

Division of Urology
University of Toronto
Restricted Registration
Terms of Reference
May 2008

This objective of this document is to inform the practice of Restricted Registration (RR) during the province-wide pilot phase, as it applies to the Division of Urology at the University of Toronto. These terms of reference are designed to ensure that this practice does not interfere with the clinical and/or academic training and experience of residents within the program.

Background

In 2004 the College of Physicians and Surgeons of Ontario proposed the practice of RR for Residents. RR also known as “limited licensure” is defined as: “*Residents registered in postgraduate medical education programs leading to certification with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada who provide clinical services for remuneration outside of the residency program.*” (Council of Ontario Faculties of Medicine).

In September 2006, the Ontario Ministry of Health and Long Term Care identified Restricted Registration as a potential solution to the health human resources challenges in the province. In November 2006, the Post-Graduate Medical Education Councils of Faculties of Medicine (PGE-COFM) approved a proposal to the CPSO and the MOHLTC. At the request of the Minister and after consultations with stakeholders, including CPSO, PAIRO and other medical schools, the University of Toronto has developed a pilot project for RR. The Project Officer is Laura Silver as outlined above.

A limited license differs from an educational license in that it enables residents to deliver patient care outside of their formal educational training program, *within an area of practice in which they have demonstrated expertise.* There must be *appropriate* supervision from an independently licensed physician and *residents’ practice would be appropriate to their level degree of training.*

What Limited Licensure Is Not

Prior to the licensure changes of 1993, after completing a one-year general rotating internship residents received a general unlimited license to practice medicine. This practice was referred to as moonlighting and during their specialty training, residents worked extra shifts outside their residency training programs, covering hospital wards, emergency departments and providing locums. RR is not a return to this practice.

STANDARD EXPECTATIONS AND REGULATIONS

In conjunction with the CPSO, MOHLTC, PGME-COFM, The Council of Academic Hospitals of Ontario (CAHO), Professional Association of Interns and Residents of Ontario (PAIRO) and the University of Toronto, standard guidelines and expectations have been created for **ALL** residents participating in the program. These guidelines are summarized below:

1. The Program director will have full authority to refuse any resident permission to participate in the pilot or to discontinue their involvement after an application has been accepted;
2. There is NO opportunity for residents to contest a denied application during the pilot phase;
3. Residents must, at a minimum, have successfully completed the MCCQE Parts I and II, 18 months of residency training and be in good academic standing;
4. Each participating program will develop further criteria and training requirements for residents;
5. No resident will be allowed to work in environments which compromise the safety of patients, the resident themselves or their educational training of their home program. The CPSO clearly states:

“The College affirms that neither patient safety nor the well-being of residents be compromised for the purpose of meeting the administrative/staffing needs of hospitals or the personal financial concerns of residents.”

6. Residents MUST work in environments only at their level of training and level of supervision, as expected by their program;
7. The PAIRO-CAHO contract MUST be followed and no exceptions will be made – residents must finish an RR shift at least 12 hours prior to resuming the academic responsibilities of their program:

“...consistent with the collective agreement, residents will be bound by a 1 in 4 call maximum for both residency and extra-rotational shifts. A resident must not schedule an extra-rotational shift such that he/she is post call from this shift on a day in which they have regularly scheduled resident clinical duties.”

8. Residents wishing to work in Intensive/Critical Care Units must have successfully completed training in Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS).

SPECIFIC EXPECTATIONS AND REGULATIONS: Division of Urology, University of Toronto

In addition to the minimum guidelines mentioned above, the Division of Urology at the University of Toronto has outlined the following requirements:

1. The educational mandate of the residency-training program will take priority at all times. RR will not supercede nor interfere with the clinical and academic goals and objectives for residents on clinical or research-based rotations, either stated or implied;
2. The Program Director (PD) has the right to deny/remove any/all residents from RR at any time. This includes residents in both the clinical and research (surgeon scientist) streams. There is NO appeal process for this practice. As well, all RR placement must be approved by the Department of Surgery's Head of Post Graduate Training.
3. Within the Division of Urology, this practice will be limited to the teaching and community hospitals within the GTA as approved by the PD. The resident must demonstrate the educational content of such activity and that it is aligned with the mandate of the residency-training program. An appropriate surgical supervisor must be clearly identified (may or may not be the Most Responsible Physician) and agree to supervise the resident in a manner that satisfies the PD;
4. Residents will not be placed in circumstances where their own safety or the safety of patients could be compromised;
5. Residents must have completed a minimum of 24 months of clinical training and have passed the LMCC part II to participate in the RR program;
6. Residents participating in the RR program must have good academic standing within the program;
7. Residents must be certified in both Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS) to participate in RR;
8. The maximum allowable frequency of RR shifts is 4/month if the resident has not taken any holidays and the total number of shifts must be PAIRO-CAHO compliant;
9. During their holidays, residents may work as many shifts as they wish to do so, however, they must finish the RR shift at least 12 hours prior to resuming the academic responsibilities of their program;
10. Urology residents at the U of T may work in the following environments:
 - a. As surgical assistants in urology/general surgery cases
 - b. In an Intensive Care Unit in a teaching hospital (as defined by PD)
 - c. Emergency care of urology/general surgery patients, including as a resident consultant in an Emergency Department

- d. In-patient care of urology/general surgery patients
 - e. Resident-level appropriate operative care of urology/general surgery patients (as defined by PD and agreed by Supervisor and MRP)
11. The Urology Residency Program Training Committee and the Urology Council will monitor this activity. Concerns about misuse of RR can be brought forth to the RPC or Urology Council by any faculty or resident member of the Division of Urology.
12. All RR shifts must address all CanMEDS educational objectives. (Appendix A)

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APPENDIX A: CanMEDS Goals and Objectives for Limited Licensure

1) Professional

- deliver highest quality care with integrity, honesty and compassion
- exhibit appropriate personal and interpersonal professional behaviours
- always works with patients, families and staff in best interest of patient

2) Health Care Advocate

- identify the important determinants of health affecting patients
- identify and prevent risk factors for disease and injury
- contribute effectively to improved health of patients
- advocate for patients in their time of need

3) Scholar

- critically appraise sources of necessary medical information
- contribute to surgical literature involving urology and related subspecialty medicine

4) Medical Expert

- demonstrate diagnostic and therapeutic skills for ethical and effective patient care
- access and apply relevant information to surgical settings
- demonstrate effective consultation services with respect to patient care and education
- utilize information technology to optimize patient care, life-long learning and other activities

5) Manager

- utilize resources effectively to balance patient care, learning needs and outside activities
- work effectively and efficiently within the larger healthcare organization

6) Communicator

- communicate effectively with patients families, MRP, supervisor and other health care professionals
- discuss appropriate information with patients/families, allied health professionals and other members of the health care team
- ensure and protect appropriate patient confidentiality within the doctor-patient relationship

7) Collaborator

- consult and work effectively with other physicians and health care professionals
- contribute effectively to other interdisciplinary team activities