Family & Community Medicine
UNIVERSITY OF TORONTO

Temerty Medicine

# Undergraduate Program

# Family Medicine Electives

*Supervisor Manual*

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# 1. Introduction to Supervising, Family and Community Medicine Electives

As Electives Coordinator for the Undergraduate Education Program of the Department of Family and Community Medicine, I would like to thank you for your contributions to undergraduate education. Your enthusiasm and dedication to teaching are helping shape our future family doctors. I am becoming increasingly aware of the challenges you face in incorporating teaching into your hectic practices. Moreover, I recognize your financial sacrifice as you dedicate significant amounts of your valuable time.

In response to an expressed need for more guidance in teaching Family and Community Medicine electives, a manual for supervisors has been developed. I hope that the information included will provide you with administrative information, as well as some practical teaching tools that you can incorporate into your undergraduate teaching.

If you have questions or feel you need further assistance, please contact the electives administrator, Alicia Tulloch, Undergraduate Program Assistant at familymed.undergrad@utoronto.ca.

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Electives Coordinator, Undergraduate Education Program

# 2. Objectives for Family and Community Medicine Electives & the Can MEDS-FMU

Electives are a mandatory part of the Undergraduate Curriculum. The majority of electives occur between September and December of fourth year. Effective May 2020, third year students will be offered 2 weeks of elective time in May and June to provide additional career exploration prior to fourth year elective. Students complete a minimum of 13 weeks of electives most of which span 2-4 weeks.

The objectives for the Family and Community Medicine Electives are as follows:

a) To provide opportunities to explore family and community medicine as a career
b) To gain experience in aspects of family and community medicine beyond the core curriculum
c) To have the opportunity to study aspects of family and community medicine in greater depth

Many of you may recall the Four Principles of Family Medicine:

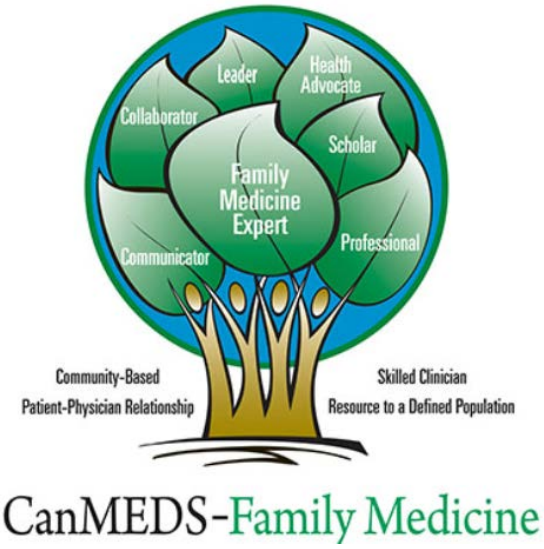
1. The family physician is a skilled clinician.
2. Family Medicine is a community-based discipline.
3. The family physician is a resource to a defined practice population.
4. The patient-physician relationship is central to the role of the family physician.

Although these concepts continue to guide our training of family physicians, medical education is guided by competency-based curricula. Student objectives are considered within the context of the CanMEDS competencies. In keeping with the unique approach that Family Medicine takes towards the whole patient (patient-centered vs. disease-centered care), The College of Family Physicians Section of Teachers created the CanMEDS-FMU 2009 (Family Medicine Undergraduate) document, describing learning objectives using this same framework.

The CanMEDs-FM competency framework was updated in 2017. It applies to all family physicians regardless of practice type, location or population served and defines the abilities needed by family physicians across the education continuum. The CanMEDS-FM 2017 framework includes an emphasis on generalism, cultural and patient safety, as well as quality improvement.

The seven CanMEDS-FMU roles are:

- The Family Medicine Expert
- The Family Medicine Communicator
- The Family Medicine Collaborator
- The Family Medicine Leader
- The Family Medicine Health Advocate
- The Family Medicine Scholar
- The Family Medicine Professional



# 3. The Mechanics of Undergraduate Electives

**Elective Bookings:** Descriptions of each elective are found in the Undergraduate Medicine Electives Catalogue: http://medsis.utoronto.ca/electives/. Students independently arrange placements based on this information**. Students must send an official request for approval through MedSIS**. Supervisors can approve and comment on these requests in response to the MedSIS email request.

**Elective Attendance:** Students are expected to complete 9-10 half days per week, not including weekends unless on-call. They may have a half day off to catch up on dictations/charts or another structured activity not necessarily related to patient care (reading labs/reports) or shadowing allied health. Requests for time off requires prior approval by the supervisor and the Electives Office. Students should submit their absence requests to the university, including for unplanned absence due to illness.

**Evaluation:** There are two types of evaluation - formative and summative. Formative evaluations are designed to provide the student with useful feedback during a learning experience and may be organized informally. Such assessments must be free of threat, as the aim is to get the students to reveal their strengths and weaknesses rather than to disguise them. I encourage you to give regular feedback to your students so that they may direct their learning activities appropriately. Feedback sessions are most helpful when they are scheduled and both parties set goals and objectives.

Summative evaluations are formal and carry academic weight. They are designed to help make decisions about a student's competence at the end of a period of instruction. An elective evaluation form represents a summative evaluation. It is the student's responsibility to ensure the completion of the Clinical Assessment Form (Appendix 1) and the Learner Assessment of Clinical Teacher (LACT) Form (Appendix 2). These evaluation forms are computer-based and on MedSIS. They are reviewed and feedback given to the supervisor periodically.

To instill professionalism amongst the electives students the program has adopted a Clerkship Professionalism Form (Appendix 3) which will also be completed on MedSIS. This form allows you to document any lapses in professionalism amongst the electives students. If you are unsure if there has been a lapse in student behaviour, please feel free to contact us for further discussion.

**The Student in Academic Difficulty:** Occasionally the supervisor may encounter a student with academic or attitudinal difficulties. These cases should immediately be brought to the attention of the Electives Coordinator who will assist in addressing the problem. Appropriate individuals will be notified if the situation is serious and the student is in danger of failing the elective.

**Student Wellness:** See Appendix 4 for Tips for Supporting Students in Distress.

**Insurance:** University of Toronto Clinical Clerks are covered under the University of Toronto's Comprehensive General Liability Insurance policy against legal liability, including medical malpractice liability, arising out of the performance of the student's elective duties. The College of Physicians and Surgeons of Ontario has produced guidelines concerning services clinical clerks may provide: Professional Responsibilities in Undergraduate Medical Education.

**Visiting Students:** MD students attending Canadian/American/International schools use the AFMC (Association of Faculties of Medicine of Canada) portal to seek and book electives. Liability and Insurance Coverage must be confirmed, hence, these electives must be authorized through the official channels.

If you have any concerns regarding non-U of T students, please contact the following Electives Administrators:

**Sheila Binns Visiting Electives Program Administrator for Canadian & US Clerkship Students**
**Sheila Binns Interim Visiting International Electives Program Administrator**

# 4. Faculty Appointments

As teachers of Family and Community Medicine for the University of Toronto, you must apply for and receive a faculty appointment. Most elective supervisors hold the academic rank of *Lecturer*. In addition, longstanding and consistent excellence in education, research or creative professional activity may make you eligible for promotion to *Assistant Professor.* The procedure for such a promotion requires careful preparation of a detailed promotions dossier including a teaching log. We have included a sample teaching log form you may use for this documentation (Appendix 5). Your local hospital chief or program director must recommend you to the Junior Promotions Committee who reviews the candidates. The committee subsequently makes its recommendations to the Executive Committee and, once endorsed, the Chair submits the recommendation to the Dean of the Faculty of Medicine for approval. Although the procedure for promotion seems overly bureaucratic, the rigorous process supports the advancement of our faculty members to their maximum potential. For a detailed description of the promotions process to *Assistant Professor,* please visit the departmental website: http://www.dfcm.utoronto.ca/junior-promotion

# 5. How and What to Teach

It can be overwhelming at the outset particularly for the novice teacher to know how or where to begin with an elective student. A few useful teaching tools and tips have been summarized below to assist you in the process.

**Develop a Learning Contract (see Appendix 6)**
A learning contract can be a useful tool to help focus the student's experience. You and your student should spend a few minutes at the start of the rotation or elective to draw up a written learning contract.

1) First, help the student define his or her objectives:
   - These might be different for each student.
   - They should be specific, achievable and concrete.
   - They should include areas where the student needs more experience.
   - If the student isn't sure of objectives you can help identify needs by reviewing his or her training to date, and identifying any special areas of interest.
   - It is helpful to divide the objectives into categories of knowledge base, skills (interviewing skills, procedures, examination techniques), and attitudes.

2) Next, develop together a plan of action and clearly define responsibilities in order to meet the objectives.
   - Decide what type of patients the student should see.
   - Make some suggestions of where the student can find information and identify available resources.
   - You may also choose to define a special project such as developing an approach to a clinical problem, or studying a particular topic.

3) Finally, set dates to review performance and to check if objectives are being met. This should occur at least once during the rotation and of course at the end.

**Topics to Cover**
What topics to cover depends on the learning contract. These are some areas to consider:
- Focused history, physical, differential diagnosis, plan
- Common illnesses
- Illness prevention, health promotion and screening
- MD/patient relationship
- Clinical epidemiology and natural history of disease
- Critical appraisal of medical literature
- Cost effectiveness
- Health policy/quality assessment
- Documentation of the patient encounter (S.O.A.P. Notes)
- Medical record keeping (paper and EMR)

- Telephone advice
- Ethics
- Social Identity
- The Hub

**Teaching Techniques**
Students are often inundated with facts and figures and may find it difficult to sort through the information overload. You can focus their knowledge by highlighting key issues in the clinical setting. You can create a *need to know* by showing the importance of something in its real life context. Be ready to seize *teachable moments* when a clinical situation arises, or when the student observes something or makes a mistake. Remember that the student is an adult and is able to share responsibility for his or her learning.

There are many different strategies for office teaching. We offer a few examples and encourage you to try many different strategies to determine what works best for each individual student. One is *exposure* or *observation*. The student follows her/his supervisor from patient to patient at the normal pace of the practice. Before starting in the office, the student will be asked to watch for certain aspects of the principles of family medicine. For example, on the first day the student may be asked to identify how the physician uses resources in the community to help the patients, or to identify elements of prevention/screening in the practice. On the next day, he/she may be asked to focus on the doctor/patient relationship, or to think about the effect of continuity of care in a particular situation and the family physician's role.

The exposure model can be effective, especially to meet the goal of exposing the student to the discipline of family medicine. However, if used too much, it would obviously become boring for student and teacher alike. One or two days at the beginning of the rotation at most are likely enough.

An *in-depth approach* allows the student to see the patient alone, do the entire history/physical, and attempt to formulate a diagnosis and treatment plan. This process is more or less extensive depending on the problem. The supervisor can then discuss the case with the student outside the room, formulate a plan and then enter together. Alternatively, the supervisor can rejoin the student and patient, and the student can present the case to the supervisor with the patient present. In this second method, the patient acts as a control and ensures that the student has grasped the problem. In either case, the supervisor may repeat part of the history/physical to verify findings and then implements a plan of action for treatment after discussing it with patient and student.

This model should also move at the pace of the practice if possible, with the supervisor seeing patients concurrently with the student. The supervisor will choose appropriate patients, based on the student's needs as identified in the learning contract.

As much as possible the student should be involved in the follow-up of a patient they have seen. This involvement might include rebooking patients when the student could see them again, and checking results of lab work and other investigations.

The modified *problem-based learning model* is less labour-intensive and allows the supervisor to see a full office while the student is there.

The student sees two to three patients per half-day, with certain learning goals in mind. The patients may be scheduled specifically to see the student or they may be chosen from the existing list. After the patient interview, the student may independently research a topic coming out of the interview, using office time or at home. The student could then present the topic to the supervisor.

Remember, we often 'teach' students in a manner that we would like best if we were the student. Students may have a different learning style than we do. We encourage you to ask your students about strategies that work best for them.

## 5. How and What to Teach (continued)

**Setting**
Teaching often takes place in the office setting, but the supervisor is encouraged to take the student to the emergency room, chronic care hospitals, home visits, obstetrical deliveries, or any other clinical activity in which they are involved.

**A Multidisciplinary Experience**
Family physicians practice amongst a team in their community. Supervisors are encouraged (depending on the length of the elective experience) to have the student spend time with other health professionals such as the office nurse, public health nurse, social worker or local pharmacist.

**Patient Log**
In order to ensure that objectives are being met, it is very useful for the student to keep a patient log. This will allow the student to follow up on lab results and referral reports. The student can arrange for patients to return to follow up on their condition and learn the natural history of the illness. A log can keep track of the number and type of patients seen, and be a guide to ensuring goals are met, and can identify gaps in knowledge and experience, especially at the mid-rotation review.

## 6. Practical Tips for Organization and Time Management

Community physicians may be concerned about the impact students will have on their busy practices. It is true that teaching does involve extra time, but there are some steps that may streamline the process.

Prepare patients ahead of time that they may be asked to see a student. It is helpful to hang a notice in the waiting room to inform patients that this is a teaching practice. This information can also be included in a practice brochure or memo (see Appendix 7) presented to new patients. The office receptionist may inform patients in advance that there is a student working that day.

Finding time to facilitate learning opportunities can be a challenge. You can squeeze the teaching in before the first patient, at the end of the day between patients, or at lunch. Some supervisors schedule gaps in the bookings to catch up on teaching. Have students see patients who may take a long time such as chronic patients, or periodic assessments, or have students see walk-in or urgent patients who have been added on.

Students can do jobs or projects that can actually improve efficiency such as update the cumulative patient profile, organize and review complicated charts, prepare consultation requests, and phone patients or consultants, to name a few. These strategies can actually free up the supervisor to see patients or get other work done.

## 7. Virtual Supervision

During the COVID-19 pandemic, physicians had to quickly learn how to provide virtual patient care. Supervision of medical students also required a shift to virtual modalities (Telephone/Video). While clinician teachers struggled to gain their own expertise in providing virtual care, virtual supervision added another layer of complexity. We understand that your practice may be a blended model of in-person and virtual care. This dual approach to patient care is now the ideal learning environment for our future family doctors. Teaching virtually can be done easily and we can help you. There are plenty of resources available on Virtual Supervision. Please acquaint yourself with this very useful website: Educational Resources for Faculty .

## 8. Site Visits Program

***Please note that site visits are on hold during the COVID-19 pandemic.***
This program was developed to allow us to liaise with all our community sites and provide educational needs to our community preceptors. We acknowledge the time, effort, and excellence in teaching you provide medical students and we want to ensure you feel connected with the Department. In addition, we enjoy taking a tour of the site to assess the learning environment and opportunities for our students. Site visits are usually made every 3-5 years. We look forward to meeting all of our preceptors.

## 9. Remuneration

There is a Preceptor Payment Program administered through the PostMD Office. Funds are received through an agreement with the MOHLTC. Community doctors may be entitled to a maximum of $1,000 per learner, per 4-week block. Payments are distributed quarterly. Please note that payments are received only for supervision of UofT medical students, not visiting students. Please see Appendix 8 for further details.

## 10. Undergraduate Education Resources

**Faculty Development**
Faculty development is the acquisition of new skills to help achieve career progression and growth, thereby enabling one to contribute to their career in a meaningful way.

We want to help you achieve your faculty development goals. Here is the link http://www.dfcm.utoronto.ca/landing-page/faculty-development to the Faculty Development homepage. If you are interested in contacting your Faculty Development Lead, please search http://www.dfcm.utoronto.ca/find-your-faculty-development-lead. Your Faculty Development Lead can provide details and advice about promotions, mentorship, faculty development events, awards, funds, or your PDP plan, to name a few. If you do not have a Faculty Development Lead, please contact Dr. Susan Goldstein at susan.goldstein@utoronto.ca.

**Workshops**
A number of faculty development activities are offered by the DFCM. They include the Undergraduate Preceptor Education Evening, the Annual DFCM Conference, and internet and literature search workshops.

**Interprofessional Applied Practical Teaching and Learning in the Health Professions (INTAPT)**
This 2-week modular course is designed to provide participants with a broad introductory overview of teaching and learning issues in health professional training as a field of scholarly inquiry and research and examines the major topics which are important in developing educational programs for health sciences. This course will introduce students to some of the important literature in the field of teaching and learning including as it is applied to practicum/field supervision. This course also provides participants with opportunities to develop a scholarly and practical approach to teaching with generous use of case studies and in working in small groups and multidisciplinary teams. For information please contact healthteach.grad@utoronto.ca or 416-978-1914.

**Clinical Teacher Certificate**
This four module program's goal is to provide advanced training in Health Professions Education for interdisciplinary faculty members who want to increase their teaching effectiveness. It is suitable for part time teachers at all career levels; new, mid-career and seasoned. The two required courses examine the theoretical base and current issues generic in clinical education and applications to real life teaching. For more information visit our website http://www.dfcm.utoronto.ca/ctc or contact familymed.grad@utoronto.ca or 416-978-1914.

# Undergraduate Education Resources (con't)

**Academic Fellowship**
The DFCM Academic Fellowship program is designed to provide academic training or preparation for faculty with an emphasis on teaching, professional leadership and critical appraisal. Faculty may join this program on a part-time or full-time basis. For information, contact familymed.grad@utoronto.ca or 416-978-1914.

**Graduate Studies**
The DFCM also offers two unique graduate studies degrees intended to strengthen the practice of family medicine and primary care by developing leadership, teaching and research skills of the practitioners. MScCH (FCM) and the MPH (FCM) are designed for practicing health professionals who are or can reasonably expect to become teachers and leaders in their professional fields. For information, visit our website http://www.dfcm.utoronto.ca/graduate-studies or contact familymed.grad@utoronto.ca | 416-978-1914.

**Basics Program**
Whether you are new to the department or a seasoned faculty member, connect with the people and resources at DFCM through the Basics faculty development workshop series. You will gain access to valuable tools at each stage of your career. These workshops are tailored to the specific needs of family medicine teachers and also provide opportunities for networking. Choose from: Basics for New Faculty, Beyond Basics, Leadership Basics, Wellness and Resilience Series, Scholarship Basics - An Introduction to Education Scholarship. For more information, visit our website http://www.dfcm.utoronto.ca/landing-page/faculty-development or contact pd.familymed@utoronto.ca | 416-978-1914.

**B.P.E.R. Rounds**
Best Practice in Education Rounds (B.P.E.R) are a weekly accredited group learning activities held Tuesdays at 12pm. These presentations originate from St. Michael's Hospital, and are video cast to a number of GTA hospital locations as well as by direct webcast, and through the use of the Periscope App. BPER focus on topics of special interest to faculty involved in teaching and education. Past years presentations are archived on their website. BPER is co-sponsored and organized by the Center for Faculty Development and The Wilson Centre. Further information can be found at https://cfd.utoronto.ca/bper

**Teaching Tools**
The University of Toronto libraries provide many services to support your research, teaching, and learning. As a U of T faculty member, you have access to electronic resources, full text articles, and mobile resource available through https://gerstein.library.utoronto.ca

**The Hub**
The Hub Family Medicine is an online guide created to address students' need for up to date, relevant and distilled resources for clinical reference and study during the Family and Community Medicine rotation. The Hub is designed to provide references and resources for all core objectives for the course, and it should be used to complement the clinical experiences and seminars that students encounter during their rotation. http://thehub.utoronto.ca/family/

**Physician Wellness and Mentorship**
Whether you seek guidance from a mentor or desire to foster a relationship with a promising mentee, our mentoring resources are here to help. https://www.dfcm.utoronto.ca/mentoring-resources

OMA Physician Health Program: A confidential service providing assistance on issues such as stress, burnout, mental health, and substance use issues, to both physicians and their families. Please visit their website for more information or call their 1-800-851-6606.

*Every Doctor: Healthier Doctors=Healthier Patients*: Written by Dr. Michael Kidd, Chair of the DFCM and Dr. Leanne Rowe, this book provides advice on how to thrive in medicine at a time of massive advances and changes in global health systems and medical services.

# 11. Teaching Tools

## One Minute Preceptor

*The One-minute Preceptor: Shaping the Teaching Conversation. Neher, Jon O. & Stevens, Nancy G. Family Medicine 35(6), June 2003.*

1. Get a Commitment
2. Probe for Supporting Evidence
3. Teach General Rules
4. Reinforce what was done right
5. Correct Mistakes

1. **GET A COMMITMENT:**
   - Find out what the learner thinks is going on
   - What do they want to do now?
   - For early learner might be a commitment about how to figure out the diagnosis for more advanced learners might be about how to manage situation.

2. **PROBE FOR SUPPORTING EVIDENCE:**
   - Find out how the learner arrived at the commitment
   - What factors did they consider in making that decision?
   - Helps to understand their clinical reasoning and evaluate knowledge base

3. **TEACH GENERAL RULES:**
   - Clinical pearls
   - Summary of key features of a diagnosis
   - Don't try to teach everything on one case
   - If knowledge is lacking can assign reading or plan review session

4. **& 5. REINFORCE WHAT WAS DONE RIGHT/CORRECT MISTAKES:**
   - Should be:
     i. well timed
     ii. expected
     iii. case specific
     iv. behaviour focused
     v. descriptive rather than evaluative
   - Label it as feedback

## SNAPPS

*SNAPPS: A Learner-centred Model for Outpatient Education. Wolpaw, Terry M et al. Academic Medicine 78(9), September 2003.*

1. **S**ummarize history & findings
2. **N**arrow the differential
3. **A**nalyze the differential
4. **P**robe the preceptor
5. **P**lan the management
6. **S**elect an issue for learning

1. **SUMMARIZE BRIEFLY** THE HISTORY AND FINDINGS:
   a. Should be condensed, concise summary of relevant information
   b. Preceptor can probe for further details as needed

2. **NARROW THE DIFFERENTIAL** TO 2-3 RELEVANT POSSIBILITIES:
   a. Should focus on most likely possibilities
   b. Similar to "Make a commitment" step in One minute preceptor

3. **ANALYZE THE DIFFERENTIAL** BY COMPARING AND CONTRASTING THE POSSIBILITIES:
   a. Learner should discuss how and why they ruled in/out a particular diagnosis
   b. Teacher can identify knowledge gaps/ errors in clinical reasoning

4. **PROBE THE PRECEPTOR** BY ASKING QUESTIONS ABOUT UNCERTAINTIES, DIFFICULTIES OR ALTERNATIVE APPROACHES:
   a. Learner driven educational discussion
   b. Can discuss teaching point

**5.** **PLAN MANAGEMENT** FOR THE PATIENT'S MEDICAL ISSUES:
   a. Bringing steps 1-5 together to create a management plan

**6.** SELECT A CASE RELATED ISSUE FOR **SELF-DIRECTED LEARNING:**
   a. Set learning objective
   b. Try to make points specific rather than unfocused/general


MD Program
UNIVERSITY OF TORONTO | Office of Faculty Development

# A faculty primer: Portraying Social Identities in Medical Curriculum

## What are social identities?

A social identity is a set of common experiences, qualities, beliefs, and perceptions that describe a group of individuals. Individuals can share identities as determined by external forces (society, law, and other people) as well as internal forces (schema, self-perception). Criteria for belonging to a specific social identity are complex, constantly in flux, and often arbitrary. For example, racial identity categories are defined differently in different countries, and change over time based on political interests.

## Why is understanding social identities important for medical students?

Although social identities are artificially constructed, they shape the way that every individual experiences illness, the medical system, and treatment. As such, physicians need to understand the importance of various aspects of identity, and how to practically apply this knowledge in a therapeutic encounter. Including a diverse range of identities in educational materials will equip students with the skills to think critically about how someone's identity may shape their experience with the medical system.

This resource was collaboratively developed by faculty and students in the MD Program, Faculty of Medicine, University of Toronto, in response to concerns about how various social identities (i.e. gender, race, sexuality, etc.) are portrayed in our curriculum. The attached tool has been designed as a reference for medical educators when creating or delivering lectures, CBL cases, seminars, or other teaching and learning materials.

### How can I use the Social Identities tool in my teaching?

The attached tool poses five questions for educators to consider regarding the portrayal of different social identities in medical education material.

The tool features a border of icons meant to represent various categories of social identities. These images and descriptions do not constitute an exhaustive list of categories, but are meant to serve as a reminder of some of the groups to keep in mind when considering the following five points:

| 1 | **Do learning materials consider the nuances of terminology used to describe various identities?** |
|---|---|

*Avoid using different terms such as race and ethnicity or gender and sex interchangeably. These distinctions are important for learners to develop accurate medical knowledge and patient rapport.*

**For example...** A lecture refers to a genetic condition as more prevalent among people of a certain gender, when the intended meaning was people of a certain sex.

**Instead...** Stay up to date with the terminology of identity using the glossary resource developed and updated by medical students that accompanies this document.

| 2 | **Do learning materials inadvertently reinforce prejudices against marginalized populations?** |
|---|---|

*Marginalized people face prejudices in society which can be inadvertently propagated by medical education.*

**For example...** The prejudice that all Indigenous people struggle with alcoholism may be reinforced by a clinical example of alcoholism that involves an Indigenous person, especially if that is the only mention of alcoholism or Indigenous people.

**Instead...** If you use that example, explain some of the social and historical context for why alcoholism is more prevalent in Indigenous populations. Alternatively, choose an identity for the alcoholism case that may not be as stereotypical but still important to learn about (i.e. an upper-class individual who struggles with alcoholism).

## How was this resource developed?

This resource was developed by students in the MD Program, Faculty of Medicine, University of Toronto, in response to concerns from classmates about the representation of certain identities in our curriculum. We collected feedback from students about how various social identities (i.e. gender, race, sexuality, etc.) were portrayed in lectures across both years of preclerkship. We conducted a thematic analysis of this feedback and, with the aid of faculty, developed this resource for medical educators.


Developed by:

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Elise Jackson

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Reviewed by:

Dr. Lisa Richardson

Dr. Lisa Robinson

Dr. Pier Bryden



**References**

Taylor, G., & Spencer, S. (2004). *Social identities: Multidisciplinary approaches.* London: Routledge.

Twohig, P. L., Kalitzkus, V. (2008). *Social studies of health, illness and disease: Perspectives from the social sciences and humanities.* Amsterdam.

Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: an emerging agenda for applied psychology. Applied Psychology, 58(1), 1-23.


| 3 | **Do learning materials overlook differences in identities with regards to diagnosis, treatment, or ability to access health care?** |
|---|---|

*Medical educators should seek to present medical knowledge that accounts for differences in identity. Where this is not available, the limitations of generalizing information specific to one group of people should be clearly stated.*

**For example...** Appearance of skin conditions such as rashes or discoloration may only be illustrated on a single skin tone in some older dermatological visual scales.

**Instead...** An educator could seek out newer scales with a range of skin tones, or if these tools don't exist, bring attention to the limitations of the existing tools.

| 4 | **Do learning materials place implicit blame on individuals for their health status?** |
|---|---|

*Materials should avoid suggesting that people become ill solely because of their choices, and not because of their environments.*

**For example...** When giving a lecture on obesity, it would not be responsible to represent obesity with a picture of a hamburger and french fries (unless the slide includes multiple pictures that each illustrate a risk factor for obesity).

**Instead...** Focus on presenting social and environmental risk factors in addition to individual ones. Understanding the context of illness can increase doctor-patient rapport and open up the door for referral to other services (ie. social work).

| 5 | **Do learning materials incorporate various identities in a way that is not strictly limited to illustrative epidemiological examples?** |
|---|---|

*Incorporating diverse identities into ALL medical cases, whether epidemiologically relevant or not, illustrates underlying similarities among people and reduces the tokenization of marginalized groups.*

**For example...** When a clinical example makes reference to the patient being South Asian, the condition is often cardiovascular disease related.

**Instead...** Clinical examples highlighting the propensity for South Asians to develop cardiovascular disease are important, but South Asian patients should be represented in cases that are not medically related to ethnicity as well.


**Portraying Social Identities in Medical Curriculum – Abridged Glossary**

MD Program
UNIVERSITY OF TORONTO

# Portraying Social Identities


## Do my learning materials...

1. CONSIDER THE **NUANCES OF TERMINOLOGY** USED TO DESCRIBE VARIOUS IDENTITIES?
   E.G. SEX VS. GENDER; RACE VS. ETHNICITY
2. **INADVERTENTLY REINFORCE PREJUDICES** ABOUT MARGINALIZED POPULATIONS?
   E.G. ALCOHOLISM AMONG INDIGENOUS PEOPLES
3. **OVERLOOK DIFFERENCES** IN IDENTITIES WITH REGARDS TO DIAGNOSIS, TREATMENT, OR ABILITY TO ACCESS HEALTH CARE?
   E.G. DIFFERENCES IN DERMATOLOGICAL PRESENTATION BASED ON SKIN TONE
4. **PLACE IMPLICIT BLAME** ON PATIENTS FOR THEIR HEALTH STATUS?
   E.G. EQUATING OBESITY TO LAZINESS
5. INCORPORATE VARIOUS IDENTITIES IN A WAY THAT IS **NOT STRICTLY LIMITED TO ILLUSTRATIVE EPIDEMIOLOGICAL EXAMPLES?**
   E.G. SOUTH ASIANS WITHOUT HEART DISEASE

# Appendix 1 Clinical Assessment

Clinical Assessment

PICTURE NOT AVAILABLE

**Tips for completing this assessment**

**Medical Expert/Skilled Clinician**

| | Unsatisfactory | Below Expectations | Meets Expectations | Exceeds Expectations | Outstanding | N/A |
|---|---|---|---|---|---|---|
| Knowledge (Basic Science and Clinical) | ○ All or most aspects of knowledge base are observably lower than expected at this level of training; major gaps are present. | ○ Large gaps in knowledge base for stage of training. | ○ Displays adequate factual knowledge for level of study. | ○ Comprehensive knowledge base; recognizes most issues; very few gaps identified. | ○ Displays medical knowledge far beyond level of training. | ○ |
| History Taking | ○ Sketchy, incomplete, major omissions, lacks focus. | ○ Often misses several aspects of history. Provides cursory detail. Poorly organized. | ○ Usually complete, accurate and organized. | ○ Thorough, logical, complete, elicits some subtle historical points. | ○ Comprehensive, accurate problem identification and characterization, excellent interviewing skills. | ○ |
| Physical Examination | ○ Incomplete, misses obvious findings, major technical deficiencies, lacks focus. | ○ Physical examination skills are often less than adequate or inappropriate. Often unable to elicit most of the relevant findings. | ○ Carefully done, most findings detected, technically sound, organized approach. | ○ Complete, detects some subtle findings, sensitive to patient. | ○ Very thorough, well-organized, all important findings detected, often finds subtle or difficult findings. | ○ |
| Diagnostic Test Interpretation | ○ Grossly inappropriate use of diagnostic tests; unable to interpret or apply results. | ○ Use of diagnostic tests often inappropriate. Often unable to interpret or apply results. | ○ Usually orders appropriate tests for clinical scenario. Able to interpret and apply results of common investigations to patient care. | ○ Consistently orders appropriate tests for clinical scenario. Able to interpret and apply results for nearly all common investigations. | ○ Exceptional understanding of diagnostic tests. Able to apply that knowledge in patient care, even in challenging situations. | ○ |
| Problem Formulation and Management Plan (Clinical Judgment) | ○ Assessments usually incomplete or inaccurate. Great difficulty generating differential diagnosis. Diagnostic and therapeutic plans incomplete and/or not logically derived from data. | ○ Assessments often incomplete or inaccurate. Limitations in ability to integrate data and arrive at differential diagnosis, and diagnostic and therapeutic plans. | ○ Able to solve common problems and generate reasonable differential diagnosis and management plan. | ○ Consistently accurate and thorough in generating differential diagnosis and proposing plan. Able to integrate more complex issues and solve some uncommon problems. | ○ Exceptional judgment. Able to generate differential diagnosis, provisional diagnosis, and provide a thorough plan of management even for complex problems. | ○ |
| Technical and Procedural Skills | ○ Difficulty using proper techniques, inadequate knowledge of procedures; avoids procedural experience. | ○ Techniques and skill often inadequate. Requires a great deal of assistance with basic procedures. | ○ Completes some procedures well, reasonable knowledge of procedures. | ○ Completes most procedures without difficulty, good understanding of risks and benefits, sensitive to patient. | ○ Technical expertise well beyond expected for level of study. Inspires confidence in patients. | ○ |

**Communicator/Doctor-Patient Relationship**

| | Unsatisfactory | Below | Meets | Exceeds | Outstanding | N/A |
|---|---|---|---|---|---|---|

| | | Expectations | Expectations | Expectations | | |
|---|---|---|---|---|---|---|
| Communication with Patients/Families /Community | ○ Remote, insensitive, little rapport. Lack of concern for patients and/or families. Unable to deal with common or routine situations. | ○ Often has difficulty in establishing rapport and relating to patients and/or families. Often unable to deal with common or routine situations. | ○ Conveys interest and concern for patients and/or families. Establishes rapport. Empathetic and respectful. Culturally sensitive. Uses non-verbal skills effectively. | ○ Consistently able to effectively communicate with patients and/or families. Very effective in establishing rapport. | ○ Exceptional ability to establish good rapport with patients and/or families, even in challenging situations. Exceptionally empathetic. Wins confidence and cooperation. | ○ |
| Written Records | ○ Incomplete, disorganized, confusing, difficult to trace patient's problems and management. | ○ Notes are often incomplete, inaccurate disorganized, or difficult to read. | ○ Generally complete, accurate, legible and organized; reasonably good documentation of diagnosis, therapeutic plans and interventions. | ○ Complete, logical, very clear, easy to follow, includes all important information. | ○ Outstanding, conscientious and accurate record keeping, well-organized, intelligently written. | ○ |
| Oral Reports | ○ Presentations usually disorganized, ineffective, incomplete, illogical, lots of errors. | ○ Many omissions of relevant information, and/or inaccuracies. Often disorganized. | ○ Reasonably clear, complete, accurate, occasional need to pose a few questions to complete or clarify. | ○ Concise, clear, organized, accurate, facts presented in a logical manner. | ○ Succinct, precise, relevant issues clearly delineated, conveys excellent understanding of complex issues. | ○ |

**Collaborator**

| | Unsatisfactory | Below Expectations | Meets Expectations | Exceeds Expectations | Outstanding | N/A |
|---|---|---|---|---|---|---|
| Team Participation (Contribution within Interdisciplinary Team) | ○ Uncooperative and poorly integrated team member. | ○ Often uncooperative or poorly integrated into team. | ○ Generally functions well as team member. | ○ Consistently makes extra effort to be part of the team in the provision of care. | ○ Consistently offers to take on extra tasks to help the team provide effective care. | ○ |

**Leader**

| | Unsatisfactory | Below Expectations | Meets Expectations | Exceeds Expectations | Outstanding | N/A |
|---|---|---|---|---|---|---|
| Awareness of and Appropriate Use of Healthcare Resources | ○ Unaware of appropriate use of health care resources. | ○ Often unaware of appropriate use of health care resources. | ○ Appropriately aware of the generally available health care resources and knows how to access these. | ○ Consistently aware of the generally available health care resources and employs them in appropriate situations. | ○ Exceptionally wise stewardship of available resources in the context of resource allocation and individual patient care. | ○ |

**Health Advocate**

| | Unsatisfactory | Below Expectations | Meets Expectations | Exceeds Expectations | Outstanding | N/A |
|---|---|---|---|---|---|---|
| Patient Advocacy | ○ Does not advocate for patients when appropriate situations arise. | ○ Often misses the opportunity to provide patient advocacy. | ○ Usually advocates on behalf of patients in an appropriate manner and in the right situations. | ○ Consistently advocates on behalf of patients in an appropriate manner and in the right situations. | ○ Exceptional ability to advocate on behalf of patients in an appropriate manner and in the right situations. | ○ |

**Scholar**

| | Unsatisfactory | Below Expectations | Meets Expectations | Exceeds Expectations | Outstanding | N/A |
|---|---|---|---|---|---|---|
| Self-Directed Learning | ○ Does not assume responsibility for learning, resists or fails to respond to constructive feedback, unaware of own inadequacies. | ○ Generally lacking in responsibility for own learning. Not very receptive to constructive feedback. | ○ Assumes responsibility for own learning, shows adequate insight, requests and accepts constructive feedback, reads | ○ Keenly interested in learning. Consistently learns around cases. Consistently requests, accepts and acts | ○ Exceptional interest in learning. Solicits and receives criticism, able to effect change, consistent effort at self- | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | around cases. | on feedback. | improvement. | |
| Contribution to Rounds, Seminars and Other Learning Events | ○ | ○ | ○ | ○ | ○ | ○ |

**N.B. Please note that unsatisfactory in any one category within a competency may be grounds for a failing grade**

**Overall assessment**
A rating of "Meets Expectations" or above is required on this item to be satisfactory in the elective

| | Unsatisfactory | Below Expectations | Meets Expectations | Exceeds Expectations | Outstanding |
|---|---|---|---|---|---|
| Holistic judgement of the student's performance<br>*This overall rating is informed by, but not an average of, the ratings on the individual competencies* | ○ | ○ | ○ | ○ | ○ |

**Comments**

Strengths:

Suggestions for improvement:

| | No | Yes |
|---|---|---|
| Professionalism form completed | ○ | ○ |

Save Submit

# Appendix 2 Learner Assessment of Clinical Teacher (LACT)


Learner Assessment of Clinical Teacher (LACT)

### About your assessment of teachers

- Based on the described encounter(s) only.
- Feedback to teachers is an important professional obligation of learners.
- Your assessments are confidential - with only anonymized aggregated summaries provided.

### How we will use the information

- Ratings of 2 or less trigger an automatic email alert to program leaders.
- Teachers, sites and clinical departments use teacher assessment to monitor, support and improve teacher practices and the learning environment.
- Aggregated data is used to evaluate the teacher/faculty, rotation, and sites on a regular basis.

**Rating scale:**

- 1-5 (low to high)
- Not Applicable (n/a) is permissible for all ratings EXCEPT overall
- *Overall rating of 3 is the "Minimum acceptable level of performance" for this assessment form*

**Teaching Format**

☐ Ambulatory/clinic ☐ Diagnostics ☐ Emergency/urgent care
☐ Inpatient/ward ☐ Office ☐ Operating room
☐ Seminar/workshop ☐ Simulation ☐ Virtual care (i.e. phone, video)
☐ Other (please specify):

**Teaching contact**
Please estimate the amount of contact you had with the teacher using the description below:

○ **Brief** (e.g. single clinic, single lab/microscope session, a few hours on-call, short OR shift)
○ **Moderate** (e.g. 2-4 clinics, 1 – 2 weeks in lab/microscope sessions, 1-2 on-call shift, 1-2 OR shifts, 1 – 2 weeks rotation)
○ **Extensive** (e.g. 5+ clinics, 3+ weeks in lab/microscope sessions, 3+ OR or on-call shifts, 3+ weeks rotation)

**Assessment of Teaching**

| | Poor | Unsatisfactory | Minimally Acceptable | Good | Superior | N/A |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| The teacher/faculty provides **effective clinical teaching** that stimulates learners to build knowledge and skills safely while offering graded responsibility for patient care. | ○ Ineffective, unavailable, or impediment to learning | ○ | ○ Good learning support matched to ability levels | ○ | ○ Superior educational experience responsive to learner's level | ○ |

**Comments**

| | Poor | Unsatisfactory | Minimally Acceptable | Good | Superior | N/A |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| The teacher/faculty created **responsive relationships with effective feedback** to support learner and teacher collegiality, collaboration and co-learning. | ○ Ineffective, insufficient or negative communication support or feedback | ○ | ○ Respectful, responsive, available, and constructive | ○ | ○ Excellent communication, collaboration, and detailed coaching | ○ |

**Comments**

| | Poor | Unsatisfactory | Minimally Acceptable | Good | Superior | N/A |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| The teacher/faculty was a **positive role model** for the learner as a clinician, teacher and professional. | ○ Poor role model causing ineffective or negative educational experience | ○ | ○ Suitable role model in all areas | ○ | ○ Exemplary role model in all areas demonstrating the highest standard | ○ |

**Comments**

| | Poor | Unsatisfactory | Minimally Acceptable | Good | Superior | N/A |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| The teacher/faculty created an effective **learning climate** providing clear expectations and balancing learning/teaching/assessments effectively. | ○ Reluctant to teach, set appropriate expectations, and address learning climate issues | ○ | ○ Willing to teach and include learners respectfully with appropriate expectations in a positive learning climate | ○ | ○ Enthusiastic, respectful, and proactive in ensuring positive climate and effective learning to learner needs regarding case mix | ○ |

**Comments**

| | Unsatisfactory Teacher | Weak Teacher | Acceptable Teacher | Good Teacher | Superior Teacher |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| **OVERALL rating for this teacher/faculty at this site/location/time** (i.e., considering clinical teaching; respectful and responsive relationships and effective feedback; personal and professional model; learning climate.) | ○ Significant limitations to suitability of this teacher | ○ Limitations in this teacher's performance | ○ Effective teacher enabling effective learning | ○ Very effective, proactive teacher supporting positive learning | ○ An exceptional role model as a teacher |

**Comments**

**Describe STRENGTHS of this teacher/faculty**

**Actions or Areas FOR IMPROVEMENT**

**OTHER Comments**

# Appendix 3 Professionalism Evaluation

Professionalism Assessment


Preface: Assessment of student professionalism is organized according to six professionalism domains, each of which includes criteria that reflect specific behaviours that characterize the respective domain. Teachers are asked to assess students in each domain based on the criteria applicable to the student's learning activity. Teachers may indicate that they were not in a position to assess one or more of the professionalism domains.

Teachers are required to provide comments regarding any scores of 1 or 2. If the score was based on a critical incident, the teacher will be required to provide additional information. Teachers may also provide comments regarding a student's strengths and areas for improvement.

Further details about the assessment of student professionalism are provided in the MD Program's Guidelines for the Assessment of Student Professionalism. Those guidelines, including case-based examples on how to fill out the professionalism assessment form, are summarized in an Introduction to Assessing Professionalism in the MD Program eModule.

Suspected breaches of academic integrity (e.g. cheating, plagiarism, etc.) are to be investigated and reported in accordance with the MD Program's academic integrity guidelines.

This form must be completed no later than six weeks following the end of the required learning experience (e.g., a small group session). Please contact the Course Director if you have any professionalism concerns about a student not documented within this period. Please see the MD Program standards for timely completion of student assessment and release of marks.

| Professional Domains and Criteria | Meets very few applicable criteria or has significant deficiencies<br>1 | Meets some applicable criteria with minor deficiencies<br>2 | Usually meets applicable criteria with no deficiencies<br>3 | Meets most applicable criteria and is exemplary in some areas<br>4 | Consistently meets all applicable criteria and exemplary in many<br>5 | Was not in a position to assess<br>N/A |
|---|---|---|---|---|---|---|
| **Altruism** | | | | | | |
| • Demonstrates sensitivity to patients' and others' needs, including taking time to comfort the sick patient<br>• Listens with empathy to others<br>• Prioritizes patients' interests appropriately<br>• Balances group learning with his/her own | ○ | ○ | ○ | ○ | ○ | ○ |
| **Duty: Reliability and Responsibility** | | | | | | |
| • Fulfills obligations in a timely manner, including transfer of responsibility for patient care<br>• Informs supervisor/colleagues when tasks are incomplete, mistakes or medical errors are made, or when faced with a conflict of interest<br>• Provides appropriate reasons for lateness or absence in a timely fashion<br>• Prepared for academic and clinical encounters<br>• Actively participates in discussions<br>• Fulfills call duties<br>• Timely completion of MD Program and hospital registration requirements | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Excellence: Self-improvement and Adaptability**<br>• Accepts and provides constructive feedback<br>• Incorporates feedback to make changes in behaviour<br>• Recognizes own limits and seeks appropriate help<br>• Prioritizes rounds, seminars and other learning events appropriately | ○ | ○ | ○ | ○ | ○ | ○ |
| **Respect for Others: Relationships with Students, Faculty and Staff**<br>• Maintains appropriate boundaries in work and educational settings<br>• Establishes rapport with team members<br>• Dresses in an appropriate manner (context specific)<br>• Respects donated tissue; cadavers<br>• Relates well to patients, colleagues, team members, laboratory staff, service, and administrative staff | ○ | ○ | ○ | ○ | ○ | ○ |
| **Honour and Integrity: Upholding Student and Professional Codes of Conduct**<br>• Accurately represents qualifications<br>• Uses appropriate language in discussions about cases and with or about patients and colleagues<br>• Behaves honestly<br>• Resolves conflicts in a manner that respects the dignity of those involved<br>• Maintains appropriate boundaries with patients<br>• Respects confidentiality<br>• Uses social media appropriately<br>• Respects diversity of race, gender, religion, sexual orientation, age, disability, intelligence and socio-economic status | ○ | ○ | ○ | ○ | ○ | ○ |
| **Recognize and Respond to Ethical Issues in Practice**<br>• Recognizes ethical issues and dilemmas in case vignettes and in practice<br>• Examines personal values in relation to challenges in educational and clinical settings<br>• Applies ethical reasoning skills to case situations<br>• Acts appropriately with respect to complex ethical issues<br>• Understands options to respond to unprofessional and unethical behaviours of others | ○ | ○ | ○ | ○ | ○ | ○ |

**Comments**

(mandatory) Please provide comments regarding any scores of 1 or 2. If the score was based on a critical incident, please complete the critical incident section below

## Appendix 4 Tips for Supporting Students in Distress

# Tips for Tutors

MD Program
UNIVERSITY OF TORONTO

1 → 2 → 3

## Tips for Supporting Students in Distress

### 1 Remember

- You are NOT in a clinical physician role
- Personal health information is still managed as per PHIPA
- Safety over confidentiality

| Don't: | Instead: |
|---|---|
| Take a history | ▸ Acknowledge student's distress<br>▸ Connect them to appropriate resources, including any supports student currently has in place<br>▸ Keep notes on your encounter |
| Promise absolute confidentiality | ▸ Reassure student you will keep information as private as you can, and that you will take direction from them, unless you are concerned about safety |
| Offer/provide psychotherapy | ▸ Follow up/check in with the student to ensure they have connected with appropriate resources, if student gives you permission to do so<br>▸ Maintain appropriate, professional boundaries |

### 2 Responses

Link students to appropriate resources (3) based on the type of concern.

| Type of Concern | Details | Suggested Resource |
|---|---|---|
| Emergent | ▸ Imminent risk of harm to self or others<br>▸ Sudden/significant change in level of function | ▸ Dial 911<br>▸ Local Emergency Department<br>▸ 2, 4, 9, 10, 13 |
| Urgent | ▸ Attention needed within 48 hours | ▸ As per emergent above<br>▸ 1, 4, 5, 12 |
| Non-urgent | ▸ Attention needed within 2 weeks | ▸ 1, 5, 6, 12 |
| Student Mistreatment | ▸ See 7 & 8<br>▸ Consider if situation is reportable | ▸ 1, 3, 11 |
| Unsure | ▸ You are looking for some direction re how to proceed | ▸ 1 |

# Tips for Tutors (continued)

## 3 Resources

| Resource: | Contact Info: |
|---|---|
| **1. OHPSA**<br>Naylor Building, 6 Queen's Park Cres. W., 3rd Floor | 416-978-2764<br>md.utoronto.ca/ohpsa |
| **2. CAMH Emergency Department**<br>250 College Street | 416-979-6885<br>camh.ca |
| **3. College of Physicians and Surgeons of Ontario (CPSO)**<br>80 College Street | 1-800-268-7096<br>cpso.on.ca |
| **4. Gerstein Centre (24hr crisis phone service)**<br>100 Charles Street East or 1045 Bloor Street West | 416-929-5200<br>gersteincentre.org |
| **5. Health & Wellness Centre (St. George)**<br>214 College Street, 2nd floor Suite #232 | 416-978-8030<br>studentlife.utoronto.ca/hwc |
| **6. Health & Wellness Centre (UTM)**<br>1123A – 3359 Mississauga Rd. N., Davis Building (around the corner from the Bookstore) | 905-828-5255<br>utm.utoronto.ca/health/wellness |
| **7. Protocol for addressing incidents of discrimination, harassment, mistreatment, and other unprofessional behaviour** | md.utoronto.ca/student-mistreatment |

## 3 Resources

| Resource: | Contact Info: |
|---|---|
| **8. University of Toronto Conflict of Interest and Close Personal Relations** | provost.utoronto.ca/planning-policy/conflict-of-interest-close-personal-relations |
| **9. St. George – Campus Police**<br>21 Sussex Ave | Enquiries: 416-978-2323<br>Emergency: 416-978-2222<br>campuspolice.utoronto.ca |
| **10. UTM – Campus Police**<br>3116–3359 Mississauga Rd. N., Davis Building | Enquiries: 905-828-5200<br>Emergency: 905-569-4333<br>utm.utoronto.ca/campus-police/ |
| **11. U of T Sexual Violence Prevention & Support Centre**<br>St. George campus: Gerstein Science Information Centre (Gerstein Library), Suite B139<br>UTM: Davis Building, Room 3094G | 416-978-2266<br>(for both locations)<br>svpcentre.utoronto.ca |
| **12. What's up Walk-in Clinic(s)**<br>Toronto – downtown<br>Toronto – west | 416-395-0660 (downtown)<br>416-394-2424 (west)<br>whatsupwalkin.ca |
| **13. Other** | safety.utoronto.ca |

# Appendix 5 Teaching Log

**Department of Family and Community Medicine**
**Undergraduate Electives Program**

This log will help you to keep track of the undergraduate teaching you do in the Family Medicine Electives Program. An accurate record of teaching is essential for application for appointment or promotion.

NAME OF PHYSICIAN: _____ ACADEMIC YEAR: _____

| STUDENT'S NAME | YR 1,2,3 or 4 | DATES OF ELECTIVE | # OF HALF-DAYS |
|---|---|---|---|
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# Appendix 6 Sample Learning Contract

Student: _____Supervisor: _____

| Learning Objectives | Resources & Strategies | Evidence of Accomplishment | Target Date for Completion |
|---|---|---|---|
| **A) KNOWLEDGE**<br>- exposure to ambulatory care approach to some of the most common probs in F.P., e.g.<br>pharyngitis | - review previous rotations, electives, interests, projects<br>- After Hours Clinic, observe different preceptors for different approaches | - log card<br>- able to treat | - mid-evaluation |
| vaginitis | - direct observation<br>- STD clinic<br>- textbook, article | - case review with preceptor<br>- narrative report | |
| diabetes mell. | - Diabetes Ed'n Clinic<br>- direct observation<br>- Cdn Diabetes Assoc<br>- reference articles | - COSS<br>- OSCE exam | - end unit |
| - learn about most current treatment strategies for osteoporosis | - osteoporosis program<br>- chart review, textbook<br>- book specific pt<br>- medline search, internet | - academic project presentation | - end unit |
| - acquire familiarity with common OTC meds & how to prescribe | - pharmacy in area<br>- pharmaceutical rep<br>- reference articles<br>- ask pts what works | - increasing prescribing over course of rotation | |
| **B) SKILLS**<br>- focused history taking | - review notes with preceptor<br>- case presentation<br>- videotape | | |
| - improve MSK exam skills<br>- knee<br>- shoulder<br>- ankle | - direct observation<br>- Sports Med Clinic, physiotherapy clinic<br>- rheumatology selective | - summarize case<br>- OSCE; role play<br>- videotape | |
| - begin to develop time mgt skills | - clock in room<br>- secretary to help<br>- patient to help | | |
| - improve common Xray interpretation skills | - ER<br>- Radiologist | - increase # patients seen/day | |
| **C) ATTITUDES**<br>- develop a non-judgmental approach to sensitive issues | - role model<br>- observe 1 way mirror<br>- book appropriate pt | - role play | |
| - recognize impact of illness on pt/family | - interview family members<br>- house visits | | |
| - medicolegal issues | - review College notices, reports done by preceptor<br>- case studies e.g. child abuse | - review students notes and medicolegal issues related to them | |

Date of 1st review: _____ Date of mid-unit review: _____ Date of end-of-unit review: _____

# Appendix 7 Sample Memo

**TO:** **Our Patients**

**FROM:** **Dr. Greig, Dr. Harris, Dr. Newman and Dr. Rosen**

Our practice has been chosen as a teaching practice; this means that university medical students will spend time in our office, seeing our patients under our supervision and direction.

We feel honoured by our selection to be part of the clinical teaching team associated with the university, but we recognize that for some patients this may pose a problem. Some patients feel reluctant to be seen by a medical student, even though we will be supervising. Of course it is very helpful for the students to develop their skills seeing patients in an office, and we are grateful to all patients who help and participate in this process. However, the comfort and security of our patients is a major priority, so if any patients object to being seen by a medical student, please let your preference be known and we will schedule your appointment when no students are in the office.

# Appendix 8 Preceptor Payment Program Guidelines

Post MD Education
UNIVERSITY OF TORONTO

## Preceptor Funding Program – Guidelines

### Background

Since January 2011, the Faculty of Medicine has received funding from the MOHLTC to support preceptors who teach clerks and residents in community based sites, clinics and offices. The Faculty of Medicine receives the funds through an agreement with the MOHLTC, and the relevant community sites have entered into an agreement with the Faculty of Medicine which outlines terms, conditions and responsibilities associated with the funding. The Preceptor Payment Program is administered through the PostMD Office. Below are the current guidelines for funding of community preceptor teaching activity and the payment process. As the MOHLTC has provided a fixed amount for this teaching activity, it is important to adhere to these guidelines.

### Funding

- A maximum of $1,000 per learner, per 4-week (28 days) block is available.
- Funding paid based on a daily rate of $35.71/day.
- Funding follows learners, not the preceptor;
- Funding will be issued to the community hospital, teaching site, Public Health Unit, specialized setting, or directly to the preceptor as indicated by validated U of T rotational data (down to the ½ day).
- Funding can only be paid to teaching sites and public health units with a U of T affiliation.
- HST is not included in the preceptor payment amounts paid to hospitals. Hospitals paying HST to preceptors at their site will invoice the Post MD Education office for reimbursement of HST paid.

### Learner & Rotational Guidelines

- All funding decisions will be based on U of T rotational data with the exception of clerks over the holiday break during which only 2 weeks of the rotation will be paid.
- Learners must be U of T residents and Year 3 and 4 medical students training in community hospitals, teaching practices, Public Health Units, or doctor's offices i.e. not AHSC full affiliates
- Core rotations, electives and selectives are eligible for residents and undergraduate clerks, but the rotation **must** be required to complete the MD or residency program i.e. rotations cannot be done on a voluntary basis.
- All non-degree U of T undergraduate MD student and sponsored residents are eligible for funding. Clinical Fellow rotations are ineligible for preceptor funding.
- Supervision of Family Medicine residents on Family Medicine rotations is not eligible, however supervision of Family medicine residents doing eligible specialty rotations and supervision of clerks on family medicine blocks is eligible.

### Preceptor Guidelines

- Preceptors must be MDs, and, have a current U of T academic appointment with a Faculty of Medicine Clinical Department or the Dalla Lana School of Public Health
- Preceptors may hold an academic appointment at another University in addition to the U of T appointment.
- Preceptors who are funded from another source which recognizes teaching of students and/or residents are ineligible for preceptor funding. Such sources would include: Alternate Funding Plans (AFP funds); Alternate Payment Plans (APP funds); Practice Plans which recognize teaching; Salary or stipends which recognize supervision or education included in the job description; ROMP funded rotations

If you have any questions regarding teaching activity and verification of data input to the T-IME system, please contact natali.chin@utoronto.ca . Questions regarding payment may be directed to colin.fleming@utoronto.ca