



## Faculty of Medicine Policy

<b>Policy Name:</b>	<b>FPGME Resident Assessment, Promotion, Remediation, Probation, Suspension and Dismissal Policy</b>
<b>Application/Scope:</b>	All Postgraduate Medical Education Residents
<b>Approved (Date):</b>	FEC, 16Jan09; Addendum 11March09; FPGME Executive Nov. 6, 2008
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### BACKGROUND

The training requirements of residency programs define specific competencies attained by residents in accordance with the standards and objectives of the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC).

The processes of resident assessment, progression and promotion are guided by the following principles:

- The assessment is linked to the rotation-specific learning objectives.
- The assessment is criterion-based.
- The process is clear and is uniformly applied.
- The assessment provides informative, accurate and timely feedback to the residents and to the Residency Program Directors.
- The formative assessment information supports ongoing resident development and provides valuable information to instructors in order to design appropriate remediation experiences.
- Summative assessment information obtained from end of rotation assessments support the ongoing learning of residents and assist in confirming that residents have met the required standards and are safe to practice upon completion of their residency training.
- The process ensures fairness, the right of the resident to be heard and to respond within a reasonable period of time.
- All decisions pertaining to the assessment and the potential outcomes for residents **must** be justified and documented in writing.
- It is important that the process for identification of those learners who may be in academic difficulty is timely, transparent and fair.

### DEFINITIONS

**Academic Year** – is the time interval that commences July 1<sup>st</sup> and finishes June 30<sup>th</sup> and constitutes thirteen four-week blocks of training for residents. On occasion, a trainee may be out-of-phase and may have a starting date other than July 1<sup>st</sup> and will be promoted to the next year of training on the anniversary of his/her start date, adjusted on an ongoing basis.

**Anonymous materials** - materials in which the authorship has not been disclosed

**Assessment - Borderline** – is one where the resident is deemed to have passed but there are weaknesses that warrant further attention. This may occur on a rotation assessment (ITER) on a Summary Assessment.

**Assessment - Formative** – is a process that provides information to residents and faculty about how well the resident is progressing in each area being assessed. This information supports the ongoing learning and development for the residents. Furthermore, it may provide diagnostic information regarding the need for remediation.

**Assessment - Mid-Rotation Evaluations**– are interim assessments that occur as close to the mid-point of the rotation as is feasible

**Assessment - Summary** – is a process that is based on multiple information sources on the global performance of the resident over a specified period of time.

**Assessment – Unsatisfactory (Failed)** - is one where the resident has failed to meet the primary goals and objectives of the rotation and the resident is considered to have failed that rotation.

**Block** – is one of thirteen intervals within each year of training. With the exception of the first and last (Block 13), all blocks are four-week intervals of training and are considered equivalent for the purposes of scheduling educational activities for residents.

**CFPC** – College of Family Physicians of Canada

**CMPA** – Canadian Medical Protective Association

**CPSM** – College of Physicians and Surgeons of Manitoba

**Dismissal** – is the termination of the resident's involvement with the training program for reasons of academic and/or general unsuitability.

**FPGME** – Faculty (of Medicine) Postgraduate Medical Education

**Forward Feeding** – is the sharing of summative assessment information about a resident by his/her Residency Program Director with specific faculty for rotations to which the resident is scheduled in the future.

**ITER / ITAR** – In Training Evaluation / Assessment Report

**PARIM** – Professional Association of Residents and Interns of Manitoba

**Probation** – is an interval outside of the scheduled rotations for the resident which is designed to allow specific additional opportunity for a resident to correct areas of clinical, academic or professional deficiency as well as to determine the suitability of the resident for continuation in the Residency Program.

**Probation Agreement** – is a formal document approved by the Associate Dean, PGME detailing the terms, outcomes and specific conditions of a probationary rotation.

**Probation Committee** – is an ad hoc sub-committee of the FPGME Executive Committee struck by the Associate Dean, PGME to deliberate over requests from Residency Program Director(s) to place resident(s) on probation.

**RCPSC** – Royal College of Physicians and Surgeons of Canada

**Remediation** – is an interval of training which is designed to allow specific opportunity for a resident to correct areas of learning deficiency. The remediation interval is outside of the scheduled rotations for the resident.

**Rotation** – is an interval of time, usually consisting of one or more blocks, to which residents are assigned for training. For each rotation there are specific learning objectives. Rotations are usually a minimum of four weeks in duration in order to allow for appropriate resident assessment. There are several allowable exceptions where rotations may be two weeks in duration.

**Rotation - Incomplete** – is a rotation in which the resident has missed more than 25% of the rotational activities for any reason, such as medical illness, conference or holiday.

**Supervisor - Clinical** – is the physician to whom the resident reports during a given interval of time, such as an on-call shift.

**Supervisor - Rotation** – is a member of the teaching faculty who has direct responsibility for the resident's academic program activities, such as meeting the specific learning objectives and competencies during the rotation.

**Suspension** – is the temporary removal of a resident from clinical and academic activities.

**Trigger event** - is any event that sets a course of action in motion. Previous decisions are revisited and new needs are recognized. With respect to resident training and assessment, the trigger event may involve unsatisfactory performance or failure to attain the necessary clinical, academic or professional goals and objectives. This may lead to a series of actions, including Remediation, Probation or Dismissal of the resident.

**WRHA** – Winnipeg Regional Health Authority

**Working Days** – shall be counted as Monday to Friday days only and will exclude weekend days, statutory days and acknowledged University of Manitoba closure days.

## **1. PURPOSE**

- 1.1 Outline the policies and procedures for the fair and transparent assessment, progression and promotion of postgraduate learners.
- 1.2 Outline the policies and procedures for managing postgraduate learners with areas of deficiency in their training. The policies and procedures will include the following and are illustrated in the process flow chart in **Appendix 1**:
  - 1.2.1 Remediation
  - 1.2.2 Probation
  - 1.2.3 Suspension
  - 1.2.4 Dismissal

## 2. STATEMENT OF POLICY – ASSESSMENT

- 2.1 For all Residency Programs, there must be a clear statement outlining the goals and the educational objectives for the residents.
- 2.2 There must be clearly-defined rotation-specific objectives as follows:
  - 2.2.1 The objectives must cover the CanMEDS competencies for specialty programs.
  - 2.2.2 The objectives must cover the CanMEDS-FM competencies and must be consistent with the CFPC Triple C Curriculum for Family Medicine.
  - 2.2.3 The educational objectives must be reflected in the assessment of residents.
  - 2.2.4 The current goals and objectives for the Residency Program must be distributed to all residents and faculty prior to the beginning of the rotation.
  - 2.2.5 The statement of goals and objectives must be reviewed regularly (at least every two years) by the Residency Program Director and the Residency Program Committee.
- 2.3 For all Residency Programs, the residents must receive regular and timely feedback on their performance and progress by means of the use of appropriate written and performance-based assessment as well as by direct observation.
  - 2.3.1 No anonymous materials may be used in any evaluative or disciplinary proceeding or action involving a resident. The Dean or Associate Dean, PGME may inquire or investigate into matters raised by anonymous materials.
- 2.4 Resident assessment must comply with the following:
  - 2.4.1 Assessment must occur on a regular basis as follows:
    - 2.4.1.1 Mid-rotation assessment is very important as it is intended to be formative to guide the resident toward successful completion of the rotation. As such, it is **not** subject to appeal.
    - 2.4.1.2 End-of-rotation assessment must occur with the resident on a face-to face basis **and** the assessment must be documented in writing/online (see 2.5).
    - 2.4.1.3 End of the Year and other Summary Assessment (see 2.6)
  - 2.4.2 Assessment must be timely
  - 2.4.3 The assessment must meet the specific requirements of the Residency Program
  - 2.4.4 The assessment must be appropriate for the competency being assessed

- 2.4.5 Assessment must be based on the rotation-specific goals and objectives
- 2.4.6 The assessment process must include identification of the expected level of resident performance
- 2.5 All Residency Programs must have formal written/online mid-rotation and end-of-rotation forms (ITER) for resident assessment. Guidelines for minimum standards for ITERs are included in **Appendix 2 and two sample ITERs follows**. The forms must comply with the following:
  - 2.5.1 Approved by the Residency Program Committee
  - 2.5.2 Include assessment of the rotation-specific goals and objectives
  - 2.5.3 Available to all residents prior to commencement of the rotation
  - 2.5.4 Include a clear indication of the performance of the residents
  - 2.5.5 Include space for the resident to sign the assessment and to write comments
- 2.6 At least once every academic year, the Residency Program Director or designate must complete a written/online summary assessment for each resident in the Residency Program and must discuss it with the resident at a face-to-face meeting.
- 2.7 Assessments are the property of the resident and the University of Manitoba and will be kept confidential unless patient safety could be compromised in the process.
  - 2.7.1 The Residency Program Committee will make a decision regarding the benefit to the resident of Forward Feeding to Rotation Supervisors of future rotations, the areas of deficiency requiring improvement.

### **3. PROCEDURES – ASSESSMENT**

- 3.1 **Prior to** commencement of the rotation, the following procedures apply:
  - 3.1.1 The resident must be provided with and must review information from his/her Residency Home Program that clearly outlines the goals and objectives and the assessment processes for the rotation.
  - 3.1.2 The resident should meet face-to-face with the Rotation Supervisor and review the goals and objectives, clinical, academic and professional expectations and duties for the rotation.
- 3.2 At the **mid-point** of the rotation, the following procedures apply:

- 3.2.1 For all rotations of less than six weeks in duration, a face-to-face discussion by the Rotation Supervisor with the resident is acceptable, unless there is **borderline** or **unsatisfactory** performance.
- 3.2.2 For all rotations of at least six weeks in duration, the Rotation Supervisor must complete a written/online mid-rotation report. The report must be discussed at a timely face-to-face meeting with the resident.
- 3.2.3 For residents considered to have **borderline** or **unsatisfactory** performance, regardless of the duration of the rotation, the Rotation Supervisor must complete a written/online mid-rotation report **and** must discuss it at a face-to-face meeting with the resident.
  - 3.2.3.1 The report must clearly state that the resident's performance is **borderline** or **unsatisfactory** and must outline the specific areas of deficiency that require improvement by the completion of the rotation.
  - 3.2.3.2 The resident must sign each assessment report as verification that he/she has read it. The signature implies neither agreement nor acceptance on the part of the resident.

3.3 At the **completion** of the rotation, the following procedures apply:

- 3.3.1 The Rotation Supervisor must complete a written/online assessment report (ITER) which must be available to the resident within ten working days of the last day of the rotation.
  - 3.3.1.1 The resident must sign each assessment report as verification that he/she has read it. The signature implies neither agreement nor acceptance on the part of the resident.
  - 3.3.1.2 The resident is free to add any comments to the report.
  - 3.3.1.3 Failure to sign the report is considered unprofessional conduct.
  - 3.3.1.4 The resident may decide to appeal the assessment (see Resident Appeals Policy; Faculty of Medicine, Student Appeals Policy; University of Manitoba, Senate Appeals Policy).
- 3.3.2 For the resident whose overall performance meets or exceeds the expectations of the rotation, the Rotation Supervisor must discuss the assessment report at a face-to-face meeting with the resident, preferably prior to the last day of the rotation.
- 3.3.3 For any resident whose overall performance is **borderline** or **unsatisfactory**, the Rotation Supervisor **and** the Home Residency Program Director or Stream Director for Family Medicine residency programs, must discuss the assessment report at a face-to-face meeting with the resident, ideally, within ten working days of the last

day of the rotation, or as soon after. Where Stream Leads are based in distributed sites, teleconference (phone or videoconferencing) is equivalent to the face-to-face meeting.

3.4 For **Incomplete Rotations**, the following procedures apply:

3.4.1 Should a resident fail to complete seventy-five per cent of a rotation, then the Rotation Supervisor and/or Residency Program Director must record this as an incomplete rotation on the rotation assessment.

3.4.2 In order to receive credit on the rotation the resident must complete a supplementary rotation and must meet all of the goals and objectives of the rotation, taking both the original incomplete and the supplementary rotation credits into account.

3.4.2.1 The exact nature and duration of a supplementary rotation may vary depending on the nature of the original rotation and the proportion missed, but shall not exceed the duration of the original rotation. This will be determined by the Rotation Supervisor and the Residency Program Director.

3.4.2.2 If a resident completes a supplementary rotation and passes, then he/she will receive credit for a pass on one rotation.

3.4.2.3 If the resident's assessment is **borderline** or **unsatisfactory** on the combination of the incomplete and supplementary rotations taken as a whole, then this will be considered to be the equivalent of a **borderline** or **unsatisfactory** assessment on the original rotation.

3.5 In the case of an assessment that indicates unsatisfactory resident performance and the Residency Program Director considers there to be a clinical, academic or professional deficiency of a particularly serious nature, then the Residency Program Director must consult the Associate Dean, PGME for advice with respect to considering Probation (see Section **8** and Section **9**).

3.6 For **Summary Assessments** (End of Year and other), the following procedures apply:

3.6.1 The Summary Assessments are global and are based on multiple sources as follows:

3.6.1.1 Rotation assessments

3.6.1.2 Feedback from health care team members, patients and families

3.6.1.3 In-training and other examination results

3.6.2 The Summary Assessments must include the resident's strengths, weaknesses and opportunities for improvement.

- 3.6.3 The Summary Assessments may conclude that a resident's performance is **borderline** or **unsatisfactory** despite the absence of similar outcomes on individual rotation assessments.
- 3.6.4 The Residency Program Director must complete the Summary Assessment report as a written/online document for each resident in the Residency Program **and** must discuss the report with each resident at a face-to-face meeting.
  - 3.6.4.1 The resident must sign each Summary Assessment report as verification that he/she has read it. The signature implies neither agreement nor acceptance on the part of the resident.
  - 3.6.4.2 The resident is free to add any comments to the report.
  - 3.6.4.3 Failure to sign the report is considered unprofessional conduct.
  - 3.6.4.4 The resident may decide to appeal the assessment (see Resident Appeals Policy; Faculty of Medicine, Student Appeals Policy; University of Manitoba, Senate Appeals Policy).
- 3.6.5 In the case of an **unsatisfactory** Summary Assessment and the Residency Program Director considers there to be a clinical, academic or professional deficiency of a particularly serious nature, then the Residency Program Director must consult the Associate Dean, PGME for advice with respect to considering Probation (see Section **8** and Section **9**).

3.7 For **Borderline Assessments**, the following procedures apply:

- 3.7.1 While a single **borderline** assessment is not in and of itself a failure, the Residency Program Director may decide that **Remediation** is the most appropriate option.
- 3.7.2 Two **borderline** assessments must be considered equivalent to an **unsatisfactory** assessment. This situation constitutes grounds for **Remediation**.
- 3.7.3 Two **borderline** assessments will be considered equivalent to an **unsatisfactory** assessment for the purpose of calculating the maximum of three **unsatisfactory** assessments.

3.8 For **Unsatisfactory Assessments**, the following procedures apply:

- 3.8.1 In the event of an **unsatisfactory** assessment on a rotation, the Rotation Supervisor will immediately inform the Home Residency Program Director that the resident has **failed** the rotation.
- 3.8.2 The Residency Program Director and Rotation Supervisor must discuss the assessment at a face-to-face meeting with the resident within ten working days of the last day of the rotation.



- 3.8.3 The Residency Program Director must inform the resident that he/she will require **Remediation** in light of the assessment.
- 3.8.4 The Residency Program Director must submit a written/e-mail request for **Remediation** to the Associate Dean, PGME within five working days of receiving notification of the assessment by the Rotation Supervisor.

#### 4. STATEMENT OF POLICY – PROMOTION

- 4.1 A resident shall be promoted from one to the next level of training when he/she has overall met expectations with respect to assessment for **all** rotations and Summary Assessments for the preceding academic year.
- 4.2 Time spent in **Remediation** may or may not be counted toward the total of the thirteen blocks comprising the year of training (see **Appendix 4: Remediation Contract**).
- 4.3 Time spent on **Probation** is not counted toward the total of the thirteen blocks comprising the year of training (see **Appendix 5: Probation Contract**).

#### 5. PROCEDURES – PROMOTION

- 5.1 The Residency Program Director in discussion with the Residency Program Committee must approve all promotions of residents in the Residency Program.
- 5.2 The Residency Program Director must submit on behalf of each resident, a signed **Notice of Renewal/Change form (Appendix 2)** for signed approval by the Associate Dean, PGME.
  - 5.2.1 Any changes in the resident's starting date for the next year of training must be documented.
- 5.3 For a resident in his/her final year of training who is expected to successfully complete the Residency Program, the completed and signed **Final In-Training Evaluation Report (FITER)** must be submitted for signed approval by the Associate Dean, PGME.

#### 6. STATEMENT OF POLICY – REMEDIATION

- 6.1 Remediation is generally considered a learning opportunity for the resident to correct a deficiency related to clinical, academic or professional competencies or objectives.
- 6.2 A resident is required to undergo a remedial rotation on the basis of one or more of the following:
  - 6.2.1 One **unsatisfactory** rotation assessment

- 6.2.2 Two **borderline** rotation assessments
- 6.2.3 A pattern of consistent deficiency or weakness resulting in an **unsatisfactory** Summary Assessment
- 6.2.4 A failing grade on an in-training examination
- 6.3 The duration of a Remediation must not exceed the length of the failed rotation.
- 6.4 The duration of a Remediation must not be less than one-half the length of the failed rotation or four weeks.
- 6.5 The Associate Dean, PGME must approve all Remediation Plans prior to commencement of the Remediation rotation.

## 7. PROCEDURES – REMEDIATION

- 7.1 The Residency Program Director must submit a formal request for Remediation to the Associate Dean, PGME with a copy to the resident, within five working days of the notification to the Program Director of the “trigger event” for the Remediation. The reason(s) for the request for Remediation must be included in the submission.
- 7.2 The Residency Program Director must submit a formal **Remediation Plan** to the Associate Dean, PGME within fifteen working days of the notification to the Program Director of the occurrence of the “trigger event” for the Remediation. An extension of this timeline may be allowed, upon request to the Associate Dean PGME in cases of marked complexity. The Remediation Plan must include the following:
  - 7.2.1 Description of the deficiencies
  - 7.2.2 The specific resources being offered and deployed for correcting the deficiencies
  - 7.2.3 Duration of the Remediation rotation (see 6.3 and 6.4)
  - 7.2.4 Potential outcomes
  - 7.2.5 Remediation Supervisor, who is one of the following:
    - 7.2.5.1 One of the Residency Program faculty
    - 7.2.5.2 Not the Rotation Supervisor
    - 7.2.5.3 Not administratively involved in the sequence of events that led to the Remediation

- 7.3 The formal Remediation Plan must be detailed in conformity with the **Remediation Agreement Document** of the University of Manitoba, Faculty of Medicine and must be signed by the resident, Residency Program Director, Remediation Supervisor and Associate Dean, PGME (see 6.5).
- 7.4 A rotation assessment will be completed for the Remediation rotation (see 3.2 and 3.3)
- 7.5 If the resident passes the Remediation rotation, then he/she subsequently returns to his/her regularly scheduled rotations in the Residency Program.
- 7.5.1 The time spent during Remediation is usually **not** credited toward the final requirements of training
- 7.5.2 The Associate Dean, PGME will exercise discretion in determining whether the Remediation is credited in accordance with the requirements of the RCPSC and CFPC.
- 7.6 If the resident does **not** pass the Remediation rotation, then the Residency Program Director will recommend to the Associate Dean, PGME, one of the following:
- 7.6.1 An additional Remediation rotation
- 7.6.2 A Probation rotation
- 7.6.3 Dismissal from the Residency Program
- 7.7 The Associate Dean, PGME will consider the recommendations of the Residency Program Director and prior to approval will ensure that all policies and procedures have been followed.

## 8. STATEMENT OF POLICY – PROBATION

- 8.1 A resident may be required to undergo Probation on the basis of one or more of the following:
- 8.1.1 One **unsatisfactory** Remediation rotation assessment
- 8.1.2 One **unsatisfactory** regular rotation assessment, if the clinical, academic or professional deficiency is considered by the **Probation Committee** to be of sufficient gravity to warrant immediate Probation
- 8.1.3 Two **borderline** rotation assessments, if the clinical, academic, or professional deficiency is considered by the **Probation Committee** to warrant immediate Probation

- 8.1.4 A failing grade on an in-training examination, if the deficiency is considered by the **Probation Committee** to be of sufficient gravity to warrant immediate Probation
  - 8.1.5 One **unsatisfactory** Summary Assessment, if the clinical, academic or professional deficiency is considered by the **Probation Committee** to warrant immediate Probation
  - 8.1.6 The occurrence of a clinical, academic or professional event or incident that indicates a deficiency considered by the **Probation Committee** to be either non-remediable or of sufficient gravity to warrant immediate Probation
- 8.2 The duration of a Probation rotation will be at least four weeks or one-half of the duration of the failed rotation, whichever is longer.
- 8.3 The duration of the Probation rotation will not exceed twelve weeks or the duration of the failed rotation, whichever is shorter.
- 8.4 The Associate Dean, PGME must approve all Probation Plans prior to the commencement of the Probation rotation.

## 9. PROCEDURES – PROBATION

- 9.1 The Residency Program Director, in consultation with the Residency Program Committee must submit a formal request for Probation to the Associate Dean, PGME with a copy to the resident within five working days of the notification to the Program Director of the occurrence of the “trigger event” for the Probation. The reason(s) for the request must be included in the submission.
- 9.2 The Associate Dean, PGME will convene a **Probation Committee** within ten working days of the request for Probation.
- 9.3 With respect to the **Probation Committee**, the following apply:
- 9.3.1 Membership includes the following:
    - 9.3.1.1 Chair - a Residency Program Director from a Program that has not had supervisory involvement with the resident
    - 9.3.1.2 Two Faculty Representatives
      - 9.3.1.2.1 One member from the Home Residency Program of the resident facing Probation and who has not had a supervisory relationship with the resident
      - 9.3.1.2.2 One member from an external department and who has not had a supervisory relationship with the resident

- 9.3.1.3 One Resident Representative – a resident from another Residency Program who does not have a working relationship with the resident facing Probation
- 9.3.2 The Committee must be appointed by the Associate Dean, PGME within ten working days of the request for Probation or Dismissal by a Residency Program Director.
- 9.3.3 The Committee will meet at the call of the Chair within five working days of the receipt of the request for Probation or Dismissal **and** Probation Plan (if applicable) from the Residency Program Director. At the meeting, the following will occur:
  - 9.3.3.1 The Residency Program Director, the resident facing possible Probation Dismissal, and any other witnesses deemed by the Chair to be relevant and appropriate will be interviewed.
    - 9.3.3.1.1 The resident is entitled to representation by a Student Advocate.
    - 9.3.3.1.2 The resident and the faculty, and/or their respective representatives excluding legal counsel, shall have the right to call, hear and cross-examine witnesses, to submit other evidence, and to have access to all documents submitted for consideration. Written notice to call any witness shall be given to the other party prior to the meeting.
    - 9.3.3.1.3 The resident is entitled to be present during the interview of the Residency Program Director and other witnesses.
    - 9.3.3.1.4 Lawyers may attend as observers only and may not speak on behalf of the resident or interrogate witnesses.
  - 9.3.3.2 The grounds for Probation or Dismissal will be reviewed
  - 9.3.3.3 The Committee is expected to review all germane resident file materials, including assessments.
    - 9.3.3.3.1 The resident may request the Chair to arrange for other documents to be provided. The Chair will arrange for such documents to be provided if they are deemed by the Chair to be relevant and required for the resident to receive a fair hearing before the Committee.
  - 9.3.3.4 The Committee may seek input as needed in order to recommend to the Associate Dean, PGME one of the following actions:
    - 9.3.3.4.1 Re-instatement without further intervention
    - 9.3.3.4.2 Remediation without Probation

9.3.3.4.3 Probation

9.3.3.4.4 Dismissal

9.3.4 If the Probation Committee upholds a request to proceed with Probation, then at the same meeting the **Probation Plan** will be reviewed and the Committee will approve it as written or may modify it as necessary, and the final **Probation Plan** will be submitted to the Residency Program Director and to the Associate Dean, PGME (see 9.4).

9.3.5 During the **Probation Rotation**, the following apply:

9.3.5.1 The Probation Supervisor will provide interim reports to the Chair of the Probation Committee as stipulated in the Probation Agreement.

9.3.5.2 The Chair will share the interim assessments with other Committee members, as necessary

9.3.5.3 At the completion of the Probation rotation, the Committee will again meet to review the assessments and to recommend to the Associate Dean, PGME one of the following:

9.3.5.3.1 Re-instatement

9.3.5.3.2 Extension of the Probation with specification of deficiencies remaining to be addressed and specific plans for resolution

9.3.5.3.3 Dismissal

9.3.6 The resident involved must receive a copy of all documentary evidence.

9.4 The Residency Program Director must submit a copy of the request for Probation along with a formal **Probation Plan** to the Chair of the Probation Committee within 15 working days of the notification to the Program Director of the occurrence of the “trigger event”. This Plan must include the following:

9.4.1 Description of the deficiencies

9.4.2 Specific resources available for correcting the deficiencies

9.4.3 Duration of the Probation rotation (see 8.2 and 8.3)

9.4.4 Potential outcomes

9.4.5 Probation Supervisor, who is one of the following:

9.4.5.1 One of the Residency Program faculty

9.4.5.2 Not a Rotation Supervisor

9.4.5.3 Not administratively involved in the sequence of events that led to the Probation

9.5 A Probation rotation, including nature and content will be determined by the Residency Program Director and the Probation Committee and detailed in the **Probation Agreement Document** and will include the following:

9.5.1 Goals and objectives

9.5.2 Resources identified to achieve the goals and objectives

9.6 The formal Probation Plan must be detailed using the **Probation Agreement Document** of the University of Manitoba, Faculty of Medicine and signed by the resident, Residency Program Director, Probation Supervisor and Chair of the Probation Committee.

9.7 The Associate Dean, PGME may change any element of the Probation Plan after consulting with the Probation Committee, to ensure that all policies and procedures have been followed (see 8.4).

9.8 A rotation assessment will be completed for the Probation rotation (see 3.2 and 3.3).

9.9 If the resident passes the Probation rotation assessment, then he/she subsequently returns to his/her regularly scheduled rotations in the Residency Program.

9.9.1 The time spent during the Probation rotation is not credited toward the final requirements of training and the total training interval is adjusted accordingly.

9.10 If the resident does **not** pass the Probation rotation assessment, then the Probation Committee, in consultation with the Residency Program Director, will recommend one of the following outcomes:

9.10.1 Pass – Return to Training

9.10.2 An extended Probation rotation

9.10.3 Dismissal

9.11 The Associate Dean, PGME will review the recommendations of the Probation Committee to ensure that all policies and procedures have been followed.

9.12 The decision to place a resident on Probation may be appealed as an academic appeal per the **Faculty Appeals Policy**.

## 10. STATEMENT OF POLICY – SUSPENSION

10.1 Suspension of a resident may be imposed as an interim measure for determination of the best definitive course of action in the following circumstances:

10.1.1 There is a breach of the policies, by-laws or Codes of Conduct of and/or suspension of clinical privileges by one or more of the following:

10.1.1.1 University of Manitoba

10.1.1.2 WRHA

10.1.1.3 CPSM

10.1.2 There is reasonable suspicion of improper conduct of such a nature that the continued presence of the resident in the Residency Program would pose a threat to the well-being of the patients, colleagues, students, staff and/or the resident him/herself.

10.1.3 There is reasonable suspicion of improper conduct of such a nature that the continued presence of the resident in the Residency Program would pose a threat to University of Manitoba, WRHA or other property.

10.1.4 Failure of the resident to agree to a Remediation Plan or a Probation Plan.

10.2 When a resident is placed on **Suspension**, the following principles apply:

10.2.1 Licensure and registration with CPSM are suspended.

10.2.2 Payment through WRHA may be suspended.

10.2.3 Medical malpractice coverage (CMPA) may be suspended.

## 11. PROCEDURES – SUSPENSION

11.1 In the event of a circumstance warranting **Suspension**, the Residency Program must immediately inform the Department Head **and** the Associate Dean, PGME in writing, indicating the following:

11.1.1 The inciting circumstances leading to the Suspension

11.1.2 The request for the resident's interim Suspension pending determination of the appropriate course of action

11.2 The Residency Program Director must inform the resident immediately in writing of a request for Suspension.



11.3 The resident should be provided the opportunity of a face-to-face meeting with the Residency Program Director to discuss the following:

11.3.1 The reasons for the Suspension

11.3.2 Expected duration of the Suspension

11.3.3 Expected outcomes of the Suspension

11.4 The request for resident Suspension must be reviewed by the Associate Dean, PGME, who determines the course of action as follows:

11.4.1 Denial of the request for Suspension

11.4.2 Affirmation of the Suspension on an interim basis pending further investigation (see 11.5)

11.4.3 Recommendation of proceeding directly to Remediation, Probation or Dismissal

11.5 Where a Suspension is affirmed, the Associate Dean, PGME will conduct an investigation into the matters of concern that led to the Suspension within ten working days of the commencement of the Suspension **and** thereafter will make a final decision on how the matters should be addressed.

11.6 When a resident is placed on or taken off Suspension, the FPGME Office must ensure the following:

11.6.1 Notification of CPSM regarding licensure and registration

11.6.2 Notification of WRHA regarding payment and medical malpractice coverage (CMPA)

11.6.3 Notification of PARIM in writing that a resident has been suspended within 24 hours of such suspension.

11.7 The resident may appeal the decision for Suspension as an academic appeal per the **Faculty Appeals Policy**.

11.8 The University of Manitoba has the authority to implement a **Disciplinary Suspension** in accordance with the **Student Discipline By-Law**.

## 12. STATEMENT OF POLICY – DISMISSAL

12.1 Grounds for Dismissal of a resident from the Residency Program may include reasons of academic and/or general unsuitability for practice.

12.1.1 Academic

12.1.1.1 A resident will be dismissed after **unsatisfactory** (failing) assessments on any three rotations over the course of his/her Residency Program. Typically, these would be **unsatisfactory** assessments on a rotation and the subsequent Remediation and Probation, **but** it could also include any combination of regular rotations and Remediation rotations.

An example: A resident who passes two separate Remediation rotation assessments after two separate **unsatisfactory** regular rotation assessments will still face the possibility of Dismissal upon a third new **unsatisfactory** regular rotation assessment (also see 3.7.2 and 3.7.3 regarding **borderline** assessment and **unsatisfactory** assessment equivalency).

#### 12.1.2 Unsuitability for Practice

12.1.2.1 This may be on the basis of behavior that would be considered inconsistent with reasonable standards of professionalism, ethics, competence and judgment in conformity with any **Professional Unsuitability By-Law** adopted by the University of Manitoba, Faculty of Medicine and the professional and ethical standards of the CPSM.

### 13. PROCEDURES – DISMISSAL

13.1 The Residency Program Director, after consultation with the Residency Program Committee must submit a written/ e-mail request for Dismissal to the Associate Dean, PGME within five working days of the notification to the Program Director of the occurrence of the “trigger event “for the Dismissal, including the following:

13.1.1 Reason(s) for the request

13.1.2 A copy of the request must be sent to the resident

13.2 The Associate Dean, PGME must appoint a **Probation Committee** within five working days of the request for Dismissal (see 9.2 and 9.3)

13.3 The Probation Committee will meet within ten working days of the request for Dismissal to determine whether Dismissal is warranted or if another course of action is indicated (see 9.3.3.5).

13.4 If the Probation Committee upholds the request for Dismissal, then the Chair of the Committee informs the Associate Dean, PGME immediately, in writing.

13.5 The Associate Dean, PGME presents the decision regarding Dismissal at the FPGME Executive Committee for final review.

13.5.1 If the FPGME Executive Committee upholds the decision, then the resident will be dismissed from all further postgraduate training at the University of Manitoba.

13.6 When a resident is dismissed from Postgraduate training, the FPGME Office must ensure the following:

13.6.1 Notification of CPSM regarding licensure and registration

13.6.2 Notification of WRHA regarding payment and medical malpractice coverage (i.e. CMPA).

13.6.3 Notification of PARIM in writing that a resident has been dismissed within 24 hours of such dismissal.

13.7 The decision for Dismissal may be appealed as an academic appeal per the **Faculty Appeals Policy** and the University of Manitoba **Senate Committee on Appeals**.

**POLICY CONTACT:** Associate Dean, PGME

## REFERENCES

College of Family Physicians, Triple C Curriculum

[http://www.cfpc.ca/Triple\\_C/](http://www.cfpc.ca/Triple_C/)

Royal College of Physicians & Surgeons, General Standards of Accreditation, The Descriptors Document, January 2011 / Editorial Revision July 2012

[http://www.royalcollege.ca/portal/page/portal/rc/common/documents/accreditation/accreditation\\_b\\_lue\\_book\\_b\\_descriptors\\_e.pdf](http://www.royalcollege.ca/portal/page/portal/rc/common/documents/accreditation/accreditation_b_lue_book_b_descriptors_e.pdf)

University of Manitoba, Governing Documents: Senate Appeals Policy and Procedure

[http://umanitoba.ca/admin/governance/governing\\_documents/students/senate\\_committee\\_on\\_appeals\\_policy.html](http://umanitoba.ca/admin/governance/governing_documents/students/senate_committee_on_appeals_policy.html)

[http://umanitoba.ca/admin/governance/governing\\_documents/students/senate\\_committee\\_on\\_appeals\\_procedures.html](http://umanitoba.ca/admin/governance/governing_documents/students/senate_committee_on_appeals_procedures.html)

University of Manitoba, Faculty of Medicine, Student Appeals Policy

[http://umanitoba.ca/faculties/medicine/media/Student\\_Appeals\\_\(final\\_June\\_12\\_2012\).pdf](http://umanitoba.ca/faculties/medicine/media/Student_Appeals_(final_June_12_2012).pdf)

[http://umanitoba.ca/faculties/medicine/media/Appeal\\_Form\(1\).pdf](http://umanitoba.ca/faculties/medicine/media/Appeal_Form(1).pdf)

University of Manitoba, Faculty of Medicine, PGME Resident Appeals Policy; Draft, July 2013

Link to be noted when on PGME website:

University of Manitoba, Faculty of Medicine, PGME Forward Feeding Policy, Draft, July 2013

Link to be noted when on PGME website:

University of Toronto, Postgraduate Medical Education, PGME Minimum Standards for Resident in Training Evaluation Reports (ITERS), PGMEAC April 27, 2012

## APPENDICES

**Appendix 1:** PGME Assessment, Remediation, Probation Flow Chart

**Appendix 2:** PGME Minimum Standards for Resident in Training Evaluation Reports (ITERS); two sample ITER forms

**Appendix 3:** PGME Renewal Change Form

Link to Form:

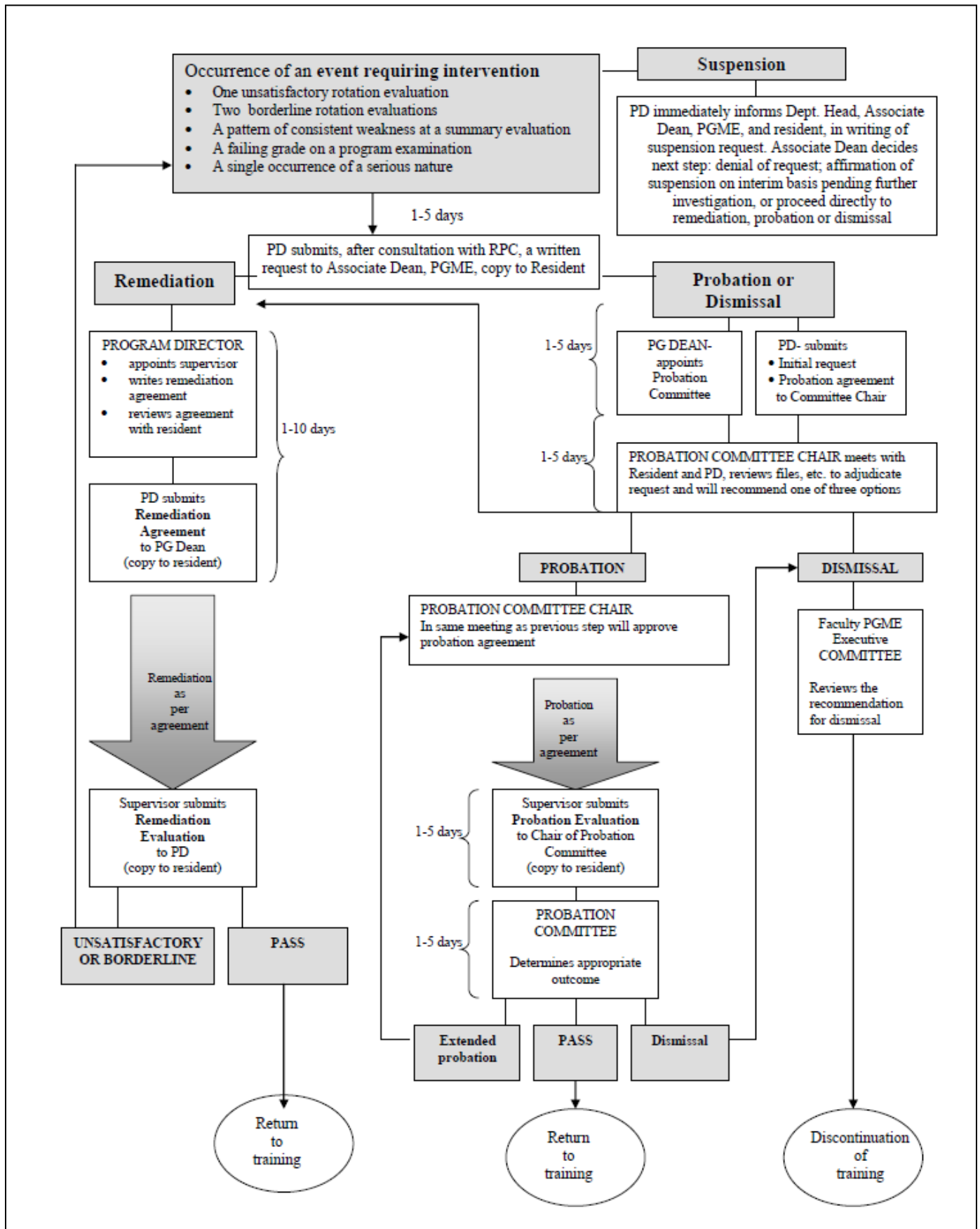
**Appendix 4:** PGME Remediation Agreement Template

Link to Template

**Appendix 5:** PGME Probation Agreement Template

Link to Template

## Appendix 1: PGME Assessment, Remediation, Probation Flow Chart



## Appendix 2: PGME Minimum Standards for Resident in Training Evaluation Reports (ITERS)

### PGME MINIMUM STANDARDS FOR RESIDENT IN-TRAINING EVALUATION REPORTS

(Source: University of Toronto, Postgraduate Medical Education, PGME Minimum Standards for Resident in Training Evaluation Reports (ITERS), PGMEAC April 27, 2012)

1. ITERS must be integrated as one assessment method within the residency program's in-training evaluation system which must:
  - a. Be based on the goals and objectives
  - b. Clearly identify the methods by which residents are to be evaluated, and
  - c. Clearly identify the level of performance expected of residents in the achievement of these objectives (General Standards B6.1, July 2012)
  
2. ITERS should:
  - a. Be of reasonable length
  - b. Reflect an explicit and integrated mapping of:
    - i. Rotation specific goals and objectives
    - ii. Different practice contexts (i.e. patient populations, clinical/practice, settings)
    - iii. Graded responsibility (i.e. appropriate varying expectations between years of training and/or development from junior to senior trainees)
    - iv. Allow some flexibility to incorporate program and environment specific design
  
3. All ratings questions will be on a 5 point scale (3 point scale for Family Medicine) with appropriate anchors. The anchors will be designed such that :
  - a. The anchor equivalent to value 1 will be the lowest or worst ranking
  - b. The anchor equivalent to value 5 will be the highest or best ranking
  - c. A rating of 3 or more is a pass (i.e. less than 3 is a failure for that item)
  
4. All forms will have 1 question that serves as the overall global performance question.
  - a. This question will be rated on a 5 point scale with 1 being the lowest or worst ranking and 5 being the highest or best ranking) that follows the rules set out in point #1 above; for Family Medicine, will be "Pass-Borderline Pass-Fail- Incomplete"
  - b. This question will stand alone from other general performance questions and be considered the definitive score for global evaluation
  - c. A rating of less than 3 is a failure of that experience.
  
5. ITER forms should be coded with questions pertaining to the CanMEDs roles
  - a. Each CanMEDs role should appear on at least 1 ITER form in your Program per training level.

#### NOTES:

- It is important to have as many ITERS completed/multiple raters to increase reliability of ratings. When designing ITERS consider that faculty are more likely to complete a form that will take 3-5 minutes than a longer form.
  
- Non-ratings questions would include questions such as the number of procedures performed, yes/no questions and all others where the user is not asked to rate or evaluate using a set of values and anchors

## 2 SAMPLE ITER FORMS: Emergency Medicine & Family Medicine

**UNIVERSITY OF MANITOBA - FACULTY OF MEDICINE  
ROYAL COLLEGE EMERGENCY MEDICINE TRAINING PROGRAM  
In-Training Evaluation Report**

(Type or print, and score appropriately)

NAME OF RESIDENT:

ROTATION:

PERIOD(S):

DATES:

HOSPITAL:

PROGRAM DIRECTOR: Dr. Wes Palatnick

Evaluation Codes: 1 - Unsatisfactory, 2 - Below Average, 3 - Average/Good, 4 - Above Average, 5 - Outstanding

**CRITERIA:**

1. COMMUNICATOR:	N/A	1	2	3	4	5
1. Can consistently present history and physical findings to the attending physician in an organized manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Charts are legible, focused and contain all pertinent information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Can provide other staff, patients and family with a clear discussion of the diagnosis, treatment plan and follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. MEDICAL EXPERT:</b>						
<b>A) Knowledge</b>						
1. Basic science.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Clinical judgement and decision-making.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Basic knowledge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Emergency Medicine literature.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B) Skills</b>						
1. Physical Exam.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Choice, use and interpretation of investigations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Procedural skills in Emergency Medicine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Resuscitation skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Able to formulate an appropriate differential diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Able to arrive at a reasonable working or final diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. COLLABORATOR:</b>						
1. Works effectively with all members of the health care team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Maintains a high quality professional relationship with patients and/or family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is aware of the cost of health care services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. MANAGER:</b>						
1. Uses time effectively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Keeps the Emergency Department organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Prioritizes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Supervises others well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. SCHOLAR:</b>						
1. Identifies gaps in knowledge and expertise and works to correct them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Uses the medical literature in clinical practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Teaches others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE SEE REVERSE SIDE**

6. PROFESSIONAL:	N/A	1	2	3	4	5
1. Has a good sense of responsibility.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Motivation and ability to learn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Dependability/punctuality.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Behaves in a professional manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Deals with ethical issues such as truth-telling, confidentiality and end of life care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. HEALTH ADVOCATE:	N/A	1	2	3	4	5
1. Considers the social determinants resulting in ED presentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Acts as a patient advocate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Able to balance effectively the reasonable needs of the individual patient with available resources and the need for the department to run effectively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**BASIS FOR ASSESSMENT**

1. Assessment was based on contact with: a) one physician \_\_\_\_\_ b) a group of physicians \_\_\_\_\_

2. Contact time - estimated contact time between trainee and Attending Physician(s).

Weeks \_\_\_\_\_ Hours \_\_\_\_\_ Shifts \_\_\_\_\_

3. Estimate number of trainee's:  
a) Records reviewed \_\_\_\_\_  
b) Histories reviewed \_\_\_\_\_  
c) Examinations witnessed \_\_\_\_\_

4. Do you consider that this resident has successfully completed the objectives of this rotation?  
YES  NO

5. Was this evaluation discussed with the resident? YES  NO

**COMMENTS** (Please write or type clearly)

**STRENGTHS:** \_\_\_\_\_  
\_\_\_\_\_

**WEAKNESSES:** \_\_\_\_\_  
\_\_\_\_\_

**RECOMMENDATIONS:** \_\_\_\_\_

**OTHER COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
Evaluator's Signature Title


\_\_\_\_\_  
Please print name Date

**TRAINEE'S ATTESTATION:** I HAVE SEEN THIS REPORT, AND I : ACCEPT IT  DO NOT ACCEPT IT

\_\_\_\_\_  
Resident's Signature Date

**PLEASE RETURN COMPLETED FORM TO:** Department of Emergency Medicine, Chris Cowan, Program Asst,  
T258- 770 Bannatyne Avenue, Winnipeg, MB, R3E 0W3



 <p>UNIVERSITY OF MANITOBA</p> <p>DEPARTMENT OF <b>FAMILY MEDICINE</b></p> <p>FACULTY OF MEDICINE</p>	<p><b>In-Training Evaluation Report</b>  <b>Rotation:</b> <u>Family Medicine Block Time</u>  <b>Resident:</b>  <b>Site:</b>  <b>Dates:</b>  <b>Period No:</b></p>
<p><b>Outcome:</b></p> <p><input type="checkbox"/> <b>Pass</b>                      <input type="checkbox"/> <b>Borderline Pass</b>  <input type="checkbox"/> <b>Incomplete</b>            <input type="checkbox"/> <b>Fail</b></p>	<p><b>Type of Evaluation:</b>    <input type="checkbox"/> <b>Mid-Term</b>  <input type="checkbox"/> <b>Final</b></p>
<p>Please fax each resident's ITER separately to:  Winnipeg: 204-977-6917                      Toll Free: 1-866-238-2406</p>	

**Evaluation Criteria**

Family Medicine Expert

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Displays a fund of FM medical knowledge appropriate for level of training				
2. Demonstrates skilled interviewing techniques in gathering clinical data				
3. Demonstrates skilled physical examination techniques in gathering clinical data				
4. Explores both the disease and the patient's personal experience of illness				
5. Generates differential diagnoses that incorporate patient specific findings informed by local considerations (prevalence, community incidence)				
6. Investigates selectively incorporating patient specific contexts then accurately and efficiently interprets results of investigations				
7. Identifies relevant priorities for management and recommends appropriate treatments				
8. Is proficient in performing relevant diagnostic and therapeutic procedures, including obtaining informed consent when necessary				
9. Manages simultaneously multiple clinical issues, both acute and chronic, often in a context of uncertainty				
10. Arranges for appropriate follow-up after clinical encounters				
11. Differentiates between situations that require an urgent response and those in which a "watch & wait" approach is most appropriate				

Family Medicine Block Time

**Communicator**

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Finds common ground with the patient in regard to defining problems and priorities and setting management goals				
2. Establishes positive therapeutic relationships with patients and their families while incorporating racial, cultural, social-economic and gender considerations				
3. Effectively conveys information from and to patients/families, colleagues and other health professionals				
4. Appropriately initiates discussions about difficult issues (e.g., breaking bad news, suitability for driving, end-of-life care)				
5. Communicates clearly and concisely across all domains (charting, letters, reports, transfer of care) and mediums (oral, written, electronic)				

**Collaborator**

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Works as a respectful and functional member of health care teams				
2. Collaborates within a network of health care providers				
3. Participates effectively in inter-professional team meetings				
4. Constructively works towards resolving conflicts				

**Manager**

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Manages time and resources effectively				
2. Selectively initiates referrals considering best evidence, likely benefit to the patient and availability of resources				
3. Completes patient related paperwork effectively and in a timely fashion				

Approved April 17, 2013

2

Family Medicine Block Time

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
4. Adapts to the varied information management systems encountered across educational settings				
5. Attends to the business/financial aspect of medical practice				

Health Advocate

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Advocates for individual patients when their healthcare needs are not being met by the system				
2. Is familiar with and knows how to access community-based resources for patients				
3. Identifies when determinants of health are impacting patients and/or the communities in which they live				
4. Incorporates prevention and health promotion into patient care, through application of current standards for the practice population				
5. Advocates for broader social change to address the determinants of health when opportunities arise				

Scholar

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Critically appraises medical information and applies this to patient care				
2. Effectively teaches others (e.g., other learners, patients/families, other healthcare professionals)				
3. Takes initiative in identifying personal knowledge gaps and in seeking out appropriate sources of information to fill these gaps				
4. Presentations in teaching sessions and/or rounds are well-prepared, clear and concise with appropriate use of technology				

Approved April 17, 2013

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Family Medicine Block Time

Professional

	Novice (Comments needed)	Advanced Beginner	Competent Practitioner	Not Observed
1. Exhibits professional behaviours in practice, including honesty, integrity, reliability, compassion, respect, altruism, commitment to patient well-being and respect for professional boundaries				
2. Recognizes self-limitations and seeks assistance appropriately				
3. Practices in accordance with the principles and limits of patient confidentiality as defined by professional practice standards and the law				
4. Responsibly transfers and receives patient care and information with respect to on-call duties				
5. Is consistently available and responds in a timely fashion when on call				
6. Reliably attends all scheduled activities; in case of unexpected absence, responsibly ensures patient care is transferred appropriately				

Comments:

Please identify specific strengths and areas for development

Approved April 17, 2013

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**Administrative Tracking**

1. Has had adequate exposure to the following aspects of FM inpatient care:  
 Admission    Daily care    Discharge Planning    Discharge Summary
  
2. Has had adequate exposure to the following patient groups:  
 Newborns                       Children                       Adolescents  
 Adults                               Elderly  
 Gynaecology Patients         Prenatal Patients
  
3. Degree to which the resident experienced continuity of care of patients in the office setting:  
 Minimal                       Moderate                       Significant
  
4. Had opportunity to assess and manage patients in the following settings:  
 Phone                       Clinic                       ER  
 Hospital ward               Patient's home               PCH
  
5. Number of days absent from rotation: \_\_\_\_\_
  
6. Completes Field Notes daily  
 80 – 100% of the time     60 – 80% of the time     Less than 60% of the time
  
7. Completes Field Notes  
 Self-initiated               With prompting               With pressure

Needs further learning experiences directed to:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Family Medicine Block Time

Please list the procedures the resident has gained experience with and the highest level of competence reached:

Procedure	Resident Observed	Performed with significant support	Performed with minimal support	Performed Independently

**Overall Evaluation**

- PASS**
- BORDERLINE PASS**
- FAIL (written comments needed; please append letter)**
- INCOMPLETE (written comments needed; please append letter)**

***SUPERVISOR'S COMMENTS:***

**Supervisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**This evaluation has been discussed with the trainee:**    **Yes**       **No**

---

***TRAINEE'S COMMENTS:***

**I agree with this evaluation**                       **I disagree with this evaluation**

**Trainee's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

---

Education Director's Initials:

# Appendix 3: PGME Renewal Change Form



**POSTGRADUATE MEDICAL EDUCATION**



Winnipeg Regional Health Authority  
Office régional de la santé de Winnipeg  
Caring for Health À l'écoute de notre santé

**Renewal  | Change Form**

*Please complete this form for all renewing residents who will be training in your program, and submit to the PGME Office, 260 Brodie. Also use this form for any changes for an existing resident. The PGME Office maintains this documentation as the official confirmation of appointment for training within your program, and will also register the resident with Payroll for the confirmed dates of appointment.*

Date: \_\_\_\_\_ Program Year \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Program: \_\_\_\_\_

Student Number # \_\_\_\_\_ CRN # \_\_\_\_\_ Currently on Leave Yes  No

PGY LEVEL  Dual Registration

Change in PGY level to 

I	II	III	IV	V	VI	VII	VIII
---	----	-----	----	---	----	-----	------

 Effective \_\_\_\_\_

Anticipated Completion of Training Date: \_\_\_\_\_

CHANGE IN ANTICIPATED COMPLETION OF TRAINING DATE  
From: \_\_\_\_\_ To: \_\_\_\_\_

CHANGE IN PROGRAM/STREAM  
From: \_\_\_\_\_ To: \_\_\_\_\_  
Effective: \_\_\_\_\_

CHANGE IN FUNDING  
Funding Source: From: \_\_\_\_\_ To: \_\_\_\_\_  
Effective: \_\_\_\_\_

Program Director Name (please print) \_\_\_\_\_

Dr. Cliff Yaffe, Associate Dean PGME

Program Director Signature \_\_\_\_\_

Date \_\_\_\_\_

CHANGE IN ADDRESS  
\_\_\_\_\_  
\_\_\_\_\_

CHANGE IN EMAIL ADDRESS  
\_\_\_\_\_

CHANGE IN HOME/CELL PHONE  
\_\_\_\_\_

Effective \_\_\_\_\_

PGME Office Only

CPSM  PARIM  MSAS  PGME Master  Aurora Reg