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INTRODUCTION AND OVERVIEW

The Medical Microbiology Program at Dalhousie University is centered at the QEII Health Sciences Centre, located within the largest integrated academic health district in Atlantic Canada, known as the Capital Health District. Capital Health is the largest of nine health districts in Nova Scotia and provides core health services to 395,000 residents, or 40 per cent of the population of Nova Scotia, and tertiary and quaternary acute care services to residents of Atlantic Canada.

The Medical Microbiology service is concentrated at the Victoria General Hospital site. In 2009-2010 year, there over 365 000 tests processed through the laboratory. The QEII laboratory provides a full range of microbiology service to all of CDHA including, bacteriology, virology, parasitology, special pathogens, and molecular and serologic detection of pathogens. Our laboratory has the only level 3 diagnostic containment facility in the province. In it we work on select pathogens such as tuberculosis or dimorphic fungi. In addition the QEII laboratory is the anchor laboratory for the Nova Scotia Provincial Public Health Network and provides reference services to other laboratories in Nova Scotia and in some cases to Prince Edward Island and New Brunswick.

Program: The program is organized in compliance with the requirements of the Royal College of Physicians and Surgeons of Canada. There are currently two streams, a dedicated five year Medical Microbiology program and the combined Infectious Disease/Medical Microbiology program that requires core internal medicine training. We currently do not have funding to offer the five year program as part of CaRMS but do offer it to qualified candidates whose are externally funded.

Medical Microbiology (5 Year program): During the first year, residents will do 12 months of clinical rotations. Although flexible, the year is designed to provide a broad experience and will typically have rotations from Internal Medicine and its subspecialties, General Surgery, Paediatrics and Intensive Care. Over the next four years, residents spend 24 months in the microbiology laboratory rotating through the various disciplines and 12 months of infectious diseases training including two months of Paediatric Infectious Disease and Medical Microbiology. The additional 12 months of training is flexible that can be tailored to the ultimate career goals of the resident which could include sub-specialization in a particular area of microbiology, further clinical training or research. Included in this package are the goals and objectives outlined by the Royal College and for each of the specific residency rotations.

Combined Infectious Disease/ Medical Microbiology: After three years of core internal medicine training, residents will enrol in a three year combined program which includes, 24 months of Medical microbiology training in the various disciplines and 12 months of infectious diseases training including two months of Paediatric Infectious Disease and Medical Microbiology

While the Medical Microbiology program is small (one or two residents), additional residents including those in General and Anatomic Pathology, Adult or Pediatric Infectious Diseases may

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participate in many of the shared learning opportunities. The smaller size of our program means that the residents have a tremendous amount of first hand experience in many areas of infectious disease and it allows us to take advantage of some of the community based experiences with our very skilled New Brunswick colleagues. We have also had a very good working relationship with our Public Health counterparts who coordinate a month long rotation during the residency

Faculty: The Residency Program is well structured with close integration with the Pediatric Microbiology Laboratory at the neighbouring IWK hospital. There is an excellent blend of service and education. The faculty at the QEII HSC includes four Medical Microbiologists, three of whom are dually trained in Infectious Diseases, two Ph.D. clinical microbiologists and four full time adult infectious disease physicians. At the IWK, there are four infectious disease physicians, one of whom is also trained in Medical Microbiology and directs the clinical laboratory at that hospital. There is also two infectious disease specialists (one of whom is also certified in MM) and an PhD clinical microbiologist at the campus in St. John. Residents will spend some time at this hospital which will provide a more community based experience.

Research Opportunities: Division members are active in a number of areas of research, both clinical and basic and there are ample opportunities for research. Members of the Division have cross appointments with the Canadian Center for Vaccinology and the Dalhousie Department Immunology and Microbiology. A number of basic scientists with a research interest in bacterial pathogenesis are well integrated into our program. Wet lab research space is available in close proximity to the clinical laboratory and infectious disease clinic. Within the clinical laboratory, an active molecular diagnostics group provides residents with an opportunity to gain applied experience in the tools of molecular biology while providing an opportunity for molecular epidemiology and method development research.



Resident Well Being

Your health is paramount; a healthy resident is a happy resident. This includes both your physical and mental well being. If you are new to the area, your program director can help you find a family physician or specialist if you require one.

Although Residency will be stressful at times, it should ultimately be fun and rewarding. You will be learning new things, while experiencing, first-hand, interactions with patients who are ill with an infectious disease and dealing with the diagnostic challenges that accompany them. Like most small training programs, we do not have a dedicated counselling program. When you have a problem or complaint about some aspect of the Training Program, you should contact your Program Director or the Chief of Service of a particular rotation. If you are not satisfied with the response of the Chief of Service, contact the Program Director. In addition, the Program Director makes every effort to oversee all aspects of the trainee's program and keep in frequent contact to obtain verbal feedback as the training proceeds.

Residents are encouraged to discuss personal issues with the Program Director or any member of faculty who they feel comfortable with. If the resident feels uncomfortable discussing it with the Program Director or members of the Division, there are other people available to meet with or talk to. We have established an "Omsbuddy" who is a resource person at arms length from the Division who can be contacted if the resident has any issues that he/she feels uncomfortable discussing with members of the Division or the Program Director (<http://postgraduate.medicine.dal.ca/calendar34.html>). The Omsbuddy functions as an independent facilitator to provide advice, mediate disputes, and promote just and reasonable solutions to problems (see appendix 21). Weii Huang and Kelly Dakin Hache in Antaomical Pathology are the Omsbuddies for the Medical Microbiology residents. In addition, Dr. Gina Lacuesta (Allergy and Immunology) is the Omsbuddy for the Infectious Diseases program and would be happy to speak with residents if they are more comfortable.

Remember, if we know about the problem, we might be able to help.

Residents also have access to Dalhousie University psychological services, which is totally confidential and independent of the Faculty of Medicine and the "PIETA Program" (<http://postgraduate.medicine.dal.ca/pieta.html>). This is a confidential program that was created by Doctors Nova Scotia. It has no affiliation with the Medical School or the interns' and residents' programs within the hospitals. The volunteer physicians in the PIETA Program have agreed to assist any trainee with chemical dependency and/or personal problems. A confidential help line number **(902- 468-8215)** is available for this program.

The Program director can give you a copy of the CanMEDS Physician Health Guide. This excellent resource "is designed to help educators and learners better understand the broad meaning of physician health, to discover practical strategies to promote professional health and to apply such knowledge to real-world situations".



MEDICAL MICROBIOLOGY RESIDENTS RESPONSIBILITIES AND EXPECTATIONS

a. Clinical Microbiology Rotation

The Core Microbiology training is done in 24 different four week blocks. During this time the residents will focus on the various areas within the laboratory. During the first 12-18 months the residents will shadow technologists at the bench side who dedicated to teaching them the practical hands on aspects of microbiology. During that time, the residents will be expected to come in at a time dictated by when the technologist starts their day. The mornings will be spent at the bench. The afternoons will be reserved for self directed learning and review sessions with the faculty. These sessions will be based on the Goals and Objectives set out by the Royal College

Each day the attending microbiologist does rounds in the bacteriology laboratory to answer technologist's questions that arise during work up of patient specimens. This generally occurs around 1030. The Residents will be expected to round with the attending as it offers an opportunity for very practical teaching about the approach to working up patient specimens.

Recognizing that many residents will have little prior experience with medical microbiology, we offer an introductory "mini" course in medical microbiology for residents at the beginning of their second year of training. To maximize learning opportunities, this course is also offered at the same time to General Pathology and Infectious Disease residents. During the 12 week block, these residents will work collectively with a dedicated technologist in the mornings to review hands on approach to identification of pathogens from a variety of different specimen types. In the afternoon there as self directed case studies that will be reviewed with one of the medical microbiologists. This combination of hands-on practical approach and the tutorial base teaching around the clinical aspects of microbiology gives the resident an excellent overview of microbiology and teaches them an approach to the identification of microbes and their pathogenesis in infection and disease. In their second year (the first year in the clinical laboratory, the Medical Microbiology resident will participate in the mini course as a learner. In the subsequent year, the Medical Microbiology resident will assume graduated responsibility for teaching the other residents both at the bench and in the afternoon case oriented sessions.

b. Clinical Responsibilities During Infectious Disease Rotations:

First six months of clinical ID consultation:

- Works with the other clinical housestaff seeing consultations on the wards or in clinic and reviews the consults with the attending physician later in the day.
- Completes consultations on his/her own patients, reviews diagnostic imaging and laboratory results and writes up case in the progress notes.
- Maintains an up-to-date in-patient list and encounter portfolio.
- Ensures that at least one Tuesday morning case is presented from his/her group and coordinates Tuesday Case Conference presentations with the ID resident. If there is no ID subspecialty resident the Medical Microbiology resident will be responsible coordinating the presentations.



After the first six blocks of ID consultation:

In addition to the above, as part of graduated responsibility, the resident will be expected to,

- Coordinate activities of housestaff on the Infectious Disease Service.
- Take a greater responsibility in running the consultation service by distributing new consultations to learners, appropriate to levels of training.
- Complete their consultation on the consultation form.
- Review other learners' cases with them (if other responsibilities permit), and develop an appropriate diagnostic and management plan prior to rounds with the attending. If other responsibilities preclude review of the learners' cases before rounds, the ID resident will be expected to lead the discussion of the case in the presence of the attending staff.

Additional experience in the last two blocks of clinical infectious disease consultations (Junior Attending Role)

As part of graduated responsibility during the Infectious Disease rotations, the resident should have sufficient knowledge and experience that he/she will be expected to function as a junior attending. This essentially means the resident will have greater autonomy in managing the in-patient consultation service. The goals and objectives will be the same as those for the in-patients rotations, additionally they will be expected to manage the service and their other out-patient clinics or other responsibilities much like an attending staff. The following are some specific differences that are expected to occur as they take on this role:

- The resident will manage all aspects of the inpatient service
- Consults will be phoned to the designated senior house staff who either see them themselves or distribute them to other house staff for assessment.
- The resident will review the patient with the house staff, develop a diagnostic, treatment and follow up plan.
- The resident will be expected to teach the junior house staff (both clinical skills and infectious disease knowledge) around issues that arise from the cases.
- If multiple consults occur at the same time the resident may have to see the some consults on their own while the house staff are reviewing others.
- The resident will be expected to write a concise summary of the case on the consultants form with a clear outline of the diagnostic, treatment and follow up plan.
- The resident is expected to maintain the inpatient list.
- The resident should demonstrate the ability to use all possible information resources to come up with the treatment plan based on the current best practices.
- The resident will be responsible for seeing follow-ups. The maximum number of patients that they will follow at any one time is 15. Ideally, the housestaff who saw them initially in consult should be responsible for daily follow-up and then can round with the resident to review issues. However, if the service is busy and the housestaff are seeing new consults, the resident should round on the designated follow up patients on their own and be able to discuss issues with the attending staff at the end of the day or sooner in case of emergencies. Follow up of patients exceeding 15 will be the responsibility of the attending staff.



- Attending staff will review the new patients with the resident at the end of the day to discuss and teach around issues with each case. This may be with or without the housestaff present
- The Attending staff will give as much autonomy as possible but will always be available to discuss cases or address emergency situations.

c. Clinics

- Once they have completed the first three blocks residents are expected to participate in at least one ½ day clinics/week for the duration of their training. The patient population will be mixed and must include HIV patients. As the resident progresses in their training they will be given more autonomy such that as they approach the end of their training they will be following their own patients weekly with minimal supervision. An attending staff will always be available to discuss the case. During purely outpatient rotations, the resident will participate in clinics daily
- During rotations at the IWK the resident is expected to see only follow-ups in their outpatient clinic.
- While in the clinical microbiology laboratory (with the exception of the mini course) residents will be expected to participate in one afternoon clinic a week.

STD Clinics

Residents are expected to attend at least eight STD clinics over the course of their training, preferably when ID faculty are in attendance. These clinics are best scheduled during the Clinical Microbiology rotation so as not to interfere with activities on the Infectious Disease consultation service.

d. IWK/Grace Rotation

While at the IWK/Grace, residents are expected to participate in all QEII site educational activities unless there is another specific structured teaching experience which prevents their attendance. They will be expected to be placed on the pediatric ID call schedule.

e. Telephone Consults

After the first six blocks of laboratory or clinical training residents will be expected to respond to telephone requests for advice in the respective disciplines. Residents should appropriately identify themselves and their level of training and document the nature of the problem and the information provided. They should record the callers name and contact information for potential follow up. If uncertainty exists, then the resident should obtain additional information or discuss with the responsible ID or Microbiology consultant before getting back to the physician requesting the advice. All records of telephone consultation should be retained for at least two years. All advice should be reviewed with faculty within 24 hours. A staff person will be available at all times to discuss any issues that arise.

f. On Call Responsibilities

Medical Microbiology: After the first six month blocks of training residents will be expected to take Microbiology call. Call is taken at home. Call on the weekday evenings is generally very light. The resident can expect the occasional outside call from a physician looking for advice or a technologist with a clinical question. All attending physicians round daily and are available by cell phone or pager to take questions from technologists or physicians regarding microbiology related questions.



- Residents would be expected to be on call one weekend and 4 other weekdays each month. The only months they will not be on call in Halifax is when they are out of the city for an elective rotation. Call schedules are made in accordance with the PARI-MP Collective agreement (<http://www.parimp.ca/pictures/File/PARI-MP%202008-2011%20Agreement.pdf>):
- On the weekends, the residents will be expected to round with the attending staff in the laboratory.
- Reading PCP smears and help in interpreting Gram stains is generally the only query that would require the resident to return to the laboratory after-hours when on call. The resident would be expected to read the smear first after which the attending would review the slide.
- As the resident progresses through the program, they will take more responsibility and independence by rounding prior to the staff and reviewing issues at a pre-determined time after they have completed rounds. After the first six months of laboratory focused training the resident will be expected to take “first call” for telephone consults.

Infectious Disease: Once the Medical Microbiology residents have started on their infectious disease clinical rotations, they will be expected to take infectious disease call. Infectious Diseases call is taken at home. Call on the weekday evenings is generally very light. Weekend call is variable but on average the resident can expect 3-6 consults over the weekend. Call schedules are made in accordance with the PARI-MP Collective agreement (<http://www.parimp.ca/pictures/File/PARI-MP%202008-2011%20Agreement.pdf>):

- Once they have started their clinical Infectious Disease Rotations the Medical Microbiology resident will be expected to be on call for Infectious diseases 1 weekend each month and 4 other week days throughout the month in accordance with the PARI-MP collective agreement. This will be expected for the remainder of their training (e.g. years 4 and 5 or sooner if their clinical ID rotations begin earlier). The only months they will not be on call in Halifax is when they are out of the city for an elective rotation or when they are on the paediatric rotation where they will be expected to take paediatric infectious disease call.
- Because the call for Medical Microbiology is very light, the Medical Microbiology resident will also cover the Medical Microbiology call at the same time.
- The residents will be expected to cover holidays in an equitable fashion with other housestaff.

g. Teaching Responsibilities and Expectations

One of the roles of a resident is teacher to more junior house-staff. Effective teaching demonstrates success in meeting various CanMEDs competencies, including communicator, scholar, and medical expert. The different teaching roles expected of residents will depend on their progress through the program but may include:

- Taking a leadership role in the coordination and teaching of the microbiology “mini course” for pathology and infectious disease residents as they progress in their microbiology training.
- Leading the discussions and coordination of plate rounds



- Informal teaching sessions with the pathology residents, infectious disease residents and elective students regarding Medical Microbiology issues. These can be focused on an interesting patient result, clinical isolate or informal discussions around topics of interest.
- Informal teaching sessions with the internal medicine and non-internal medicine house-staff regarding infectious disease and Medical Microbiology issues. In their last six months of infectious disease rotations when they transition to the senior Infectious Disease resident
- Take responsibility for leading the learning exams with house-staff after completing their first three months of the Infectious Diseases clinical rotation. These are regularly scheduled and appear on the weekly schedule. When there are residents at two sites at the same time, it is expected that they will alternate these weekly sessions.
- Leading the antimicrobial reviews sessions that are held once a month for new house-staff who have joined the consult service. When there are more than one Medical Microbiology resident, it is expected that they will alternate these sessions.
- Briefly review a topic that is highlighted during the interesting case presentations
- Review journal articles during the infectious diseases Thursday morning educational sessions (once every other month) and the Medical Microbiology Journal Club (monthly).
- Teach at least two sessions/year during the ID/Medical Microbiology academic half-day.

Many of the educational sessions are accredited and evaluated so that feedback is given to the presenter. The resident will be expected to develop a teaching dossier that will catalogue teaching experiences and evaluations, and assist in preparation for future positions and promotion.

h. Academic Responsibilities and Expectations

Our Medical Microbiology program and Infectious Disease teaching service has always been credited with having a very good education to service ratio. We have a number of educational focused rounds and teaching sessions throughout the week. The following list details the formal rounds and sessions, along with the residents' expectations and responsibilities:

Plate Rounds: Once a week the Infectious Disease and Medical Microbiology faculty and housestaff come to the laboratory to review interesting patient specimens and isolates. This hands-on teaching session helps develop a practical basic approach to clinical microbiology and pathogen identification. Once the core microbiology rotations have begun, the Medical Microbiology residents will gradually be expected to take increasing responsibility for these rounds. They will be expected to collect interesting isolates and walk the house staff through the identification and discussions of the organisms.

Tuesday Morning ID Case Conferences: These rounds are an opportunity to present interesting cases seen on the clinical service. They are presented in a format in which the diagnosis is unknown, in order to generate discussion regarding differential diagnosis and approach to management. These are followed by a short presentation on an ID issue pertinent to the case.

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- Medical Microbiology residents are expected to attend these weekly rounds starting in their second year.
- During their clinical rotations, the Medical Microbiology resident will be expected to present interesting cases seen on the clinical service in coordination with the other infectious disease residents on service.
- It's normally expected that cases for presentation will be identified prior to the week-end either by the resident or the attending staff.
- Case presentations will ordinarily be accompanied by a **brief** review of a specific subject area relevant to the case.
- Once the Medical Microbiology residents have started their clinical ID rotations, they will be expected to alternate with the Infectious Disease subspecialty residents as the initial discussant for at least one case with a faculty member providing back up and further input.

Academic Half-day: Each Tuesday from 0915-1055 there is a scheduled session where a specific topic taken from the Infectious Diseases Royal College Goals and Objectives is presented and discussed. These occur throughout the year and are attended by the Adult and Paediatric Subspecialty residents. The different perspectives brought by the Infectious Diseases and Medical Microbiology residents' enhance the discussions. This is a mandatory component of training from which residents must be excused from clinical duties. The resident will sign over their pager to the attending staff during this time.

- Residents will be expected to attend each of these sessions unless on vacation or out of town.
- Residents will be expected to present at least two in their first year and three in their second and third years.

Thursday Morning Sessions:

Sign over (0800): During this weekly session, the members of the two Infectious Diseases consultation services meet and review the patient list to highlight issues as potential teaching points or as a venue to get advice on specific clinical questions surrounding the case. Although this is generally led by the attending physician, after the resident has spent 3 months on the ID service he/she will be expected to provide a concise summary on the patients he/she is following. As their training progresses and they function as a junior attending they will be responsible for presenting the patient list on the 15 patients they are responsible for. Because it is a forum to learn from specific clinical problems, the medical microbiology resident will be expected to attend in years 3-5.

Infectious Diseases Journal Club (0830): This session occurs once a month. The responsibility of choosing the articles to review is assigned to different faculty members, who will approach house-staff to review and present the articles. We have developed guidelines for the format of these journal clubs (XX). Medical Microbiology Residents



are expected to present at ID Journal Club every second month during their last 2 years unless on vacation or out of town. Residents will also have the opportunity to take more of a leadership role in their final year by choosing the articles and coordinating one journal club.

Medical Microbiology Journal Club: The journal club is held monthly on a Thursday from 1000 – 1100. The form of the rounds consists of presentations from two people, usually a resident or supervisor paired with one of the staff microbiologists. The rounds may examine papers around a specific topic of interest to the presenters but should try to focus on subjects and reviews that may stimulate discussions on possible changes to how we deliver service in the laboratory. The resident will be expected to present at least one paper a month.

Participation in Morbidity / Mortality Review (0830): At least two weeks prior to this session, cases are assigned to faculty members to review. During the rounds, the reviewer presents a concise overview of the case highlighting any issues that need to be discussed regarding the ID related care and non-ID aspects that may have contributed to the morbidity or death of the patient. Medical Microbiology residents are expected to review at least three cases in the usual format on two occasions yearly

CanMEDs Curriculum (appendix 15): The resident will be expected to attend the various lectures and programs put on by the Postgraduate office. These deal with many of the other CanMEDs competencies and are a great opportunity to meet residents from other programs. The resident will be excused from clinical duties during these sessions and will be expected to sign over the pager to the attending staff.

Courses: Resident will be encouraged to audit one course in each of the fall and winter semesters. The choice of course should be decided on in consultation with the program director.

The Microbial Hour: This session occurs once a month on a Wednesday evening at 1730 hrs. It is an opportunity to review a specific topic of interest. This may be ongoing research, a clinical syndrome, or interesting pathogen. These are accredited sessions and the feedback received can be used for the resident's teaching dossier.

- Residents are expected to attend ID Microbial Hour unless on vacation or out-of-town
- Residents are expected to present at least one Microbial Hour every 2 years

Attendance at Infection Control Committee Meetings: Residents are expected to attend the quarterly Infection Control committee meetings unless on vacation or out of town.

Attendance at Antimicrobial Committee: Residents are expected to attend each meeting beginning in their third year. In addition they may be asked to present an antimicrobial agent for formulary review and will be expected to do an antimicrobial utilization review for one agent.



Attendance at Microbiology Management Committee Meetings: In the final two years of training, Residents will be expected to attend the Microbiology management meetings including the Divisional management meeting, the Quality Management meeting.

Pathology Grand Rounds: The Residents will be expected to attend Pathology Grand rounds when they are not on clinical rotations or out of the province. In their senior years they will be expected to present at Grand Rounds on at least one occasion.

i. Scholarly Expectations

Principles for Scholarly activity:

1. Collaboration between faculty member and resident strengthens the Department.
2. Research projects may span a wide range of intensity.
3. Early consideration of a Research Ethics Board application may be advantageous.
4. Sufficient time and resources must be available to complete projects.
5. Supervising faculty will be available to discuss concepts and research approach.
6. Simultaneous resident participation in more than two projects may be disadvantageous, and should be discussed with the research coordinator and program director.

Research is an integral and mandatory component of residency training. Some trainees have considerable pre-residency research experience, while others may have limited exposure before starting their residency. During the first two months of residency, each resident will meet with the Research coordinator (Dr. LeBlanc) to discuss research interests and career goals so that he/she can be matched with a faculty member with similar interests and establish a plan for research activities. Establishing an early mentorship relationship with a suitable faculty member will help ensure that their research project is successful. Within the first four months of their core Microbiology training, residents will identify at least one research project to undertake. In addition, the residents will then meet with the research coordinator every 6 months to review their progress. At the end of the first year residents should submit to Dr. LeBlanc and the Program Director, a brief summary (not more than three pages) describing progress on their projects.

The resident should, in November or December, present to the group a research plan for the forthcoming year. Residents are also expected to submit at least 2 abstracts to ID and Department of Pathology Research Day.

Residents are expected to publish a case report or review and are normally expected to complete at least one more comprehensive project during their training. It is expected that residents will present at one national or international meeting in the second and third years of their program and/or publish the results in a peer reviewed publication.



VACATION AND LEAVE

Vacation: Except under extraordinary circumstances, Medical Microbiology residents are expected to give at least three months notice of vacation. Residents are expected to complete a vacation request form (see appendix 1). Residents are expected to communicate with the staff person on any affected rotations. Residents should also make the Microbiology Service Chief aware. The Program Director is ultimately responsible for approving the vacation request. Residents will not be allowed to take off more than 7 days during any 28 day rotation. During the first year of off-service clinical rotations they should request vacation from the service affected at least 3 months in advance to ensure that they can be granted.

Conference Leave: Residents are permitted to take up to ten working days per annum to attend conferences or courses. Conference leave should be requested from the division chief. Attendance for other activities (such as PARI-MP duties, internal program reviews, etc) are excluded, but are approved at the discretion of the program director, depending on a resident's performance.

The Dalhousie Pathology Department will normally pay for reasonable travel, registration and accommodation expenses at a meeting during which a resident is presenting a scientific paper or poster. Application for funding must be made at least three months in advance of the proposed travel. The limit of support is currently \$2000.00, and is restricted to one conference per year of residency. Residents are expected to present their work at the Departmental Research Day, in advance of the conference presentation.

See conference travel application form and guidelines, in Part II Appendix 10. (Also available from Debby Caldwell in Room 737, 7th floor, Mackenzie Building)

When preparing posters for presentation, residents are expected to be price conscious and compare the costs quoted by various providers.

Maternity Leave: Residents who take maternity or other leave during residency **may** be forgiven up to three months of training time by their program, if they perform exceptionally well during residency. **Residents should not assume that forgiveness of time will be guaranteed.** The decision will be made by the RTC during the resident's PGY5 year. If time is forgiven, the program director informs Dalhousie PGME and the Royal College in writing

HOW TO REQUEST VACATION LEAVE

You should direct your vacation leave requests to the laboratory Chief of Service or the infectious diseases physician on the consulting service and/or in the clinic (as appropriate) of your current rotation because your absence from service responsibilities must be approved by this person. In your first year during the off service clinical rotations you should contact the program director of that service (or their administrative support) to determine the vacation policies specific to that service. In general, the sooner you can make the vacation request, the more likely it will be considered. **After approval has been received, your Program Director**



and administrative assistant for the Programs must also be informed because a record of your vacation leaves needs to be maintained.

Should you feel a reasonable vacation request has not been permitted, you should contact the Program Director for advice.

Carry over of vacation leave from one academic year to another is not usually permitted.

The policies regarding parental leaves of absence are outlined in the PGME Calendar as follows:

Maternity/Parental/Adoption Leave

The PARI-MP Collective Agreement states, under Article 18.01 (b) Maternity Leave, that “A pregnant Resident, who has been employed with the Employer for at least one (1) year, is entitled to an unpaid leave of absence of up to seventeen (17) weeks, subject to the provisions regarding Pregnancy Leave Allowance...”; under Article 18.03

(a) Parental Leave, that ‘A Resident who has been employed with the Employer for at least one (1) year, and who becomes a parent for one or more children through the birth of the child or children is entitled to an unpaid leave of absence of up to thirty-five (35) weeks.’; and, under Article 18.05 (a) Adoption Leave, that ‘A Resident who has been employed with the Employer for at least one (1) year, who becomes a parent of one or more children through the placement of the child or children in the care of the employee for the purpose of adoption of the child or children pursuant to the law of the Province is entitled to an unpaid leave of absence of up to thirty-five (35) weeks, or more, if required by the adoption agency.’ 18.01 (c) A Resident shall, no later than the fifth (5th) month of pregnancy, forward to the Employer a written request for pregnancy leave.

Capital District Health has developed guidelines for residents applying for maternity, parental, or adoption leaves of absence (LOA) and benefits. Please refer to the CDHA Guidelines for specific information at the following web site:

http://postgraduate.medicine.dal.ca/LOA_instructions.pdf

For more information regarding Maternity, Parental, & Adoption Leave (Notification of Leave, Leave Periods, Performance of Duties, Service and Seniority, Benefits, Supplementary Unemployment Benefits), please refer to the PARI-MP Collective Agreement:
<http://www.parimp.ca/>

Moonlighting During Maternity/Parental/Adoption Leave

The Postgraduate Medical Education Offices current practice for processing Maternity and Parental Leaves is to inform all agencies: CPSNS, CPSNB, CMPA, PARI-MP, the Capital District, and any other hospital a resident is assigned to, of the time a trainee will be off. A residents training status is basically in “suspension” during any leave of absence, as this provision ensures that sufficient funding is available when the trainee rejoins his or her program. CMPA is suspended for most or all of this period and the money is refunded to the employer.



Both a Dalhousie contract and CMPA must be in place for an educational license to be valid, and of course hospital credentialing requires CMPA and a license to be in effect.

There is a federal provision for those on Employment Insurance for parental/maternal leave that permits an individual to work a certain number of hours per week. In the case of a resident, the individual must ensure that they have an active license and CMPA and appropriate credentialing in place during this period. Residents who wish to pursue this option will need to discuss licenses, CMPA and credentialing directly with the agencies involved.

Guidelines for Considering a Waiver of Training Following a Leave of Absence (Rev. May 2009)

The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada expect all residents to successfully complete all aspects of their training program, including the length of training. Leaves of absence (LOA) are encountered during residency training (due to illness, parental leave, personal reasons etc) and result in a change in the end date of training equal to the amount of time for the LOA. The required training time missed will ordinarily be made up by the resident with equivalent time upon return to training. In some circumstances a reduction in training time (waiver of training) may be permitted upon approval from the Residency Training Committee (RTC) and the Associate Dean, PGME. Each program will determine whether to permit waivers of training and the criteria the RTC will use to grant such requests. Such waivers are not permitted for voluntary LOAs or extended training due to failed rotations, and will be considered only for residents whose performance demonstrates that all competencies set out by the respective college have been met.

Guidelines:

1. A reduction of training time can be considered only in the final year of training for RC programs, and the last 6 months for Family Medicine programs. RTCs need to be able to evaluate each resident's competency before considering such requests. It is not possible to do this at the time of the LOA.
2. The maximum time to be considered for reduction is set out by the RCPSC (for specialty residents) and the CFPC (for Family Medicine residents).

RCPSC, CFPC and CMQ Maximum Allowable Times for Waivers

Length of Program	Maximum Allowable Waive Time
One year program	No waiver allowed
Less than one year for remediation or enhanced skills	No waiver allowed
2 year program (excluding Family Medicine)	Up to 6 Weeks
2 year program (i.e. Family Medicine)	Up to 4 Weeks
3 year program	Up to 6 Weeks
4 year program	Up to 3 Months
5 year program	Up to 3 Months
6 year program	Up to 3 Months



For residents taking subspecialty training (Internal Medicine and Pediatrics), up to six weeks is allowable during PGY3 for core training and up to six weeks is allowable for subspecialty training in the final year of training. The Postgraduate Dean where the core training took place must approve the waiver request for the core training.

3. A reduction in training time should be based on resident's performance and competency. The resident's ITERs and other evaluations must reflect that all competencies set out by the credentialing authority (Royal College or College of Family Physicians) have been met. Each program allowing such waivers will define how such competency is demonstrated.

4. The request for a reduction of training time should come from the resident in writing to the RTC prior to the start of their final year of training. Granting a waiver is not automatic, and the RTC will make a recommendation to the Associate Dean, PGME using the attached form. The recommendation must be approved by the Associate Dean, PGME and will be communicated by the PGME Office to the respective national body (RCPSC or College of Family Physicians of Canada). A decision not to grant a waiver of training cannot be appealed.

5. Reduction of training time will not be granted for any period of leave taken after the final certifying examinations.

Absence of work due to illness

1) Residents must advise the program administrator (Kim Trigg or Lezlie Kehoe) when they cannot work due to illness. Residents must also advise their assigned service of this information.

2) The resident must advise the program administration when they have reported back to work.

3) Administrators must input any occurrence of illness and return to duty on One45. The importance of maintaining an accounting of the number of trainees who are ill and who remain in the system is of utmost importance during health care emergencies (such as influenza pandemics), as programs, the hospital and PGME office will be availing themselves of this information.

4) If the administrator is away from the office, please ensure that clear instructions are left with the contact information of the person who is filling in.

5) Residents who are rotating to services and cities outside of the location of the home program must report illness to their home program.



RESIDENT EVALUATIONS

The ITER is a central and key component of resident formative evaluation, which gives the resident feedback about his/her performance in the program. ITERs give the Program Director and the RPC information on the progress of the resident and on the effectiveness of their teaching. ITERs will be completed online using the web One45 system to facilitate timely completion of these important documents. In addition, the resident will have a mid term evaluation, both oral and written, to highlight any areas where improvement is needed.

FREQUENCY OF ITER EVALUATION

ITER evaluations are required at 3 month intervals or at the end of a rotation, whichever comes first. Mid rotation evaluations will always be performed in order to alert residents to opportunities for improvement.

ITER RATING LEVELS

There are 5 categories of ratings: consistently exceeds, some times exceeds, generally meets, inconsistently meets and rarely meets. Because the rating system is created based on the bell-shaped curve merit distribution, most residents should receive **the rating of generally meets**.

The “Consistently exceeds” is reserved for exceptional residents. The Royal College suggests this category reflects residents in the top 5%. Such as a resident always exceeds expectations by a wide margin.

The “Sometimes exceeds” is for performance above average but below the exceptional or outstanding category.

The “Inconsistently meets” is a performance that is clearly below average but not clearly a failure (unsatisfactory).

The “Rarely meets” is for poor performance, given when it is the opinion of the evaluator that the resident has failed to meet a minimally acceptable standard.

All ratings should take into account the amount of training that the resident has had in the program. All ratings of “consistently exceeds”, “inconsistently meets”, or “rarely meets” must have specific examples provided to support the basis of this assessment. This is particularly important in below average ratings “inconsistently meets”, or “rarely meets”

THE CATEGORIES TO BE EVALUATED

The ITER outlines the expected competencies the resident should have attained in each of the CanMEDS categories:

- | | |
|-------------------|--------------------|
| 1. Medical Expert | 5. Health Advocate |
| 2. Communicator | 6. Scholar |
| 3. Collaborator | 7. Professional |
| 4. Manager | |



Each ITER is tailored to reflect the expected competencies as outlined in the goals and objectives that were reviewed at the beginning of the rotation. Not all competencies are required to be evaluated during each rotation, but at the end of your training, all competencies must have been adequately taught and evaluated.

POLICY ON FEEDBACK TO RESIDENTS

Mid term and on-going feedback: In the middle of the rotation, there should be verbal and written feedback in the form of a mid-term evaluation. This is particularly important if there are deficiencies noted as it provides time for the resident to work to correct them prior to the end of the rotation. If issues arise after the mid term evaluation, they must be discussed with the resident within 24-48 hours so that the resident can work on correcting the deficiencies. If deficiencies noted during the rotation are not discussed with the resident, they should not be used for the ITER. It is unfair to fail a resident at the end of the rotation without providing constructive feedback throughout the rotation to try and help improve performance.

Completion of the ITER: Feedback to a resident on the results of an ITER evaluation should be provided within 14 days of the completion deadline for the ITER. ***Feedback will only be given once the resident has submitted the evaluation of service.*** Residents should normally sign and date ITERs as evidence of this feedback. In general, residents have the right to see individual ITERs and this includes a right to see who made adverse comments. Any deviation from this policy should be only for exceptional circumstances. The ITER(s) should be reviewed with the resident by the person responsible for the rotation. When a significant problem is identified, it is usual practice for the Program Director to review the ITER results with the resident.

It is usual practice for the Program Director, or a designate, to interview all residents whose performance is judged to be borderline or unsatisfactory. The purpose is to make sure the resident is aware of the situation, to analyse the problem, and to design a remedial program, if appropriate. In some cases, the resident and staff concerned may be interviewed by the Training Committee. The purpose of this would be to help define a problem and propose help where indicated.

Repeated unsatisfactory performance on ITER and exam evaluations might be used as evidence of unsatisfactory academic performance by the Training Committee.

OTHER FORMS OF EVALUATION

While written examinations will be a mainstay in the assessment of the medical expert competency assessing the knowledge base around the goals and objectives of the program, the other CanMEDs competencies are more difficult to formally evaluate. Traditionally the main evaluation tool of resident performance has been direct observation. However, as the Royal College moves more towards standardized methods of evaluating the competencies other than medical expert, the resident can expect new and innovative ways that they may be evaluated.



These can include writing an essay around a certain topic (e.g. Health Advocacy), encounter based evaluation, multi-source feedback, and the compilation of portfolios or logbooks.

Clinical encounter Portfolio. During the Infectious Disease rotations, the resident should enter clinical encounter data after each inpatient or outpatient consultation to keep track of the types of clinical problems encountered. This provides an opportunity to reflect on how each of the interactions has instructed you on one of the Can MEDs competencies. This will also familiarize residents with managing billing information in preparation for their career as an independent consultant. Appendix 19 has an example of a Portfolio template.

Microbiology Laboratory Portfolio. A similar Portfolio for medical Microbiology has been developed to record the types of isolates and clinical scenarios encountered in the laboratory and how they have instructed you on of the CanMEDs competencies.

Clinical Encounter Form. All Medical microbiology residents will also have a formal assessment of their clinical skills by having a witnessed clinical encounter during each clinical rotation (see attached from). These encounters will be completed by the attending staff or designated staff person where they will assess their history and physical skills.

RESIDENT EVALUATION OF ROTATIONS AND COURSES

A standard "Resident Evaluation of Program" form has been designed to facilitate feedback from trainees. This is filled in at the end of each rotation and given to the Program Director. Individual residents are also welcome to discuss particular problems pertaining to rotations with the Program Director, privately at any time or at the regular 3 monthly Program Director - Resident meetings.

DISTRIBUTION OF COMPLETED ITERs

Completed ITERs should be sent to the Program Director after review and signing by the resident. The Program Director is responsible for putting an ITER copy in the resident's file and for sending a copy to the Dean's office

For information regarding the Post Graduate Office's policy on Resident assessment of training and Promotion, you can find it in the PGME calendar

<http://postgraduate.medicine.dal.ca/calendar10.html#assessment>



Dalhousie Medical Microbiology Resident Clinical Encounter Assessment

RESIDENT: _____

ROTATION: _____

PGY **1** **2** **3** **4**

STAFF: _____

DATE: _____

1. HISTORY (Describe history resident was asked to obtain) _____

COMMENTS _____

History: (Please circle score)	Failure 1	Marginal 2	Acceptable 3	Outstanding 4
--------------------------------	--------------	---------------	-----------------	------------------

2. PHYSICAL EXAM (Describe what exam resident was asked to perform) _____

COMMENTS _____

Physical Exam: (Please circle score)	Failure 1	Marginal 2	Acceptable 3	Outstanding 4
--------------------------------------	--------------	---------------	-----------------	------------------

3. CLINICAL SCENARIO (Describe what scenario resident was given) _____

COMMENTS _____

Clinical Scenario: (Please circle score)	Failure 1	Marginal 2	Acceptable 3	Outstanding 4
--	--------------	---------------	-----------------	------------------

Overall Total Score (1 - 4): _____

The resident has demonstrated level appropriate: Knowledge Y / N Skills Y / N Attitude Y / N

Based on this encounter, I am satisfied with resident's professionalism: **YES** **NO** **UNCERTAIN**

Other Comments _____

Staff Signature _____

Revised April 8/2005 IB



APPEAL PROCESS IN THE PROGRAM

In the event that a resident should appeal a fail at the end of a rotation, the resident is encouraged to re-discuss the failing evaluation with the rotation supervisor after a reasonable period of considering the circumstances that lead to the failure. The resident is encouraged to do so within 28 days of receiving the failing grade. If the resident and supervisor are unable to agree on the final evaluation, the resident is encouraged to discuss the matter with the Program Director, who will then collect the appropriate information and documentation.

If the resident wishes to appeal, then the failed ITER is discussed by the Residency Program Committee (RPC) at a scheduled meeting. The resident is invited to come to this meeting alone or to bring one or more faculty members who may wish to support him/ her during the process. The decision of the RPC will be made after the resident has departed the committee room.

A resident has the right to appeal any unfavourable evaluation to the RPC, including an unfavourable decision of the RPC, such as a decision that the resident withdraw from the Program. Should the resident want to appeal to the RPC, this request will be made in writing and addressed to the Program Director. Documentary evidence, if there is any, supporting the resident's position should accompany the request. The resident may want to discuss the issue with his/her Omsbuddy and Program Director before taking this formal step.

If the resident is still unhappy with the results of the RPC appeal, the Associate Dean of Postgraduate Medicine is requested to review the case. Should the Associate Dean not be able to resolve the matter, the steps outlined in the Postgraduate Education calendar are to be followed.

If at any time during the above process, the resident wishes to stop appealing the failed ITER, he/she will be asked to select the most suitable time to repeat the failed rotation.



Resident Annual Activity Report

Residents are expected to complete an annual activity report, which documents non-“medical expert” type activities, including: teaching activities, research presentations and publications, attendance at CME activities, presentation at rounds, etc. The forms are submitted to Mrs. Debby Caldwell at the completion of each year of residency. See Appendix 1.



APPENDIX 1:

MEDICAL MICROBIOLOGY RESIDENT ACTIVITY REPORT (Revised: March, 2010)

NAME: _____

PGY LEVEL:

A. PRESENTATIONS

1. PATHOLOGY PRESENTATIONS AT ROUNDS AND ACADEMIC HALF DAY

List the date and name of the Rounds at which you present pathological findings e.g. Thursday Departmental Conference, Gross-Micro Correlation, Journal Club, Interdisciplinary Rounds, etc.

[illegible]



TEACHING

List details of teaching that you have done e.g.:

Med I, Med II labs, teaching pathologist duties, cytotech. students, etc.

DATE	DETAILS (e.g. type of teaching, topic)

B. ADMINISTRATION ACTIVITIES (e.g. Committees, PARI-MP duties, Chief/Associate Chief Roles)

DATES	



c. RESEARCH ACTIVITIES (Research presentations, publications, etc.)

DATE	Title of abstract, paper, etc. (Please indicate venue of any presentations)

D. CME Attendance (courses, workshops, etc.)

DATE	TITLE

E. OTHER (e.g. Volunteer activities, community participation, etc.)

DATE	ACTIVITY



APPENDIX 2a: Vacation Request Form

VACATION REQUEST FORM Medical Microbiology Resident

All vacation requests should be made a minimum of three (3) months in advance. Vacation requests made less than a month before the requested date cannot be guaranteed.

It is the resident's responsibility to ensure that the appropriate supervisors sign the vacation request form before submitting to the Program Director or designate.

Residents are entitled to 28 days of vacation (the 28 days comprising five (5) working days and either the weekend before or the weekend after from 5:00 p.m. on Friday to 8:00 a.m. on Monday) during each complete academic year. A maximum of seven (7) vacation days can be taken per 28-day rotation block.

Vacation cannot be included as part of the Christmas break. Do not assume that you will have weekends off at both the start and end of your scheduled time-off. However, you will be guaranteed one weekend off, either before or after a minimum of 5 vacation days. Therefore, all requests for 5 days vacation (e.g. Monday to Friday) will count as 7 days vacation (or 14 days, for 10 days vacation).

You will receive an email reply within 2 weeks of submitting the request. Do not assume that your vacation request is approved merely by submitting the form. Although every attempt will be made to accommodate your request, it may not be always possible to do so.

RESIDENT _____ PGY Level: _____

Email address: _____

NEW

Dates: _____ Rotation _____

CHANGE

Old Dates: _____ Rotation: _____

New Dates: _____ Rotation: _____

APPROVAL

Service Contact: _____ Date: _____

Service Contact: _____ Date: _____
(2nd if necessary)

Chief Resident: _____ Date: _____

Program Director: _____ Date: _____

Return completed form to:

1. Residency Training Office (Kim Trigg, Room 404, Mackenzie Building VG Site, 473-6469)
2. Microbiology Service Chief



APPENDIX 2b: Travel Guidelines for Residents & Graduate Students

Department of Pathology Travel Guidelines for Residents & Graduate Students

The Department of Pathology will reimburse residents and/or graduate students *whose abstract is accepted for presentation to eligible scientific meetings*. Expenses to a maximum of \$2,000 will be reimbursed for one conference per fiscal year per resident or graduate student.

In order to be eligible for these travel funds, residents and graduate students are expected to participate in the departmental annual Research Day.

The attached “Request for Travel Funding” form must be submitted at least three months prior to proposed travel to Christine Anjowski, Administrator, Rm. 11B, Tupper Bldg.

Eligible Expenses (see Dalhousie University Financial Services Travel Policy & Procedures for details):

Transportation - must be the most economical mode by the shortest direct route; air travel shall be arranged so as to incur the lowest air fares (e.g. if special fares are not available, economy class is to be used; there will be no reimbursement for upgrades to business/first class).

Privately owned vehicles - may be used and will be reimbursed in accordance with approved rates. If air travel is more economical, the University will reimburse the cost of the equivalent economy air travel rather than the kilometrage rate.

Accommodation - must be secured at a reasonable rate. If University/College housing is available, then this must be arranged. If travelling to the same meeting, *efforts should be made to share room costs where appropriate*. Ineligible expenses are in-room movies, personal long distance telephone calls and additional costs for family members or others beyond the *single* room rate.

Ground transportation – reasonable reimbursement is available for travel to/from airports and/or hotel/meeting site.

Meals – may claim reimbursement on either the approved per diem rate or actual expense basis. A combination of the two methods is permitted on any one particular trip.

Upon Your Return: In accordance with income tax regulations, all expenses must be receipted with original tickets, invoices and receipts, except per diem or e-ticket airline tickets. If electronic tickets are issued by the airline, the e-ticket plus all boarding passes must be provided. The hotel invoice plus an original credit card statement (or an online printed version) showing payment is required. Photocopies of receipts are not acceptable.

Graduate students – submit all receipts to Eileen Kaiser, Rm. 11B, Tupper Bldg.

Residents – submit all receipts to Debby Caldwell, Rm. 737, Mackenzie Bldg.

For Canadian Association of Pathologists (CAP) annual meeting reimbursements, a reimbursement will be processed *minus \$300.00*. Receipts will be returned to the individual so that they can apply directly to the CAP for the \$300.00 travel award.

Continuing Medical Education Allowance for Residents

The Department will reimburse senior (PGY5) residents (for Hematopathology, PGY4) up to a maximum of \$1,000.00 for continuing medical education. PGY4 residents may also be eligible for this allowance, however, they would then not receive this funding as a PGY5 resident). This is a one-time only reimbursement and must be for appropriate educational purposes only. The “Request for Travel Funding” form must be submitted at least three months prior to the proposed travel. Upon your return, submit receipts to Debby Caldwell, Rm. 737, Mackenzie Bldg.



Request for Travel Funding - Department of Pathology

Return completed form, including confirmation of acceptance of your presentation and/or abstract and verification of request and/or receipts of external travel support funding to Christine Anjowski, Administrator, by mail (Rm. 11B, Tupper Bldg.) or FAX 494-2519 at least three months prior to proposed travel.

Date: _____

Name: _____

Banner ID #: _____

Affiliation (resident or graduate student): _____

If resident, indicate year: _____

Mailing address & tel #: _____

Email address: _____

Name of meeting: _____

Dates of meeting: _____

Location of meeting: _____

Estimated Expenses:

Registration: \$ _____

Workshop(s): \$ _____

Accommodation
(indicate if you will be sharing and with whom): \$ _____

Airfare: \$ _____

Minus CAP travel award (if applicable): \$300.00

Total Funding Requested:: \$ _____

Check box below if this is a request for continuing education allowance funding for residents:

☐

Revised: August 2009



Appendix 3: Medical Microbiology Resident Safety Policy

Introduction

Although the Post Graduate Office has developed a policy on Resident Safety (<http://postgraduate.medicine.dal.ca/ResidentSafetyPolicy.html>), The Department of Pathology, Dalhousie University has tailored this policy specifically for Residents in Pathology and Laboratory Medicine.

The Department of Pathology recognizes that residents require a safe environment during their residency training. The responsibility for promoting a culture and environment of safety rests with the Faculty of Medicine, Capitol District Health Authority Pathology staff, residency training programs and with the residents themselves.

Responsibilities:

For Residents: to promptly inform the program of safety concerns and to comply with safety policies.

For Residency Training Programs: to act promptly to address safety concerns or incidents and to help promote a safe learning environment.

Physical safety

These policies apply only during residents' activities that are related to their residency related duties:

- Residents should understand and adhere to the 'General Requirements for Laboratory Safety Policies' (see Appendix 4)
- Residents must attend the laboratory safety session during the AP-GP orientation session given at the start of PGY2
- Residents must attend the Biosafety Orientation session held by the Biosafety committee at Dalhousie
- Residents must observe universal precautions when indicated.
- Residents should be familiar with the location and services offered by the Occupational Health and Safety Office. This includes familiarity with policies and procedures for infection control and policies following exposure to contaminated fluids, needle stick/scalpel injuries and reportable infectious diseases.
- Residents should keep their immunizations up to date. Overseas travel immunizations and advice should be sought well in advance when travelling abroad for electives and meetings.
- Pregnant residents should be aware of specific risks to themselves and their fetus in the laboratory/training environment and request accommodations when indicated. Residents should notify their Program Director and consult the Occupational Health Office for information.



- Residents should adhere to the PGME safety procedures which also apply when training in an environment outside of the laboratory and when traveling to and from community rotations or Saint John Regional Hospital.

Psychological Safety

- Learning environments must be free from intimidation, harassment and discrimination.
- Residents should be aware of the Departmental Ombuddies and their roles (see Ombuddy contact information)
- Residents should be aware of and have access to resources in place to help with psychological problems, substance abuse, harassment and inequity issues (see PGME resources: PIETA, Dalhousie University Counseling Services, PARI-MP).

Professional Safety

- Programs should promote a culture of safety in which residents are able to report and discuss adverse events, critical incidents and patient safety concerns without fear of reprisal.
- Residents should have adequate support from the program following an adverse event or critical incident.
- Residents must be members of the CMPA and follow CMPA recommendations in the case of real, threatened or anticipated legal action.
- In addition to CMPA coverage for patient actions, residents are indemnified for actions or lawsuits arising from the actions or decisions made by committees (eg tenure, appeals, residency training) they may serve on, under the university insurance for lawsuits related to academic issues.
- Residency program committee members must not divulge information regarding residents. It is the responsibility of the residency Program Directors to make the decision and to disclose information regarding residents (eg personal information and evaluations) outside of the RTC and to do so only when there is reasonable cause. The resident's file is confidential.
- With regard to resident files, programs must be aware of and comply with the Freedom of Information and Privacy Act (FOIPOP) (see Dalhousie University Access and Privacy Coordinator).
- Resident feedback and complaints must be handled in a manner that ensures resident anonymity, unless the resident explicitly consents otherwise. However, in the case of a serious threat, the Program Director may immediately consult the Associate PGME Dean (see PGME policies). In general, the Program Director should serve as a resource and advocate for the resident in a complaints process.



CONTACT INFORMATION:

CMPA

http://www.cmpa-acpm.ca/cm_p.asp?04&doc=highlighta.cfm

PAR-MP

www.parmp.ca/

Dalhousie University Counselling Services

<http://counselling-services.dal.ca/>

Dalhousie University Office of Human Rights, Equity & Harassment Prevention

<http://ohrep.dal.ca/>

Office of Human Rights, Equity & Harassment Prevention Room 2,
Basement Level, Henry Hicks Academic Administration Building
s/o The President's Office, 6290 South Street

Halifax, Nova Scotia, B3H 4H6

Phone: (902) 404-6672/444-1337

Fax: (902) 404-1379

Email: hreh@dhal.ca

Dalhousie University Office of the Ombudsperson

<http://ombudsperson.dal.ca/>

Student Union Building

Room 407, 6130 University Avenue, Halifax, NS B3H 4J2

Telephone: (902) 404-6666

Fax: (902) 404-2609

E-Mail: ombudsperson@dal.ca

Dalhousie University Freedom of Information and Privacy Policy

<http://www.dal.ca/>

John Hope, FOI/PA Coordinator

Dalhousie University

Room 226, Henry Hicks Academic and Administration Building

Halifax, Nova Scotia B3H 4H6

Phone (902) 404-2184

Fax (902) 404-1668

John.Hope@Dal.Ca

PIETA program

<http://postgraduate.medicine.dal.ca/pieta.html>

Capital Health Occupational Health Office

Room 2584, Camp Veterans' Memorial Building

5555 Veterans' Memorial Lane

Halifax, Nova Scotia B3H 2E1

Phone: (902) 473-4773

Fax: (902) 473-2415

Room 231, Sedgwick Building

276 Tower Road, Halifax

Nova Scotia B3H 2Y9

Phone: (902) 473-2415

Fax: (902) 473-2603



Appendix 4: Department of Pathology General Safety Guidelines

Purpose

A guideline for all laboratories to ensure a standard level of safe practices, procedures, and processes. This guideline applies to all areas of the laboratory, technical as well as non-technical.

Policy

Laboratories are considered hazardous areas. Capital District Health Authority (CDHA) Department of Pathology and Laboratory Medicine (DPLM) strives to limit and reduce hazards by promoting safe work practices that are applicable to all divisions and sites.

Definitions

Technical area

Space in a laboratory dedicated to the preparation, processing, testing, and storage of biological material. Any area that contains substances used in the preparation, processing, testing, and storage of biological material.

Non-Technical area

Space in a laboratory defined by the hazard assessment and signage that separates it from a technical area. There are no biological or hazardous materials permitted in this area. It may be used for eating, drinking, and temporary storage of personal items. Offices are classified as non-technical areas.

Supporting Statements

Food, Drink, and like substances

Each division and site must clearly identify areas in which food and drink may be stored and consumed. These areas must be separated from technical areas where biohazardous materials and chemicals are stored and used by the hazard assessment and signage. Refrigerators reserved exclusively for food and drinks can only be located in areas where it is permitted to eat. They must be clearly identified as consumable items only.

Cosmetics/ Contact Lenses

Application of cosmetics in technical areas is prohibited. Adjustment or insertion of contact lenses in technical areas is prohibited.

Hair and beards

Hair that falls below the shoulders shall be restrained from falling in front of the face or shoulders where it may get caught in equipment or hang into biological or hazardous material. Beards



	<p>must be kept restrained for the same reasons. Beards cannot be worn with respirators in compliance with CSA standard Z94.4-02</p>
Jewelry and Neckties	<p>Jewelry or neckties must not dangle so that they may become caught in machinery or hang into biological or hazardous material. I.Ds worn on neck chains must have breakaway capability.</p>
Personal Property	<p>No personal property shall be stored in technical areas. This includes drawers and cupboards located in technical areas. Personal property must be stored in clean areas, or preferably in secure lockers.</p>
Footwear	<p>Appropriate footwear is required for anyone entering a technical area. This includes staff, medical faculty, students, contractors, and visitors. Appropriate footwear has fully enclosed heels, toes, and sides and is of a fluid resistant material. Canvas is not an acceptable material.</p>
Personal Protective Equipment (PPE)	<p>All PPE must be changed at regular intervals or whenever visibly contaminated. Lab coats must be worn when performing work in technical areas. These lab coats must not be worn in non-technical areas. Lab coats must be buttoned appropriately for the task being performed. All lab coats are to be laundered by the contractor for Capital Health, they are not to be taken home. Lab coats must be hung individually with no coat overhanging another. Aprons may be worn over lab coats as added protection, but never worn in place of a lab coat. Gloves must be worn whenever there is a risk of direct contact between skin, blood, body fluids and other biohazardous materials. Every division and site will identify procedures requiring gloves in their hazard assessments. Gloves must not be reused. All divisions and sites will identify the necessity for other types of PPE in their hazard assessments.</p>
Respiratory Protection	<p>All employees who require respirators will be fit tested according to Capital Health's Personal Protective Equipment (CH80-100) policy. Each division and site will determine which tasks require employees to wear respirators and develop appropriate safe work procedures.</p>



Hand washing	All employees will follow Capital Health's Hand Hygiene policy (IC 06-016) for hand washing and Capital Health's Nail care policy (IC06-015). Sinks shall be designated specifically for hand washing. Antiseptic hand cleansers may be used in areas where sink areas are limited (phlebotomy stations).
Eye washes and Emergency Showers	Eye washes and emergency showers shall be conveniently located wherever hazardous products are used or stored. Eyewashes shall be flushed weekly by staff and recorded appropriately. Emergency showers are maintained and tested by engineering services. Portable eyewash stations shall only be used if there is a problem with the general water supply as a temporary measure.
Good Housekeeping	All areas shall be kept tidy and uncluttered. Each division shall establish disinfection protocols for each section. Routine housekeeping (cleaning of floors, sinks, etc) shall be carried out by the company contracted through Capital Health.
Transport of specimens	Capital Health follows TDG regulations for all specimens received from outside sources and when sending specimens to other locations. All specimens must also comply with applicable WHMIS regulations.
Glassware	Whenever possible, glassware shall be replaced with non-breakable materials. Damaged or stained glassware shall be discarded in the appropriate waste container.
Pipetting	Mouth pipetting is prohibited. Use mechanical devices.
Waste segregation	All waste in Capital Health laboratories shall be discarded in the appropriate container. Biohazardous non-sharp waste shall be placed in double yellow bags. Biohazardous sharps shall be placed in a puncture proof container and clearly identified with biohazardous sharps labels. Waste with chemical residue and anatomical waste shall be placed in properly labeled red bags or buckets. Non-biohazardous, non-sharp waste shall be placed in green bags. Non-biohazardous sharps shall be placed in a puncture proof container and labeled as sharps. Confidential waste shall be



placed in appropriate shredder boxes. All other paper shall be recycled if possible.

**Emergency Preparedness/
Disaster Planning**

Capital Health laboratories shall have a written disaster response plan in accordance with CDHA Administrative Policy CH 80-030. This plan must be updated as staff and faculty change. It must be part of the divisional orientation and staff competency assessments.

Violence in the Workplace

Every laboratory division and site shall have a written assessment of the risk of violence in the workplace. This assessment shall be on file.

Hazard Assessments

Every division and site shall perform a hazard assessment of every task done in the workplace. This shall be written and filed. It shall detail every hazard and measures taken to correct or reduce the hazard. It shall be in compliance with the Workplace Hazard Identification and Safety Inspections and Compliance policy (CH 80-021). This is what is used to identify technical and non-technical areas of the laboratory.

Responsibility

Department Head/Laboratory Mgt. District Service Chiefs	<ul style="list-style-type: none"> - Ensures laboratory safety policies are implemented and enforced. - Ensures safety manual and training are available to staff. - Ensures appropriate PPE is available to all persons when required. - Ensures areas of the laboratories are properly classified.
Laboratory Safety Services Team (LSST)	<ul style="list-style-type: none"> - Assists Dept. Head/District chief, or designate, in fulfilling the Department of Laboratory and Pathology Medicine's responsibility for providing a safe Workplace for CDHA employees. - Ensure that the Safety Manual is available to staff and is required reading.
Divisional Safety Teams	<ul style="list-style-type: none"> - Respond to questions related to policies
Staff	<ul style="list-style-type: none"> - Participate in safety orientation and training as required. - Use appropriate PPE as necessary. - Read the Safety Manual and comply with safety policies. - Use safe work practices and other safety processes to ensure the protection of themselves, coworkers, patients and the public.



Supporting Documents

Document Name	Document #	Document Location
Laboratory Safety Manual	[Para-Link]	Paradigm
Fire Safety Program	CH80-025	Administrative Manual
Personal Protective Equipment	CH80-055	Administrative Manual
Dress Standards	CH40-095	Administrative Manual
Hand Hygiene	IC06-016	
Nail Policy	IC06-015	

References

Occupational Health and Safety Act, Statutes of Nova Scotia, Violence in the Workplace Regulation 209/2007, 1996; Section 82.

Occupational Health and Safety Act, Statutes of Nova Scotia, Workplace Hazardous Materials Information System (WHMIS) Regulation 64/89, 1996; Section 82.

NCCLS, Clinical Laboratory Safety; Approved Guideline – Second Edition. NCCLS document GP17-A2 (ISBN 1-56238-530-5) NCCLS, 940 West Valley Road, Suite 1400, Wayne, Pennsylvania 19087-1898 USA, 2004

Standards Council of Canada, Medical Laboratories – Requirements for Safety. National Standard of Canada CAN/CSA-Z15190-05 (ISBN 1-55397-821-8) Canadian Standards Association, 5060 Spectrum Way, Suite 100, Mississauga, Ontario, Canada L4W 5N6 2005

Standards Council of Canada, Selection, Use and Care of Respirators, National Standard of Canada CAN/CSA-Z94.4-02, Canadian Standards Association, 5060 Spectrum Way, Suite 100, Mississauga, Ontario, Canada L4W 5N6 2003



APPENDIX 5: Royal College Goals and Objectives:

<http://rcpsc.medical.org/residency/accreditation/index.php>



APPENDIX 6: Royal College Accreditation Standards, Rotation Goals and Objectives
<http://rcpsc.medical.org/residency/accreditation/index.php>



APPENDIX 7: Educational Objectives – Junior Bacteriology

Objectives of Training Residents in Medical Microbiology Introductory six month block

MEDICAL EXPERT

Knowledge

- Describe an approach to classification and identification of specific bacteria, fungi and parasites (see list appended).
- Describe the pathogenesis and virulence factors of specific bacteria, fungi and parasites and the relationship to infectious diseases
- Describe an approach to viral classification and identification.
- Describe a practical approach to disinfection and sterilization and the appropriate handling and disposal of infectious materials.
- Describe the manifestations of common infectious diseases as they relate to body sites.
- Describe newer molecular diagnostic methodologies (including molecular fingerprinting, resistance, determination, and the detection of pathogens).
- Describe the differences between normal microbiologic flora and pathogens common to various infection sites.

Skills

- Describe and perform common bench level methods, including manual, semi-manual, and automated systems.
 - Prepare and interpret Gram, acid fast and other special stains for fungi and parasites.
- Perform and interpret fluorescent microscopy.
- Develop an approach to common bacterial species using conventional biochemical tests and commonly used kits.
- Recognize common bacteria and parasites in human tissue.
- Develop an approach to serologic and culture investigations for the diagnosis of common infections.
- Perform and interpret susceptibility testing.

Communications

- Develop effective communications with other members of medical staff, housestaff, and other members of the healthcare delivery team.
- Develop awareness of appropriate timeliness, clarity, and accuracy of verbal and written microbiology related communications.

Collaborator

- Work effectively with other members of the laboratory team.



Health Advocate

- Describe the role of the Microbiology laboratory in the public health system.
- Describe the role of the Microbiology laboratory in population screening

Scholar

- Describe and perform a critical review of the Medical Microbiology literature.
- Present new knowledge to other learners through plate rounds, journal clubs and other academic for a.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 8: Educational Objectives – Senior Bacteriology

**Objectives of Training
Residents in Medical Microbiology
Second six month block
Bacteriology and Special pathogens**

MEDICAL EXPERT

Knowledge

- Describe an approach to classification and identification of specific bacteria, fungi and parasites (see list appended).
- Describe the pathogenesis and virulence factors of specific bacteria, fungi and parasites and the relationship to infectious diseases
- Describe an approach to viral classification and identification.
- Describe a practical approach to disinfection and sterilization and the appropriate handling and disposal of infectious materials.
- Describe the manifestations of common infectious diseases as they relate to body sites.
- Describe newer molecular diagnostic methodologies (including molecular fingerprinting, resistance, determination, and the detection of pathogens).
- Describe the differences between normal microbiologic flora and pathogens common to various infection sites.
- Describe WHMIS and TDG regulations
- Describe the rules and regulations relating to notifiable communicable diseases.
- Describe laboratory safety programs and their maintenance

Skills

- Describe and perform common bench level methods, including manual, semi-manual, and automated systems.
- Prepare and interpret Gram, acid fast and other special stains for fungi and parasites.
- Perform and interpret fluorescent microscopy.
- Develop an approach to common bacterial species using conventional biochemical tests and commonly used kits.
- Recognize common bacteria and parasites in human tissue.
- Develop an approach to serologic and culture investigations for the diagnosis of common infections.
- Develop and interpret a quality management program within the Medical Microbiology laboratory
- Perform and interpret susceptibility testing.

Communications

- Develop effective communications with other members of medical staff, housestaff, and other members of the healthcare delivery team.
- Develop awareness of appropriate timeliness, clarity, and accuracy of verbal and written microbiology related communications.

Collaborator

- Work effectively with other members of the healthcare team, with emphasis on interactions with the Infectious Diseases and Infection Control teams.

Management

- Describe the use of information technology to more efficiently manage the laboratory.
- Describe an approach to staffing and human resource management and budgeting.
- Describe the principles around quality control, quality assurance, and continued quality improvement as they relate to microbiology

Health Advocate

- Describe the role of the Microbiology laboratory in the public health system.
- Describe the role of the Microbiology laboratory in population screening.

Scholar

- Describe and perform a critical review of the Medical Microbiology literature.
- Present new knowledge to other learners through plate rounds, journal clubs and other academic fora.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 9: Educational Objectives – Molecular Diagnostics

**Objectives of Training
Residents in Medical Microbiology
Molecular Diagnostics Block**

MEDICAL EXPERT

Knowledge

- Describe the principles of DNA/RNA, genes and the regulation of gene expression.
- Describe the principals and applications of both conventional and real time Nucleic acid amplification tests (NAAT) (including PCR, TMA, SDA, used in both in house and commercially available amplification methods), restriction enzymes, PFGE,.
- Describe an approach to trouble shooting the above methodologies.
- Describe the use of molecular testing in the diagnosis of infectious diseases
- Describe the role of the molecular laboratory in studying the epidemiology of infectious agents in a number of settings.

Skills

Develop hands on experience with:

- A. PCR for mec and VRE genes.
- B. PCR for HSV and enteroviruses in CSF.
- C. PFGE for *S. aureus* / or another collection currently in the laboratory.
- D. Preparing amplicons for cloning into appropriate vector.
- E. Use of both conventional and real time PCR techniques
- F. Preparing amplicons for sequencing.
- G. Searching for sequences in GenBank
- H. Interpretation of PFGE patterns.
- I. PCR for Influenza and other respiratory pathogens.
- J. Use of imaging software for documentation of results of molecular analysis.
- K. PCR on bacterial isolates.
- L. PCR for DNA virus.
- M. PCR for RNA target.
- N.

Communications

- To develop effective communications with other members of medical staff, housestaff, and other members of the healthcare delivery team.
- To develop awareness of appropriate timeliness, clarity, and accuracy of verbal and written microbiology related communications.

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Programs in Infectious Diseases
and Medical Microbiology*



Collaborator

- Work effectively with other members of the laboratory team.

Health Advocate

- Describe the pros and cons of applying resources to molecular methods.

Scholar

- Describe and perform a critical review of the Medical Microbiology literature.
- Present new knowledge to other learners through plate rounds, journal clubs and other academic fora.
- Describe an approach to the use of molecular tools to investigate infection control questions.
- Critically appraise the use of molecular methods in diagnostic microbiology.
- Describe and teach molecular methods to other learners.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 10: Educational Objectives – Virology

**Objectives in Training
Residents in Medical Microbiology
Virology Block**

MEDICAL EXPERT

Knowledge

- To acquire a more detailed knowledge of viral taxonomy, virus-cell interactions, mechanisms of viral replication.
- Describe the immunologic response to viral infection.
- Describe the pathogenesis of viral infections including, concepts of latency and persistence.
- Describe the appropriate clinical specimens to diagnosing important virologic infections, including, specimen collection and transport.
- Describe the various specimen transportation systems available to a virology laboratory.
- Describe the usual cell culture lines used in clinical virology labs, the typical changes seen in cell culture, the maintenance and quality control of tissue culture lines.
- Describe the principles of serologic testing including, hemagglutination inhibition testing, enzyme immunoassay, plaque reduction neutralization testing, and immunofluorescence.
- Describe the uses and limitation of rapid antigen detection assays and the diagnosis of viral infection.
- Describe the typical immunologic responses to viral infection including, HIV, hepatitis A, B, and C, EBV, etc.
- Describe the commercial systems currently available for serologic and nucleic acid amplification testing.
- Describe the clinical manifestations of important viral infections.
- Describe the principles associated with viral genotyping, especially as applied to HCV and HIV.
- To describe the currently available antiviral drugs, their mechanism of action, pharmacokinetics and pharmacodynamics, adverse affects and clinical indications.
- Describe the mechanisms of antiviral resistance.
- Describe the methodologies and roles for viral quantitative assays.
- Describe how antiviral resistance testing is undertaken, and its clinical application.
- Describe the use of vaccination strategies in adults and children and in specific populations such as post transplantation.
- Describe the role of viral infection/diseases in transplantation.
- Describe the approach to screening of infectious diseases in transplantation from both the donor and recipient perspective

Skills

- Manipulation of cell cultures, including microscopic examination and the recognition of common cell lines.
- Recognize common viruses morphology on electron microscopy.
- Preparation and inoculation of tissue culture specimens.
- Perform and interpret *C. difficile* cell culture based cytotoxicity assays.
- Recognize the common patterns of cytopathogenic effect in tissue culture.



Communications

- To further increase skills in communicating with laboratory staff, Infectious Disease physicians, Infection Control, public health officials, and referring laboratories and physicians.

Health Advocate

- Describe the role of the Virology laboratory in disease surveillance.
- Describe the role of the laboratory in supporting public health immunization programs.
- Describe the role of the Virology laboratory in the recognition and control of outbreaks.

Scholar

- Describe further experience in the critical review of the medical microbiology literature as it relates to virology.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 11: Educational Objectives – Special Pathogens

**Objectives of Training
Special pathogens
Residents in Medical Microbiology**

MEDICAL EXPERT

Knowledge

- To increase knowledge of specific mycobacteria, fungi and parasites (see list appended).
- To increase knowledge of infectious disease pathogenesis as relates to these agents.
- To increase knowledge of mycobacterial and fungal susceptibility testing and the interpretation of results.

Skills

- To learn common bench level methods, including manual, semi-manual, and automated systems.
- To acquire the ability to prepare and interpret acid fast and other special stains for fungi and parasites.
- To develop the ability to perform and interpret fluorescent microscopy
- To develop the ability to recognize common mycobacteria and fungi using conventional biochemical tests and commonly used kits.
- To acquire the ability to recognize common parasites in human tissue.
- To develop the ability to utilize serologic and culture investigations for the diagnosis of common parasitic and fungal infections.
- To develop the ability to perform and interpret susceptibility testing and to interpret the results.
- To develop the ability to develop, and subsequently, interpret a quality management program as applied to the special pathogens section.

Communications

- To develop effective communications with other members of medical staff, housestaff, and other members of the healthcare delivery team.
- To develop awareness of appropriate timeliness, clarity, and accuracy of verbal and written microbiology related communications.

Collaborator

- To learn to work effectively with other members of the healthcare team, with emphasis on interactions with the Infectious Diseases and Infection Control teams.

Management

- To understand how to use information technology to more efficiently manage the laboratory.
- To become familiar with staffing and human resource management and budgeting.
- To understand principles around quality control, quality assurance, and continued quality improvement as they relate to microbiology.

Health Advocate

- To understand the role of the Microbiology laboratory in the public health system with special reference to tuberculosis and food and water borne pathogens.
- To understand role of the Microbiology laboratory in environmental surveillance.

Scholar

- To gain experience in the critical review of the Medical Microbiology literature.
- To acquire experience presenting new knowledge to other learners.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



Appendix 12: Educational Objectives – Paediatric Medical Microbiology

**Specialty Training in Pediatric Medical Microbiology
Educational Objectives**

Medical Expert

During each rotation, the trainee will develop increasing familiarity with the use of the laboratory in the diagnosis and management of infections in children, in particular:

1. Diagnosis, etiology, pathogenesis, natural history, pathology, clinical features and management (with emphasis on developing a laboratory approach).
 - a) acute illnesses due to a wide variety of microbial agents, including the acute communicable diseases occurring in the normal host;
 - d) nosocomial infections;
 - e) maternal infections as they affect the fetus;
 - f) infections in the neonate;
 - g) pulmonary infections in children;
 - j) childhood exanthems and other characteristically childhood infections
 - n) STIs;
 - o) children who have recently travelled;
 - p) congenital immunodeficiencies;
 - d) the appropriate use of laboratory and other tests to evaluate the competency of the immune system and the characterization and extent of any immunologic deficit.
2. To become familiar with the microbiological evaluation of potential child abuse cases, including the sensitivity and specificity of conventional and molecular testing modalities
3. To develop/expand on knowledge of antimicrobials in children to include:
 - a) childhood pharmacokinetics in normal and abnormal hosts;
 - b) laboratory monitoring of children on anti-infectives;
 - c) toxicity differences in childhood;
 - e) clinical indications and use in children.
4. To become familiar with specific issues surrounding the collection and processing of pediatric specimens and developing proficiency in the interpretation of results.
5. To become familiar with alternate strategies to the organization of a Clinical Microbiology laboratory.
6. To gain exposure to alternate strategies to testing clinical specimens for infectious agents, including manual, semi-automated and automated methods.
7. To gain experience with the diagnosis of infectious agents rarely seen in adult practice.



Communicator

1. Knowledge of teaching techniques and related evaluation strategies.
2. Knowledge of key differences in communication strategies in relation to the intended audience.
3. The ability to effectively communicate verbally and in writing with children, families, allied health personnel, colleagues and the public.

Collaborator

1. To consult effectively with other physicians and health care professionals.
2. To contribute effectively to interdisciplinary team activities involved in patient care.

Manager

1. The ability to identify the essential cost components in various diagnostic strategies.
2. To gain exposure to additional perspectives on the management of smaller clinical microbiology laboratory.

Health Advocate

1. To develop a thorough understanding of the microbiologist's role in the public health system, both as a facilitator for communication of reportable results and as an advocate for prevention strategies in the community.

Scholar

1. The increase skills to conduct searches of the medical literature on subjects related to infectious diseases and to critically appraise the literature.
2. Knowledge of the breadth and depth of pediatric literature related to infectious diseases, and development of a personal continuing education strategy.

Professional

1. Knowledge of ethical issues particular to the practice of ID in pediatrics.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 13: Educational Objectives – Infectious Diseases In-patient Consultation

**Educational Objectives
Adult Inpatient Consultation Rotations
Specialty Training in Adult Infectious Diseases**

During this rotation the resident will develop the knowledge, skills, aptitudes, and behaviours that will allow him/her to meet the following CanMEDS competencies expected of an Infectious Diseases physician:

Medical Expert

To function effectively as an Infectious Diseases consultant

- Perform a consultation effectively, including the presentation of well-documented assessments and recommendations in written and/or verbal form
- Identify and appropriately respond to relevant ethical issues arising in patient care
- Prioritize professional duties effectively and appropriately when faced with multiple patients and problems
- Demonstrate compassionate and patient-centered care

To establish and maintain clinical knowledge, skills and attitudes

- Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to Infectious Diseases
 - Demonstrate knowledge about infectious agents to include:
 - taxonomy, structure, physiology, life cycle, virulence factors, pathology, and antimicrobial susceptibility
 - structure and pathogenesis of proteinaceous infectious particles (prions)
 - Demonstrate the appropriate level of knowledge relating to the etiology, epidemiology, pathogenesis, natural history, pathology, clinical features, prevention and management of the following acute and chronic infectious diseases:
 - community-acquired infections that are commonly seen (e.g., bacteremia, pneumonia, gastroenteritis, sexually transmitted diseases, and endovascular, central nervous system, skin and soft tissue, bone and joint infections)
 - infectious diseases caused by specific pathogens (e.g. bacteria, mycobacteria, fungi, viruses, parasites, and prions)
 - infectious diseases in special hosts or specific populations (e.g. immune compromised patients, travellers, immigrants, pregnant women)
 - nosocomial infections
 - infectious diseases occurring as a result of emerging pathogens and bioterrorism
 - zoonoses
 - Demonstrate knowledge of the clinical and laboratory approach and differential diagnosis of complex problems in which infections may play a role, such as:



- fever syndromes (e.g. fever of unknown origin, fever and skin eruption, fever in the immune compromised patient, periodic fever, recurrent/relapsing fever)
- sepsis, systemic inflammatory response syndrome and multiple organ dysfunction/failure syndrome
- pulmonary infiltrates of uncertain etiology, particularly in the immune compromised host
- Apply an understanding of the following components of medical microbiology and clinical laboratory testing:
 - specimen selection, collection, and transportation
 - assessment of specimen quality
 - how laboratory tests are performed and to be interpreted
 - rapid diagnostic tests, including enzyme immune assays
 - antimicrobial susceptibility testing
 - molecular methods for detection of microorganisms, including 16s rDNA
 - direct microscopy (e.g. KOH preps; AFB, DFA, and Gram stains)
- Demonstrate knowledge about immunology, including:
 - innate and adaptive immunity
 - pathogenic mechanisms by which immune responses facilitate or prevent disease (e.g. cytokines, graft versus host diseases, transplant rejection)
 - immunological evaluation of the patient with recurrent infections
 - effects of emerging therapies, such as monoclonal antibodies that selectively target specific components involved in host response (e.g., TNF receptor antagonists)
- Demonstrate knowledge about antimicrobial agents and other infectious diseases therapies:
 - classification of licensed agents
 - pharmacokinetics and pharmacodynamics in normal and abnormal hosts
 - mechanisms of action and resistance
 - toxicities and drug interactions
 - clinical indications, contraindications, and use
 - economic implications of antimicrobial use
 - chemoprophylaxis including surgical perioperative chemoprophylaxis
 - process of acquiring antimicrobials through the special access program
- Apply the lifelong learning skills of the Scholar to implement a personal program to keep up-to-date, and enhance areas of professional competence in relation to infectious diseases.
 - Identify and regularly access resources that report emerging infectious diseases
 - Effectively search the literature for new information and guidelines
- Contribute to the enhancement of quality care and patient safety, in particular as related to infectious diseases, and integrate best evidence and practices into clinical care
 - Prescribe antimicrobial agents in a safe and effective manner, considering their positive and negative effects in individual patients and the community in general

To perform a complete and appropriate assessment of a patient



- Identify and explore issues to be addressed in a patient encounter, including the patient's context and preferences
- Elicit a history that is relevant, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis and/ or management,
 - Inquire about travel, work, and personal behaviours and/or exposures that may predispose the patient to certain infectious diseases
 - Inquire about such things as predisposing factors, family history, recurrent or recent infections that may suggest a history of immune compromise or infection with an antimicrobial resistant microorganism
- Perform a complete physical examination that is relevant and accurate for the purposes of diagnosis and/or management
- Select medically appropriate investigative methods in a resource-effective manner
 - Identify the most appropriate microbiological tests for the specific infection under consideration
 - Be familiar with diagnostic imaging modalities that are useful in the investigation of infectious diseases and infection mimics
- Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnoses and management plans
 - Anticipate short and long term complications of infectious diseases and their treatments, (e.g. the potential for drug-drug interactions, occurrence of superinfections)
 - Suggest alternative diagnoses as the cause of illness due to infection mimics

To use preventive and therapeutic interventions effectively

- Implement a management plan in collaboration with a patient and family and consulting health professional
- Demonstrate effective, appropriate, and timely application of preventive and therapeutic interventions
 - Recognize those infections that represent a medical emergency (e.g. malaria, meningitis, septic shock, necrotizing fasciitis)
 - Identify patients for whom chemoprophylaxis is recommended (e.g. solid organ and hematopoietic stem cell transplant recipients, patients with advanced HIV)

Communicator

To develop rapport, trust, and ethical therapeutic relationships with patients and families

- Recognize that being a good communicator is a core clinical skill, and that effective communication can foster patient and physician satisfaction, adherence and improved outcomes
 - Communicate complicated information to patients and families in an understandable manner, considering language skills and educational level
- Recognize that patients may identify individuals other than family members as their significant supports
- Demonstrate a positive, non-judgmental attitude towards patients and their families/supports



- Establish positive therapeutic relationships with patients, families/supports that are characterized by understanding, trust, respect, honesty and empathy
 - Recognize the importance of developing and maintaining these relationships with vulnerable and marginalized patient populations who may be stigmatized because of their infectious disease and/or the factors that put them at risk of infection
- Respect patient confidentiality, privacy and autonomy
 - Recognize that patients with an infectious disease may feel more vulnerable in terms of confidentiality, privacy, and autonomy
- Listen effectively, obtain and synthesize relevant history from patients, families/supports, and communities
 - Be aware of and responsive to nonverbal cues
 - Recognize that some patients may feel embarrassed or ashamed by having an infectious disease, or of the behaviours that led to the infection, which may lead them to exhibit nonverbal cues
 - Use various strategies to engage the reluctant, ambivalent, or hostile patient during the course of a clinical encounter
 - Display skill and caring in identifying and exploring issues that may be sensitive to the patient, such as sexual and drug-using practices
 - Familiarize oneself with the health and illness beliefs of patients from other ethnocultural backgrounds

To convey relevant information and explanations to patients and families/supports, colleagues and other professionals

- Deliver information in a manner that it is understandable, respectful, and encourages discussion and participation in decision-making
 - Be aware of the potential for mixed messages to be delivered to patients and their families, particularly as this relates to choice of diagnostic procedures, antimicrobial agents and duration of antimicrobial therapy
- Communicate with other health professionals in a manner that facilitates the delivery of consistent messages to the patients and their families
- Convey information about a medical encounter
 - Maintain clear, concise, accurate, and appropriate records of clinical encounters with rationale (e.g., written or electronic) for plans
 - Present verbal reports of clinical encounters and plans effectively

Collaborator

To participate in interprofessional health care teams

- Recognize and respect the diversity of roles, responsibilities and competencies of other professionals in relation to their own
- Work with others to assess, plan, provide and integrate care for individual patients (or groups of patients)
 - Be aware that integration of care may involve health care and non-health care providers in both the hospital and community setting



- Demonstrate leadership in the healthcare team by supervising the activities of junior housestaff
- Demonstrate a respectful attitude towards other colleagues and members of an interprofessional team
- Respect professional differences
 - Recognize that different professionals have varying levels of knowledge, attitudes and adherence to accepted infection prevention and control and antimicrobial prescribing practices
 - Be collegial and collaborative in efforts to educate other professionals in accepted infection prevention and control and antimicrobial prescribing practices
- Recognize that one's own opinions and limitations may contribute to interprofessional tension

Manager

To manage their practice and career effectively

- Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
- Implement processes to ensure personal practice improvement
 - Develop a continuing professional education strategy including participating in teaching rounds and journal club
 - To manage resources as it relates to appropriate use of diagnostic and other health care resources
 - Employ information technology appropriately for patient care
- Apply evidence and management processes for cost-appropriate care
 - Access and apply a broad base of information to the care of patients in the inpatient setting, including knowledge of the most cost effective laboratory procedures

To manage resources as it relates to appropriate use of diagnostic and other health care resources.

Health Advocate

To respond to individual patient health needs and issues as part of patient care

- Identify the health needs of an individual patient
- Identify opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care
 - Appreciate that patients with infectious diseases may be vulnerable to discrimination, poverty, and violence (including sexual assault)
 - Advocate on behalf of the patient on the health care team
 - Identify behaviours such as recreational drug use, excess drinking, unsafe travel, unsafe food handling, and unsafe sexual practices that place patients at risk for adverse health outcomes and recommend strategies to reduce those risks
 - Promote and educate an evidence-based approach to infectious diseases prevention and management (e.g. vaccination, pitfalls of unproven therapies)



- Recognize that isolation and quarantine measures to prevent the spread of infection may interfere with the patient's autonomy and liberty
- Recognize that legislated reporting requirements for infectious diseases may place the physician in conflict with the patient's desire for confidentiality and privacy
- Describe the role of the medical profession in advocating collectively for health and patient safety

Scholar

To maintain and enhance professional activities through ongoing learning

- Recognize and reflect learning issues in practice
- Access and interpret the relevant evidence
- Integrate new learning into practice
- Evaluate the impact of any change in practice
- Document the learning process

To critically evaluate medical information and its sources and apply to practice decisions

- Critically appraise retrieved evidence in order to address a clinical question
- Integrate critical appraisal conclusions into clinical care

To facilitate the learning of students, residents, and other health professionals

- Collaboratively identify the learning needs and desired learning outcomes of others
- Select effective teaching strategies and content to facilitate others' learning
- Demonstrate an effective lecture or presentation
- Assess and reflect on a teaching encounter
- Provide effective feedback

Professional

To demonstrate a commitment to patients, profession, and society through ethical practice

- Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect, an appreciation of diversity, and altruism
 - Demonstrate an understanding of one's own beliefs and values as they relate to issues around infectious diseases that may influence one's professional care
 - Demonstrate self-awareness
- Demonstrate a commitment to delivering the highest quality care and maintenance of competence
- Recognize and appropriately respond to ethical issues encountered in Infectious Diseases, such as informed consent, confidentiality, and isolation
- Demonstrate ethical decision-making processes
- Demonstrate knowledge of legal and ethical codes of professional behavior and the obligations that apply to infectious diseases physicians, such as public health legislation around reportable infections



- Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law, which includes:
 - Confidentiality issues that are critical to the proper practice of infectious disease (e.g., HIV disclosure)
 - Communicate with patients, as appropriate, those situations where the physician may be required by law to divulge personal patient information such as a communicable infection
- Maintain appropriate professional relationships with patients
- Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation
 - Demonstrate tolerance for ambiguity and uncertainty and the possibility of error in decision-making; flexibility and willingness to adjust appropriately to changing circumstances
- Fulfill the regulatory and legal obligations required of current practice
- Demonstrate accountability to professional regulatory bodies
- Recognize and respond to others' unprofessional behaviours in practice
- Participate in peer review

To demonstrate a commitment to physician health and sustainable practice

- Balance personal and professional priorities to ensure personal health and a sustainable practice
- Strive to heighten personal and professional awareness and insight
- Recognize other professionals in need and respond appropriately

Educational strategies and expectations

- In the first year of training, the resident will be the first person to see consultations. Having developed a summary of the history and physical findings, and an assessment and plan, the resident will present this to the staff person for review and feedback.
- In the second year of training, the resident will have increasing responsibility, including responsibility for decision making and teaching junior housestaff, under the supervision of the faculty.
- The resident will participate in all educational rounds, presenting as outlined in Residents' Responsibilities. These rounds include clinical rounds, journal review, miscellaneous other infectious disease seminars, quality assurance/morbidity review and regular meetings of the infectious disease group to review clinical care, microbiology, research and hospital administration issues.
- The resident will have access to online searching tools and medical information through CDHA and Dalhousie University libraries and internet.



Method of Evaluation

- The trainee will be evaluated by his/her supervisors during each rotations. In-training evaluation reports will be presented to the trainee by one of the principal supervisors at the end of each rotation. Formal assessment may take the form of oral short answer questions on clinical issues. The resident will be notified at least one week before any such assessment

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 14: Educational Objectives – Infection Control

Educational Objectives - Infection Prevention and Control Specialty Training in Adult Infectious Diseases

Preamble

Infectious Disease Training for Royal College approval requires hospital infection prevention and control education. Generally, this training is taken during a one block (4 weeks) period and regular attendance at Infection Control Committee meetings. During this rotation the resident will develop the knowledge, skills, aptitudes, and behaviours that will allow him/her to meet the following CanMEDS competencies expected of an Infectious Diseases physician:

Medical Expert

To function effectively as a consultant in infection prevention and control, the resident should be able to:

- Recognize that the nature of infection prevention and control, including outbreaks, is unpredictable, making it important that the Infectious Diseases physician be able to demonstrate flexibility and strong prioritization skills
- Identify and appropriately respond to relevant ethical issues arising in infection prevention and control
- Prioritize professional duties effectively and appropriately when faced with multiple infection prevention and control issues

To establish and maintain clinical knowledge, skills and attitudes regarding the practice of infection prevention and control, the resident should be able to describe the following:

- Duties and responsibilities of the infection control practitioner and hospital epidemiologist
- Role of infection control committees in the health care setting
- Theory and application of infection prevention and control precautions
- Strategies for the recognition and investigation of outbreaks
- The application of molecular epidemiology techniques in infection prevention and control
- Reporting requirements of outbreaks to local public health authorities
- Principles and practice of surveillance
- Economic implications of nosocomial infections and infection prevention and control
- Principles of prevention and implementation of infectious prevention and control interventions, including educational strategies;
- Occupational infections, including postexposure prophylaxis
- Surgical site infection prophylaxis;
- Water and foodborne illnesses in facilities;
- Disinfection and sterilization, including implications of disinfection and sterilization failure



Communicator

- The Resident should be able to communicate effectively the principles of infection prevention and control to health care workers, administrators, patients, and the general public

Collaborator

Through participation in interprofessional health care teams, the resident should be able to:

- Describe clearly the roles and responsibilities of the hospital epidemiologist
- Describe the role and structure of the Infection Prevention and Control Committee
- Participate effectively in Infection Prevention and Control Department team meetings
- Work effectively with other health professionals to prevent, negotiate, and resolve interprofessional conflict
 - Respect team ethics, including confidentiality, resource allocation and professionalism
 - Demonstrate a respectful attitude towards other colleagues and members of the infection prevention and control department
- Work with other professionals to prevent conflicts
 - Recognize that infection prevention and control activities may be a source of conflict between Infectious Diseases physicians and other health care workers
 - Employ strategies to minimize the potential for conflict related to infection prevention and control responsibilities
- Employ collaborative negotiation to resolve conflicts
 - Be able to satisfactorily resolve conflicts arising out of infection prevention and control responsibilities
 - Respect professional differences
- Recognize that different professionals have varying levels of knowledge, attitudes and adherence to accepted infection prevention and control practices
- Be collegial and collaborative in efforts to educate other professionals in accepted infection prevention and control practices
- Recognize that one's own opinions and limitations may contribute to interprofessional tension

Manager

Through participation in activities that contribute to the effectiveness of the healthcare organization the resident should be able to:

- Work collaboratively with others to advise on
 - Infection prevention and control activities
 - Occupational health issues related to infection in the health care setting
- Describe and participate in systematic quality process evaluation and improvement



- Attend Infection Prevention and Control Committee meetings
- Demonstrate an understanding of the structure and function of the health care system as it relates to Infectious Diseases
 - The roles and responsibilities of local, provincial, and federal public health professionals and agencies in relation to infection prevention and control in health care settings
- Allocate finite healthcare resources appropriately
 - Apply infection prevention and control practices and knowledge to prevent nosocomial infections and investigate infection outbreaks in the hospital setting
 - Access and apply a broad base of information, including knowledge of the most cost effective infection prevention and control interventions
- Serve in administration and leadership roles
 - Be an effective resource to the Infection Control Committee

Health Advocate

To promote the health of patients

- Describe how policy impacts on the health of the populations served
 - Identify policies that affect health, either positively or negatively, such as isolation, antimicrobial restrictions, and post-exposure prophylaxis.
- Identify points of influence in the healthcare system and its structure
 - Identify contacts within the healthcare system (e.g. hospital administrators) who have the ability to effect change through support of infection prevention and control
- Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism
 - Recognize that isolation measures to prevent the spread of infection may interfere with the patient's autonomy and liberty
- Describe the role of the medical profession in advocating collectively for health and patient safety through infection prevention and control programs

Scholar

To maintain and enhance professional activities through ongoing learning

- Access and interpret the relevant evidence
- Integrate new learning into practice
- Evaluate the impact of any change in practice

To evaluate the literature and apply it appropriately to infection prevention and control

- Critically appraise retrieved evidence in order to address a clinical question
- Integrate critical appraisal conclusions into infection prevention and control interventions



Professional

To demonstrate a commitment to patients, the profession, and society through ethical practice

- Appropriately manage conflicts of interest
 - Recognize the potential for conflicts of interest related to interactions with manufacturers and/or distributors of infection prevention devices and equipment
- Demonstrate knowledge of legal and ethical codes of professional behavior and the obligations that apply to infectious diseases physicians, such as public health legislation around reportable infections
- Recognize and appropriately respond to ethical issues encountered in infection prevention and control such as confidentiality, isolation, and dealing with individuals who may put others at risk by virtue of their behaviours,
- Appreciate the professional, legal and ethical codes of practice, including
 - Appropriate conduct when interacting with industry, including the manufacturers and distributors of infection prevention devices and equipment

Educational Strategies

- Shadowing of infection control practitioners in the adult and pediatric settings, with some delegation of responsibility for management of daily infection control problems
- Attendance at Infection Control Department and Committee meetings
- Research and development of a topical infection control policy
- Investigation of an outbreak
- Completion of infection prevention and control assignments

Method of Evaluation

- The trainee will be evaluated by the hospital epidemiologist. Formal assessment will take the form of written assignments on relevant infection control issues. The trainee will be given the assignments at the beginning of the rotation and expected to return them within 3 months of completing the rotation. All written assignments will be discussed in person with the trainee. Additionally, there will be a written examination to evaluate knowledge by the end of their formal training period.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 15: Educational Objectives – Junior Consultant Rotations

Educational Objectives Junior Consultant Rotations Specialty Training in Adult Infectious Diseases

As part of graduated responsibility during the Infectious Disease clinical training in the Medical Microbiology Residency, the resident should have attained sufficient knowledge and experience that it will be expected that they function as a junior attending during the final two 4 week blocks of in-patient consultation service. This essentially means the resident will have greater autonomy in managing the in-patient consultation service. In addition to the specific CanMEDS competencies objectives outlined in the Adult ID consultation service, the Goals and objectives of this rotation include the expectation that the senior ID resident will manage the service and their other out-patient clinics or other responsibilities much like an attending staff.

Medical Expert/Clinical Decision-Maker:

As per the objectives outlined in the Adult ID consultation service

Communicator:

- The Resident will be expected to teach the junior house staff (both clinical skills and infectious disease knowledge) around issues that arise from the cases.
- The resident will be expected to write a concise summary of the case on the consultants form with a clear outline of the diagnostic, treatment and follow up plan.

Collaborator:

As per the objectives outlined in the Adult ID consultation service

Manager:

- The resident will manage all consults. The senior resident on service will be the primary point of contact for consults and distribute them to house staff who will first assess the patient. The ID junior house staff will then review the patient with the house staff, develop a diagnostic, treatment and follow up plan.
- If multiple consults occur at the same time the resident may have to see the some consults on their own while the house staff are reviewing others.
- The resident will be responsible for seeing follow-ups. The maximum number of patients that they will follow at any one time is 15. Follow up of patients exceeding this number will be the responsibility of the attending staff.
- The Attending staff will give as much autonomy as possible but will always be available to discuss cases or address emergency situations.
- Attending staff will review the new patients with the resident at the end of the day to discuss and teach around issues with each case.

Health Advocate:

As per the objectives outlined in the Adult ID consultation service

Scholar:

- The resident should demonstrate the ability to use all possible information resources to come up with the treatment plan based on the current best practices.



Professional:

As per the objectives outlined in the Adult ID consultation service

Method of Evaluation

- The trainee will be evaluated by his/her supervisors during the rotations. In-training evaluation reports will be presented to the trainee by one of the principle supervisors at the end of each rotation. Formal assessment may take the form of oral short answer questions on clinical issues. The resident will be notified at least one week before any such assessment.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 16: Educational Objectives – Outpatient Clinics

**Specific Educational Objectives - Outpatient Clinic;
General Infectious Diseases
Specialty Training in Adult Infectious Diseases
Adult Clinical Infectious Diseases Rotation**

SPECIFIC OBJECTIVES

During this rotation the resident will develop the knowledge, skills, aptitudes, and behaviours that will allow him/her to meet the following CanMEDS competencies expected of an Infectious Diseases physician:

Medical Expert/Clinical Decision-Maker

Specific Requirements

A. Knowledge

- The trainee is expected to increase his/her level of knowledge relating to the etiology, epidemiology, pathogenesis, natural history, pathology, clinical features, prevention and management of the following acute and chronic infectious diseases:
 - a) mycobacterial and fungal infections;
 - b) sexually transmitted diseases;
 - c) infections in immigrants/refugees and travellers;
 - d) human immunodeficiency virus (HIV) infection and its complications;
 - e) infections in the immunologically compromised host (other than HIV),
 - i. transplant recipients, congenital immunodeficiency and other acquired deficiencies;
 - f) anatomic and organ specific infections such as skin and soft tissue, musculoskeletal, cardiac, CNS infections, etc.
 - g) infections occurring as a result of emerging pathogens and bioterrorism;
 - h) viral hepatitis;
 - i) Important infections in the pregnant patient
 - j) zoonoses.
 - k) other viral and bacterial infections
- A knowledge of immunology and immunization to include:
 - a) details of innate and adaptive immunity;
 - b) pathogenic mechanisms by which immune responses facilitate or prevent disease, including the role of cytokines, and immune modulators;
 - c) adult vaccinology principles and practice;
 - d) immunological evaluation of patient with recurrent infections.
- Principles and practice of prevention of infection by immunization and chemoprophylaxis. This should include the indications, contraindications, efficacy, effectiveness, and adverse effects of passive and active immunization



- Principles and practice of infection prevention and control with an emphasis on the out-patient setting
- Antimicrobials and other therapies in infectious diseases with emphasis on oral and home IV administration:
 - a) classification of agents with emphasis on oral agents;
 - b) pharmacokinetics and pharmacodynamics in the normal and abnormal host;
 - c) mechanism of action;
 - d) mechanism of resistance;
 - e) monitoring outpatients for toxicity and drug interactions;
 - f) clinical indications and use;
 - g) principles of pharmacoeconomics as they relate to home therapy.

B. Skills

- Elicit a history that is relevant, concise, accurate and appropriate to the patient's problem(s), including the relevant epidemiologic and travel history related to particular infectious diseases.
- Perform a physical examination that is relevant, accurate and appropriate.
- Perform an LP, TST and a pelvic examination in an efficient and confident manner.
- Select medically appropriate investigate tools, including microbiologic tests, in a cost-effective, ethical and useful manner.
- Retrieve and implement the information necessary to provide health care to patients.
- Access, retrieve, appraise and apply relevant information to various infectious disease problems.
- Anticipate short and long term consequences of infectious diseases and their treatments.
- Appropriately deliver patient/family education using the above-mentioned knowledge.
- Demonstrate insight into his/her own limitations.

Communicator

- To develop skills in effectively communicating consultation findings and recommendations to referring physicians.
- Establish a therapeutic relationship with patients and their families on a more long term basis than is possible on the inpatient service.
- To develop skills to communicate effectively with other health care professions.

Collaborator

- Develop understanding of the roles of other health care practitioners in the assessment and care of outpatients, with emphasis on delivery of home care programs.
- Develop understanding of the role of other family members in the provision of care at home.
- Develops an effective working relationship with the members of the multi-disciplinary HIV team.
- Effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict



Manager

- Able to prioritize and manage patients effectively in an outpatient setting.
- Understand the organization and management of home IV programs.
- Understand the cost/benefits of delivery of care in alternative care settings.
- To learn models for the delivery of infectious disease consultation services on an outpatient basis.
- Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
- Employ information technology appropriately for patient care
- Develop an understanding of the general processes to manage a medical practice including the financing and human resources

Health Advocate

- To understand barriers to the delivery of health care services at home.
- Understands the specialist's role to respond to the health care needs of patients with respect to the social, economic and biologic factors affecting their health.
- Understands the specialist's role to respond to the health care needs of the community with respect to the social, economic and biologic factors that may affect community health.
- To understand barriers to the delivery of health care services in the community.
- Demonstrates knowledge of infectious diseases and public health related policy in order to target primary and secondary preventive strategies for patient groups that are at risk of infectious diseases and their consequences (such as HIV, viral hepatitis, STDs, tuberculosis and vaccine-preventable diseases).

Scholar

- Demonstrates a commitment to continuous learning and develops and implements an ongoing and effective personal learning strategy.
- Facilitate the learning of patients, families, students, residents, other health professionals, the public, and others, as appropriate
- Contribute to the creation, dissemination, application, and translation of new medical knowledge and practices as appropriate.
- Develop the ability to critically evaluate medical information and its sources, and apply this appropriately to practice decisions

Professional

- To better understand issues around end-of-life care in alternate care settings, including improving the quality of life and dying with dignity
- Demonstrates integrity, honesty, compassion and respect for diversity.
- Fulfills medical, legal and professional obligations of the specialist.
- Meets deadlines, is punctual, monitors patients and provides appropriate follow up.

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- Demonstrates an understanding of the principles of ethics and applies these in clinical situations including the concepts of altruism, social justice, autonomy, integrity and idealism.
- . Demonstrates an awareness of personal limitations, seeking advice when necessary and accepts advice graciously.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 17: Educational Objectives – Paediatric Infectious Diseases

**Education Objectives
Specialty Training in Paediatric Infectious Diseases
Dalhousie University and IWK Health Centre
Pediatric Clinical Infectious Diseases Rotation - Adult MM Trainees**

Preamble

Specialty training requirements for Royal College certification in Medical Microbiology includes a minimum of one year clinical residency in Infectious Diseases. For adult MM trainees, this is comprised of 10 months of Adult Infectious Diseases and two months of Paediatric Infectious Diseases.

Medical Expert/Clinical Decision-Maker

During each rotation, the trainee will develop increasing familiarity with infections in children; in particular:

1. Diagnosis, etiology, pathogenesis, natural history, pathology, clinical features and management:
 - a) acute illnesses due to a wide variety of microbial agents including, the acute communicable diseases occurring in the normal host;
 - d) nosocomial infections;
 - e) maternal infections as they affect the fetus;
 - f) infections in the neonate;
 - g) fever of unknown origin in childhood, how it may differ from adults;
 - j) pulmonary infections in children;
 - k) Childhood exanthems and other characteristically childhood infections
 - l) infections in the immunologically compromised host;
 - n) recurrent infections in children.
 - o) Clinical syndromes commonly seen in children that may mimic infections.
2. A knowledge of immunology and immunization to include:
 - a) details of humoral, cell-mediated and phagocytic responses to microbial colonization and invasion in the normal and abnormal host;
 - b) pathogenic mechanisms by which immune responses facilitate or prevent disease;
 - c) principles and practice of immunization techniques together with adverse events and efficacy of immunizing agents;
 - d) the appropriate use of laboratory and other tests to evaluate the competency of the immune system and the characterization and extent of any immunologic deficit.
3. Knowledge of antimicrobial pharmacology to include:
 - a) childhood pharmacokinetics in normal and abnormal hosts;
 - c) toxicity differences in childhood;
 - e) clinical indications and use in children.



Communicator

- Knowledge of teaching techniques and related evaluation strategies.
- Knowledge of key differences in communication strategies in relation to the intended audience.
- The ability to effectively communicate verbally and in writing with children, families, allied health personnel, colleagues and the public.

Collaborator

- To consult effectively with other physicians and health care professionals.
- To contribute effectively to interdisciplinary team activities involved in patient care.

Manager

- The ability to identify the essential cost components in various strategies of care.
- Knowledge of the cost-effectiveness of various strategies of care and quality assurance.

Health Advocate

- To identify the important determinants of infectious diseases affecting children and to recognize how the consultant can contribute to improvement in the health of children and communities.

Scholar

- The increased skills to conduct searches of the medical literature on subjects related to infectious diseases and to critically appraise the literature.
- Knowledge of the breadth and depth of medical literature related to infectious diseases, and development of a personal continuing education strategy.

Professional

- Knowledge of ethical issues particular to the practice of ID in pediatrics.
- The ability to deal effectively and compassionately within a culturally sensitive manner with children and families from different ethnocultural backgrounds, recognizing differences in health perceptions, values, beliefs and behaviors.

Educational Strategies

- In the first one-month rotation, the resident will be the first person to see in-patient and ambulatory infectious disease consultations. Having developed a summary of the history and physical findings and an assessment and plan, the trainee will present this to the staff person for review and feedback. In the second month of training, the resident will have increasing responsibility for decision making and teaching junior housestaff, under the supervision of the faculty.
- The resident will be observed doing a history and physical at least once monthly by a faculty member.
- While on the Infectious Disease service, the resident will see Pediatric Immunology consultations with the staff person on that service.

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- The resident will participate in all educational rounds, presenting at least monthly. These rounds include clinical rounds, journal review, pediatric residency infectious disease seminars, quality assurance/morbidity review and regular meetings of the infectious disease group to review clinical care, microbiology, research and hospital administration issues.
- The resident will have access to online searching services through the IWK Medical Library, as well as access to materials through that library and the Killam Medical Library.

Method of Evaluation

- The trainee will be evaluated by his supervisors during the rotations. In-training evaluation reports will be presented to the trainee by one of the principal supervisors at the end of each rotation. Formal assessment may take the form of oral short answer questions on clinical issues or written “mock” consultations. The candidate will be notified at least one week before any such assessment.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



APPENDIX 18: Educational Objectives – Public Health

Educational Objectives Public Health Services, Capital District Health Authority

PREAMBLE

During this rotation the resident will develop the knowledge, skills, aptitudes, and behaviours that will allow him/her to meet the following CanMEDS competencies expected of an Infectious Diseases physician. This rotation will be undertaken as a one month block with the approval of the Medical Officer of Health (MOH). Residents will be expected to maintain a high degree of self direction during the block. Objectives will be set jointly with the resident and the MOH and reviewed regularly throughout the rotation. At a minimum, objectives will include the following:

Medical Expert/Decision Maker

1. To aide in a community outbreak investigation, including:
 - Making / revising a case definition, line listing
 - Assist in case finding
 - Create and interpret an epidemiologic curve
 - Create a hypothesis
 - Institute control measures
 - Monitor for improvement
 - Prepare and participate in outbreak debrief

Communicator

1. To give direction to and receive input from Communicable Disease Control and Prevention (CDPC) nurses as needed.
2. To give direction to and receive input from Public Health inspectors in the Departments of Environment and Labour and Agriculture, as needed.
3. To respond to members of the public and health care professionals at large, in writing when necessary, under the supervision of the Medical Officer of Health. This may include responding to media inquiries.

Collaborator

1. To become acquainted with the various players in the public health system and their roles in public health system at the local, provincial, and federal levels.
2. To seek opportunities for collaboration with those individuals on the daily issues and projects at hand during the rotation.

Manager

1. To assist in the day-to-day management of Communicable Disease issues within the district by assuming the role of “associate” Medical Officer of Health within Public Health Services.
2. To direct the activities of the CDPC and Outbreak Team in the absence of the MOH.



3. To liaise with the manager, CDPC, regarding staffing or other items requiring attention so that Communicable Disease issues may be dealt with effectively and efficiently.

Health Advocate

To identify Communicable Disease issues within the District by review of surveillance data, and to assist policy and advocacy discussions aimed at creating positive change.

Scholar

1. To assist the work of the team by providing input based on regular review of the scientific literature, especially that related to:
 - Tuberculosis Prevention and Control
 - Sexually Transmitted Infections'
 - Blood Borne Pathogens
 - Vaccine Preventable Diseases
 - Enteric Diseases
 - Zoonoses
2. To complete one scholarly or management project aimed at enhancing the quality or efficiency of CDPC work.

Professional

To create positive working relationships with the CDPC team and PHS Management Council, as well as with other PHS stakeholders as necessary.

Educational Strategies will include

- Shadowing of the Medical Officer of Health in Communicable Disease Prevention and Control work (meetings, etc.).
- Participation in all regular meetings of the CDPC team.
- Management of daily CDPC issues (from PHNs, PHIs, or public at large) under supervision of MOH.
- Shadowing of PHNs on Intake Line, Travel Clinic and home visits when available.
- Shadowing of PHIs on environmental health and food safety inspections.
- One day shadowing of Provincial Medical Officers of Health at NSHPP site ("downtown"), whenever available.
- Completion of at least one CDPC related project.
- Participation in teaching sessions provided by the MOH (minimum of 2).
- Review of pertinent texts or papers.

Required reading

- PHS Orientation Package - CDPC
- NS Health Protection Act

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- CCDR Article - Unwilling / Unable Protocol
- "Management of an Outbreak" - Oxford Handbook of Public Health
- LMCC chapter on Population Health
- Naylor Report (Executive Summary)
- NS Communicable Disease Prevention and Control Manual

Resident requirements

- Must have transportation to PHS (Burnside Industrial Park). Rotation may require transportation to various locations in a single day.
- Must have active e-mail account
- Call requirements - none, but availability for public health emergencies will be reviewed at the start of rotation.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



Appendix 19: Educational Objectives – STD

Educational Objectives – STI Clinic Rotations

During this rotation the resident will develop the knowledge, skills, aptitudes, and behaviours that will allow him/her to meet the following CanMEDS competencies expected of an Infectious Diseases physician:

Medical Expert/Clinical Decision-Maker

- Can explain appropriate specimen collection, transport and storage measures for different clinical specimens and presentations of STIs.
- Can obtain urethral and cervical specimen.
- Can outline the bedside diagnosis of STIs including urethral discharge gram staining, and wet mount examination and KOH testing of vaginal discharge.
- Can describe an approach to patients presenting STIs
- Can describe the presentations of common STIs including gonorrhoea, Chlamydia, syphilis, HSV, and HPV
- Can describe the different testing options for GC and Chlamydia
- Can describe the typical serologic response of HIV and syphilis
- Can describe the different testing algorithms available for the diagnosis of syphilis
- Can describe the epidemiology of the different STIs and the risk factors for them
- Can describe the natural history of STIs including HIV, syphilis, HPV and HSV
- Can describe the different treatment options available for STIs including GC, Chlamydia, HPV, HSV and syphilis
- Can describe post exposure prophylaxis in patients exposed to HIV and HBV
- Can describe the different vaccination strategies available for STIs.
- Can explain, (citing examples), the role of molecular methods (PCR, NASBA etc), in the diagnosis of a variety of STIs,
- Can describe the public health implications of STI diagnoses including which are notifiable disease and the issue around partner notification



Communicator

- Communicate information to patients in a non-judgmental and understandable manner, considering language skills and educational level
- Be able to describe the pre and posttest counseling in HIV testing
- Be able to counsel patient son the natural history of HSV.
- Respect patient confidentiality, privacy and autonomy
- Be aware of and responsive to nonverbal cues
- Recognize that some patients may feel embarrassed or ashamed by having an infectious disease, or of the behaviours that led to the infection, which may lead them to exhibit nonverbal cues

Collaborator

Works effectively and demonstrates a respectful attitude towards other colleagues and members of an interprofessional team

Health Advocate

- Identify the health needs of an individual patient
- Identify opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care
- Appreciate that patients with infectious diseases may be vulnerable to discrimination, poverty, and violence (including sexual assault)
- Advocate on behalf of the patient on the health care team
- Identify behaviours such as recreational drug use, excess drinking, unsafe travel, and unsafe sexual practices that place patients at risk for adverse health outcomes and recommend strategies to reduce those risks



Scholar

- Can demonstrate how to access knowledge resources in print and electronically.
- Can calculate sensitivity, specificity and describe how the prevalence of disease can affect the positive and negative predictive values of diagnostic tests as they apply to STIs.

Professional

- Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect, an appreciation of diversity, and altruism
- Demonstrate an understanding of one's own beliefs and values as they relate to issues around infectious diseases that may influence one's professional care
- Demonstrate self-awareness
- Demonstrate a commitment to delivering the highest quality care and maintenance of competence
- Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law, which includes:
 - *Confidentiality issues that are critical to the proper practice of infectious disease (e.g., HIV disclosure)*

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



Appendix 20: Educational Objectives – Research

**Educational Objectives - Research
Specialty Training in Medical Microbiology**

Medical Expert/Clinical Decision Maker

- A. Under the guidance of a trained and experienced researcher, design and execute a research protocol that includes:
 - (i) Understands the principles and practice of evidenced based medicine.
 - (ii) Can develop a hypothesis based on literature review and design a research protocol in accordance with the chosen area of study.
 - (iii) Demonstrates an understanding and can select the appropriate design from the different research methodologies necessary to address different research questions or hypothesis.
 - (iv) Demonstrates an understanding of statistical methods used in study design and evaluation
 - (v) Can critically appraise data
 - (vi) Understands the role of the Research Ethic Board and how it functions
 - (vii) Understands the Helsinki declaration which provides World Recommendations Guiding Medical Doctors in Biomedical Research Involving Human Subjects
 - (viii) Demonstrates an understanding of the requirements for authorship.

PROCEDURES AND TECHNICAL SKILLS

- A. Demonstrates proficiency in the laboratory techniques or other technical aspects (such as database design, management or analysis) required to complete the research protocol.
- B. Demonstrates proficiency in conducting a thorough literature review around a research question or hypothesis.
- C. Demonstrates proficiency in determination of sample size and power calculations.
- D. Demonstrates proficiency in performing simple statistical calculations such as determination of sensitivity, specificity, positive and negative predictive values; Non-parametric and parametric tests including simple student T test, chi square analysis.

COLLABORATOR

- A. Appreciates how they, in the capacity of an Infectious Diseases resident, can contribute to the research programs of other researchers as well as pursue independent studies
- B. Understands the collaborative nature of a research which often involves a multi-disciplinary team approach that benefits from the expertise of technologists, nurses, graduate students, medical residents and the research supervisor.

MANAGER

- A. Has an appreciation for the technical, intellectual, financial and personal challenges associated with maintaining a productive research laboratory/program
- B. Makes cost-effective use of limited research resources based on sound judgment.
- C. Sets realistic priorities and manages time effectively through multitasking in order to optimize professional performance.
- D. Understands laboratory safety issues



HEALTH ADVOCATE

- A. Understands the specialist role to intervene on behalf of patients with respect to the social, economic and biologic factors that may impact on their health.
- B. Can apply basic and clinical research to patient care
- C. Understands the difference between research and routine clinical or “standard” of care and can explain the role and benefits and risks of participation in a study to a patient
- D. Understands the specialist role to intervene on behalf of the community with respect to the social, economic and biologic factors that may impact on community health
- E. Recognizes and responds appropriately in advocacy situations.
- F. Can put the results of research questions into context for the public.

COMMUNICATOR

- A. Can clearly present data in an oral format at a level of understanding that is appropriate for the audience
- B. Can clearly present data in an written format at a level of understanding that is appropriate for the audience
- C. Can write a ethics submission or grant proposal

SCHOLAR

- A. Collaborate in both basic science and clinical research and understand the concepts of clinical research design
- B. Critically assess and synthesise the current literature on a topic of interest, identify deficiencies in that body of knowledge and ask an appropriate related research question to address the deficiencies
- C. Successfully integrates information from a variety of sources.
- D. Demonstrates an understanding and a commitment to the need for continuous learning. Develops and implements an ongoing and effective personal learning strategy.
- E. Understand the concept of academic freedom
- F. Can execute a systematic search for evidence and critically evaluate medical literature to identify research questions.
- G. Applies the principles necessary to evaluate quality of research in peer reviewed and non-peer reviewed publications.

PROFESSIONAL

- A. Set priorities and make effective use of time, is punctual, and meets deadlines
- B. Demonstrates integrity in the collection and presentation of research data including
- C. Understands and applies the principles of informed consent, confidentiality, autonomy.
- D. Demonstrates an awareness of own limitations, seeking advice when necessary. Accepts advice graciously.
- E. Demonstrates respect for co-workers.

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Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date

RESIDENT'S COMMENTS

Appendix 21: Educational Objectives – Med Micro Mini Course

Educational Objectives – Medical Microbiology Mini-course Rotation

During this rotation the resident will develop the knowledge, skills, aptitudes, and behaviours that will allow him/her to meet the following CanMEDS competencies expected of an Infectious Diseases physician:

Medical Expert/Clinical Decision-Maker

Specimen Accessioning

- Can explain appropriate specimen collection, transport and storage measures for different clinical specimens.
- Can explain the rationale and criteria for assessing the suitability of clinical specimens.
- Can Q score a sputum and wound specimen.
- Can describe routine specimen processing for routine bacteriology, mycology, mycobacteriology, parasitology and virology / immunology.
- Can explain the rationale for the choice of specific media and incubation conditions for commonly examined specimen.

Media and Sterilization

- Could recommend specific sterilization and disinfection practices for use in the laboratory and throughout the hospital.

Clinical Bacteriology

- Can perform and interpret a Gram stain of clinical materials from respiratory, genital tract , wound, skin and soft tissues
- Can interpret culture results from all clinical sites.
- Can explain the principles behind commonly used identification schemes.
- Can describe commonly available susceptibility testing systems, including disc diffusion, micro dilution and automated methods.
- Can discuss the rationale behind CLSI guidelines for antibiotic susceptibility testing.
- Is aware of methods for processing blood cultures.

- Can describe frequently occurring bacterial pathogens, their epidemiology, virulence factors, microbiologic characteristics and typical susceptibility patterns.
- Can describe the major mechanisms by which bacteria develop resistance to commonly used antibiotics.
- Can identify circumstances where antibiotic resistance may develop on treatment.
- Can describe how agents of bioterrorism and other high risk organisms must be handled in a clinical laboratory setting.

Molecular Epidemiology

- Understands the structure and properties of DNA / RNA and can describe the processes of transcription, reverse transcription, and translation.
- Can discuss the advantages and disadvantages of genotypic (molecular methods) vs phenotypic (biochemical methods) for the identification of bacterial and viral pathogens
- Can discuss the issues of contamination in the molecular laboratory and clinical implications.
- Can identify specimens appropriate for molecular diagnostics and common PCR inhibitors.
- Can describe the process involved in PCR and the detection of an amplicon and is aware of other nucleic acid amplification techniques.
- Can discuss the principles and use of nucleic acid hybridization.
- Understands the principle behind DNA sequencing and its application in bacterial identification / typing and can discuss the rationale use of 16s rDNA PCR amplification and sequencing.
- Can explain the use of molecular fingerprinting and the principles that dictate strain relatedness at the molecular level and can explain the principles behind PFGE and its interpretation.
- Can explain, (citing examples), the role of molecular methods (PCR, NASBA etc), in the diagnosis of a variety of infectious diseases (STDs, respiratory viruses, HIV, CMV, Norovirus, enteroviruses, papillomaviruses, etc)

Mycology

- Can describe the KOH preparations and calcofluor white staining.
- Can describe the principals around the use of selective media.

- Recognizes morphologic and biochemical characteristics of commonly occurring pathogens and contaminants.
- Can discuss the issues methods and issues relating to antifungal susceptibility testing.

Parasitology

- Can illustrate the lifecycles of commonly occurring and high impact parasites.
- Becomes aware of methods used for processing specimens for parasitic examination, including advantages and disadvantages of available methods.
- Performs examination of both direct and concentrated fecal specimens.
- Recognizes *Pneumocystis jirovecii* in clinical specimens and can discuss sensitivity and specificity of the immunofluorescence procedure.
- Can discuss the role of EIAs in the diagnosis of parasitic infections (Cryptosporidia, Giardia, Malaria)

Mycobacteriology

- Can explain the classification of mycobacteria, epidemiology, microbiologic characteristics and typical susceptibility patterns.
 - *Mycobacterium tuberculosis*
 - Atypical mycobacteria
- Can describe the initial processing of mycobacterial specimen for direct examination and culture.
- Can describe commonly used mycobacterial culture media, their inoculation, incubation and initial processing.
- Can describe the strategy to identify *Mycobacterium tuberculosis*.
- Can describe the manner by which atypical mycobacteria are identified.
- Demonstrates an understanding of principals around mycobacterial susceptibility testing.

Virology / Immunology

- Can describe the general life cycle of a simple RNA, DNA virus and HIV.
- Can describe how commonly used anti-virals agents act
- Can explain how viruses become resistant to anti-virals
- Observes and can explain how viruses can be detected and identified in tissue cultures.
- Observes and can describe how electron microscopy is performed on clinical samples..
- Observes and can explain the principles of immunofluorescence - direct and indirect.

- Can explain the laboratory diagnostic strategies for EBV, CMV, Varicella-zoster, Herpes simplex detection and typing, identification and detection of respiratory viruses, eg. RSV, adenovirus, parainfluenza viruses and influenza virus.
- Can explain the principles behind EIA testing.
- Can describe the diagnostic approach strategy applied to standardized molecular diagnostic tests for *Chlamydia trachomatis* and HCV and viral load measurement for CMV and HIV.
- Can describe how HIV susceptibility testing is performed.

Laboratory Safety

- Can describe the elements of the WHMIS program.
- Can describe the elements of the Transport of Dangerous Goods program.
- Can describe threats to the safety of laboratory staff and the manner in which risks can be mitigated.
- Can describe the different containment levels employed in the laboratory.
- Can describe the different types of biological safety cabinets and why they are different.

Communicator

- Communicates effectively with laboratory technologists and other laboratory staff.

Collaborator

- Works effectively with other members of the microbiology course and laboratory team.

Manager

- Can discuss issues around the cost effectiveness of different laboratory tests and approaches to diagnosis.
- Can describe safety and occupational health issues from a laboratory perspective.
- Can describe the elements of a laboratory disaster plan.

Health Advocate

See general objectives.

Scholar

- Can demonstrate how to access microbiology knowledge resources in print and electronically.
- Can calculate sensitivity, specificity and describe how the prevalence of disease can affect the positive and negative predictive values of diagnostic tests.

Professional

See general objectives.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date



Appendix 22: Educational Objectives – Junior Staff Microbiology

Objectives of Training Junior Staff Block Residents in Medical Microbiology

The focus of the resident's months as a "Junior Staff Physician" is to synthesize the training he/she has received the preceding years, with a focus on developing skills and confidence in solving the day-to-day problems that are posed by medical microbiology practice. The resident will be expected to develop a big-picture view of a complex microbiology laboratory where provision of service to clients, resource management, quality management systems, information systems and laboratory safety, education and research are integrated.

MEDICAL EXPERT

Knowledge

- To increase knowledge of clinically important bacteria, viruses, fungi and parasites.
- To increase knowledge of infectious disease pathogenesis.
- To increase knowledge of the role of the laboratory in hospital infection control and prevention activities.
- To increase knowledge of disinfection and sterilization and the appropriate handling and disposal of infectious materials.
- To acquire knowledge of rules and regulations relating to notifiable communicable diseases.
- To increase knowledge of common infectious diseases as they relate to body sites.
- To increase knowledge of molecular diagnostic methodologies (including molecular fingerprinting, resistance, determination, and the detection of pathogens).

Skills

- Apply common bench level methods, including manual, semi-manual, and automated systems.
- Interpret Gram, acid fast and other special stains for fungi and parasites.
- Perform and interpret fluorescent microscopy.
- Recognize common bacterial species using conventional biochemical tests and commonly used kits.
- Recognize common bacteria and parasites in human tissue.
- Describe an approach to serologic and culture investigations for the diagnosis of common infections.
- Perform and interpret susceptibility testing and to interpret the results.
- Develop and interpret a quality management program within the Medical Microbiology laboratory.



Communications

- Effectively communicate with other members of medical staff, housestaff, and other members of the healthcare delivery team.
- Understand and apply the appropriate timeliness, clarity, and accuracy of verbal and written microbiology related communications.

Collaborator

- Work effectively with other members of the healthcare team, with emphasis on interactions with Public Health staff and the Infectious Diseases and Infection Control teams.

Management

- Describe the principles and implementation of resource utilization in the Microbiology laboratory.
- Describe how information technology is used to more efficiently manage the laboratory.
- Describe the principles and participate in human resource management.
- Describe how a microbiology laboratory funding is structured.
- Describe how microbiology workload is measured.
- Describe the principles around quality control, quality assurance, and continued quality improvement as they relate to microbiology
- Direct the activities of laboratory technologists.
- Develop and describe an approach to evaluating clinical specimens.
- Describe employee health and safety issues.
- Describe the principles of Biosafety and biosecurity as they relate to the different containment levels within the clinical laboratory.
- Describe and participate in the process of budget development.

Health Advocate

- Describe the role of the Microbiology laboratory in the public health system.
- Describe role of the Microbiology laboratory in population screening.
- Describe an approach to matching available resources with laboratory priorities and the demands for patient testing.
- Describe the role of advocacy for a strong public health and diagnostic laboratory system
- Describe the role for advocacy for quality programs at the hospital, provincial and federal levels



Scholar

- To increase experience in the critical review of the Medical Microbiology literature.
- To increase experience presenting new knowledge to other learners.

Date approved by Residency Committee

Signature of Supervisor

Date

Signature of Resident

Date

CNS Infections

1. A 14-year-old high school student develops the sudden onset of fever and headache. Stiff neck and delirium are present on presentation to the emergency room.
 - (a) What is the clinical syndrome and what is the likely etiological agent?
 - (b) What diagnostic studies should be carried out and what initial treatment should be given in the emergency room?
 - (c) Are any public health measures warranted in this case?
2. A 72-year-old man with a history of peptic ulcer disease develops the gradual onset of fever, chills, headache and gait disturbance. On physical examination there is mild obtundation and a stiff neck. Lumbar puncture reveals 700 white cells, 50% of which are polymorphonuclear leukocytes and CSF glucose of 1.0. A gram stain of the specimen is negative.
 - (a) What other diagnostic studies should be carried out?
 - (b) Should empiric therapy be given in this instance and what antimicrobials would you consider?
3. A 25-year-old man with an unrepaired VSD develops fever, chills and right frontal headache. Examination demonstrates no neurologic findings, but absent venous pulsations and a harsh systolic murmur at the left sternal border. Two out of three blood cultures grow a microaerophilic streptococcus.
 - (a) What diagnosis may be responsible for this man's illness?
 - (b) What further diagnostic studies should be considered?
 - (c) Based on your likely diagnosis what therapeutic options would you consider?
4. A previously healthy 68-year-old man underwent a transurethral prostatectomy. In the postoperative period he developed the acute onset of headache, fever and a stiff neck. On examination the patient was obtunded, but there were no focal abnormalities on neurologic exam. Venous pulsations were present. Lumbar puncture demonstrated 2,000 WBCs, (85% polymorphonuclear leukocytes) and glucose of 1.2. A Gram stain did not reveal any microorganisms.
 - (a) What pathogens would you consider in this man's illness?
 - (b) What empiric antibiotic therapy would you consider prior to results of blood and CSF cultures?
5. A 60-year-old woman presents to Emergency febrile and mildly confused, her family having found her at home "not quite herself". On examination her temperature is 38.5°C and she is disoriented to time and place. She appears to have trouble finding the words when you speak with her. There is no meningismus. While examining her, she has a seizure.
 - (a) What is your differential diagnosis?
 - (b) What other history would be important to making the correct etiological diagnosis?
 - (c) What diagnostic studies would you order and what would you expect them to show?
 - (d) How would you treat this patient?

References:

1. Med J Aust 2002; 176:389-96.
2. Neurologic Clinics 1998; 16:419-47.
3. NEJM 1997; 336:708-716.
4. NEJM 2002; 347:1549-56

Antimicrobials

1. Amoxicillin-clavulanic acid is effective against what bacteria that are resistant to amoxicillin?
2. How do cefotaxime and ceftriaxone differ in spectrum of activity, pharmacokinetics, and side effects?
3. How do ceftazidime and ceftriaxone differ in spectrum of activity?
4. What are the mechanisms of resistance to ampicillin in *N. gonorrhoeae*?
5. What bacteria do the macrolides have activity against?
6. What is the drug(s) of choice for the treatment of:
 - (a) Cellulitis in the absence of a diabetic foot ulcer?
 - (b) *P. aeruginosa* UTI
 - (c) *E. cloacae* pneumonia
 - (d) *S. maltophilia* bacteremia
 - (e) Sinusitis following a viral RTI
 - (f) Pneumocystis pneumonia
 - (g) *E. faecalis* endocarditis
 - (h) Shingles in a 60-year-old man with CLL
 - (i) Pneumonia in a 25-year-old who is not ill enough to be admitted to hospital
 - (j) Penicillin-resistant *S. pneumoniae* meningitis
 - (k) Severe cellulitis due to “toxic” strep
 - (l) *E. coli* 0157:H7 diarrhea
 - (m) CMV viral load of 5,000 in a liver transplant recipient
 - (n) Cryptococcal meningitis
 - (o) *Aspergillus* pneumonia
 - (p) Influenza B

References:

Mandell, Douglas, Bennett. Principles and Practice of Infectious Diseases.
The Sanford Guide to Antimicrobial Therapy.

Revised June 2007

HIV

1. A physician from the community has asked you to see one of his patients: a 28-year-old lawyer who's developed oral thrush following a course of oral steroids and amoxil for an infective exacerbation of his asthma. The patient is worried about HIV because of the thrush.
 - (a) How will you deal with this situation?
 - (b) What issues must be addressed in the course of recommending HIV testing?
2. Briefly outline the pathogenesis and natural history of untreated HIV infection.
3. How has the natural history of HIV changed over the last several years? What factors have contributed to those changes?
4. A 30-year-old female has recently tested positive for HIV, after hearing that a former boyfriend has been diagnosed with AIDS. Her CD4 count is 480 and viral load 75,000 copies/ml. She wants to discuss treatment options with you.
 - (a) What are the current recommendations for treating HIV?
 - (b) How do you monitor the response to antiretroviral therapy?
 - (c) Name the classes of the currently available antiretrovirals, indicating their mechanism of action, and their more common side effects.
5. There are a number of strategies available for the prevention of HIV-related opportunistic infections. Outline what antimicrobial prophylactic regimens are available and when you would start them.
6. Your 33-year-old patient with HIV comes to you because of diplopia that has gradually become apparent over the last 2 weeks. He has no other neurological symptoms. On exam, he has right ptosis and his eye is deviated downward and outward. His CT scan shows a ring-enhancing lesion in the left occipital lobe. He has done poorly on antiretroviral therapy and has CD4 of 60. He is on aerosolized pentamidine for PCP prophylaxis.
 - (a) What do you consider in your differential diagnosis?
 - (b) What investigations do you perform?
 - (c) What therapy do you consider?
7. A 42-year-old male with HIV for 14 years and a CD4 of 30 presents with anorexia, fatigue, weight loss and a 10-day history of fever to 39° and night sweats. He has no other symptoms and his physical exam does not suggest a focus of infection.
 - (a) What etiologies do you consider in the differential diagnosis?
 - (b) What investigations do you order?
 - (c) What immediate therapies do you consider necessary, if any?

References

1. CMA. Counseling Guidelines for HIV Testing. 1995.
2. AIDS info. http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66
3. JAMA 2008; 300: 555.
4. MMWR Recomm Rep 2009; 58(RR-4):1-207.
5. Infect Dis Clinics NA 2007 1013-1032

Reviewed May 2009

Infections in the Immune Compromised Host

1. Splenectomy is planned for a 28 year-old woman with ITP. What immunizations would you recommend to her and what is their optimal timing? What other infection-related advice would you recommend to the patient?
2. A 45- year old male is 9 months post cardiac transplant for dilated cardiomyopathy. He has had 2-3 episodes of rejection requiring intensification of his immunosuppressive therapy. Over the last 2 weeks he has felt increasingly unwell with increasing cough, shortness of breath, pleuritic chest pain, and low- grade fever. On exam he has decreased air entry at the RLL with bronchial breathing and coarse crackles. CXR shows a right lower lobe opacification and effusion. WBC is 12,500, hemoglobin 124, and platelets 495,000. What are the potential pathogens to consider, what investigations will you undertake, and what treatment will you recommend?
3. A 68- year old woman was started on infliximab for her rheumatoid arthritis several months prior. She was brought by her family to the ED with a 3- day history of fever, headache, and 1 day history of poor balance and confusion. On examination, she had meningismus and was very confused and unable to respond to commands. The WBC was 13, 500, hemoglobin 106, and platelets 145,000. What is your diagnosis, what are the likely pathogens, and what treatment will you initiate?
4. A 32- year old journalist student in your practice is considering a trip to Africa. He had an allogeneic hematopoietic stem cell transplant 16 months ago for AML and is doing very well. He comes to you wondering whether there might be any special considerations for him, given his medical history. What advice will you offer?
5. A 54 year-old woman presents 32 weeks after liver transplant for primary biliary cirrhosis with fevers, fatigue, anorexia, odynophagia, and diarrhea. She has done well post-transplant with no rejection episodes. On exam her abdomen is diffusely tender but her examination is otherwise unremarkable. WBC is 2400, hemoglobin 99, and platelets 125,000. What pathogens are most likely, what investigations will you perform, and what treatment will you consider?

References

<http://www2.ncid.cdc.gov/travel/yb/utls/ybGet.asp?section=special&obj=hivtrav.htm>

<http://www.phac-aspc.gc.ca/publicat/cig-gci/index.html>

Expert Review of Antiinfective Therapy 2007; 5:295-304

Progress in Transplantation 2004; 14:114-29

Clinical Infectious Diseases 2001; 33:629-40

International J Surg 2009; 421-423

Reviewed June 2010

Intra-abdominal Sepsis

1. A 40-year-old alcoholic male with cirrhosis and ascites presents with acute peritonitis.
 - (a) How would you confirm the diagnosis and the etiological agent(s)?
 - (b) List the characteristics of the specimen obtained.
 - (c) What antimicrobial(s) would you begin empirically and why?
2. List three predisposing conditions for secondary bacterial peritonitis. How many different species of microorganisms would you expect to isolate and name those most commonly isolated. Give 2 alternative antibiotic regimens for therapy and explain your rationale for this choice.
3. A 20-year-old male presents with fever, right shoulder tip pain and right pleural effusion after abdominal surgery.
 - (a) What is the most likely diagnosis?
 - (b) How would you confirm the diagnosis?
 - (c) Briefly outline the management.
4. What are the diagnostic criteria for peritonitis in the peritoneal dialysis patient? Outline the management of peritonitis in this setting.
5. Multiple space occupying lesions are demonstrated on an ultrasound of the liver scan. What are the most likely organisms? What antimicrobial(s) would you use to treat pyogenic liver abscess and for how long?
6. Briefly outline the factors that affect antibiotic activity in abscesses.
7. A 50-year-old alcoholic male presents with epigastric pain and a high serum amylase. Subsequently he develops fever and an epigastric mass.
 - (a) What is the likely diagnosis?
 - (b) Outline steps for diagnosis and therapy.
8. What is tertiary peritonitis? What are the usual pathogens?

References

1. Mandell, Douglas, Bennett. Principles and Practice of Infectious Diseases.
2. Marshall JC, Innes M. Intensive care management of intraabdominal infection. Crit Care Med 2003; 31:2228-37.
3. Bujik SE, Bruning HA. Future directions in the management of tertiary peritonitis. Intens Care Med 2002; 28:1024-9.
4. Voinescu CG, Khanna R. Peritonitis in peritoneal dialysis. Intl J Artif Organs 2002; 25:249-60.

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Nosocomial and Occupational Infections

1. A 29-year-old respiratory therapist has stuck herself while doing a blood gas in the ER on a 30 year old IDU with RUL pneumonia. The patient has never had an HIV test. She is worried about HIV.
 - (a) What other information do you need in your assessment of the situation?
 - (b) What treatment recommendations do you make?
 - (c) What counseling do you provide to the respiratory therapist?

2. A 75-year-old male was admitted to the MSNICU 72 hours ago following evacuation of a subdural hematoma. He has been intubated and ventilated since that time. Today he has a fever, purulent endotracheal secretions, and new air space opacification in the RML. A Gram stain of the ETT secretions shows many PMNs, no squamous epithelial cells, and small gram-negative coccobacilli.
 - (a) What is your diagnosis and what are the usual pathogens?
 - (b) What other investigations will you order?
 - (c) What empiric antimicrobial treatment will you start?

The patient recovered from his infection. However, his subsequent course was complicated such that he is still in the unit 3 weeks later. Over the last 24 hours he has had an increase in ventilatory requirements, recurrence of low-grade fever, and increasing ETT secretions that are thick and creamy in appearance.

 - (d) What is your diagnosis and what are the usual pathogens?
 - (e) What other investigations will you order?
 - (f) What empiric antimicrobial treatment will you start?

3. A 65-year-old DM female is 5 days post-CABAG. After several hours of feeling achy and tired, she spikes a fever to 39°C, and drops her BP to 90/60 from 120/85. She still has a right carotid cordis and pacing wires in place. She has no respiratory complaints and her CXR has no opacifications.
 - (a) What are the most likely sites of infection?
 - (b) What are the most likely pathogens?
 - (c) What investigations will you order?
 - (d) What empiric antimicrobial therapy will you start?

4. You are asked to see a 78-year-old man with an indwelling Foley catheter on the family practice service. The nurses sent a urine for culture, as it was looking cloudy. The culture report has come back positive with >100,000 *P.aeruginosa* susceptible to gentamicin, ceftazidime, and piperacillin but resistant to ciprofloxacin. What do you suggest be done in this situation?

References:

1. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>
2. Am J Respir Crit Care Med 2002; 165:867-903
3. Drugs and Aging 2005; 22:627-39
4. Arch Intern Med 2000; 160:673-7
5. Curr Opin Infect Dis 2004; 17:303-7
6. J Hosp Infect 2003; 53:46-57
7. Infect Control Hosp Epidemiol 2002; 23:759-69

Reviewed June 2007

Osteomyelitis/Septic Arthritis

1. A 63-year-old male, with a history of prostatism and bacteruria, presents with acute lower back pain, fever, and chills. Examination demonstrates tenderness over the L1-2 area. WBC count is 15,000 and CRP 75.
 - (a) What is the likely diagnosis of this man's illness?
 - (b) What diagnostic studies would you use to confirm the diagnosis?
 - (c) Would you consider empiric therapy in this illness, and with what agents?
2. A 45-year-old diabetic female develops acute tenderness and swelling of the right great toe following several weeks of ulceration and drainage of purulent material.
 - (a) Discuss the likely pattern you would find on bone and indium scans and their diagnostic utility.
 - (b) What other diagnostic studies would you consider?
 - (c) What empiric therapy would you begin?
3. Discuss the management of a 45-year-old man with an old shrapnel wound of the lower leg, who has an intermittent chronic draining sinus associated with low-grade fever and pain. Culture of the purulent material grows *Staphylococcus aureus*.
4. A 20-year-old female presents with acute painful swelling of the right wrist associated with fever, chills and scattered pustular lesions of the upper and lower extremities.
 - (a) What is the likely diagnosis?
 - (b) How would you try to isolate the infecting microorganism?
 - (c) What would be the optimal antibiotic treatment?
5. A 68-year-old man, with a total knee replacement, develops pain and swelling of the knee two months following surgery. On examination, there is warmth and erythema as well as painful motion. Temperature is 38.1C and WBC count 12,000 cu/mm.
 - (a) What are the likely microorganisms responsible for this condition?
 - (b) What would be the optimal management of this case, including the use of appropriate antibiotics?
6. A 36-year-old man is in a bar room brawl and receives a cut on the knuckle after a hard right to his opponent's mouth. Twenty-four hours later there is acute pain, erythema and swelling of the 1st and 2nd MCP joints with loss of function.
 - (a) What is the differential diagnosis of this condition?
 - (b) What are the important principles of management?
 - (c) What empiric antibiotic therapy would you start?

References:

1. Gottlieb T, Atkins BL, Shaw DR. Soft tissue, bone and joint infections. Medical J Aust 2002; 176:609-15.
2. Lew DP, Waldvogel FA. Osteomyelitis. NEJM 1997; 336:999-1007.
3. Shirliff ME, Mader JT. Acute septic arthritis. Clin Microbiol Rev 2002; 15:527-44.
4. Goldstein EJ. Current concepts on animal bites: bacteriology and therapy. Curr Clin Topics Infect Dis 1999; 19:99-111.

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Tuberculosis

1. Describe areas of the world that are highly endemic for TB and compare their rates with Canada's incidence rate. Describe one area of the world in which multi-drug resistance is uncontrolled.
2. Explain why HIV infection and TB infection have a synergistic interaction. Outline one important drug interaction that must be considered when concurrently treating both infections.
3. Describe the strengths and weaknesses of the following diagnostic tests used for TB:
 - a. Tuberculin Skin Test
 - b. CXR
 - c. Sputum smear for acid fast bacilli
 - d. Sputum culture for mycobacteria
4. Describe how isolation of a patient with pulmonary TB would differ from isolation of a patient with influenza, and explain why these differences exist.
5. Primary TB is disease occurring at the time of infection. Reactivation TB is disease occurring months to years after infection. Describe the differences in the CXR pattern of these two diseases and explain why these differences are seen.
6. Regarding INH treatment for latent TB, there are several factors to be considered. Discuss host factors, TST factors (size of induration, possible false positives and negatives, effect of BCG vaccine), timing of infection, and drug toxicity.
7. Describe the management of a 1 year old child whose mother is diagnosed with smear positive pulmonary TB.
8. What is the boosting phenomenon and how can it be distinguished from TST conversion?
9. The four drugs used for first line therapy of TB are isoniazid, rifampin, ethambutol, and pyrazinamide. Explain the role of each drug in treating TB and describe the major toxicities for each.
10. Identify when adjunctive steroids should be used in treating TB.
11. Outline the monitoring that should be done for patients on treatment for pulmonary TB.
12. Describe the public health department response to a teacher diagnosed with pulmonary TB.

References:

1. Canadian Tuberculosis Standards. http://www.hc-sc.gc.ca/pphb-dgspsp/tbpc-latb/pubs_e.html
2. CDC latent TB treatment guidelines. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5231a4.htm>
3. CDC active TB treatment guidelines. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm>

Revised June 2007

The Febrile Patient

1. A 45-year-old man with a bioprosthetic aortic valve presents with a 2-day history of fever, rigors, sweats and several hours of increasing dyspnea. On exam, he has a III/VI SEM and II/VI diastolic murmur, both heard along the LSB.
 - (a) What is your working diagnosis and what investigations will you order?
 - (b) What are the most likely pathogen(s) and what empiric therapy will you start?
 - (c) What complications will you monitor for?
2. A 35-year-old woman is 12 days post allogeneic bone marrow transplant for AML. She has had persistent fever over the last 3 days despite antimicrobial therapy with meropenem and prophylactic fluconazole. She has severe mucositis, but no other symptoms and her physical exam is unremarkable apart from the mucositis. Her WBC is 150 with 98% lymphocytes.
 - (a) What infectious processes and microbial etiologies need to be considered in this patient?
 - (b) What investigations will you order?
 - (c) What antimicrobial therapy will you suggest?
3. A 22-year-old education student returned 10 days ago from a summer of hiking in Thailand. He presents to the ER with 36 hours of fever, headache, myalgias and fatigue. His physical exam is unremarkable. WBC is 9400, hemoglobin 136 and platelets 130,000.
 - (a) What is your differential diagnosis?
 - (b) What investigations will you order?
 - (c) What therapy will you consider starting?
4. A 72-year-old woman presents with a 3-4 week history of fever, sweats, anorexia and 5-pound weight loss. She has no other symptoms and her physical exam reveals no abnormalities. Her past medical history is unremarkable and she was adopted.
 - (a) What diagnostic possibilities will you consider in this woman with fever of unknown etiology?
 - (b) What investigations will you order?

References:

1. Hughes et al. 2002 Guidelines for the use of antimicrobial agents in neutropenic patients with cancer. Clin Infect Dis 2002; 34:730-57.
2. Mylonakis E, Calderwood SB. Infective endocarditis in adults. NEJM 2001; 345:1318-30.
3. Mourad O, Palda V, Detsky AS. A comprehensive evidence-based approach to fever of unknown origin. Arch Intern Med 2003; 163:545-51.
4. Knockaert DC, Vanderschueren S, Blockmans S. Fever of unknown origin in adults: 40 years on. J Intern Med 2003; 253:263-75.
5. Assessment of travelers who return home ill. Lancet 2003; 361:1459-69.
6. Ryan ET, Wilson ME, Kain KC. Illness after international travel. NEJM 2002; 347:505-16.

Reviewed June 2007

The Pregnant/Postpartum Female

1. A 29-year-old G1P0 presents at 10 weeks gestation with her first episode of symptomatic genital herpes.
 - (a) How would you confirm the diagnosis?
 - (b) How are you going to treat the infection?
 - (c) What implications does this have for her pregnancy?
2. List 2 etiologies of cervicitis. What alternative therapy would you use in pregnancy for cervicitis due to a penicillin-resistant organism?
3. A 26-year-old female at 14 weeks gestation is referred for interpretation of the results of toxoplasmosis serology and further advice. Both the IgG and IgM are positive. She has not had any symptoms to suggest an acute toxoplasma infection.
 - (a) What other investigations would you order?
 - (b) What are the implications of toxoplasmosis during pregnancy?
 - (c) If acute toxoplasmosis is confirmed by testing, what fetal investigations and maternal treatment are recommended?
4. A 22-year-old female with HIV and HCV secondary to IDU comes at 16 weeks gestation for her first prenatal visit. She has never had antiretroviral therapy. Her CD4 is 480 and viral load is 33,000. She has no symptoms related to her HCV or HIV.
 - (a) What would you advise her regarding antiretroviral therapy?
 - (b) What antiretrovirals would you recommend?
 - (c) Is therapy for HCV recommended in this situation?
 - (d) What recommendation will you make regarding the mode of delivery?
5. A 33-year-old G1P1 develops lower abdominal pain and fever 3 days postpartum. On examination she has uterine tenderness, confirmed on bimanual exam. Her WBC is 15,000 with a normal differential.
 - (a) What is your working diagnosis and what are the most likely pathogens?
 - (b) What investigations will you order?
 - (c) What empiric therapy will you start?
 - (d) If she remains febrile after 3 days of antibiotics, what will your differential diagnosis be and what further investigations and/or treatment changes will you undertake?
6. A 25-year-old woman at 12 weeks gestation presents with cellulitis following a cat bite.
 - (a) What antibiotic(s) will you choose?
 - (b) What special considerations need to be taken into account when prescribing antibiotics for a pregnant woman?

References:

Emer Med Clin NA 2008;345-366
Lancet Infect Dis 2006; 6:83-90
Curr Opin Infect Dis 2006; 19:33-8
Am J Med 2005; 118:212-6
Obstetrics & Gynecol 2005; 106:845-56
Int J Gynec Obstet 2009; 167-171
Pharmazie 2005; 60:483-93
Clin Infect Dis 2009; 48:449-55m

Reviewed Jun 2010

Sepsis

1. A 60-year-old female, with long standing rheumatoid arthritis, presents with fever, hypotension and acute swelling and pain in the right knee. On exam, there is mild jaundice and conjunctivitis, diffuse erythema of the skin, and tender swelling of the right knee. The other joints appear inactive. WBC is 16,000 with 40% PMNs and 30% bands. The patient is hypocalcemic and has a platelet count of 50,000 cu/mm.
 - (a) What is the likely diagnosis in this case?
 - (b) What is its pathogenesis?
 - (c) What are the potential pathogens?
 - (d) What therapeutic options should you consider?
2. A 78-year-old male, previously well apart from prostatic hypertrophy, presents to the Emergency Department confused and agitated since waking that morning. On exam his BP is 80/50, T 39.8°C, HR 128, and RR 28. His bladder is palpable to his umbilicus and tender. His WBC is 22,000 with 60% PMNs and 20% bands.
 - (a) What is the likely diagnosis and what investigations will you order?
 - (b) What is the pathogenesis?
 - (c) What are the most likely pathogens?
 - (d) What antibiotic(s) will you start empirically?
3. A 17-year-old girl was found confused and lethargic by her parents. Before going to school that morning she had complained of headache and fatigue. In the Emergency Department her BP is 70/50, HR 140, T 40°C, and RR 22. Her neck is supple and physical exam unremarkable apart from a petechial and purpuric rash on her lower legs.
 - (a) What is the likely diagnosis and what investigations will you order?
 - (b) What is the pathogenesis?
 - (c) What antibiotic(s) will you start empirically?
4. A 23-year-old IDU presents with a 3 day history of fever, rigors, and increasing dyspnea. BP is 88/40, HR 120, T 38.9°C, and RR 28. He has a III/VI SEM at the base and a III/VI diastolic murmur heard along the LSB. There are crackles throughout both lung fields. His WBC is 12,000, Hgb 128, and platelets 120,000.
 - (a) What is the most likely pathogen?
 - (b) What is the pathogenesis of this infection?
5. A 37-year-old male who had a splenectomy ten years ago for ITP is taken to the Emergency Department with fever, rigors, and lightheadedness. Two days before he was accidentally bitten as he tried to wrestle a shoe from his dog. His BP is 90/68, HR 110, T 39°C, and RR 24. His physical examination is unremarkable apart from a superficial bite on his hand with which there is mild associated erythema, swelling, and grayish discharge.
 - (a) What is the likely pathogen?

References:

Mandell, Douglas, Bennett. Principles and Practice of Infectious Diseases. Annual Rev Microbiol 2001; 55:77-104.
Am J Therap 2003; 10:127-31.
Med J Australia 2003; 178:134-7.

Reviewed June 2007

Sexually Transmitted Infections

1. A 30-year-old male presents with frequency, urgency, dysuria, and a urethral discharge.
 - (a) List 3 possible etiologic agents.
 - (b) Outline steps you would take to make the diagnosis.
 - (c) Indicate what drug therapy you would prescribe.
2. A 28-year-old male presents with a single, large, painless, indurated penile ulcer.
 - (a) What is the likely diagnosis and how would you confirm this?
 - (b) What therapy would you prescribe?
 - (c) Which sexual partners should be examined and/or treated?
3. What characteristics allow differentiation of the three different infectious causes of vaginitis and how is each type of vaginitis treated?
4. A 30-year-old gay male presents to clinic for assessment of a possible STD following unprotected intercourse with a casual partner.
 - (a) What sites would you culture for diagnosing gonococcal infection?
 - (b) What other STIs would you evaluate him for and how?
5. A 45-year-old woman received a letter from the Canadian Blood Services telling her that she was deferred from blood donation. Her RPR was 1:32 and MHA-TP positive. She does not recall ever being exposed to or treated for syphilis.
 - (a) What is your diagnosis?
 - (b) Are there other investigations that you will perform?
 - (c) What treatment will you prescribe?
 - (d) What contact tracing is necessary?
6. A 28-year-old female presents with a 2-day history of increasing lower abdominal pain, fever, and thick vaginal discharge. On examination there is tenderness and fullness in the LLQ as well as cervical motion and adnexal tenderness on bimanual examination.
 - (a) What is your diagnosis?
 - (b) What specimens will you obtain to make a microbiological diagnosis?
 - (c) What antimicrobials will you order?

References:

1. STD Treatment Guidelines 2006. <http://www.cdc.gov/std/treatment/default.htm>
2. Canadian STD Guidelines. http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts98/pdf/std98_e.pdf.

Revised June 2007

APPENDIX 24: Faculty Evaluation Form

**FACULTY EVALUATION FORM
MEDICAL MICROBIOLOGY / INFECTIOUS DISEASES
RESIDENCY TRAINING PROGRAM**

Form completed: Date _____

Faculty Member: _____

	Strongly Disagree		Agree		Strongly Agree
	1	2	3	4	5
Often initiates teaching activities without prompting.	Γ	Γ	Γ	Γ	Γ
Is enthusiastic about teaching.	Γ	Γ	Γ	Γ	Γ
Stimulates intellectual curiosity.	Γ	Γ	Γ	Γ	Γ
Encourages and motivates self directed learning.	Γ	Γ	Γ	Γ	Γ
Is competent and credible and serves as a good role model.	Γ	Γ	Γ	Γ	Γ
Has a teaching style that fosters conceptual understanding.	Γ	Γ	Γ	Γ	Γ
Promotes problem solving, making difficult concepts easy to understand.	Γ	Γ	Γ	Γ	Γ
Answers questions carefully and precisely.	Γ	Γ	Γ	Γ	Γ
Encourages participation and criticism and is open to discussion and questions.	Γ	Γ	Γ	Γ	Γ
Includes current material that is interesting, practical, and relevant and accurate to the practice of Microbiology.	Γ	Γ	Γ	Γ	Γ
Develops an educational relationship with residents, displaying genuine interest in them and is aware of their needs.	Γ	Γ	Γ	Γ	Γ
Provides fair and constructive criticism without belittling.	Γ	Γ	Γ	Γ	Γ

Appendix 25: Academic Half-Day Program

PRINCIPLES AND PRACTICE OF INFECTIOUS DISEASES AND MICROBIOLOGY
An example of type of topics covered in the past

TOPIC	Staff
Bacterial Pathogenesis and virulence Factors	
Host Defense Mechanisms	
General and Non Specific Mechanisms, Antibodies and Complement	RB
Human Genetics and Infection, Granulocytes and Cell-Mediated Immunity	RB
Anti-infectives	
Mechanisms of Antibiotic Activity and Resistance	RJD
Penicillins, Cephalosporins, and Other Beta Lactams	RJD
Aminoglycosides, Tetracyclines, and Chloramphenicol	RJD
Macrolides and Clindamycin	RJD
Vancomycin, Teicoplanin, and Synercid	RJD
Quinolones	RJD
Antituberculous and Antimycobacterial Drugs	DJMH
Antifungal Drugs	DJMH
Antiviral Drugs	TH
Anti-parasitic Drugs	DH
Clinical Syndromes	
Fever of Unknown Origin	WS
Upper Respiratory Tract Infections	RJD
Pneumonia	LJ
Bacterial and Atypical	
Viral	
Urinary Tract Infections	SMcN
Sepsis Syndrome	WS
Intraabdominal Infections	KF
Cardiovascular Infections	SMcN
Bacterial CNS Infections	WS
Skin and Soft Tissue Infections	SMcN
Bacterial Gastroenteritis	SH
Viral Gastroenteritis	WS
<i>C. diff</i> Associated Colitis	LJ
Eye Infections	
Arthritis	
Osteomyelitis	DH
Viruses and the Disease They Cause	
Herpes Simplex Infections	DH
Varicella Zoster Infections	TH
Cytomegalovirus Infections	WS
EBV Infections	TH
Other Herpes Infections	TH
Human Papillomavirus Infections	KF
Hepatitis B and D	TH
Hepatitis C	TH
Parvovirus B19	TH
Influenza	TH
Paramyxoviruses	TH
Coronaviruses and Agents of the Common Cold	TH
Enteroviral Infection	TM
Rabies	KF

TOPIC	Staff
Exotic and Hemorrhagic Viral Infection	TH
Prions	TH
Chlamydia and Gonorrhoea	DH
Non-Genital Chlamydia Infections	DH
Mycoplasma Infections	DJMH
Rickettsial Infections (to include Q Fever, RMSF)	DJMH
Ehrlichia Infections	WS
Bacteria and their Diseases	
Staphylococcus aureus	SMcN
<i>Coagulase Negative Staphylococci</i>	RJD
Pyogenic Streptococci	SH
<i>Viridans Streptococci and Intermedius Group</i>	DJMH
Diphtheria and Rhodococcus	WS
Listeria	WS
Anthrax	WS
Erysipelothrix	WS
Gram Negative Cocci	DJMH
Vibrionaceae	DJMH
Campylobacter	DJMH
Helicobacter	DJMH
Enterobacteriaceae	DJMH
Pseudomonas, Stenotrophomonas, and Burkholderia	DJMH
<i>Pneumocystis carinii</i>	DH
Hemophilus and the HACEK Group	DJMH
<i>Legionella</i> sp.	WS
Bordetella and Pertussis	SH
Lyme Disease and Other Spiral Bacteria	KF
Anaerobic Bacteria	KF
Mycobacteria	DJMH
Non-Tuberculous Bacteria	DJMH
Yeast	DJMH
Dimorphic Fungi	DJMH
Other Fungi	DJMH
Syphilis	DH
Parasitic Diseases	DJMH
Malaria	DH
Leishmania and Trypanosoma	TM
Toxoplasmosis	TM
Other Gastrointestinal Protozoa	DJMH
Worm Infections	DJMH
Ectoparasite Infections	DH
Protection of Travellers and Travel Medicine	DJMH
Other Topics	
Surgical Prophylaxis	SMcN
Medical Prophylaxis	LJ



APPENDIX 26: ID/MM Residency Program Committee Terms of Reference

**Departments of Medicine and Pathology
Division of Infectious Diseases
Infectious Diseases and Medical Microbiology
Residency Training Program Committee
Terms of Reference**

Purpose

The Infectious Diseases and Medical Microbiology Residency Training Program Committee (RTPC) supports and advises the Program Director in the planning, organization and supervision of the Infectious Diseases and Medical Microbiology training programs. The RTPC is thus an advisory body to assist the Program Director in the policy and planning aspects of the two training programs.

Membership

Infectious Diseases and Medical Microbiology Residency Training Program Director(s)
Resident Research Coordinator
Infectious Diseases Division Chief
Medical Microbiology Division Chief
Public Health Representative
Pediatric Infectious Diseases Program Director or designate
Infectious Diseases Resident
Medical Microbiology Resident

Chair

Infectious Diseases or Medical Microbiology Residency Training Program Director

Quorum

A minimum of four physicians and one resident serves as a quorum.

Frequency of Meetings

The Committee meets quarterly during the academic year, however during times of peak activity (e.g. while reviewing new applications) or when circumstances arise. additional meetings may be held.

Attendance

Members are to attend at least 50% of the meetings or send a designate if unavailable.

Reports to

Associate Dean, Postgraduate Medical Education, Faculty of Medicine
Head, Department of Medicine and the Chief, Division of Infectious Diseases
Head, Department of Pathology and the Chief, Division of Medical Microbiology

Specific Duties and Responsibilities of the Program Director,

I. To the Infectious Diseases and Medical Microbiology Training Programs:

1. The Program Director has the final responsibility and authority for the operation of the residency training programs, including the details of the day to day operation. The Program Director for the Infectious Diseases Residency Training Program is appointed by the Head, Department of Medicine, and reports to the Head as well as to the Associate Dean, Postgraduate Medical Education, Faculty of Medicine and the Chief, Division of Infectious Diseases. The Program Director for the Medical Microbiology Residency Training Program is appointed by the Head, Department of Pathology, and reports to the Head as well as to the Associate Dean, Postgraduate Medical Education, Faculty of Medicine and the Chief, Division of Medical Microbiology.
2. Develop the overall educational plan for the ID and MM residency training programs.
3. Chair the ID and MM RTPC. Ensure the ongoing functioning of the ID/MM RTPC including the scheduling, conduct and recording of regular meetings.
4. Review the makeup of the ID/MM RTPC every year to ensure that it is representative of the various constituencies it serves.
5. Recruit new trainees into the Infectious Diseases and Medical Microbiology residency training programs, including the development of informational material and promotion of the program.
6. Maintain records on residents in the ID and MM residency training programs.
7. Advocate for the residents in the Infectious Diseases and Medical Microbiology residency training programs.
8. Meet regularly with the ID and MM residents to review their progress.
9. Review the ID and MM educational program yearly.
10. Ensure timely and regular ID and MM resident evaluations using the In-training Evaluation Report (ITER), which includes assessment of knowledge, clinical skills, behaviours, and attitudes.
11. Review on a yearly basis attending staff and rotation evaluations in terms of the quality of service and education, and provide feedback to the attending staff.
12. Serve as a resource as needed for residents who feel unjustly treated by any member of faculty and in dealing with issues such as personal stress, gender discrimination, etc.
13. Ensure that the minutes of each meeting of the RTPC are circulated to committee members.
14. Apply the Infectious Diseases and Medical Microbiology RTPC policy for design of ID and MM program content and scheduling.
15. Liaison with the individuals responsible for the undergraduate and continuing medical education activities within the Departments of Medicine and Pathology.

II. To the Departments of Medicine and Pathology and Divisions of Infectious Diseases and Medical Microbiology:

1. Sit on the Department of Medicine Postgraduate Medical Education Committee and fully participate in all its activities.
2. Sit on the Department of Pathology RPC and fully participate in its activities.
3. Convey relevant information from the Department of Medicine Postgraduate Medical Education Committee to the Division of Infectious Diseases.
4. Develop a means whereby there is regular and frequent communication with the Division Chiefs, Infectious Diseases and Medical Microbiology, to ensure that there is adequate discussion of educational items and they are fully informed of decisions and processes as they relate to residency education.
5. Seek the opinion of Infectious Diseases and Medical Microbiology Division members on the educational program and bring information from the Division to the Department Postgraduate Medical Education Committee.
6. Ensure that discussion of educational items has a high profile at Divisional meetings.

III. To the Faculty of Medicine

- i) Postgraduate Medical Education
 1. Participate fully in all activities of the Postgraduate Medical Education Committee and keep informed of its business through review of the minutes.
 2. Support the decisions that are taken by the Postgraduate Medical Education Committee.
 3. Bring forward issues that you feel must be dealt with by this Committee.
 4. Bring the opinions of the Infectious Diseases and Medical Microbiology RTPC and the disciplines of Infectious Diseases and Medical Microbiology to this Committee on issues under discussion.
 5. Take back to the Infectious Diseases and Medical Microbiology RTPC and the Divisions of Infectious Diseases and Medical Microbiology information from the Postgraduate Medical Education Committee that is relevant to them.
 6. Work cooperatively with the Postgraduate Medical Education Office with regards to the provision of materials on promotions, schedules, Final-in-Training Evaluation Reports (FITERs), and disciplinary matters.
- ii) Internal Reviews
 1. Provide the documentation required for these reviews.
 2. Participate in the review process as a reviewer when requested.
 3. Coordinate the logistics of your program reviews (external and internal).
 4. Provide leadership in the disciplines of Infectious Diseases and Medical Microbiology relating to the internal and external reviews.

IV. To the Royal College of Physicians and Surgeons of Canada

1. Develop and monitor educational objectives.
2. To monitor the documents for accreditation, training requirements, surveys, etc.
3. To comment on questions raised by the Royal College of Physicians and Surgeons of Canada relating to residency education.
4. To keep abreast of policy as it relates to the infectious diseases and medical microbiology which is sent out directly by or through publications of the Royal College of Physicians and Surgeons of Canada.
5. To find out how the Royal College of Physicians and Surgeons of Canada residency training system works and try to influence it in areas which are of concern.
6. To sit as a member of the Royal College of Physicians and Surgeons of Canada Infectious Diseases and Medical Microbiology Specialty Committees.

IV. To the Colleges of Physicians and Surgeons of Nova Scotia, Prince Edward Island, and New Brunswick

1. Be aware of licensure regulations that are relevant to residents within the Infectious Diseases and Medical Microbiology residency training programs.

V. To Physician Resource Planning

1. Be aware of current local and national information in this area, especially as it relates to Infectious Diseases and Medical Microbiology human resources supply and demand
2. Serve as a faculty resource on these issues.

Specific Responsibilities of the Resident Research Coordinator:

1. Meet with each new ID and MM resident within 2 months of beginning the program, and then semiannually, in order to review research opportunities and expectations within the division and monitor progress towards achieving the resident's research deliverables.
2. With input from the Program Director and resident, identify and select a research mentor for each resident who is a good match with the resident's research goals and personality
3. Be a resource to provide guidance and support to ID and MM residents in their research.

Specific Responsibilities of the Members of the Infectious Diseases and Medical Microbiology RTPC :

1. Advise, support, and assist the Program Director in his/her role and in whatever matters are before the Committee.
2. Participate fully in RTPC discussions in order to arrive at decisions by consensus.
3. Support decisions that are taken in relation to the Infectious Diseases and Medical Microbiology residency training programs.
4. Fully participate in all activities of the Infectious Diseases and Medical Microbiology RTPC and keep informed of its business through review of the minutes.
5. Participate in ongoing development of the Infectious Diseases and Medical Microbiology residency training programs, including development and review of the goals and objectives.
6. Encourage and facilitate the ID and MM residents in their development of intellectual curiosity and conduct of scholarly activities.
7. Assist the Program Director in the selection of candidates for admission into the Infectious Diseases and Medical Microbiology training programs, and in decisions regarding their promotion or dismissal from the program.
8. Contribute to policy development as it relates to program content and scheduling, always maintaining balance between service and education.
9. Develop and review methods for evaluating attending staff and rotation educational quality and for providing feedback to attending staff in response to evaluations received.
10. Contribute to the organization, content, and delivery of the ID and MM academic half-day seminars, clinical case discussions, and rounds; ensuring that these educational forums meet the criteria for inclusion in the Continuing Professional Development Program of the Royal College of Physicians and Surgeons of Canada.
11. Develop and review evaluation methods to provide feedback to residents on their performance.
12. Assist the program director in the conduct of the Infectious Diseases and Medical Microbiology residency training programs. This includes regular evaluation of each rotation in terms of the types and volume of clinical problems, resident supervision and autonomy, conduct of rounds, formal and informal teaching, quality of teaching by attending staff, and opportunities for teaching and acquiring all elements of the CanMEDS competencies by the ID and MM residents.

Ombuddy Role in Postgraduate Medical Education

The primary role of the Ombuddy is to insure that residents and other members of the Postgraduate Medical Education community receive fair and equitable treatment during their residency training at Dalhousie University. The Ombuddy shall function as an independent facilitator to provide advice, mediate disputes and promote a just and reasonable solution.

Each Residency Training Program ("program") will identify a person who agrees to act as an Ombuddy for residents in that program. The Ombuddy may be a member of the Department associated with that program, but must not be a member of that program's Resident Training Committee. All residents must be made aware of the contact information for the Ombuddy for their program.

The Ombuddy agrees to advise residents on all cases. The Ombuddy will treat all discussions as strictly confidential unless the resident explicitly agrees otherwise. Ombuddys are advisors and mediators, not decision makers. If after hearing the Ombuddy's opinion and considering the options the resident wishes to prepare a formal appeal, the Ombuddy will refer him or her to the Postgraduate Medical Education Calendar containing policies and information regarding appeals.

The Ombuddy has no formal or binding authority; however, he/she does have the ability to recommend, persuade and discuss with all parties involved. The Ombuddy must consider all sides of a question in an impartial manner and is guided by the following:

Philosophy:	<i>OBJECTIVITY</i>	<i>INDEPENDENCE</i>
	<i>ACCESSIBILITY</i>	<i>CONFIDENTIALITY</i>
	<i>FAIRNESS</i>	

Of these, the Ombuddy role as supporters of fairness and due process is of the utmost importance. The goal is to work cooperatively to insure fairness in our training programs.

Functions:

Advocates for fairness.

The Ombuddy is an ideal person to start with if you are unclear about the particular nature of your complaint or are unsure where to go for help.

The Ombuddy Practice Is To:

Listen and Clarify

Listen carefully and on a confidential basis to the concerns, and ask questions of the resident to help clarify his or her concerns. Gather all of the relevant facts of the case.
Make inquiries on behalf of the resident.

Advise and Inform

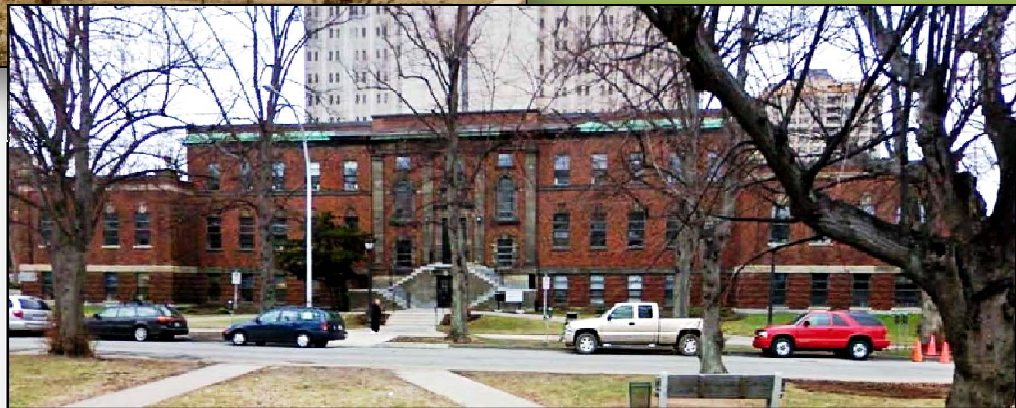
Advise the resident how to access appropriate decision makers.
Refer the resident to another appropriate agency if necessary.
Inform the resident of relevant academic regulations or appeals procedures.
Guide the resident through the preparation of an articulate and informative case to help the decision maker come to a fair resolution.

Mediate and Explore

Mediate or negotiate with the resident and other parties.
Explore options with the resident, regardless of the outcome of the case.

2011-2012 Calendar

Postgraduate Medical Education



Faculty of Medicine

Dalhousie University

www.dal.ca

Postgraduate Medical Education

Mailing Address: 1459 Oxford Street, Halifax, NS, B3H 4R2
Office Location and Courier: Room C234, Clinical Research Centre, 5849 University Ave, Halifax, NS, B3H 4H7
Fax (902) 494-3644 <http://postgraduate.medicine.dal.ca/>

POSITION	NAME	DIRECT NUMBER	E-MAIL ADDRESS
PGME Clerk	Ms. Lily Brown	(902) 494-8321	PGMEdesk@dal.ca
Responsibilities: General Inquiries; Orientation & Registration; Resident Contracts & Information Profiles; LOA Notifications; Certificates of Completion of Training; Electives from other Cdn Universities			
Secretary to Associate Dean	Ms. Diane Thimot	(902) 494-1850	Diane.Thimot@dal.ca
Responsibilities: Dr. Gardner's Appointments; Evaluations (ITERs, EOREs, & Royal College Evaluations); Postgraduate Medical Education Committee (Agenda & Minutes); New PGME Trainees; Orientation & Registration; General Inquiries			
Records Management Administrator Monday-Thursday	Mrs. Denise Mitchell	(902) 494-2362	Denise.Mitchell@dal.ca
Responsibilities : Records Management (training program extensions, LOA's, part-time training); Re-Entry Program; Verifications; Orientation & Registration; General Inquiries			
Visa/IMG Programs Administrator	Mr. Charles Hsuen	(902) 494-7038	visaimgdesk@dal.ca charlesh@dal.ca
Responsibilities: All issues relating to Visa Trainees; Employment Authorizations; Health Insurance; Electives from International Medical Schools; IMG Orientation; Registration Visa Trainees; International Medical Graduate Inquiries			
Visa/IMG Clerk	Ms. Melissa Hiscott	(902) 494-3300	Melissa.Hiscott@dal.ca
Responsibilities: Clerical support for all issues relating to Visa/IMG Trainees; Web Site Maintenance; PGME Calendar; Policies & Procedures Manual; Orientation & Registration; Maintenance of Program/Hospital Contact Lists; General Inquiries			
Administrator	Mrs. Carolyn Hicks	(902) 494-2154	Carolyn.Hicks@dal.ca
Responsibilities: Accreditation; Internal Reviews; PGY1 Schedule; CanMEDS Curriculum; Orientation & Registration; General Inquiries			
Medical Education Clerk	Ms. Jenny Acuna	(902) 494-3117	pgme@dal.ca
Responsibilities: Clerical support for Accreditation; CanMEDS Workshops; One45 Evaluations; PGY1 Schedule Changes; RPC Minutes; Orientation & Registration; General Inquiries			
Director	Mrs. Christine Silver Smith	(902) 494-1885	Christine.Silver@dal.ca
Responsibilities: Overseeing of all aspects of Postgraduate Medical Education			
Assistant Dean	Dr. Guy Brisseau	(902) 494-8321	Guy.brisseau@dal.ca
Associate Dean	Dr. Martin Gardner	(902) 494-1881	Martin.Gardner@dal.ca
Dean, Faculty of Medicine	Dr. Tom Marrie	(902) 494-1846	Dean.Medicine@dal.ca

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Welcome

We are delighted that you have accepted our offer to do residency training at Dalhousie University. On behalf of the Faculty of Medicine, welcome. The role of the Postgraduate Medical Education Office is one of coordination, with you, with our teaching hospitals, and with all of our program directors. We are here to serve your needs, answer your questions, and assist you in acquiring the best training you possibly can. Our contact with you lasts long after you have completed your program as we also provide verification of training letters when you apply for licensure or hospital privileges, as well as letters of reference and other forms of documentation. The Dalhousie Postgraduate Medical Education system is a relatively unique one which involves many teaching hospitals in three Maritime provinces. Not all trainees rotate to all hospitals, but ample opportunity is provided to experience the practice of medicine in a variety of locations. Moving about these three lovely provinces can have its difficult moments. If you do have the misfortune to develop an academic problem, your first contact should be the individual in that hospital responsible for the educational experience or your Program Director. For personal problems, you may wish to contact the PIETA program (please see the appropriate section of this Calendar). You are welcome to call the Postgraduate Medical Education office at any time.

The scenery in the Maritimes is spectacular; the patients are fascinating and the educational programs second to none. We feel confident that you will enjoy your time at Dalhousie University and wish you good fortune in your academic pursuits.

Introduction

The Postgraduate Medical Education Office of Dalhousie University is located on the Main Floor of the Clinical Research Centre, 5849 University Avenue, Room C234, Halifax, Nova Scotia, B3H 4H7.
Telephone (902) 494-8321 Fax (902) 494-3644 Office Hours: 8:30 a.m. to 4:30 p.m. Atlantic Standard Time

The Associate Dean of Postgraduate Medical Education is Dr. Martin Gardner. The purpose of the Postgraduate Medical Education Office is to assist educational planning and functioning in the Faculty of Medicine by coordinating the activities of the specialty and family medicine training programs. The Associate Dean for Postgraduate Medical Education maintains and develops the Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada Postgraduate Programs on behalf of the Postgraduate Medical Education Committee. Major tasks associated with this function include coordination of the PGY1 Programs through many hospitals in the Maritimes, coordinating periodic reviews of the trainees and the training programs and undertaking corrective measures where appropriate. The major thrust of this Office is to try to make the approved postgraduate programs more uniform and coordinate their administration at a University level. In conjunction with this role, the Associate Dean deals with the Maritime Provinces Higher Education Commission and as an advisor to the representatives of the Office of the President of Dalhousie University in matters related to specialty training.

Postgraduate Medical Training

Dalhousie University, through its Faculty of Medicine, offers university-arranged and university-supervised clinical training for postgraduate medical trainees which meets national accreditation standards. Specialty training is approved by the Royal College of Physicians and Surgeons of Canada and is conducted in affiliated teaching hospitals in Nova Scotia and New Brunswick. Dalhousie University currently holds Royal College approval for over 50 specialty training programs. Postgraduate training in Family Medicine is approved by the College of Family Physicians of Canada and carried out in Nova Scotia, New Brunswick, and Prince Edward Island teaching hospitals and family practice teaching units.

Most of our training programs provide a portion of their educational experience at teaching hospitals outside of Halifax. Hospitals participating in the programs must meet all Dalhousie University requirements for affiliation which include having an effective continuing medical education program in each department receiving trainees. Trainees are not assigned to a hospital but rather to a service within a hospital. Each trainee is assessed on each service by an evaluation which becomes part of the Postgraduate Medical Education Office record and is called the In-training Evaluation Report (ITER).

Admissions Criteria

Admission to Dalhousie University Postgraduate Medicine PGY1 positions is conducted through the Canadian Resident Matching Service (CaRMS). **You must be a Canadian Citizen or Permanent Resident of Canada to apply.** The definition of a Permanent Resident is a Canadian immigrant who has permanent resident status in Canada but is not yet a Canadian citizen. International Medical Graduates who have previous post-graduate training in either Canada or the United States, that is creditable for the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada certification, are not eligible to participate in CaRMS in the first iteration for Dalhousie University positions. The first iteration of the CaRMS match includes two parallel streams.

- One stream for Canadian Medical School graduates who have not had previous post-MD/clinical training.
- The second stream will be open to international medical graduates who have not had previous Canadian post-MD/clinical training. There will be a selection of programs in both Family Medicine and Specialty training that will be made available. All international medical graduates matching to these designated positions will be required to sign a return of service contract with the Ministry of Health for either the Province of Nova Scotia, the Province of New Brunswick, or the Province of Prince Edward Island in the specialty (including Family Medicine) to which they have been matched prior to beginning their residency.

There will be one residency position for international medical graduates in each Family Medicine training site (Halifax and Sydney, Nova Scotia, Moncton, Saint John and Fredericton, New Brunswick, and Charlottetown, Prince Edward Island). One of these residency positions will have a return of service commitment to New Brunswick, one will have a return of service commitment to Prince Edward Island and the remainder will have return of service commitments to Nova Scotia. There will be five residency positions in Royal College specialty training programs. These change annually. Please visit the CaRMS web site for up-to-date information.

All unfilled positions will be committed to the second iteration of the CaRMS match and will be open to all candidates including graduates of Canadian medical schools and international medical graduates who fulfil the eligibility criteria. Those applicants in the second iteration who are matched to unfilled first iteration International Medical Graduate positions will be required to sign a return of service contract with the Ministry of Health for either the Province of Nova Scotia, New Brunswick, or Prince Edward Island in the specialty (including Family Medicine) to which they have been matched.

The following 6 requirements for International Medical Graduates must be provided in order to be considered for residency training at Dalhousie University:

1. Legal Status

IMGs must be a Canadian citizen or Permanent Resident at the time of application. When applying you must submit one of the following verifications:

- Notarized/certified photocopy of Birth Certificate issued by an authority in Canada with any photo ID; or
- Notarized/certified photocopy of Canadian Passport; or
- Notarized/certified photocopy of Canadian citizenship certificate, Record of Landing; or
- Notarized/certified photocopy of Permanent Resident Card/Canadian Citizen Card.

2. Proof of MD Degree

IMGs must be a graduate of an acceptable medical school on the Foundation for Advancement of International Medical Education and Research (FAIMER) list. A notarized/certified copy of medical school marks/transcripts and medical degree/diploma must be submitted. Documents that are not in English must be accompanied by a notarized translation.

3. Language

Because English is the language of study at Dalhousie, all applicants whose first language is not English must provide proof of proficiency. You must have achieved the required proficiency in one of the following English language tests:

Test of English as a Foreign Language (TOEFL)

- Minimum score 600 for paper based; or
- Minimum score 250 for computer based; or
- Minimum score 100 for internet based (IBT); or
- **International English Language Testing System (IELTS).** We require a band score of 7.

Scores that are less than those stated above will not be considered.

Exemptions to English language tests will be made **only** if the language of instruction throughout the entire undergraduate medical education curriculum was in English. A letter of attestation of this from the Dean of the Medical School must be provided with the application.

4. Medical Council of Canada

A current pass in the Medical Council of Canada Evaluating Exam (MCCEE) is required, and if applicants provide proof of performance on the Medical Council of Canada Qualifying Exams (MCCQE) (parts 1 and 2) or the United States Medical Licensing Examination (USLME) Parts 1, 2 and 3 this will also be considered. For further information regarding Medical Council of Canada examinations you may contact:

Medical Council of Canada, 2283, boul St. Laurent Blvd. Ottawa, ON, K1G 5A2

Phone: (613) 521-6012

Website: www.mcc.ca

Applications for the MCCEE and the MCCQE (part 1) are available from most Canadian Employment and Immigration Commissions outside of Canada. To be eligible to take the Medical Council of Canada Qualifying Examination Part 1, your medical school must be listed in the World Health Organization Directory of Medical Schools.

5. Provincial Licensure Requirements

All applicants must be eligible to register for an educational license with the College of Physicians and Surgeons of Nova Scotia, New Brunswick and Prince Edward Island. The College of Physicians and Surgeons of Nova Scotia requires international medical graduates to include proof, as part of the completed license application, that verification through the PCRC has been initiated.

6. Return of Service Agreement

IMGs must be eligible to enter into a return of service agreement with (Nova Scotia), and available to undertake their return of service period beginning within 3 months after completion of their residency. IMGs who have undischarged ROS obligations may not be eligible to begin Ministry-funded training positions in (Nova Scotia). IMGs holding return of service (ROS) obligations must disclose pre-existing obligations at the time of their application. Such individuals may wish to contact the Ministry for further information.

Other criteria

Preference will be given to international medical graduates who are living in the Atlantic Provinces working in an area of health care. Preference will be given to international medical graduates who have the Clinical Assessment for Practice Program (CAPP) or equivalent. You can find information regarding CAPP at the following site: <http://www.capprogram.ca/>

Return of Service

In the CaRMS process, a number of residency positions will require Return of Service (RoS) commitments. In the first round of the CaRMS process, these positions will be available to International Medical Graduates (IMGs) only. However, in the second round of the CaRMS process, both IMGs and Canadian Medical Graduates (CMGs) will be eligible to apply for these positions. Those individuals (IMG or CMG) who are matched through CaRMS to residency positions associated with Return of Service (RoS) commitments will be required to sign a contract for RoS to a specific Maritime province. The basic conditions of the RoS contract that will be employed have been developed jointly by the four Atlantic Provinces and will incorporate a length of return service equal to the number of years the physician spent in his/her residency training program.

If a resident does not meet the terms of the return of service agreement, repayment will be required, subject to the conditions specific to each province.

The positions allocated to the IMG stream, and the Department of Health they will have a RoS with, is updated annually and advertised on the CaRMS web site. Should you wish to receive a contract template for a specific province, or to discuss terms and conditions of the Return for Service in each of the jurisdictions, the provincial contacts are as follows:

Nova Scotia Department of Health & Wellness: Joanne MacKinnon: joanne.mackinnon@gov.ns.ca

New Brunswick Department of Health: Lyne St. Pierre-Ellis: lyne.st-pierre-ellis@gnb.ca

Prince Edward Island Department of Health: Treena Bellamy: tibellamy@ihis.org

Direct Entry Programs

For specific requirements of entrance to each one of these programs and for the information on curricula, please refer to the most recent PGY1 Program Directory on the CaRMS website (<http://www.carms.ca>). The CaRMS Directory also gives information on all of the hospitals that are associated with the Dalhousie PGY1 Programs.

Anesthesia	Nuclear Medicine
Cardiac Surgery	Obstetrics & Gynecology
Dermatology	Ophthalmology
Diagnostic Radiology	Orthopedic Surgery
Emergency Medicine	Otolaryngology
Family Medicine	Pediatrics
General Surgery	Physical Medicine & Rehabilitation
Internal Medicine	Plastic Surgery
Laboratory Medicine: <i>Entry in second year to Anatomical, General or Hematological Pathology</i>	Psychiatry
Neurology	Radiation Oncology
Neurosurgery	Urology

Re-Entry Program

There are two residency training positions available through the Re-Entry Program. Applications for re-entry positions are only available to physicians who are Canadian citizens or Permanent Residents in Canada who have practiced in Nova Scotia for a minimum of two years. The individual must hold an unrestricted license for independent practice and must have a satisfactory "certificate of professional conduct" from the College of Physicians and Surgeons of Nova Scotia. Applications will be considered for specialty training areas with a perceived projected resource need as determined by the Department of Health and the Postgraduate Medical Education Office. All successful applicants must sign a return for service contract for a rural community with the Department of Health.

Candidates interested in the Re-Entry Program must submit a written request by October 1st to Denise Mitchell, Office of the Associate Dean of Postgraduate Medical Education (PGME) for a residency to start the following July. Contact Denise.Mitchell@Dal.Ca (902) 494-2362. The PGME Office will consult the training program and confirm whether or not that program has the resources to take an additional resident. Upon approval from the training program to consider an application, the PGME Office will contact the Department of Health for approval as a specialty of need. Upon receipt of DOH approval, an application will be sent to the candidate. The deadline for Postgraduate Medical Education to receive completed applications is November 15th.

Family Medicine Programs

The Family Medicine program at Dalhousie is a two-year integrated program. The first year is designed to be as family practice oriented as possible with all PGY1s spending a consecutive 12 week block time in Family Medicine as well as doing clinical half days back from specialty rotations. PGY1s are linked to one of six Family Medicine home bases in Fredericton, Moncton or Saint John, New Brunswick, Charlottetown, Prince Edward Island, or Sydney or Halifax, Nova Scotia, where they will complete 60-80% of their clinical training throughout the two-year program. Moncton PGY1s stay in Moncton for their PGY1 year; Saint John PGY1s stay in Saint John for their PGY1 year; Fredericton PGY1s stay in Fredericton for their PGY1 year; and, Cape Breton PGY1s stay in Cape Breton for their PGY1 year. In their PGY1 year most Halifax-based Family Medicine residents are assigned to specialty services in either Saint John or Fredericton where responsibility and one-on-one teaching are more readily available. The second year is specific in its orientation to family practice in addressing the needs of physicians who intend to practice in rural communities which have reasonable access to specialty services. The emphasis is on primary and secondary care appropriate to family practice trainees.

Program Director: Dr. Jennifer Hall Program Manager: Nancy McCarther Medical Education Coordinator: Ms. Margaret Garnier	jlhall@dal.ca Tele (902) 473-8047 Fax (902) 473-4760 Tele (902) 473-4746 Fax (902) 473-4760 margaret.garnier@dal.ca Tele (902) 473-4749 Fax (902) 473-4760	Department of Family Medicine 8 th Floor, Abbie Lane Site QEII Health Sciences Centre 5909 Veteran's Memorial Lane Halifax, NS, B3H 2E2
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Program Sites/Email	Site Director	Address
Family Medicine Cape Breton Jacksonm@cbdha.nshealth.ca	Dr. J. MacKillop Tele (902) 567-8055 Fax (902) 567-8149	Cape Breton Healthcare Complex Level 3, Medical Education Unit 1482 George St., Sydney, NS B1P 1P3
Family Medicine Fredericton stephanie.suter@horizonnb.ca	Dr. S. Tatemichi Dr. A.M. McGibbon Tele (506) 452-5705 Fax (506) 452-5710	Horizon Health Network– Zone 3 700 Priestman St., PO Box 9000 Fredericton, NB E3B 5N5
Family Medicine Halifax Allister.Barton@dal.ca	Dr. J. Zed Tele (902) 473-4744 Fax (902) 473-4760	Department of Family Medicine 8th Floor, Room 8420, Abbie J. Lane Site QEII Health Sciences Centre 5909 Veteran's Memorial Lane Halifax, NS, B3H 2E2
Family Medicine Northumberland irene.knowles@horizonnb.ca	Dr. K. Dufour Dr. L. Murphy-Kaulbeck Tele (506) 857-5660 Fax (506) 857-5661	Horizon Health Network– Zone 1 Medical Education Office 135 MacBeath Ave. Moncton, NB E1C 6Z8
Family Medicine Prince Edward Island midriscoll@ihis.org	Dr. G.H. Carruthers Tele (902) 894-2536 Fax (902) 620-3896	Queen Elizabeth Hospital c/o Medical Programs 60 Riverside Drive, P. O. Box 6600 Charlottetown, PE C1A 8T5
Family Medicine Saint John Dawn.Keenan@horizonnb.ca	Dr. J. Hall Tele (506) 648-6810 Fax (506) 648-6833	Horizon Health Network Authority B – Zone 2 400 University Ave, PO Box 2100 Saint John, NB E2L 4L2
Family Medicine - Emergency Medicine emergency.medicine@dal.ca	Dr. M. L. Watson Tele (902) 473-4220 Fax (902) 473-3617	Department of Emergency Medicine Room 355 3 rd Floor, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7

Family Medicine – Integrated Emergency Medicine Dawn.Keenan@horizonnb.ca	Dr. P. A. Ross Tele (506) 649-2582 Fax (506) 648-6833	Medical Education Office Horizon Health Network Authority B – Zone 2 400 University Ave, PO Box 2100 Saint John, NB E2L 4L2
Family Medicine - Health Care of the Elderly Kelly.MacDonald@cdha.nshealth.ca	Dr. B. Clarke District Medical Director Tele (902) 487-0813 Fax 454-2684	Health Care of the Elderly Residency Program, Dalhousie Family Medicine Suite 2056, Mumford Professional Centre 6960 Mumford Road, Halifax, NS B2I 4P1
Family Medicine - Palliative Medicine Noma.White@cdha.nshealth.ca	Dr. D. Dupere Tele (902) 473-4356 Fax 473-6602	Division of Palliative Medicine Room 311, Bethune Bldg., VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Specialty Programs

The list of Program Directors provides information on the Specialty Training Programs approved by the Royal College of Physicians and Surgeons of Canada which are currently offered at Dalhousie University. These programs are intended to prepare candidates to write the Royal College Certification Examinations and practice in that specialty.

Because there are a large number of training programs, all except direct entry programs, are administered by each department through the Program Director. For specific information about the training program and requirements for entry, contact the Program Director of the specialty in which you wish to train.

Program/Email	Program Director	Address
Anesthesia AnesthesiaResidency@dal.ca	Dr. J. Chisholm Tele (902) 473-2325 Fax (902) 473-1035	Department of Anesthesia Room 231A, 10 th Floor West, Victoria Building VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Cardiac Surgery Debbie.White@cdha.nshealth.ca	Dr. R. Baskett Tele (902)473-3808 Fax (902) 473-4448	Division of Cardiovascular Surgery Room 2269, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7
Dermatology Katherine.Crosby@cdha.nshealth.ca	Dr. P. J. Green Tele (902) 473-7934 Fax (902) 473-2655	Division of Dermatology, Room 4190 Dickson Bldg., Victoria General Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Diagnostic Radiology Gisele.Phelan@cdha.nshealth.ca	Dr. M. P. Brown Tele (902) 473-5453 Fax (902) 473-2018	Department of Radiology North Wing, 3rd Floor, Room 319 VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Emergency Medicine Emergency.Medicine@dal.ca Leigh.Thibideau@cdha.nshealth.ca	Dr. K. D. Magee Tele (902) 473-4220 Fax (902) 473-3617	Department of Emergency Medicine Room 355, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7
General Surgery Sheila.Reid@dal.ca	Dr. M. J. Walsh Tele (902) 473-5570 Fax (902) 473-4442	Education Office, Dept. Of Surgery, Room 849 8 th Floor, Victoria Building, Victoria General Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Internal Medicine - Halifax Meegan.Dowe@cdha.nshealth.ca	Dr. D. J. White Tele (902) 473-2253 Fax (902) 473-4067	Department of Medicine 4th Floor, Room 483, Bethune Building, VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Internal Medicine – Saint John Angeles.Damil@horizonnb.ca	Dr. E. N. Grant (Site Director) Tele (506) 648-6803 Fax (506) 648-7379	Department of Medicine Horizon Health Network, Zone 2, 400 University Ave., PO Box 2100 Saint John, NB, E2L 4L2
Laboratory Medicine: Anatomical Pathology Debby.Caldwell@cdha.nshealth.ca	Dr. P. Barnes Tele (902) 473-7589 Fax (902) 473-6588	Department of Pathology 7th Floor, Room 737, MacKenzie Building, VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Laboratory Medicine: General Pathology Debby.Caldwell@cdha.nshealth.ca	Dr. D. Werner Tele (902) 473-7589 Fax (902) 473-6588	Department of Pathology 7th Floor, Room 737, MacKenzie Building, VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Laboratory Medicine: Hematological Pathology Debby.Caldwell@cdha.nshealth.ca	Dr. A. A. K. Shawwa Tele (902) 473-7589 Fax (902) 473-6588	Division of Hematology, c/o Dept. of Pathology 7th Floor, Room 737, MacKenzie Building, VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Medical Microbiology Kimberly.Trigg@cdha.nshealth.ca	Dr. T. F. Hatchette Tele (902) 473-6469 Fax (902) 473-7971	Immunology/Virology: Department of Microbiology 4 th Floor, Room 404, MacKenzie Building, VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Neurology – Adult Andrea.Ellis@cdha.nshealth.ca	Dr. V. Bhan Tele (902) 473-3731 Fax (902) 473-4438	Department of Medicine, Division of Neurology Room 3822, 3 rd Floor, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7
Neurology – Pediatric Janet.Avery@iwk.nshealth.ca	Dr. P. Brna Tele (902) 470-8475 Fax (902) 470-8486	Pediatric Neurology, Department of Pediatrics 8 th Floor South, IWK Health Centre Children's Site 5850/5980 University Avenue P. O. Box 9700, Halifax, NS, B3K 6R8
Neurosurgery sladeeb@cdha.nshealth.ca	Dr. P.D. McNeely Tele (902) 473-8919 Fax (902) 473-6609	Division of Neurosurgery Level 3, Room 3844, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7
Nuclear Medicine Gisele.Phelan@cdha.nshealth.ca	Dr. J.R. Clarke Tele (902) 473-5453 Fax (902) 473-2018	Department of Radiology 3rd Floor, Room 319, North Wing, VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Obstetrics & Gynecology Mary.Boudreau@iwk.nshealth.ca	Dr. J. B. Wenning Tele (902) 470-6675 Fax (902) 425-1125	Department of Obstetrics & Gynecology Room 2114, Women's & Maternity Site IWK Health Centre 5850/5980 University Avenue P.O. Box 9700, Halifax, NS, B3K 6R8
Ophthalmology Michelle.Snyder@dal.ca	Dr. V. Kozousek Tele (902) 473-2517 Fax (902) 425-9915	Department of Ophthalmology & Visual Sciences Room 2026, 2 West, Victoria Bldg. QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Orthopedic Surgery Marlo.Ferguson@cdha.nshealth.ca	Dr. W. Oxner Tele (902) 473-6156 Fax (902) 473-3563	Division of Orthopedic Surgery Room 4520, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7

Otolaryngology Brenda.Oake@dal.ca	Dr. E.A.S. Massoud Tele (902) 473-2737 Fax (902) 473-3854	Division of Otolaryngology Room 3053, 3 rd Floor, Dickson Bldg., VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Pediatrics Elizabeth.Myers@iwk.nshealth.ca	Dr. E. P. Wood Tele (902) 470-8119 Fax (902) 470-7542	PG Medical Office, Department of Pediatrics IWK Health Centre, 4 West Children's Site 5850/5980 University Avenue P. O. Box 9700, Halifax, NS, B3K 6R8
Physical Medicine & Rehabilitation Laura.Scott@cdha.nshealth.ca	Dr. A. Saric Tele (902) 473-3232 Fax (902) 473-3204	Department of Medicine, Room 211 Nova Scotia Rehabilitation Site QEII Health Sciences Centre 1341 Summer Street, Halifax, NS, B3H 4K4
Plastic Surgery Denise.Boutin@iwk.nshealth.ca	Dr. K. Wilson Tele (902) 470-8168 Fax (902) 470-7939	Division of Plastic Surgery Main Floor, Children's Site IWK Health Centre 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Psychiatry Carrie.Wipp@cdha.nshealth.ca	Dr. M. Rajda Tele (902) 473-5664 Fax (902) 473-4545	Department of Psychiatry 8th Floor, Abbie J. Lane Site QEII Health Sciences Centre 5909 Veterans Memorial Ln., Hfx NS, B3H 2E2
Radiation Oncology Leanne.Picketts@cdha.nshealth.ca	Dr. M. Rajaraman Tele (902) 473-6068 Fax (902) 473-7205	Department of Radiation Oncology Nova Scotia Cancer Centre, Room 2028A Dickson Bldg., Victoria General Site QEII Health Sciences Centre 5820 University Avenue, Halifax, NS, B3H 1V7
Urology Laila.Rockman@dal.ca	Dr. G.G. Bailly Tele (902) 473-5469 Fax (902) 473-5850	Department of Urology Room 294, 5 Victoria Wing, VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Subspecialty Programs

Program/Email	Program Director	Address / Email
Cardiology – Adult Nicole.Chiasson@cdha.nshealth.ca	Dr. S. D. Jackson Tele (902) 473-6608 Fax (902) 473-2434	Department of Medicine, Division of Cardiology Room 2102, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7
Cardiology – Pediatric Debbie.Clarke@iwk.nshealth.ca	Dr. K. K. Wong Tele (902) 470-8407 Fax (902) 470-6616	Children's Heart Centre 3rd Floor Link, Children's Site IWK Health Centre, 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Clinical Immunology and Allergy Helene.Whitford@iwk.nshealth.ca	Dr. S. Kapur Tele (902) 470-6554 Fax (902) 470-7308	Allergy Administrative Office Division of Allergy Main Floor- Children's Site IWK Health Centre, 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Critical Care Medicine - Adult Karen.Berry@cdha.nshealth.ca	Dr. S. D. Beed Tele (902) 473-3608 Fax (902) 473-3610	Department of Medicine Room 377, Bethune Building, VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Endocrinology & Metabolism Julie.Fraser@cdha.nshealth.ca	Dr. S. M. Kaiser Tele (902) 473-3712 Fax (902) 473-3726	Division of Endocrinology 7 North, Victoria Building, Room 044 VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Gastroenterology - Adult Jessica.Carter@cdha.nshealth.ca	Dr. S. T. Patel Tele (902) 473-1499 Fax (902) 473-4487	Division of Gastroenterology Room 932, Centennial Bldg., VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
General Medicine Cynthia.Capstick@cdha.nshealth.ca	Dr. J. D. Manning Tele (902) 473-3961 Fax (902) 473-8430	Department of Medicine Room 409, Bethune Building, VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS B3H 2Y9
Geriatric Medicine Marisa.Maclean@cdha.nshealth.ca	Dr. C. MacKnight Tele (902) 473-3888 Fax (902) 473-7133	Division of Geriatric Medicine, Room 1308, Veterans Memorial Bldg. QEII Health Sciences Centre, 5955 Veterans Memorial Lane Halifax, NS, B3H 2E1
Gynecologic Reproductive Endocrinology and Infertility Catherine.Hamblin@iwk.nshealth.ca	Dr. R. Bouzayen Tele (902) 470-7098 Fax (902) 425-1125	Department of Obstetrics & Gynecology IWK Health Centre, Main Level Women's & Maternity Site 5850/5980 University Avenue P. O. Box 9700, Halifax, NS, B3K 6R8
Hematology - Adult Brandy.Phillips@cdha.nshealth.ca	Dr. A. Kew Tele (902) 473-4642 Fax (902) 473-4447	Department of Medicine, Division of Hematology 4th Floor, Room 431 Bethune Building, Victoria General Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Pediatric Haematology/Oncology Alicia MacDonald@iwk.nshealth.ca	Dr. V. E. Price Tele (902) 470-6839 Fax (902) 470-7216	Division of Pediatric Haematology/Oncology Department of Pediatrics Main Floor, Room K2915, Children's Site IWK Health Centre, 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Infectious Disease – Adult Kimberly.Trigg@cdha.nshealth.ca	Dr. T. Hatchette Tele (902) 473-6469 Fax (902) 473-7971	Immunology & Virology, Department of Microbiology Room 404, 4 th Floor Dr. D. J. MacKenzie Building, VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Infectious Disease – Pediatric Tasha.Brown@iwk.nshealth.ca	Dr. R.A. Bortolussi Tele (902) 470-7584 Fax (902) 470-7232	Room 4014, 4 th Floor, Goldbloom Centre, Children's Site, IWK Health Centre 5850/5980 University Ave, P.O. Box 9700 Halifax, NS, B3K 6R8
Maternal-Fetal Medicine Mary.Boudreau@iwk.nshealth.ca	Dr. V. Allen Tele (902) 470-6675 Fax (902) 425-1125	Department of Obstetrics & Gynecology Room 2114, Women's & Maternity Site IWK Health Centre, 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Medical Oncology Elizabeth.Hogue@cdha.nshealth.ca	Dr. B.D.O. Colwell Tele (902) 473-3748 Fax (902) 473-6186	Division of Medical Oncology Room 457, 4 th Floor, Bethune Bldg. Victoria General Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Neonatal-Perinatal Medicine Wendy.Mitchell@dal.ca	Dr. D. McMillan Dr. M. A. Graven Tele (902) 470-6466 Fax (902) 470-6469	Division of Neonatal Pediatrics Room G2174, Women's & Maternity Site IWK Health Centre, 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Nephrology - Adult Nicole.Deveau@cdha.nshealth.ca	Dr. T. M. Keough-Ryan Tele (902) 473-4612 Fax (902) 473-2675	Department of Medicine, Division of Nephrology 5th Floor, Room 5097, Dickson Bldg. Victoria General Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Nephrology - Pediatric Philip.Acott@iwk.nshealth.ca	Dr. P. D. Acott Tele (902) 470-8195 Fax (902) 470-8900	Department of Pediatrics, Division of Pediatric Nephrology, 4 th Floor East, Room 415 IWK Health Centre Children's Site 5850/5980 University Avenue P. O. Box 9700, Halifax, NS B3K 6R8
Neuroradiology Gisele.Phelan@cdha.nshealth.ca	Dr. R.A. Vandrope Tele (902) 473-5453 Fax (902) 473-2018	Department of Radiology 3 rd Floor, Room 312, North Wing, Victoria Building VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9
Pediatric Emergency Medicine Leigh.Thibideau@cdha.nshealth.ca	Dr. B. Blackie Tele (902) 473-4220 Fax (902) 473-3617	Department of Pediatrics Division of Pediatric Emergency Medicine IWK Health Centre, Children's Site 5850/5980 University Ave. P. O. Box 9700, Halifax, NS, B3K 6R8
Pediatric General Surgery Judy.Charman@iwk.nshealth.ca	Dr. G.F. Brisseau Tele (902) 470-8113 Fax (902) 470-7260	Department of Surgery IWK Health Centre Children's Site, 5850/5980 University Avenue P. O. Box 9700, Halifax, NS, B3K 6R8
Respirology Shelley.Sani@cdha.nshealth.ca	Dr. C. McParland Tele (902) 473-3698 Fax (902) 473-6202	Division of Respirology Level 4, Rm 4448, Halifax Infirmary Site QEII Health Sciences Centre 1796 Summer Street, Halifax, NS, B3H 3A7
Rheumatology Shelly.Brown@cdha.nshealth.ca	Dr. V. Bakowsky Tele (902) 473-3818 Fax (902) 473-7019	Division of Rheumatology Room 245, Nova Scotia Rehabilitation Centre QEII Health Sciences Centre 1341 Summer Street, Halifax, NS, B3H 4K4
Transfusion Medicine Debby.Caldwell@cdha.nshealth.ca	Dr. I. Sadek Tele (902) 473-7589 Fax (902) 473-6588	Division of Hematology, c/o Dept. of Pathology 7th Floor, Room 737, MacKenzie Building, VG Site, QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Special Programs

<i>Program/Email</i>	<i>Program Director</i>	<i>Address / Email</i>
Clinician Investigator Program Jesslyn.Kinney@dal.ca	Dr. R. Bortolussi Tele (902) 494-1395 Fax (902) 494-7119	Medical Research Services Room C-203, Clinical Research Centre 5849 University Avenue, Halifax, B3H 4H7
Palliative Medicine Noma.White@cdha.nshealth.ca	Dr. D. Dupere Tele (902) 473-4356 Fax (902) 473-6602	Division of Palliative Medicine Room 311, Bethune Building, VG Site QEII Health Sciences Centre 1276 South Park St, Halifax, NS, B3H 2Y9

Start Date

Residency training is preceded by a mandatory one-day Postgraduate Orientation for new trainees in Halifax. For all international medical graduates and Visa trainees, there is a special orientation-introduction to the Canadian Health Care System that is held over two weeks starting mid June and attendance is expected. Clinical training begins at 9:00 a.m. on July 1st. Having accepted appointment, postgraduate medical trainees are expected to report for duty on the starting date and to serve for the full training year, unless they are incapacitated by illness, or unless they give four weeks notice for reasons acceptable to the Director of Training. The postgraduate medical trainee's signature on the contract form indicates agreement "to adhere to all Dalhousie University Faculty of Medicine and Hospital regulations." All new and returning trainees are required to complete the Resident Information Profile and a Contract.

Teaching Hospitals

QEII Health Sciences Centre (Halifax):

Abbie J. Lane Memorial Building
5909 Veteran's Memorial Lane
Halifax, NS, B3H 2E2
473-2700

Halifax Infirmary
1796 Summer Street
Halifax, NS, B3H 3A7
473-2700

Nova Scotia Cancer Centre
5820 University Avenue
Halifax, NS, B3H 1V7
473-6000

Nova Scotia Rehabilitation Centre
1341 Summer Street
Halifax, NS, B3H 4K4
473-2700

Veterans Memorial Building
5955 Veteran's Memorial Lane
Halifax, NS, B3H 2E1
473-2700

Victoria General Site
1276 South Park Street
Halifax, NS, B3H 2Y9
473-2700

IWK Health Centre (Halifax):
1 888-470-5888

Women's & Maternity Site
5850/5980 University Avenue
P. O. Box 9700
Halifax, NS, B3K 6R8
470-8888

Children's Site
5850/5980 University Avenue
P. O. Box 9700
Halifax, NS, B3K 6R8
470-8888

Nova Scotia Hospital
P.O. Box 1004, 300 Pleasant Street
Dartmouth, NS, B2Y 3Z9
464-3111

Canadian Forces Health Services Centre
Maritime Forces Atlantic
P. O. Box 99000 Station Forces
Halifax, NS, B3K 5X5
721-8700

Cape Breton Healthcare Complex
1482 George Street
Sydney, NS
B1P 1P3
902-567-8000

Horizon Health Network – Zone 1 (Moncton)
135 MacBeath Avenue
Moncton, NB, E1C 6Z8
506-857-5111

Horizon Health Network – Zone 2 (Saint John)
400 Univeristy Avenue, P.O. Box 2100
Saint John, NB, E2L 4L2
506-648-6000

Horizon Health Network – Zone 3 (Fredericton)
700 Priestman Street, P.O. Box 9000
Fredericton, NB, E3B 5N5
506-452-5400

Queen Elizabeth Hospital
P.O. Box 6600, 60 Riverside Drive
Charlottetown, PE, C1A 8T5
902-894-2111

Prince County Hospital
65 Roy Boates Avenue
Summerside, PE, C1N 6M8
902-438-4200

Academic Fees

The University academic fee for Postgraduate Medicine for the academic year 2011/12 has not been set but is in the vicinity of \$2,800. The resident's portion of the 2011/12 academic fee is \$300. All residents must arrange for the payment of their academic fee (\$300) directly with Student Accounts by cheque or credit card by June 15th. **Residents who are funded by external sponsoring agencies must pay the full academic fee and arrange with their sponsor for reimbursement of the portion exceeding \$300.**

ACLS

It is mandatory that all PGY1s complete an ACLS course prior to commencement of training. Dalhousie does not provide nor offer reimbursement for this course to incoming trainees. Residents may be required to participate in running arrest codes. Residents must provide the Postgraduate Office with a photocopy of their ACLS card during registration. Those residents without ACLS will be reported to their Program Director and will require a waiver from their Program in order to commence their residency training.

Appeal and Reconsideration Regulations

1.0 Appeal of an Unsatisfactory ITER

1.1 Grounds for Appeal

Only ITERs rated as "Fail", "Unsatisfactory" or "Not Pass" can be appealed. An appeal of an ITER can be made only on the basis that the Clinical Supervisor and/or the Rotation Supervisor failed to follow the process set out in section 1.1 of the Assessment of Training and Promotion Regulations, or on the basis that there are extraordinary mitigating personal circumstances that ought to be considered.

1.2 Time Limitation

An appeal of an ITER is a two-stage process that must be initiated within 10 working days of the resident being sent the ITER. The first stage must be completed within 15 working days of the resident being sent the ITER; the second stage must be completed within 40 working days of the resident being sent the ITER. Any deadline except the deadline to initiate the appeal in the first instance may be extended by Program Director, in his or her sole discretion, at the request of any party to the appeal.

1.3 First Stage

The first stage is an informal stage in which the resident must discuss the ITER with the Faculty supervisor who completed it and identify whatever additional information the resident believes should be considered (e.g. external factors which influenced the resident's performance; identification of other individuals who could add an additional perspective on the resident's performance).

Within 15 working days of the resident being sent the ITER, the faculty supervisor must either a) revise the ITER in which event the revised ITER becomes the official ITER, replacing the earlier one; or b) advise the resident in writing that the ITER will remain unchanged.

1.4 Second Stage

If the resident is not satisfied with the review by the faculty supervisor, the resident may proceed to the second and formal stage of the appeal process by notifying the Program Director in writing of his or her intention to do so. This notice must be delivered no later than 5 working days following receipt of the faculty supervisor's decision under section 1.3 above.

Upon receipt of written notice from the resident, the Program Director shall ask the Chair of the Department within which the Program resides to strike a Department Appeal Committee comprising two faculty members from the Department who have had no direct involvement in the evaluation of the resident in relation to the rotation in issue, one of whom shall be appointed Chair of the Department Appeal Committee, and, at the resident's election, another resident. If the resident appealing the ITER elects to have a resident appointed to the Department Appeal Committee, such resident shall be selected by the Associate Dean, PGME and in the case of small Departments may be a resident from another program. In the event that the resident does not elect to have a resident appointed to the Committee, the Chair of the Department shall appoint a third faculty member to the Committee.

Coincident with the appointment of the Department Appeal Committee members, the Chair of the Department shall set a date for the appeal. The appeal must be scheduled and heard within 20 working days of the Program Director receiving written notice from the resident.

The Program Director and resident shall provide the Department Appeal Committee with all documentation (i.e. evaluations, correspondence) relevant to the issues under appeal no later than 5 working days prior to the appeal. The Department Appeal Committee will provide the Program Director and resident respectively with copies of materials submitted by the other.

The Program Director and resident shall attend the appeal meeting and will be provided the opportunity to make submissions. The Department Appeal Committee shall then deliberate *in camera*. Minutes shall be kept of the appeal meeting including *in camera* deliberations on a form provided by PGME. The Department Appeal Committee has the power to:

- a) uphold the original ITER rating; or
- b) change the ITER to a rating of "Pass" or "Borderline".

A copy of the minutes will be provided to the Associate Dean PGME. These minutes will not become part of the PGME resident file.

The Departmental Appeal Committee will prepare a written decision, including reasons. A copy of the decision will be provided to the resident and the Program Director. The Program Director will provide the decision to the Residency Training Committee ("RTC").

If the Department Appeal Committee's decision is to change the ITER rating, the RTC, in consultation with the Program Director, will determine what, if any, plans are required to address deficiencies.

The decision of the Department Appeal Committee is final. It is tantamount to a final decision on a grade reassessment and is not subject to further appeal.

2.0 Reconsideration of the Residency Training Committee's decision to require a Remedial Training Program, the contents of a Remedial Training Program, or the Terms and Conditions of Probation

2.1 Availability of a Reconsideration

A resident may request that the RTC reconsider:

- a) its decision to require a resident to complete a Remedial Training Program under section 6.2 of the Assessment of Training and Promotion Regulations;
- b) the contents of a remedial training program imposed by the RTC under section 6.3(a) of the Assessment of Training and Promotion Regulations; and/or

c) the terms and conditions of probation imposed by the RTC under section 7.2 of the Assessment of Training and Promotion Regulations.

2.2 Time Limitations

A request for reconsideration under section 2.1 must be made in writing by the resident to the Program Director within 10 working days of delivery of the written notification of the RTC's decision to the resident. Any deadline except the deadline to initiate the review in the first instance may be extended by Program Director, in his or her sole discretion.

2.3 Procedure

Upon receipt of the request for reconsideration from the resident, the Program Director will set a date for the reconsideration hearing and provide notice to the resident and the RTC. The reconsideration hearing must be scheduled and heard within 20 working days of receipt of the written notice to the Program Director. The Program Director shall provide the resident access to all documentation (i.e. evaluations, correspondence, minutes) forming the basis for the RTC decision being reconsidered, no later than ten working days prior to the hearing. The resident shall provide the Program Director with any additional materials he or she wishes the RTC to consider no later than five working days prior to the hearing.

The resident shall attend the reconsideration hearing and be provided the opportunity to make submissions. The RTC shall then deliberate in camera. Minutes shall be kept of the hearing including in camera deliberations on a form provided by PGME. The RTC may:

- a) reaffirm its original decision, in whole or in part;
- b) reverse its decision to require the resident to complete a remedial training program; or
- c) make specific modifications to the contents of the remedial training program or to the terms and conditions of probation, as the case may be.

The RTC will prepare a written decision, including reasons. The Program Director will provide a copy of the decision to the resident. A copy of the decision will also be forwarded to the Associate Dean, PGME for inclusion in the resident's file. A copy of the minutes will be forwarded to the Associate Dean PGME, but will not become part of the resident's file.

The decision of the RTC may be appealed to the Faculty Appeal Committee.

3.0 Appeal of a Reconsideration by the RTC or of a Decision to Dismiss or Suspend a Resident from the Program

3.1 Grounds for Appeal

A resident may appeal a decision of the RTC:

- a) in relation to its reconsideration of its decision to require a resident to complete a Remedial Training Program and/or of the contents of a Remedial Training Program under section 2.1 of these regulations;
- b) in relation to its reconsideration of the terms and conditions of academic probation under section 2.1 of these regulations, or
- c) to dismiss or suspend a resident from the program under sections 9.1 or 9.2 of the Assessment of Training and Promotion Regulations,

A resident's appeal may be made only on the following grounds:

- a) that the RTC had no jurisdiction to make the decision; or
- b) that the RTC denied the resident natural justice (procedural fairness) in rendering its decision.

3.2 Time Limitation

An appeal of a decision of the RTC under this section must be made within 15 working days of delivery of the written notification by the Program Director of the RTC's decision. To initiate an appeal, the resident must notify the Associate Dean PGME in writing of his or her intention to appeal, enclosing a copy of the decision of the RTC. Any deadline except the deadline to initiate the appeal in the first instance may be extended by Associate Dean, PGME, in his or her sole discretion, at the request of any party to the appeal.

Faculty Appeal Committee

Upon receipt of the notice of appeal from the resident, and on notice to the Program Director, the Associate Dean PGME shall strike a Faculty Appeal Committee (the "Committee") comprising two faculty members from among the members of the Faculty Postgraduate Training Committee (one of whom shall be appointed Chair) and one resident, none of whom shall have had any prior connection with the issues under appeal. The Associate Dean, PGME will review the appeal process with the resident.

3.3 Pre-Hearing Procedures

The Associate Dean, PGME shall:

- a) set a date for the appeal hearing which shall be no later than 20 working days after receipt of the resident's notice of appeal and provide notice of the appeal date to the Program Director and to the resident;
- b) establish a deadline for the Program Director to provide the Chair with copies of all documentation considered by the RTC in making the decision under appeal, together with a copy of the RTC's written decision;
- c) provide copies of the material provided by the Program Director under subsection b) to the resident and establish a deadline for the resident to provide written submissions outlining the basis for the appeal and any supporting documentation;
- d) provide copies of the resident's submissions to the Program Director and establish a deadline for the Program Director to provide written submissions responding to the resident's submissions;
- e) provide the resident with a copy of the Program Director's submissions;
- f) provide the Committee members with both sets of submissions and supporting documentation.

3.4 The Appeal Meeting

The resident and the Program Director shall attend the appeal meeting and be provided the opportunity to make submissions, and to respond to questions from the Committee or the other party. The resident has the right to have a support person or other representative present for the meeting.

3.5 Deliberations and Decision

The Committee shall then deliberate in camera.

3.5.1 In relation an appeal under section 3.1(a) or (b), the Committee has the power to:

- a) dismiss the appeal, thereby permitting the RTC's decision to stand; or

- b) allow the appeal in whole or in part, providing direction to the RTC for further consideration as may be appropriate.

3.5.2 In relation to an appeal of a decision to suspend or dismiss a resident, the Committee has the power to:

a) dismiss the appeal; or

b) allow the appeal, in whole or in part, directing the RTC to place the resident on probation and providing recommendations concerning the terms of probation the Committee deems appropriate.

Minutes shall be kept of the appeal meeting including in camera deliberations. The Committee will provide a written decision, including reasons and the minutes to the Associate Dean PGME. The Associate Dean, PGME, shall provide the decision to the resident and to the Program Director.

The Committee's minutes will not become part of the resident's file.

Assessment of Training and Promotion Regulations

Approved by the Postgraduate Education Committee June 2, 2011

1.0 METHODS OF ASSESSMENT

There are a variety of methods of assessment used to evaluate the academic and clinical performance of residents, depending upon the residency program, including, but not limited to: examinations (written, oral, clinical and/or national standard), In-Training Evaluation Reports (ITERS) prepared in the context of clinical rotations, and participation in scheduled academic sessions. All evaluations are copied to Postgraduate Medical Education Office and form part of each resident's permanent file.

1.1 ITERS. Evaluation methods may vary depending upon the residency training program; however the completion of the ITER for clinical rotations is a required method of evaluation for all residency training programs. The Clinical Supervisor and/or the Rotation Supervisor complete an ITER for each resident at the conclusion of all clinical rotations; and for rotations that are in excess of six months, at regular intervals so that the resident is evaluated at least every three months. Each ITER must be signed promptly by the resident in acknowledgement that s/he has reviewed the ITER. The resident may insert any comments above his/her signature. Signing the ITER does not indicate agreement with, or acceptance of, the content of the ITER, and has no impact the resident's right to appeal the ITER issued at the end of the rotation.

Routine mid-point evaluations are strongly encouraged and are required when a resident's performance is considered unsatisfactory at the mid-point of a rotation. The Clinical Supervisor and/or the Rotation Supervisor must meet with the resident to provide detailed feedback in connection with a mid-point evaluation, including a written summary of the identified deficiencies in the resident's performance. The resident must acknowledge, on the face of the written summary, or elsewhere in writing, that the deficiencies were discussed with him or her. Signing the written summary does not indicate agreement with, or acceptance of, the content of the summary, and has no impact the resident's right to appeal the ITER issued at the end of the rotation. It is the joint responsibility of the resident and the Clinical Supervisor/Rotation Supervisor to make prompt arrangements for such a meeting.

At the conclusion of the rotation, the Clinical Supervisor and/or the Rotation Supervisor must meet with the resident to provide detailed feedback in connection with the ITER. In the case of

an unsatisfactory and/or borderline ITER, details of the resident's deficiencies should be expressly noted on the ITER and discussed with the resident. The resident must acknowledge, on the face of the ITER, or elsewhere in writing, that the deficiencies were discussed with him or her.

1.2 Other forms of evaluation. In addition to ITERs, programs may have other means of evaluation (including, but not limited to: OSCEs, national exams, written exams, daily logs, field notes, clinical encounters, etc.) that are routinely performed and documented. Each program shall identify all methods of academic evaluation. In the event that a resident receives an unsatisfactory evaluation, s/he shall meet with the Program Director to discuss the identified deficiencies, and shall acknowledge, in writing that the deficiencies were discussed. It is the joint responsibility of the resident and the Clinical Supervisor/Rotation Supervisor to make prompt arrangements for such a meeting.

1.3 FITER. At the conclusion of the residency program, the Program Director prepares a Final In-Training Evaluation Report for each resident who has successfully completed all academic requirements for completion of the program. The FITER is a global assessment of all evaluations throughout the residency and reflects the final status of the resident, not the average of the entire residency. Residents are required to sign the FITER prior to it being submitted to the Associate Dean, PGME, who also signs. All signatures are required before the FITER can be submitted to the Royal College of Physicians and Surgeons of Canada.

1.4 Certificate of Completion. The Certification of Completion form for the College of Family Physicians of Canada only requires the signatures of the program director of Family Medicine and Associate Dean, PGME.

2.0 PROFESSIONAL CONDUCT

Residents are expected to adhere to the standards of ethical behaviour for the medical profession and their professional activities are expected to be characterized by honesty, integrity, conscientiousness and reliability. Behaviour which violates these principles, and which affects the performance of professional activities, is viewed as a demonstration of lack of suitability to be a physician.

2.1 Assessment of behavioural and ethical performance will be related to the following educational objectives:

- a)** The resident must display adequate skill at communicating and interacting appropriately with patients, families, colleagues, and allied health care professionals;
- b)** Residents should demonstrate:
 - i) respect, empathy and compassion for patients and their families;
 - ii) concern for the needs of the patients and their families to understand the nature of the illness and the goals and possible complications of investigations and treatment;
 - iii) respect for, and ability to work harmoniously with other allied health care personnel and medical colleagues;
 - iv) recognition of the importance of self-assessment and of lifelong learning for the maintenance of competent performance;

- v) a willingness to teach others in their own specialty, as well as other allied health care professionals;
- vi) an understanding of the appropriate requirements for involvement of patients and their families in research;
- vii) awareness of the effects that differences in cultural and social background have on the maintenance of health and the development of, and reaction to, illness; and
- viii) respect for the patient as an informed participant in decisions regarding his/her care, wherever possible.

2.2 Behaviour unacceptable to the professional practice of medicine includes but is not limited to:

- i) breach of any of the above principles of behaviour;
- ii) referring to oneself as, or holding oneself to be, more qualified than one is;
- ii) behaviour or inappropriate judgement which adversely affects the medical education of others;
- iii) commission of a criminal act;
- iv) failure to be available while on call;
- v) failure to respect patients' rights;
- vi) breach of confidentiality;
- vii) failure to provide transfer of responsibility for patient care;
- viii) failure to keep proper medical records;
- ix) falsification of medical records;
- x) sexual impropriety with a patient;
- xi) being under the influence of alcohol or drugs while participating in patient care or on call;
- xii) sexual or other harassment of colleagues or other members of the health care team; and
- xiii) any conduct unbecoming of a practising physician.

Other behaviours not listed may also be unacceptable. The above is not an exhaustive list. Breaches of these ethical and behavioural standards are serious matters, represent a failure to meet accepted standards and may result in remedial training, probation, removal from clinical service or dismissal from the program under these Regulations.

3.0 INCOMPLETE ROTATIONS

It is critical that a resident obtain sufficient clinical experience to meet pedagogical requirements, and to provide adequate opportunity to be appropriately evaluated. A clinical rotation that includes less than 75% of the expected clinical experience, regardless of the reasons (illness, leave, holidays, etc.), may be considered as incomplete. In such cases, the Program Director, in consultation with the Clinical Supervisor and/or Rotation Supervisor, will determine whether the clinical experience of the resident was sufficient for meaningful evaluation. If so, that evaluation may be “pass”, “fail” or “borderline”. If not, it will be “incomplete” and the requirements for the completion of the rotation will be outlined. The requirements for completing the rotation will be based on the performance of the resident, the nature of the experience and the need for continuity of the clinical experience.

4.0 EVALUATION RATINGS

4.1 ITERs. In addition to evaluations of specific skills or activities, each resident will receive a global rating of “Pass” (or “Meets Expectation”), “Fail”, (“Not Pass”, or “Fails to Meets Expectations”), or “Borderline” on the ITER. Ratings of “Not Pass”, “Fail”, or “Fails to Meet Expectations” are considered unsatisfactory. Residents receiving unsatisfactory evaluations will be required to complete a remedial training program if they are otherwise eligible to continue in the program. A second “borderline” assessment within a twelve month period of an ITER will be referred to the Residency Training Committee (“RTC”) to consider if remedial training is appropriate.

4.2 Other Evaluations. A resident who receives an unsatisfactory evaluation on any other forms of assessment may be required to complete a remedial training program, at the discretion of the Program Director and the RTC, if they are otherwise eligible to continue in the program.

5.0 PROMOTION

A resident will be promoted to the next academic year level when all assessments for the academic year level, including any remedial training, have been completed with ratings of “satisfactory” or equivalent or higher. This determination shall be made by the Associate Dean PGME, upon the recommendation of the Program Director.

6.0 REMEDIAL TRAINING

Remediation is a formal program designed to assist the resident in correcting his or her identified deficiencies in clinical, academic and professional performance so that the resident has the opportunity to be successful in the program.

6.1 Circumstances Requiring Remediation. A resident is required to complete a remedial training program when the resident receives a “Fail”, “Not Pass”, or “Failed to Meet Expectations” rating in an ITER;

6.2 Circumstances that may require Remediation. The RTC shall decide whether a resident must complete a remedial training program:

- a) when the resident has received an unsatisfactory evaluation on any other form of assessment. Such a decision takes into account the nature of the assessment and whether the deficiencies in the resident’s performance are being otherwise addressed through regular training;

- b) when the resident receives a second “Borderline” rating on an ITER within a 12 month period. Such a decision takes into account the nature of the assessment and whether the deficiencies in the resident’s performance are being otherwise addressed through regular training;
- c) when significant concerns about the professional conduct of the resident have been raised and are in an area that is deemed remediable.

6.3 Remedial Program Design. All remedial programs will be designed following a form developed and available through the PGME office.

a) Contents of the Remedial Program. The remedial training program will be designed by the Program Director, in consultation with the Residency Training Committee, to address the identified deficiencies in the resident’s performance. The remedial training program shall be summarized in writing, and shall include the following elements:

- i) nature of the remedial program;
- ii) identified areas to remediate;
- iii) expected outcomes of remedial training;
- iv) time frame for elements of the remedial program, including completion;
- v) outline of the methods of evaluations to be used; and
- vi) consequences for failure to satisfactorily complete the remediation program having regard to the status of the resident at the time of remediation.

The resident must sign the remediation plan prior to its commencement.

b) Remedial program rating. The remedial program will have a “pass/ fail” global rating. There will not be a “borderline” category for a remedial program.

6.4 Leaves of Absence/Holidays. Except in extraordinary circumstances, a resident participating in remedial training shall not be permitted to take a leave of absence. Any vacation must be approved in writing in advance by the Program Director. In the event that the Program Director determines that a leave of absence is appropriate in the circumstances, the remedial program will be considered incomplete. In such event, the remedial program will be redesigned by the Program Director, in consultation with the Residency Training Committee, upon the resident’s return, taking into account the nature of the deficiencies identified, the performance of the resident to date, and the need continuity of clinical experience.

6.5 Academic Credit. Except in exceptional circumstances as recommended by the Program Director and approved by the Associate Dean PGME, no academic credit will be separately granted for the successful completion of the remediation program.

7.0 PROBATION

Probation is a formal academic standing that identifies a resident as being at serious academic risk. A resident will be placed on probation in the following circumstances:

- a) where the resident has been required to complete remedial training for the second time in any academic year; or
- b) where significant concerns about the resident's professional conduct, as outlined in section 2, have been raised.

7.2 **Conditions.** While on probation, a resident must meet the following conditions: The resident must:

- a) achieve a minimum of "pass" or "meets expectations" on every final rotation ITER;
- b) receive satisfactory evaluations on all other forms of assessment;
- c) fully comply with all other academic expectations as per all the mandatory components as outlined in the program objectives provided by the training program; and
- d) fully comply with any other terms and conditions prescribed by the Residency Training Committee.

Failure to meet these conditions may result in a recommendation of dismissal from the program.

7.3 **Duration.** The RTC will specify the duration of probation period, considering the circumstances leading to the probation. The duration will ordinarily be no longer than 6 months.

8.0 REMOVAL FROM CLINICAL SERVICE

A Clinical Supervisor and/or the Rotation Supervisor may request that the Program Director remove a resident from clinical service where, in their opinion, there is a reasonable basis to conclude that the resident is jeopardizing patient care and safety and/or the resident is or has engaged in unprofessional conduct. The Program Director shall refer the matter to the Residency Training Committee as soon as reasonably possible to determine whether the resident ought to be dismissed from the program. The Associate Dean, PGME will act in place of the Program Director in the event that the Program Director is absent or otherwise unavailable to act promptly under this provision.

9. DISMISSAL FROM THE PROGRAM

9.1 Subject to section 9.3, a resident may be dismissed from the program by the Residency Training Committee in the following circumstances:

- a) where the resident has failed a remedial training program;
- b) where the resident has failed to meet all of the conditions of probation;
- c) where the resident has been placed on probation a second time in an academic year;
- d) where the resident has engaged in unprofessional conduct that, in the judgment of the residency training committee, cannot be remedied through remedial training; and
- e) where the resident has been suspended from the program and has failed to meet the terms imposed for returning to the program, within the timeframe prescribed.

9.2 Notwithstanding section 9.1, in the discretion the Associate Dean, PGME and based on the recommendation of the Residency Training Committee, a resident who otherwise meets the criteria for dismissal set out above may be instead suspended from the program because of extraordinary personal circumstances. In such event, the Associate Dean will set out the terms of the suspension in writing, including, but not limited to, the duration of the suspension and any conditions the resident must meet prior to continuing in the program.

9.3 The resident must be given the opportunity to attend the Residency Training Committee meeting at which his or her dismissal is under consideration and to make representations to it. To this end, the Program Director must provide the resident with:

- a. notice of the meeting at which the dismissal will be considered;
- b. copies of the documentation to be considered by the Residency Training Committee;
- c. the opportunity to make written submissions to the Residency Training Committee;
- d. the opportunity to make oral submissions to the Residency Training Committee; and
- e. the right to have a support person or other representative present.

9.4 The Residency Training Committee shall deliberate *in camera*. The Residency Training Committee shall take minutes of the meeting including *in camera* deliberations. The Residency Training Committee shall forward the minutes and a written decision including reasons to the Associate Dean PGME who shall provide the decision to the resident. The minutes will not become part of the PGME resident file. The Associate Dean PGME shall also advise the resident of the right to appeal the decision to a Faculty Appeals Committee in accordance with section 3.0 of the Appeal Regulations.

10.0 APPEALS

A resident may appeal a Failed ITER under section 1.0 of the Appeal Regulations.

A resident may request reconsideration of the decision to require remedial training pursuant to section 6.2 of these Regulations, the contents of a remedial training program pursuant to section 6.3(a) of these Regulations, or the terms and conditions of probation pursuant to section 7.2 of these Regulations under section 2.0 of the Appeal Regulations.

A resident may appeal a reconsideration by the RTC regarding remediation or the terms and conditions of academic probation under section 3.0 of the Appeal Regulations.

A resident may also appeal a decision to dismiss or suspend a resident from the program under section 3.0 of the Appeal Regulations.

Changeover Time Policy for PGY1s

The official changeover time is 12 Noon on the final Wednesday of a rotation. Those trainees remaining in the same city will report to their new rotation at 2:00 p.m. on Wednesday. Those trainees who are changing cities are to be excused from their rotation at 12 Noon on the Tuesday prior to changeover. They will then report to their new rotation at 2:00 p.m. on Wednesday. This will facilitate adequate travel time as well as ensure that all trainees will be present for orientation at the same time. Education Offices and Service Chiefs are to ensure that the trainee required to travel from one city to another is not required to be on call on the Monday night prior to changeover.

Defined Licensure for Postgraduate Trainees

During their residency training postgraduate trainees may provide locum tenens in areas of physician shortage during their free time. It is intended that the trainees will be supervised in the same fashion as they are during their residency training. It is recognized that moonlighting is outside the scope of an education license. Residents must apply for a Moonlighting license from the College of Physicians and Surgeons. Please refer to Page 49 for Moonlighting Guidelines for Residents with a Defined License and Applying for a Moonlighting License.

Elective Experiences Outside Maritime Provinces (Royal College Programs)

Under normal circumstances not more than 3 months should be taken outside the parent program. Exceptions for extending this time beyond 3 months to a maximum of 6 months include the following: 1) Training in areas that are not available at Dalhousie; 2) Compassionate grounds.

Elective Experiences Outside Maritime Provinces (Family Medicine Programs)

Under normal circumstances not more than 4 WEEKS should be taken outside the parent program. Exceptions for extending this time beyond 4 WEEKS include the following: 1) Compassionate grounds; 2) Training in areas that are not available at Dalhousie.

Policy for Residents Requesting International Electives (June 2005)

Requests for electives outside of Canada must comply with the following:

1. The resident complies with any requirements outlined by their program beyond those cited in this policy.
2. The residents comply with the requirements outlined in the Global Health Office & Postgraduate Medical Education Office International Elective Instruction Sheet found on the Global Health Office website at: <http://gho.medicine.dal.ca/> (This includes making application to the International Health Office a minimum of four weeks prior to departure – see International Elective Application below.)
3. Any elective that is completed by a trainee who does not fulfill the above requirements will not be counted towards his/her residency training.

In addition, electives taken in an unaccredited setting may be accepted towards specialty or subspecialty training requirements if all of the following conditions are met.

1. In Royal College programs, the total duration of unaccredited elective rotations must not exceed six months of the total training for the specialty or subspecialty.
In Family Medicine programs not more than 4 weeks should be taken outside the Maritime Provinces. Exceptions for extending this time beyond 4 weeks include the following: 1) Compassionate grounds, 2) training in areas that are not available at Dalhousie (eg. International electives)
2. The resident must be enrolled in a recognized program at the time the elective is taken.
3. The program director and the resident that is then accepted by the program director as meeting the specialty training requirements plan the elective period.
4. There is a clearly designated elective supervisor.

5. There are clearly defined and understood educational objectives.
6. There is a well defined in-training evaluation system to include evaluation of the resident during the elective period that is based on the educational objectives of the elective and that is clearly understood beforehand by the resident, the elective supervisor, and the program director.

International Elective Application

The Global Health Office provides support to Residents participating in a global health elective. If you are planning on doing an international elective please follow the steps in the pre-departure section of our Residents' Page at <http://gho.medicine.dal.ca/international-students/index.htm> **Note that this information is part of the approval process for your elective.** Please be sure to check with your department to ensure that you have met all of their requirements as well.

Also, please note that electives in countries where Foreign Affairs Canada has issued a Level 3 "Avoid Non-essential Travel" advisory or higher will not be approved. For up to date travel reports, please visit the Foreign Affairs Canada website at: <http://www.voyage.gc.ca/index-eng.asp>

Dalhousie University E-Mail and Faculty of Medicine Intranet (DalMedix)

Having and maintaining a Dalhousie University email is required. Dalhousie University provides faculty, staff and students with email on a central email server. All information provided by the PGME Office and any other Dalhousie University department, such as Student Accounts and the Registrar's Office, **will only** be communicated to you by email to your Dalhousie email account. Please check and maintain your email account on a regular basis. New postgraduate medicine trainees at Dalhousie University are provided with a Banner ID number which is used to obtain their email ("NetID") username online at www.dal.ca/netid. Your Dalhousie email account is a component of the new on-line mechanism for inputting, on DalMedix, your monthly-calls **for which you will receive remuneration.** A separate username and password are provided for accessing DalMedix which is the Intranet (password-protected website) for the Faculty of Medicine. Articles for PGME workshops will be posted on the Faculty of Medicine Intranet: DalMedix. The instructions to access DalMedix and set up your Dalhousie email account are sent to all new trainees from the PGME Office with their orientation information.

PLEASE NOTE: To download materials from the DalMedix site the minimum requirements for login include:

- Internet Explorer 5.x
- Netscape 6.x
- Firefox 1.x
- MAC Safari 1.x

Users must have "cookies" enabled, "javascript" enabled, and pop ups enabled – these are settings that are sometimes disabled in order to provide a very high level of security. However, they will prevent components of DalMedix from working.

For technical problems please contact DalMedix@dal.ca For telephone support, call within Halifax: 902-494-1234 or toll free outside Halifax: 1-866-327-8256.

E-Mail may be read over the web using My Dal (<http://my.dal.ca/>) or by using an e-mail client program. For instructions on how to set up My Dal, or other recommended email clients, go to <http://ucis.dal.ca/services/email/> and click on the "Choosing Email Software" link on the left side of the screen.

Students who do not have their own computer connected to the Internet may use My Dal (<http://my.dal.ca/>) from the student Learning Commons areas within the libraries on campus. This includes the Kellogg library that is within the Tupper Building, as well as the main Killam library.

Acceptable Use Policy

A. PURPOSE

The purpose of this policy is to outline appropriate use of Information Technology Resources owned, leased, controlled and/or operated by the University.

B. APPLICATION

This policy applies to all individuals who have been granted a NetID and/or Banner account by the University.

This policy does not replace other policies, procedures or guidelines concerning the use of specific IT Resources or data management but rather sets out a minimum standard of acceptable use.

C. DEFINITIONS

In this Policy,

“User Account” means a NetID and/or Banner account issued by the University;
“Information Technology Resources”, or “IT Resources”, means computing equipment, peripherals, facilities, networks or systems owned, leased, controlled or operated by the University, including those purchased through research funds;
“User” means an individual who has been issued a User Account.

D. POLICY

1.0 Accounts

- 1.1 Authorized access to IT Resources requires a User Account. User Accounts are nontransferrable.
- 1.2 Users are responsible for any and all uses of their User Account and are expected to take reasonable steps to ensure the security of their User Account.

2.0 Acceptable Use

- 2.1 Users shall use IT Resources for authorized purposes only.
- 2.2 No User shall use IT Resources for any disruptive or unauthorized purpose, or in a manner that violates any law, University regulations, policies or procedures. Examples of unacceptable uses of IT Resources include, but are not limited to, the following:
 - 2.2.1 using another person’s User Account, or misrepresenting themselves as another User;
 - 2.2.2 disclosing passwords or other access codes assigned to themselves or others;
 - 2.2.3 interfering with the normal operation of IT Resources by, among other things, unauthorized network interception, network traffic, flooding the network with messages, sending chain letters or pyramid solicitations;
 - 2.2.4 copying, removing or distributing proprietary software and/or data without authorization;
 - 2.2.5 breaching terms and conditions of software licensing agreements;
 - 2.2.6 accessing, displaying, transmitting, or otherwise making available information that is discriminatory, obscene, abusive, derogatory, harassing or otherwise objectionable in a university setting;

- 2.2.7 destroying, misplacing, misfiling, or rendering inoperable any stored information on a University administered computer or other information storage, processing or retrieval system;
- 2.2.8 unauthorized use of IT Resources for profit or commercial gain; and
- 2.2.9 attempting to or circumventing security facilities on any system or network.

3.0 Consequences of Unacceptable Use

- 3.1 If there is reason to suspect that a User has violated this policy, the Assistant Vice-President, Information Technology Services or the Information Security Manager may temporarily revoke or restrict User Account access privileges of any User, pending further investigation by the Information Security Manager.
- 3.2 To aid in the investigation of a suspected violation of this policy, the Information Security Manager may examine a User's User Account information, including, but not limited to, emails, files, and any other material or data connected with the User Account, provided that s/he obtains the Assistant Vice-President Information Technology Services' prior written approval. If the User in issue works within the Information Technology Services Department, then approval must be obtained from the President.
- 3.3 If the investigation concludes that a violation of this policy has occurred, the Assistant Vice-President Information Technology Services may restrict, suspend or revoke the User's access to any or all of the University's IT Resources, and may
 - 3.3.1 in the case of students, initiate disciplinary proceedings under the Code of Student Conduct; or
 - 3.3.2 in the case of employees, refer the matter for consideration of discipline in accordance with applicable collective agreements or human resource policies, as appropriate.

Faculty Regulations

Residents are required to adhere to the general university regulations but are also governed by the agreement between the Employer and the Professional Association of Residents in the Maritime Provinces (PARI-MP) which sets out the employment conditions as well as appropriate grievance procedures for issues covered under the contract. All new and returning trainees are required to complete a Resident Information Profile and a Contract. The postgraduate medical trainee's signature on the Contract indicates agreement "to adhere to all Dalhousie University Faculty of Medicine and Hospital regulations."

- Postgraduate medical trainees will be subject to the rules and regulations of the hospital department to which they are assigned concerning hours of duty, holidays, etc.
- Any violation of such regulations will be dealt with as if a University regulation were violated.
- Patient care responsibilities override University and statutory holidays.
- All University regulations respecting fees apply to the Faculty of Medicine.
- Registration and payment of fees must be completed to the satisfaction of the Postgraduate Medical Education Office before any postgraduate medical trainee may begin clinical training.
- All trainees will be issued a student ID number and must complete registration with the University on-line.
- New trainees must show evidence that they are paid up members of CMPA, have a current educational license in Nova Scotia and/or Prince Edward Island and/or New Brunswick, as appropriate, provide proof of ACLS training, and proof of immunization.
- Proof of immunization must be written documentation obtained from a physician and/or public health facility and must include the date of immunization for tetanus, diphtheria, polio, measles, mumps, rubella, chicken pox and hepatitis B. (See the Faculty Policy on Immunization)
- Immunization against influenza is recommended.
- Skin testing to establish tuberculin status is also recommended.
- It is mandatory that all PGY1s complete an ACLS course prior to commencement of training.

- Those residents without ACLS will be reported to their Program Director and will require a waiver from their Program in order to commence their residency training.

Residency training is preceded by a mandatory Postgraduate Orientation Day. Clinical training starts at 9:00 a.m. on July 1st. Having accepted appointment, postgraduate medical trainees are expected to report for duty on the starting date and to serve for the full training year, unless they are incapacitated by illness, or unless they give four weeks notice for reasons acceptable to the Director of Training.

Postgraduate Fellowships & Scholarships

Dalhousie Medical Research Foundation Fellowships

Fellowships are available to medical graduates or graduates of recognized PhD programs to undertake postgraduate training at Dalhousie in basic or clinical science for a period of one to three years. The level of support will be determined by the Medical Research Council of Canada's scale of pay for MD's, based on the number of years of postgraduate training. Preference will be given to candidates who have potential to contribute to academic medicine in the Maritime provinces of Canada.

Fellowship competitions are generally held in April each year but deadlines will vary. To obtain a current schedule of competitions, terms of reference and applications visit the Foundation's home page at www.dmrh.org or contact the Dalhousie Medical Research Foundation, Main Floor, Sir Charles Tupper Medical Building, College Street, Halifax, Nova Scotia, B3H 4H7 or by calling (902) 494-3502.

Killam Scholarship, Samuel R. McLaughlin Fellowship, Ross Stewart Smith Memorial Fellowship

Applications and regulations for the ***Killam Postgraduate Medical Scholarship, Samuel R. McLaughlin Fellowship, and the Ross Stewart Smith Memorial Fellowship*** awards can be obtained from the Postgraduate Medical Education Office, c/o Mrs. Christine Silver-Smith, Room C233, Clinical Research Centre, 5849 University Avenue, Halifax, Nova Scotia, B3H 4H7 telephone number (902) 494-1885. The deadline for submission of these applications for consideration by the Scholarships and Awards Committee is mid-January.

➤ ***Killam Postgraduate Medical Scholarships***

These scholarships were established by the late Mrs. Izaak Walton Killam. They are awarded to postgraduate students in the third, fourth, or fifth year of training in a clinical department of the Faculty of Medicine, Dalhousie University or elsewhere. Selection by the Faculty Awards Committee is based on the recommendation of the department head that the candidate is likely to contribute to the advancement of learning or to win distinction in his/her specialty and could be recommended for appointment to the faculty of a medical school on completion of training.

➤ ***Samuel R. McLaughlin Fellowship***

This fund was established in 2001 when the Samuel R. McLaughlin Foundation donated \$500,000 to Dalhousie as a final gift before closing its doors permanently. The purpose of the fund is to support medical fellowships, medical training or research, or other medical education programs. Candidates must be Canadian citizens or Landed Immigrants and currently registered with Dalhousie University in a Residency Training Program. Preference will be given to those who will be studying at an institute other than their own. Selection will be made by the Postgraduate Medical Education Scholarship Committee.

➤ ***The Ross Stewart Smith Memorial Fellowship in Medical Research***

This Fellowship, being a portion of the income from a generous bequest to Dalhousie University, was established by Dr. James Ross Smith and his wife, the late Mrs. Eliza Cochran Smith, as a memorial to their son, Ross Stewart Smith, who died while attending Dalhousie. It is open to students of exceptional ability following graduation from the Faculty of Medicine, Dalhousie University. The research may be in clinical medicine or in the basic medical sciences.

Ophthalmology

The E. A. Baker Foundation for the Prevention of Blindness of the CNIB, annually awards Fellowships for advanced post-graduate training in ophthalmic sub-specialties. An academic posting in Canada on completion of training is a requirement. Geographic need will be given priority consideration, as well as commitment to research on return. The amount of the Fellowship is determined annually, depending upon investment income. Recent

fellowships have been \$50,000. This amount is the maximum provided and other income sources such as stipends, bursaries, subsidies or scholarships will be deducted from this amount.

The Foundation also offers a two-year fellowship and funding for research for the first year of return at the approved Canadian facility. This is contingent on matching funds for the first year of their return only to the parent institution which the applicant is requested to obtain (from the academic facility or other sources). Deadline for receipt of applications is December 1, with grant payments being made quarterly commencing July 1 the following year.

Contact:

National Research Department, CNIB, 1929 Bayview Avenue, Toronto, ON, M4G 3E8

Tel: 416-486-2500 x7657 Fax: 416-480-7059

Email: research@cnib.ca Website: <http://www.cnib.ca/en/research/funding/eabaker-fellowship/>

Policy for Students Regarding Infectious Diseases & Immunization

The following policies pertain to all students of the Faculty of Medicine working in a health care setting or in an education or research environment. All medical students accepted for study at Dalhousie Medical School are required to show proof of immunization for tetanus, diphtheria, polio, measles, mumps, rubella, mantoux (TB), chicken pox and Hepatitis B (sero conversion). Proof of immunization must be written documentation obtained from a physician and/or public health facility. This documentation must include the date of immunization. Immunization against influenza is recommended. An immunization card for recording immunizations is sent to all residents, on their acceptance to Dalhousie University, from the Postgraduate Office with instructions to have it satisfactorily completed prior to beginning their studies. Students should have hepatitis B immunization as well as tuberculin testing carried out by Student Health Services after the school term begins, with the results recorded on their immunization card and with positive reactions appropriately followed up. As hepatitis B immunization is given in a series of three injections, it is necessary to document that all injections have been carried out. Undergraduate students who will receive their three immunizations through student health services, should have their immunizations recorded on their medical school immunization card by Student Health. Post-graduate students who are not from Dalhousie University are required to submit their completed medical school immunization card, demonstrating appropriate immunization including three injections for hepatitis B by December 31st of the year they begin their training program.

Universal Precautions

1. All students are expected to understand universal precautions and to practice these precautions in all health care and relevant educational and research settings as the minimum standard for prevention of transmission of blood borne pathogens.

HIV Testing

1. All students who have personal risk factors for HIV are encouraged to seek voluntary HIV testing.

HBV Vaccination

1. All students must be vaccinated against HBV unless contraindicated by a physician's order.
2. Following vaccination, all students must be tested for their HBV antibody status and counselled regarding the results.

Occupational Exposures

1. All students who have had a significant exposure to blood or other high risk body fluids in a health care or relevant educational or research setting are recommended to seek voluntary testing for HIV, HBV and HCV, where indicated, through the appropriate health services facility of the University or hospital. Situations of particular risk for transmission of blood borne viruses are where:
 - a. The source individual is known to be infected with HIV, HBV or HCV
 - b. The source individual suggest a risk of infectivity (high risk sexual practices, IV drug abuse)
2. All students have an ethical obligation to report to their supervising physician a significant exposure of their blood to a patient.

Risk of Infection

1. All students with an infection that could put a patient or a volunteer (eg: research subject, simulated patient) at risk are encouraged to seek advice through the appropriate health service of the University or the hospital with respect to the potential for transmission of the infection to patients or volunteers and of the appropriate precautions.
2. Students known to be infected with HIV, HBV or HCV who are involved with invasive procedures in a health care setting should be knowledgeable of and adhere to policies governing such practice in the health care institution in which these activities take place.
3. If a student is aware that a patient or volunteer has been exposed to the blood of an individual infected with a blood borne pathogen, the student should inform the supervising physician of the situation. The supervising physician will undertake to inform the occupational health service of the institution which will arrange counselling regarding the risk and advisability of testing and prophylaxis. It is not appropriate that the identity of the source individual be disclosed to the patient or volunteer.

Policy for Applicants and Postgraduate Residents with a Communicable Infection (Approved by the Faculty Council, October 9, 2007)

Objective:

To outline the course of action to be taken when postgraduate resident in the Faculty of Medicine has a communicable infection.

Principles:

The Faculty of Medicine at Dalhousie University is committed to protecting and maintaining the rights of patients and health care workers as well as the integrity of the educational process of Medical professionals.

To study or work in the health care professions is a privilege offered to those who are prepared for a lifetime of service to the public. Students, residents, faculty, and health care workers (HCW) have a fundamental responsibility to provide care to all patients assigned to them. A failure to accept this responsibility violates a basic tenet of the medical profession – to place the patient's interest and welfare first. Thus, health care workers have an ethical obligation to their patients to know their own infectious disease status where that may impact on the health of the patient.

The requirements of each residency training program are set according to the standards of the credentialing agency (the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada). A communicable infection may prevent a resident from achieving the requirements of some programs, and thus make that person unable to complete the program.

Residents in health care professions are at risk of contracting infectious diseases during the course of providing patient care¹⁻⁵. A policy of mandatory immunizations combined with consistent application of infection prevention and control practices helps to protect residents from some of these infectious diseases. A patient's right to informed consent may outweigh the worker's right to privacy when a recognized risk of disease transmission is present.

Terms

"Communicable Infections Committee" means the committee described in Section 2.0;

"Exposure-prone procedures" is used for the purpose of managing the risk of bloodborne pathogens transmitted in Canada. They are procedures during which transmission of HBV, HCV or HIV from a HCW to patients is most likely to occur and include the following: digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site, e.g. during major abdominal, cardiothoracic, vaginal and/or orthopedic operations, or repair of major traumatic injuries, or major cutting or removal of any oral or perioral tissue, including tooth structures"... (Note: from the Public Health Agency of Canada's consensus report on infected health care workers⁶ which further states that this definition is quite broad in its scope and recommends that an expert panel make an informed decision based on factors in a specific case).

“Program” means the Faculty of resident training programs.

1.0 Hepatitis B (HBV) Immunization and Immune status of residents registered in the Program.

Applicants to a residency training program must be able to meet the core requirements outlined by the program. All Dalhousie University training programs are accredited through the RCPS and CFPC, and must meet the standards of these accrediting agencies that permit trainees to apply for certification exams. The Faculty of Medicine may refuse acceptance to the Program on the basis of disease status. The HBV status of all **residents** admitted to the Program is required so as to assess whether modification to the **residents'** training in the Program is necessary to ensure patient and resident safety.

2.0 The Communicable Infections Committee

There shall be a Communicable Infections Committee that shall comprise the Assistant Dean of Admissions and Student Affairs, the Associate Dean of Postgraduate Medical Education, and a faculty member who is an infectious disease specialist who is appointed by the Department Head for the Department of Medicine. The latter member shall be appointed for a three (3) year term. The function of this Committee is to assist the Associate Dean of Postgraduate Medical Education in counseling residents, and in evaluating and structuring modifications to the Program as may be required by the resident's disease or immune status, as more particularly set out in this Policy.

3.0 HBV immunization

HBV immunization is required of all **residents** registered in the Program prior to joining their training program. **Residents** shall provide results of post-immunization HBV antibody (HBsAb) testing to the Assistant Dean, Admissions and Student Affairs. **Residents** who test negative for HBsAb following HBV immunization will be required to provide results of hepatitis B surface antigen (HBsAg) testing (see 3.2). The course of action to be followed based on the hepatitis B serological results^{7,8} are summarized below:

3.1 HBsAg positive: Residents whose serologic profile indicates that they are HBsAg positive will be evaluated by the Communicable Infections Committee to determine whether their clinical experiences require modification to allow them to complete Program requirements while at the same time ensuring patient and resident safety or whether they may continue in the training program. The Communicable Infections Committee shall assist in developing any such modifications and will provide counseling to the **residents** as may be required. Every reasonable attempt will be made to ensure that the learning objectives of the curriculum are met, but this may not be possible in all cases.

Career counseling to such **residents** will be provided by the Associate Dean, Postgraduate Medicine, and consultation with a Committee for Career Options. This committee will be comprised of representatives from each specialty who will review and advise the Assistant Dean in matter of alternative career options for residents.

The Associate Dean of Postgraduate Medicine Affairs shall notify the Advisory Committee on Blood Borne Pathogens of the College of Physicians and Surgeons of Nova Scotia of the resident's serologic status.

Note: The purpose of excluding HBsAg positive residents with an increased likelihood of transmitting HBV from surgical procedures and surgical training is to protect patients from acquiring HBV. There is precedence for such a policy of exclusion in Canada^{9, 10, 11}, the United States^{12,13} and outside North America¹⁴⁻¹⁶. The Public Health Agency of Canada also supports a policy of exclusion⁵.

Note: Not all HBsAg positive residents need to be excluded; HBV viral load is an important determinant.

3.2 Non-responders to Hepatitis B vaccine: Individuals who have been vaccinated but are either non-responders or have inadequate antibody titres after completing two series (three doses /series) of HBV vaccine are not considered immune¹⁶. These residents will be required to sign the Agreement Form for HBsAg testing (Appendix 1) and to undergo serologic testing on an annual basis.

The resident's HBsAb and HBsAg status must be reported to the Communicable Infections Committee annually or after an exposure incident, until graduation from the Program.

The Communicable Infections Committee shall provide counseling to such residents relative to their training and health status. Career counseling will be provided to such residents by the Assistant Dean of Postgraduate Medical Education.

3.3 Declination of Hepatitis B vaccine: Residents declining to be immunized against HBV on religious or similar grounds or for medical reasons are to be counseled by the Communicable Infections Committee. Their request for a waiver of the immunization requirements set out in this policy will be assessed on a case-by-case basis.

Such residents must sign The Agreement Form for HBsAb and HBsAg Testing (Appendix 1) and the Hepatitis B Vaccine Declination Statement (Appendix 2) and to undergo annual serologic testing as specified in 3.2 in order to be allowed to continue their studies.

4.0 HIV Testing

Residents with risk factors for HIV and who are involved in exposure-prone procedures have a moral and ethical obligation to undergo HIV testing on a voluntary basis. HIV-infected residents will be counseled by the Communicable Infections Committee. The Associate Dean of Postgraduate Medicine will notify the Advisory Committee on Blood Borne Pathogens of the College of Physicians and Surgeons of Nova Scotia of the resident's serologic status

5.0 Hepatitis C (HCV) Testing

Residents with risk factors for HCV and who are involved in exposure-prone procedures have a moral and ethical obligation to undergo HCV testing on a voluntary basis. HCV-infected residents will be counseled by the Communicable Infections Committee. The Associate Dean of Postgraduate Medicine will notify the Advisory Committee on Blood Borne Pathogens of the College of Physicians and Surgeons of Nova Scotia of the resident's serologic status.

6.0 Other Communicable Infections and Residents

Any resident who has or develops a communicable infection is required to inform the Associate Dean of Postgraduate Medicine in order to discuss whether this condition could impact on his or her ability to participate fully in the Program. The Associate Dean of Postgraduate Medicine may engage in counseling the resident, in evaluating the need for modification to the resident's participation in the Program and in structuring any required modifications.

Residents who have acute or chronic medical conditions that render them susceptible to infection should discuss with their personal physicians and the Associate Dean of Postgraduate Medicine whether the condition might affect their ability to safely perform their duties.

This policy is consistent with the Canadian Medical Association's Code of Ethics which states, under "Responsibilities to Oneself":¹⁷

"Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession."

The reporting obligations will be consistent with the requirements of the Nova Scotia government. This policy document should be reviewed biannually or more frequently as needed by the Communicable Infections Committee to ensure that it reflects current knowledge and opinion.

Resident Intimidation & Harassment

Trust, respect, fairness and a spirit of collegiality between faculty and residents at Dalhousie is essential for creating the best possible environment for learning. In a teaching hospital, creating this environment will attract the best trainees to Dalhousie as well as produce top quality physicians. Research has shown that harassment and intimidation actually achieves the opposite environment - one that hinders learning. Incidents of harassment or intimidation undermine professional confidence, and in some cases compromise health care delivery. Simply put, it's unprofessional.

Break the Cycle

The only way to break the cycle is to come forward. Dalhousie has a process that is open and responsive to these issues. Like any form of abuse, resident harassment will continue in a generational pattern. If residents are taught in a way that focuses on learning through intimidation, they will be more likely to teach their future residents in the same destructive manner. All faculty and residents must help break this cycle.

Educational Strategies

- a) Educate Program Directors, Faculty and residents about appropriate behaviour in the learning environment.
- b) Educate resident representatives as to their role and responsibilities on residency Program Committees.
- c) Inform residents about the importance of their participation during the accreditation process (both internal and external surveys).

Canadian Medical Association Code of Ethics

1. Consider first the well-being of the patients.
2. Honour your profession and its traditions.
3. Recognize your limitations and the special skills of others in the prevention and treatment of disease.
4. Protect the patients' secrets (confidences).
5. Teach and be taught.
6. Remember that integrity and professional ability should be your best advertisement.
7. Be responsible in setting a value on your services.

An ethical code of conduct should at all times ensure that we will:

1. Treat residents with respect regardless of level of training, race, creed, religion, colour, gender, sexual orientation, field of study, recognizing that there is a power differential between the teacher and resident.
2. Refrain from the intimidation and harassment of residents in any fashion - emotional, physical or sexual.
3. Teach the knowledge, skills, attitudes and behaviour and provide the experience that the resident requires to become a physician in his/her chosen career.
4. Supervise residents and allow them responsibility as is appropriate to their level of training and commensurate with their ability.
5. Demonstrate to residents the rational basis for clinical decision-making from investigation to diagnosis and to treatment, based on the best evidence available.
6. Assess carefully and accurately on appropriate criteria, the resident's abilities and provide timely verbal and written feedback to the resident.
7. Support and facilitate remedial teaching when it is necessary.

The educational environment we want to foster and support in Postgraduate Medical Education at Dalhousie should:

- encourage faculty/resident respect;
- encourage the spirit of collegiality and fairness;
- when problems arise, ensure natural justice occurs.

Link to: *The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada on : Accreditation and the Issue of Intimidation and Harassment in Postgraduate Medical Education Guidelines for Surveyors and Programs.*

http://rcpsc.medical.org/residency/accreditation/positionpapers/Intimidation_and_Harassment_e.pdf

The kinds of unacceptable behaviour that trainees can face include, but are not limited to:

1. Verbal abuse: shouting, swearing, belittling, ridiculing, disparaging remarks of sexist, homophobic, religious and ethnic grounds;
2. Physical abuse: throwing objects at, pushing, slapping or threatening gestures;
3. Sexual abuse: unwelcome comments, gestures, touching or actions of a sexual nature;
4. Workload abuse: contractual infraction, excessive service volume, lack of supervision, not making reasonable allowances for illness, disability or leave;
5. Reprisal for negative feedback of staff or program;
6. Reprisal for having lodged, or being a witness in, a harassment or intimidation complaint;
7. Educational compromise: grading unfairly, reasonable exclusion from a learning experience.

Personal Harassment Policy for Medical Students and Residents

1.0 Purpose

The Faculty of Medicine at Dalhousie University is committed to providing its students and residents with a learning environment that is free of harassment. All students, residents, faculty and staff within the Faculty of Medicine share responsibility for establishing and maintaining a climate of respect and for taking appropriate steps to seek advice and/or address harassment when it occurs.

The purpose of this Policy is to define personal harassment and to set out clear procedures to be followed in instances where a student or resident believes he or she has been personally harassed by a student, resident, faculty or staff member of the Faculty of Medicine.

2.0 Application

This Policy applies to all students, residents, faculty and staff within the Faculty of Medicine:

- a) where conduct occurs on the premises of Dalhousie University or any affiliated institutions;
- b) where conduct occurs elsewhere in the course of activities sponsored by Dalhousie University; or
- c) where the conduct is alleged to affect, disrupt or interfere with another person's reasonable participation in the Faculty of Medicine.

This Policy is administered by the Faculty of Medicine, through the appropriate Dean, as indicated below.

This Policy does not apply to complaints of sexual harassment, complaints of harassment based on any of the characteristics protected by applicable human rights legislation, or complaints of harassment by Dalhousie employees against other Dalhousie employees.

Complaints of sexual harassment should be addressed to the Office of Human Rights, Equity and Harassment Prevention in accordance with Dalhousie's "Sexual Harassment Policy".

Complaints of harassment based on any of the characteristics protected by human rights legislation are considered a form of discrimination and should be addressed to the Office of Human Rights, Equity and Harassment Prevention, in accordance with Dalhousie's "Statement on Prohibited Discrimination".

Complaints of personal harassment by Dalhousie employees against other Dalhousie employees should be addressed to the Office of Human Rights, Equity and Harassment Prevention, in accordance with Dalhousie's Personal Harassment Policy.

3.0 Definitions

For the purposes of this Policy:

3.1 "Dean" means:

- For an undergraduate medical student, the Assistant Dean of Student Affairs.
- For a postgraduate medical resident, the Associate Dean of Postgraduate Medical Education.

3.2 "Employee" means:

- a person employed by Dalhousie University in the Faculty of Medicine, or
- a person who holds an academic appointment to a Department in the Faculty of Medicine.

3.3 "Personal harassment" means: repeated or persistent patterns of abusive, vexatious or demeaning treatment of a Student(s) that is known or ought reasonably to be known to be unwelcome. A single

incident, if sufficiently severe, may also constitute harassment. Harassment does not include appropriate supervision, instruction, feedback or evaluation.

3.4 “Investigation Committee” means: an *ad hoc* committee appointed pursuant to section 4.2.5.1 of this Policy.

3.5 “Respondent” means: an individual alleged to have engaged in harassing behaviour.

3.6 “Student/Resident” means: a person registered in the Faculty of Medicine as an undergraduate medical student or as a postgraduate medical resident.

4.0 Procedures for Complaints of Personal Harassment:

A Student/Resident(s) who feel that he or she has been personally harassed by a Student/Resident(s) or Employee(s) may attempt to resolve the matter through the Informal Resolution Process and/or the Formal Complaint Process, described in more detail below. Reasonable attempts to explore informal resolution will be made before proceeding to the Formal Complaint Process.

The Advisor, Harassment Prevention/Conflict Management, in the Office of Human Rights, Equity and Harassment Prevention (“Advisor”), may be accessed by the Complainant, Respondent, Dean and/or the Investigation Committee as a resource with respect to the administration of this Policy.

4.1 Informal Resolution Process

If a Student/Resident(s) believes he or she is being personally harassed, he or she may discuss options to address the issue with his or her Clinical Supervisor, Program Director, the Dean, the Advisor, the Program Ombudsperson, the PGME Ombudsperson and/or other appropriate resource people within the University.

Parties may be able to resolve the issue informally in a number of ways, including, but not limited to:

- Telling the other party(s) verbally that her/his behaviour is unwelcome and unwanted, and that the behaviour must stop immediately;
- Communicating concerns in writing to the other party(s) – describe the offending behaviour, the impact of the behaviour, and ask that the behaviour stop immediately;
- Requesting that the Dean or the Advisor arrange an informal mediation using a neutral party to help the parties reach a mutual resolution of the matter.

4.2 Formal Complaint Process

The Dean will ensure that reasonable attempts at informal resolution have been explored prior to commencing the formal complaint process. The parties may also resolve the matter at any point during the formal complaint process.

The formal complaint process is as follows:

4.2.1 The Student/Resident(s) (complainant(s)) must deliver the written complaint to the Dean. (Complaints against an Associate Dean or the Senior Associate Dean will be directed to the Senior Associate Dean or the Dean, respectively.) The complaint must include the name(s) of the Respondent(s) and a detailed description of the alleged conduct that forms the basis of the complaint.

4.2.2 If the allegations fall within this Policy and could result in a finding of personal harassment if proven true, the Dean will provide a copy of the complaint and a copy of this Policy to the Respondent(s) within 5 working days of receiving the complaint.

- 4.2.3 The Respondent(s) will have 10 working days to provide his or her response to the Dean in writing which will be provided to the complainant.
- 4.2.4 The Dean will appoint an Investigation Committee to investigate the matter.
- 4.2.5.1 An Investigation Committee consists of 2 faculty members and one Student/Resident who will investigate a complaint under this Policy. In the case of a complaint by an undergraduate medical student, the student representative will be an undergraduate medical student. In the case of a complaint by a postgraduate medical resident, the student representative will be a postgraduate medical resident.
- 4.2.5.2 The Investigation Committee will make all reasonable efforts to complete its work within 60 working days of being appointed by the Dean to investigate the complaint.
- 4.2.6.1 After reviewing the complaint and response, the Investigation Committee will convene a meeting with the complainant(s) to give him or her an opportunity to present his or her complaint and to identify other relevant information and witnesses.
- 4.2.6.2 The Investigation Committee will then convene a meeting with the Respondent(s), to give him or her an opportunity to address the allegations in the complaint and to identify other relevant information and witnesses.
- 4.2.6.3 The Investigation Committee may convene meetings with witnesses who they deem relevant to the issues raised in the complaint.
- 4.2.6.4 The Investigation Committee may meet subsequently with the Complainant(s) and/or the Respondent(s) in light of information they have received in the course of the investigation.
- 4.2.7 The Investigation Committee will review all of the information gathered in the course of the investigation and will submit a report to the Dean that includes an opinion regarding the facts of the case and an opinion as to whether the Respondent has engaged in personal harassment.
- 4.2.8 The Dean will determine which portions of the report are appropriate to provide to the complainant(s) or Respondent(s), in accordance with Dalhousie's privacy obligations and any health and safety concerns.
- 4.2.9 The Dean will provide a copy of the report to the complainant(s) and Respondent(s) who will have 5 working days to provide written submissions on the report.
- 4.2.10 Upon reviewing the report and the submissions of the complainant(s) and Respondent(s), the Dean will make a decision as to whether the Respondent has engaged in personal harassment. Remedial or disciplinary action taken against any person as a result of a violation of this Policy will be taken in accordance with applicable processes for Employees or Students/Residents, as appropriate.
- 4.2.11 The Dean will advise the parties in writing of his or her decision regarding whether the Respondent has engaged in personal harassment.
- 4.2.12 The time limits in this section may be extended by the Dean in exceptional circumstances.

5.0 Confidentiality

Any communication or information gathered in any case is confidential except to the extent that disclosure is necessary to effectively implement this Policy or to undertake any disciplinary or remedial steps arising from a decision made under this Policy.

6.0 False Accusations

A complaint made in bad faith will constitute grounds for disciplinary action against the complainant, which will be

commenced in accordance with applicable disciplinary processes. A bad faith complaint is a complaint that is made with a conscious design to mislead or deceive, or with a malicious or fraudulent intent.

7.0 Retaliation

There will be no retaliation against any person on account of a complaint or an expressed intention to complain under this Policy or on account of evidence or assistance given with respect to a complaint or a proposed complaint under this Policy. Such retaliation will be grounds for a complaint under this Policy.

8.0 Limitations

A complaint must be made within twelve months of the last alleged instance of the action or conduct. An additional period of not more than twelve months may be granted in exceptional circumstances by the Dean.

9.0 Annual Reporting

At the end of each academic year, both Deans will provide a report to the Advisor, Harassment Prevention/Conflict Management, in the Office of Human Rights, Equity and Harassment Prevention. Each report will confirm the number of complaints made under this Policy, the number and nature of informal resolutions reached, and the number and nature of decisions made by the Deans with respect to the formal complaint process.

10.0 Other Proceedings

This Policy does not affect the right of the complainant(s) or other parties from pursuing a complaint under any applicable legislation or from filing a grievance in accordance with any right to do so pursuant to a provision of an applicable collective agreement.

If the Dean perceives an immediate threat to the physical safety of the complainant or any other member of the University community he or she will contact Security Services.

Conflicts involving criminal behaviour, physical violence or situations where an individual's personal safety and security is in danger must be reported immediately to Security Services at extension 4109, who will communicate with the Halifax Regional Police, where appropriate. This Policy does not replace this obligation.

J-1 VISA Process

Residents who train for any period of time, either a single rotation or for a longer elective period, in the United States should apply for a J-1 Visa through U.S. Immigration. You must verify with the institution you plan to do your elective whether or not they require a J-1 Visa. Although not all institutions require a J-1 Visa for elective training, **trainees must complete the paperwork for a DS2019 with the Educational Commission for Foreign Medical Graduates (ECFMG)**. It can take up to six months to obtain a J-1 Visa and a State license, so please factor this into your decision as to when you should apply. Residents should note that CMPA coverage does not extend beyond the borders of Canada and you will need to purchase coverage for the duration of this training.

The DS2019 is issued by Educational Commission for Foreign Medical Graduates in Philadelphia. The ECFMG sponsors physicians from around the world to undertake ACGME accredited residencies and fellowships. The DS2019 is a form that says the holder is eligible to receive a J-1 Visa. The J-1 Visa is issued by United States immigration authorities to physicians undertaking postgraduate medical training programs in the U.S. Canadian Citizens do not have to obtain the actual Visa, but must show the DS2019 at the port of entry to the U.S.

In selected universities in the U.S. (notably the University of Pittsburgh and the University of Maryland), the institutional policy states the visiting resident who is attending a program of less than six months - short term elective or rotation - **must also apply** for J-1 Visa.

Please note there are two processes to obtain a Category A-J1 Visa, one for short-term electives (less than six months in duration), and the other for longer periods of training or for those who will be doing fellowships or RCPSC recognized subspecialties. Please read "Statements of Need for Postgraduate Medical Training in the United States" before proceeding: <http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/postgrad-postdoc/index-eng.php>

The application form for a J-1 Visa can be downloaded or printed from the Health Canada web site by selecting the link: How do I apply for a Statement of Need, and then choosing your category.

Contact in Health Canada: Ms. Judith Lewis, Program Administrator
Telephone: (613) 952-1912 Facsimile: (613) 948-8081
Email: j1visa@hc-sc.gc.ca Health Canada web site: <http://www.hc-sc.gc.ca/>

Contact in Postgraduate Medical Education Office, Dalhousie University:
Ms. Christine Silver Smith, Director Email: Christine.Silver@Dal.ca

Contact in Nova Scotia Department of Health
Heather Coady: coadyhe@gov.ns.ca

Health Canada: Statements of Need for Postgraduate Training in the United States - Medical graduates currently enrolled in a Canadian specialty residency training program who wish to pursue a short-term elective or rotation [Category A ST]

Eligibility:

Canadian Citizenship or Permanent Residency in Canada. The physician **must** be currently enrolled in a Canadian postgraduate medical residency program and will be pursuing a short-term rotation or elective of less than six months in duration.

Condition:

Physicians will be returning to Canada to complete their residency.

Process:

1. **Contact the Postgraduate Medical Education Office (PGME) and request a letter in support of the proposed rotation or elective**, signed by the Dean or Associate Dean of PGME, and addressed to the Program Administrator, Health Canada. Send your request by e-mail with "Your Name, J-1 Visa Request - Short Term" in the subject line to the PGME Office Christine.Silver@Dal.Ca and include the following information:
 - Your name, address, phone number, e-mail
 - Your current residency/specialty program: program and level of training;
 - The location and type of short-term rotation or elective;
 - Evidence of expected attendance at the short-term rotation or elective program (this can be a letter of confirmation from either your Program Director or from your supervisor at the receiving hospital. Please attach a scanned copy of the confirmation to us in your e-mailed request);
 - The start and end dates of the rotation or elective

Upon the approval of your request, the PGME Office will send an e-mail to the Program Administrator, Health Canada as an attachment (and a copy of your request, as decided by PGME).

2. **Complete the application process for a Statement of Need.** Go to the Health Canada web site at http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/postgrad-postdoc/cat_a_st-eng.php
Read the instructions for Category A (Short-Term) before sending the remaining documents to Health Canada.

Health Canada: Statements of Need for Postgraduate Training in the United States - Medical graduates currently enrolled in a Canadian specialty residency training program who wish to pursue a fellowship or RCPSC recognized subspecialty [Category A]

Eligibility:

Canadian Citizenship or Permanent Residency in Canada. The physician **must** be currently enrolled in a Canadian postgraduate medical residency program and will be pursuing a fellowship or subspecialty of six months or more in duration.

Conditions:

Physicians will be subject to any physician resource management policies in existence at the time of their return to Canada. Physicians' practices in a province or territory will be subject to obtaining certification from the Royal College of Physicians and Surgeons of Canada **and** licensure from the provincial or territorial licensing body according to the requirements in place at the time of application for a medical license.

Process:

1. **Contact the Postgraduate Medical Education Office (PGME) and request a letter in support of the proposed training**, signed by the Dean or Associate Dean of PGME, addressed to the Nova Scotia Department of Health. Send your request by e-mail with AYour Name, J1 Visa Request@ in the subject line to the Postgraduate Medical Education Office Christine.Silver@Dal.Ca and include the following information:
 - your name, address, phone number, e-mail address;
 - your current residency/specialty program: program and level of training;
 - the location and type of the proposed fellowship/sub-specialty program;
 - proof of acceptance into a U.S. fellowship/sub-specialty training program, such as a copy of your contract or letter of offer (please submit a scanned copy with your request); and,
 - the start and end dates of the fellowship/sub-specialty program.

Upon approval of your request, the PGME Office will send an e-mail to the Provincial Health Ministry/Department with the Dean's letter as an attachment (and a copy of your request, as decided by PGME).

2. **Contact the Nova Scotia Department of Health to request provincial support of the proposed training**. Send your request by e-mail with AYour Name, J1 Visa Request@ in the subject line to the Nova Scotia Department of Health noting that you have already requested a letter from the PGME Dean, and include the following information:
 - reasons for pursuing fellowship/sub-specialty training in the U.S.; and,
 - proof of acceptance into a U.S. fellowship/sub-specialty training program, such as a copy of your contract or letter of offer;
 - proof of permanent residence in the province, if required by your province.

Upon approval of your request, the Nova Scotia Department of Health will send an e-mail to Health Canada with two documents, namely the provincial letter of support and the Dean's letter of support, as attachments (and a copy of your request, as decided by PGME).

3. **Complete the application process for a Statement of Need**. Go to the Health Canada web site at: http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/postgrad-postdoc/cat_a-eng.php
Read the instructions for a Category A before sending your documents to Health Canada.

Library Facilities and Services Available for Use by Residents: W. K. Kellogg Health Sciences Library

The [W.K. Kellogg Health Sciences Library](#) is part of the Dalhousie University Libraries system. Located in the Tupper Medical Building on College St., the Kellogg Library serves the students, faculty and staff at Dalhousie University, as well as health practitioners in the Maritime Provinces. The [Pharmacy Library](#) is a branch of the Kellogg Library located in the Burbidge Pharmacy Building at 5968 College St.

Important phone numbers:

- Reference Desk: (902) 494-2482
- Circulation Desk: (902) 494-2479
- Administration: (902) 494-2458
- Health Sciences Librarian (902) 494-1669 (Patrick Ellis)
- Email: kellogg.library@dal.ca

Residents enjoy full library privileges at all Dalhousie University libraries. Most services, including mediated database searching, access to electronic journals and texts, and document delivery, are also available remotely via the Web. Explore the Library's home page at:

http://libraries.dal.ca/locations_services/locations/w_k_kellogg_healthscienceslibrary.html

Residents based outside the Halifax-Dartmouth area may also use the Library's web-based resources (see [Remote Access to Library Resources](#) below). Hospital-based residents may also use the Library's resources indirectly through that hospital's own library.

Library staff will be happy to train and or assist residents with database searches, Refworks management, document delivery, or any other facet of providing you with the best possible information.

Through the Library's web site, residents have networked access to our growing collection of databases, electronic books and journals.

The Library provides computer workstations and, laptops for loan (both PC and MAC), as well as on site laptop computer hook-ups wireless access.

The online catalogue for Dalhousie University Libraries is *Novanet*, which is shared with all the post secondary institutions in Nova Scotia except Acadia University. Novanet is linked on the main page of the Kellogg Library. Through Novanet residents can use their library-validated student card to borrow materials online from all the Novanet libraries. Residents based outside the Halifax area can also obtain an Atlantic Scholarly Information Network (ASIN) card from the Kellogg Library, which will permit them to borrow materials directly from all university libraries in Canada. And of course they also have library privileges at the health sciences library of the hospital to which they are assigned.

Hours: The Kellogg Library is open 94 hours per week during the academic term (early September to the end of May), and 50 hours per week during the summer months. Reference service is available 52 hours per week during the academic term and 40 hours per week during the summer.

Loan Policies: <http://www.library.dal.ca/Services/Borrow/Renew/>

- Books: 3 weeks
- Reserve materials: Loan periods range from 2 hours to 1 week, depending on the item. Renewals are possible but must be made in person.
- Serials/Journals: Most of our journal collection is now electronic. Paper journals do not circulate. Self-service photocopiers are available in the Library

Document Delivery Services : There is no charge to Dalhousie faculty, staff and students for this service and requests may be submitted using our online request form. We are now offering desktop delivery of scanned journal articles via Document Delivery.

Please note: You must register in Novanet in order to use Document Delivery.

Further information can be found at:

http://aleph1.novanet.ns.ca/F/PMJMYAN15942EUCGJ7Q7FMM42SNKTU921HS4TGNT65KK96XST7-51688?func=find-b-0&local_base=U-NOV01

Remote Access to Library Resources

When you try to access a Dalhousie database or electronic journal from an off-campus computer:

- Link to the Kellogg Webpage: <http://www.library.dal.ca/kellogg>
- You will then be prompted for your Dalhousie NetID (Username and Password)
 - If you don't know your NetID, you can look it up at: <http://www.library.dal.ca/Find/Remote/>
- First time users of DalNetID must claim their password. Go to:
 - My.Dal.ca: <http://my.dal.ca/>
 - Select the "New Users" tab and follow the instructions.

Moonlighting During Maternity/Parental/Adoption Leave

The Postgraduate Medical Education Office's current practice for processing Maternity and Parental Leaves is to inform all agencies: CPSNS, CPSNB, CPSPEI, CMPA, PARI-MP, the CDHA, and any other hospital a resident is assigned to, of the time a trainee will be off. A resident's training status is basically in "suspension" during any leave of absence, as this provision ensures that sufficient funding is available when the trainee rejoins his or her program. CMPA is suspended for most or all of this period and the money is refunded to the employer. Both a Dalhousie contract and CMPA must be in place for an educational license to be valid, and of course hospital credentialing requires CMPA and a license to be in effect.

There is a federal provision for those on Employment Insurance for parental/maternal leave that permits an individual to work a certain number of hours per week. In the case of a resident, the individual must ensure that they have an active license and CMPA and appropriate credentialing in place during this period. Residents who wish to pursue this option will need to discuss licenses, CMPA and credentialing directly with the agencies involved.



RCPSC STATEMENT ON MOONLIGHTING

Residents are encouraged to maintain a balance between their personal and professional life to promote their own physical and mental health and well-being as essential to effective life-long practice.

The Royal College of Physicians and Surgeons of Canada defines moonlighting as the independent practice of medicine during residency training in situations that are not part of required training in the residency program.

The RCPSC neither condemns nor condones the practice of moonlighting during residency training.

However, if moonlighting does occur, the following principles should be considered:

1. Moonlighting must not be coercive.

< *Residents must not be required by their residency program to engage in moonlighting.*

2. The moonlighting workload must not interfere with the ability of the resident to achieve the educational goals and objectives of the residency program.

< *All program directors have an obligation to monitor resident performance to assure that factors such as resident fatigue from any cause are not contributing to diminished learning or performance or detracting from patient safety.*

< *Program directors should bring to the attention of all residents any factors which appear to detrimentally affect the performance of the resident.*

< *To facilitate this, it is advisable that the program director be informed when a resident chooses to moonlight.*

3. If residents do moonlight, it should not occur on the same unit or service to which they are currently assigned as a resident.

< *For example, a resident on an ICU rotation and taking call should not also cover the same ICU as a moonlighting physician on other days of the same rotation. This has been seen to lead to difficulties in lines of responsibility and resident evaluation.*

Confirmation of licensing, credentialing and appropriate liability coverage is the responsibility of the employer.

Approved by Accreditation Committee - 10 January 2002

Moonlighting Guidelines for Residents with a Defined License

(October 2001 & Updated May 2009)

Introduction

The Postgraduate Education Committee believes that the resident's prime responsibility is to his/her educational requirements and the associated clinical activities within their specialty. However, the defined licensure can allow the postgraduate trainee, during their residency training, to provide service in areas of physician shortage. This experience may also provide residents with a wider exposure to clinical practice in the community setting. It must be clearly understood that any such services provided by residents are considered by Dalhousie to be outside the scope of their educational program. As noted below (item #4), moonlighting may only take place if the moonlighting period ends at least 12 hours before their next scheduled program activity. This will ordinarily preclude residents from doing moonlighting shifts anytime from Sunday evening to Friday evening and when on call during the weekend. The resident is responsible for ensuring that the guidelines set out below are met.

Guidelines

1. If a resident is Moonlighting in his/her Royal College specialty it should be in the final two years of training or in the final six months of Family Medicine training at Dalhousie University. This may not necessarily apply to other coverage, i.e. ICU.
2. The resident must provide full particulars of the proposed moonlighting arrangement to the Program Director and there must be approval or disapproval in writing by the Program Director to ensure there is no compromise of the resident's academic achievements or patient safety. If there is a disagreement about this between the resident and the program the resident can appeal the decision to the Postgraduate Dean or his/her designate. His/Her decision will be final.
3. The residents shall, if they do not have a full license, confirm that appropriate supervision is available.
4. Coverage provided by a resident using a defined license will normally end 12 hours prior to the resident returning to work in his/her program.
5. Internal moonlighting by residents for service coverage within the affiliated teaching hospitals will be allowed on a case by case basis, i.e. ICU.

The Program Director reserves the right to withhold or withdraw permission to moonlight at any time if, in his/her opinion, the guidelines are not met, if resident's academic achievements are being compromised or if the Program Director has reason to believe that the moonlighting arrangement is otherwise inappropriate.
(Please refer to the Royal College of Physicians and Surgeons Statement on Moonlighting on the previous page.)

Applying for a Moonlighting License

Applications for internal and external moonlighting, along with the College of Physicians and Surgeons of Nova Scotia's policy regarding each, can be obtained directly from the College's website at: <http://cpsns.ns.ca/>

The College would like to point out that it could take several weeks for all required documentation to be received by the College and advises that all applicants should realize that a defined license for postgraduate trainees cannot be granted "spur of the moment". If you are considering moonlighting during the current academic year you can submit an application to the College as soon as possible to expedite the process. You can provide the following documentation with your application:

- Photocopy of your medical degree (if not already on file)
- Photocopy of your LMCC certificate (if not already on file)
- ACLS/ATLS (if applicable)
- Neonatal Resuscitation Course (if applicable)
- Registration fee (which will be held on file until the license is granted)
- Contact your Program Director for a letter of approval and endorsement
- Contact CMPA to upgrade your coverage to Code 14 – Residents with Moonlighting

Once you have made arrangements for locum/moonlighting coverage you will need to ensure that the following documentation is provided to the College:

- Letter of sponsorship/supervision from the physician where the locum/moonlighting will be performed
- Documented evidence of approved hospital privileges (if applicable)
- Documented evidence of Code 14 CMPA coverage

The College will hold the application on file until all required documentation is received.

Please do not start your Locum/Moonlighting coverage until you receive confirmation from the College of Physicians and Surgeons of Nova Scotia that you have been granted a license to provide Locum/Moonlighting coverage.

Ombuddy Role for Residents at Dalhousie University

The primary role of the Ombuddy is to insure that residents and other members of the Postgraduate Medical Education community receive fair and equitable treatment during their residency training at Dalhousie University. The Ombuddy shall function as an independent facilitator to provide advice, mediate disputes and promote a just and reasonable solution.

Each Residency Training Program ("program") will identify a person who agrees to act as an Ombuddy for residents in that program. The Ombuddy may be a member of the Department associated with that program, but must not be a member of that program's Resident Program Committee. All residents must be made aware of the contact information for the Ombuddy for their program.

The Ombuddy agrees to advise residents on all cases. The Ombuddy will treat all discussions as strictly confidential unless the resident explicitly agrees otherwise, or in the opinion of the Ombuddy there are serious concerns regarding the health or safety of the resident.

Ombuddys are advisors and mediators, not decision makers. If after hearing the Ombuddy's opinion and considering the options the resident wishes to prepare a formal appeal, the Ombuddy will refer him or her to the Postgraduate Medical Education Calendar containing policies and information regarding appeals.

The Ombuddy has no formal or binding authority; however, he/she does have the ability to recommend, persuade and discuss with all parties involved. The Ombuddy must consider all sides of a question in an impartial manner and is guided by the following:

Philosophy: *OBJECTIVITY* *INDEPENDENCE*
 ACCESSIBILITY *CONFIDENTIALITY*
 FAIRNESS

Of these, the Ombuddy role as supporters of fairness and due process is of the utmost importance. The goal is to work cooperatively to insure fairness in our training programs.

Functions:

Advocates for fairness.

The Ombuddy is an ideal person to start with if you are unclear about the particular nature of your complaint or are unsure where to go for help.

The Ombuddy Practice Is To:

Listen and Clarify

Listen carefully and on a confidential basis to the concerns, and ask questions of the resident to help clarify his or her concerns. Gather all of the relevant facts of the case.

Make inquiries on behalf of the resident.

Advise and Inform

Advise the resident how to access appropriate decision makers.

Refer the resident to another appropriate agency if necessary.

Inform the resident of relevant academic regulations or appeals procedures.

Guide the resident through the preparation of an articulate and informative case to help the decision maker come to a fair resolution.

Mediate and Explore

Mediate or negotiate with the resident and other parties.

Explore options with the resident, regardless of the outcome of the case.

Orientation

A mandatory one-day orientation will be held at the beginning of each PGY1 year. During this day residents will complete University registration, meet the Dean of Medicine, the Associate Dean of Postgraduate Medicine, members of Faculty, members of PARI-MP have an in-depth hospital orientation and complete forms required for payroll. Partners/Spouses are invited to attend a session with the Postgraduate Dean to discuss issues such as what residency programs are all about, where to go for help, etc.

Part-Time Residency Training (Jan. 2004)

While in most instances residency training programs will be full-time, a part-time residency program may be necessary or desirable to accommodate family or personal responsibilities, illness, disability or job sharing with a spouse for childcare. It is further understood that residents need to take responsibility for completing their residency training program in a reasonable length of time.

Logistical considerations that may be encountered establishing part-time residency programs include:

- Scheduling problems for rotations,
- Incomplete or inconsistent educational experiences,
- Lack of peer group support,
- Devolved responsibility to others in the training program,
- Service needs not met,
- Financial implications,
- Lack of commitment of trainee, or
- Loss of appreciation of continuity of disease process.

This policy statement refers only to the educational implications of part-time residency training. It recognizes the desirability and hopefully facilitates the development of part-time residency programs. However, the financial, salary and contractual implications fall within the jurisdiction of the PARI-MP Collective Agreement.

Development of part-time residency programs will be determined on an individual basis and according to what each program can reasonably provide in this regard.

Principles

1. Application for part-time residency training may be considered under special circumstances.
2. In all cases the regulations of the applicable national college regarding part-time residency will apply.
 - a. For RCPSC programs, these are outlined in the "Policies and Procedures for Certification and Fellowship", Section IV, 4.3.1 **Fractional (Part-time) Residency Training** which can be found on the Royal College web site at: <http://rcpsc.medical.org/publications/index.php> Fractional residency training must be approved by the RCPSC Credentials Committee.

- b. For CFPC programs, there is no formal policy on part-time residency programs. Residents and program directors should ensure that proposed part-time residency programs are acceptable to the applicable national college prior to commencement of a part-time residency.
3. There may be obligatory full-time rotations mandated as part of the overall residency program since clinical education must include a period of on-call experience.

Conditions for Acceptability of Part-time Residency

1. Applicants must be acceptable to a program as defined by the regular admission requirements.
2. Prior approval of the Postgraduate Dean must be obtained for all residents commencing part-time residency training.
3. The reason for part-time residency must be acceptable to the residency program director, the residency program committee and the Postgraduate office.
4. The training program designed for a part-time resident must include all components of the residency program. The curriculum will be designed by the program director in consultation with the resident prior to the start of the program and the resident will have a copy prior to commencing the program. The resident will be in agreement with the proposed curriculum.
5. The program director will certify that the supervision and assessment is equivalent to that of the other residents in the program and the educational experience is equivalent in all other respects to the normal full-time training program.
6. All part-time residents shall be registered as residents in training but will receive credit only for the fraction of training for which they are registered.
7. Approval of the appropriate accrediting national college must be obtained in advance for the part-time component of the residency program.
8. Part-time residency training may continue for a trainee if satisfactory progress is made throughout the program. Residents may be required to undertake a period of full-time training if progress as a part-time resident is considered to be unsatisfactory by the residency program committee at any time.
9. If there is disagreement between the resident and the program, either party may appeal to the Postgraduate Dean.

Queen Elizabeth II EMPLOYMENT GUIDELINES FOR PART-TIME TRAINING

The academic year is broken into 13 rotations of 28 days each 364 days OR 12 calendar month rotations.

VACATION

Vacation entitlement for a full time resident is 4 weeks /year or 20 weekdays.

A resident earns an entitlement of 1.54 days vacation for each full time 28-day rotation.

OR

A resident earns an entitlement of 1.67 days for each calendar month.

Example: If a resident is a 60% FTE scheduled into 28 day rotations, then they would earn $0.6 \times 1.54 = 0.924$ days vacation during that rotation.

e.g. a 60% resident would be entitled to 12 vacation days per year.

This can be calculated by one of 2 methods: $20 \times 0.6 = 12$ or $0.924 \times 13 = 12$

If a resident varies between percentages of full time equivalencies then use monthly calculations and sum the total to calculate the annual vacation entitlement.

LEAVE OF ABSENCES AND VACATION

It is the responsibility of the Program Director to both approve and track vacation taken each year. According to Article 19.03 of the Collective Agreement, a resident who is unable to take his/her full vacation entitlement in one academic year may carry over a maximum of two weeks vacation into the next academic year subject to the agreement of the resident and the resident's own Program Director.

Paid leaves of absences do not affect vacation entitlement.

During unpaid leave of absences; e.g. maternity / paternity leave, the resident does not earn vacation credit during the time that they are off on unpaid leave. Vacation entitlement should be prorated for the months worked.

Example:

- A. If a full time resident takes a 3-month unpaid leave of absence during an academic year they are then entitled to 3 weeks vacation for that year.
- B. If a 60% resident takes a 3-month unpaid leave of absence during an academic year, they would be entitled to 9 vacation days for that year.

CALL AND PART TIME

Full time residents are expected to take call up to a maximum of 1:4 ratio. During a 28 day rotation a full time resident would do 7 call nights. Call should be prorated to the percentage equivalency of a part time resident.

Example: A 60% FTE resident would be expected to do $7 \times 0.6 = 4.2$ call shifts each 28-day rotation block.

Note: According to Article 17.01(a) call can be spread pro-rata over the length of the rotation up to a three-month schedule.

Example: A 60% FTE resident is assigned to a three-month rotation. Instead of calculating 3 months call at 4.2 shifts per month, the call can then be spread over the three months, as long as all other components of Article 17 are adhered to.

e.g. $92 \text{ days} / 4 = 23 \text{ calls over the 3 months} \times 60\% = 13.8 \text{ calls}$

SWITCHING BACK AND FORTH BETWEEN FULL TIME AND PART TIME (to be defined)

It is recognized that some rotations must be completed full time. However, the payroll system is bi-weekly and not geared to easily accommodate switches on a weekly or monthly basis.

We need to work on an acceptable guideline for this situation which would accommodate payroll, postgraduate and Royal College concerns.

A concern would be that a resident not be paid at a higher percentage than they are actually working i.e. averaged out over the year or program.

An example would be 6 months at 100% and 6 months at 60% - if the resident is paid at 80% for the year but the first 6 months worked are 60% then they have been overpaid if they leave during or after the first 6 months. Then if they leave the program or reduce their percentage, the potential exists for them to owe monies, which are very difficult to recover.

DALHOUSIE UNIVERSITY TUITION GUIDELINES

Regardless of the percentage of training a resident will do within an academic year, they will pay full tuition fees. The trainee in question will only pay fees for the duration of the program at 100% training. For example, Family Medicine is a 2-year program at full time. A part-time student will pay full-time fees for 2 years and fees for any remaining portion of training time will be waived for all additional training periods.



The Royal College of Physicians and Surgeons of Canada
Le Collège royal des médecins et chirurgiens du Canada
Credentials Unit Unité des titres

This form is for Information Only. If you wish to request part-time training, please print a copy of this form from the Calendar on the Postgraduate Website:

<http://postgraduate.medicine.dal.ca/>

REQUEST FOR PART-TIME RESIDENCY TRAINING

This form is to be completed by program directors for residents who request part-time residency training. The request for part-time training must be done in advance, the resident must give a reason why part-time residency training is being requested (i.e. family responsibility) and must be approved by the program director as well as the Postgraduate Dean. A syllabus for the applicant's entire program (full- and part-time components) must be provided by the Program Director. Part-time commitment must equal at least 50 percent of that of a full-time resident.

Name of resident applying for part-time training: _____

_____ please print complete name

Specialty: _____

University: _____

Name of Program Director: _____

1. At what level of training is the applicant applying for part-time training?

Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
PGY-1 PGY-2 PGY-3 PGY-4 PGY-5 PGY-6 PGY-7 PGY-8

2. Please state the start and end of the **part-time** training:

Start: ____/____/____ day month year End: ____/____/____ day month year

3. Please provide revised end of training date for entire residency: ____/____/____

day month year

4. This request is at least equivalent to that of other residents in the program and that the total educational experience is fully equivalent to normal full-time residency. YES ____ NO ____
Please provide the percentage (%) of time: _____

5. Reason for request of part-time training: _____

6. Please attach a syllabus for the applicant's entire program, including both part-time and full-time components.

I, Dr. _____ certify that the supervision and assessment of the part-time resident is at least equivalent to that of other residents in the program and that the total educational experience is fully equivalent to normal full-time residency.

Signature of resident

Date

Signature of Program Director

Date

Signature of Post-Graduate Dean

Date

Enclosure – syllabus

This form is for Information Only. If you wish to request part-time training, please print a copy of this form from the Calendar on the Postgraduate Website:

<http://postgraduate.medicine.dal.ca/>

774 promenade Echo Drive, Ottawa, Canada K1S 5N8 Tel.: 613-730-8191 1-800-668-3740 Fax: 613-730-3707

PIETA Program

PARI-MP, the Dalhousie Medical School, the Professionals' Support Program of the Medical Society of Nova Scotia and the New Brunswick Medical Society have banded together and created the **Residents PIETA Program** to provide confidential helpers across the Maritime Provinces for residents. Strict confidentiality is essential to the PIETA Program.

These helpers, be they psychologists, counsellors, financial advisors or psychiatrists, are not affiliated with the Medical School or any hospital program. The Coordinator of the PIETA Program and the PIETA physicians, Dr. Robert Frederickson and Dr. Janice Goodwin, family physicians, will discuss with you your concerns and help you choose the most appropriate helper for your specific problem. Services are also available for spouses, partners and family. All discussions are strictly confidential.

PIETA means compassion. These individual physicians have been chosen and have agreed to work with the PIETA Program because they care.

- Prevent** drug, alcohol or emotional disease.
- Identify** with you the nature and degree of you or a colleague's problem.
- Educate** and counsel as to how to solve or stop progression of the problem.
- Treat** or refer to treatment confidentially should disease be present.
- Acceptance** of the problems and the need for treatment.

If a resident recognizes that he or she has a drug/alcohol or psychiatric problem, they may contact PIETA. However, many residents with such problems would not voluntarily seek help. Potential problems may be identified by peers, faculty, friends or family. In this event, a concerned individual can approach the PIETA program.

If you are concerned about yourself or one of your peers, **CALL THE CONFIDENTIAL HELP LINE** at: (902) 468-8215 (All calls returned within 24 hours).

Residents can also call PARI-MP directly for physician-at-risk matters, (902) 473-4091 or 473-7861.

POSTGRADUATE RECORDS - Dalhousie University, Faculty of Medicine

January 2002

General

Student Records consist of two components:

- 1] Undergraduate File (where applicable)
 - a] Confidential Information
 - b] Non-confidential Information
- 2] Postgraduate File (where applicable)
 - a] Confidential Information
 - b] Non-confidential Information

For information on the Undergraduate Student Record Review Policy, contact the Associate Dean, Undergraduate Medical Education, 494-1890.

Postgraduate Record Review - Confidential Information

Confidential information will be stamped as such and stored in an envelope marked "confidential" at the back of each Postgraduate student file. Included in confidential materials are 1] CaRMS confidential application records (including letters of reference and official transcripts) 2] Postgraduate Dean's recommendation letters, 3] letters received or written at the request of the student regarding health or personal issues that affect academic progress or performance, 4] the Personal Information Profile collected yearly before registration in postgraduate medical education, 5] physician letters regarding health related matters and 6] letters regarding legal matters not pertaining to current training position.

Non-confidential Information

Included in this will be 1] information on academic progress (such as ITERs) 2] unofficial transcripts of academic performance, 3] registration information, 4] scholarship applications, and 5] other unsolicited, general letters.

Security

The Postgraduate student files are kept in a locked cabinet in the Postgraduate Medical Education Office of the Faculty of Medicine. The key to the locked cabinet is in the possession of the Postgraduate Coordinator.

Copies of Student Information

Students will not be given xeroxed copies of documents on file unless such documents originated from the student. Faculty members will be permitted a xeroxed copy of documents in a student's file if these documents originated from that individual faculty member. A composite ITER can be prepared but only at the written request of the Postgraduate student concerned.

Disposition

At the time of the student's completion of training, or in the event of withdrawal or dismissal, Postgraduate student files will be placed in locked storage.

Normal Student Access to Files; Access to Files in the Event of an Appeal; and Access to Postgraduate student files by Other Parties: The Dalhousie University FOIPOP Policy on Access to Resident Files supercedes the Faculty of Medicine 2002 Policy: see Policy below

FOIPOP Policy on Access to Resident File

June 2, 2005

The following policy is to address access to Resident Files.

Residents. A resident shall have access to his/her Resident File with the exception of reference letters, and other documents or material that were received by the Program with the request that it be kept confidential. The policy is not intended to be a replacement for disclosure obligations prescribed by Faculty Regulations Relating to Suspension from Postgraduate Study of Medicine, shall be interpreted in a manner consistent with such regulations.

Other Members of the University. The University Regulation: Release of Information About Students states the following, in part:

- // ***Disclosure to Faculty, Administrative Officers, and Committees of the University.***
Information on students may be disclosed without the consent of the student to University Officials or committees deemed to have a legitimate educational interest.

Under this policy, a **Program Director** is deemed to have a legitimate educational interest in the Resident Files for those residents registered in the Program for which s/he is responsible. Requests for access to a Resident File by **Faculty/Resident Training Committee members and Administrative Officers** will be made to the relevant Program Director who shall determine whether such person has a legitimate educational interest in reviewing all or part of the Resident File.

Accreditation Survey Teams. Accreditation survey teams shall be granted access to Resident Files for the sole purpose of conducting an audit or review in connection with authorized institutional or program accreditation processes.

Other requests

Any other requests for information relating to files not expressly addressed in this policy must be made to the University FOIPOP Coordinator (University Legal Council) as an access to information request.

For a complete overview to the Dalhousie University access to information please go to the Dalhousie Registrar's website, <http://www.registrar.dal.ca>, and follow the links to the appropriate site regarding the freedom of information and protection of privacy act.

Prayer Places

The Postgraduate Office provides Programs with the dates for Muslim Holy Days but it is the responsibility of the resident to make arrangements with their Program Director, many weeks in advance, for any time off for religious occasions.

Dalhousie University Multifaith Centre, 1321 Edward Street, Halifax, NS B3H 3H5

The Dalhousie Multifaith Centre has a team of eleven chaplains who represent eleven different faith communities, reflecting five of the world's major faiths. Most of the chaplains are scheduled with regular hours in the Multifaith Centre. A Roman Catholic mass is celebrated Tues-Friday at Noon at the St. Joseph's Newman Centre, 6345 Coburg Road. Muslim - Islamic prayer is held at 1 p.m. on Fridays in the Student Union Building. The Multifaith Prayer and Meditation Room is open from 9 am to 4 pm throughout the year and is available for individual and small group meditation, prayer, and worship. You may e-mail a specific chaplain to determine an appointment time. Visit the Multifaith Centre Web Site at: <http://multifaithcentre.studentservices.dal.ca/> to get more information on Worship and Events on or near the Dalhousie campus.

Hospital Prayer Rooms include:

Cape Breton: Contact Mary Jackson
(902) 567-8055 jacksonm@cbdha.nshealth.ca
Moncton: Contact Irene Roy Knowles
(506) 857-5660 irene.royknowles@horizonnb.ca
Fredericton: Contact Debby Cougle
(506) 452-5701 debby.cougle@horizonnb.ca

Saint John: Contact Charlene Ross
(506) 648-6370 charlene.ross@horizonnb.ca
Prince Edward Island: Non-denominational Chapel
(902) 894-2053 sbsteele@ihis.org

HALIFAX SITES MULTI FAITH CHAPELS:

**Halifax Infirmary – Summer Street entrance 1st floor and
Victoria Site - located on Level 2 next to the cafeteria**

These Multi-faith chapels were created to meet the spiritual need for faith communities to worship in their own traditions. A design consideration to encompass all faith groups was taken into consideration at the planning stage and included input from the Christian, Jewish and Muslim faith communities. There are no permanently fixed religious symbols and all furniture is movable. The Multi-Faith Chapel is open on a 24-hour basis, with room off of the main worship space for private worship. A regular interdenominational service is held every Sunday at 2:00 pm and on the first Thursday of each month at 2:00 pm. A Muslim Prayer Room is located in the Victoria Site, beside the Chapel.

Professional Appearance of Postgraduate Trainees

As physicians, along with other health professionals, your principal focus is the client - your patient. Patients come from a wide range of cultures, diverse economic and educational backgrounds, as well as extremes in age groups. In addition, they and their families come to us often under a great deal of stress and vulnerability. It behoves us all to present ourselves as professionals who are sensitive and responsive to our patient's expectations regarding appropriate identification, apparel, et cetera while on active duty.

Professional Association of Residents in the Maritime Provinces (PARI-MP)

The Professional Association of Residents in the Maritime Provinces (PARI-MP), is the voluntary organization which represents the interests of approximately 480 resident physicians in the Dalhousie University Postgraduate Medicine Programs. PARI-MP acts on behalf of its members in negotiations with the Employer regarding contract matters. PARI-MP has representatives on various committees involved in monitoring the quality of education and working conditions of residents, including the Postgraduate Medical Education Committee and Internal Review Committees. PARI-MP also has representatives who offer input to groups involved in political decisions which will affect the practice of medicine. PARI-MP regularly communicates with the other provincial house staff organizations and the national group, the Canadian Association of Interns and Residents (CAIR). PARI-MP is

available to advise individuals requiring assistance, especially in the areas of appeals, grievances and physician at risk matters. Member dues are collected bi-weekly (at 1.3% of resident salaries) and funds are used to finance operations and activities of the organization and CAIR.

PARI-MP is also the administrator of the resident benefits plan, including medical, dental, travel, life insurance and disability. For more information on the benefits plan, please contact Leanne Bryan, Benefits Coordinator, at: (902) 404-3594 or Leanne@parimp.ca

The PARI-MP office is located in Suite 460 of the Halifax Professional Centre, 5991 Spring Garden Rd, Halifax, Nova Scotia, B3H 1Y6. Feel free to contact the office any time at (902) 404-3595, 1-877-972-7467, Fax (902) 404-3599, E-mail: Verlie@parimp.ca or visit www.parimp.ca

Payroll and Benefits Information

The QEII functions as the paying agent for the Dalhousie Postgraduate Medical Education Programs. There is currently a mandatory direct deposit transfer system which will automatically credit the member's bank account on a bi-weekly basis. All members are also entitled to the benefits stated in the Collective Agreement. These include Manulife Financial health, dental, travel, life and long term disability coverage. The amount paid by members for single coverage is \$7/bi-weekly* and the amount for family is \$29/bi-weekly*. If a member can show proof of alternate health/dental coverage, then health/dental coverage can be waived – but travel, life and long term disability are mandatory, the cost will be \$2.50/bi-weekly*. (*Rates subject to change at any time.)

Salary

	PGY1	PGY2	PGY3	PGY4	PGY5	PGY6	PGY7	PGY8
July 1/10	\$51,546	\$60,102	\$64,178	\$68,429	\$73,035	\$77,963	\$80,610	\$86,252

**The Collective Agreement for 2011 is currently being negotiated as of July 1, 2011
Salaries are subject to change when agreements are reached.

CMPA

The Employer will pay directly to CMPA the cost of coverage for all residents except those not covered by the collective agreement.

Faculty of Medicine Professionalism Policy

The Faculty of Medicine is committed to creating an environment that is optimal for learning, teaching, conducting research and providing clinical care. To achieve and sustain this, the Faculty of Medicine expects students, residents, faculty, administration and staff to display professionalism, individually and collectively, in all their interactions with each other, with patients and families/significant others, with colleagues in other professions, and with members of the public when acting under the auspices of Dalhousie University and the Faculty of Medicine.

Physicians and scientists have privileged positions in society. Professionalism is central to the ethos of both the practice of medicine and conduct of research and an expression of our commitment to patients and society.

The following principles of professionalism and examples given below are not intended to be exhaustive. They are articulated and described to guide us in our actions and interactions with others.

Respect for others

Professionals demonstrate consideration and respect for others including patients, their families and support persons, colleagues, classmates, teachers, other professionals and the public.

- We do not allow our conduct to negatively impact on others' learning or clinical activities.
- We do not discriminate against others on the basis of such grounds as age, race, colour, ancestry, place of origin, ethnicity, political beliefs, religion, marital status, family status, physical or mental disability, sex, sexual orientation, or gender identity.

- We demonstrate respect for the dignity and rights of patients and their families or support persons, taking into account their diversities, both in their presence and in discussion with other members of the healthcare team.
- We accept and promote patient autonomy in decision-making, and when the patient lacks capacity, we consult with and appropriately take direction from surrogate decision-makers.
- We respect the personal boundaries of others and refrain from making unwanted or inappropriate romantic or sexual overtures towards others.
- We communicate respectfully with others both verbally and in writing.
- We respect the privacy and confidentiality of those to whom we owe that duty.

Honesty and Integrity

Professionals demonstrate adherence to the highest standards of personal, professional and academic honesty and integrity.

- We communicate truthfully with others verbally and in writing.
- We do not falsify documents or records.
- We acknowledge and manage conflicts of interest appropriately, avoiding conflicts of interest, real or apparent, whenever there is potential detriment to others.
- We admit and disclose errors.
- We make accurate records of conversations, histories, physical findings and other information pertinent to patient care.
- We do not engage in plagiarism nor do we give or receive assistance during an examination or in completion of an assignment unless such is expressly permitted.
- We conduct research in an ethical manner, analyzing and reporting results accurately and fairly.
- We credit the ideas and work of others appropriately and fairly.

Compassion and Empathy

Professionals demonstrate compassion and empathy for those in distress and especially for patients, their families and support persons.

- We demonstrate effective listening.
- We are aware of and respectful of others' differences and respond appropriately to their needs.
- We show compassion and provide support for patients, their families and support persons dealing with illness and/or dying and death.

Duty and Responsibility

Professionals acknowledge their duties to patients, their profession and society and accept the responsibilities that flow from these duties.

- We attend to patients' best interests and well-being as the first priority.
- We work cooperatively with others for the benefit of our patients and contribute to a healthy working environment for all.
- We make equitable and prudent use of healthcare resources under our control.
- We are responsible to society for matters relating to public health.
- We recognize and adhere appropriately to policies, codes, guidelines, and laws that govern us and our work.
- We participate in the process of self-regulation of the profession.
- We address misconduct, incompetence, or behaviours that put patients or others at risk.
- We share resources and expertise, and assume responsibility for our portion of a fairly distributed workload. Where issues of fair distribution arise, we act most immediately in the patient's best interests, and seek to resolve issues of fairness through appropriate channels.
- We respond in an appropriate, non-judgmental and non-demeaning manner when our expertise is sought.
- We do not take advantage of colleagues, learners, patients, their families or support persons, or others for emotional, financial, sexual or other personal purposes, and we conduct research and educational activities with these groups only with appropriate informed consent.

- We fulfill commitments, meet deadlines, and are punctual particularly where these behaviours have significant impact on others. Where we are unable to do so, we communicate appropriately to mitigate any negative impacts.
- We engage in lifelong learning, maintain clinical competence, and strive for continuous quality improvement.
- We take appropriate and necessary responsibility for our personal health and well-being.
- We recognize our own limitations and seek assistance appropriately.
- We display dress, behaviour and demeanor in the educational and healthcare setting in keeping with appropriate pedagogical, clinical, or safety standards.

This policy is intended to complement Canadian law, policies, guidelines and codes of conduct established for the profession of medicine, and other policies, regulations and ethical standards that govern students, residents, faculty and staff of Dalhousie University, the Faculty of Medicine, the Undergraduate Medical Education program and all Postgraduate (Residency Training) Medical Education programs.

For reference, these documents and resources include but are not limited to the following:

- Royal College of Physicians and Surgeons of Canada CanMEDS Physician Competency Framework: <http://rcpsc.medical.org/canmeds/index.php>
- College of Family Physicians of Canada Four Principles Family Medicine: <http://www.cfpc.ca/Principles/>
- Policies and Guidelines of the College of Physicians and Surgeons of Nova Scotia: <http://www.cpsns.ns.ca/publications/index.html#1>
- Canadian Medical Association Code of Ethics: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>
- Dalhousie University's Student Code of Conduct, Policy on Scholarly Integrity, and other relevant Dalhousie University policies: <http://www.registrar.dal.ca/calendar/ug/UREG.htm#15>
- Dalhousie University Office of Human Rights, Equity, and Harassment Prevention: <http://hrehp.dal.ca/index.php>
- *On Being a Scientist. Responsible Conduct in Research* http://www.nap.edu/openbook.php?record_id'4917
- *Teaching the Responsible Conduct of Research in Humans (RCRH)*: <http://www.medsch.ucla.edu/public/korenman/chapter1>

Faculty of Medicine: Resident Research Day

Faculty of Medicine Resident Research Day is an annual event held in late May. Presentations are in oral and poster format and major prizes are awarded at an evening reception. The selection of award winners will be made by the judges who review and evaluate the presentations. There are a number of Awards presented at this event:

- CSCI/CIHR/Postgraduate Award for best overall presentation
- Award for best overall basic science presentation
- Award for best overall clinical presentation
- Award for best overall poster presentation
- Two Dalhousie Medical Research Foundation Awards
- Two Dalhousie Medical Alumni Association Awards
- One Professional Association of Residents (PARI-MP) Award
- Runner-up Prizes for best basic science, clinical, and poster presentations

For a list of the Awards and award winners, visit the Faculty of Medicine, Resident Research Day website at: <http://rrd.medicine.dal.ca/>

Departmental Research Prizes and Awards

Anesthesia:

The Department of Anesthesia offers two research prizes to support resident research development in Anesthesia: the Emerson A. Moffitt Book Prize for Postgraduate Research in Anesthesia, and the New Brunswick Division of C.A.S. Research Prize (\$500).

Diagnostic Radiology:

The Department of Radiology Offers a Radiology Residents Research Award, sponsored by the Nova Scotia Association of Radiologists. This award is given to the best paper presented at the annual Scientific Meeting of the Atlantic Provinces Radiologists Meeting held each October. This competition is open to all Diagnostic Radiology and Nuclear Medicine residents of Dalhousie University and also residents from Memorial University.

Emergency Medicine:

The “Dr. Douglas E. Sinclair Award in Emergency Medicine Research” is presented at the annual Emergency Medicine Research Day. This award is presented by the Dalhousie University, Department of Emergency Medicine, for most significant research in Emergency Medicine performed by a resident. It is judged on the following criteria: objectives, background, methodology, results, analysis, discussion focussed on the results and methodology, conclusions, overall presentation, critical appraisal, and appropriateness to Emergency Medicine/Clinical Practice.

Family Medicine:

The “Doug Mulholland Award” for the best resident project. The projects are judged on originality, relevance to family medicine and critical thinking.

General Surgery:

There is an annual General Surgery Resident Research Day held every spring. Both basic science and clinical abstracts are presented by residents at all levels. Two awards are given of \$150 each for the two best abstracts.

Internal Medicine:

Resident research awards are presented during the Department of Medicine Research Day for Best Oral and Poster Presentations for residents, medical students & subspecialty residents, Best Case Presentation by a resident, and the Residents’ Choice Award. The Resident Excellence in Research award is based on resident research throughout the year and the recipient is chosen by the Resident Research Committee. The ACP Research Award is presented annually to a resident with active membership in the American College of Physicians based on their research involvement throughout the year.

Medical Oncology & Radiation Oncology

The Department of Radiation Oncology and the Division of Medical Oncology hold an annual research day in the spring with awards for the best student and resident presentations. Cash prizes are given to all winners. Representation is multidisciplinary with an oncology theme.

Obstetrics and Gynaecology:

The Canadian Foundation for Women’s Health sponsors an annual award (\$500) for the best project related to women’s health at the Department of Obstetrics and Gynaecology Resident Research Day. Each resident, graduate student, or fellow who presents a completed research project or ongoing research study receives \$100.

Ophthalmology:

The Department of Ophthalmology holds an Annual Residents Research Day competition. The first and second place winners of this competition are awarded prizes in the form of funding to attend a national or international conference at which they must present their project. Traditionally the first prize submits their abstract to the ARVO conference in Florida and the second prize to the COS. The prizes are not named. In addition, residents who present research communications at other important meetings are given financial assistance for approved expenses.

Otolaryngology:

A \$200 book prize is given for the best presentation at the Division of Otolaryngology Research Day.

Pathology:

The Department of Pathology holds an annual Research Day competition. Prizes are awarded for the best presentation, either oral or poster, of on-going departmental research projects in the following three categories: Department residents, Department graduate students, or post doctoral fellows and trainees external to the Department of Pathology. A prize of \$250 is awarded to the winner in each of these categories with the best presentation at the Department of Pathology Research Day.

Pediatrics:

The Department of Pediatrics holds an Annual Departmental Research day where all residents are encouraged to present their ongoing or completed research projects. Cash prizes are awarded for the best oral or poster presentations in basic and clinical research by trainees within the Department of Pediatrics.

Physical Medicine & Rehabilitation:

The Division of Physical Medicine & Rehabilitation holds an Annual Resident Research Contest open to physiatry residents in the Dalhousie program. The winner is selected on the basis of oral or poster presentations to the Atlantic Rehabilitation Research Association.

Psychiatry:

The Department of Psychiatry holds an Annual Research Day every March where residents are encouraged to present papers. The best resident paper receives a prize of \$300.

Surgery:

The Department of Surgery holds two important research events each year. The first is the DAL Surgery Research Day. It is held in April of each year. A distinguished international surgeon is invited to be the Gordon Bethune Visiting Professor and Visiting Speaker. Residents, Fellows and Students under the supervision of members of the Department have the opportunity to present their work. Abstracts are submitted and reviewed by the DAL Surgery Research Committee to determine the 32 presentations to be made. Prizes are awarded to the top Residents and Students, and as of 2006, the Dr. Robert Stone Traveling Fellowship is awarded to the First Place Resident. There is an evening reception and dinner where prizes are announced and awarded. The second event, which usually occurs in October, is Research Information Day. At this event surgeons and affiliated scientists in the Department of Surgery present their current research. This event is designed to provide information to residents and medical students who may want to pursue research projects within the Department. It also stimulates multi-disciplinary collaboration in research within the Department. If you require more information about these events or any other issues regarding research within the Department of Surgery, please contact Elaine Marsh in the DAL Surgery Research Office: Elaine.Marsh@dal.ca

Urology:

The Nova Scotia Medical Society (Section of Urology) awards an annual prize for the best resident research presentation. The runner-up for this competition also receives an award. The Dr. Stan G. Lannon Award is given annually to the resident who best exemplifies dedication to the teaching mission of the Urology Department. This award is displayed prominently within the Department and is accompanied by a cash amount.

Institutional Guidelines for Good Research Conduct

These guidelines represent an attempt by the Faculty of Medicine at Dalhousie University to address the issue of research fraud and misconduct through the development of a set of guidelines for students, staff and faculty that provide guidance in the area. In developing these guidelines, the Research Office of the Faculty of Medicine has relied heavily on the 1989 Association of American Medical Colleges document "Framework for Institutional Policies and Procedures to Deal with Misconduct in Research". These guidelines expand upon, but at the same time, are consistent with the Dalhousie University Policy on Integrity in Scholarly Activity as approved by Senate on December 11, 1995. These guidelines for good research conduct were approved by the Faculty of Medicine Faculty Council and Faculty of the whole in 1990. They respond to the requirements of both the Medical Research Council of Canada and the National Institutes of Health in Washington, that the Institution have in place policies and procedures to deal with research fraud. This document provides clear guidelines which all departments should follow in conducting research at all levels.

Introduction:

Researchers in the Faculty of Medicine at Dalhousie University working both within the research laboratories of the University and the Affiliated Teaching Hospitals are involved in a wide variety of research, from basic, wet-laboratory research at one extreme, to patient oriented clinical trials and chart reviews at the other. In spite of the diversity of the research being conducted, we like to think that the principles guiding clinical and basic science researchers is a conviction to a set of truths which are related to the fundamental process of scientific inquiry. The basic and most important element in this whole process of data accumulation, interpretation and reporting is the objective and scrupulous attention to the detailed procedures which each and every scientist must apply to the scientific process, to ensure that the ultimate conclusions and interpretation of the work is scientifically valid. In spite of hopes that the scientific process is above reproach, a number of very serious allegations of blatant research fraud have been made and substantiated in The United States over the past ten years. More alarming are the increasing numbers of concerns and allegations that research is being conducted in a manner which is questionable, with the suggestion of misconduct. Although we would like to think that these are the problems of large research laboratories in big American institutions, the fact of the matter is that a number of Canadian universities, including, the Faculty of Medicine at Dalhousie University, have had to investigate and deal with accusations of research misconduct. In dealing with such allegations it is important for the administration at all levels to remain open and sensitive to the need to protect the innocent, while at the same time ensuring that justice is not only done but is seen to be done. The process must be such that it can withstand legal challenges and at all times must protect the rights of the accused. In all of this, there must be a balance between ensuring that the process is fair and that the reputations of honest individuals and the Institution are upheld. Although the number of cases of research misconduct have been relatively few in Canada, when they have occurred it has been clear that in most instances the Institution has no formal procedure in place to deal with this issue, regardless of the severity. There is then a very pressing need for Dalhousie University to put in place a credible system for dealing with this important issue.

Definition of Misconduct in Research:

The words "research fraud" have a very sinister connotation and for that reason we prefer to follow the example of the AAMC and ACMC in using the term Research Misconduct. Research misconduct is itself not an easy term to define. There has been much debate on this and as a result we are also adopting the definition set out by the AAMC and ACMC: "Research misconduct" or "misconduct in science" will be defined as the fabrication, falsification, plagiarism, deception or any other practice that seriously deviates from those that are commonly accepted within the scientific community for proposing, conducting, or reporting research. In using this rather narrow definition, it is assumed that the ethical issues related to the use of human and animal subjects, as well as the use of biohazardous materials have been covered by other institutional mechanisms which are specific for each of these special areas. In addition, investigators should refer to Sections 3.1 to 3.12 of the Senate document on "Integrity in Scholarly Activity" for a more detailed list of specific examples of Research Misconduct that apply across the whole university.

Prevention of Misconduct in Research: Code of Good Laboratory Practice:

In spite of the level of experience that any individual researcher may have, there are some very simple and fundamentally important steps which can be taken at all levels to help reduce the chance that research will be conducted in a way which may ultimately be viewed as suspect or fraudulent.

A. Supervision of Trainees and Technicians:

1. Each trainee and research technician must have a clearly designated supervisor. It is the responsibility of the Department Head (in larger departments through the Divisional Head) to ensure that this is the case.
2. The ratio of trainees to supervisors should be small enough that close interaction is possible to ensure both meaningful scientific exchange and to facilitate reasonable overview of work in progress at all stages.
3. Each supervisor shall be encouraged to meet with research trainees and technicians at regular intervals to review data, progress and future plans. The Supervisor or Department Head is responsible for ensuring the designation of replacement supervision in the event of the supervisor's absence for extended periods of time (in excess of one month).
4. Researchers (supervisors and trainees) shall be encouraged to present findings at laboratory, as well as at Departmental review sessions and seminars, to promote open and realistic assessment of progress.
5. The supervisor should provide each new staff member and trainee, whatever the level, with applicable governmental and institutional requirements for the conduct of studies involving health volunteers or patients, animals, radioactive or other hazardous substances, including recombinant DNA. Copies of these documents should also be provided by the Faculty of Medicine Research Office.

B. Data Gathering, Storage and Retention:

1. The procedure for recording, storage and retention of primary research data should be formally outlined by the supervisor at the beginning of the project.
2. All primary data should be recorded in clear, adequate, original and permanent form, and where possible, data and all notes should be recorded in bound notebooks. It is the responsibility of the principal investigator to ensure that all original and primary laboratory data is retained by the laboratory or research unit in which they are generated; however, an investigator trainee may make copies of the primary data for his/her own use. The department head, division head or chief, immediate supervisor and all collaborators must have free access at all times to review all data and products of an investigator's research. Data for a given study must be retrievable for at least five years after the work is completed (if the data form permits).
3. Upon the departure of a trainee from Dalhousie University, Faculty of Medicine, all permanent primary data will normally remain in the laboratory or unit where they were generated. Departing investigators may take copies of data with them, or may make alternate arrangements with their supervisor (Principal Investigator) with the knowledge of the Department Head, to have copies kept by Dalhousie University, instead of the original records. Where primary data is allowed to leave Dalhousie University, written acceptance of responsibility for maintaining this data will be required from the new institutional home.
4. Upon the departure of a faculty member from Dalhousie University, Faculty of Medicine, custody of permanent primary data will normally be transferred to the new institution. Such an arrangement must be made with the Department Head's written consent, with copies of this correspondence to the investigators file in the Dean's Office. Where primary data is allowed to leave Dalhousie University, written acceptance of responsibility for maintaining this data will be required from the new institutional home.
5. Before disposing of any material products of research activity such as cell lines, bacterial clones, other specific organisms and substances, or software developed and prepared during the course of research, for non-commercial scientific purposes within or without the laboratory, the approval of the principal investigator or supervisor must be obtained, and through the principal investigator, the department head should be informed.
6. Disposition of material products by non-faculty for the purpose of commercializing such products, requires the approval of the Office of Technology Transfer (Dalhousie University) and the Office of Research Services.
7. When a department head wishes to remove his/her own primary data from Dalhousie University, the written consent of the Dean of Medicine is required.

C: Authorship:

As the need for collaborative research increases with the advancement of scientific technology and the diverse approach to the investigation of complex biological problems, the responsibility for multi-authored or collaborative studies has become increasingly important but also more difficult to define. There are, however, some crucial safeguards which should be considered in the publication of scientific results:

1. One author, usually the senior author, must be identified as being responsible for the validity of the entire manuscript.
2. Ideally, all listed authors should have been involved in the research from its inception. However, at the very least, it is expected that all authors have made a significant intellectual or practical contribution to the project and have participated in the writing of the paper and understand the significance of the conclusions and can share in the responsibility for the scientific content and reliability of the reported data. The concept of "honourary authorship" is unacceptable.
3. There should be clearly stated guidelines within each department or laboratory concerning where research trainees' names will appear on papers and what their responsibilities are. This policy should be discussed with all trainees at the beginning of their rotation in the laboratory.
4. Since Department Heads are responsible to the Dean of Medicine for all activities of department members within their academic unit, Department Heads are expected to be kept informed of the ongoing activities of each laboratory by the Principal Investigator. Therefore, at least one copy of all publications and conference abstracts, as well as all grant applications and contracts must be submitted either before or at the time of external submission to the Department Head. These will be kept in the departmental files.
5. All co-authors should be encouraged to sign manuscripts to acknowledge responsibility for the contents before their submission.

D. Collaborative Research

In cases of collaborative work at a number of sites, the principal investigator should ensure that all co-workers are familiar with the whole project (at very least with the broad details) and that protocols and ethical requirements for all sites have been approved.

Postgraduate Guidelines Regarding Requests for PGY1 Schedule Changes

Dalhousie University Postgraduate Medical Education is conducted in affiliated teaching hospitals in the Maritime Provinces. The Postgraduate Medical Education Office is charged with the duty of filling training services in these accredited hospitals. The scheduling programme that creates the PGY1 schedule takes all Residency Training Program approved rotations, all hospital service quotas and all PGY1 resident requests for scheduling preferences into consideration. It should be noted that residents will not always receive their first choice of rotation preferences. The assignment of residents to services meets the educational objectives set out by each Residency Training Program.

Requests for schedule changes are not encouraged and will only be considered under exceptional circumstances, i.e. for medical considerations. Requests for leaving an approved residency rotation/service for reasons that are not exceptional, cannot be considered. Requests for changes to the schedule must be discussed with a resident's Program Director. We are obligated to provide educational experience once the Final PGY1 Schedule is distributed. Any request for a change must comply with the following procedures:

1. Requests for changes must be received at least three months in advance of the rotation change requested;
2. If the experience is available within the Dalhousie system, you will not be permitted to go elsewhere;
3. Residents must get approval from the service they wish to join, and permission from the service they wish to leave;
4. Notice of approvals must be sent to the Postgraduate Medical Education Office, who will ensure all individuals and departments are notified of any change; and,
5. The Program Director must approve any changes to mandatory rotations or rotations not specified in the overall program design for the PGY1 year. Specification for PGY1 schedules can be discussed with your home program.

Resident Safety Policy (PGME)

PREAMBLE

The PGME Office recognizes that residents have the right to a safe environment during their residency training. The responsibility for promoting a culture and environment of safety for residents rests with the Faculty of Medicine, district health authorities, clinical departments, residency training programs and residents themselves. The concept of resident safety includes physical, emotional, and professional security.

KEY RESPONSIBILITIES:

For Residents

- To provide information and communicate safety concerns to the program and to comply with safety policies.

For Residency Training Programs

- To act promptly to address identified safety concerns and incidents and to be proactive in providing a safe learning environment.

PHYSICAL SAFETY

These policies apply only during residents' activities that are related to the execution of residency duties:

- When residents are traveling for clinical or other academic assignments by private vehicle, it is expected that they maintain their vehicle adequately and travel with appropriate supplies and contact information. Provincial laws will be adhered to regarding cell phone use, except hands free, and text messaging in the performance of residency duties while driving.
- For long distance travel for clinical or other academic assignments, residents should ensure that a colleague or the home residency office is aware of their itinerary.
- Residents should not be on call the day before long distance travel for clinical or other academic assignments by car. When long distance travel is required in order to begin a new rotation, the resident should request that they not be on call on the last day of the preceding rotation. If this cannot be arranged then there should be a designated travel day on the first day of the new rotation before the start of any clinical activities.
- Residents are not to be expected to travel long distances during inclement weather for clinical or other academic assignments. If such weather prevents travel, the resident is expected to contact the program office promptly. Assignment of an alternate activity is at the discretion of the Program Director.
- Residents should not work alone after hours in health care or academic facilities without adequate support from Security Services.
- Residents are not expected to work alone at after-hours clinics.
- Residents are not expected to make unaccompanied home visits.
- Residents should only telephone patients using caller blocking.
- Residents are not expected to walk alone for any major or unsafe distances at night. This includes walking on the hospital premises and parking lots. The residents are expected to request security escort if such circumstances occur. Residents should not drive home after call if they have not had adequate rest.
- When interacting with patients with potential for violence, residents should ascertain that there is backup from security staff and that the patients are seen in an area which allows for safe and easy exit
- The physical space requirements for management of violent patients must be provided where appropriate.
- Special training should be provided to residents who are expected to encounter aggressive patients.
- Site orientations should include a review of local safety procedures.
- Residents should familiarize themselves with the location and services offered by the Occupational Health Office. This includes familiarity with policies and procedures for infection control and protocols following exposure to contaminated fluids, needle stick injuries, and reportable infectious diseases.
- Residents must observe universal precautions and isolation procedures when indicated.
- Residents should keep their immunizations up to date. Overseas travel immunizations and advice should be sought well in advance when traveling abroad for electives or meetings.
- Call rooms and lounges provided for residents must be clean, smoke free, located in safe locations, and have adequate lighting, a phone, fire alarms, and smoke detectors. Any appliances supplied are to be in good working order. There must be adequate locks on doors.
- Residents working in areas of high and long term exposure to radiation must follow radiation safety policies and minimize their exposure according to current guidelines.
- Radiation protective garments (aprons, gloves, neck shields) should be used by all residents using fluoroscopic techniques.

- Pregnant residents should be aware of specific risks to themselves and their fetus in the training environment and request accommodations where indicated. Residents should consult the Occupational Health Office for information.

PSYCHOLOGICAL SAFETY

- Learning environments must be free from intimidation, harassment, and discrimination.
- When a resident's performance is affected or threatened by poor health or psychological conditions, the resident should be granted a leave of absence and receive appropriate support. Such residents should not return to work until an appropriate assessor has declared them ready.
- All programs will appoint an ombudsperson (Ombuddy) and ensure that all residents in the program are informed as to the policies regarding the Ombuddy role and contact information.
- Residents should be aware of and have easy access to the available sources of immediate and long-term help for psychological problems, substance abuse problems, harassment, and inequity issues. Resources include the PIETA Support Program, Dalhousie University Counseling Services and Sexual Harassment Office, the Dalhousie University Office of Human Rights, Equity & Harassment Prevention and PARI MP.

PROFESSIONAL SAFETY

- Some physicians may experience conflicts between their ethical or religious beliefs and the training requirements and professional obligations of physicians. Resources should be made available to residents to deal with such conflicts. Examples include the College of Physicians and Surgeons of Nova Scotia, Dalhousie University Faculty of Medicine, and the district health authority.
- Programs are bound by PARI MP contract allowances for religious holidays.
- Residents should have adequate support from the program following an adverse event or critical incident.
- Programs should promote a culture of safety in which residents are able to report and discuss adverse events, critical incidents, 'near misses', and patient safety concerns without fear of punishment.
- Residency program committee members must not divulge information regarding residents. It is the responsibility of the residency Program Directors to make the decision and to disclose information regarding residents (e.g. personal information and evaluations) outside of the residency program committee and to do so only when there is reasonable cause. The resident file is confidential.
- With regard to resident files, programs must be aware of and comply with the Freedom of Information and Privacy (FOIPOP) Act. Programs can obtain guidance about FOIPOP issues from the Dalhousie University Access and Privacy Coordinator. Contact information is found on the University Secretariat's webpage.
- Resident feedback and complaints must be handled in a manner that ensures resident anonymity, unless the resident explicitly consents otherwise. However, in the case of a complaint that must be dealt with due to its severity or threat to other residents, a Program Director may be obliged to proceed, against the complainant's wishes. In that case the Associate Dean of Postgraduate Medical Education or the main campus Harassment Office should be consulted immediately. Depending on the nature of the complaint, the regional health authority and/or the College of Physicians and Surgeons of NS may need to be informed and involved. In general, the Program Director should serve as a resource and advocate for the resident in the complaints process.
- Residents must be members of the CMPA and follow CMPA recommendations in the case of real, threatened, or anticipated legal action.
- In addition to CMPA coverage for patient actions, residents are indemnified for actions or lawsuits arising from the actions or decisions made by committees (e.g. tenure, appeals, residency training) they may serve on, under the university insurance for lawsuits related to academic issues.

PGME Committee approval April 7, 2011

CONTACT INFORMATION:

CMPA

<https://www.cmpa-acpm.ca/cmpapd04/docs/highlights-e.cfm>

PARI-MP

www.parimp.ca/

Dalhousie University Counselling Services

<http://counsellingservices.dal.ca/>

Dalhousie University Office of Human Rights, Equity & Harassment Prevention

<http://hrehp.dal.ca/>

Office of Human Rights, Equity & Harassment Prevention Room 2,

Basement Level, Henry Hicks Academic Administration Building

c/o The President's Office, 6299 South Street

Halifax, Nova Scotia, B3H 4H6

Phone: (902) 494-6672/494-1137

Fax: (902) 494-1179

Email: hrehp@dal.ca

Dalhousie University Office of the Ombudsperson

<http://ombudsperson.dal.ca/>

Student Union Building

Room 407, 6136 University Avenue, Halifax, NS B3H 4J2

Telephone: (902) 494-6583

Fax: (902) 494-2698

E-Mail: ombudsperson@dal.ca

Dalhousie University Freedom of Information and Privacy Policy

<http://foipop.dal.ca/>

John Hope, FOIPOP Coordinator

Dalhousie University

Room 225, Henry Hicks Academic and Administration Building

Halifax, Nova Scotia B3H 4H6

Phone (902) 494-2184

Fax (902) 494-1658

John.Hope@Dal.Ca

PIETA program

<http://postgraduate.medicine.dal.ca/pieta.html>

Capital Health Occupational Health Office

Room 2554, Camp Veterans' Memorial Building

5955 Veterans' Memorial Lane

Halifax, Nova Scotia B3H 2E1

Phone: (902) 473-4773

Fax: (902) 473-2451

Room B31, Bethune Building

1278 Tower Road, Halifax

Nova Scotia B3H 2Y9

Phone: (902) 473-8416

Fax: (902) 473-2963

Status of Residents

Residents are medical doctors involved in a university-operated educational program, based in various modes of health-care delivery which, following satisfactory completion of certification exams, will enable them to qualify for specialist status. Therefore, residents are full-time university students and at the same time provide medical service in hospitals for remuneration and benefits, and these roles are inseparable. In the pyramid of medical students and residents, higher level students teach those below. This is an excellent way to learn and is encouraged. Any formal teaching commitments above this will be negotiated with the Department Head and Program Director concerned. The ultimate responsibility for patient care lies with the appointed attending staff physician and not with the resident. Residents are expected to provide a clinical service, appropriate to their level of training, to patients admitted to teaching units. Residents have a duty to provide care in emergency situations to other patients in hospitals where they are training. Any further coverage of these other patients is by mutual agreement between the resident and the attending staff physician concerned, and requires the attending staff physician to provide the same academic responsibilities and supervision as he/she does on teaching units. Where the trainee is not provided with adequate supervision and/or responsibility for patient care by the attending staff physician, the patient cannot be regarded as a teaching patient. It is Faculty of Medicine policy that duty periods be regulated to provide both adequate patient care and essential patient exposure while also allowing sufficient time for rest as well as specific and general medical reading and other academic activities. As physicians, along with other health professionals, your principal focus is the patient. Patients come from a wide range of cultures, diverse economic and educational backgrounds, as well as extremes in age groups. In addition, they and their families come to us often under a great deal of stress and vulnerability. It behoves us all to present ourselves as professionals who are sensitive and responsive to our patient's expectations regarding appropriate identification, apparel, et cetera while on active duty. In addition to formal unscheduled teaching from attending staff physicians, the attendance and participation of all staff physicians in academic half days or formal teaching sessions occur as teaching rounds. The University claims sole right in, and responsibility for, the selection of residents for the Dalhousie Integrated Training Programs. Residents are subject to the regulations of the hospital in which they train and this applies as well to resignation, suspension, termination and dismissal procedures. The University has the right to suspend or dismiss a resident whose academic performance does not meet accepted standards. See Regulations Relating to Suspension from Postgraduate Study of Medicine.

University Storm Closures

When the University is closed, the Tupper Medical Building, Tupper Link and the Clinical Research Centre are closed, along with other buildings on the Dalhousie campus. Therefore, all offices (**except for those considered to be essential services***) are closed and classes located at Dalhousie are cancelled. This policy includes classes normally held anywhere on campus at Dalhousie University and applies to undergraduate medical and graduate students in the Faculty of Medicine.

*As per the University's policy on class/examination cancellation or curtailment of other University activities or services due to adverse conditions, **occupations designated as essential in the Faculty of Medicine are faculty/staff in clinical areas and designated Animal Care staff.**

Clinical clerks and residents are expected to carry out their clinical learning responsibilities as usual and are asked to make every reasonable effort to report to the hospitals or other teaching sites outside the Dalhousie campus. If the weather is severe, it's a good idea to check with your program director or faculty member.

Resident Supervision

The University will require all residents who are engaged in studies and supervised patient care to subject themselves to and comply with the bylaws, rules, regulations and policies set down by each teaching hospital. All services at all times have coverage available provided by the medical faculty. Graded responsibility is an important concept in postgraduate medical education. This ensures that as residents progress throughout their program they will take advantage of educational opportunities, being at all times supervised. This is always the responsibility of the faculty member to ensure that adequate supervision is provided. Specific policies that apply to resident supervision will vary in different departments and each department is responsible for developing their own guidelines.

Policy for Transfers from One Program to Another within Dalhousie

Feb 02/Rev. Feb 2011

Principles

1. Residents must first meet with the Associate Dean of Postgraduate Medicine before beginning the process of requesting a transfer.
2. Resident must have a valid and substantive reason for switching programs. Normally, such a process would take place after an appropriate exposure to the discipline.
3. The training programs are given allocations determined by physician resource needs. No program should train residents beyond these needs. Physician resource needs will be considered before allowing any transfer.
4. Confidentiality should be maintained as far as possible.
5. No program will be required to accept a postgraduate trainee who does not meet the programs' admission criteria or for whom adequate training resources are not available.
6. Funds for postgraduate training will follow the resident.
7. Negative impacts on programs resulting from transfers should be minimized. This may require compensatory transfers of entry positions in subsequent years.
8. The donor program should be given 3 months' notice of a trainee leaving its program.

Mechanism of Transfer

- a) All residents will be notified of the availability of this policy at orientation as well as the proper procedures for carrying it out.
- b) Residents initially must first apply in confidentiality to the Postgraduate Office with a request to switch to a specific program within this university.
- c) The appropriate Program Director is then notified regarding any requests of a resident to transfer into that program.
- d) A formal application process will then be undertaken. The potential recipient Residency Program Committee(s) shall proceed with an appropriate process to determine the resident's acceptability, which will normally be completed within 30 days of the notification of the program director(s) of the transfer request by the resident.
- e) Evaluations from the program in which the resident currently has a position, should be made available to the program to which the resident is applying. Consideration should be given to the possibility of references being supplied. All possible mechanisms should be entertained to maintain confidentiality. However, this must be balanced against the need of the accepting program to have good recent information on the candidate.
- f) Applicants through this procedure will have to meet all of the criteria that the program normally sets out. There is no obligation to accept the resident.
- g) If the resident is fully acceptable and meets all of the criteria laid out by the accepting program, it is then up to the Program Directors of each discipline concerned as to whether a position will be offered. If no vacancy exists in the program to which the resident is transferring, adequate funding from the donating program to cover the rest of the resident's training must transfer to the receiving program.
- h) If additional negotiations are required between the program directors of the donating and recipient programs regarding possible compensation or exchange of entry positions, these must be completed and agreed too before the transfer is completed. The program directors may utilize the Associate Dean, PGME to facilitate such discussion and resolution.
- i) The Postgraduate Office will then be notified of the program decision. Sufficient time should be allocated to allow for future planning of CaRMS positions and will not interfere with the CaRMS interview process.
- j) The donor program should be given three months notice of a resident's departure to join a new program.

Listed below is the required documentation for a resident transfer:

1. A resident seeking a transfer must provide to his/her current program a letter requesting release from the program and the date of release.
2. In addition, the resident will need to provide to his/her current program a copy of the letter of offer to his/her new training program, with the official start date noted.
3. The current program must provide a written letter release for their trainee with the finalized end date that has been agreed to by all parties.

4. The Dalhousie Postgraduate Medical Education office requires 3 weeks to process a transfer from the final date that copies of all required documentation regarding the transfer has been received.

Guidelines for Transfers from One Program to Another Interprovincial

Overview

Dec 2010

Inter-provincial resident transfers occur infrequently for a variety of reasons. The institution of an Inter-provincial PGME Transfer Guideline will provide a transparent mechanism for both the resident and Universities involved.

Purpose

The Inter-provincial Transfer Guideline will outline the step by step process required of residents to facilitate such transfers, allowing for minimal impact to training programs and relative administrative ease for the universities involved.

Scope

Residents who are currently enrolled in PGME training in Canada (subject to criteria for provincial jurisdiction and the RECEIVING University).

Guideline

Prior to engaging in discussion regarding a transfer, it is the responsibility of the resident to review and follow the admission criteria for the RECEIVING university(s).

Principle

The following are basic principles that all PGME offices adhere to in regards to resident transfers.

- Transfers should not subvert the CaRMS match, and consideration will not be given until after 6 months or after acceptable exposure to the resident's home program.
- Discussions regarding transfer will remain confidential until such time as the resident consents to disclosure.
- Provincial government funding is not transferrable between provinces.
- The local school's guideline/guidelines take precedent over the national guidelines.
- Residents have the ability to access positions in the second iteration of CARMS, with the exception of Quebec
- It is the Residents responsibility to clear any Return of service commitments with the provincial Ministry of Health, with the exception of Quebec.

Process

1. A resident who is interested in pursuing a transfer to another Canadian University should make an informal inquiry to the PGME office of the RECEIVING school to register their interest in transferring. The RECEIVING PGME office will review request and determine whether capacity and funding is available. If consideration is possible, then the RECEIVING PGME office will further provide the resident with program contact information so further pursuit can be established. The RECEIVING PGME office will also advise interested candidates if there is no program available. The PGME office of the Resident's CURRENT school will be copied on the email for either of the above situations.
2. If there is agreement by the RECEIVING program to consider the candidate, then this would be done through the program selection process.

3. If the resident is accepted into the program, the PGME, in consultation with the program, will issue a conditional offer contingent on the release from their current program. The letter of offer will be provided to the CURRENT program.
4. Should the resident decide to accept, s/he are expected to follow any additional internal steps required by their CURRENT PGME office.
5. The resident must write a request for release from his/her CURRENT Program Director and arrive at a mutually acceptable departure date.
6. The CURRENT PGME office in consultation with the home program will provide a written release, including the agreed to transfer date. This will be accompanied by the letter from the CURRENT PGME office agreeing to the release, and verifying all training dates. All this documentation will be provided via the CURRENT PGME office to the RECEIVING PGME office.

Documentation required for Residents who are transferring to another University:

1. A resident seeking a transfer must provide to his/her current program a letter requesting release from the program and the date of release.
2. In addition, the resident will need to provide to his/her current program a copy of the letter of offer to his/her new training program, with the official start date noted.
3. The current program must provide a written letter release for their trainee with the finalized end date that has been agreed to by all parties.
4. The Dalhousie Postgraduate Medical Education office requires 3 weeks to process a transfer from the final date that copies of all required documentation regarding the transfer has been received.
5. Dalhousie PGME Office will provide the receiving PGME office with a letter confirming the trainee's release from the university as well as an overview of all training dates, including leaves of absences, for the period of residency training at Dalhousie.

PGY1 VACATION REQUEST FORM

Rev. Feb 2007

This form is to serve as the PGY1 Vacation Request Form. **NOTE: Residents are responsible for ensuring forms have been signed and processed.**

Please note that your home program director has final approval of vacation requests. You are also required to obtain signatures from the appropriate services you are assigned to. Your program director will be the final signature, as s/he will require proof that you have been released from your service for the time specified below.

Residents are entitled to 28 days of vacation (the 28 days comprising five (5) working days and either the weekend before or the weekend after from 5:00 p.m. on Friday to 8:00 a.m. on Monday) during each complete academic year.

- A maximum of seven (7) vacation days can be taken per 28-day rotation block.
- There is no service that is exempt from permitting vacation.

All vacation/conference requests should be made a minimum of 3 months in advance. Services cannot guarantee requests received with less than 3 months notice. As well, decisions regarding approval by services for vacation requests should be given to the applicant within 2 weeks of the date of submission.

It is the resident's responsibility to ensure that the appropriate supervisors sign the vacation request form before submitting to the Home Program Director or designate.

A copy of the approved Vacation/Conference form must be sent to your Residency Program Manager.

Vacation cannot be included as part of the Christmas break. Do not assume that you will have weekends off at both the start and end of your scheduled time-off. However, you will be guaranteed one weekend off, either before or after a minimum of 5 consecutive vacation days. Therefore, all requests for 5 consecutive days vacation (eg. Monday to Friday) will count as 7 days vacation (or 14 days, for 10 days vacation). Vacation cannot be taken during remedial training.

Although every attempt will be made to accommodate your request, it may not be always possible to do so.

Resident: _____ Program: _____

Service assigned to: _____ Location: _____

Duration of request: FROM _____ TO _____

Date request submitted: _____ Date Approved: _____

First Signature: Service
(See attached list): _____

Date submitted to Home Program: _____ Date Approved: _____

Second Signature: Home Program Director:

Copies should be retained by all those who sign for record keeping purposes.



RESIDENT VACATION/CONFERENCE REQUEST FORM

This form is to serve as the **(program name)** Vacation Request Form.

Please note that your home program director has final approval of vacation requests for rotations outside of your home program. You are also required to obtain signatures from the appropriate services you are assigned to. Your program director will be the final signature, as s/he will require proof that you have been released from your service for the time specified below.

Residents are entitled to 28 days of vacation (the 28 days comprising five (5) working days and either the weekend before or the weekend after from 5:00 p.m. on Friday to 8:00 a.m. on Monday) during each complete academic year.

A maximum of seven (7) vacation days can be taken per 28-day rotation block.

Your program should provide you with a list of rotations that are considered exempt from permitting vacation.

All vacation/conference requests should be made a minimum of 3 months in advance. Services cannot guarantee requests received with less than 3 months notice. As well, decisions regarding approval by services for vacation requests should be given to the applicant within 2 weeks of the date of submission.

It is the resident's responsibility to ensure that the appropriate supervisors sign the vacation request form before submitting to the Home Program Director or designate.

A copy of the approved Vacation/Conference form must be sent to your Residency Program Manager.

Vacation cannot be included as part of the Christmas break. Do not assume that you will have weekends off at both the start and end of your scheduled time-off. However, you will be guaranteed one weekend off, either before or after a minimum of 5 consecutive vacation days. Therefore, all requests for 5 consecutive days vacation (eg. Monday to Friday) will count as 7 days vacation (or 14 days, for 10 days vacation). Vacation cannot be taken during remedial training.

Although every attempt will be made to accommodate your request, it may not be always possible to do so.

Resident: _____ Program: _____

Service assigned to: _____ Location: _____

Duration of request: FROM _____ TO _____

Date request submitted: _____ Date Approved: _____

Signature Service (See attached list): _____

Date submitted to Home Program: _____ Date Approved: _____

Signature Home Program Director: _____

Copies should be retained by all those who sign for record keeping purposes.

Guidelines for Considering a Waiver of Training Following a Leave of Absence (Rev. May 2009)

The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada expect all residents to successfully complete all aspects of their training program, including the length of training. Leaves of absence (LOA) are encountered during residency training (due to illness, parental leave, personal reasons etc) and result in a change in the end date of training equal to the amount of time for the LOA. The required training time missed will ordinarily be made up by the resident with equivalent time upon return to training. In some circumstances a reduction in training time (waiver of training) may be permitted upon approval from the Residency Training Committee (RTC) and the Associate Dean, PGME. Each program will determine whether to permit waivers of training and the criteria the RTC will use to grant such requests. Such waivers are not permitted for voluntary LOAs or extended training due to failed rotations, and will be considered only for residents whose performance demonstrates that all competencies set out by the respective college have been met.

Guidelines:

1. A reduction of training time can be considered only in the final year of training for RC programs, and the last 6 months for Family Medicine programs. RTCs need to be able to evaluate each resident's competency before considering such requests. It is not possible to do this at the time of the LOA.
2. The maximum time to be considered for reduction is set out by the RCPSC (for specialty residents) and the CFPC (for Family Medicine residents).

RCPSC, CFPC and CMQ Maximum Allowable Times for Waivers	
Length of Program	Maximum Allowable Waive Time
One year program	No waiver allowed
Less than one year for remediation or enhanced skills	No waiver allowed
2 year program (excluding Family Medicine)	Up to 6 Weeks
2 year program (i.e. Family Medicine)	Up to 4 Weeks
3 year program	Up to 6 Weeks
4 year program	Up to 3 Months
5 year program	Up to 3 Months
6 year program	Up to 3 Months
For residents taking subspecialty training (Internal Medicine and Pediatrics), up to six weeks is allowable during PGY3 for core training and up to six weeks is allowable for subspecialty training in the final year of training. The Postgraduate Dean where the core training took place must approve the waiver request for the core training.	

3. A reduction in training time should be based on resident's performance and competency. *The resident's ITERs and other evaluations must reflect that all competencies set out by the credentialing authority (Royal College or College of Family Physicians) have been met. Each program allowing such waivers will define how such competency is demonstrated.*
4. The request for a reduction of training time should come from the resident in writing to the RTC prior to the start of their final year of training. Granting a waiver is not automatic, and the RTC will make a recommendation to the Associate Dean, PGME using the attached form. The recommendation must be approved by the Associate Dean, PGME and will be communicated by the PGME Office to the respective national body (RCPSC or College of Family Physicians of Canada). A decision not to grant a waiver of training cannot be appealed.
5. Reduction of training time will not be granted for any period of leave taken after the final certifying examinations.

The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, and the College des medecins du Quebec joint policy on "**Waiver of Training after a Leave of Absence from Residency**" can be found in the Royal College Policies and Procedures for Certification and Fellowship, Section IV, 4.3.2, on the Royal College web site at: <http://rcpsc.medical.org/publications/index.php>

Application for Waiver of Training Following a Leave of Absence from Residency (Rev. May 2009)

Name of Resident: _____

Residency Program: _____

Start Date of resident in the program: _____

Anticipated completion date for resident (in the absence of waiver of training): _____

Current year (PGY level) of resident in the program: _____

Dates of Leave: Date commencing leave: _____
 Date of return to service: _____
 Total duration of leave (months): _____

Reason for Leave: _____

Has this resident ever failed a rotation (yes/no): _____

Has this resident ever required a period of remediation or probation (yes/no): _____

Date of certification exam: _____

I, (program director) _____, on behalf of the Residency Training Committee, consider this resident to have successfully completed all competencies set out by the Royal College/ College of Family Physicians of Canada and recommend that ____ (months or weeks) of her/his residency training be waived.

New program proposed end-date: _____

Date: _____

Program Director signature: _____

Postgraduate Dean's signature: _____

Please include a brief summary of the information on which you have based this recommendation (eg. ITERs, national in-training examinations, OSCE's, peer assessments, abstracts, publications etc.). Your summary should describe the resident's performance based on the CanMEDS/Four Principles of Family Medicine criteria. You may include copies of any relevant documents. Please also provide any other information that you feel makes this resident's application for waiver of training satisfy the requirement of competency.

Please return form to: Postgraduate Medical Education Office, Fax: 494-3644



APPENDIX 29: Faculty Bios

B. Lynn Johnston, MD, FRCPC
Division Head

A native of Prince Edward Island, Dr. Johnston received her medical degree from Dalhousie University. This was followed by a rotating internship in Edmonton and residency in Internal Medicine at Dalhousie University. She completed a fellowship in Infectious Disease at the University of California, Los Angeles and did a year of Hospital Epidemiology at the University of Virginia. More recently, she completed the course work for an MSc in Epidemiology from the Faculty of Public Health Sciences at the University of Toronto.

Current appointments include active staff physician and Hospital Epidemiologist at the Queen Elizabeth II Health Sciences Centre, Division Head, Infectious Diseases and Professor of Medicine, Dalhousie University. She holds a cross-appointment to the Department of Community Health and Epidemiology. Dr. Johnston is chair of the Steering Committee on Infection Control Guidelines (Health Canada) and a founding member of the Canadian Hospital Epidemiology Committee that, with Health Canada, operates the Canadian Nosocomial Infection Surveillance Program. She is Chair of the Specialty Committee in Infectious Diseases, Royal College of Physicians and Surgeons of Canada.

Her research interests include the epidemiology of hospital-acquired infections, including those due to antimicrobial resistant bacteria. She is co-investigator on a number of clinical trials involving HIV and / or HCV infected patients.

Public Health Agency of Canada (PHAC)
<http://www.phac-aspc.gc.ca/>

Association of Medical Microbiology and Infectious Disease Canada (AMMI)
<http://www.ammi.ca/index.php>

Dr. Ian Davis

Ross J. Davidson, PhD

Dr. Davidson holds an academic appointment (Assistant Professor) at Dalhousie University in the Department of Microbiology & Immunology and is cross-appointed in the Departments of Medicine, Division of Infectious Diseases, and Pathology. Dr. Davidson completed his undergraduate (Microbiology) and graduate Medical Microbiology degrees at the University of Manitoba. He completed his fellowship training in Clinical Microbiology at the University of Toronto and Mount Sinai Hospital. In 1998, Dr. Davidson assumed the roles of Associate Director, Division of Microbiology and Director of the Molecular Epidemiology laboratory at the

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Queen Elizabeth II Health Sciences. Dr. Davidson's research interests are focused on the molecular mechanisms of action and resistance in antibiotics used in the management of respiratory tract infections, primarily the macrolide and fluoroquinolone classes. Dr. Davidson also has an interest in the epidemiology and surveillance of antibiotic resistant pathogens.

Kevin R. Forward, MD, FRCPC
Service Chief, Microbiology

Professor, Departments of Pathology, Medicine, and Microbiology and Immunology, Dalhousie University; Service Chief, Division of Microbiology, QEII Health Sciences Centre. Dr. Forward is an infectious disease physician and medical microbiologist. He received his MD and completed an Internal Medicine residency at Memorial University. After this, he did a subspecialty residency in Infectious Diseases at the University of Manitoba and Medical Microbiology at the University of Toronto. Dr. Forward has served on the executives of the Canadian Association of Medical Microbiologists and the Canadian Coordinating Committee for Antimicrobial Resistance. He is past president of the Canadian Infectious Disease Society and past chair of the National Specialty Committee for Medical Microbiology. His research interests relate primarily to antimicrobial resistance and to the optimized use of the Clinical Microbiology laboratory.

Rafael Garduno, PhD

Dr. Garduno earned his Ph.D. in Microbiology from the University of Victoria, British Columbia. He pursued postdoctoral work at the University of Victoria, South Dakota State University, and (as a Killam Postdoctoral Fellow) Dalhousie University. Dr. Garduno is now Associate Professor, with a recent appointment to a Tier II Canada Research Chair, in the Departments of Microbiology & Immunology, and Medicine - Division of Infectious Diseases.

David A. Haase, MBBS, FRCPC

A Jamaican by birth, Dr. Haase is a graduate of the University of the West Indies. Following a rotating internship in Jamaica, he completed an Internal Medicine Residency at Dalhousie University and an Infectious Diseases Fellowship at the University of Manitoba, Winnipeg. He has taken correspondence courses in medical education from the University of Dundee in Scotland.

Current appointments include Professor, Department of Medicine. He was named Atlantic Regional Director of the Canadian Trials Network (CTN) for HIV research in 2003. He is a member of the active staff at the Queen Elizabeth II Health Sciences Centre and Director of the STD Clinic.

Dr. Haase has been involved in many research studies as Principal Investigator and Co-Investigator. These have included studies in treatment of urinary tract infections, febrile

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neutropenia, genital herpes, HIV infection and infections in patients with cystic fibrosis. He has also been involved in HSV vaccine studies.

David J. M. Haldane, MB, FRCPC
Medical Director, Public Health Laboratory

Associate Professor, Dept of Pathology and Microbiology and Immunology; Assistant Professor of Medicine; Director of Bacteriology and Special Pathogens, Division of Microbiology, QEII Health Sciences Centre. Dr Haldane earned his MBChB at the University of Dundee, Scotland, in 1980. He completed his residency in Medical Microbiology at the University of British Columbia. Dr. Haldane has participated on numerous Federal/Provincial working groups, including those addressing tuberculosis and fungal contamination of buildings. He has served on the Executive of the Canadian Association of Medical Microbiologists and as an Examiner for the Royal College specialty examination for Medical Microbiology. His research interests are in clinical microbiology.

Todd F. Hatchette, MD, FRCPC
Program Director

Dr. Hatchette earned his MD from Memorial University of Newfoundland in 1995. After completion of Internal Medicine training at Memorial University followed by a Fellowship in Infectious Diseases and Medical Microbiology at Dalhousie University, Dr. Hatchette undertook postdoctoral research training in virology at St. Jude Children's Research Hospital in Memphis Tennessee under the supervision of Dr. Robert G. Webster a world authority on influenza A. He is currently the Director of the Virology and Immunology section of the Division of Microbiology, QEII Health Science Center. As the Province's only clinical virologist, Dr. Hatchette has expertise in the clinical and laboratory diagnosis of viral infections and has given CME lectures to various health care professional and serves as an advisor on a number of local and provincial committees. In particular he is involved quite heavily in Pandemic Influenza Planning Committees at the Canadian National level where he is the Provincial a co-chair of the Laboratory Subgroup for the Canadian Pandemic Influenza Planning Committee. He has participated in the development of guidelines including those for the diagnosis of influenza and mumps infection.

Dr. Hatchette's main area of interest is Influenza A. Dr. Hatchette is also a collaborator in the CFI-funded, Canadian Center for Vaccinology, Halifax, (CCVH) and is a member of the PHAC/CIHR Influenza Research Network (PCIRN) where his laboratory provides diagnostic support to the various PCIRN themes. In addition he has research interests in zoonotic diseases such as Q fever and other arthropod related illnesses.

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Jason LeBlanc, PhD

Dr. Jason LeBlanc received his B.S. and M.S. degrees in Biochemistry at the University of Moncton. His early training involved isolation of immunomodulatory peptides from Lactobacillus-fermented milk (probiotics) to prevent pathogenic E. coli 0157:H7 infection. In 2006, he earned his Ph.D. from the Department of Microbiology and Immunology at Dalhousie University, where he studied the molecular mechanisms regulating oxidative stress responses in Legionella pneumophila. After completing his Ph.D., Dr. LeBlanc worked as a technical specialist at the Queen Elizabeth II Health Sciences Centre and then completed a fellowship training program in Clinical Microbiology. He currently holds the position of co-Director of Immunology, Virology, and Molecular Epidemiology in the Division of Microbiology. Dr. LeBlanc is an Assistant Professor in Department of Pathology and is appointed in the Departments of Medicine and Microbiology and Immunology, Faculty of Medicine, Dalhousie University.

Research Interests

Dr. LeBlanc's laboratory uses molecular engineering and structural mimicry to identify peptides capable of inhibiting toxins, such as TcdA and TcdB of Clostridium difficile. With the emergence hypervirulent strains associated with increased severity and high rates of recurrent disease, toxin-neutralizing peptides (peptide antagonists or peptidomimetics) could lead to non-antibiotic based therapies that could alleviate the clinical manifestations of C. difficile infection, without altering the endogenous microflora.

Shelly A. McNeil, MD, FRCPC

Born in Nova Scotia, Dr. McNeil earned her MD from Dalhousie University. She completed Internal Medicine training at Dalhousie, followed by a Fellowship in Infectious Diseases at the University of Michigan School of Medicine.

She is currently Associate Professor, Department of Medicine and Division of Infectious Diseases and active staff physician at the Queen Elizabeth Health Sciences Centre. She is Research Director for the Division of Infectious Diseases. In 2005, she was named a Faculty of Medicine Clinical Research Scholar.

Dr. McNeil's primary research interest lies in the epidemiology, prevention and management of infections.

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Walter F. Schlech, MD, FACP, FRCP

Born in California, Dr. Schlech graduated from Cornell University with his medical degree after two years in the US military as a hospital corpsman, including one year of active duty in Vietnam. He went on to intern and complete his residency at Dartmouth Medical School, then spent two years as a fellow in infectious diseases at Vanderbilt University in Tennessee. He worked two years with the Epidemic Intelligence Service of the Centers for Disease Control in Atlanta, Georgia, carrying out seminal studies of toxic shock syndrome, Legionnaires' disease and listeriosis.

Current appointments include Professor, Department of Medicine and Division of Infectious Diseases. He is a member of active staff at the Queen Elizabeth II Health Sciences Centre.

Dr. Schlech's research in the area of infectious diseases has been widely published in journals including *The Lancet*, the *New England Journal of Medicine*, *AIDS*, and the *Journal of the American Medical Association*. His current research area is prevention and treatment of HIV in Africa.

Kathryn Slayter, BSc Pharm, Pharm D.

Dr. Kathy Slayter is involved in many areas of research. She is the co-primary investigator of a national clinical trial studying pneumococcal conjugate vaccine in HIV-infected individuals and site investigator of a trial assessing the effects of aging on the pharmacokinetics of nelfinavir and M-8 in HIV-1 infected individuals.

Dr. Slayter has recently conducted a clinical pharmacokinetic trial investigating oseltamavir pharmacokinetics in morbid obesity. Of note this was the first trial to be conducted at the Clinical Challenge Unit at the Canadian Centre for Vaccinology.

In addition, Dr. Slayter's research has focused on qualitative research including antimicrobials in acute exacerbations of COPD and time to next exacerbation, pharmacoeconomics of penicillin allergy, appropriate vaccination of splenectomised patients, treatment strategies and responses in hepatitis C patients, barriers to receipt of recommended vaccines among Canadian adults, and management and resources utilization in Canadian patients hospitalized with febrile neutropenia.

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Nikhil Thomas, PhD

Dr. Thomas joined the Division in 2006, coming from the University of British Columbia where he had been a postdoctoral research associate in the laboratory of Dr. Brett Finlay at the Michael Smith Laboratories since 2001. He did his PhD in Microbiology and Immunology at Queen's University. Dr. Thomas has held Michael Smith Foundation for Health Research and NSERC Postdoctoral Associate Awards. He is currently an Assistant Professor with the Department of Medicine and Microbiology and Immunology.

Dr. Thomas' area of research interest is in the molecular mechanisms by which gastrointestinal pathogens mediate intestinal disease.