Internal Review—A Fruitful Family Practice Evaluation Tool

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In 1975 the Department of Family and Community Medicine, University of Toronto, initiated a system of internal review of its undergraduate and postgraduate programs. During the next six months each of the major teaching resources for the family practice component of the programs was visited by an inspection team. A detailed report with recommendations was prepared and received wide distribution. After this initial review, the internal medicine and pediatric components of the curriculum were evaluated. Again reports and recommendations were made. At the present time the surgical and psychiatric components of the program are being evaluated.

This ongoing internal review has had several benefits including specific changes in programs, better organization, and a better understanding of the department and its goals. Some of the difficulties are the time and organization necessary for a valid and appropriate review.

The review of educational programs by external bodies has been in vogue since the Flexner Report of 1910. Many organizations conduct reviews of hospital care, medical care, and teaching programs. These organizations include various hospital accreditation bodies, the medical colleges' accreditation bodies, and various professional standards groups. Internal review has also been done in the past but in a less organized way and on a less regular basis. More attention is now being paid to this educational technique.[1]

The Department of Family and Community Medicine at the University of Toronto was created in 1969. From its initiation it has had a specific core undergraduate role in the clinical clerkship (fourth year). In 1970, the department began a residency program. The department has had to develop large and complex undergraduate and postgraduate training programs. There are about 250 medical students in each of four undergraduate years at the University of Toronto, and the department now has over 130 residents in a two-year postgraduate program with a small number of additional residents in an optional third year of further training. The department has seven teaching hospital units and four community health centers as major teaching resources as well as over 40 approved teaching practices. Much of the teaching takes place in the hospitals' family practice units.

This organization and rapid development make curriculum coordination and evaluation a major task. Between 1970 and 1973 the department developed detailed objectives and curriculum for

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Table 1. Number of Recommendations by Category

	General University Recommendations	Specific Hospital Recommendations
Administration	0	4
Organization	2	7
Staffing	0	2
Program Objectives	1	7
Program Content	3	8
Type of Experience	3	5
Records	1	0
Evaluation	1	1

both undergraduate and postgraduate students.[2,3] In 1975, to facilitate the process of curriculum evaluation, the department began a system of internal review of its programs and the various components of these programs. The initial internal review methodology and results will be described, the further review stages will be outlined, and then some of the advantages and problems of the process will be discussed.

Methodology

It was decided by the departmental executive committee (department chairman, heads of the hospital units, and the major departmental coordinators) that the initial review would be of the family practice components of the residency program and the undergraduate curriculum. Although the department coordinates and presents an interdisciplinary program for students, especially at the residency level, the first assessment would be related to our educational contribution to our own programs.

An "on-site inspection" team was created consisting of six members. These members were three senior and experienced staff from the department, two nonphysician representatives, and one senior resident. One of the nonphysician members was a behavioral scientist-researcher-educator with experience teaching in the family practice program at another medical school. The other was a professor of industrial engineering with experience in medical practice organization and medical records. The full team visited each of the seven teaching hospital family practice units, spending approximately one half-day per visit. Members of the team also visited three of the community health centers. The visits were scheduled at approximately two-week intervals.

Each visit was organized to correspond and replicate as nearly as possible the visits to the other units. Before each visit the hospital family practice department head received a questionnaire which had to be completed and returned before the scheduled visit. This questionnaire included details about unit organization including ancillary staffing, specific medical student and resident ro-

Table 2. Reference of Specific Recommendations to Departments

Department	Number of Recommendations
Family practice	17
Internal medicine	5
Surgery	5
Obstetrics-gynecology	5
Pediatrics	4
Psychiatry	3
General	2

tations, special departmental staff skills, and local seminars and education programs. In addition, comments on any local problems were requested. Each team member received these details prior to the visit. On the day of each visit the team met with the hospital department head, several residents, and one or more clinical clerks. The resident group had representatives from both first and second years present. This initial session usually took one half hour. The department head presented the basic program in his unit and answered and elaborated on any inquiries regarding the questionnaire. All information was gathered in relation to the detailed objectives of the clerkship and the residency programs. Next, the department head left the room and the team spent approximately one-and-one-half hours discussing the program in detail with the clerks and the residents. The team then spent about one half hour visiting the unit and discussing with selected nurses, social workers, and other staff, questions about the organization, quality of patient care, and ancillary staff educational contributions to the clerkship and residency training. Finally, a second half hour was spent with the department head to clarify any questions or concerns which might have arisen during the visit.

Following the on-site visit, a draft report was prepared using the departmental objectives as a guide. When the team had approved the preliminary report it was forwarded to the hospital unit head for comments and any suggested modifications. Following the receipt of these comments a final hospital report was prepared with specific recommendations for changes within the unit and/or its educational programs. When all the units had been visited and all the individual hospital unit reports had been prepared, the on-site visiting team met one final time and prepared a general report with university departmental recommendations. The full report, which included both the general departmental report and the individual hospital reports as well as the general and the specific hospital recommendations, was then forwarded to the university department chairman. Each individual hospital report was forwarded to the hospital family practice unit head. One confidential recommendation was sent in private to the department chairman and was not included in the report. After consideration by the department chairman, the full report was circulated to the dean of the medical school and to the full departmental executive committee. The report contained recommendations regarding organization,

patient care, and practice management as well as educational concerns.

Tables 1 and 2 show a breakdown of the recommendations related to category and also the departments referred to in the specific recommendations. Since there may be several areas or departments mentioned in a single recommendation the totals do not correspond in the two tables.

Outcome From the Visits

From the beginning all of the participants took the process seriously, including the students at various levels. The competitive response to the evaluation was interesting and satisfying. The total process from initial planning to the final report took approximately six months. By the time the final report was presented to the executive committee nearly 50 percent of the specific hospital recommendations had been implemented. In fact, either the hospital heads anticipated the inspection team or vice versa because frequently comments related to the preliminary reports stated that the recommended changes were planned or were being implemented in the near future (within one month of the visit!). It would be foolish to state that all of more than 40 general and specific recommendations were followed. In fact, all the recommendations were neither feasible nor justified. Nonetheless, about one year later it appeared that about three quarters of the recommendations had been implemented partially or completely.

Several examples will be given to illustrate specifically some of the recommendations and the responses to them.

Among the general recommendations were the following two:

Recommendation Number Three:

"Whereas all residency training programs offer adequate training experiences for residents in Stream A and Stream B but lack the resources necessary to offer appropriate training experiences related to practice in rural areas,

The Department of Family and Community Medicine should concentrate the Stream C experience in the second year in a minority of the programs which would develop the necessary resources to offer the required training."

The University of Toronto residency objectives are organized around Stream A (urban practice), Stream B (standard practice), and Stream C (remote and rural practice). This recommendation is still being considered by the department but all hospital units have increased their resources related to Stream C training.

Recommendation Number Six:

"Whereas monitoring of clinical performance, evaluation, and ongoing feedback are essential to a training program,

Residents should receive direct and ongoing feedback, positive and negative, on their clinical performance and the management of patient problems, particularly from supervising physicians."

This recommendation led to a subcommittee of the postgraduate education committee which prepared and implemented a specific report on evaluation. This report outlined minimum departmental requirements for frequency, type, and extent of evaluation and feedback, related both to the total program and to the residents' daily experiences.

Examples of specific hospital recommendations are as follows:

Hospital A

"The family practice unit should work with the hospital department of internal medicine to discontinue the ambulatory clinics held in the family practice unit by two subspecialty internists."

These clinics were discontinued shortly after the report was completed.

Hospital B

"The family practice department should hire a full time staff person who would be responsible for the residency program."

With university departmental assistance a major part-time appointment was made.

Hospital C

"Residents should have more opportunity for delivering babies in the obstetrical and family practice rotations."

The obstetrical rotation was supplemented by another hospital assignment.

Hospital D

"The teaching functions of the X Health Center should be available as a resource to both years of the residency program."

This health center continues to be used nearly exclusively for clerkship and second-year residency training.

In addition to the changes in the department due to the report, several other outcomes occurred. The senior departmental members on the committee gained increased knowledge and insight into the workings of a complex and large teaching program. The coordinator of the residency program was a member of the visiting team. He found the detailed knowledge of the individual units useful both for evaluation and for the organization of varied and complex scheduling. The department chairman, although not on the team, gained more hard facts for deciding questions of allocation of resources and finances. Each hospital unit head learned many new things about his unit, how it functioned, and how the educational process worked in his setting.

The committee spawned several more committees. Because of the time of year during which this on-site review took place, the team was unable to make a complete assessment of the undergraduate clerkship program. Since 1976, the department coordinator of undergraduate programs has undertaken an on-site visit each year to interview clerks and to assess the adequacy of their program. The coordinator, the unit heads, and the departmental undergraduate education committee have found these visits very useful for ongoing clerkship curriculum assessment and change. During 1976, the Departments of Internal Medicine and Pediatrics of the University of Toronto agreed to a similar on-site internal evaluation of their contribution to the family practice residency program. These visiting teams included senior faculty from the respective departments as members of the team (including a former Dean of medicine on the pediatric visiting team). The final reports regarding these departments were forwarded to the university department chairman involved as well as to the Dean of Medicine. Again, these reports and their recommendations have led to both a better understanding of the educational process and to specific changes in programs. Through this process senior faculty of other university departments have become informed about the objectives of the Department of Family and Community Medicine. The residents' organization also conducted a thorough review of their program mainly in response to the report of the original on-site team. At the present time the university Departments of Surgery and Psychiatry are cooperating in the evaluation of their contributions to the family practice residency program.

All these endeavors of internal review have helped the department continually modify and improve programs. Recently, department development and student numbers have leveled off and stabilized. One of the outcomes of these various reviews has been the understanding that there are several major changes that would be beneficial to the overall program. Regrettably, there is not enough time in the curriculum to accomplish all that has been suggested in the review process. Therefore, the departmental executive committee has created a major committee to suggest future directions and major changes in programs. This committee will analyze the data and recommendations of the several review committees as well as other data, and decide priorities and mechanisms to evolve the best program possible.

Discussion

Internal review as undertaken by the Department of Family and Community Medicine, University of Toronto, is a major undertaking. It involved about 300 hours of senior faculty, resident, and staff time for the family practice on-site review. If the time for the internal medicine, pediatric, surgery, psychiatry, and residents' review is included, this figure would be doubled. Interestingly enough, the residents who make a major and essential contribution to the review process have the most difficulty freeing up the time to make an appropriate input. There is no doubt the internal review process is very time consuming although it appears that, once an initial review has been accomplished, yearly reviews by one individual can maintain the impetus and information needed for further change.

At about the same time the department began its family practice on-site review, two other groups were doing an external review of the university department. The College of Family Physi-

cians of Canada was conducting its external review of accredited family practice programs at the University of Toronto. In addition, a Dean's ad hoc committee was doing a review of the development and programs of the Department of Family and Community Medicine. The latter committee did not make a report with specific recommendations but functioned more as an information gathering committee. The College of Family Physicians' report was both pertinent and helpful to the department. Nevertheless, the internal review appeared to be much more useful to the department and its further development. An external review covers the basic and gross needs of an educational program whereas an internal review gives both a basic review and also suggests the fine tuning needed for a better and more effective program. With senior faculty of the department as members of the review team several benefits accrue. First, they are knowledgeable about the departmental objectives, curriculum, and organization. Thus their assessment and recommendations can be much more relevant and feasible. Secondly, these team members are involved in the implementation of the recommendations. The team also needs the input of outsiders, both learners and nondepartmental members. Without discounting the benefits of and need for external review, it appears that an appropriate internal review process is more beneficial for educational review and change.

In summary, what are the benefits of the internal review process as conducted by the Department of Family and Community Medicine, University of Toronto? First and foremost, the specific recommendations of the review team give the department direction and assistance to improve organization, patient care, and educational programs. Secondly, their intimate knowledge of the departmental programs assists faculty in judging and planning future developments within the department. During the review process the staff members at all levels are forced to look at themselves and their input into the educational process. This is a potent force for staff development. The more staff members are realistically involved in the review procedures, the better the outcome is likely to be. The senior staff members involved in coordination of the programming should, if possible, be on the review team. In addition to the increased understanding the staff gains, the residents both help themselves understand the objectives and process of their education and help to make the program better for their peers.

The hospital unit heads found the hospital reports useful as a specific tool to obtain better facilities and resources for adequate programming in their individual hospitals. In fact, more than one of the unit heads asked the team to make specific recommendations so they would have ammunition to take to various hospital committees for better programming. In all but one instance, the final report contained the requested recommendation.

The problems of this technique are mainly those of time and scheduling; time to organize the endeavor, time for the review process, and time to write and act on the reports. Probably the most difficult problem is that of scheduling. It is necessary for the same members to visit each unit. Within the University of Toronto department there are seven main hospital units as well as several major community health centers and numerous teaching practices. The scheduling of visits to accommodate the team and the units takes commitment and effort. One senior member of the department must be responsible for the process and must make considerable effort to maintain the interest and initiative within the department.

Is it all worth it? In this author's estimation the considerable time and effort is definitely worth it. In fact, I feel any university department that wishes to appropriately fine-tune its organization, patient care, and educational programming must undertake some form of internal review and self-evaluation.

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