Diagnostic Radiology Resident Manual

Memorial University

Revised: December 31, 2021

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HOW TO USE THIS MANUAL

This manual is divided into 4 sections for ease of reference:

SECTION 1 – Contains program information regarding Royal College training requirements, MUN Radiology General Program Goals and objectives, organization of the program, Terms of Reference of the Residency Training Committee, and evaluations and appeals processes.

SECTION 2 - Contains Departmental and Eastern Health policies.

SECTION 3 - Contains goals and objectives for the PGY1 year of basic clinical training, as well as rotation specific clinical radiology goals and objectives to be achieved during rotations at various levels of training. These objectives form the basis of rotation evaluations.

All residents should familiarize themselves with the contents of sections 1, and 2. Residents should review appropriate parts in section 3 before each radiology rotation and refer to it throughout each rotation.

All residents should also review the Radiology Resident Research Manual for Research Requirements during Radiology Residency at Memorial University.

SECTION 1

Program Information

DEFINITION OF DIAGNOSTIC IMAGING

Diagnostic Radiology is a branch of medical practice concerned with the use of imaging techniques in the study, diagnosis and treatment of disease.

GOALS

On completion of the educational program, the graduate physician will be competent to function as a consultant in Diagnostic Radiology. This requires the physician to have the ability to supervise, advise on and perform imaging procedures to such a level of competence, and across a broad range of medical practice, as to function as a consultant to referring family physicians and specialists.

Communication skills, knowledge, and technical skills are the three pillars on which a radiological career is built, and all are dependent on the acquisition of an attitude to the practice of medicine which recognizes both the need to establish a habit of continuous learning and a recognition of the importance of promoting a team approach to the provision of imaging services. Residents must demonstrate the knowledge, skills and attitudes relating to gender, culture and ethnicity pertinent to Diagnostic Radiology. In addition, all residents must demonstrate an ability to incorporate gender, culture and ethnic perspectives in research methodology, data presentation and analysis.

SPECIFIC OBJECTIVES

At the completion of training, the resident will have acquired the following competencies and will function effectively as a:

Medical expert/clinical decision-maker

General Requirements:

Demonstrate diagnostic and therapeutic skills for ethical and effective patient care.

Access and apply relevant information to clinical practice so as to have competence in clinical radiological skills.

Demonstrate effective consultation services with respect to patient care, education and legal opinions

Specific Requirements:

Understand the nature of formation of all types of radiological images, including physical and technical aspects, patient positioning, and contrast media.

Knowledge of the theoretical, practical and legal aspects of radiation protection, including other imaging techniques and their possible harmful effects.

Knowledge of human anatomy at all ages, both conventional and multiplanar, with emphasis on radiological applications.

Knowledge of all aspects of clinical radiology, including understanding of disease, appropriate application of imaging to patients, importance of informed consent, complications such as contrast media reactions, and factors affecting interpretation and differential diagnosis.

Understand the fundamentals of quality assurance in radiology.

Understand the fundamentals of epidemiology, biostatistics and decision analysis.

Show competence in manual and procedural skills and in diagnostic and interpretive skills.

Demonstrate the ability to manage the patient independently during a procedure, in close association with a specialist or other physician who has referred the patient. The radiologist should know when the patients' best interests are served by discontinuing a procedure, or referring the patient to another physician.

Understand the acceptable and expected results of investigations and/or interventional therapy as well as unacceptable and unexpected results. This must include knowledge of and ability to manage radiological complications effectively.

Understand the appropriate follow-up care of patients who have received investigations and/or interventional therapy.

Show understanding of a sound and systematic style of reporting.

Competence in effective consultation, conduct of clinical-radiological conferences, and the ability to present scholarly material and lead case discussions.

These objectives are achieved frequently over the 5-year training. Individual rotation objectives are listed in SECTION 3.

Communicator

General Requirements:

Establish appropriate therapeutic relationships with patients/families.

Listen effectively.

Obtain the appropriate information during consultation with referring physicians in order to be able to make recommendations regarding the most appropriate testing and/or management of patients.

Discuss appropriate information with patients/families and the health care team, and be able to obtain informed consent for tests and procedures when this is needed.

Specific Requirements:

Have the ability to produce a radiologic report which will describe the imaging findings, most likely differential diagnoses, and, when indicated, recommend further testing and/or management.

Understand the importance of communication with referring physicians, including an understanding of when the results of an investigation or procedure should be urgently communicated.

Communicate effectively with patients and their families and have a compassionate interest in them.

Recognize the physical and psychological needs of the patient and their families undergoing radiological investigations and/or treatment, including the needs of culture, race and gender.

Collaborator

General Requirements:

Consult effectively with other physicians and health care professionals.

Contribute effectively to other interdisciplinary team activities.

Specific Requirements:

Have the ability to function as a member of a multi-disciplinary healthcare team in the optimal practice of radiology.

The skills of being a collaborator are developed on a day to day basis. Residents are strongly encouraged to interact with house staff and referring physicians as “first contact” in order to better develop these skills. In addition, residents will be required to be active participants in inter and intra discipline rounds.

Manager

General Requirements:

Utilize resources effectively to balance patient care, learning needs, and other activities.

Allocate finite health care resources wisely.

Work effectively and efficiently in a healthcare organization.

Utilize information technology to optimize patient care, life-long learning and other activities.

Specific Requirements:

Be competent in conducting or supervising quality assurance including an understanding of safety issues and economic considerations.

Be competent in computer science as it pertains to the practice of radiology.

These skills are learned on a day to day basis as well as through lectures. These lectures are given by the Department Manager and will teach residents how to run a department in terms of issues of equipment and staffing. In addition, residents will be exposed to situations when equipment is purchased for the department and through this will learn the basics of equipment purchase and tendering. The role of chief resident is another opportunity to develop managerial skills.

Health Advocate

General Requirements:

Identify the important determinants of health affecting patients.

Contribute effectively to improve the health of patients and communities.

Recognize and respond to those issues where advocacy is appropriate.

Specific Requirements:

Understand and communicate the benefits and risks of radiological investigation and treatment including population screening.

Recognize when radiological investigation or treatment would be detrimental to the health of a patient.

Educate and advise on the use and misuse of radiological imaging.

These skills are learned on a day to day basis and are incorporated as in the objectives of

medical experts/decision maker. In addition, community involvement of residents will be encouraged including community education and charity projects.

Scholar

General Requirements:

Develop, implement and monitor a personal continuing education strategy.

Critically appraise sources of medical information.

Facilitate learning of patients, house staff/students and other health professionals.

Contribute to development of new knowledge.

Specific Requirements:

Competence in evaluation of the medical literature.

The ability to be an effective teacher of radiology to medical students, residents, technologists and clinical colleagues.

The ability to conduct a radiology research project, which may include quality assurance.

Appreciation of the important role that basic and clinical research plays in the critical analysis of current scientific developments related to radiology.

The skills of being a medical scholar are learned on a day to day basis under the umbrella of a long term plan. For a resident, this would include seeing as many cases as possible during the days with follow-up reading performed at night. It is recommended that a junior resident be reading at least two hours a night whereas a senior resident should be planning to read approximately four hours per night. It is very important not to fall behind and to understand the personal commitment to radiology and the personal responsibility. Critical appraisal skills will be enhanced through Journal Club but these skills should not, of course, be limited to this. Residents also participate in the TIPS workshop. Residents will be required to present and teach to other residents, medical students and house staff.

Professional

General Requirements:

Deliver highest quality care with integrity, honesty and compassion.

Exhibit appropriate personal and interpersonal professional behaviors.

Practice medicine ethically consistent with the obligations of a physician respecting the needs of culture, race and gender.

Specific Requirements:

Be able to accurately assess one's own performance, strengths and weaknesses.

Understand the ethical and medical-legal requirements of radiologists.

The skills of being a medical professional were first introduced in medical school and are carried through the residency program and beyond. These qualities are developed through day to day activities on a continuing basis and hopefully enhanced through role models.

Please see below the Physician Charter.

TRAINING IN CANADA

The foregoing represents the general and specific objectives that all candidates for the Royal College examinations in Diagnostic Radiology are expected to meet. For those training in Canadian programs, these objectives will be accomplished in a staged manner.

ORGANIZATIONAL OUTLINE OF THE PROGRAM

Interim Academic Chair	Dr. Peter Collingwood, MD, FRCPC
Program Director	Dr. Lisa Smyth, MD, FRCPC, ABR
Assistant Program Director CBD Lead Discipline Lead for Radiology CLSC Advisory Council	Dr. Jennifer Young, MD, FRCPC, ABR
Undergraduate Medical Education Director	Dr. Wesley Chan, MD, FRCPC
Research Director	Dr. Jeff Flemming, MD, FRCPC

RESIDENCY PROGRAM COMMITTEE (RPC)

COMPOSITION OF THE RPC AS OF JULY, 2021
(AS APPOINTED BY THE ACADEMIC CHAIR)

VOTING	
Chairperson: The Program Director	Dr. Lisa Smyth

Assistant Program Director and Competence by Design Lead Appointed by the Academic Chair	Dr. Jennifer Young
Site Residency Coordinators: Voting members of the committee that bring representation and concerns from the major residency training sites.	HSC*: Dr. Wes Chan Dr. Melissa Skanes SCMH*: Dr. Melanie Stenback JW*: Dr. Nicole Hughes
Research Director: Approved by academic chair and program director. Provides guidance, coordinates and supports research with residents, medical students and staff. Also Chair of DIRAD group.	Dr. Jeff Flemming
Nuclear Medicine Coordinator	Dr. Jeff Flemming
Professor and Interim Chair (Ex-officio)	Dr. Peter Collingwood
Administrative Resident: Selected by Program Director in consultation with RPC). Voting member of the committee that brings representation and concerns from residents.	Dr. Melissa Walsh and Dr. Brian O'Meara
Junior Resident Representative: Elected by residents. Voting member of the committee that brings representation and concerns from residents.	Dr. Danielle McNicholas
NONVOTING	
Program Administrator/Recording Secretary/Secretary: The work of the committee is supported by the academic program administrator, program executive assistant and secretary.	Program Administrator: Ms. Jennifer Collins Recording Secretary: Ms. Jennifer Collins Academic Program Assistant: Ms. Michelle Penney

*HSC – Health Science Centre, SCMH – St. Clares Mercy Hospital, JW – Janeway Children's Hospital

GENERAL TERMS OF REFERENCE FOR RESIDENCY PROGRAM COMMITTEES (RPC)

1. Meets approximately every three months throughout the academic year.
2. All major decisions, complaints, and concerns are voiced and discussed.
3. The resident representatives are strongly encouraged to present the residents' concerns to the Program Director prior to the meeting and if not resolved, these concerns are discussed at the next scheduled RPC meeting.
4. Individual residents are also strongly encouraged to present their concerns to the Administrative resident(s) and/or to other residents that may be on the Committee.

5. Initial discussion should take place at each hospital site with the Residency Coordinator.
6. Quorum: 50% plus one of voting members. If quorum is not achieved at the meeting, voting can occur electronically. Chair will vote only in case of a tie vote.

SPECIFIC ROLES AND RESPONSIBILITIES OF THE RADIOLOGY RESIDENCY PROGRAM COMMITTEE (RPC)

1. To develop a clear program plan, using CanMEDs objectives relating to knowledge, skills and attitudes and based upon the standard and specific objectives of training in the specialty training requirements of the Royal College of Physicians and Surgeons of Canada. This plan should also indicate the methods by which the objectives are to be achieved and the role played by each rotation and by each participating institution.
2. Interview and select all new residents to the Radiology program in accordance with policies determined by the faculty postgraduate medical education committee. This occurs through the CaRMS selection sub-committee (see below).
3. To conduct the program, including the rotation of residents to ensure that each resident is advancing and gaining in experience and responsibility in accordance with the educational plan
4. Ensure appropriate promotion of all residents throughout their residency. This occurs through the Promotions sub-committee (see below).
5. Ensure the highest degree of patient care and safety is delivered by radiology residents
6. Administer and oversee oral examinations during the academic year
7. Evaluate, formally and informally; the performance of all residents in the program through a well-organized program of in-training evaluation which will include the final evaluation at the end of the program as required by the College
8. To maintain an appeal mechanism through which the residency program committee should receive and review appeals from residents and, where appropriate, refer the matter to the faculty Postgraduate Medical Studies Committee.
9. Review the program on a regular basis to ensure excellence in radiology training
10. Ensure the appropriate levels of supervision and responsibility are provided to radiology residents
11. Address resident concerns in a timely and efficient manner
12. Ensure the adequate resources are available to residents throughout their training
13. Provide support, career planning, and counselling to all residents, but particularly those residents having difficulty within the program and experiencing psychological stress
14. Provide, through various committees, the highest degree of academic training that can be provided.
15. Foster life-long learning and research activities throughout all levels of training.

16. Confidentiality and professionally administer the program with respects to resident issues.
17. Such other responsibilities which may be considered specific to the individual program

CaRMS SELECTION SUBCOMMITTEE

COMPOSITION OF THE CaRMS SELECTION SUBCOMMITTEE (AS APPOINTED BY THE PROGRAM DIRECTOR)

VOTING	
Chairperson: **Program Director** **SCMH Site Representative**	Dr. Lisa Smyth
Assistant Program Director **Discipline Lead for Radiology CLSC Advisory Council** **CBD Lead** **HSC Site Representative**	Dr. Jennifer Young
Director of Undergraduate Medical Education **HSC Site Representative**	Dr. Wesley Chan
Janeway Site Representative	Dr. Nicole Hughes
Senior Resident Representative Administrative residents	Dr. Brian O'Meara Dr. Melissa Walsh
Junior Resident Representative Junior resident representatives as elected by resident body.	Dr. Danielle McNicholas NYD
NONVOTING	
Administrative Staff	Academic Program Administrator Ms. Jennifer Collins Academic Program Assistant Ms. Michelle Penney

TERMS OF REFERENCE OF THE CaRMS SELECTION SUBCOMMITTEE

1. To select the best possible applicants for the Memorial University Radiology Residency Program.
2. To ensure that applicants to the Memorial University Radiology Residency program are ranked according to objective criteria.
3. To ensure that the selection process is fair, unbiased and equitable to all applicants.
4. To abide scrupulously by the Charter of Rights and Freedoms and Human Rights Legislation, and all rules and regulations set by the PGME office and the CaRMS.
5. Quorum: 50% plus one of voting members. If quorum is not achieved at the meeting, voting can occur electronically. Chair will vote only in case of a tie vote.

6. The CaRMS Selection Subcommittee reports to the Discipline of Radiology Residency Program Committee.
7. The Committee develops and revises standardized forms for the file assessment and the interview process for the CaRMS applicants and for transfer applicants.
8. The CaRMS Selection Subcommittee meets once in the fall of the year to solidify membership, to plan the upcoming file review, and to prepare for the interview process. 2-3 meetings will then occur in January -February prior to file review to discuss details of the process and timelines. A subsequent meeting will occur after file review is complete, prior to the interview process to discuss any outstanding issues and plan the details of the interview process. A final, usually lengthy, meeting will occur after the interview process is complete to review and submit the final rank order list.

SUMMARY OF SELECTION PROCESS

1. CaRMS application files are assessed by at least 2 independent voting members of the CaRMS Selection Subcommittee. This is typically a faculty member and resident, and is done by using the standardized forms, which creates a ranking from 1-10 based solely on the written application. This average accounts for 25% of the applicants final score.
2. Interviews are conducted by voting members of the CaRMS Selection Subcommittee using the standardized interview forms and agreed upon questions. These can be done in person, virtually, or under extenuating circumstances, the telephone. All applicants are interviewed by the same panel of people, usually through 3 independent interviews. Applicants are rated on a scale of 1-10 based on their suitability for Memorial University's Radiology Residency program. This average accounts for 75% of the applicants final score.
3. Reviewers are invited to flag any file or interview for further review by the Selection Subcommittee due to unusual or exceptional circumstances noted in the file or to uncertainty regarding scoring.
4. Rank order list is produced based on the application and interview scores. This is then reviewed with the entire Selection Subcommittee. Any issues or concerns with this order are discussed. After consideration of multiple factors, the Committee makes a decision to either a - leave the applicant scored as is, b - recalculate the overall score and position in the rank order list, or c - not rank the applicant based on the overall assessment of the file. Once the list is complete, a vote occurs to accept and finalize this list and the list is submitted to the CaRMS. Should this vote not pass, we return to the initial list and review each applicant again with the entire Selection Subcommittee.

COMPETENCE AND PROMOTIONS SUBCOMMITTEE (CPC)

COMPOSITION OF THE COMPETENCE AND PROMOTIONS SUBCOMMITTEE 2021-2023 (AS APPOINTED BY THE PROGRAM DIRECTOR AND ACADEMIC CHAIR)

VOTING	
Chairperson	Dr. Jennifer Young
Competence by Design Lead	Dr. Jennifer Young
External Representative	Dr. Dawn Armstrong
Janeway Site Representative	Dr. Stephanie Jackman
Health Science Site Representative	Dr. Maureen Hogan
St. Clares Site Representative	Dr. Connie Hapgood
Nuclear Medicine Representative	Dr. Mathew Kuruvilla
NONVOTING	
Program Director	Dr. Lisa Smyth
Administrative Staff	Academic Program Administrator Ms. Jennifer Collins Academic Program Assistant Ms. Michelle Penney

MEMBERSHIP

The Competence and Promotions Committee (CPC) will be comprised of the following members:

- Competence by Design Lead (Voting)
- Program Director (Non-voting)
- Site Representatives (Voting)

One member from each of the following training sites:

- HSC, Janeway, St. Clare's, Nuclear Medicine and External Administrative (Non-voting)

The CPC Chair will be selected by vote, amongst all voting members. Members not eligible for this role include: The Program Director and External Site Representative. This position is a two-year term with the option of multiple renewable terms.

Site Representatives will be appointed by the CPC Chair and/or the Program Director to ensure a broad range of subspecialty expertise and resident educational involvements. The CPC members must be able to interpret multiple sources of qualitative and quantitative observation data to achieve consensus, where possible, in order to make judgments on outcomes.

Term:

Each Site Representative will serve a 2 year-term with the option to renew for subsequent terms.

The CBD lead, Program Director and Academic Chair will serve throughout the entirety of their respective appointments.

Training:

Each member must complete training in Unconscious Bias.

Meetings:

The Competence and Promotions Committee will meet at minimum four times per year, at an approximate quarterly interval. Additional meetings may be required to meet the needs of the Radiology Residency Program Committee. A CBD resident's portfolio must be reviewed within one month prior to promotion to the next stage of training.

SPECIFIC ROLES OF THE COMPETENCE AND PROMOTIONS COMMITTEE

The Competence and Promotions Committee is a sub-committee of the Residency Program Committee responsible for ensuring the regular, systematic and transparent review of every Radiology Resident's progression towards achieving competence and completion of the educational requirements of the Royal College of Canada in Diagnostic Radiology. The purpose is to ensure residents who complete the Diagnostic Imaging Program have the skills, knowledge and attitude to provide competent and safe patient care.

MANDATE

To provide an informed group discussion to collate feedback, performance and assessment markers to establish a global picture of a resident's progression towards competence. The committee is responsible for reviewing and discussing each resident's educational portfolio in order to:

- Advise/guide resident learning and growth
- Modify a resident's learning plan
- Make decisions on a learner's achievement of Entrustable Professional Activities (EPAs)[1]
- Recommend learner status changes to the Residency Program Committee
- Provide the resident with a written summary of the review

Once every resident in the Standard Diagnostic Radiology Royal College Stream (Pre-Competence by Design) has completed residency, the Competence and Promotions Committee (CPC) will transition to "Competence Committee" and will be mandated under the current Terms of Reference.

SPECIFIC RESPONSIBILITIES OF THE COMPETENCE AND PROMOTIONS COMMITTEE

The Competence and Promotions Committee reports to the Residency Program Committee (RPC) via the Program Director or CPC Chair and will be responsible for:

1. Monitoring and making decisions on the progress of each Radiology Resident in demonstrating achievement of the EPAs or independent milestones within each stage of a competency-based residency training program.
2. Collate the results from multiple assessments markers and observations, including but not limited to: Daily Assessment Cards, On-Call Cards, ITERS, end of rotation exams, oral exams, OSCE exams, ACR exam, teaching feedback, interdisciplinary feedback. The CPC will make recommendations to the RPC related to:
   - The promotion of residents to the next stage of training
   - The review and approval of individual learning plans developed to address areas for improvement
   - Determining readiness to challenge the Royal College examinations
   - Determining readiness to enter independent practice on completion of the transition to practice stage or PGY 5 year
   - Determining that a trainee is failing to progress within the prograM
   - Monitoring the outcome of any learning or improvement plan established for an individual resident.

GUIDING PRINCIPLES OF THE COMPETENCE AND PROMOTIONS COMMITTEE:

The roles, responsibilities and activities of the CPC will be guided by the following principles:

1. The committee will be guided by the program specific documents from the Royal College of Canada in the specialty of Diagnostic Radiology as well as relevant Memorial University/RPC documents and policies.
2. Maintaining confidentiality and promoting trust by sharing information only with individuals directly involved in the development or implementation of learning or improvement plans.
3. Committee decisions must be based on all documented formative and summative evaluations in the trainee's file (paper and electronic). Individual committee member experience can only be introduced with appropriate documentation in the resident's evaluation portfolio.
4. Decisions on the achievement of EPAs and individual milestones as well as readiness to progress between stages must be documented.
5. Individual trainees may be invited to discuss their own progress with the members of the Competence Committee, should an appeal process be formally made to the Program Director.
6. All committee decisions must be timely in order to ensure fairness and appropriate sequencing of training experiences. Decisions for remediation, a modified learning plan, suspension, or dismissal must be made in writing to the resident within 30 days of decision.
7. All committee decisions are to be made in a spirit of supporting each trainee in achieving their own individual progression of competence.

PROMOTIONS AND COMPETENCE COMMITTEE POLICIES AND PROCEDURES

1. **Agenda Development**: Trainees are selected for a planned Competence Committee meeting by the CPC Chair and/or the Program Director. This must occur in advance of the Committee meeting to provide applicable reviewers (See below) adequate time to prepare for the meeting.
2. **Frequency**: Every trainee in the program must be discussed a minimum of twice per year. However, greater frequency may be required for residents where an area of concern has been raised or to allow for promotion to a subsequent stage.
3. **Quorum**: There should be at least 50% attendance from the voting members of the CPC to achieve quorum.
4. **Selection**: Trainees may be selected for Competence Committee review based on any one of the following criteria:
    a. Regularly timed review
    b. A concern has been flagged by the PD or RPC
    c. Completion of stage requirements and eligible for promotion or completion of training
    d. Requirement to determine readiness for the Royal College exam
    e. Apparent significant delay in the trainee's progress or academic performance
5. **PD Review**: Each trainee will be reviewed by the PD every six months. A detailed review of the resident's academic progress will be documented electronically in the form of a Resident Report Card and supporting Resident Meeting Form Document. The Resident Report Card includes longitudinal documentation of Oral Exams, OSCE exams, End of Rotation Exams, ACR exams and Absenteeism.
6. **Secondary Review**: Each CPC Member will be responsible for an in-depth review of one to two residents per meeting. Prior to the CPC meeting, reviewers will be granted access to the resident's electronic portfolio as well as secured access to the Longitudinal Resident Report Card and additional supporting documentation since the resident's last CPC review which may include but not limited to: ITERS, Daily Card Summary, On-Call card Summary, Teaching feedback, Interdisciplinary Feedback, Professionalism Feedback or written feedback. The secondary reviewer should collate the trainee's assessment markers and observational feedback to identify patterns in performance based upon the provided documentation and provide a verbal summary and recommended "Learner Status" to the CPC.
7. **Committee Procedures:**
    a. The Chair welcomes members and orients all present to the agenda and the decisions to be made.
    b. The Chair reminds members regarding the confidentiality of the proceedings.
    c. Each Trainee is considered in turn with the CPC reviewer presenting their summary, sharing/displaying any relevant reports, assessment markers and/or written feedback relevant to resident progression. Each summary should include a recommended "Learner Status" for the trainee going forward in the program (Table 1).
    d. All members are invited to discuss the proposed recommendation for the trainee. Should the recommendation of a trainee's learner status fall in the "Not Progressing as Expected" or "Failure to Progress" Categories, a more detailed

discussion including recommendations to modify the learning plan or formal remediation should be discussed.

e. The Chair will call a vote for the proposed recommendation for the trainee. A majority of voting members (>50%) are required to support a proposed motion.
f. Decisions can be deferred should the committee require additional documentation. If a deferral is required, all deferrals must be discussed at the next CPC meeting.
g. A summary of the discussion and recommendations will be documented on the CPC Resident Review Form and will be forwarded to the RPC.

8. Post Competence Committee meeting: A formal letter summarizing the discussion of the CPC meeting will be provided to each trainee following approval by the RPC. The resident can discuss the decisions and recommendations of the CPC committee with the PD or CPC Chair.
9. Appeal Process: A trainee may appeal the decision of the Competence Committee according to Memorial University PGME appeals guidelines:

https://www.med.mun.ca/Medicine/Policy/Policies-and-Procedures/Postgraduate-Medical-Education-en.aspx

RESIDENT LEARNER STATUS AND ACTION PLAN

Learner Status	Learner - Resident Action	PG Dean approval / awareness
Progressing As Expected	Monitor Learner - Resident	Not required
	Modify Learning Plan – Suggested Focus on EPA/IM observations or RTE	Not required
	Promote Learner - Resident – to Stage 2	Not required
	Promote Learner - Resident – to Stage 3	Not required
	Promote Learner - Resident – RC Exam Eligible*	Awareness
	Promote Learner - Resident – to Stage 4	Not required
	Promote Learner - Resident – RC Certification Eligible	Required*
Not Progressing As Expected	Modify Learning Plan – Additional Focus on EPA/IM observations or RTE	Not required
	Formal Remediation	Required
Progress Is Accelerated	Modify Learning Plan – Modify required EPA/IM observations or RTE	Awareness
	Promote Learner - Resident – to Stage 2	Awareness
	Promote Learner - Resident – to Stage 3	Awareness
	Promote Learner - Resident – RC Exam Eligible	Awareness
	Promote Learner - Resident – to Stage 4	Awareness
	Promote Learner - Resident – RC Certification Eligible	Required*
Failure to Progress	Modify Learning Plan – Additional Focus on EPA/IM observations or RTE	Awareness
	Formal Remediation	Required
	Withdraw Training	Required
Inactive	Monitor Learner - Resident (i.e. expected return - parental leave, sick leave, etc.)	Required
	Withdraw Training	Required

https://www.royalcollege.ca/rcsite/cbd/assessment/committees/competence-committees-status-recommendations-e

REPORTING OF THE COMPETENCE AND PROMOTIONS COMMITTEE

The Competence and Promotions committee will provide the RPC with a written summary report which, following the review of each resident on the CPC Resident Review Form, documenting assessment markers, discussions, outcomes and recommendations. This summary document can be used by the RPC for discussion and validation. A formal letter summarizing the CPC discussion and recommendations will be issued to each resident following RPC approval.

WELLNESS AND RESILIENCY SUBCOMMITTEE

COMPOSITION OF THE WELLNESS AND RESILIENCY SUBCOMMITTEE COMMITTEE 2021-2023 (AS ELECTED BY THE RESIDENT BODY)

VOTING	
Chairperson	Dr. Lisa Smyth
Competence by Design Lead	Dr. Jennifer Young
Faculty Wellness Lead	Dr. Scott Harris
Senior Resident Wellness Lead	Dr. Mellisa Walsh
Junior Resident Wellness Lead	Dr. Danielle McNicholas
St. Clares Site Representative	Dr. Connie Hapgood
Administrative Staff	Academic Program Administrator Ms. Jennifer Collins Academic Program Assistant Ms. Michelle Penney

GENERAL RESPONSIBILITIES OF THE WELLNESS AND RESILIENCY COMMITTEE

Recognizing the mental health and wellness of our learners, staff and faculty is of paramount importance to the success of the Faculty of Medicine, the Discipline of Radiology has established a Resident Wellness and Resiliency Lead to undertake initiatives to assist residents in addressing issues of work/study life balance, stress management and career planning.

This resident will help guide fellow residents/colleagues in fostering a culture of respect and wellness, as well as collaborate with the Residency Program Committee to maintain focus on overall resident well-being.

SPECIFIC RESPONSIBILITIES OF THE WELLNESS SUBCOMMITTEE

The elected Radiology Resident Wellness Lead (2 year term) must:

- be a resident currently enrolled at Memorial University
- have an interest in resident wellness and education
- be approachable and committed to confidentiality

- preferably not be the chief resident

The Faculty Wellness Lead (3 year term) must:

- Hold a primary clinical or academic appointment in the Department of Diagnostic Imaging
- Working knowledge/willingness to learn of issues regarding wellness and burnout prevention in healthcare
- Have strong communication and interpersonal skills.
- Demonstrate leadership/advocacy ability
- Demonstrate approachability and commitment to confidentiality
- Ordinarily should not be the in a clinical leadership position (eg. department/division chair, program director, site chief)

It is the responsibility of this subcommittee to help to:

1. Help identify factors contributing to resident burnout and provide resources and support to residents (example: NLMA's *inConfidence Employee and Family Assistance Program*, PAIRNL).
2. Liaise with the Residency Program Committee to identify solutions in order to diminish resident burnout.
3. Act as a liaison between the resident body and program administration by attending Residency Program Committee meetings twice a year with the goal of maintaining focus on overall resident's wellness.
4. Organize non-academic activities for the Radiology residents (example: annual dinner/retreat/town hall) funded by the Division.
5. Coordinate non-academic non-funded social events/activities for the Radiology residents (examples: game day, backyard potluck, ice cream day)
6. Mentor and support residents, while maintaining confidentiality, and guide them to resources
7. Foster an environment that encourages wellness for all by encouraging adoption of personal wellness strategies by disseminating and promoting resources available through Eastern Health, Memorial University and professional organizations like the Newfoundland Medical Association and the College of Physicians and Surgeons of Newfoundland and Labrador.
8. Aid in the maintenance and updating of the Wellness and Resiliency section in the Resident Manual of the Discipline of Radiology
9. Aid in recruiting speakers (local, regional, national) who can present on topics related to Wellness and Resiliency at least 2 times per year, in addition to work with the resident lead to organize wellness retreat/town hall annually.
10. Helps promote the tracking/evaluation of Wellness through initiatives like stakeholder focus groups, interviews and surveys through Memorial University Faculty of Medicine
11. Faculty representative to provide an Introduction/welcome and ensure annual communication with new residents during the first year of appointment to ensure they are well supported in their role. Communication can be in the form of email with offer of in

person meeting if requested by the new resident.

12. Serves as a resource (in addition to Division Chair) to learners who are seeking confidential advice on wellness issues and assists connecting them with resources available through Eastern Health, Memorial University and the NLMA.

ROUNDS AND TEACHING

OVERVIEW

Rounds are held daily and offer residents an exposure to radiology and related teaching topics in didactic and case-based format. Rounds are attended by staff radiologists and in most cases led by that person. There are opportunities for residents to develop teaching and presentation skills through “subspecialty” and “resident grand round” sessions. Residents are taught the essentials of radiology case discussion including the presentation of case material and the approach to evaluating this material. Cased based teaching offers residents an opportunity to develop consultative skills necessary to practice radiology and prepare for the Royal College examinations.
All residents are freed from clinical duties to attend all rounds described below.

MONDAY Resident Subspecialty Rounds (Monday from 4:00-5:00 pm)
These rounds are organized by a staff member and a resident.
Residents present cases in PowerPoint format around a topic selected by them in conjunction with the staff radiologist.

TUESDAY Interesting Case Rounds (Tuesday from 12:00-1:00 pm)
These rounds are held at both the Health Science site and St. Clare's Mercy Hospital site for staff and residents at each location.
Residents will attend these rounds and bring interesting cases in PowerPoint format with prepared discussion.
Residents attend the rounds at the site that they are rotating through.
Any resident at the Janeway site would attend the Health Science site rounds.
At the Health Science Site, a single staff member is assigned for each ICR session to run the session and help the resident present the cases.
During these rounds, the resident presented with the case will offer a description of the images provided, provide a differential diagnosis and offer further management suggestions.
Staff present for rounds will ensure this is done in a concise and efficient manner offering assistance and feedback as necessary to complete the case.
It is the goal that each resident in attendance be shown a case.

WEDNESDAY - Academic Half Day (Wednesday from 12:30-5:00 pm)
12:30-1:15 - *Physics Lecture prior to ½ day teaching*
1:30 – 5:00 pm – Staff lead rounds, usually takes the form of a didactic or case-based lecture

component.
All residents go to the hospital where the Academic Half day is being taught that week. Residents are occasionally divided into junior and senior groups and each group is assigned a room and staff person. Teaching material is prepared and presented by staff radiologists. Subjects are selected to cover topics from the radiology curriculum.
Cases presented by staff are routinely taken by individual residents in a format similar to the ICR rounds outlined above.

THURSDAY - Staff Subspecialty Rounds (Thursday from 12:00 – 1:00 pm or 4:00 – 5:00 pm)
Topic based similar to the Monday subspecialty rounds. The difference is that all teaching material and cases are prepared and presented by a staff radiologist scheduled.
These rounds will often reflect a topic in a core area of radiology.
This is also an opportunity for residents to be exposed to subspecialty interests of the staff radiologist.

THURSDAY - Case based Rounds (Every second Thursday from 4:00 – 5:00 pm)
Case based rounds given by Drs. Chan and Hogan to concentrate on technique for taking cases orally. Cases are prepared by staff and presented by attending residents. Cases are selected to cover common radiology cases and topics from the radiology curriculum. All residents travel to the HSc for these rounds.

FRIDAY – Fundamentals of Radiology OR Grand Rounds
Fundamentals of Radiology is held on Fridays between 4-5:00 pm and is a great Memorial Radiology tradition that focuses on basic fundamental topics at each session, loosely based on the core textbook for the program. This lecture series has become popular with residents of all levels of training. It is a lecture-based series that began informally to assist new residents in development of an academic base for radiology training. It attempts to guide residents through the core chapters of a major radiology text, “Fundamentals of Diagnostic Radiology”, By Brandt and Helms.

Grand Rounds are held on Fridays from 12:00- 1:00 pm. These rounds are done approximately 11 times per year (each resident presents one grand rounds per year). These rounds are broadcast across the city via Blackboard Collaborate (or equivalent) and all radiology staff and residents are invited to attend. These are presented by the resident, in conjunction with a supervising staff radiologist. The topics often include, but are not limited to, review of new or updated guidelines or imaging techniques, or a novel approach to imaging.

Summer Radiology Call Bootcamp (8 summer sessions, Wednesday from 8:00- 9:00 am)
These rounds occur over 8 sessions during the months of July and August, and cover high yield concepts/pathology frequently encountered on call. These sessions are presented by the senior residents (PGY 4 and 5), and is a great opportunity for all learners to ask questions and enhance their knowledge.

Blackboard Collaborate (or equivalent) is used to stream the above rounds between the Health

Science site and the teaching room at St. Clare's Mercy Hospital, and vice versa, when required.

FOUR TIMES YEARLY - Journal Club (scheduled in the evenings by the presenters)

Journal club will occur 4 times each year. These 4 will have a strong critical appraisal component. Additional Journal Clubs can be held, if there are other interesting topics that are brought forward, using other approaches.This is meant to be a resident led endeavor, and as such the junior chief resident will be tasked with organizing the journal club schedule. There will be 2 residents assigned to each journal club (1 during each quarter of the academic year) who have the responsibility of identifying a staff mentor, potentially in a specific area of interest. Together they will decide on journal articles to review with the emphasis on critical appraisal.

The organizers should feel free to explore different times and venues, as journal clubs are often meant to also serve as a social event.

PGY 1 ROUNDS ATTENDANCE

PGY-1 house-staff are encouraged to attend rounds, including Journal Club, if attendance does not interfere with their clinical duties. Residents in PGY1 year have half day teaching on Fridays and are encouraged to attend any rounds held at that time in the radiology department. The Fundamentals of Radiology lecture series is a great introduction to residents entering the radiology program. PGY1 residents should complete the online ethics course (www.pre.ethics.gc.ca/english/tutorial/) during this period.

During PGY1, residents are informed of this site through the Postgraduate Office. This information is also on One45 and is linked to each of the individual rotations.

A PGY -1 Online Emergency Radiology Course is offered online and should be completed throughout the PGY 1 year to help prepare for radiology call. This is module based, and will provide the learner with immediate evaluation and feedback based on readings and associated online evaluations/quizzes.

JOURNAL CLUB

Journal Club is an opportunity for residents to practice critical appraisal techniques as they pertain directly to radiology. Journal Club is held approximately five times per year and, generally, two papers are discussed during a session. Staff radiologists with specialty interest in the field covered by the paper are asked to attend sessions. Papers and topics are chosen by residents in consultation with a staff radiologist. These papers must offer some educational value to residents. The paper must be amenable to critical appraisal. Typically such papers tend to be found in scientific journals such as The American Journal of Radiology or Canadian Journal of Radiology for example. Articles of a review nature typically do not lend themselves to critical appraisal unless they consist of a meta-analysis in which case they may be more complex. While

such review articles are of great interest in the practice of radiology they are better reserved for presentation in the context of other rounds/conferences.

VISITING PROFESSOR PROGRAM

Each year, 2 – 3 visiting professors spend 2-3 days each with residents providing small group teaching sessions and mock oral examinations. Guest professors are invited to speak to staff in addition to holding teaching sessions with residents. This offers an invaluable opportunity for residents to learn a fresh perspective from a range of excellent radiologists practicing throughout North America.

ETHICS TRAINING

Ethics training is an important part of our radiology residency program. The ethics of patient care is an important part of daily clinical practice and is discussed on a regular basis at the viewbox. It does also involve teaching, videotapes, care-based discussion, and review of journal articles. Dr. Christopher Kaposy, Memorial University Ethicists, are available to speak with residents and are involved in ongoing ethics teaching. There are approximately four sessions per year. Also, please refer to the Royal College Policy regarding “Physicians and Industry – Conflicts of Interest”. Ethics has an online course for HREA Health Research Ethics Authority in PGY1 year.

COMMUNICATIONS TRAINING

A didactic presentation of reporting will be made early each academic year. Reporting formats will be reviewed along with discussion of legal obligations. This will be in addition to day to day review of resident reports. Please see below guidelines. Further, residents receive ongoing training as they review cases with staff radiologists and dictate their findings. Staff radiologists review all resident reports and will offer feedback as necessary. Feedback early in training is strongly encouraged to help guide residents in proper reporting technique.

RESIDENT RESPONSIBILITIES AND ETIQUETTE

1. **Attendance** at rounds and lectures is *mandatory* for radiology residents scheduled to work that day, to ensure maximal exposure to curriculum. Attendance at rounds post call is encouraged, but not mandatory. Attendance records are kept. Speakers spend time preparing for lectures and rounds and will not be encouraged to improve their teaching material if attendance is low. Attendance at multidisciplinary rounds is also mandatory, some of which may occur outside of normal duty hours. These rounds are important to ensure continuity of patient care.
2. **Be punctual**. Residents have priority to attend departmental rounds and teaching. It is the staff radiologist’s responsibility to cover radiology services during this period.
3. **Participate** and be enthusiastic. Contribute to rounds. This will benefit fellow residents

presented with the case and benefit your learning through case preparation.

4. **Collect cases** during your rotation. Cases are to be prepared in PowerPoint format with a brief summary of findings and discussion of the main learning points.
5. **Be responsible** and switch time slots in advance if you cannot present case/topic material on assigned time. Inform the academic office so that an email can be sent to inform every one of the change. Rounds must be discussed with assigned staff several days before rounds are presented.

RESIDENT CALL DUTIES

Radiology Residents at Memorial University share call duties with staff radiologists. There is a graded system of increasing responsibility on call. The frequency of call varies over the course of residency training. Call in our program is categorized as “home call,” not “in house.” The resident on call covers the Health Science site, the Janeway site, and the St. Clare’s site. For all stages of call, there is a staff radiologist on call at each site available to the resident(s) at all times.

Exposure to call is structured to allow residents time to obtain the necessary radiology skills to function in a first call capacity. Every effort is made for all PGY2 residents to rotate through ultrasound, emergency, body CT, chest CT and neuro CT blocks before any call without senior resident supervision.

Residents at all levels of training are encouraged to seek the assistance of staff when concerns or problems arise. Staff are very approachable and readily available on call. Staff radiologists are committed to a process of graded responsibility and to resident education 24 hours a day. On evening shifts, staff radiologists are expected to check in by 2200 hours with the resident on call, and when possible, sign off the studies already completed. On weekend shifts, staff are encouraged to check in by 1200 as well as at the end of the residents shift. Open communication between staff and residents throughout the call shift is encouraged. Residents are strongly encouraged to call staff and ask for help with cases or dictating if overwhelmed with volume.

The responsibility for creating the resident call schedule falls with the chief resident. This is a fair process and includes the input of all residents where possible. Whenever possible, limiting the number of residents post call on any Monday to 3 residents is attempted.

CALL STRUCTURE

Call shifts are broken up into evening call coverage for weekdays (Monday –Thursday), with call beginning at 1700 hours and ending at 0800 the next morning. Weekend and holiday call shifts are split shifts. One resident covers the Friday evening shift and Sunday evening shift (1700-0800), a second resident covers Saturday and Sunday day shift (0800-1700), and a third resident covers the Saturday evening shift (1700-0800). For 1700 hours handover on weekends/statutory holidays, the resident finishing the day shift should stay until all studies that they have reviewed have been dictated, and until 1800 hours at the latest to help with any studies that were imaged but unread as of 1700 hours. The resident beginning call at 1700

hours should start with the oldest study that has not yet been looked at, unless a truly emergent study requires immediate attention. All residents are expected to communicate what studies are ready for staff review with the on-call radiologist at each site prior to ending their shifts.

The graduated responsibility call pyramid is detailed below:

Shadow Call

- PGY1 residents do a minimum of 6 shifts of shadow call per radiology rotation (for a total of 12) while in PGY1. There is an online PGY1 ER radiology course delivered during this year to help with call. Junior residents then do 6 shifts of shadow call when they enter PGY2 over the first two blocks of PGY2.

- The process of learning/observing call gives residents the opportunity to watch and learn as more senior residents field pages, consult with clinicians, communicate with radiology technologists, oversee imaging studies, review these studies, and report to the ordering physician. This low stress experience is extremely valuable.

- This is typically a 5-hour shift on evenings (1700-2200 hours) and a 9 hour shift on weekend days/statutory holidays (0800 – 1700 hours). There is no post call after an evening shadow shift but residents will be permitted a post call day on Monday following a Saturday/Sunday daytime shift.

Mandatory Backup Call

- After completion of shadow call, residents start being on call with mandatory backup/double read with the senior (PGY 5) residents. This continues for 15 shifts. This cannot begin prior to completing a minimum of 2 blocks of PGY 2 in Diagnostic Radiology.

- During this time the PGY2 resident will carry the on call pager and report directly to a senior resident who reviews all studies with the junior resident in hospital.

- This is a full call shift (1700-0800 on weekdays, 0800-1700 or 1700-0800 on weekends). Post call days are given (as per the post call policy below) to both the junior resident and the senior resident providing mandatory backup.

Optional Backup Call

- After mandatory backup call is completed, residents have 9 more optional backup call where a senior resident is available to help in any capacity if needed.

- In the late fall the PGY2 resident will be evaluated with an emergency OSCE examination covering many areas within radiology. Upon successful completion of this

exam (PASS mark 70%) and following successful completion of core radiology rotations the resident will be ready to begin first call duties with staff backup.

- Post call is provided to the junior resident on call as per the below policy. Post call will be provided to the senior resident providing back up call should the senior resident have to provide back up for the junior resident after midnight.

Double PGY 2 call

- After the optional backup call is completed, residents have 6 more shifts where they will be paired with another PGY 2. Two PGY 2 residents will be on call together and will share the responsibilities 50/50. This will help with managing call volume and case complexity.

- This cannot begin prior to having completed 7 blocks/rotations in PGY 2 in Diagnostic Radiology.

This is a total of 48 shifts of call in this graduated system.

After these 48 shifts are completed, there is one resident on call at a time with the staff person(s) on call.

PGY 5 CALL RESPONSIBILITIES

PGY 5 residents cover all backup shifts of all normally scheduled PGY 2 residents. Backup call shifts of PGY 2 residents who are behind their cohort due to leave or remediation can be covered by PGY 4 residents. Typically, after PGY 2 backup call shifts are complete, PGY 5 residents are removed from the call schedule for the remainder of their PGY 5 year (with the exception of NLAR weekend - see below). However it is possible, that in extenuating circumstances, PGY 5 residents may be placed back on the call schedule with approval from the RPC.

PGY5 residents may have to take call during the weekend of NLAR, which typically occurs in March, to allow the junior residents to attend. However, any resident who chooses not to attend NLAR and is not on approved leave at that time, will be expected to cover call for this weekend before PGY 5s are brought back on the call schedule. To clarify, if all residents PGY2-4 attend NLAR, it is the responsibility of the PGY5 residents to cover call for that weekend (if the conference is in person) or for the scheduled conference time (if this conference is held virtually). A resident who is attending NLAR should not be post call - it would fall to a resident not attending NLAR or a PGY5 resident to cover the call shift that would make any attendee post call. Any PGY 2-4 resident who chooses not to attend NLAR will be placed on the call schedule preferentially over the PGY 5 residents.

ON CALL REPORTING POLICY

Residents engaged in on-call duties are expected to review imaging studies in a timely fashion and to provide a report of the findings to the ordering physician. Any urgent or emergent findings in the report must be issued verbally to the ordering physician and/or physician responsible for care of the patient in question. A typed report of major findings must also be transcribed and accompany the imaging study on the PACS system for review by consultants involved in the case. Careful documentation of when verbal reports were provided, as well as to whom, must be included in every report.
Should the resident report differ significantly from the staff opinion the following day, it is the responsibility of the staff person to provide updated verbal reports to the ordering physicians, and alter the reports, as per Eastern Health's Resident Preliminary Reports policy.

POST CALL POLICY

Residents are no longer on call as of the scheduled end of their call shift, but must complete post call responsibilities including:

1. Communication with the staff radiologist on call/responsible for the studies done on call regarding the number and type of studies as well as any concerns. Review of every case is not expected however some studies may require review. This can be done at the request of either the staff or resident.
2. Handover of any pending studies arranged on call to the appropriate technologists and radiologist or resident.
3. The dictation of complete radiology reports using the Powerscribe voice dictation system for all studies interpreted during the call shift.
4. Post call is provided to the resident on call should they be called in after midnight on an evening call shift, as well as to residents completing the Saturday/Sunday day shifts (post call is on Monday).
5. Note is made that there may be 2-3 residents post call on Monday, with the exception being 4 residents post call on Monday. This may happen as the Friday/Sunday evening shift resident, the Friday/Sunday mandatory backup senior resident, the Saturday/Sunday day shift resident, and the Saturday/Sunday day shift backup resident may all theoretically be post call on Monday.
6. Residents are encouraged to participate in teaching while post call when able.
7. Post call after an evening shift begins at 8 am, however the resident should remain variable by telephone until 10 am should staff require clarification on any reports sent to them.

ADMINISTRATIVE/CHIEF RESIDENT

STRUCTURE

The radiology chief resident's role is largely administrative. Calls schedules, teaching schedules/organization, and work schedules (leave requests) occupy a major portion of time. The chief resident represents the residents to the faculty, and is expected to work closely with administration and the program director in implementing the teaching and service objectives of the department.

A single chief resident is designated for a single period of time. This is typically a PGY 4 resident, as PGY 5 residents are preoccupied with exam preparation. However, PGY 5 past-chief residents should be available for advisory purposes to the PGY chief. This term could be a full year term, extending from July to June in PGY 4, or this role can be shared by two PGY 4 residents equally, each performing these duties consecutively for a period of 6 months of the PGY 4 year.

CHARACTERISTICS OF A CHIEF RESIDENT

Not every resident has the ability, aptitude or desire to be a chief resident. Requirements of the chief resident include:

1. Organizational skills
2. Prompt attention to email or telephone correspondence
3. Leadership skills
4. Ability to prioritize
5. Diplomacy and fairness
6. Respect from residents/faculty
7. Academically accomplished, so the time commitment required does not negatively impact the academic achievement of the resident.

SELECTION OF A CHIEF RESIDENT

Selection of the chief resident will be by resident nomination. This will be done in spring for the subsequent academic year. Nominations, including self nomination, come from the resident body to the administrative staff, who will then bring the nominations to the RPC. The RPC will then decide on the chief resident/residents for the following year, with approval of the academic chair.

DUTIES OF A CHIEF RESIDENT

The responsibilities of the chief resident predominantly include ensuring the resident component of the clinical and academic activities are optimized, and run smoothly, on a daily basis. Specifically, these duties include:

1. Generation and distribution of the call schedule
2. Generation of the vacation schedule
3. Approval of all resident leave requests to ensure adequate coverage for call and daily clinical duties
4. Personnel management within the department and interdepartmental
    a. concerns from other department chief residents or from other faculty often go through the chief resident for the initial attempt at resolution
    b. the first point of contact for resolution of any resident issues or concerns
5. Recruiters for the discipline
    a. often the first point of contact for medical students exploring radiology

   b. involved in the CaRMS selection process as part of the CaRMS committee
   c. a point of contact for any resident considering transfer into a radiology program
6. Liaison with administrative staff and PGME for leave requests, attendance at rounds, pandemic work availability, etc.
7. Aid in generation of daily work schedule modifications for unexpected circumstances such as global pandemics etc.
8. Serve on the RPC as a resident representative, and act as a point of communication between the RPC and the resident body.

DIAGNOSTIC RADIOLOGY REPORTS

PREPARE AN INFORMATIVE AND CONCISE REPORT

Communication is a critical component of the art and science of medicine and is especially important in Diagnostic Radiology. Diagnostic Radiology is one of the most important consultative services in medicine. This standard has been largely based on the ACR guidelines, which we acknowledge.

The final product of any consultation is the submission of a report on the results of the consultation. In addition, the diagnostic radiologist and the referring physician have many opportunities to communicate directly with each other during the course of a patient's case management. Such communication should be encouraged because it leads to more effective and appropriate utilization of Diagnostic Radiology in addressing clinical problems and focuses attention on such concerns as radiation exposure, appropriate imaging studies, clinical efficacy, and cost-effective examinations.

In order to afford optimal care to the patient and enhance the cost effectiveness of each diagnostic examination, radiological consultations ought to be provided and radiographs interpreted within a known clinical setting. The Canadian Association of Radiologists (CAR) supports radiologists who insist on clinical data with each consultation request. This standard is based on the Communications Standard of the American College of Radiology.

CONTENT OF THE DIAGNOSTIC RADIOLOGY REPORT

An authenticated written interpretation should be performed on all radiographic (imaging) procedures. The report should include the following items:

1. Name of patient and another identifier, such as birth date, pertinent ID number, or hospital or office identification number.
   a. name of referring (attending) physician:
   b. Name of most responsible physician
   c. Names of other physician(s)
2. Name of type of examination.
3. Date of dictation
4. Date of the examination and transcription

5. Time of the examination (for ICU / CCU patients)
6. Body of the report - The effective transmission of radiographic information from the radiologist's mind to the clinician constitutes the purpose of the report. The report should be clear and concise. Normal or unequivocally positive reports can be short and precise. Whenever indicated, the report should include:
    a. Include in the report a description of the procedures performed and any contrast media (agent, concentration, volume, and reaction, if any), medications, catheters and devices, if not reported elsewhere.
    b. Findings - use precise anatomical and radiological terminology to describe the findings accurately.
    c. Limitations - where appropriate, identify factors that can limit the sensitivity and specificity of the examination. Such factors might include technical factors, patient anatomy (e.g., dense breast pattern), limitations of the technique (e.g., chest examination for pulmonary embolism), incomplete bowel preparation (e.g., barium enema for neoplasm), wrist examination for carpal scaphoid injury, or skeletal examination for detection of stress fracture.
    d. Clinical Issues - the report should address or answer any pertinent clinical issues raised in the request for the imaging examination. For example, to rule out pneumothorax, state: "There is no evidence of pneumothorax"; or to rule out fracture, "There is no evidence of fracture". It is not advisable to use such universal disclaimers as "the mammography examination does not exclude the possibility of cancer".
    e. Comparative Data - Comparisons with previous examinations and reports when possible are part of the radiologic consultation and report and, optionally, may be part of the "impression" section.
7. Conclusion of Diagnosis - each examination should contain a "conclusion" section unless the study is being compared with other recent studies, and no changes have occurred during the interval, or the body of the report is brief.
    a. *Give a precise diagnosis whenever possible.*
    b. Give a differential diagnosis when appropriate.
    c. Recommend, only when appropriate, follow-up, additional diagnostic radiologic studies to clarify or confirm the impression, or management suggestions (such as specialist consultation).

Written Communication:

An authenticated written interpretation should be performed on all radiographic (imaging) procedures. The report should include the following items:

1. The timeliness of reporting any radiologic examination varies with the nature and urgency of the clinical problem. The written radiological report should be made available in a clinically appropriate, timely manner.

2. The final report should be proofread carefully to avoid typographical errors, deleted

words, and confusing or conflicting statements, and signed (authenticated) by a radiologist, whenever possible.

***Comment**: Electronic or rubber-stamp signature devices, instead of a written signature, are acceptable if access to them is secure. The signature of the radiologist who dictated the report should appear on the report. If this is not possible, the initials or name of the radiologist who dictated the report as well as the initials or name of the radiologist who signed it should appear on the report.*

3. A copy of the final report should accompany the exchange of relevant radiographic examinations from one health professional to another health professional.

Direct Communication:

An authenticated written interpretation should be performed on all radiographic (imaging) procedures. The report should include the following items:

1. Radiologists should attempt to coordinate their efforts with those of the referring physician in order to best serve the patient's well-being. In some circumstances, such coordination may require direct communication of unusual, unexpected, or urgent findings to the referring physician in advance of the formal written report. Examples include:
   (a) *The probable detection of conditions carrying the risk of acute morbidity and/or mortality which may require immediate case management decisions.*
   (b) *The probable detection of disease with non-acute morbidity or mortality sufficiently serious that it may require prompt notification of the patient, clinical evaluation, or initiation of treatment.*
2. In these circumstances, the radiologist – or his/her representative – should attempt to communicate directly (in person or by telephone) with the referring physician or his/her representative. The timeliness of direct communication should be based upon the immediacy of the clinical situation.
3. Documentation of actual or attempted direct communication is appropriate in accordance with department policy, legal advisability, understanding with the referring physician, and individual judgement.
4. Any discrepancy between an emergency or preliminary report and the final written report should be promptly reconciled by direct communication to the referring physician or his/her representative.

NOTE: *This standard is structured with statements of principles followed by rationales or comments. Only the principles define the range of suggested practices. The rationales or comments serve only to clarify the principles*

SUPERVISION OF RESIDENTS

The supervising radiologist has a dual professional responsibility to provide appropriate patient care and to provide education for trainees. There must be a careful assessment of the responsibility delegated to the trainee. The resident has a dual responsibility to ensure patients (and their families) for whom they are providing care know they are on a teaching unit and to keep attending and consulting physicians informed about their patients.

ATTENDING RADIOLOGIST RESPONSIBILITIES

It is the responsibility of the attending physician to:

1. Review the examinations and procedures with the resident in a timely manner. This includes:
    - A discussion of the findings and their significance to patient management.
    - Involvement in major decisions relating to diagnosis and management.
    - Involvement with the planning and performance of procedures including direct supervision when required by patient safety or requested by the trainee.
    - Trainees should be assisted directly by staff commensurate with their level of training.
    - Identification of the main teaching points of a case requiring educational emphasis.
2. Be accessible (available in person or by pager/phone at all times).

RESIDENT RESPONSIBILITIES

It is the responsibility of every resident to:

1. Identify oneself as a resident and inform patient (or family) that they are on a teaching unit and that patient care is a team approach under the supervision of the attending physician.

2. Notify the supervising radiologist, or consulting physician, as appropriate when:
    - a patient's condition is deteriorating,
    - the diagnosis or management is in doubt,
    - a procedure with possible serious morbidity is planned.

3. Notify the attending or consulting physician of any abnormal imaging results that may need urgent management or may significantly affect current patient management.

4. Record in writing on the patient's report the notification of the attending or consulting physician.

PROGRAM OUTLINE

TRADITIONAL STREAM - BY NUMBER OF BLOCKS PER YEAR (1 BLOCK = 4 WEEKS)

As per the 2017 Specialty Training requirements (STR's) of the Royal College of Physicians and Surgeons of Canada:

PGY 1 (or equivalent according to STR's)

1 block	Rural Obstetrics/Gynecology
2 blocks	Selective
2 blocks	General Diagnostic Radiology
1 block	Pediatrics - Ward
2 blocks	Internal medicine
1 block	Elective
1 block	Adult Emergency
1 block	Pediatric Emergency
2 blocks	General Surgery
13 blocks	

PGY 2

1 block	Breast
2 block	Body CT Gastrointestinal/Genitourinary Radiology
1 block	Musculoskeletal Radiology
2 blocks	Cardiothoracic
2 blocks	Ultrasound
2 blocks	Neuroradiology
1 block	Pediatrics
1 block	Emergency
1 block	Body CT
13 blocks	

PGY 3

3 blocks	Angiography and Interventional Radiology
1 block	Nuclear Medicine
1 block	Elective
1 block	Ultrasound
1 block	Neuroradiology/ENT
1 block	Body CT
2 blocks	Cardiothoracic
1 block	Breast
1 block	MRI Body
1 block	Musculoskeletal

13 blocks	

PGY 4

1 block	Cardiothoracic
2 blocks	Musculoskeletal
1 block	Body CT
1 block	Breast
2 blocks	Pediatrics
1 block	Ultrasound
1 block	Neuro CT
1 block	Neuro MRI
1 block	Obstetrics
1 block	Nuclear Medicine
1 block	AIRP
13 blocks	

PGY 5

1 block	Ultrasound
1 block	Body CT
2 blocks	Neuroradiology CT and MRI
1 block	Body MRI
1 block	OBS
1 block	Cardiothoracic
1 block	Musculoskeletal Radiology
1 block	Elective (must be NUCS if writing ABE)
1 block	Rural
1 block	Breast
1 block	Pediatrics
1 block	Nuclear Medicine
13 blocks	

BY NUMBER OF BLOCKS PER ROTATION

PGY 1

Rural Obstetrics/Gynecology	1
Selective	2
General Diagnostic Radiology	2
Pediatrics - Ward	1
Internal medicine	2
Elective	1
Adult Emergency	1
Pediatric Emergency	1
General Surgery	2
Total	13

PGY 2-5

	PGY 2	PGY 3	PGY 4	PGY 5	Total	*STR
Thoracic Imaging						
Cardiothoracic	2	2	1	1	**6**	**6**
Imaging of the Abdomen and Pelvis					**13**	**13**
GI/GU	2					
Body CT	1	1		1		
MRI		1		1		
US	1	1	1	1		
OBS			1	1		
Vascular and Interventional Imaging		3			**3**	**3**
Musculoskeletal Imaging					**6**	**6**
MSK	1	1	2	1		
Nuclear Medicine		1				
Neurological Imaging					**6**	**6**
Neuro CT	2		1			
ENT		1				
MRI			1	1		
Breast Imaging	1	1	1	1	**4**	**4**
Pediatric Imaging	1		2	1	**4**	**4**
Other					**10**	**10**
2 Nuclear Medicine			1	1		
1 AIRP			1			
1 Rural Rotation				1		
1 Emergency	1					
3 electives		1	1	1		
1 junior staff				1		
1 US	1					
Totals	**13**	**13**	**13**	**13**	**52**	**52**

*Total number required as per the Specialty Training Requirements in Diagnostic Radiology
To Note: Residents wishing to write the American Board examinations must do an additional elective in Nuclear Medicine.

RESIDENT EVALUATIONS

BACKGROUND

Evaluation is an essential part of our Residency Program. It is meant to be a process of continuous communication. Evaluations from residents are an important reference for program improvement.

Process of Evaluation:

1. All trainees will be provided with a copy of the resident manual, including the "Resident Evaluations" section at the beginning of their PGY 1 or 2 year and at any time these standards are changed.
2. All trainees will be provided with a copy of "Resident Assessment, Promotion, Dismissal and Appeal" policy of the Post Graduate Medical Education Office of the Faculty of Medicine at Memorial University at the beginning of their PGY 1 year.
3. At the beginning of a rotation, you must discuss rotation objectives with your preceptor(s).
4. You should complete *Daily Performance Assessment (DPA) cards for each day works, and *On Call Assessment (OCA) cards for each call shift, and forward them to the appropriate preceptor/supervisor. The preceptor/supervisor will then complete the card and forward to the Program Administrator, who will compile the feedback for your rotation supervisor.
5. Midway through the rotation, the resident must discuss their progress with their preceptor. A reminder email will be sent. At the midpoint of any rotation which is 2 months or longer, the supervisor must provide the resident a mid-way evaluation.
6. At the end of the rotation, a summative evaluation (ITER) should be completed by your preceptor and discussed with you. This form should be designed and adopted by the Residency Program Committee. The form must be accompanied by guidelines to assist the supervisor(s) in marking individual items. Comments should be made on any specific areas of performance, which contribute significantly to the evaluation, especially in areas of weakness. For the purpose of completing the form, appropriate medical and non-medical personnel should be consulted about the resident's performance. If a problem is identified at any point during a rotation, the supervisor must bring this to the attention of the resident promptly.
7. The electronic form/ITER (through WebEvaluation) will be validated by the resident.
8. Completed evaluation forms are to be reviewed by the program director within three months of the end of rotation, should the ITER be completed. This will allow the program coordinator to be aware of and if appropriate, address problems in the rotation or relating to the residents' performance in a timely fashion. Any supervisor providing a "inconsistently meets", "rarely meets", "significant concerns noted", or "some concerns noted" is requested to speak directly to the program director before the end of rotation. One45 evaluation systems alerts the program director to these **Low Performance** grades.
9. Results of ACR Exams, End of Rotation Exams, and completion of the Research requirement will be sent to and reviewed by the Program Director.
10. A resident should receive/have online access to a copy of and/or be provided with verbal details of all evaluation results. All such results should as well be kept as part of the resident's University file.

RESIDENT EVALUATION TOOLS AND MINIMUM PERFORMANCE STANDARDS

The goal of our residency training program is to ensure that our residents receive the best possible training to master the knowledge, skills and attitudes required of our specialty. A number of evaluation tools will be used to provide feedback, and to judge and measure performance.

Detailed and timely feedback allows a trainee's program to be enhanced in any area of

weakness. If problems occur, the resident can be informed early and can be provided with adequate opportunity for remedial assistance.

This document identifies the evaluation system and guidelines for our disicpline. It was last reviewed by the RTC in December, 2021.

Evaluation Tool (PGY 2-5)	**Minimum Performance Standard**
ITER	"generally meets expectations" on all sections and overall
OCA Cards	"3" on 80% of submitted cards in PGY 2-3 "4" on 80% of submitted cards in PGY 4-5
DPA Cards	"meets expectations" on 80% of submitted cards
End of Rotation Exam	PASS (usually 70% or above, or 30th percentile)
Teaching Feedback	"neutral" on 80% of teaching feedback received.
ACR Written Exam	20th percentile for level
Biennial Oral Exam	70 percent overall
Biennial OSCE Exam	Overall PASS for level or within 10% of average for level of training
Biennial RadExam	Approaching national average.
Research Requirement	Completed and submitted for publication by completion of PGY 4. Research presentation annually until project complete and submitted for publication.

WEBEVALUATION/One45

WebEval is an online web evaluation system. It was created by One45 Software for both undergraduate and postgraduate university programs.

Core Benefits of WebEval**:**

- Improve workflow efficiency
- Enhance communications across all levels
- Centralize student, resident and faculty information
- Identify trends for decision making

- Better service students, resident and staff

Benefits for Electronic Evaluation:

- Automate the sending, receiving, and collating of evaluations
- Evaluate rotations, courses, academic half-day, teaching rounds, residents, students, and faculty
- Establish low performance flags to identify those students and residents having problems
- Collect valuable research data with surveys
- Generate email reminders for overdue forms
- Display photos on the forms

How does it work?

- You will receive e-mail reminders with username and password information to complete evaluations online. Your login information is confidential.
- You will need to complete the faculty and rotation evaluation
- Once forms are completed and confirmed they will be stored in the resident file.

If you notice any errors in your personal information or have any trouble accessing the site please contact the administrator at 777-2201.

DAILY PERFORMANCE ASSESSMENT (DPA) AND ON CALL ASSESSMENT (OCA) CARDS

DPA cards are cards filled out by the resident upon completion of each day of work that describes what the resident did each day. The learner then sends this card on to any staff or supervisor that they worked with that day, who completes the evaluation portion of this card and then forwards the card to the Academic Program Administrator, who compiles this data for the rotation supervisor midway through each rotation and at the end of the rotation. This data is meant to provide more points of feedback for the resident, as they work with many different supervisors during a rotation.
Please see an example below.

Memorial University Daily Performance Assessment (DPA) Card

INSTRUCTIONS FOR RADIOLOGISTS:

Please complete your sections of this electronic form by pressing "FORWARD," addressing the email to radiology@med.mun.ca, editing your comments/assessment in the "Staff Information" section below, and then "SEND".

INSTRUCTIONS FOR RESIDENTS:

Copy and paste this form into an email. Please complete your sections of this electronic form editing your name/rotation/date/volume in the "Resident Information" section below, and then "FORWARD" to the applicable staff as well as to radiology@med.mun.ca, with "YOUR SURNAME - DPA Card" in the subject line.

Resident Information

Resident _____

Rotation _____

Date _____

Volume:

CR:		MG:	
CT:		NM:	
US:		IR:	
MR:		Other:	
RF:		Teaching/AHD:	

Staff Information

COMMENTS (What did this resident excel at? What could this resident improve? Focusing on CanMed roles as they apply to Radiology would help):

_____

OVERALL PERFORMANCE (please mark an "X"):

Could not evaluate:	Does not meet expectations:	
Meets expectations:	Above expectations:	Exceeds expectations:

OCA cards are similar, but are meant to reflect the resident's performance on call. These are filled out by the resident and then sent to any staff that they interacted with on call, or any senior residents who may be supervising them on call. This data is sent to the Academic Program Administrator and is compiled every 3 months, and shared with the Program Director and Assistant Program Director to provide direct feedback to the resident on their on call performance.
Please see an example below.

Memorial University On-Call Assessment (OCA) Card

INSTRUCTIONS FOR RADIOLOGISTS:

Please complete your sections of this electronic form by pressing "FORWARD," addressing the email to radiology@med.mun.ca editing your comments/assessment in the "Staff Information" section below, and then "SEND".

INSTRUCTIONS FOR RESIDENTS:

Copy and paste this form into an email. Please complete your sections of this electronic form editing your name/rotation/date/volume in the "Resident Information" section below, and then "FORWARD" to the applicable staff as well as to radiology@med.mun.ca with "YOUR SURNAME - OCA Card" in the subject line.

Resident Information

Resident _____

Date _____

Total Call Volume:

US: _____ CR: _____

CT: _____ OTHER: _____

Staff /Jr. Staff Assessment

Diagnostic Ability (Medical Expert):

PLEASE SELECT ONE OF THE FOLLOWING (MARK WITH X)

1. Misses significant findings on multiple cases, some concerns about patient safety	2. Identifies most findings, misses subtle abnormalities, occasionally misinterprets findings	3. Identifies all significant findings, occasionally misses subtle findings. Rarely misinterprets significance of findings	4. Identifies all significant findings and rarely misses subtle findings. Analyzes findings correctly	5. Identifies all significant and subtle findings, analyzes them correctly and integrates overall clinical context into decision making

Written Reports (Medical Expert, Collaborator, Communicator):

PLEASE SELECT ONE OF THE FOLLOWING (MARK WITH X)

1. Reports contain significant errors. Major revisions required before approval	2. Reports occasionally require significant revisions	3. Reports occasionally require minor revisions	4. Reports clear and concise and rarely require revision	5. Reports can be signed without revision

Additional Comments (ie: interaction with resident on call, timeliness of reports, professionalism, etc.):

_____

CONTINGENCIES FOR FAILURE TO MEET DEFINED MINIMUM PERFORMANCE STANDARDS

Rarely do residents fall below the minimum performance standards of the Department, but if this should occur, the resident, the faculty and the Department members responsible for the training program need to understand the program which will be structured for the resident.

In general, if a resident's weakness is focused then the resident will be assigned extra assistance by the rotation supervisor. If there is a more general or significant problem documented, a more structured program of Departmental assistance will be assigned under the supervision of the Program Director. Continued difficulties which necessitate a change in the usual program of resident rotations will generally require a more formal program of

remediation which will be structured and monitored under guidelines of the post graduate department of the Faculty of Medicine and Residency Training Committee/Competence and Promotions Subcommittee. This may lead to interruption in the normal promotion through residency.

Specific criteria for remediation is described below, as applies to PGY 2-4:

1. If a resident is evaluated at "inconsistently meets" or "rarely meets" on two ITER sections (Medical Expert, Scholar, Advocate, etc…) or end of rotation exams within the same year, the resident will be assigned remedial assistance (relevant to the section of weakness) by the Program Director in consultation with the Residency Program Committee/Competence and Competence and Promotions Subcommittee and/or rotation supervisors.

2. If a resident, on <u>any one</u> of the following evaluation tools, receives:

    a. "inconsistently meets" or "rarely meets" on three ITER sections (Medical Expert, Scholar, Advocate, etc…)

    b. "significant concerns noted" or "some concerns noted" on any ITER

    c. a grade on the ACR below the expected level

    d. a grade below the minimum standard in the ORAL/OSCE

    e. staff evaluations on DPA or OCA cards, or documented in writing in another form, regularly below minimum standards

    The resident will meet with the Program Director to discuss the problem(s). The resident may be assigned remedial work which could include any combination of assigned reading or academic review, work with an assigned mentor or repeat exams at the discretion of the Program Director. This remedial work could extend up to three months and will be evaluated under the direction of the Program Director.

    If within one year of commencing this Departmental remedial work the resident receives a <u>second</u> <u>evaluation</u> below the minimum performance standard the resident may be recommended for a more intensive program of remedial assistance.

    If within one year of commencing the Departmental remedial work the resident receives a <u>third</u> <u>evaluation</u> below the minimum performance standard, the resident may be recommended to a <u>formal</u> program of remediation, or remediation with a modified learning plan, or a modified learning plan by the Program Director with the guidance of the Residency Program Committee/Competence and Promotions Subcommittee. This recommendation will be subject to review by the Post Graduate Medical Education office of Memorial University. The remediation program and evaluation guidelines will be indicated in writing prior to the start of the program.

    If the remediation program is successful, the resident may be recommended for continuation in the program at the appropriate level. If this program is not successful, the resident will be recommended for further remediation, remediation with a modified

learning plan or a modified learning plan. Credit for remediation rotations may not be given if the goal(s) of the remediation is not attained.
Remediation with a modified learning plan or a modified learning plan implies the possibility of refusal for promotion or of dismissal if the resident is unwilling or unable to meet the required standards of performance. This is subject to review by the Post Graduate Medical Education Office of Memorial University of Newfoundland.

If a resident successfully completes a program of remediation but within the next twelve months falls below the minimum performance standard on any evaluation, the resident will again be recommended for a further formal program of remediation, remediation with a modified learning plan, a modified learning plan or withdrawal of training.

3. In PGY 5, failure to meet the minimum performance standard on any ITER overall or other evaluation item will be grounds for an immediate review of training performance and recommendation for formal remediation. Failure to meet the minimum performance standard on two evaluations in the PGY 5 year will be grounds for recommending notification to the Royal College that Training Standards were not met and for recommending the resident not proceed to the college exams. This will also be grounds for recommending the resident repeat the PGY 5 year. This decision will be made by the Residency Program Committee/Competence and Promotions Committee.
4. In addition, each resident will be reviewed by the Competence and Promotions Subcommittee on a biennial basis. Terms of Reference of this committee are listed above. Each learner will be reviewed as per the Terms of Reference, and a recommendation of that “Learner Status” for each resident will be made to the Residency Program Committee. Decisions on the “Learner Status” will be formally communicated to each resident in writing.
5. With regards to ethics and conduct, a resident can be recommended for dismissal by the Program Director, subject to approval by the Resident Training Committee if he/she is found to have violated the University Codes of Ethical Behavior, the Code of Ethics of The College of Physicians and Surgeons of Newfoundland and Labrador, or the Code of Ethics of the Canadian Medical Association. A resident can be recommended by the Program Director for suspension for improper conduct, pending a hearing and formal review, if the conduct is such that the continued presence of the resident in the clinical setting would be potentially hazardous to persons or to the academic function of the training program. Faculty of Medicine guidelines will be followed in all such matters.

If unusual or extenuating circumstances exist concerning a resident subject to any of the above items, the Residency Program Committee/Competence and Promotions Committee and/or Post Graduate Medical Education can alter the recommendations listed.

Any decision to recommend remediation for, a modified learning plan for, or withdrawal of training of a resident must be made in consultation with, and approval by the Residency Program Committee/Competence and Promotions Subcommittee of the Department of

Diagnostic Imaging. The Chair of the Department and Post Graduate Medical Education shall be informed of all decisions.

Any decision to recommend remediation for, a modified learning plan for, or dismissal of a resident must be reviewed and approved by the Postgraduate Education Evaluation Board of Memorial University. Any decision to dismiss must also be approved by the Chair of the Department and by the Associate Dean, as indicated in University Guidelines.

Any decision by the Board may be appealed by a resident according to the University's Guidelines for appeals.

CONFLICT RESOLUTION AND APPEALS

If a resident has a concern he/she should address it at earliest convenience according to the following process.

APPEAL PROCEDURE FOR AN UNSATISFACTORY EVALUATION

In the training of Radiologists the Memorial University Radiology Residency Program aims to provide an educational program which will be adequate to meet the trainee's educational and professional needs. We strive to evaluate the trainees to ensure that they have successfully acquired the required knowledge, skills, attitudes, behaviors and ethical standards to practice competently.

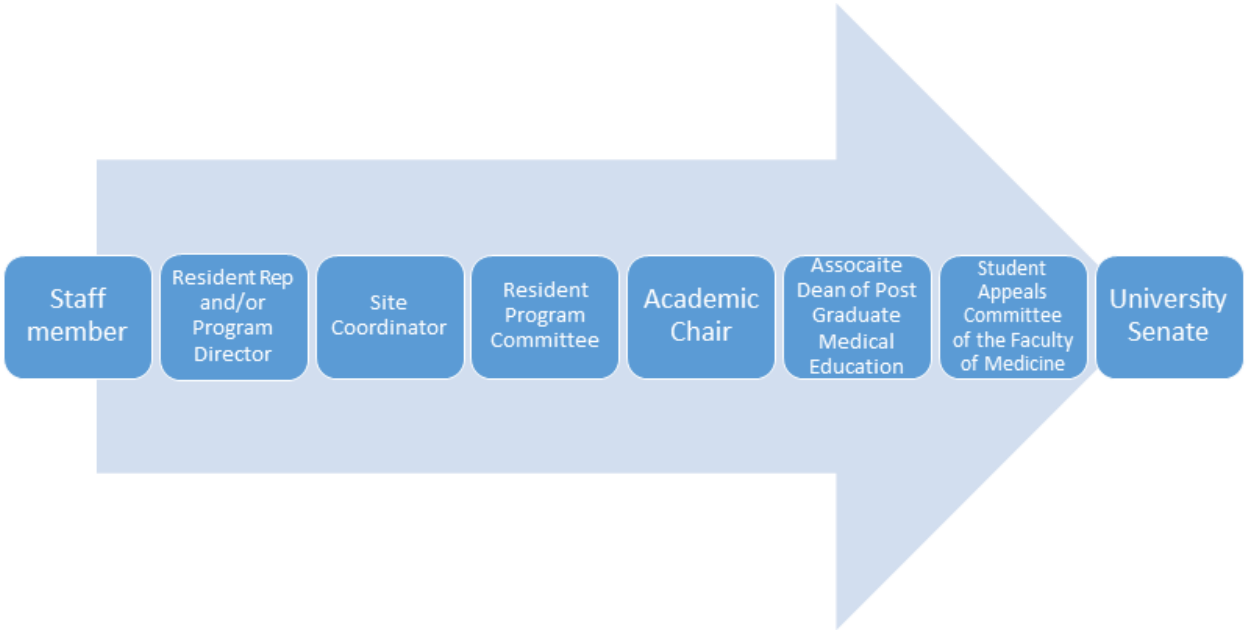
While regrettable, there may be the occasional trainee whose academic performance or professional behavior is unsatisfactory requiring that the resident's program be extended or that the training be terminated. It is essential that the evaluation systems be valid and appeal mechanisms fair. Residents may appeal an evaluation through their Residency Program Committee. Residents should be aware that an appeal process may or may not support their case.

Where applicable, residents are urged to first discuss an evaluation or concern with the rotation supervisor.

The resident then may appeal first to the Program Director in order that the appeal can be reviewed by the Residency Program Committee. This can be done by the resident alone, the resident accompanied by the chief resident or staff radiologist of the resident's choosing. The Residency Program Committee will convene in a reasonable time not to exceed 2 weeks.

If the resident is unsatisfied with the findings and decision of Residency Program Committee, an appeal can be made to the Associate Dean, Post Graduate Medical Education, for the appeal to be heard by the Post Graduate Medical Education Committee. The decision reached by the PGME Committee will be forwarded to the Program Director. After an appeal to the PGME Committee the trainee can appeal to the Student Appeal

Committee of the Faculty of Medicine, Memorial University of Newfoundland.



The Program Director can be approached directly as deemed appropriate by the resident.

SECTION 2

Departmental and Eastern Health Policies

RESIDENT TRAVEL AND LEAVE

FUNDING

Resident travel and funding guidelines are policies of the PGME office, as below:
Travel Policies\Resident Travel for Research and Scholarly Work Guidelines.docx

Travel Policies\RESIDENT TRAVEL GUIDELINES.docx

Travel Policies\Resident CPD Guidelines.docx

CONFERENCE LEAVE

7 days/year per resident (this includes the day before and the day after). A single email containing all of the below documents should be forwarded prior to the date you are requesting leave. The **SINGLE leave request email** must include:

1. The appropriate "Conference Leave Request Form" signed by **rotation supervisor** and **chief resident (or written approval from both documenting the same)**
2. The "Conference Leave Form" with both signatures (as noted above) must be accompanied by both:
   - **Conference Agenda/Brochure AND**
   - **Conference Registration Confirmation**

SICK LEAVE

Contract states 2 days/month – cumulative during each contract year. Forms ***must*** be completed and submitted to the academic office within 5 upon returning to work.

VACATION TIME

4 weeks/year, preferably taken in one-week blocks. No more than one week off per 4 week rotation. At discretion of Administrative Resident, Hospital Chief, and Program Director.If vacation has not been arranged for each year, it may be arbitrarily assigned. Vacation is not carried over or paid out unless otherwise specified in extenuating circumstances (pandemic etc).

Vacation leave forms must be signed and returned to the Chairperson's office prior to any leave being approved. If not, we will not guarantee that payroll will continue the resident's salary during this time off. A single email containing all of the below documents should be forwarded prior to the date you are requesting leave.

The **SINGLE leave request email** must include the appropriate leave form signed by **rotation supervisor** and **chief resident (or written approval from both documenting the same).** The program strives to have at least 2 residents at each site at all times, with the exception of the Janeway site.

Please refer to PARNL contract for further details.

CRITICAL INCIDENT AND STRESS POLICY (Adopted September, 2010)

PURPOSE

To establish authority and process to be followed within the Discipline of Radiology in response to a Critical Incident or Significant Stressor ultimately assisting residents who are involved directly or indirectly in patient care situations that involve negative outcomes, either real or perceived or assisting residents confronted with other significant stressors.

SCOPE

This policy will apply to all residents in the Discipline of Radiology as well as any residents or medical students who are participating in a radiology elective at the time of a critical incident.

DEFINITIONS

Critical Incident (CI) - An occurrence in which the resident is exposed to a negative patient outcome over which he or she feels they had a direct or indirect influence. This could include a patient's death that they personally witnessed or were involved with, regardless of whether they felt they acted appropriately or not.

Significant Stressor – Any significant stimulus contributing to a level of undue stress on a radiology resident that is identified by the resident, staff radiologist or other individual which requires attention to improve the quality of life, quality of work, academic progress, well-being of the resident and/or patient care.

Program Director – The faculty member responsible for the Radiology Residency Program

Staff Radiologist – Radiologist employed by Eastern health and engaged in resident education.

REPORTING A CRITICAL INCIDENT

A critical incident occurs in which the resident or supervising staff radiologist feels the resident needs to have a debriefing regarding the event. Either the resident or supervising staff shall be responsible for identifying the incident to the program director. Examples of CI may include any adverse outcome during a patient encounter. This would be most relevant to residents on rotations with procedural components such as interventional radiology.

REPORTING A SIGNIFICANT STRESSOR

A significant resident stressor may be identified by the resident him/herself, the program director or another individual(s).

REFERRAL AND MEETING GUIDELINES

The staff person is responsible for referring the resident to the CI/stress process. Referral is made to the program director by the staff person or resident involved. The referral can also be made by another health care provider who has knowledge of the event.

Where possible the referral for CI/stressor must be made within 3 days of the event. In situations where the effect of the CI/stressor is not immediately obvious, the referral must be made as soon as possible after the effect becomes obvious. The program director will arrange the meeting.

The first meeting shall be attended by the program director and the involved resident +/- the attending staff. The resident may elect to have another staff radiologist or mentor present/involved if there is a preference. If the resident designates such a staff to assist in the process then the program director may be excused.

Further referrals to other experts may be deemed appropriate; the Program Director or designated staff will be responsible for arranging such meetings with permission of the resident.

The confidentiality of the meeting is paramount and discussions will not leave the room. The only documentation shall be that the meeting occurred, who was present, when the next meeting is scheduled and that all parties are in agreement with what was discussed. This meeting shall not become part of the resident's permanent record.

There must be a follow-up meeting between the program director/other designated staff radiologist and resident, within 2 weeks to ensure any outstanding issues are resolved and that the resident is coping with the event. The Program Director or designated staff will arrange this meeting.

Support Services for Residents Involved in a Critical Incident or facing significant stressors:

The Resident shall be offered or referred for further counselling to one or more of the following services:

1. Ms. Rosemary Lahey (Professionals' Assistance Program 754-3007, 1-800-563-9133)
2. Dr. Rick Singleton (Pastoral Care 777-6959)
3. Eastern Health's Employee and Family Assistance Program (EFAP, 777-7777)

4. PAIRN, if appropriate
5. CMPA, if appropriate

HARASSMENT POLICY

A formal policy on Intimidation and Harassment is available through Postgraduate Medical Education Office.This policy also briefly addresses ethics and guidelines of conduct. The web site is: http://www.med.mun.ca/getdoc/759aa8ce-9b52-4989-bb50-f55c9f4c8a7e/Policy-on-Intimidation- and-Harassment.aspx

Support is offered by the office of Postgraduate Medical Studies through their Postgraduate Counsellor, Dr. Scott Moffatt. Dr. Moffatt is available directly or through the Postgraduate Office. This confidential service is separate in every way from the residents' evaluations and the discipline's assessments of the resident. Issues which arise among residents include the academic stress of residency, career choice issues, interpersonal conflict, financial stresses, and personal issues as a resident tries to find balance between their personal life and their life as a resident. The services are confidential and there is full backup support. In addition the Postgraduate Medical Studies office has had visiting speakers discussing stress management.

MEMORIAL UNIVERSITY RESIDENCY PROGRAM SAFETY POLICY

The Radiology Residency Program is committed to ensuring residency safety. We accept and follow a safety policy drafted by the Post Graduate Medical Education office. Please refer to this appended safety policy.

Herein the phrase, "the resident", refers to any person currently enrolled in post graduate radiology residency training at Memorial University of Newfoundland or any person not enrolled that is authorized by educational authorities to rotate through the radiology services of Eastern Health.

1. Safety policies of the Memorial University Radiology program reflect the broader safety policies of the postgraduate office, Eastern Health and Memorial University of Newfoundland. Please refer to each authority for current policies. Policies of those authorities supersede points 2 through 5 below.
2. Assessment of safety threats in the day to day performance of tasks performed as a radiology resident is left to the discretion of the resident.
3. Any work place situation deemed a threat is to be avoided at the discretion of the resident until such a time that the resident has sufficient support from other staff and/or security to proceed.
4. Campus police and civil police are available at 7280 and 911 respectively and should be notified of significant security/safety risks at the discretion of the resident.
5. Resident travel encompasses a variety of transportation modes potentially used by the resident through the course of residency training. It is the responsibility of the resident

to ensure that travel, in the context of the residency training requirements, is safe in all respects. All travel choices are at the discretion of the resident. Residents are encouraged to consult relevant agencies or authorities when traveling or planning to travel for necessary information to aid in the decision process.

DRESS CODE AS PER MEMORIAL UNIVERSITY FACULTY OF MEDICINE

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 behooves us all to present ourselves as professionals who are sensitive and responsive to our patient's expectations regarding appropriate identification, apparel etcetera while on duty.

In general clothing must be clean, proper fitting, comfortable and non restrictive. Beach style clothing, crop tops, halter tops and revealing clothing are not appropriate. Stiletto heels are also not appropriate.

PROGRAM TRANSFER POLICY

The Postgraduate Medical Education Committee recognizes that postgraduate trainees may wish to change programs and has developed the following policy and procedure in an attempt to ensure a fair and equitable process which will work to the benefit of all stakeholders. Although all requests for transfers will be considered, there must be recognition that not all requests will be granted.
This policy applies only to those who are in positions matched through CaRMS.

1. Postgraduate trainees should have options if they are enrolled in a program which they feel is inappropriate for their needs.

2. 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.

3. All transfer requests will go through the Postgraduate Medical Studies Office. The PGME Office will facilitate application while maintaining postgraduate trainee confidentiality.

4. The application and approval process will follow the "Procedures for Transfer".

5. Potential recipient programs will have access to the trainee's original CaRMS application, in-training evaluations and academic record; with signed authorization of release by the applicant.

6. Approved transfers will occur:
   i. January – first changeover in January
   ii. July – start date of academic year

7. In order for programs to have an opportunity to review all potential candidates, the deadline for completed application will be:
   i. October 30 - for January transfer
   ii. April 30 - for July transfer

8. All trainees will be advised of this policy at orientation and a copy of the policy will be contained in the PGY I Handbook.

9. Recognizing the potential stresses related to decisions to transfer, all applicants are encouraged to seek counseling through EAP or the Postgraduate Counselor. (Candidates may be required to seek this following that interview with the Postgraduate Dean).

10. Candidates with return-in-service agreements must clear potential transfers with their Sponsoring body.

11. Candidates who have received bursaries must clear potential transfers with the Department Of Health prior to application deadlines.

12. This transfer process is not intended to subvert the CaRMS match.

13. Candidates are not eligible for transfer prior to their PGY I year.

OTHER EASTERN HEALTH POLICIES

Policies can be accessed on the Eastern Health intranet at:
http://intranet.easternhealth.ca/EH/policies.aspx

Samples include (but are not limited to):

- Requests for Diagnostic Imaging Services
- Distribution of Reports
- Verbal Reports
- Copying of Images
- Professional Ethics
- Emergency Department D.I. Reports
- Significant Findings
- Contrast Medium
- Infection Control in D.I.

- Imaging of Female Patients of Child Bearing Age
- Radiation Equipment
- Radiation Protection Patients-Public
- Diagnostic Imaging Safety
- Diagnostic Imaging Safety Orientation, Education and Training
- CT Patient Shielding.pdf
- Virtual Colonography Preparation Kits
- Requests for Mammography
- Breast Imaging Guidelines
- Consent for Mammography Procedures
- Galactogram
- Imaging the Post Lactating Breast

SECTION 3

Aims and Objectives for PGY 1-5 RCPSC Specialty Programs

INTRODUCTION

A training program must have clear and measurable objectives. These objectives must include both cognitive and non-cognitive areas and appropriate evaluation is essential. In-training evaluation will be completed by the designated attending staff in each rotation. The trainee will be responsible for completing the trainee evaluation of the rotation. The in-training objectives and the trainees' attention to these objectives become very important as they attempt to achieve the goals we have set. These objectives are intended to serve as an outline of the essential elements of each rotation. Although not all named conditions may be seen by every trainee for every rotation, trainees should be familiar with them. In many cases, you may be able to achieve a much higher level of knowledge than outlined by these minimal objectives.

PGY 1 OBJECTIVES

The up to date objectives for the PGY1 RCPSC Non Radiology Specialty Programs can be found at http://www.med.mun.ca/Radiology/Residents/Curriculum/PGY-1.aspx

PGY 2-5 OBJECTIVES

The up to date objectives for the PGY 2-5 RCPSC Radiology Specialty Programs can be found at
https://www.med.mun.ca/Radiology/Residents/Curriculum/PGY-2.aspx
https://www.med.mun.ca/Radiology/Residents/Curriculum/PGY-3.aspx
https://www.med.mun.ca/Radiology/Residents/Curriculum/PGY-4.aspx
https://www.med.mun.ca/Radiology/Residents/Curriculum/PGY-5.aspx
https://www.med.mun.ca/Radiology/Residents/Curriculum/Physics.aspx