UNIVERSITY OF SASKATCHEWAN
College of Medicine

Policies and Procedures for the Allocation of Ministry Funded Post Graduate Medical Education Training Positions

College of Medicine
University of Saskatchewan

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Rationale:

Postgraduate Medical training positions had historically been allocated to achieve a provincial 60:40 ratio between Royal College of Physicians and Surgeons of Canada (RCPSC) and College of Family Physicians of Canada (CFPC) PGY1 programs – 40% of positions allocated to Family Medicine programs (urban and rural streams) and the remaining 60% distributed across direct entry Royal College programs. Allocation of positions among Royal College programs had largely been based on history and capacity and had not changed much over a number of years.

With the expansion of undergraduate and postgraduate programs and being cognizant of health human resource needs in Saskatchewan, there is a need for a clear approach to decision-making and for transparent allocation of PGY positions for the CaRMS match.

Current Training Programs

CFPC:

1. Family Medicine - Saskatoon
2. Family Medicine – Regina
3. Family Medicine Rural (Prince Albert)
4. Family Medicine Rural (Swift Current)
5. Family Medicine Rural (LaRonge) – pilot 2012
6. Family Medicine / Emergency Medicine (one-year program post Family Medicine)
7. Sites being developed (additional rural sites)

RCPSC:

Those considered core programs:

1. General Surgery
2. Internal Medicine (IM)
3. Obstetrics and Gynecology
4. Pediatrics
5. Psychiatry

Those considered non-core:
1. Anesthesia
2. Diagnostic Radiology
3. Emergency Medicine
4. Neurology (Adult)
5. Neurology (Pediatrics)
6. Neurosurgery
7. Ophthalmology
8. Orthopedic Surgery
9. Pathology (General)
10. Physical Medicine & Rehabilitation
11. Public Health & Preventive Medicine

Subspecialty Entry programs and others include:
1. Cardiology (post core IM)*
2. General Internal Medicine (post core IM)*
3. Nephrology (post core IM)*
4. Respirology (post core IM)*
5. Rheumatology (post core IM)*
6. Neonatal-Perinatal Medicine (post core Pediatrics)
7. Clinician Investigator Program

*Historically, total number of positions based on number of Ministry funded PGY1 entry positions for that cohort

Main Principles:

1. *Reassessment of allocation*: Position allocation should be reviewed on a regular annual basis to facilitate optimal allocation of positions and responsiveness to capacity and health human resource needs. Although the annual review will be primarily directed at allocation for the upcoming academic year, it is recognized that a longer term perspective is helpful and the committee will have the ability to make long range recommendations for position allocation.

2. *Capacity*: Programs should not be required to undertake training of residents in excess of their capacity to provide effective training and supervision. At present the only available capacity measure is an annual questionnaire sent to all programs assessing their self-reported ability and willingness to take on additional trainees. There is no formal approach to assessing or verifying capacity or even to differentiate true capacity from a desire (or not) to expand a program. Capacity may be influenced by a wide variety to factors from administrative infrastructure (time and resources for: clerical staff, program administrator, program director), faculty availability, access to procedures and patients, training resources etc. If 'capacity' as reported by programs becomes an obstacle to expanding high priority programs, a more objective process to assess capacity and a strategy to address deficiencies may need to be developed.

3. *Strong training in core areas should be emphasized*: Core areas are generally disciplines in which there is demand for a steady output of practitioners, and where an increase in training numbers could be supported on a sustainable basis. In some cases, these programs also form the basis for further training in subspecialty areas. A critical mass of trainees in core areas is important in supporting the training of JURSIs as core areas form the bulk of the clinical clerkship period and are the main rotations in which a hierarchical model of training is necessary both for appropriate training of JURSIs and to meet Royal College requirements of training. Postgraduate trainees in core areas play a critical role in supporting the education of JURSIs.

4. *Successful programs should be prioritized for additional positions:* Programs with a proven track record of success should be given preference for additional positions over programs that are experiencing difficulties. Program success will be measured by consideration of a wide range of factors, including but not necessarily limited to:
    a. recruitment of trainees
    b. retention of ministry funded (non return of service) trainees within the province,
    c. accreditation by the relevant agency (CFPC or RCPSC)
    d. effective educational programs
        i. exam pass rates
        ii. strong didactic programs
        iii. clear and sustained commitment to distributed education
        iv. effective and timely evaluation systems
        v. effective remediation of residents in difficulty
        vi. compliance with accreditations standards
        vii. compliance with College of Medicine policies and procedures
        viii. where appropriate, objective statistics will be averaged over sufficient time periods to minimize cohort effects (i.e.: exam pass rates, CaRMS success rates etc.)

    Where resident critical mass is a key factor in a program experiencing deficiencies, this may be an important exception. Where the addition of incremental positions may help a struggling program to be successful, the onus would be on the residency program committee to demonstrate how additional positions would be used to strengthen the program, and to demonstrate that deficiencies unrelated to critical mass are addressed prior to allocation of additional training positions.

5. *Health Human resource needs:* Provincial health human resource needs should be considered in allocation of positions as training within the province does increase the likelihood of retention. Neither PGME, nor the COM, has the resources to generate reliable information on health human resource needs of the province and would best be determined by the Ministry of Health. In considering health human resource needs it is important to consider the fact that training of a specialist requires 4-7

years and therefore planning based on these needs must be anticipatory rather than reactionary. A system to collect, tabulate and compare predictive health human resource data over a multi-year cycle would be beneficial. This process, however, should not be delegated to regions, the College of Medicine, or specialty groups etc. but would best be done by the Department of Health or by a non-partisan agency on behalf of the Department of Health. Many different groups, including those mentioned above, would have a role to provide information that could contribute to the development of a comprehensive provincial health human resource needs document.

6. *Need for training in disciplines not available locally:* There are a number of primary and secondary entry programs that are not offered at this institution but for which there is a demonstrated provincial need. Need for these non core disciplines can fluctuate substantially over time and in some disciplines it may take only a small number of new physicians entering practice to meet the need. In such cases it does not make sense to develop new training programs and continue to produce a steady stream of specialist physicians, many of whom may be unlikely to find work in the province. However, the lack of a provincial training program does make recruitment more challenging. Strategies should continue to be developed to allow the ability to offer some training in low volume areas. Some trainees have accessed externally funded training – these arrangements sometimes require substantial increases in cost over training locally. It would be advantageous to develop collaborative relationships with specific institutions outside the province that would keep these additional costs to a minimum. An organized, collaborative approach would be much preferred over the 'one off' external funding arrangements. Where training is conducted outside of the province, and especially in the absence of a collaborative program, a return of service commitment should be entered into between the trainee and Saskatchewan Health.

7. *Development of long range plans:* In the process of annually reviewing the allocation of residents, consideration should be given to the development of long term plans for program and position management that can inform future decision making.

8. *Discontinuation of programs:* Formal discontinuation of programs is not part of the mandate of this committee. In the planning process, the committee may identify programs for which discontinuation may be appropriate. The committee may make recommendations to review the viability of programs, but will not have the ability to make binding decisions regarding discontinuation of programs.

Process:

1. *Stakeholders*
    a. Government of Saskatchewan, Ministry of Health
    b. Health regions
        i. Regions involved in training (including rural training sites)
        ii. Regions seeking to recruit trainees
    c. College of Medicine
    d. Departments, faculty, residency program committees
    e. Residents

2. *Requirements*
    a. The process should balance the need for an objective and non partisan approach to allocation, and the need for stakeholders to have input into the process. While the process may not directly involve all stakeholders in the actual decision making process (it may be difficult to avoid partisan influence in such a case) there should be ample opportunity for all stakeholders to inform decision making.
    b. The process needs to function in a timely manner so that decisions can be made both proactively and on short notice.
    c. Timing: for routine incremental positions, the number of PGY1 entry positions should ideally be established by the May/June prior to the CaRMS match to allow for adequate decision making and posting of information on the CaRMS website. Incremental positions can be added until quite late in the CaRMS process but it is best to have as close to final numbers as possible by late August/early September as students may consider position numbers as one factor in their application and interviewing choices. Where there may be a series of incremental positions over a number of years, it would be helpful to have a long range plan with target position numbers over 3-5 years rather than focusing solely on a single year.
    d. Capacity survey: should continue to be done on an annual basis. For disciplines for which health human resource needs are significant but where capacity is limited, supplemental information around the capacity limiting factors should be sought, to determine if capacity issues can be satisfactorily addressed in the short or long term. It may be helpful in such situations to expand the capacity survey and where possible be conducted in the format of an interview with a PGME staff member rather than by a paper or e mail questionnaire. In-person interviews may allow for more detailed information and more accurate comparisons across programs.

e. Health human resource needs: Saskatchewan Health should make provincial health human resource needs data available for the decision making process. Efforts should be made to obtain more objective and robust data and to obtain information that looks 4-8 years ahead rather than focusing on immediate needs. Health human resource needs information should be coordinated through Saskatchewan Health rather than submitted independently by various agencies.

Composition of Allocation Committee:

1) Representation from Saskatchewan Health
2) ~~Associate Dean of Medical Education~~ [no such position at present]
3) Associate Dean of Postgraduate Medical Education
4) Associate Dean - Regina
5) Administrative Assistant PGME (Recording) – non voting
6) PGME Staff (CaRMS/Planning) – non voting
7) Observers: two members of the PGME committee:
    a) Non voting members
    b) To be appointed through a nomination and election process
    c) Role is strictly to observe the process and report back to PGME if necessary. The role of the observers is NOT to advocate on behalf of any particular stakeholder(s)

Procedure and Timelines:

1. Annual capacity survey to be conducted by PGME office late April to early May.
2. Available PGY1 entry positions (total number) to be reported by Saskatchewan Health to PGME office by May.
3. Re-entry/RHA expression of interest related to health human resource needs will be coordinated and collected by Saskatchewan Health. Saskatchewan Health will summarize and report the information in writing to the PGME Office by May.
4. Expression of program interest by the undergraduate medical students participating in the upcoming CaRMS Match will be reported by the Class rep(s) to the PGME Office by the end of May.
5. All information will be compiled and summarized for presentation to the PGME Committee in June. PGME members will have opportunity in the PGME meeting or in writing (within one week of the meeting), to respond to the information. PGME discussions will be minuted.
6. All information will be forwarded to Allocation Committee members for review in July/August.
7. Allocation Committee meets in July/August to review capacity survey, health human resource needs, entry positions, undergraduate medical student interests, PGME discussions and any written comments provided.
8. Allocation decision should be completed by August 31.

9. Decisions on network/sponsored seats will be made by Saskatchewan Health and shared with the Allocation Committee for information only.
10. During the process of adding 'boluses' of new positions, we should strive to maintain the 40:60 family medicine: specialty ratio over the long range. In some cases, however, to achieve particular goals, it may be appropriate to allow transient fluctuation from this ratio in order to address particular needs. In a situation where there is insufficient capacity in Family Medicine, the 40:60 ratio must be waived if capacity issues cannot reasonably be expected to be satisfactorily resolved prior to entrance of the cohort.
11. Shared positions: small programs which may be able to increase training to a limited extent, or where health human resource needs may be limited, may be targeted for expansion on an intermittent / alternating pattern. For example: Neurology and Neurosurgery (each with one position) may share an incremental position in alternate years. In such an arrangement it may also be appropriate to exercise the CaRMS transfer option in any given year if one of the two programs does not fill first round. Other program links should be identified (Pathology and DI, Ophthalmology or Orthopedics and PM&R….). The option for shared positions would not be restricted to small programs.
12. Whenever possible decision making should be by consensus.
13. Decision of the Allocation Committee will be reported to the Budget, Planning and Priorities Committee, the PGME Committee and Faculty Council for information. Each of these groups will have opportunity to respond to the allocation and to provide input to be considered in the next allocation process.
14. If there is an impasse in decision making by the committee, the committee will consult with the Dean of Medicine and the Deputy Minister of Health in reaching a final decision.
15. In extenuating circumstances and in collaboration with Saskatchewan Health, additional spots may be added (new program development) or removed (capacity reduction) from CaRMS quota after the decision has been made.

R3 and R4 Matches

R3 (Family Medicine / Emergency Medicine – one year program post Family Medicine) and R4 Medicine Subspecialty and Pediatric Subspecialty matches are based upon capacity information obtained from those programs and decisions are made jointly by Saskatchewan Health and the Associate Dean, Postgraduate Medical Education.

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