DEPT. OF FAMILY MEDICINE

PRECEPTOR TOOLKIT

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1. Introduction

Welcome to teaching with the University of Manitoba's Department of Family Medicine. We hope you experience the rewards that come along with sharing your knowledge and skills with learners. Recognizing that we all have different starting points and strengths regarding teaching, we've put together this toolkit with the basic tools you need in the preceptor role. This resource is not a static document; content will be updated to reflect policy changes, new research, and curriculum change.

You will likely find the contents helpful at different points of your teaching path. We welcome your feedback and wish you the best in your teaching.

2. Programs

2.1 Faculty Development

As new faculty, your first encounter with faculty development is through orientation. You are encouraged to attend a general orientation day. In addition, each Family Medicine site coordinates a local orientation, which generally includes an introduction to the particular organization, instruction on clinic work flows, and an explanation of how teaching is integrated into clinical care.

To assist you in developing competence as teachers, the College of Medicine Department of Medical Education offers a two-day teaching improvement workshop. Also, your clinic director, or a designated alternate, coaches new faculty members as they develop their clinical teaching skills. In addition, the university offers web-based written resource materials such as the teaching handbook through The Centre for Advancement on Teaching and Learning. Throughout the year, the Department of Medical Education offers free workshops and seminars to improve various aspects of teaching.

Throughout the year, you are encouraged to attend Department of Family Medicine faculty development opportunities which include two hours of seminars or workshops three times a year and full-day sessions twice a year. Among core topics regularly included in the faculty development day programming are Resident Assessment and Feedback.

Another excellent way to develop and improve teaching skills is through the McMaster Small Group Modules. The department has purchased a number of modules focused on core teaching skills and offers sessions on each.

You may find it challenging to find time away from other duties to develop your knowledge and skills in the area of teaching. The reward, however, generally offsets the costs; faculty development within the department offers a time to reflect on your work and connect with others, which can be both validating and reenergizing.
Here’s what some faculty have said in their end of session evaluation forms from the past several years:

“Thoroughly enjoyed this session. Would like it for our residents.”

“Very useful.”

“From this session, I have learned how to recognize the difficulties facing learners and ways to work with them.”

2.2 Undergraduate Program

There are several opportunities for family medicine faculty to participate in undergraduate medical education. Renewal of the undergraduate curriculum has identified generalism as a priority as well as the importance of increased exposure to family medicine throughout the curriculum.

Opportunities exist for both community based clinical teaching and small group facilitation for both pre-clerkship and clerkship students.

These include the following:

- Clinical and Communication Skills teaching
- Clinical Reasoning small group facilitation
- Community Based Learning clinical placements
- Interprofessional Education small group facilitation
- Elective clinical placements
- Comprehensive Patient Assessment facilitation
- Rural clerkship clinical placements
- Evidence based medicine small group facilitation
- Academic half-day small group facilitation

For more information on these opportunities, or to find out how to get involved, please contact Amanda Condon. Contact information is available later in this section.

2.3 Postgraduate Program

The goal of the University of Manitoba Department of Family Medicine Residency Program is to train family physicians who are able to provide comprehensive, high quality, continuous care in urban, rural, and remote settings.

As teachers of residents, you will work within the Triple C Curriculum framework which is **Comprehensive**, focused on **Continuity** of education and patient care, and **Centered** in Family Medicine. Residents are assessed based on levels of competency, and depending on your role (clinical or competency coach, mentor, or academic advisor), you will be expected to provide residents with ongoing feedback as well as document assessment of competency.

You are also encouraged to become involved in academic sessions, and teaching in your area of interest.
RESOURCES:

Triple C Curriculum
http://www.cfpc.ca/Triple_C/

Resident Manual

Residency Competency Framework

Postgraduate Website
http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/postgrad/index.html

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3. Preceptor Roles & Responsibilities

In this section, appointment definitions and descriptions of responsibilities can provide context for your teaching activities. The section concludes with the Fundamental Teaching Activities Framework, which has been developed by the Section of Teachers, CFPC. The framework provides a way to understand your teaching activities along a continuum and will allow you to identify not only where you fit, but also to consider areas in which you need development, training you can offer your peers, and activities you may want to include in your application for promotion. Finally, as teachers in Family Medicine you are part of an interprofessional team and will benefit from your work with others within a collaborative model.

3.1 Definitions

These definitions help to understand the various preceptor designations and roles.

**GFT** - Geographic Full Time

**NSA** (previously known as NIL) - nil salaried appointment

**Cross Appointment** - a discontinued practice; in the past, a person might work primarily in one specialty such as Internal Medicine but also precept in another specialty such as Family Medicine. This person would hold a cross appointment.

**Preceptor** - a teaching health professional

Note: depending on profession, other terms may be used in lieu of precept such as “cover” in nursing.

**Community Preceptor** - The following link offers a description of educational and administrative duties and responsibilities of the community preceptor: http://umanitoba.ca/faculties/medicine/units/family_medicine/media/job_description_Community_Preceptor.pdf

**Clinical Preceptor** - the domain of clinical preceptor falls into two categories:

1. **Clinical Coach** - a supervisor in day-to-day practice whose activities may include:
   - Explicitly embody the roles, attitudes and competencies of a family physician in clinical work
   - Promote and stimulate clinical reasoning and problem solving
   - Give timely, learner-centered, and comprehensive feedback
   - Use program assessment tools to document observed learner performance according to level of training
   - Employ reflective practices to refine clinical supervision

RESOURCES:

- Full Glossary (See page 42)
- Community Preceptor Administrative Duties and Responsibilities http://umanitoba.ca/faculties/medicine/units/family_medicine/media/job_description_Community_Preceptor.pdf
2. Competency Coach - an educational advisor along the course of learner training whose activities may include:

- Assist learner in his or her professional development
- Help learner design and update his or her individual learning plan
- Guide a comprehensive periodic progress review informed by the learner's self analysis
- Adjust interventions to support a learner facing progression challenges

Mentor - An experienced individual who offers an ongoing supportive relationship to new faculty or learners. This relationship provides the opportunity to build knowledge in an open and non-judgemental environment. Mentorship may focus on career development, shared experiences, practical advice and provision of networking.

3.2 Fundamental Teaching Activities Framework, 2015

Section of Teachers of Family Medicine, CFPC

The Fundamental Teaching Activities in Family Medicine Framework for faculty development is a resource tool that facilitates teaching development. Created by the CFPC's Working Group on Faculty Development, this framework includes three main teaching domains and the tasks that are commonly associated with each sphere. Each task is linked to fundamental teaching activities which can provide teachers with a sense of what is expected of them and how they may guide their own development within their role. Its purpose is to guide self-reflection, professional development and facilitation in developing programming in faculty development.

3.3 Interprofessional Collaboration Model

Interprofessional faculty (IPF) contribute to all aspects of the work of the FM Teaching Clinics and the Department of Family Medicine, including clinical practice, education and research and scholarly work. IPF are health professionals working with their physician colleagues in the Family Medicine teaching clinics. Together, IPF, physician faculty and Family Medicine residents work to provide high quality care, role modeling the values and principles of Family Medicine.

Teaching Activities

Interprofessional faculty practice independently and collaboratively with physician faculty and a range of learners, demonstrating the scope of practice of their respective discipline.
This team effort creates interdisciplinary learning opportunities in a family practice setting. Among the activities are the following:

- Lead and contribute to clinical quality improvement initiatives, facilitating learning opportunities for Family Medicine residents
- Participate in the selection of graduate medical learners (CaRMS processes)
- Supervise, coach, collaborate with learners
- Contribute to evaluation of learners, bringing a different lens to evaluation processes including: review of resident progress, simulated office oral examinations, and clinical observation
- Teach academic content e.g., clinical guideline review, undergraduate medical education undergraduate and post-graduate teaching in other health faculties
- Lead, contribute to research and scholarly activity, as well as helping to advance the research agenda of the Department of Family Medicine
- Coach and supervise learner scholarly projects, thereby contributing to the development of competencies associated with the Can-MEDS-FM Role of the Scholar, i.e., lifelong learning skills, research skills

The Interprofessional Faculty Committee advocates for and supports IPF in teaching, clinical practice/collaboration, and innovative scholarly activity within the department.
4. Triple C Curriculum

A national move towards the Triple-C Curriculum for Family Medicine postgraduate programs is underway. At the University of Manitoba, these changes are also being implemented, with resources being added to the departmental website as programs evolve. Triple C curriculum is comprehensive, competency-based training that is centered in Family Medicine and offers continuity of education and patient care.

Our academic curriculum is competency based. Accordingly, learning objectives and end of program evaluations reflect expectations related to competency. As curriculum changes are implemented that reflect the Triple-C philosophy, the focus will shift away from learning experiences centered on specialty or problem to learning experiences centered on patients across lifecycles from a Family Medicine perspective.

As new preceptors and staff, you are encouraged to participate in the change process by seeking clarity, asking questions, and discussing the changes being implemented. By offering your observations and experiences, you help to build a strong program of learning with optimal outcomes for learners, patients, and their families.

RESOURCE:

You can access the CFPC’s documents, videos and other supporting information here:

http://www.cfpc.ca/Triple_C/

4.1 Definition of Competency Based Education

“Competency Based Education is an approach to preparing physicians for practice that is fundamentally oriented to graduate outcome abilities and organized around competencies derived from an analysis of societal and patient needs. It de-emphasizes time-based training and promises greater accountability, flexibility, and learner centeredness.”

4.2 CanMEDS-FM Framework

The CanMEDS-FM tree (previous page) is adapted from the Royal College of Physicians and Surgeons’ CanMEDS roles to integrate the four principles of family medicine. In the image, seven roles include the family medicine expert as integrating role. The four principles are imagined as inspiring and informing the roles.

FOUR PRINCIPLES OF FAMILY MEDICINE:

1. The family physician is a skilled clinician.
2. Family medicine is a community-based discipline.
3. The family physician is a resource to a defined practice population.
4. The patient-physician relationship is central to the role of the family physician.

The University of Manitoba Family Medicine program has identified Family Medicine foundational and domain-specific competencies that residents will achieve by the end of their residency. These have been organized under CanMEDS roles with consideration of the new CanMEDS 2015 framework. Under each of the roles below, foundational competencies are listed with links to enabling competencies.

MEDICAL EXPERT

FAM1 Understand the role of the Family Physician in the healthcare system
FAM2 Provide comprehensive preventative care throughout the life cycle incorporating strategies that modify risk factors and detect disease in early treatable stages
FAM3 Perform a patient-centered clinical assessment with the goal of establishing a management plan of common (key) conditions in family medicine
FAM4 Distinguish, investigate and respond appropriately to serious acute, urgent, emergent conditions in all settings
FAM5 Demonstrate an effective approach to the presentation of undifferentiated symptoms/conditions
FAM6 Demonstrate an effective approach to the ongoing care of patients with chronic conditions
FAM7 Perform family medicine specialty-appropriate procedures to meet the needs of individual patients and is knowledgeable about procedures performed by other specialists to guide their patients’ care
FAM8 Establish patient-centered care plans that include the patient, their family, other health professionals and consultant physicians
FAM9 Actively participate, as an individual or as a member of a team providing care, in the continuous improvement of health care quality and patient safety
COMMUNICATOR

FAM10  Establish effective professional relationships with patients and their families

FAM11  Elicit and synthesize accurate and relevant information, incorporating the perspectives of patients and their families

FAM12  Share healthcare information and plans with patients and their families

FAM13  Engage patients and their families in developing plans that reflect the patient’s health care needs and goals

FAM14  Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy

COLLABORATOR

FAM15  Work effectively with physicians and other colleagues in the health care professions

FAM16  Hand over the care of a patient to another healthcare professional to facilitate continuity of safe patient care

LEADER/MANAGER

FAM17  Contribute to the improvement of health care delivery in teams, organizations, and systems

FAM18  Organize and manage patient information in an EMR in order to better manage and individual patient’s care

FAM19  Organize and manage patient information in an EMR in order to better manage care in a practice population

FAM20  Engage in the stewardship of health care resources

FAM21  Demonstrate leadership in professional practice

FAM22  Manage their practice and career effectively

FAM23  Implement processes to ensure personal practice improvement

HEALTH ADVOCATE

FAM24  Respond to an individual patient’s health needs by advocating with the patient within and beyond the clinical environment

FAM25  Respond to the needs of the communities they serve by advocating with them for system-level change in a socially accountable manner
SCHOLAR

FAM26 Engage in the continuous enhancement of their professional activities through ongoing learning and reflection

FAM27 Integrate best available evidence, contextualized to specific situations, into real-time decision-making

FAM28 Contribute to the creation, dissemination, application and translation of new knowledge and practices

FAM29 Facilitate the learning of students, residents, the public and other healthcare professionals

PROFESSIONAL

FAM30 Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards

FAM31 Demonstrate a commitment to society by recognizing and responding to societal expectations in health care

FAM32 Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation

FAM33 Demonstrate a commitment to physician health and well-being to foster optimal patient care

4.3 Domains of Care & Special Topics

In addition to their foundational competencies, residents will gain competency in various domains of care. (See the Family Medicine Residency Curricular Grid for more information).

The domains focus on phases of a patient’s lifecycle; special topics address learning related to particular populations and patient needs. The scholarly curriculum addresses competencies physicians require to learn, put into practice, and disseminate research. Specific key and enabling competencies are itemized in the linked competency framework document.

RESOURCES:

Residency Competency Framework
5. Essential Tools for Preceptors

From preparing your office for the learner to the nitty gritty of learning and assessment, this section provides basic pointers to consider in your role as preceptor.

5.1. Preparing your Office for the Learner

Integrating learners into a busy office practice is challenging. Here are some practical tips to prepare yourself and your office for the presence of a learner.

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**Family Medicine Residency Curricular Grid**

<table>
<thead>
<tr>
<th>FAMILY MEDICINE FOUNDATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Med Foundation Program objectives Competencies Milestones EPA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOMAINS OF CARE</th>
<th>CLINICAL EXPERIENCES</th>
<th>NON-CLINICAL LEARNING</th>
<th>OBJECTIVES</th>
<th>EVALUATION TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal care Competencies EPA</td>
<td>Obstetrics rotation</td>
<td>AI ARM Obstetrical Emergency Simulations</td>
<td>Rotation objectives Longitudinal exposure objectives</td>
<td>ALARM results ITER Maternal care field notes</td>
</tr>
<tr>
<td>Care of Children Adolescents Competencies EPA</td>
<td>Neonatology (longitudinal) In-patient Pediatric</td>
<td>NRP PALS (Northern Remote)</td>
<td>Rotation objectives Rotation objectives Rotation objectives</td>
<td>NRP Results PALS Results ITER E&amp;F end-of-shift evaluations Field notes</td>
</tr>
<tr>
<td>Care of Adults Competencies EPA</td>
<td>Family Medicine (outpatient)</td>
<td>ACLS</td>
<td>Rotation objectives</td>
<td>ACLS results ATLS results FR end-of-shift evaluations Field notes ITER 360 evaluations</td>
</tr>
<tr>
<td>Life cycle</td>
<td>Surgical care</td>
<td>Longitudinal exposure objectives</td>
<td>Rotation objectives</td>
<td>Field notes ITER</td>
</tr>
<tr>
<td>Special topics</td>
<td>Palliative Care Competencies EPA</td>
<td>Palliative care rotation</td>
<td>Longitudinal exposure objectives</td>
<td>Field notes ITER</td>
</tr>
<tr>
<td>Scholarly curriculum</td>
<td>Care of First Nations, Inuit, and Métis Population Competencies EPA</td>
<td>Objectives</td>
<td>Field Notes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care of Vulnerable and Underserved Populations Competencies EPA</td>
<td>Objectives</td>
<td>Field Notes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavioural Medicine Competencies EPA</td>
<td>Shared-care psychiatry (longitudinal)</td>
<td>Longitudinal exposure objectives</td>
<td>Field Notes ITER</td>
</tr>
<tr>
<td></td>
<td>Scholarly curriculum</td>
<td>PEARLS QI curriculum SOO SAMPs</td>
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<tr>
<td></td>
<td>PGML Care curriculum</td>
<td>DFM Academic days In unit sessions Journal club PEARLS QI curriculum SOO SAMPs</td>
<td></td>
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</tr>
</tbody>
</table>

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5. Essential Tools for Preceptors

From preparing your office for the learner to the nitty gritty of learning and assessment, this section provides basic pointers to consider in your role as preceptor.

5.1. Preparing your Office for the Learner

Integrating learners into a busy office practice is challenging. Here are some practical tips to prepare yourself and your office for the presence of a learner.

**PREPARE YOUR OFFICE**

Colleagues and staff need to be aware that a learner will be in your office. They also should be informed of the learner’s goals. Staff may be able to prepare patients to interact with the learner.

Ask staff to help orient the learner. Suggestions:

- Tour of the office
- Introduce key people within the office
- Provide your learner with a small workspace

Some physicians may find it helpful to alter their schedule (e.g., the wave schedule) when a learner is present.

- Wave scheduling allows the physician to see the normal number of patients
- Make sure to inform patients who will have “double visits”

[RESOURCE: Sample Wave Schedule](http://www.practicaldoc.ca/wp-content/uploads/2012/10/Wavescheduling.pdf)


**PREPARE YOUR PATIENTS**

Notify patients beforehand that a learner will be in your office. Suggestions:

- Ask staff to notify patients when they make their appointments or when they arrive in the office
- Post a sign in the office or on the door announcing the presence of a learner
- Ask for the patient’s permission to involve the learner before the learner enters the room.
- Introduce the learner formally to the patient and explain that the learner is a part of your team.
- Thank the patient at the end of the visit.
PREPARE YOURSELF

• Review the objectives of the course/rotation
• Be familiar with the level of learner and her/his previous experience
• Book time for student orientation, mid-session feedback, and final evaluation
• Get to know your learner as an individual; express interest in his/her development

QUESTIONS TO ASK YOURSELF

• How can the learner be welcomed into my office?
• What does the learner need to know about my office?
• What changes need to be made to my office and who can arrange that?
• Does a colleague have special knowledge they may want to share with the learner?
• Are there activities that a staff member or colleague might want to take the learner to?

REFERENCES

Clinical Teaching Techniques, Medical Education

- Integrating the Learner Into the Busy Office Practice, MAHEC Office of Regional Primary Care

Education

- http://www.oucom.ohiou.edu/fd/monographs/busyoffice.htm

Practical Professor, The Alberta Rural Physician Action Plan

- http://www.practicalprof.ab.ca/preparing_to_teach/preparing_your_office.html

Setting Expectations, MAHEC Office of Regional Primary Care Education

- http://www.oucom.ohiou.edu/fd/monographs/setting.htm

Created By: Lauren Taylor, MEd; Feinberg School of Medicine; Northwestern University

If you’d like a copy of our departmental sign, contact Dr. Christine Polimeni at: Christine.Polimeni@umanitoba.ca
5.2 One Learning Model & How to Apply it to Teaching

As a preceptor, it is helpful to remember how learning happens. Teachers have become experts, and as such, much of their knowledge is tacit, and procedural knowledge automatic. When learning something new, it is helpful to have these tacit, automatic pieces made explicit and broken down. Depending on the type of task, scaffolding, repeated practice, intermittent reflection, and frequent testing all help with learning.

FOUR STAGES OF COMPETENCE

One useful model of learning for competency based education is the four stages of competence:

Stage 1: Unconsciously Incompetent

Learners do not know what they do not know or might need to know. Or, they might think they know how to do something and don’t realize they don’t until they have to do it.

Your role as teacher is to demonstrate the skill or create a situation in which the learner is challenged so that the learner realizes that s/he needs to learn.

Stage 2: Conscious incompetence

Learners are aware that they don’t know and aware of their need to learn and practice.

Teachers offer opportunities to practice with instruction, modelling, supportive feedback, and repeated attempts. Mistakes are welcomed as learning opportunities.

Stage 3: Conscious Competence

Learners can perform the skill or demonstrate their knowledge without support. However, they may still not be completely confident or always right in their demonstration of knowledge of skill.

Teachers continue to offer practice opportunities with feedback as needed. Reinforcing what is done well or right goes a long way in moving to unconscious competence.

Stage 4: Unconsciously competent

A skill or knowledge has become automatic: learners can use their knowledge and skills without conscious thought. In fact, at this level of expertise, it is sometimes difficult to explain or break down the skill or concept for others.

Teachers can encourage reflective actions of learners to make subcomponents/processes explicit so that learners can teach others or so that they can generalize to novel situations.

When considering the four stages in a learning cycle, you can link your teaching to what your learner needs.
Learning Environment
The environment for learning should be one where the learner feels safe and supported: where mistakes are opportunities to learn, where good learning is modelled, where discussion is respectful, and where feedback is tied to behaviours, not personalities.

5.3 How to Create a Learning Plan
The learning plan involves residents in their own learning and allows preceptors to see individual learning in context.

If you are a competency coach you will help the resident to create the learning plan and to revise it along the learning trajectory. The resident will have completed a self-assessment which forms the starting point for the learning plan.

REFERENCE & RESOURCE:

UBC Link
http://precepting101.familymed.ubc.ca/start-the-learning-module/part-4-introducing-task-oriented-teaching-to-students-and-residents-the-learning-cycle-0-25-m1/
If you are not a competency coach, you can still use the learning plan. Ask to see it at the start of a rotation to get to know the resident and help to inform your teaching. For example, a resident may be seeking out specific experiences or you may be able to spot signs of a learner in difficulty.

The University of Ottawa Department of Family Medicine offers a number of detailed academic support resources which may help you to determine how to move forward with a resident.

Initially, residents may require direction or modelling as they complete their learning plans. As they become more competent in all roles, they should be able to self-assess and monitor their learning more independently. The PGME Core Curriculum Lifelong Learning course can help residents with this.

5.4 Assessment

Assessment happens throughout the resident learning trajectory and may be formative or summative. Formative assessment is integral to learning, often happening in the moment or daily, principally in the form of oral or written feedback. Resident self-reflection is helpful in the formative process. Summative assessment occurs at the end of a learning block and is usually evaluative, for the purposes of determining competence.

Depending on your role, you will have more or fewer opportunities to document learner progress through various assessment tools. Most assessment will be documented on VENTIS, Faculty of Medicine’s online scheduling and assessment system. Program administrators will ensure that all preceptors at sites have access to VENTIS.

Ultimate decisions about resident acquisition of competence, EPAs and decisions for promotion are made by the Departmental Resident Progress Committee. The committee uses tools such as field notes, video-review forms, and ITARs as evidence to determine if progress is satisfactory or not. The process of assessment is conceptualized in the figure on the next page.
The elements of the Department of Family Medicine's education support and assessment process are explained in the following sections.

5.4.1 Orientation
Each new resident receives an orientation to the teaching site and program.

Each resident completes a self-assessment, which provides the basis for a learning plan.

5.4.2 Assignment of a principal preceptor
Each resident is assigned a principal preceptor. The principle preceptor is responsible for professional coaching over the two years of his/her residency. This is achieved through regular planned meetings over the period of residency program.

5.4.3 Supervision
Teachers within teaching sites ensure the supervision of clinical activities of residents. In teaching sites, a teacher is assigned to supervise a resident each time the resident does clinical work. The teachers are available to discuss cases and review patients.
5.4.4 Field Notes

Field notes provide the preceptor and resident a focus for recording observed performance and, most importantly, for providing specific feedback to the resident at the end of e.g. a clinic or call-shift. In addition to confirming for the resident what he/she did well, preceptors use field notes to identify areas requiring improvement and to help the resident find ways to achieve this.

Daily feedback and documentation with field notes is recommended. Collectively, field notes provide a method of multiple sampling of performance over time by different observers, which leads to more reliable assessment.

Field notes can be initiated by residents or preceptors. A minimum of 40 faculty-generated field notes and 25 resident-initiated field notes is required per year. Resident-initiated field notes are for self-reflection, discussion, and formative feedback. Faculty-initiated field notes inform ITARs and RORPs and help to provide summative assessment.
### Date
November 18, 2015

### Supervisor Signature

### Resident Signature

### Description
Describe the interaction (age, gender, problem):

<table>
<thead>
<tr>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Care</td>
</tr>
<tr>
<td>Care of Children/ Adolescents</td>
</tr>
<tr>
<td>Care of Adults</td>
</tr>
<tr>
<td>Care of Elderly</td>
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<tr>
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<td>Behavioral Medicine</td>
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### Competency

<table>
<thead>
<tr>
<th>99 Core topic:</th>
<th>Phase of encounter</th>
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### Comments

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<tbody>
<tr>
<td>FM Expert</td>
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<tr>
<td>Patient-centered</td>
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<tr>
<td>Selectivity</td>
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<tr>
<td>Clinical reasoning</td>
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<tr>
<td>Scholar</td>
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<tr>
<td>Professional</td>
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</tbody>
</table>

### Overall Performance

| Does not do this well (practice with full supervision) |
| Is starting to do this well (practice with supervision on demand) |
| Does this well (ready for “unsupervised” practice) |

### Action Plan

| Flag for review |

---

⚠️ Please return the signed form to your program assistant
99 Core Topics

1) Abdominal Pain  34) Eating Disorders  67) Newborn
2) ACLS  35) Elderly  68) Obesity
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14) Chronic Disease  47) Hypertension  80) Schizophrenia
15) COPD  48) Immigrants  81) Seizures
16) Contraception  49) Immunization  82) Sex
17) Cough  50) In Children  83) STI
18) Counselling  51) Infections  84) Skin Disorder
19) Crisis  52) Infertility  85) Smoking Cessation
20) Croup  53) Insomnia  86) Somatization
21) Deep Venous Thrombosis  54) Ischemic Heart Disease  87) Stress
22) Dehydration  55) Joint Disorder  88) Stroke
23) Dementia  56) Lacerations  89) Substance Abuse
24) Depression  57) Learning  90) Suicide
25) Diabetes  58) Lifestyle  91) Thyroid
26) Diarhhea  59) Loss of Consciousness  92) Trauma
27) Difficult Patient  60) Loss of Weight  93) Travel Medicine
28) Disability  61) Low-back Pain  94) URTI
29) Dizziness  62) Meningitis  95) Urinary Tract Infection
30) Domestic Violence  63) Menopause  96) Vaginal Bleeding
31) Dyspepsia  64) Mental Competency  97) Vaginitis
32) Dysuria  65) Multiple Medical Problems  98) Violent/Agressive Patient

Phases of Encounter

- Hypothesis
- Investigation
- Referral
- History
- Diagnosis
- Follow-up
- Physical
- Management
- Complete encounter

Assessment Parameters

The CFPC’s Six Dimensions of evaluation and CanMEDS are integrated into field note assessment parameters.

FM Expert
- **Patient-centered**: Focuses on the patient and his/her context and not on the disease alone
  - Explores illness - Understands whole person/context - Builds common ground - Builds relationship - Is realistic
- **Selectivity**: Demonstrates a selective approach, adapting it to the patient and the context
  - Appropriately focused – Appropriately thorough – Establishes priorities – Distinguishes between urgent and non-urgent
- **Clinical reasoning**: Generates hypothesis/ differential diagnosis – Gathers data (Hx & Px) – Makes decisions – Sets goals and objectives
  - Decision to act – Informed consent & preparation – Comfort & safety during procedure – Re-evaluation if problems - After care

Communicator: Utilizes effective verbal and non-verbal skills when interacting with patients.
- Listening skills – Verbal & written language skills – Non-verbal skills – Culture & age appropriateness – Attitudinal

Collaborator: Communicates and works effectively with colleagues and other professionals.
- Listening skills – Verbal & written language skills – Non-verbal skills – Teamwork - Handover

Leader/Manager: Takes responsibility for the delivery of excellent patient care.
- Resource allocation – Cost appropriateness – Leadership – Practice Management – Quality improvement

Health Advocate: Seeks to understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change
- Determinants of health – Community resources – Barriers to care

Scholar: Committed to continuous learning and by teaching others, evaluating evidence, and contributing to scholarship
- Identifies learning needs – Manages own learning - Integrates evidence – Teaches – Engages in scholarship

Professional: Committed to the well-being of individual patients and society through ethical practice, high personal standards of behaviour
- Responsible/Reliable – Knows limits – Flexible – Evolves Confidence – Caring/Compassionate – Respect/Boundaries – Collegial – Ethical/Honest – Maintains good balance – Mindful approach

November 18, 2015
**RESIDENT FIELD NOTE**

Date:  
Setting:  
Resident:  
Supervisor:  
Direct observation:  

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Describe the interaction (age, gender, problem):</td>
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<table>
<thead>
<tr>
<th>Domain</th>
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<tbody>
<tr>
<td>Maternal Care</td>
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<tr>
<td>Care of Children/ Adolescents</td>
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<tr>
<td>Care of Adults</td>
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<tr>
<td>Care of Elderly</td>
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<tr>
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<td>What I did well:</td>
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| What I would do differently: |

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<td>Professional</td>
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<th>Overall Performance</th>
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<td>I do not do this well (practice with full supervision)</td>
</tr>
<tr>
<td>I am starting to do this well (practice with supervision on demand)</td>
</tr>
<tr>
<td>I do this well (ready for “unsupervised” practice)</td>
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<thead>
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<th>Action Plan</th>
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<td>I want follow-up</td>
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</table>

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<tr>
<th>Supervisor Signature</th>
<th>Resident Signature</th>
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</thead>
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November 18, 2015
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Phases of Encounter

| Hypothesis | Investigation | Referral |
| History | Diagnosis | Follow-up |
| Physical | Management | Complete encounter |

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  - Explores illness - Understands whole person/context - Builds common ground - Builds relationship - Is realistic
- **Selectivity:** Demonstrates a selective approach, adapting it to the patient and the context
  - Appropriately focused - Appropriately thorough - Establishes priorities - Distinguishes between urgent and non-urgent
- **Clinical reasoning:** Gathers and interprets data in order to arrive to diagnosis and management.
  - Generates hypothesis/differential diagnosis - Gathers data (Hx & Px) - Makes decisions - Sets goals and objectives
- **Procedural skill:** Demonstrates appropriate technical skills and approaches to procedures.
  - Decision to act - Informed consent & preparation - Comfort & safety during procedure - Re-evaluation if problems - After care

**Communicator:** Utilizes effective verbal and non-verbal skills when interacting with patients.

- **Listening skills** - Verbal & written language skills - Verbal when interacting with patients.
- **Communication of data** - Informed consent & preparation - Comfort & safety - Complete encounter

**Collaborator:** Communicates and works effectively with colleagues and other professionals.

- **Listening skills** - Verbal & written language skills - Non-verbal skills - Teamwork - Handover

**Leader/Manager:** Takes responsibility for the delivery of excellent patient care.

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November 18, 2015
**PROCEDURAL SKILLS FIELD NOTE**

**Date:** November 18, 2015  
**Setting:** ☐ Outpatient  ☐ Inpatient  ☐ ER  ☐ Patient’s home  ☐ PCH

**Resident:**  
**Supervisor:**  
**Procedure:**  
**Direct observation:** ☐ YES  ☐ NO

### Procedural Skills Enabling Competencies

<table>
<thead>
<tr>
<th>Stage</th>
<th>Competency</th>
<th>Not applicable/observed</th>
<th>Does not do this well</th>
<th>Is starting to do this well</th>
<th>Does this well</th>
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</thead>
<tbody>
<tr>
<td>Pre</td>
<td>Identifies contraindications to procedure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pre</td>
<td>Recognizes personal limitations</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Procedure</td>
<td>Discusses procedure and obtains consent</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Procedure</td>
<td>Considers clinical urgency and available resources</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Procedure</td>
<td>Prepares /adapts procedure to the specific circumstances</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Procedure</td>
<td>Ensures patient safety</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Procedure</td>
<td>Responds to the unexpected</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Procedure</td>
<td>Uses proper technique</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Post</td>
<td>Develops and communicates a plan for aftercare</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Post</td>
<td>Describes normal healing and possible complications</td>
<td>☐</td>
<td>☐</td>
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</table>

### Comments

**What has been done well:**

CanMEDS
- ☐ FM Expert
  - ☐ Patient-centered
  - ☐ Selectivity
  - ☐ Clinical reasoning
  - ☐ Procedural skill
- ☐ Communicator
- ☐ Collaborator
- ☐ Leader/Manager
- ☐ Health Advocate
- ☐ Scholar
- ☐ Professional

**What could be done differently:**

CanMEDS
- ☐ FM Expert
  - ☐ Patient-centered
  - ☐ Selectivity
  - ☐ Clinical reasoning
  - ☐ Procedural skill
- ☐ Communicator
- ☐ Collaborator
- ☐ Leader/Manager
- ☐ Health Advocate
- ☐ Scholar
- ☐ Professional

**Overall Performance**
- ☐ Does not do this well (practice with full supervision)
- ☐ Is starting to do this well (practice with supervision on demand)
- ☐ Does this well (ready for "unsupervised" practice)

**Action Plan**

☐ Flag for review

**Supervisor**

**Resident**

⚠️ Please return the signed form to your program assistant
Core procedures

The DFM has subdivided the CFPC’s core procedure list into ‘Higher priority’ procedures (required to be demonstrated reliably and correctly by all residents) and ‘Lower priority’ procedures (residents must demonstrate a minimum of 10 of these procedures).

**Higher priority procedures**

*Integumentary Procedures*
- Abscess incision and drainage
- Insertion of sutures
- Laceration repair (suture, gluing)
- Skin biopsy (shave, punch, and excisional)
- Excision of dermal lesions
- Cryotherapy of skin lesions
- Removal of foreign body

*Local Anesthetic Procedures*
- Infiltration of local anesthetic
- Digital block in finger or toe

*Ear Procedures*
- Removal of cerumen

*Genitourinary and Women’s Health Procedures*
- Pap smear
- Insertion of intrauterine device
- Endometrial aspiration biopsy

*Musculoskeletal Procedures*
- Splinting of injured extremities
- Aspiration and/or injection joint
- Aspiration and/or injection of bursa

*Injections and Cannulations*
- Injections (IM, sub-cut, intradermal)

**Lower priority procedures**

*Integumentary Procedures*
- Wound debridement
- Electrocautery of skin lesions
- Skin scraping for fungus determination
- Use of Wood’s lamp
- Release subungual hematoma
- Drainage acute paronychia
- Partial toenail removal
- Wedge excision for ingrown toenail
- Pare skin callus

*Eye Procedures*
- Instillation of fluorescein
- Slit lamp examination
- Removal of corneal or conjunctival foreign body
- Application of eye patch

*Ear Procedures*
- Removal of foreign body

*Nose Procedures*
- Removal of foreign body
- Cautery for anterior epistaxis
- Anterior nasal packing

*Gastrointestinal Procedures*
- Nasogastric tube insertion
- Fecal occult blood testing
- Anoscopy/proctoscopy
- Incise and drain thrombosed external hemorrhoid

*Genitourinary and Women’s Health Procedures*
- Placement of transurethral catheter
- Cryotherapy or chemical therapy genital warts
- Aspirate breast cyst
- Diaphragm fitting and insertion

*Musculoskeletal Procedures*
- Application of sling—upper extremity
- Reduction of dislocated finger
- Reduce dislocated radial head (pulled elbow)
- Reduce dislocated shoulder
- Application of forearm cast
- Application of ulnar gutter splint
- Application of scaphoid cast
- Application of below-knee cast
- Injection of lateral epicondyle (tennis elbow)

*Resuscitation Procedures*
- Oral airway insertion
- Bag-and-mask ventilation
- Endotracheal intubation
- Cardiac defibrillation

*Injections and Cannulations*
- Venipuncture
- Peripheral intravenous line; adult and child
- Peripheral venous access—infant
- Adult lumbar puncture
5.4.5 Direct Observation

Direct observation of the resident occurs weekly during block time. To ensure reliability, multiple family medicine supervisors (3-4 per year) provide supervision to the same resident.

**ITARS – IN-TRAINING ASSESSMENT REPORTS**

Located in VENTIS, ITARs allow you to rate resident behaviours using a scale from unsatisfactory to excellent. Expected outcomes are listed according to the CanMEDS roles. Field notes and procedure logs (procedural field notes) would help to inform your rating.

ITARs are required at every two-month period during Family Medicine rotations and at the end of the rotation. They are also completed at the end of off-service rotations. Some rotations (ER, Obstetrics) use end of shift trainee feedback forms (depending on rotation) as data to be used in the completion of the end of rotation ITAR by the faculty lead.

5.5 Teaching on the Fly

One of the biggest challenges of teaching in busy workplaces is lack of time or multiple competing demands on your time. Teaching on the fly implies that you need to recognize and use teachable moments wherever and whenever they arise.

Cardiff University (Wales Deanery) has created a succinct handout for How to Teach with Patients Present.

Teaching at the Bedside is a resource created by MAHEC Office of Regional Primary Care Education, Asheville, North Carolina. It includes other teaching opportunities (e.g. hallway, conference room).

The same folks have put together a handy description with examples of the steps of the One-Minute Preceptor:

1. Get a Commitment
2. Probe for Supporting Evidence
3. Reinforce What was Done Well
4. Give Guidance About Errors and Omissions
5. Teach a General Principle
6. Conclusion

**RESOURCES:**

65 Core Procedures
http://www.cfpc.ca/uploadedFiles/Education/Procedure%20Skills.pdf

VENTIS
https://uofm.ventis.ca/

One-Minute Preceptor
http://www.oucom.ohio.edu/fd/monographs/microskills.htm

How to Teach with Patients Present
https://meded.walesdeanery.org/how-to-guides/teach-patients-present

Teaching at the Bedside
http://www.oucom.ohiou.edu/fd/monographs/bedside.htm

Practical Doc
http://www.practicaldoc.ca/teaching/practical-prof/teaching-nuts-bolts/one-minute-preceptor/

UBC Family Medicine
http://postgrad.familymed.ubc.ca/files/2012/05/OneMinutePreceptor.ppt
5.6 Mentorship

Mentorship and role-modeling provides an opportunity for junior faculty and students to enhance their learning experience and their career development under the guidance of a more experienced faculty member. Mentorship is rewarding, but if you choose to mentor a learner, you will need to advocate for protected time. Faculty members may find mentoring difficult when asked to fill other leadership roles (supervisor; preceptor) simultaneously. To better understand such roles a mentor should consider the following:

Mentorship is not….

- a clinical coaching relationship
- a counselling relationship (behavioural/psychological)
- an academic supervising relationship
- a friendship

The mentoring session may take many forms. Many resources exist that assist the mentor with models for the mentoring session along with helpful strategic questions. Remember…”Mentors are not born but developed”.

The GROW model of mentoring (from the University of New South Wales, Australia) offers one way to structure your mentoring session with a learner. The mentee (or learner) will set goals, discuss and reflect on current state, brainstorm for moving forward, and then concretize the discussion into an action plan.

As a mentor, making the resident feel comfortable and developing rapport will help promote growth. The Strategic Questioning Model (also from the University of New South Wales) lists a number of questions which can facilitate this exchange. The model also provides examples of open and closed questions.

RESOURCES:

- The Grow Model
  https://www.hr.unsw.edu.au/services/peopleandculture/grow.html
- Strategic Questioning Model
  https://www.hr.unsw.edu.au/services/peopleandculture/strategicquestioning.html

University of New South Wales- HR-People and Cultural Development 2014
https://www.hr.unsw.edu.au/services/peopleandculture/grow.html
Some key questions may include:

- What is one thing you could do to move forward in this situation?
- What is one of your greatest skills that you could offer in this circumstance?
- What would success look like in this instance?

5.7 Teaching the Scholar Role

Over the course of their residency, residents will become proficient in selecting and critically evaluating the integrity, reliability, and applicability of health-related research and literature. They do this through a variety of scholarly activities which are outlined in the residency program description as well as in the Family Medicine Resident Manual.

As a preceptor, understanding the University of Manitoba Family Medicine Scholar curriculum will help you in identifying opportunities to link learning to the scholar role and activities.

As well, depending on your role/location, you may administer the Fresno test at the start of PGY1, educate residents in EBM Enrichment camps, or teach/support residents in their chart audits, facilitating journal club, performing guideline reviews, or otherwise learning critical appraisal skills.

**SCHOLARLY PROJECT**

During residents’ first year Family Medicine Block Time (FMBT), they will be assigned to a stream-specific small-group as part of the CanMEDS-FM Scholar Role curriculum and, as a group, are expected to produce a project composed of:

A. A written paper, and

B. A presentation based on that paper

linked to the performance of a quality improvement project using chart audit as the method of measurement. See appendix C for the document outlining the expectations of the PGY-1 aspect of this project.

Guidelines for completing the project are detailed in a separate document and should be adhered to. Ethical considerations, policy requirements, and “how to” steps are outlined clearly and will help you to assist residents as they navigate this process.

If you would like supporting documents for teaching EBM, chart audits, journal club, or guideline reviews, contact Sylvia Froese at sylvia.froese@umanitoba.ca.

**RESOURCES:**

Family Medicine Resident Manual

Appendix C
(See page 53)

Candidate Guide
http://www.cfpca.ca/uploadedFiles/Education/_PDFs/FM_Candidate_Guide.pdf

CFPC Website
http://www.cfpca.ca/FMExam/

Short Answer Management Problems (SAMPS)
http://www.cfpca.ca/SAMPS/

Simulated Office Orals (SOO)
http://www.cfpca.ca/SOOs/

Objective Structured Clinical Examination (OSCE)
http://www.cfpca.ca/SOOs/
5.8 Certification Information/Resources

Examination resources, including the candidate guide, are available through the CFPC website.

Information includes requirements for residency and practicing physician eligibility, preparing for the certification examination, self study, and other pertinent topics.

Preparing for the exam, preceptors and residents will find the resources on written and clinical portions helpful. This includes Short Answer Management Problems (SAMPS), Simulated Office Orals (SOO), and Objective Structured Clinical Examination (OSCE) assessments.

6. Additional Tools for Preceptors

At any point in your teaching, you may encounter situations or learners which challenge your existing knowledge or skills. The following content addresses possible areas of concern.

6.1 Learner in Difficulty

Learners may experience difficulty in a range of areas. You may notice the difficulty in professional behaviour, clinical factors, medical illness, lifestyle, practice management, or in a combination of areas. Identifying and addressing difficulty early on can prevent problems from worsening or becoming insurmountable.

EARLY SIGNS OF DIFFICULTY

Although not exhaustive, this list can help you to identify early signs of potential difficulty so that interventions can be put into place and learning supported. (Information from FMF workshop, 2013.)

- resident seems unable to schedule time or find his/her way between point A-B
- difficulty with EMR and perseverates
- difficulty transitioning between tasks
- lack of or inability to apply knowledge e.g. from patient scenario to differential diagnosis
- can’t come up with a management plan (bio/psychosocial)
- not patient-centered at all
- cannot see shades of gray (concrete, categorical, or rules-bound thinking)
- seems unmotivated

Behaviours that warrant urgent intervention include issues of gross incompetence, professional misconduct, and substance abuse. (From Department of Medical Education, “Red Flags”)

ASSESSING AND ADDRESSING THE DIFFICULTY

Based on their review of the literature, Lacasse, Théorêt, Skalenda, and Lee (2012) use a model analogous to the medical history and physical exam to approach “assessment, educational diagnosis, and management of challenging learning situations” (see linked document below).
As you consider possible reasons for learner difficulty, you formulate a differential diagnosis which you test through the following steps of focused assessment:

- identification or personal situation;
- past “educational” history;
- habits;
- history of the present difficulties;
- review of systems (environment, teacher, learner); and
- objective examination.

6.2 Teaching About Medical Error

You are a role model to the learners with whom you work. As such, your behaviors in recognizing and acknowledging errors will be instructive to residents. Strive to encourage adaptive responses from residents when errors happen and look for ways to reduce future risk of errors.

Frame your teaching in these instances to include the following elements:

**DISCLOSURE TO PATIENTS, SUPERVISORS, AND PEERS**

Know your legal obligations and reflect on ethical and moral considerations. Make sure you are aware of current Canadian Medical Protective Association advice on adverse clinical outcomes.

**SUPPORT FOR THE LEARNER**

Learner errors are often accompanied by distress that is magnified by harm to the patient. Feelings that follow may include self-doubt and be as extreme as desire to quit the profession.

For more information about PGSS modules, contact Yuki Shi 204-789-3859 or email yuki.shi@umanitoba.ca.

**HARM PREVENTION**

Encourage learners to ask questions or let someone know when they are unsure of diagnosis or treatment. It is essential that you encourage a safe learning environment where questions are considered valuable learning opportunities and expertise is shared rather than showcased or paraded.

6.3 Teaching International Medical Graduates (IMGs)

In your teaching, you may work directly or indirectly with international medical graduate (IMG) learners. As with all residents, IMG learners have diverse backgrounds and bring different strengths and wants to their training. Although the teaching strategies you employ may not be that different from those you use with Canadian-trained learners, the focus and emphasis may be different.

**CANADIAN IMGS**
Canadian citizens who have completed their medical training outside of Canada or the USA. These trainees have the advantage of having grown up or been educated in Canada thus being privy to cultural norms and knowledge of both the country and its healthcare system.

**VISA IMGS**

Foreign-trained medical graduates, working in under-serviced areas. They hold working visas and function as physicians. Many are from the United Kingdom, New Zealand, Australia or South Africa. These foreign-trained medical graduates are sponsored (often by their governments) to train in specific medical schools or postgraduate training programs with the expectation that they will return to their sponsoring countries.

**IMMIGRANT IMGS**

Immigrants to Canada who hold recognized medical degrees

- Accessing training through IMG-specific programs
- Accessing training through the CaRMS second iteration match

**RESOURCES:**

Call the Faculty Development Office to request the PBSG-ED by McMaster on Medical Mistakes for further information: 204-789-3859.

Teaching Module: Talking About Harmful Medical Errors with Patients
https://depts.washington.edu/toolbox/errors.html
UNDERSTANDING THE IMG EXPERIENCE

The immigrant experience is complex and will differ for each IMG. The multicultural nature of most Canadian practices means that most physicians have a reasonable sense of the issues that immigrants face. IMGs, while facing many of the same immigrant issues, also experience concerns specific to medicine. All IMGs will not have experienced all of these issues. However, most will have faced one or more. Common areas include loss (professional, extended family, culture), prejudice, trauma and language. In addition, there are both direct and indirect costs associated with practicing medicine for IMGs. Any of these issues may have a profound impact on everyday functioning.

Specifically pertinent to the culture of medicine, differences may present in IMG learners’ understanding of norms related to professional behaviour and different attitudes to gender, age and status. In the training setting, IMG learners may be more affected when they perceive loss of face if a lack of knowledge or skills is identified.

The manner in which you create the learning environment and then explicitly identify why and how feedback is given/received is therefore important. In addition, empathy and the willingness to engage the learner will go a long way in preventing misunderstandings or harmful behaviours from escalating. Find out the particularities, for example, of a perceived language barrier. And be prepared to confront your own preconceptions and prejudices.

STRENGTHS OF IMG LEARNERS

The strengths IMG learners bring to their Canadian practices are many. As preceptor, you are in the position of being able to highlight or utilize these areas of expertise.

• training in other disciplines
• exposure to diseases and disease processes with which Canadian physicians have little or no familiarity
• diverse life experiences (often older)
• well-developed clinical skills due to limited access to diagnostic tests and investigations
• knowledge of cultures which may match patient experiences

RESOURCES:
AFMC, (2006). A Faculty Development Program for Teachers of International Medical Graduates
http://70.38.66.73/img/modules_en.htm

COMMON AREAS OF REMEDIATION OR CHALLENGE

- Unfamiliarity with small group, active learning approaches due to previous training relying heavily on rote learning, large group didactic experiences
- Time lag since training or practice
- Familiarity with Family Medicine
- Resource use: access, judicious use, cost
- Learning and teaching roles and expectations—many come from highly hierarchical contexts with low expectations of learners re: risk, experimentation, exploration of clinical reasoning
- Evidence based medicine
- Interprofessional relationships due to lack of experience and/or cultural differences
- Limited clinical experience re: patient contact or contact limited by gender, age, and race of patient or physician
- Clinical gaps: urogenital and rectal exams, obstetrical care, adolescent medicine, psychiatry, intensive care, geriatrics
- Psychosocial issues—psychiatric illness, family violence, abortion, rape, drug/alcohol abuse, gender roles and identities
- Doctor-patient relationship: paternalistic; unfamiliar with patient-centered approach

SOURCES FOR THIS SECTION:

Most of this section is quoted from a presentation by Tunji Fatoye, MBBS, CCFP Orienting Teachers and IMGs. June 21, 2007

6.4 Advancing your Academic Career in the Department of Family Medicine

All teaching faculty are encouraged to apply for promotion commensurate with their activity within the department. Interprofessional faculty are encouraged to explore options for promotion with their leads.

Academic physicians build their careers on four pillars: their role as teachers; as scholars; as contributors to the Department, the wider University and to other professional organizations; and of course in patient care. Promotion through the professorial stream at the U of M is an important measure of achievement that you are encouraged to pursue. Some activities are key to success: carefully collecting learner evaluations, sharing your work at local and national meetings and/or through publication, and keeping your CV up to date as you add activities.

The Promotion and Awards Committee is here to help you succeed!

KEY CONTACT - PROMOTION AND AWARDS COMMITTEE

Vice Dean of Clinical Competency & Assessment
Jeff Sisler, MD, MCISC, CCFP, FCFP
Tel: 204-789-3237
Email: jeff.sisler@umanitoba.ca
Twitter: @MBMedicineJeff
7. Conclusion

We hope the information and resources in this toolkit will be useful to you in your teaching practice. To conclude, we offer some tips to remember about your development as a preceptor.

TOP 5 THINGS TO REMEMBER ABOUT FACULTY DEVELOPMENT

1. Teaching is Lifelong Learning

To become better at teaching, reflect on your practice, accept feedback from others, and unleash your curiosity to try new things.

2. Your Peers are your Partners in Teaching

Often other preceptors have similar questions or have encountered similar situations to ones that stump or excite you. Share your knowledge and feel free to ask others. Building a community of practice with other teachers can save time and build excellence while giving you a sense that you're not in it alone.

3. Take It One Bit at a Time

You do not have to cram all your faculty development experiences into the first few years of teaching practice. But if you push yourself to engage in some aspect of faculty development a number of times each year, you will be more likely to incorporate what you learn into your practice.

4. The Department is There to Support You

If you have a question, a suggestion, or a need to talk about your ideas or questions, remember that you can contact the “key people” listed in this toolkit. Programs improve through ownership and involvement. Your input is valued.

5. Keep Track of Your Achievements

When you take the time to improve in your faculty role, you are modelling good habits for your students and residents. Keep certificates, credits, or a list of your involvements in one place such as a professional portfolio. Going beyond keeping track, spend ten minutes jotting down key learning points or reflections/questions after faculty development sessions and keep those in the portfolio as well. Over time, you will be able to track your evolution as a teacher.
8. Glossary of Terms
The Department of Family Medicine Acronyms and Activities

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>ACTIVITY</th>
<th>DESCRIPTION</th>
<th>DURING</th>
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<tbody>
<tr>
<td>ACAW</td>
<td>Aboriginal Cultures Awareness Workshop</td>
<td>Two-day workshop offered by the WRHA which introduces a basic knowledge of the worldviews, spiritual and cultural values of Aboriginal peoples, highlights historical and contemporary issues that influence Aboriginal peoples, and honours the rich diversities within Aboriginal communities. Mandatory for residents; scheduled by PG administrative assistant.</td>
<td>PGY1 FMBT</td>
</tr>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
<td>External course that all residents must pass before they enter residency and must keep current; certification is for two years; residents whose training lasts more than two years must recertify; cost is covered by PARIM/WRHA</td>
<td>PGY2</td>
</tr>
<tr>
<td>ACoRN</td>
<td>Acute Care of the At-Risk Newborn</td>
<td>Newborn Health (during Northern Primer course work)</td>
<td>PGY2</td>
</tr>
<tr>
<td>ACSS</td>
<td>Acute Care Surgery Service</td>
<td>One of the WRHA surgery services on which residents may complete their surgery rotation</td>
<td>PGY2</td>
</tr>
<tr>
<td>AD or AHD</td>
<td>Academic Day or Academic Half-Day</td>
<td>Academic sessions that residents are required to attend; often are lecture-based small group sessions; there are Combined ADs which all residents must attend as well as stream-based. Mandatory attendance (75%). Absence due to being post-call is still marked as absent. Attendance is taken so if residents are late or absent they are responsible to advise Shannon Rankin, PG administrative assistant, by voicemail at 204-977-5663.</td>
<td>PGY-1/2</td>
</tr>
<tr>
<td>ALARM</td>
<td>Advances in Labour and Risk Management</td>
<td>An educational program designed to train individuals to improve patient outcomes and the process of intra-partum and immediate post-partum care. This is a two-day course. ALARM is being phased in as a replacement for the ALSO course.</td>
<td>PGY2</td>
</tr>
<tr>
<td>ALSO</td>
<td>Advanced Life Support in Obstetrics</td>
<td>External course that all residents must pass before they complete their training; cost is covered by PARIM/WRHA. This course is being phased out in favour of ALARM.</td>
<td>PGY2</td>
</tr>
<tr>
<td>ATLS</td>
<td>Advanced Trauma Life Support</td>
<td>External course that residents in the Northern/Remote and Rural streams must pass before they complete their training; cost is covered by PARIM/WRHA To be completed prior to surgery rotation and before going North.</td>
<td>FMBT</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
<td>External course that all residents must pass before they enter residency and must keep current; this is a pre-requisite for ACLS; certification is for two years; residents whose training lasts more than two years must recertify; cost is covered by PARIM/WRHA</td>
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Shading indicates Family Medicine Block (FMBT) activities.
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<tbody>
<tr>
<td>CaRMS</td>
<td>Canadian Residency Matching Service</td>
<td>Not-for-profit organization that provides an electronic application service and computer match</td>
<td>CaRMS</td>
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<td></td>
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<td>for individuals wishing to enter into postgraduate medical training throughout Canada.</td>
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<tr>
<td>CCFP</td>
<td>Certificant, College of Family Physicians</td>
<td>The credential awarded by the CFPC to physicians who have passed the CFPC certification exam</td>
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<tr>
<td>CFPC</td>
<td>College of Family Physicians of Canada</td>
<td>National professional organization for family physicians in Canada; also sets the standards for</td>
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<td></td>
<td></td>
<td>residency training in Family Medicine and continuing professional development.</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
<td>Process by which physicians keep current in their field</td>
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<tr>
<td>CMG</td>
<td>Canadian Medical Graduate</td>
<td>Individual who has graduated from a medical school in Canada</td>
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<tr>
<td>CoE</td>
<td>Care of the Elderly</td>
<td>One of the Enhanced Skills Programs offered by Department of Family Medicine</td>
<td></td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
<td>A continuing process, outside formal undergraduate and postgraduate training, that enables</td>
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<td></td>
<td></td>
<td>individual doctors to maintain and improve standards of medical practice through the development</td>
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<td></td>
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<td>of knowledge, skills, and attitudes.</td>
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<tr>
<td>CPSM</td>
<td>College of Physicians and Surgeons of Canada</td>
<td>Licensing body for physicians in Manitoba</td>
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<tr>
<td>CSA</td>
<td>Canadian studying abroad</td>
<td>Canadian citizen who attends medical school outside of Canada and thus is an IMG</td>
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<tr>
<td>CTU</td>
<td>Clinical Teaching Unit</td>
<td>A hospital unit or service that provides undergraduate and graduate medical education under the</td>
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<td>auspices of a Faculty of Medicine. The medical care of the patient is the function of the team</td>
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<td></td>
<td></td>
<td>or staff physician, resident and clinical clerk.</td>
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<tr>
<td>DFM</td>
<td>Department of Family Medicine</td>
<td>An accredited university training program that strives to teach whole person medicine through a</td>
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<td></td>
<td>combination of patient-centred care and complementary teaching sessions</td>
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<tr>
<td>EA</td>
<td>Education Assistant</td>
<td>Support staff member within a stream who makes it all happen</td>
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<tr>
<td>EBM</td>
<td>Evidence-based Medicine</td>
<td>A way of practicing medicine that emphasizes that decisions should be based on evidence (i.e.,</td>
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<td></td>
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<td>the medical literature) rather than the beliefs of practitioners.</td>
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<tr>
<td>EDEC</td>
<td>Enhanced Distributed Education Centre</td>
<td>See FMEDEC</td>
<td>EDEC</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
<td>“A computer-based patient medical record system used to manage patient information and care within the scope of the clinic’s practice. Features include billing, scheduling and clinical information. Typically, clinical information includes encounter notes, health conditions, allergies, family history, prescriptions and medications, diagnostic test results, referral letters and consult letters.”</td>
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<td><a href="http://www.manitoba-ehealth.ca/emr-pcis-emr.html">http://www.manitoba-ehealth.ca/emr-pcis-emr.html</a></td>
<td></td>
</tr>
<tr>
<td>EPA</td>
<td>Entrustable Professional Activities</td>
<td>The mass of critical elements that define a profession and are only entrustable to a competent physician.</td>
<td></td>
</tr>
<tr>
<td>EPR</td>
<td>Electronic Patient Record</td>
<td>The Electronic Patient Record (EPR) provides a picture of your visit to a hospital by compiling demographics, scheduling, clinical and emergency department information. It facilitates patient flow and timely access to clinical data, ensuring you receive the best possible care when you visit a hospital. The introduction of the EPR at St. Boniface Hospital in 2007 set the provincial standard, and various components of the EPR are now available in Winnipeg hospitals and other sites in Manitoba. Click below to read more about some of the components you may see during your hospital visit: admission, discharge, transfer (ADT) clinical EPR computerized provider order entry (CPOE) results reporting emergency department information system (EDIS) For more information about the EPR, please watch our video, Connecting Solutions to Care.</td>
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<td></td>
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<td><a href="http://www.manitoba-ehealth.ca/about-epr.html">http://www.manitoba-ehealth.ca/about-epr.html</a></td>
<td></td>
</tr>
<tr>
<td>ESP</td>
<td>Enhanced Skills Program</td>
<td>Additional training which family medicine graduates can take after they’ve finished their two-year program. Department of Family Medicine offers seven ESPs: Emergency Medicine, Palliative Medicine, Cancer Care, FP Anesthesia, FP-Obstetrics, Sports and Exercise Medicine, and Care of the Elderly. ESPs are of differing lengths; they range in duration from 6 months to one year.</td>
<td></td>
</tr>
<tr>
<td>FCFP</td>
<td>Fellowship in The College of Family Physicians of Canada</td>
<td>An honour which the CFPC confers upon Certificant members in good standing who have maintained their Certification for a minimum of 10 consecutive years and have included 25 Mainpro-C activities for two consecutive five-year cycles, demonstrating their ongoing commitment to continuing professional development and lifelong learning.</td>
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<tbody>
<tr>
<td>FMBT</td>
<td>Family Medicine Block Time</td>
<td>Periods of time in the resident's training which is completed under the supervision of a family physician; comprises the vast majority of time in the program. 16 weeks @ 8 hours/day, 5 days/week (Monday - Friday) = 40 hours/week Minus Friday a.m. (AHD), Wednesday a.m. (In-unit) and ½ day/week (SDL) = 12 hours/week Remaining time for clinic attendance and other FMBT activities = 28 hours/week To attend at least two weekend on-calls.</td>
<td>PGY1</td>
</tr>
<tr>
<td>FMC</td>
<td>Family Medical Centre</td>
<td>One of the University of Manitoba Family Medicine urban teaching sites located across from St. Boniface General Hospital</td>
<td>PGY2</td>
</tr>
<tr>
<td>FMEDECs</td>
<td>Family Medicine Enhanced Distributed Education Centres</td>
<td>Family Medicine residency training locations outside the City of Winnipeg. FMEDECs usually train both residents and medical students. Currently sites include Steinbach, Boundary Trails, Brandon, Portage, and Dauphin</td>
<td></td>
</tr>
<tr>
<td>FPGME</td>
<td>Faculty Postgraduate Medical Education</td>
<td>The office that oversees all residency training at the University of Manitoba</td>
<td></td>
</tr>
<tr>
<td>GFT</td>
<td>Geographic Full Time</td>
<td>A physician faculty member in the College of Medicine who is employed by the University to teach residents. GFTs can be part-time or full-time University employees.</td>
<td></td>
</tr>
<tr>
<td>Gold Trauma</td>
<td>HSC acute trauma</td>
<td>A general surgery service located at the Health Sciences Centre which specializes in acute trauma. This is a three-week rotation for students or family medicine residents</td>
<td></td>
</tr>
<tr>
<td>HDB</td>
<td>Half-Days Back</td>
<td>Half day a week at your clinic after FMBT for three months during OSR (excluding Adult EM)</td>
<td></td>
</tr>
<tr>
<td>IMG</td>
<td>International Medical Graduate</td>
<td>Individual who has graduated from a medical school outside of Canada. An IMG might be a CSA (Canadian who studied abroad).</td>
<td></td>
</tr>
<tr>
<td>IPC</td>
<td>Interprofessional Collaborative Practice</td>
<td>“The development of a cohesive practice between professionals from different disciplines, and the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population.”</td>
<td></td>
</tr>
<tr>
<td>IPF</td>
<td>Interprofessional Faculty</td>
<td>All regulated health care professionals working in family medicine teaching sites. May include registered nurses, nurse practitioners, registered social workers, registered dieticians, pharmacists, research assistants, community liaison workers, shared care counsellors, psychologists occupational therapists, physiotherapists.</td>
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<tbody>
<tr>
<td>ITAR</td>
<td>In-Training Assessment Report</td>
<td>Form that is filled out evaluating a resident's performance in a rotation. A rotational mid-point evaluation is optional unless the resident is performing below expectations. Final rotational evaluations are required.</td>
<td></td>
</tr>
<tr>
<td>ITER</td>
<td>In-Training Evaluation Report</td>
<td>Another name for ITAR</td>
<td></td>
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<tr>
<td></td>
<td>In-Unit Seminars</td>
<td>Wednesday mornings at FMC. Schedule emailed weekly and attendance taken so if you are late or absent you are responsible to advise Shannon Rankin, by voice message at 204-977-5663. Seminars available at <a href="http://www.ManitobaCME.com">www.ManitobaCME.com</a> can be watched at your convenience.</td>
<td>PGY1 FMBT</td>
</tr>
<tr>
<td></td>
<td>Journal Club</td>
<td>Resident led discussions with support from a faculty physician. The group discussion is based on one of two options determined by site: a) An article related to the clinical topic chosen by the resident b) The McMaster developed Problem Based Small Group Learning Modules covering a variety of clinical topics. These are provided by the Department.</td>
<td>PGY-1/2</td>
</tr>
<tr>
<td>KMC</td>
<td>Kildonan Medical Centre</td>
<td>Located at Seven Oaks General Hospital, KMC is one of the locations that residents in the Urban stream are based</td>
<td></td>
</tr>
<tr>
<td>MBH</td>
<td>Manitoba Health, Healthy Living and Seniors</td>
<td>Government Department that funds medical residency programs; funds are provided to the University and then distributed to the departments</td>
<td></td>
</tr>
<tr>
<td>MCCEE</td>
<td>Medical Council of Canada Evaluating Examination</td>
<td>Four-hour, computer-based examination which is required for International medical school graduates as a prerequisite for eligibility to the Medical Council of Canada Qualifying Examinations.</td>
<td></td>
</tr>
<tr>
<td>MCCQE1</td>
<td>Medical Council of Canada Qualifying Examination Part 1</td>
<td>A one-day, computer-based test that assesses the competence of candidates who have obtained their medical degree and is required for entry into postgraduate training programs.</td>
<td></td>
</tr>
<tr>
<td>MCCQE2</td>
<td>Medical Council of Canada Qualifying Examination Part 2</td>
<td>Examination that assesses the competence of physicians who have finished their residency training programs and is a requirement for medical licensure in Canada prior to entry into independent clinical practice</td>
<td></td>
</tr>
<tr>
<td>NBC</td>
<td>Newborn Care</td>
<td>Two-week experience with a physician at Health Sciences Centre.</td>
<td>PGY2 FMBT</td>
</tr>
<tr>
<td>NCMC</td>
<td>Northern Connection Medical Centre</td>
<td>An urban Family Medicine teaching site in the Northern-Remote program located near Health Sciences Centre on Elgin</td>
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<tr>
<td>NMU</td>
<td>J.A. Hildes Northern Medical Unit</td>
<td>NMU is a unit within the Dept. of Community Health Sciences in the College of Medicine at the University of Manitoba. It provides health care resources (e.g., family physicians, nurses, medical specialists, social workers and support staff) to various remote northern communities in Manitoba. Currently it provides service to three hospital-based communities and 12 nursing stations. Services are provided on a contractual basis. <a href="http://umanitoba.ca/faculties/medicine/units/northern_medical_unit/index.shtml">http://umanitoba.ca/faculties/medicine/units/northern_medical_unit/index.shtml</a></td>
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<tr>
<td>ACRONYM</td>
<td>ACTIVITY</td>
<td>DESCRIPTION</td>
<td>DURING</td>
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<tr>
<td>QI</td>
<td>Quality improvement</td>
<td>A process by which changes are made to improve patient outcomes. The typical cyclical process includes review of evidence/literature, audits of performance, changes to practice, and re-evaluation of changed practice via audit.</td>
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<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
<td>National professional organization for all specialist physicians in Canada; also sets the standards for residency training in specialties other than Family Medicine (e.g., Pediatrics, Surgery, Internal Medicine) as well as continuing professional development.</td>
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<tr>
<td></td>
<td>Research/Scholarly Paper</td>
<td>First session held during July AHD followed by two sessions held twice a year. Resident to choose a topic on: Education, Policy, Research or Ethics.</td>
<td>PGY1 FMBT</td>
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<tr>
<td></td>
<td></td>
<td>Objective: To gain knowledge and skills to write a well thought-out project relevant to Family Medicine.</td>
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<tr>
<td>RoRP</td>
<td>Review of Resident Progress</td>
<td>Resident progress is periodically reviewed by faculty in the primary residency location; RoRP meetings usually include all faculty involved with the resident and take place once each block while the resident is doing FMBT; RoRP forms (available on website) document these meetings, and feedback is provided to the resident by the Education Director/Stream Lead</td>
<td>FMBT PGY-1/2</td>
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<tr>
<td></td>
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<td>Residents meet monthly with lead preceptor. Academic half day attendance reviewed.</td>
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<td>Monthly phone or in-person update during off service rotation with lead preceptor, as needed.</td>
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<tr>
<td>SAMP</td>
<td>Short Answer Management Problem</td>
<td>Practice exams: These are constructed response-type questions requiring write-in answers ranging from a few words to a few sentences. A SAMP-style question consists of a minimum of two scenarios and at least 10 questions. The written portion of the CFPC Certification Exam consists of SAMPs.</td>
<td>PGY2</td>
</tr>
<tr>
<td>SCA</td>
<td>Scheduled Clinical Activity</td>
<td>Learning activities that are planned and organized by the program to complement the Northern/Remote curriculum. Such activities are typically arranged during time that is not filled with core family medicine northern experiences.</td>
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<tr>
<td>SDL</td>
<td>Self-Directed Learning</td>
<td>A learning experience which is planned and organized by the resident. SDL experiences are used to further learning in a particular topic/area or to meet a personal learning objective. Examples of SDL activities include: studying for exams; reading journals; doing literature reviews; attending a specialty clinic (e.g., teen clinic or family planning clinic); working on resident scholarly activities.</td>
<td>PGY-1/2 FMBT</td>
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</table>

Shading indicates Family Medicine Block (FMBT) activities.
<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>ACTIVITY</th>
<th>DESCRIPTION</th>
<th>DURING</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOO</td>
<td>Simulated Office Oral</td>
<td>A method for evaluation residents’ abilities to establish effective relationships with patients by using active communication skills. The emphasis is NOT on testing the ability to make a medical diagnosis and then treat it. The oral component of the CFPC Certification Exam consists of SOOs.</td>
<td>FMBT</td>
</tr>
<tr>
<td>UG</td>
<td>Undergraduate</td>
<td>The four years of medical school comprise the undergraduate portion of a physician’s training. The third year of undergraduate medical school is called the &quot;pre-clerkship&quot; period and the fourth year is the &quot;clerkship&quot; period.</td>
<td></td>
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<tr>
<td>UGME</td>
<td>Undergraduate Medical Education</td>
<td>The office that oversees medical student training at the University of Manitoba.</td>
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<tr>
<td>WRHA</td>
<td>Winnipeg Regional Health Authority</td>
<td>The health authority that is responsible for providing health services people living in the City of Winnipeg as well as the surrounding Rural Municipalities of East and West St. Paul and the Town of Churchill, located in northern Manitoba.</td>
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<tr>
<td>VENTIS</td>
<td></td>
<td>A web-based curriculum management system used by PGME which includes scheduling, assessment, trainee portfolio and reporting functions.</td>
<td></td>
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</tbody>
</table>

*Shading indicates Family Medicine Block (FMBT) activities.*

Glossary compiled with contributions from Donna Anderson, Carol Styles, Kelly Lukaszewski, Christine Polimeni and Anita Ens.
9. Resources for Preceptors

The following resources have been selected by preceptors in the Department of Family Medicine.

**PRIMARY CARE RESEARCH GUIDE**

http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/primarycareguide.html

**CANMEDS 2015 – AN INTERACTIVE RESOURCE**

http://canmeds.royalcollege.ca/

**U OF OTTAWA I-BOOKS**

http://familymedicine.uottawa.ca/ETS3/

**MCGILL UNIVERSITY**

Resources for (Medical) Teachers

PRACTICAL DOC TEACHING RESOURCES (INCLUDES LINK TO UBCS SHORT ONLINE MODULES ON A VARIETY OF TEACHING TOPICS)

http://www.practicaldoc.ca/teaching/other-teaching-resources/
Appendix A: UGME Clinical Family Medicine Teaching

Graphic by Amanda Condon
Appendix B: UGME Non-Clinical Family Medicine Teaching

Graphic by Amanda Condon
Appendix C: Resident Scholar Project - PGY1

PGY-1 FMBT Group Project on Chart Audit and Quality Improvement

An activity associated with the CanMEDS-FM Scholar Role curriculum

During your first year Family Medicine Block Time (FMBT) rotation, you will be assigned to a stream-specific small-group as part of the CanMEDS-FM Scholar Role curriculum and, as a group, are expected to produce a project composed of:

A. A written paper, and

B. A presentation based on that paper

linked to the performance of a quality improvement project using chart audit as the method of measurement. This document outlines the expectations of the PGY-1 aspect of this project.

(In your second year, you will apply the skills you developed during this project by undertaking similar project, but on your own as an individual as opposed to in a group setting.)

The quality improvement project is to focus on data from either:

1. The out-patient clinic where you are assigned for your PGY-1 FMBT experience, or

2. The hospital ward where you are care for in-patients during your PGY-1 FMBT experience.

Within a stream, each group's project is expected to be unique (i.e. the same clinical topic cannot occur within the same teaching site).

In this document, the word project refers to:

A. the chart audit process and outcomes and

B. the proposed quality improvement plan and

C. the written paper and

D. the presentation.

A: EXPECTATIONS FOR THE CHART AUDIT MEASURE

- Outline what is important and interesting about the topic your group has chosen. Is your topic one of high frequency, high risk, or both? Tell us what aspect of care you hypothesize needs to be improved in your local setting and why you believe so (the so-called ‘care gap’).

- Explain and justify the benchmarks you are going to use. What does the literature say about the measure(s) you are using? What is the quality of that literature with regard to the benchmarks and its applicability to a family medicine setting? What specific criteria are you using to determine YES – appropriate care, or NO – care not delivered for each chart reviewed?
• If no benchmarks exist in the literature, how did you determine a consensus benchmark with a representative sample of the care providers who are most involved in delivering the aspect of medical-care you are interested in to the patient population? (i.e. Your team cannot arbitrarily set a benchmark without involving a representative sample of that group of caregivers.)

• Describe your population you wish to sample in detail, including inclusion and exclusion criteria.

• What is your goal sample size you wish to sample in order to achieve a reliably representative result? How did you determine that? What confidence interval are you considering acceptable?

• What is your search strategy to find appropriate charts?

• What is your actual sample size? Explain your results in the appropriate level of detail.

• Compare the population you actually did sample to the description of what you wanted to sample – if there are discrepancies between the two, please explain.

• How does your findings from the charts compare to your benchmarks? Are the benchmarks too lax or too rigid?

• Include a copy of your data abstraction form as an appendix to your written paper.

B: EXPECTATIONS FOR THE QUALITY IMPROVEMENT PLAN

• What needs to change (besides increasing awareness of your issue amongst the clinicians) in the system where you are working in order that the care being delivered moves closer to the benchmark criteria (i.e. the care-gap lessens or closes)? Who needs to be involved in the change besides the physicians?

• When you discuss the care-gap with representatives of the various clinicians involved – what do they see as the barriers to implementing change (beyond the universal issues of time and money)? What are reasonable, low-cost clinician-behavior changes and system-process changes to recommend so when a re-audit is done, the care being delivered is at or beyond the benchmark?

C: EXPECTATIONS FOR THE WRITTEN PAPER

• Document your discussion and summarize them for the paper

• Refer to the provided guidelines

<table>
<thead>
<tr>
<th>SECTION</th>
<th>INCLUDE</th>
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<tbody>
<tr>
<td>TITLE PAGE</td>
<td>What is meant to be improved in the title of paper</td>
</tr>
<tr>
<td></td>
<td>Names of all group members and residency stream</td>
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<td>Clinic / hospital ward where audit occurred.</td>
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<td>SECTION</td>
<td>INCLUDE</td>
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<tr>
<td>INTRODUCTION</td>
<td>Brief background knowledge of the care-gap.</td>
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<tr>
<td>(Focuses on the</td>
<td>The hypothesized problem in care delivery at your site.</td>
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<tr>
<td>rationale of your</td>
<td>Specific description of the intended aim of improvement.</td>
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<td>study)</td>
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<tr>
<td>METHODS</td>
<td>Describe the chart audit in sufficient detail that others could</td>
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<tr>
<td>(Focuses on what</td>
<td>reproduce it.</td>
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<td>you did)</td>
<td>Describe aspects of the audit that are specifically concerned</td>
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<td>with internal validity (integrity of the data) and external validity</td>
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<td></td>
<td>(generalizability).</td>
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<td></td>
<td>Include a copy of the data abstraction form as an appendix.</td>
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<tr>
<td>RESULTS</td>
<td>Explain methods used to assure data quality and adequacy.</td>
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<tr>
<td>(Focuses on what</td>
<td>Provide details of methods used to draw inferences from data.</td>
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<tr>
<td>you found)</td>
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<tr>
<td>DISCUSSION</td>
<td>Description of data obtained from chart audit.</td>
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<tr>
<td>(Focuses on what</td>
<td>Flow chart of your audit process including projected number of</td>
</tr>
<tr>
<td>your findings mean)</td>
<td>charts needed, number rejected and why, actual number assessed,</td>
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<tr>
<td></td>
<td>numbers that met criteria or didn’t, etc.</td>
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<tr>
<td>REFERENCES &amp;</td>
<td>Highlight your audit’s strengths and weaknesses to inform a change</td>
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<tr>
<td>APPENDIX</td>
<td>process in your local setting.</td>
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<td>What specific and measurable changes is your group recommending for</td>
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<td>your local site in order to close the care-gap.</td>
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<td>Indicate the main factors/rationale that contributed to the</td>
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<td>recommendation(s) of specific intervention(s).</td>
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<td>Outlines plans for how the intervention(s) is/are to be</td>
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<td>implemented.</td>
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**D: EXPECTATIONS FOR THE PRESENTATION**

A ten minute presentation with an additional five minutes for questions. (Important: we strongly suggest your group PRACTICE the presentation before giving it. Ten minutes for presenting takes a lot more work to ensure clarity and appropriateness than a longer presentation time!)
E: MARKING

Focus the presentation on the chart audit and the quality improvement recommendations. Do not spend time educating about the clinical condition or all of your time justifying the choice of benchmarks.

The following rubric will be used to generate a group mark (i.e. each person in the group will be assigned the mark of the group). The marking will be based on three aspects:

<table>
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<tr>
<th>ITEM</th>
<th>VALUE</th>
<th>CRITERIA</th>
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</table>
| PAPER      | 65%   | • To what degree has the chart audit been done so the results are reliable and valid?  
• Have the instructions for authors for the written format been followed?  
• Was the justification of the chosen benchmarks appropriate and well done?  
• Are the quality improvement suggestions specific, reasonable, feasible, and supported by a representative sample of the health-care providers who are potentially affected? |
| PRESENTATION | 20%   | • Did the presentation clearly present the findings of the audit and quality improvement suggestions?  
• Were the strengths and weaknesses of the findings and the suggestions presented?  
• Was the time for presentation respected? |
| PARTICIPATION | 15%   | Each group member will be asked to confidentially rate the participation of each member of their group. Group members who end up with a participation rating of low to very low rates will:  
A. fail the assignment, and  
B. their participation marks will NOT affect the marks of those who did participate. |

F: RESOURCES

1. Academic Day presentation and handouts outlining the expectations of the audit.
2. This project syllabus.
3. Each clinic will identify individuals who are skilled at creating inquiries with the electronic medical record in order to identify the charts you want to find.