, to assess and provide feedback to the JA on performance as a supervisor/teacher. The JA will be responsible for the overall conduct of the consult service, ensuring that referrals are seen in a timely manner, with appropriate follow up and documentation.

The JA will be released from duties to attend his/her scheduled chief clinics and academic half day. The Consultant Geriatrician will be responsible for morning case review when the JA is at chief’s clinic. IMRAC consults on Tuesday afternoons will be reviewed by the Consultant Geriatrician, but the JA is responsible for ensuring that a resident attends IMRAC on time to do the initial assessment of the patient scheduled.

The JA will attend the monthly “SJH team meeting” which is usually held immediately after the orientation session. This is where the geriatricians and case managers meet to discuss strategies to improve the function and quality of the service, problem-solve around challenges and become aware of broader hospital-based initiatives and changes relevant to geriatrics.

2. Juravinski Hospital

3. Hamilton General Hospital

At these sites the standard duties and responsibilities of the JA are as follows:

1. Supervise junior residents and other learners (if applicable):

2. Liaise daily with the Rehabilitation/Seniors Health Consultation Team RN (RN Lisa Johnson at HGH pager #1357; or RN Sue Swayze, pager #4605) on call by 9:00 am daily to be assigned patients. Because of illness or vacation if there is no covering RN, a list of patients to see may need to obtained from the Meditech Request Intake Office, located at HGH (Mamee or Tara, extension #40806).

3. If there are any problems contact the attending Geriatrician (rotates).

4. Prioritize referred hospital consults with special emphasis on:
   - Critical cases (e.g. delirium)
   - Patients referred for short stay rehabilitation on the GRU
   - Unusual and complex cases
5. After completion of hospital consults, provide recommendations as suggested Geriatric Medicine orders for referring service to approve, and subsequently review case with attending

6. Attend academic half day sessions

7. Attend outpatient ambulatory clinics at least ½ day per week (discuss with attending their individual schedules)

8. Orient other rotating residents to the service

9. Follow the rules set by PAIRO, McMaster Post-grad Medicine/Family Medicine, Royal College, hospitals, and our program, bringing any concerns about them to Program officers

INDIVIDUALIZED ACTIVITIES: To advance own knowledge & skills in service, education, research, and administration

Longitudinal Chief's Clinic

The general goals and objectives of the chief's clinic are to develop skills in the CanMEDS role of manager, to provide opportunity for longitudinal follow up of patients, and to provide opportunity for graduated responsibility. Prior to starting the PGY-5 year, each resident will select a primary site and supervisor, from a list of options provided by the program. The resident will negotiate timing and duration of the clinic (range 6-12 months) with the primary supervisor. The chief's clinic is optional for clinical fellows.

Scheduling

The longitudinal chief's clinics will occur over the last year, as a weekly half day clinic or biweekly full day clinic. Sometimes there will be circumstances where there should be no clinic scheduled that week (e.g. resident vacation). The goal is a minimum of 36 clinics over the year. Each half day clinic will start with 1 new (2hr), and 1 follow-up (30 min) per clinic. This may be increased over time according to comfort level of the resident and staff. At the outset, there needs to be a clear policy in place for notification for rescheduling/cancelled clinics - e.g. who contacts resident; unanticipated absence (e.g. supervising faculty sees patients if resident is sick and patients cannot be rescheduled), policy for when supervisor is covering another service e.g. GRU. If funding allows, the residency program will provide clerical support for each resident in the amount of 0.1FTE clerical per week for 36-52 weeks. Additional clinical support (e.g. nursing) will depend on availability at the individual sites. It is the responsibility of the resident and supervisor to schedule a volume of patients that is appropriate to the level of support available.

Expectations for Residents

Residents will abide by the CPSO policy on postgraduate education: http://www.cpso.on.ca/policies/policies/default.aspx?ID=1846

The resident will do the proper documentation and billing per OHIP rules. The supervisor should ensure that the resident is taught this at the start of the rotation.

The resident will keep booking staff and supervisor fully informed about conflicting responsibilities or need for schedule changes, at the earliest possible convenience.
**Expectations for Faculty**

The supervisor must be on site and prepared to intervene as necessary during the clinic. They must follow the PGME policy on supervision and graded responsibility, and abide by the CPSO policy on postgraduate education. All new consults must be reviewed and seen. Follow-ups should be seen until the supervisor has an adequate sense of the resident’s abilities. The supervisor may then use his/her judgment in deciding whether follow-ups need to be seen prior to leaving the clinic, reviewed verbally prior to leaving the clinic, or reviewed verbally at the end of the clinic after the patient has gone home (graded responsibility).

Supervisors should allow and facilitate graduated responsibility of the resident over the course of the year. The experience should not be a duplication of the ambulatory experience offered to PGY1-4 residents. There must be an educational dialogue every clinic, and teaching to facilitate attainment of rotation specific objectives, with a special focus on preparing the resident for independent practice.

Chief residents are not expected to supervise junior learners during this rotation, as there are other rotations in the program (GRU, Inpatient consults) where this is required and evaluated. If a patient has findings of particular learning value however, residents are encouraged to involve other housestaff if appropriate.

**Evaluation**

Formal evaluation and feedback will occur every 6 months. Informal evaluation and feedback should occur every 3 months. At least 1 (preferably 2) clinical exam STACERs must be completed over the course of the year.

**Selective and Elective Rotations**

Residents are responsible to identify areas of interest and arrange elective experiences to complement core rotations of the program. A menu of recommended options will be available on entry into the program.

These are some of the block rotations that have been selected by prior residents:

- **Neurology**
- **Palliative Care**
- **Stroke Rehabilitation Unit**
- **Clinical Pharmacology and Toxicology**

Instead of a block rotation, residents may choose to organize an assortment of clinics or experiences that they would like to pursue. The resident is responsible for contacting various clinics to arrange placements, and this should not be left too late, since clinics can fill up with other learners quickly.
In addition to academic half day, during an “assorted clinics” block residents are allowed to have 0.5 days per week protected for reading/self-directed learning, and 0.5 days per week for administrative duties. Residents must submit the final schedule to the Program Director at least 2 months in advance of the rotation. Further details regarding supervisor contacts, clinic schedules and locations are available from the Program.

These are some clinics that have been selected by prior residents:

- Falls
- General Geriatric Medicine
- Telemedicine Geriatrics
- Diabetes
- Vascular, Cardiac Prevention
- Osteoporosis
- Physiatry
- Heart Failure
- Chronic Pain Management
- Movement Disorders
- Rheumatology
- Neurology
- Bone/Calcium/Parathyroid
- Stroke prevention
- Urogynecology/Incontinence
- Back Pain
- Wound Care

**Northern Ontario Outreach Elective**

In the spring & autumn of each year (usually September & March), there is an opportunity to accompany one of our faculty geriatricians on a week long elective to Northern Ontario. This is a popular elective with almost all geriatric residents choosing to do it during the program. Interested residents should inform the Program Director and Dr. Patterson’s administrative assistant early.

**A Brief Description of Geriatric Medicine Consultation Visit to Northern Ontario**

When Dr. Patterson first immigrated to Canada in 1971, he was engaged in general practice in the town of Blind River, Northern Ontario. For five years he worked in partnership with a number of other physicians providing primary care to the local population, also practicing obstetrics and assisting at surgery. He left Blind River in 1976 to pursue post graduate training in Internal Medicine and subsequently Geriatric Medicine and Clinical Epidemiology.

In the mid 1980’s, he was approached by physicians in Blind River and Manitoulin Island to conduct regular consultation visits to Northern Ontario.

Over the years the routine has become quite well established, and he looks forward to this one week break from life in Hamilton, returning to Northern Ontario to provide geriatric medicine consultations in a variety of settings.

He is usually accompanied by a resident physician and/or student, and another health care professional, usually a nurse clinician or clinical nurse specialist.
The week is structured as follows:

**Sunday:**

Leave Hamilton late am and drive to Blind River. Usually this will be via Hwy 400, Hwy 69 and Hwy 17 (Trans Canada) although if the Bruce Peninsula – Manitoulin Island ferry is running at the time, this is an alternative route. The ferry operates during the summer months only. The party stays in a motel in Blind River. The distance from Hamilton to Blind River is approximately 600 km and usually takes about 7 hours during good weather.

**Monday:**

We spend Monday at the Blind River District Health Centre. This is a small hospital with an emergency department, a small acute unit and a larger long term care unit. We see outpatients in the emergency department area, and inpatients in the acute and long term care areas. We usually have a busy day, but aim to finish by 6:00 in time for dinner at a local restaurant. At 7:00 or 7:30 we meet with the staff to talk about the patients that we have seen during the daytime. We are always impressed by the enthusiasm of the staff and the willingness to learn.

**Tuesday:**

Before breakfast we have to pack for the journey to Espanola later in the day. We join members of the medical staff of Blind River District Health Centre at 8:00 am for about an hour. We talk about patients that we have seen, and other related issues. The physicians will attempt to recruit the resident member of the team(!) The rest of the day is spent in consultation for outpatients and inpatients, we aim to leave Blind River for Espanola, a distance of about 100 km, by 6:00 pm.

**Wednesday:**

We spend the day at Espanola General Hospital. The hospital has an emergency department, a small acute care unit, a senior’s apartment complex, a retirement home area and a long term care facility which has recently been rebuilt to a high standard. We spend the day seeing outpatients and inpatients on the different units. In addition to the medical staff a nurse practitioner is the primary care provider for a number of the long term care patients. We aim to finish by 6:30 pm, and traditionally we dine at a Chinese restaurant where some of the local physicians join us. This is another opportunity to discuss patients and various practice issues.

**Thursday:**

We pack for the journey to Wikwemikong and leave after breakfast. The journey to Wikwemikong is approximately 100 km, and we leave the mainland, crossing to Manitoulin Island at Little Current. Wikwemikong is a first nations reservation and we spend the day at the Wikwemikong Nursing Home. This is a long term care facility with a mixture of aboriginal and non aboriginal residents, the majority of the staff are of the Ojibwa nation. We spend the day seeing residents of the nursing home in consultation, and occasional outpatients. Thursday is the gastronomic highlight of the week. The cook at the nursing home (ironically named Don Cook) was a chef at the Algonquin Hotel in St. Andrew’s New Brunswick before moving to Manitoulin Island. He always prepares a special treat for visitors, and it is sure to be an interesting meal.
We aim to finish by 6:30 pm or so, and then drive back to Little Current (about 50 km) and stay at the Shaftesbury Inn, a renovated 18th Century country inn which is very comfortable. We dine in the Shaftesbury’s restaurant.

Friday:

We spend the day divided between the hospital (Manitoulin Health Centre Little Current Division); and the local nursing home, Manitoulin Centennial Manor. The hospital has an emergency department, a small acute care unit, and also a dialysis unit, outreach from the Laurentian Hospital in Sudbury. It also has the unique distinction of having a helicopter pad on the roof of the building, if you feel the whole building shaking and hear by a low pitched thumping sound, that’s the helicopter! The main challenge on Friday is being able to complete our consultations by about 5:00 pm so that we can get back to Hamilton at a reasonable hour. The distance is about 590 km. We try to get home by 1:00 am on Saturday morning.

General Comments:

All expenses will be covered, students and residents will not be expected to contribute to the cost of their meals, lodging or incidentals. Accompanying health care professionals will be reimbursed at standard Ministry of Health and Long Term Care rates for a 40 hour week and for the standard government rate of meals and hotels. Dr. Patterson will provide snacks and sandwiches for the journey to Blind River, please bring your favourite CDs and if you wish, snacks for the journey that will last for more than one day.

Consultations:

Although we may be asked to tackle any geriatric (and often general medicine) topic, one of the commonest reasons for referral is dementia and its complications. Thus we see a number of patients in follow up from previous visits. Although there is a Geriatric Psychiatry Outreach Service from Sudbury and Espanola, we are often asked to see older individuals with behavioural disturbances related to their dementia.

It is important to recognize the differences between rural and city practice. Access to consultants and investigations may be limited. For example, CT or MRI scans are available in Sudbury or Sault Ste. Marie only. There are a number of visiting consultants to most of the sites (except Wikwemikong) in the specialties of General Surgery, Cardiology, Urology. Laboratory, ultrasound and non invasive radiology is available at all sites except Wikwemikong, where only laboratory tests can be performed. Simple spirometry is available at several sites. EEG, EMG and echocardiography are not available locally.

Thus, as a consultant one must be aware of these limitations, and also that the local physicians are seeking practical helpful advice which is tailored to the reason for referral, patient and location. The environments are friendly and generally informal: it is not necessary to wear white coats, but do bring name badges and examination instruments.

The important thing to bear in mind is that we shall do our best to meet the requests of the referring physicians, practice in an ethically sound and competent manner, learn from the experience, and enjoy a satisfying and worthwhile break from the usual routine.

If there are any questions, please do not hesitate to contact Dr. Patterson before or after the trip.
SECTION 5
Academic Curriculum

The most current calendar of all academic events is available in one45.

Weekly Academic Half Day

Every Monday afternoon, residents are excused from clinical duties in order to participate in the weekly academic half day. Residents from the Family Medicine Enhanced Skills Care of the Elderly program also attend these sessions. Academic Half Day will occasionally occur on different day of the week when the teaching session is provided by another program.

THE YEARLY CURRICULUM INCLUDES:

1. Seminar Series on Core Geriatrics Topics

The program will arrange the following topics to be covered on a 2 yr basis.

A. Normal aging (includes physiology, biology, psychology, and theories of aging)
B. Geriatric Clinical Pharmacology and safe prescribing
C. Falls, Balance & Gait Disorders
D. Dementias:
   (1) Alzheimer’s Disease
   (2) Vascular Dementia
   (3) Frontotemporal Dementia
   (4) Lewy Body Dementia
   (5) Rare Dementias
E. Delirium
F. Mood and other psychiatric manifestations-
G. Mild Cognitive Impairment
H. End-of-life Care (includes Issues Symptom management, Communication, Changing goals of care, Advanced Directives)
I. Behavioural & Psychological Symptoms of Dementia & Use of Restraints
J. Nutrition / weight loss
K. Frailty
L. Urinary Incontinence
M. Pain Management
N. Bone and metabolic disorders
O. Immobility and its complications
P. Rehabilitation
Q. Consent and Decision making capacity
R. Elder abuse
S. The elderly driver
T. Health Promotion/Disease prevention
U. Clinical exam skills (e.g. Neurological, mental status, hearing, vision, mobility, nutrition)
V. Bioethics related to geriatrics (e.g. distributive justice, filial responsibility, proxy decision-making)
W. Legislation & regulations related to geriatrics (e.g. driving, advance directives, power of attorney, guardianship, trusteeship)

2. Resident Journal Club (more information below)

3. Multidisciplinary Academic Days (MAD days)
These are sessions that are organized by the Postgraduate Office on topics that are relevant to all disciplines (e.g. Pain Management, Ethics). Residents from all McMaster Residency Programs are expected to attend.

4. Additional topics of interest as organized by the chief geriatrics resident. 
(as directed by residents of the program)

**Subspecialty Medicine Combined Rounds**

These events are held jointly with other medical subspecialty programs, approximately 4 times per year. The sessions are held on Thursday afternoons, 3-5PM at St. Joseph’s Hospital. These cover broadly relevant topics such as ethics, how to give a powerful presentation, how to set up a personal portfolio, communication in the workplace, hospital administration, etc.

Examples of prior topics:
- Ethics Workshop: Truth Telling (Professional)
- Workshop: How to be a Great Presenter (Communicator)
- Multidisciplinary Team Dynamics (Collaborator)
- Educational Evaluation Tools (Scholar)
- Balancing Personal and Professional Life (Manager)
- Advocacy Workshop (Health Advocate)
- Billing Workshop (Manager)
Conferences and Workshops

The program places a high priority on supporting residents to attend major geriatrics conferences, and we strongly encourage our residents to present their research projects at the Annual Canadian Geriatrics Society Meeting. The chart below lists recommended conferences that are often attended by our trainees. Residents should be aware and monitor for registration deadlines.

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<tr>
<th>Conference</th>
<th>Frequency</th>
<th>~When</th>
<th>Website</th>
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<tr>
<td>Canadian Geriatrics Society (CGS)</td>
<td>Annual</td>
<td>Mid April</td>
<td><a href="http://www.canadiangeriatrics.ca">www.canadiangeriatrics.ca</a></td>
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<tr>
<td>American Geriatrics Society (AGS)</td>
<td>Annual</td>
<td>Early May</td>
<td><a href="http://www.americangeriatrics.org">www.americangeriatrics.org</a></td>
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<tr>
<td>Canadian Conference on Dementia</td>
<td>Every 2 years</td>
<td>Fall</td>
<td><a href="http://www.canadianconferenceondementia.com">www.canadianconferenceondementia.com</a></td>
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<tr>
<td>UCLA Board Review</td>
<td>Annual</td>
<td>September</td>
<td><a href="http://www.cme.ucla.edu">www.cme.ucla.edu</a></td>
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<tr>
<td>McMaster Review Course in Internal Medicine</td>
<td>Annual</td>
<td>Late March</td>
<td><a href="http://www.mcmasterinternalmedicine.ca/">http://www.mcmasterinternalmedicine.ca/</a></td>
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There are also local workshops and events that residents will be supported to attend (e.g. Annual Update in Geriatrics Day, Gentle Persuasive Approach workshop)
GERIATRIC MEDICINE & CARE OF THE ELDERLY ADVANCED
TRAINEE JOURNAL CLUB

INSTRUCTIONS TO RESIDENTS

Please review the ROTA and make note of the dates you are scheduled to present. If you are planning to be away, or prefer another date, please switch with a fellow resident as soon as possible and inform your program director and program assistant of the change.

The expectations are outlined below in the TERMS OF REFERENCE

Use the EBM guides and articles suggested in the RESOURCES section.

Let the faculty facilitator know the article you have chosen at least 1 week prior to the event. The earlier you can provide this, the more able we are to provide guidance in terms of appropriateness, other articles of relevance, etc... By the Wednesday preceding journal club please email your chosen article in pdf form to the program assistant. State the title of the article in the body of your email.

TERMS OF REFERENCE

Goals and Objectives:
1. To facilitate an awareness of valid, clinically applicable research findings in geriatric medicine.
2. To discuss the impact of these findings for management of patients encountered in real clinical practice.
3. To maintain and refine critical appraisal skills.
4. To develop presentation and leadership skills.

Participants:
- Geriatric Medicine and Care of the Elderly residents
- Interested Clinicians caring for elderly patients
- Pre-designated Faculty Facilitator
- Residents and clerks on geriatric rotations

Format:
Two to three articles will be reviewed and presented during Journal Club. Two to three residents will take responsibility for selecting a good quality article for review. The article will be made available to participants no later than the Wednesday preceding each journal club. The presentation should be done in 10-15 minutes followed by 15 minutes of general discussion of clinical and methodological issues and interactive learning. The individual leading the discussion will prepare a one page “bottom line” summary and submit this to the faculty facilitator.

Residents should use the suggested resources below. The article by Schwartz has a 10 item checklist to help you develop a thorough yet targeted presentation. The JAMA User’s Guide articles should be used for the critical appraisal aspect of the presentation.

Chair:
A faculty member will chair the journal club. The Chair’s responsibilities include facilitating discussion, ensuring that good critical appraisal methods are used (e.g. refer to JAMA guides as needed), and advice regarding selection of the article if needed.

**Evaluation:** A standardized evaluation tool will be used to evaluate each individual journal club presenter via One45/webEval.

**Review:** The terms of reference shall be reviewed annually or as needed.

**RESOURCES**

Schwartz MD et al. Improving journal club presentations, or, I can present that paper in under 10 minutes. Evid Based Med 2007; 12: 66-68.


**JAMA User's Guides to the Medical Literature**

See attached pdf for list of original User's Guide articles, available in JAMA.
SECTION 6

Evaluation
Performance of residents will be evaluated on an ongoing basis via these mechanisms:

1. ITERs (In Training Evaluation Reports)

These are the forms that your supervisor will fill out at the end of each rotation or clinic series. With your final evaluation of each rotation, you should receive verbal, face-to-face feedback from your supervisor, and the opportunity to respond. If this is not happening, please inform the Program Director. All items on the ITERs are organized into CanMEDS categories, and reflect the learning objectives of the rotation. Once completed, they are available to the Program Director. The Program will review and collate the ITERs to formulate the Final In Training Evaluation Report (FITER), which is sent to the Royal College, and the Semi-Annual In-Training Evaluation Reports for Saudi Trainees.

2. STACERs (Standardized Assessment of Clinical Evaluation Report)

In these evaluations the resident is directly observed by a faculty supervisor while they are performing a specific clinical task. They should be completed during the final year of training and the three scenarios involved are:
   - Clinical examination (comprehensive geriatric assessment)
   - Family Meeting
   - Interdisciplinary Team Meeting.

The program will provide STACER instructions and forms to trainees. It is the resident’s responsibility to ask clinical supervisors to arrange completion of a STACER. RCPSC Residents must complete 2 of each type (6 total). For Clinical Fellows completion of STACERS is optional. It doesn’t matter which rotation the STACERs are completed in, though GRU is the best rotation for the team meeting STACER, while Inpatient Consults and Chief's Clinic are good rotations to do the family meeting and clinical assessment STACERs. STACER forms are available in one45 - Handouts and Links section under program objects.

3. Evaluation of Written Communication

During your program, a random selection of consult notes that you have dictated will be reviewed. Targeted constructive feedback will be provided to you to optimize your written communication skills. A copy of the consult letter evaluation form and “Tips for writing a good consult letter” are also available in one45.

4. AHD attendance

You are expected to regularly participate in the academic half-day and subspecialty medicine combined rounds, and attendance at these sessions will be noted. We understand that sometimes there will be special circumstances precluding your attendance, and in this case we expect that you promptly inform the chief resident. It is also important for planning that the chief resident is aware of anticipated vacations & absences. For example, if all but one resident will be away, it would be appropriate to reschedule the session to a time when there will be greater attendance.

5. Journal Club Sessions

Your critical appraisal and presentation skills will be evaluated by peers attending journal club. The following rubric is used and the summary feedback will be provided to you for self-improvement.

DID THE PRESENTER... Agree Disagree
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<td>Clearly state a focused and relevant question?</td>
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<td>Use a logical and focused search strategy?</td>
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<td>Summarize the study design and findings into clinically relevant values (e.g. NNT)?</td>
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<td>Critically appraise the study and identify strengths and threats to validity?</td>
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<td>Discuss applicability of the study findings to patient population or context at hand?</td>
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<td>Consider health policy implications of findings (e.g. feasibility, cost, harms)?</td>
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<td>Discuss limitations of current evidence?</td>
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<td>Discuss areas of future research?</td>
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