Undergraduate Program

Family Medicine Longitudinal Experience

Preceptor Handbook 2024 - 2025

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Important Dates

	Block 1	**Block 2**
Sessional Dates	October 7, 2024 – Dec 17, 2024	Jan 6, 2025 – May 22, 2025
Student Deadline: First Assignment Submission	Clinic Day 4 (1:30pm)	Clinic Day 4 (1:30pm)
Student Deadline: Final Assignment Submission	Two weeks post clinic Day 6	Two weeks post clinic Day 6
Preceptor Deadline to mark Final Assignment	One week after Final Assignment received	One week after Final Assignment received

*Please note, we cannot require students to submit assignments during protected vacation time. If the student assignment submission deadline falls during the December two week holiday break, please proactively set up an alternative deadline with your student for after the break

Message from the FMLE Director

Thank you for being a preceptor for the Family Medicine Longitudinal Experience!

Your experience is highly valued, and we appreciate you sharing it with our medical students, many of whom will end up choosing to pursue a career in Family Medicine.

In the FMLE, our goal is to expose students to the joys and challenges of Family Medicine. Regardless of the career path they may ultimately choose, these future doctors will be working closely and collaboratively with family physicians. We hope to help all students develop an appropriate respect for and appreciation of the important role that family physicians play in our health care system. In addition, we hope that time spent with family physicians early in their training will allow students to consider Family Medicine as a potential career choice.

By bringing students out into the community, we hope to afford them a 'real life' experience of how we function as providers of primary care, including the important role of continuity of care and the special relationship with our patients that is such an integral part of what we do as family physicians. We also hope to give students the opportunity to interact with community-based patients (for some this is their first such experience), practice some of their clinical skills, (history and physical), practice their oral case presentation skills, and learn some new skills (EMR documentation and the S.O.A.P. note).

Somewhat unique to our course, is how our students view their preceptors as role models and/or mentors. This follows from both the 1:1 learning that occurs, along with the generosity that our preceptors extend to our students, where conversations often go beyond the clinic into topics such as why we love Family Medicine, how we manage work-life balance, etc.

One last thing: **The FMLE Preceptor Post is the official FMLE newsletter**. You will receive this by email twice a year. Be sure to open and review it, as we use this to communicate important information about the course.

Thank you again for your participation and your commitment to teaching our medical students. We are mindful of the current climate and are especially appreciative of the generosity of our preceptors at a time where physician burnout is so high – we greatly value you sharing your time and expertise as a preceptor! We hope that the teaching experience with the medical student helps to breathe new life into the usual routine, inspiring the student but also reminding us through their eyes how great our work can be and what a difference we make on a day to day basis. We are looking forward to working with you to provide an outstanding experience for our students and preceptors alike.

If you have any questions, comments or concerns, please contact our FMLE Coordinator, at fmle.recruit@utoronto.ca or feel free to contact me at sofia.khan@unityhealth.to

Warm regards,

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Introduction to the FMLE

Welcome to the Family Medicine Longitudinal Experience (FMLE).

The FMLE provides students an opportunity for exposure to community-based primary care. Each student is matched for 1:1 teaching with a family physician and will spend **six half days** with their family physician preceptor. The preceptor can choose for up to two of these half days to be a clinic of all virtually booked patients and/or supervised virtually via telemedicine from home if the preceptor would like to do this – it is totally optional. However, the bulk of the sessions, i.e. at least four of the six sessions, will be in person at the preceptor's clinic with predominantly in person appointments. The first session starts with the student **first observing and then quickly progressing to participating in clinical encounters**. Students will have the opportunity to practice history taking and physical exam skills learned in Clinical Skills and will also learn about the S.O.A.P. note for clinical documentation and become more familiar with the use of Electronic Medical Records (EMR) in primary care.

The FMLE has been designed to provide students with several opportunities including:

- To experience clinical care in the community-based primary care setting.
  - This might be the first time they are seeing a "real" patient as the first point of contact.
  - This might be their first opportunity to contribute in a meaningful way including attempting a diagnosis and treatment plan for a "real" patient. *
- To develop an appreciation of the significant role of family physicians and primary care
- To consider important issues in our health care environment such as physician distribution, physician remuneration, primary care reform and social accountability.
- To apply the skills learned in Clinical Skills with respect to history taking and physical examination to the ambulatory care setting.
- To also learn some new skills, for example giving immunizations.
- To learn to document a patient encounter using a S.O.A.P. ("Subjective, Objective, Assessment, Plan") note and an Electronic Medical Record (EMR) type document.
- To establish a relationship with a family physician and potentially see this physician as a role model and/or mentor.
- To reflect on Family Medicine as a potential career choice.

In particular, the FMLE Course has been designed to allow students to meet the FMLE Objectives, as set out in the next section.

* Please note that **students are expected to have knowledge gaps** at their level of training, and as such, for many presentations it is not realistic to expect a differential diagnosis. Rather the goal is just an attempt at a possible diagnosis and to try to explain their reasoning.

FMLE Objectives

Upon successful completion of the FMLE, the student should be able to:

CanMEDS-FMU Objective*	FMLE Objective	MD Program Roles and Key Competencies supported**
FM Expert 1.5 FM Communicator 2.5	1. Use the patient-centered clinical method (including a patient-centered interview) to conduct a supervised office visit	Medical Expert: 2.1, 2.2, 2.3, 2.4, 2.7 Communicator: 1.1, 1.2, 1.3, 1.4, 3.1
FM Expert 1.3	2. Use patient-centered record keeping when caring for patients	Medical Expert: 2.2 Communicator: 5.1
FM Health Advocate 5.1	3. Recognize the health needs of an individual patient and how to work with this patient to improve their health	Medical Expert: 5.1, 5.2 Advocate: 1.1, 1.2, 1.3, 1.4
FM Communicator 2.1	4. Identify that the patient-physician relationship is central to the practice of Family Medicine in allowing therapeutic relationships with patients to develop	Communicator: 1.1, 1.2, 1.3, 1.4, 1.6, 3.1, 3.3
FM Expert 1.13	5. Demonstrate an appreciation of the value of continuity of care for developing a deep knowledge of patients	Medical Expert: 2.1, 3.1, 3.2, 3.6, 3.8
FM Leader 4.1	6. Demonstrate an understanding of the role of the family physician, Family Medicine and primary health care in the overall function of the health care system including family physician roles in office-based care	Collaborator: 1.2 Leader: 1.1
FM Scholar 6.1	7. Engage in self-directed learning based on reflective practice (e.g., read around cases).	Scholar: 1.1, 1.2, 1.3, 3.1, 3.2, 3.3, 3.4
  FM Collaborator 3.2.1 FM Professional 7.1.2 FM Collaborator 3.2.4	8. Create and maintain a positive working environment by: i) Demonstrating a respectful attitude towards colleagues, other health care professionals and/or members of the health team and patients and their families. ii) Demonstrating professionalism in all aspects of care.	i) Collaborator: 1.1, 2.5, 3.1 ii) Collaborator: 2.5, 3.1 Professional: 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8

*CanMEDS-FMU Objectives are explained on the next page.

The CanMEDS-FMU Objectives

Many of you may recall the CFPC's 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, as medical education moves towards competency-based curricula and objectives, student FMLE objectives are being rewritten in the context of the "CanMEDS" competency framework. The CanMEDS construct defines seven categories of roles and describes several competencies under each role category.

In keeping with the unique approach that Family Medicine takes towards the whole patient (patient-centered vs. disease-centered care), Family Medicine has created the CanMEDS-FMU (Family Medicine Undergraduate) document, describing learning objectives using this same framework.

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

The objectives for the FMLE have been derived from some of these competencies and are referenced in the chart above.

For those who are interested, a full description of CanMEDS-FMU is contained in the document: *CanMEDS-FMU Undergraduate Competencies from a Family Medicine Perspective* which can be found at:

http://www.cfpc.ca/uploadedFiles/Education/CanMEDS-FMU_Feb2010_Final_Formatted.pdf

Covid-19 Considerations *NEW 2024-2025*

Students **CAN SEE ALL PATIENTS** in their family medicine clinic, including those who have ***screened*** **positive** for symptoms that could be related to Covid-19 (e.g., cough, fever, diarrhea, etc.) and also those who have been ***confirmed*** **positive for Covid-19** (e.g. by home RAT or by PCR), AS LONG AS THE STUDENT:

- is in compliance with UofT's Covid-19 vaccination registration requirements – this is the case for all students unless you are informed otherwise.
- has completed their PPE training in their Foundations curriculum – this is likely the case for all students.
- is wearing appropriate PPE, as determined by protocols at their local clinic (preceptor's clinic)
  - The specific PPE requirements are not mandated by UofT but rather we follow the usual protocols at the preceptor's clinic
  - **The student should clarify with their preceptor what their preceptor's clinic's guidelines are for necessary PPE** in order to see symptomatic patients. Note: Students are always welcome to wear more PPE than the

minimum requirements, as long as they are meeting at least the minimum requirements.
  - Students will bring their own face mask to use if needed.
  - *We assume that preceptors can provide disposable gloves* for students to use if needed, but if you are unable to, please let the student know ahead of time so they can procure their own.

If your clinic requires any or all of the following -- ***face shield, N95, or gown***, please let the student know and they can arrange to pick up from their campus. (1 face shield total – reusable throughout FMLE, 6 x N95 masks, and 6 x gowns, i.e., 1 N95 and gown for each FMLE session) Although students can see patients with Covid-19, **DO FEEL FREE TO USE YOUR JUDGEMENT** to override this in a given clinical scenario. For example, maybe the patient is unable to wear a mask properly, or maybe there is inadequate ventilation, or the room is too small or crowded. In these cases, the risks may outweigh the benefits for a 2nd year medical student to be involved with that particular encounter. But in general, **students should be able to see most patients** in clinic.

Logistics

Using MedSIS

MedSIS is the **Medical Student Information System**, an online administrative system and database used by the University to disseminate, collect and mark student information and evaluations. **FMLE preceptors receive email prompts from MedSIS when they are required to complete evaluation forms for their student**.

To access MedSIS you will need a User ID number and a Password. If you teach other courses, you may already have these identifiers. If you do not, the FMLE office will send a MedSIS ID number and Password to you in the next few weeks. **Please note you will be registered with MedSIS under your primary email address that you provided to the FMLE.**

How does MedSIS work? When you receive an email from MedSIS asking you to complete a student evaluation form, you simply log onto the site https://medsis.utoronto.ca. You will be asked to provide your User ID and Password which will take you to a homepage. Under "Supervisor Tasks," you will find the required form for completion.

If you have any difficulties accessing MedSIS, please contact the FMLE office at fmle.recruit@utoronto.ca.

Secure Email

There will be a number of times that you will communicate with your student by email. Students use their utoronto email address, which is NOT secure and is NOT PHIPA compliant. Students are aware from their other courses that they can submit case reports and assignments to you via their utoronto email as long as the report is de-identified (no patient name or identifying data). This is fine and part of regular practice. However, utoronto email should NOT be used to send the student patient data, a copy of a patient's CPP, etc, as this could be a privacy breach. A minority of students have access to a hospital-based email, which is secure and PHIPA compliant. In these cases, it would be OK to submit patient data if needed to facilitate a clinical encounter (of course, assuming your own email is secure and PHIPA compliant!). However, due to a number of reasons, most students do not have access to a hospital-based email, or if they do, rarely check it as they are primarily in the classroom and not clinical setting and the MD Program uses their utoronto email for all important communications. Alternative means of communication of patient information would be in person or on a private phone call.

Student Matching and Scheduling

At the beginning of the year students are assigned to either Block 1 (Fall/Winter) or Block 2 (Winter/Spring). In preparation the FMLE office will collect demographic information from both preceptors and students that is used by a computer software algorithm to produce match results. Once the match has been run, both students and preceptors will receive an email with their match results.

Once the match information is disseminated, **it is the student's responsibility to contact the preceptor within a week of the match to arrange their schedule**. Please note that there are a limited number of dates provided by the University specifically for protected FMLE time. **Students have been notified not to make conflicting plans on these dates prior to finalizing their FMLE schedule with you.** Students were very clearly advised that the schedule is based on the preceptor's availability, and that their preceptor will decide the dates from amongst the protected FMLE dates. The exception to this is for the minority of preceptors who advised us *ahead of the match* that their clinics did not fall within the protected times – these preceptors were offered to students as a voluntary "opt-in" match they could sign up for, knowing that the student and the preceptor would need to work together to find a mutually agreeable schedule outside of the FMLE protected dates.

Students and their preceptor must choose six afternoons from the protected dates listed below to be completed during their assigned block. Students may meet with their preceptors on Monday afternoons, Tuesday afternoons, Thursday afternoons, or a combination of these days. Their experience is intended to be longitudinal, so **we ask that students not attend their preceptor's office more than one time per week.** On occasion, students or preceptors may wish to schedule **two concurrent FMLE sessions** in the same day in order to have a "full day" of Family Medicine. In order to not interfere with the longitudinal nature of our program, this is permissible only once per block, if such a session is agreeable to both parties.

In certain circumstances, students and preceptors may agree to meet for their FMLE on dates other than those provided by the University. This is allowed provided that **students do not schedule their FMLE to conflict with any compulsory educational activities** (e.g., Clinical Skills, seminars, PBL, etc.), and that the student is willing to do this, as we cannot force them to do FMLE during unprotected time. As mentioned earlier, for opt-in preceptors whom students signed up for knowing in advance the preceptor would not be available on FMLE protected dates, a lot more flexibility will be expected of the student, although they still are not allowed to miss a mandatory curricular session.

Once students have finalized their schedule, the student is responsible to input these dates into MedSIS on the FMLE scheduling form.

In the past sometimes students and preceptors have just scheduled sessions one at a time. This is strongly discouraged. We ask that students and preceptors commit to six sessions, and input these into MedSIS (they have been asked to do so). Of course, unforeseen events can occur, and at times sessions may need to be rescheduled to later, which is OK. But an initial commitment is required so that the student can begin to schedule other obligations on the remaining free dates and so there is at least a provisional workable schedule in place. Please let us know if there are any difficulties.

Protected FMLE Block 1 & Block 2 Dates

Block 1

Monday	Tuesday	Thursday
October 7 – PM	October 8 – PM	October 10 - PM
	October 15 – PM	October 17 - PM
October 28 – PM	October 29 - PM	
November 4 – PM		November 7 – PM
	November 12 – PM	
	November 19 – PM	November 21 – PM
November 25 – PM		November 28 – PM
	December 3 – PM	December 5 – PM
December 9 – PM		December 12 – PM
December 16 – PM	December 17 – PM	

Block 2

Monday	Tuesday	Thursday
January 6 – PM		
	January 14 - PM	
January 20 – PM	January 21 - PM	
	January 28 - PM	
		February 13 – PM
		February 20 – PM
February 24 – PM	February 25 PM	(Friday) Feb 28 – PM
		March 6 – PM
	March 25 PM	
	April 1 – PM	
April 14 – PM		
April 21 – PM	April 22 - PM	April 24 PM
April 28 – PM		
		May 8 PM
		May 22 PM

Note:
1. Students and preceptors may schedule one FULL (combined two half-day sessions) day of clinic during their FMLE, in lieu of 2 HALF days. This may be done only ONCE per rotation and only if mutually agreeable.

2. If arranging for sessions outside of the protected days, please ensure this is mutually agreeable and that the student is not missing mandatory course requirements to attend.

Suggested Daily Schedule 2024-25 FMLE

Depending on what was agreed upon with their preceptor, students should arrive at their clinics between **1:00pm and 1:30pm**, ready to see patients. They are expected to spend approximately **3 to 4 hours** at their clinics (and the same availability at home for any virtually supervised clinics).

Below is a suggested longitudinal timetable:

	Student Tasks	Preceptor Tasks

Prior to Day 1	• Finalize your schedule with your preceptor and **input ALL SIX dates on the MedSIS FMLE Course Scheduling form** upfront.
	• Ask your preceptor what PPE you need to bring with you for in-person clinics, and make sure you **obtain your PPE supply ahead of time**. Face masks can be obtained from your hospital, and if needed, you can arrange with your campus to pick up additional PPE (e.g. a reusable face shield, an N95 mask, a gown). See handbook section on "Covid-19 Update" for details
	• **Bring your stethoscope, ID badge**, and ask your preceptor if there is anything else you should bring. Clarify the dress code, generally business casual, similar to Clinical Skills.
	• Read the **Student Handbook** and this **Suggested Daily Schedule;** skim through key items on FMLE Elentra page
	• Complete the **Individual Learning Objectives (Appendix 1)** form
	• Optional: Complete the **Virtual Care as a Core Component of Primary Care module**
	• Will be available via Quercus https://q.utoronto.ca
	• ~45-90 min. This is not marked, it's just for your own learning/preparation.
	• If you will be participating in any virtual clinics from home, ensure logistical set-up of your phone (or laptop if you will be doing video encounters). See Handbook section "Virtual Encounters" for details
		• Finalize the schedule for all 6 sessions **prior to the first session**. 0-2 of these sessions can be virtual appointments +/- supervised remotely.
		  ○ It is OK if you need to change one of the dates later, but the student needs a full preliminary schedule from you so that they can plan other activities. The student has to put these dates into MedSIS in order for evaluations to trigger at the right time.
		  ○ Let your office admin know the FMLE dates, put up the wall sign in your office, have your admin advise patients being booked into those 6 clinics that you will have a medical student working with you
		  ○ Advise the student which, if any, of the sessions the student will be doing remotely from home, and whether those will be by phone and/or video.
		  ○ Read through the **Preceptor Handbook and/or the Summary of Changes document**
		• Some preceptors find it helpful to arrange a phone call with the student prior to the first session to do the orientation in advance (this is optional). However, there does need to be clear communication with the student prior to the first session to:
		  ○ **Advise what PPE is needed** in order to see symptomatic patients. The specific requirements are not mandated by UofT but rather we follow the usual protocols at the preceptor's clinic. Students need advance notice, so they have time to obtain the PPE from their campus if needed. See Handbook section "Covid-19 Considerations" for details.
		  ○ Clarify if they need to bring anything other than their badge and stethoscope and clarify dress code.
		• **Be mindful of the two longitudinal goals for FMLE**:
		  ○ To see (in person or virtually) **at least one patient twice** over the FMLE to experience continuity of care.
		  ○ To provide care to **at least one patient virtually** (to experience

		virtual care, either by phone or video). o **Note:** you could meet both goals for example if the student sees a patient in clinic, and then you book a follow-up phone appointment to occur during a subsequent FMLE session to review progress/results • Stay tuned for new FMLE Preceptor website with collated resources, to be launched in fall 2024
Day 1	• Arrange to meet at least 15 min prior to the start of clinic to debrief (if not already done) • Bring **Individual Learning Objectives (Appendix 1)** form to review with preceptor • Discuss prior clinical experience • Set personal goals/objectives • Tell your preceptor what you are learning in Foundations this block • Observe/participate in clinical encounters	• Arrange to meet at least 15 min prior to the start of clinic to debrief (if not already done) • Orient student to office and your expectations of the student and your plan for how you'll run the sessions. Where can they put their things? Where is the washroom? How can they find you? etc. • Review FMLE objectives • Discuss student's previous training, exposure, and interests. Review the student's **Individual Learning Objectives Form** to learn about their goals and confidence • **Actively involve student in clinical encounters!**
Day 2	• Observe and **participate** in clinical encounters (remind your preceptor that it is an FMLE **mandatory requirement for you to lead at least one patient encounter this session**) • Ask your preceptor to prime you (what do you need to know about this patient, what do they want to make sure you have accomplished by the end of the interview, how much time you have to do it?) • Have a plan for help – what to do if you have finished early, need to review with your preceptor, or are worried about safety in any way? • Practice S.O.A.P. notes • Bring **First Assignment** document (Appendix 2a in your handbook and on Elentra) • Review the **Marking Scheme for First Assignment** (Appendix 2b in your handbook and on Elentra) for what should be included in your S.O.A.P. notes and what to make sure to ask the patient on history	• **The student should lead the encounter for at least one patient today!!** o PRIME the student on the patient they are about to see – what they need to know about this patient, what they should accomplish by the end of the visit, and how much time they have to do it o Allow the student to conduct that FULL interview to completion before jumping in o Can use One Minute Preceptor model when reviewing the case (Appendix 11) o Provide feedback on student's practice S.O.A.P. notes, as well as ongoing feedback on clinical skills • Complete a **Clinical Encounter Card (CEC)** (Appendix 10a) today or day 3 for early actionable feedback o **mandatory** to complete and review at least one CEC with the student during FMLE course o **CECs are NOT on MedSIS and are NOT submitted to FMLE or MedSIS.** They are just between you and the student for feedback. o **You will just be required to confirm if one was completed (yes or no)** on the FINAL ASSIGNMENT marking form at the end of the FMLE. • Arrange for appropriate* patient **for interview by student** on day 2 or 3 in

		order for student to use the encounter for FIRST ASSIGNMENT
Day 3	• Observe/participate in clinical encounters • Complete encounter for FIRST ASSIGNMENT* • Remind your preceptor to complete the **Clinical Encounter Card (CEC)** (Appendix 5) if it has not already been done. The CEC is mandatory for satisfactory completion of the FMLE • AFTER the session, finalize your First Assignment on the template provided on Elentra (Appendix 2a in handbook), **and then complete a SELF-ASSESSMENT** using the Marking Scheme template form (Appendix 2b). • **Submit BOTH of these completed tasks** (the First Assignment, and the self-completed Marking Scheme) to your preceptor and to the FMLE Coordinator (see next box) prior to the start of day 4. ○ Make sure to de-identify the note if sending from/to an email that is not PHIPPA compliant (just as you do in Clinical Skills)	• **All students should be leading at least a couple of patient encounters** • The student should attempt to interview the patient for the FIRST ASSIGNMENT independently and conduct any relevant physical exam • **Have you completed a Clinical Encounter Card yet?** If not, be sure to do so this session, and to review the feedback with your student. • See details from Day 2 above – CEC forms are NOT on MedSIS, they are found as Appendix 10 in the Preceptor Handbook. CECs are NOT submitted to FMLE/MedSIS, • **It is ultimately the preceptor's responsibility to ensure the completion of the CEC.**

Day 4	• Hand in FIRST ASSIGNMENT and your completed SELF-ASSESSMENT marking form to preceptor before or **no later than the START of this session**
	• Email a copy of FIRST ASSIGNMENT and completed SELF-ASSESSMENT to FMLE fmle.recruit@utoronto.ca
	    ○ include your full name and the document name e.g., MyName_FMLE_First Assignment
	• Check in with your preceptor about your learning goals, and provide them with feedback
	• Observe/participate in clinical encounters with increasing opportunities to lead history taking
	• Remind your preceptor if you haven't met the **two longitudinal goals for FMLE**:
	    ○ To see (in person or virtually) **at least one patient twice** over the FMLE to experience continuity of care
	    ○ To provide care to **at least one patient virtually** (to experience virtual care, either by phone or video).
		• Touch base with student about how things are going. Is there anything from their perspective that you could do differently to facilitate meeting their learning goals/objectives?
		• **Share your thoughts and feedback on the student's FIRST ASSIGNMENT** and their **SELF-ASSESSMENT FORM**, either today or at the START of Day 5 at latest.
		    ○ First Assignment is self-marked by the student. Preceptors will provide additional formative feedback/comments on the assignment and on the student's self-marking of their assignment. But the preceptor will NOT need to formally mark the First Assignment on MedSIS and the preceptor does NOT need to submit anything to the FMLE office
		    ○ Provide actionable feedback that the student can incorporate for future encounters and for their Final Assignment which will be formally marked by the Preceptor.
		• **All students should be leading at least a couple of patient encounters, with at least one done completely independently followed by review with preceptor**

Day 5	• Review First Assignment and your Self-Assessment form with your preceptor, requesting additional feedback from your preceptor if not already done	• Review FIRST ASSIGNMENT and SELF-ASSESSMENT FORM with student at start of session if not already done. • Provide actionable feedback that the student can incorporate for future encounters and for their Final Assignment. • Arrange for an appropriate** patient for interview by the student on day 5 or day 6 in order to complete the **FINAL ASSIGNMENT**

Day 6	• Complete the encounter for **FINAL ASSIGNMENT** ** (see Elentra or Appendix 3 in handbook). There is no self-evaluation required for this
	  ○ Note: the short answer questions are not the same as the First Assignment!
	• Complete the **FMLE Preceptor Evaluation** and the **FMLE Course Evaluation** on **MedSIS**
	  ○ For FMLE Preceptors, *each individual evaluation is critical* since they only get a teaching evaluation once we can collate the evaluations from 3 students to anonymize it.
	  ○ **FMLE Preceptor Evaluations are MANDATORY.** Failure to complete by the deadline will be recorded as a professionalism lapse and may require a meeting with the course director.
		• Review of FMLE and provide end of rotation feedback
		• (optional) Consider doing an *additional* Clinical Encounter Card for the student to highlight their progress
		• Will receive MedSIS prompt to complete student's **Professionalism Form** (mandatory).
		  ○ (For Resident preceptors, a link will have been emailed to you to complete online)
		• Allow students 10 minutes of privacy during session to complete their **FMLE Course Evaluation** and **FMLE Preceptor Evaluation Forms** on **MedSIS**
		  ○ Ask student to complete your preceptor evaluation, highlighting the importance of it to you personally

2 weeks after Day 6 by 5:00pm	• Deadline to submit FINAL ASSIGNMENT to preceptor
	• email copy of Final Assignment to fmle.recruit@utoronto.ca
	  ○ include your full name and the document name e.g., My Name_FMLE Final Assignment
	• Complete the **FMLE Student Evaluation of Preceptor** and the **FMLE Course Evaluation** on **MedSIS** if not already done!!
		• Deadline for students to submit their Final Assignment to you. If this falls during a holiday period (December holidays) please confirm an alternate deadline date with your student
		• Staff Preceptors will receive a MedSIS prompt to complete the **FINAL ASSIGNMENT evaluation form** (if not already done) on MedSIS
		  ○ Residents do not have access to MedSIS. The FMLE Coordinator will email Resident preceptors a link to access their student's evaluation forms (Final Assignment and Professionalism Form) to complete online.
		  ○ Residents must ask their clinical supervisor to approve their marking prior to submitting.

1 week from receipt of Final Assignment	• Please review your preceptor's feedback on your FINAL ASSIGNMENT and PROFESSIONALISM form • Last chance to complete mandatory preceptor evaluation on MedSIS. The form will irreversibly lock out at the end of the FMLE block.	• Due date for preceptors to submit the FINAL ASSIGNMENT evaluation form on MedSIS/online

Note: *Appendices referenced in Student Column refer to Student Handbook. Appendices referenced in Preceptor Column refer to Preceptor Handbook.*

*a preceptor/student may choose to use any encounter from Day Two or Day Three to complete First Assignment.
**a preceptor/student may choose to use any encounter from Day Five or Day Six to complete Final Assignment.

HOWEVER, in both cases, it should be an encounter that lends itself to a SOAP note format. i.e., meet and greets and preventative health visit /periodic health visit/ "annual physical"/ well baby/child visit should NOT be used.

Preceptor Responsibilities

As a preceptor you are responsible for:

- Providing ongoing formative feedback to the student. In addition, you are required to observe an encounter and complete an FMLE **Clinical Encounter Card (Appendix 10a)** at least once during the block. Many preceptors find it valuable to use the FMLE Clinical Encounter early in the FMLE and then again towards the end, so students can see where improvements have occurred.

- **Providing feedback on the First Assignment and Self-Evaluation (Appendix 3a and 3b)** which **should be submitted to you by 1:30pm on the student's fourth clinic.** Please provide the student with some feedback on both the assignment itself, as well as on their attempted self-marking of the first assignment. This feedback should be **completed no later than the start of Session 5** in order for the student to have an opportunity to apply the feedback. This is informal, for the student's formative feedback – you do not mark this on MedSIS and there is nothing you need to send to the FMLE office. Just go over the feedback directly with the student.

- **Marking the Final Assignment (Appendix 4b)** which **should be submitted to you by the student no later than 2 weeks after the final clinic session, by 5:00pm.** The MedSIS marking form must be **completed online on MedSIS, by the preceptor, within one week** of receipt of the student's assignment.

- **Completing the FMLE Professionalism form** (including the section allowing for written feedback to students under 'comments'). This **should be completed on the last day of the students' FMLE or soon after**. Please note that although this is entitled Professionalism form, under the comments you may provide feedback on the student's general performance during FMLE, not just professionalism feedback. This form is to be completed on MedSIS. A copy of the form for your reference is included as **Appendix 5**.

- **Reporting all Student Absences/Cancellations** either by sending the FMLE office a general email OR by completing and forwarding the FMLE Documented Absence form (see **Appendix 1**) to the FMLE Coordinator at fmle.recruit@utoronto.ca

Please note that the CPSO recently (June 2021) revised their Policy Statements # 1 – 20 "Professional Responsibilities in Medical Education." We encourage you to review these policy statements online at: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Medical-Education and copied in **Appendix 7** of this handbook

Attendance

Attendance is mandatory. In the event that a student is ill or cannot attend a scheduled clinic, **it is the expectation that the student will do all 3 of the following**:

1) be in contact with the preceptor to advise them of the absence as soon as possible
2) the student will contact the FMLE office to advise of the absence
3) the student will also log the absence on the MD Program's absences webpage.

The student is then expected to make up that clinic at a time agreed upon between the student and preceptor.

In addition, PRECEPTORS are also required to report any session the student has missed to the FMLE Coordinator in a timely manner either by sending a simple email or by completing and forwarding the FMLE Documented Absence form (see **Appendix 1**) to the FMLE Coordinator. This should be done **regardless of the reason** for the absence and **regardless of if the session is made up later**. In the event that a student misses (and does not make up) a session or misses a session without providing the preceptor with reasonable notice and rationale, the preceptor should notify the FMLE office immediately of this lapse in professionalism. This may help shed light on an underlying professionalism problem or a student in difficulty that might not get the help they need otherwise. Similarly, if a student has a recurring problem with arriving late or leaving early that you feel is a professionalism issue, please report that to us as well so we can check in on the student.

As noted in the Regulations, students are responsible for submitting notification for both planned and unplanned absences from mandatory activities. To support a more centralized and streamlined notification process, the MD Program's school absences webpage will include three notification 'buttons' – one each for student notification of an unplanned absence, student notification of a planned absence, and staff/faculty notification of student absence from a mandatory activity.

For planned absences, the request should be submitted normally at least 30 days in advance of the activity(ies) to be missed.

For unplanned absences, the notification should be submitted as soon as possible after attending to the immediate needs arising from the situation.

Further details about the guidelines that students are given in terms of planned and unplanned absences are available on the MD Program's School Absences webpage here if you are interested: http://www.md.utoronto.ca/school-absences.

Please note, compared to prior to the pandemic, we do expect there to be more unexpected absences due to illness. We ask for everyone's patience and flexibility and thank you in advance for your understanding.

In case of preceptor or student illness, please contact fmle.recruit@utoronto.ca regarding alternate arrangements.

Assessment

In order to satisfactorily complete FMLE, students must:

1) **satisfactorily complete the First and Final assignments AND**
2) **obtain a satisfactory Clinical Encounter Card (CEC) AND**
3) **achieve a satisfactory assessment of Professionalism competency**

If any of the above are not satisfactorily completed, the student will be contacted by the FMLE Director to determine the next step.

FMLE is a part of the Integrated Clinical Experience (ICE), and ICE is one of the four components that make up each course in the Foundations Curriculum. At the end of each course the student's academic

assessment data, including that from FMLE, is reviewed by the Student Progress Committee; they determine if the student has successfully completed the course ("satisfactory progress") or has shown "partial" or "unsatisfactory progress".

For more details, you can visit the Student Assessment page on the MD Program website.

Feedback

Preceptors are encouraged to provide verbal feedback to their students **during and/or at the end of each clinic and on their last clinic day**. Spending a short period of time during each half-day to discuss a student's strengths, weaknesses and suggestions for improvement helps to maximize the learning potential for the student when working in the clinical setting. When it is given regularly, it gives the student more opportunity to learn and apply that feedback to the next session.

Students appreciate specific examples of what they have done well or not, so **try to be as specific as possible**. For example, "I liked the way you considered the family history of Crohn's disease when exploring the causes of Ms. Smith's diarrhea…" is much more meaningful than comments such as "good job" or "continue to read around cases". Please avoid only bringing up ongoing concerns or feedback at the end of FMLE as this is unfair to the student who then does not have a chance to demonstrate improvement.

Formative Feedback:

During the early sessions you are already introducing the concept of the S.O.A.P note (i.e. the documentation of a "focused history and physical") and how it differs from the complete "Case Report" that students learn in their first year clinical skills course. If you are not familiar with the S.O.A.P. note terminology, there is a dedicated section later in the handbook that will review it.

Most of you are already having your student write up a quick S.O.A.P. note during the early sessions and using this as a basis for teaching and feedback. However, in order to formalize this process and create consistency of experience, we are asking all preceptors to ensure the following:

During the 1st or 2nd clinic day, please have your student write up a quick S.O.A.P note for a patient encounter. Please take a few minutes to provide feedback on the note, in order to assist students in preparing to complete the S.O.A.P. note portion of their first assignment.

Feedback for the Preceptor:

Equally important is eliciting feedback for yourself. Consider checking-in ***each*** of the 6 sessions. How are they finding the sessions? The teaching style? Anything they would like to change? Has there been any change in their learning goals/objectives?

Whether the feedback is for you or for them, **remember, it is very useful to label feedback directly**. For example, tell the student that you would like to 'give them some feedback'.

LABEL feedback for them, HIGHLIGHT for them how you have been attempting to facilitate their learning objectives and REMIND them what learning pearl you have tried to teach them that day. These actions will stick and remind them of your great teaching when they go to do the teaching evaluation form at the end of the FMLE.

Preceptor Clinical Encounter Cards

In addition to feedback provided informally to your student during FMLE clinics, an **FMLE Clinical Encounter Card (CEC)** has been created to assist in providing more formal feedback. **Please ensure you have completed at least one CEC for your student by the end of their block, ideally by the mid-way mark. Preceptors do not need to submit the CEC to the FMLE but will be prompted to confirm that they did complete a CEC (yes/no) as part of the MedSIS Final Assignment evaluation.** To make the feedback most meaningful, we have developed two cards: one for the preceptor and one for the student.

- The **Preceptor CEC (mandatory)** **(Appendix 10a)** has been designed for you, the preceptor, to use after observing your student's encounter with a patient, and to help guide a feedback session with the student. This one is mandatory for you to complete. ULTIMATELY IT IS THE PRECEPTOR'S RESPONSIBILITY TO ENSURE THAT AT LEAST ONE PRECEPTOR CEC HAS BEEN COMPLETED FOR THE STUDENT.
- The **Self-Reflection card** (optional) **(Appendix 10b)** allows the student to take a moment to reflect on his/her performance during the clinical encounter before discussing feedback with the preceptor. This one is optional.

The CEC form is pretty self-explanatory, but if you would like more guidance on filling it out you can find a training video for completing the CEC card by visiting:
https://www.youtube.com/watch?v=ZXNJLoeKZCk&feature=youtu.be

Please note: many preceptors find it valuable to use multiple FMLE CECs over the course of the FMLE, but this is optional.

Professionalism Forms

The FMLE holds students to the Professionalism standards set out by the University of Toronto which applies to all undergraduate medical trainees.

Consistent with this code of conduct is the expectation that the student will present themself in a professional manner, including dress and behaviour. In the pre-clerkship, teachers who have had significant contact with students in small group settings all complete the same **Professionalism form (Appendix 5)**. The FMLE preceptor will complete a form on their student at the end of the FMLE block.

We expect that very few (if any) student(s) will exhibit any professionalism lapses. A full description of the professionalism requirements for your reference as needed may be found at:

https://governingcouncil.utoronto.ca/secretariat/policies/professional-practice-behaviour-all-health-professional-students-standards-0

If you have any significant concerns about a Professionalism lapse, please do NOT wait to the end of the Block to address this. **These concerns should be brought to the attention of the FMLE Director as soon as possible.**

Preceptor Evaluation and Mentorship

At the end of the FMLE, students will be asked to complete evaluation forms of the course and of their preceptor **(Appendix 6)**. New in 2022-2023, the FMLE Preceptor Evaluation form was changed to the **Learner Assessment of Clinical Teacher (LACT) form** to be in line with the rest of the MD Program which had already made the change**.** The LACT form was developed to address concerns including inconsistency of evaluations across courses, unclear feedback and low number of assessment forms clinical teacher receive. It will be used to assess all clinical teachers across various courses and years of study including post-graduate learners (i.e. residents). The main benefits to you as an FMLE Preceptor, is that if you teach other aspects of the UofT MD Program (e.g. Clinical Skills, PBLs, etc.), you will have one

standard evaluation format so that it is easier to compare your teaching, and the hope is eventually UofT will enable the amalgamation of teaching scores across courses so that you don't have to wait as long to get your collated teaching evaluations. The LACT form can be found in **Appendix 6.** **We strongly encourage you to familiarize yourself with what domains are evaluated on the form so that you can feel more confident about how to approach your teaching and to maximize your teacher effectiveness scores.** Please note, students will also have the opportunity to nominate their preceptor for an FMLE teaching award.

New as of 2022-2023, after a lot of advocacy and iterations, the University of Toronto has now made it mandatory for students to evaluate certain preceptors, including FMLE Preceptors. This is great news for FMLE Preceptors! As per the longstanding University policy, preceptor evaluations cannot be released to the preceptor until there are 3 student evaluations that can be collated to preserve anonymity. As such, it is very important that each evaluation be completed in order to prevent further delays in preceptors receiving feedback on their teaching. In the past, students could not be forced to complete evaluations, resulting in years of delay with preceptors receiving their feedback. The new policy means that every FMLE student will need to evaluate their preceptor in order to avoid a professionalism lapse, and as such, preceptors can now expect more regular and timely Teaching Effectiveness Scores once they have taught 3 students. Nonetheless, it is still always a good idea to ask your student directly, which will further motivate them to provide a meaningful and complete evaluation. **Please ask your student to complete your preceptor evaluation, highlighting the importance of it to you personally and for your teaching portfolio, and thank them for their time in providing the feedback.**

Our students are often very impressed with their preceptors, seeing them not only as role models, but as potential mentors. In the event that a student indicates a wish to develop a mentoring relationship with their preceptor, we will contact the preceptor to advise and discuss the possibilities. Please note, however, that your student's choice to request you as a mentor does not mean that they will contact you immediately. Students often value their FMLE preceptors, hoping to reconnect with them further on during their clerkship when they are closer to making career decisions and in greater need of mentorship. You may find that your student will request a mentoring relationship with you and then you may not hear from them for a year or two.

Other Student Considerations

Arrival at Clinic

Please make it clear to your student your expectations regarding where they should wait when they arrive, and where they can put their things, where they can eat, and where the washroom is. For clinics with virtually booked patients, make it very clear to the student whether you are expecting them to still come into your clinic, or whether they should join you remotely from home.

Dress Code

Students are expected to dress professionally as they will be encountering patients and should wear their identification badges at all times. If you have specific requests for student attire, such as wearing a lab coat, please advise the student of this beforehand to ensure that your expectations are met.

Equipment

Students shall bring a stethoscope to clinic. They may choose to bring a laptop or memory stick to assist them in accessing the necessary file to complete their first assignment and final assignments. Students will be advised to bring face masks. Please advise them if any further items are required.

Insurance and Registration Requirements

Insurance

Students enrolled in the Doctor of Medicine program, while completing program requirements as set out by the MD Curriculum (including mandatory FMLE sessions), are covered for legal liability, including general liability and malpractice liability, under the University of Toronto's Comprehensive General Liability Insurance Policy. When applicable, WSIB coverage will be provided in the event of an injury to the student.

Immunization

University of Toronto students enrolled in the Doctor of Medicine program are required to submit proof of immunization prior to registration. These immunization requirements have been fulfilled in order to meet the Health Standards set forth in the Public Hospitals Act, Section 4.2, Ontario Regulation 518/88. UofT's MD Program takes on the job of collecting annual immunization records as part of the student registration process.

Registration Requirements

There are a number of registration requirements that students meet to be in compliance with the medical school policy. If interested, please see the UofT MD Program registration requirements website for full details https://md.utoronto.ca/registration-requirements-requests. Some key points are listed below.

Annually:
- MD program collects student immunization records annually
- MD program collects the Vulnerable Persons Criminal Record Check in year 1, and the Criminal Record Disclosure and Consent forms annually thereafter.
- students complete TAHSN approved e-modules for privacy annually.

Students also complete a number of other training courses at prescribed timepoints.
Students complete the following at the beginning of first and third year:
Hand Hygiene,
Sharps Safety,
Workplace Hazardous Materials Information System (WHMIS)
Workplace Violence and Harassment

Students complete the following once at the beginning of first year:
Prevent Slips, Trips, and Falls
Worker Health and Safety Awareness module
Working Together: The Code and the Accessibility for Ontarians with Disabilities Act (AODA) module

Injury Protocols

If a student experiences an injury while at their placement, for example a needle-stick injury, UofT does have an algorithm for how to proceed. Please see the **Appendix 1 flowchart**, which is the final page of this linked document, for the algorithm.

Note, students should be directed to contact their Academy Director ASAP to facilitate the protocol. The students are aware of who their individual Academy Director is and how to contact them.

Responsibilities of SUPERVISING PHYSICIANS when a student under their supervision is injured or potentially exposed to infectious disease in a clinical setting.

Immediately following the incident, the supervising physician is expected to:
(1) Assist the student in accessing immediate care as necessary. The site-specific workplace injury protocol should be applied.
(2) Facilitate the obtaining of consent for samples to be drawn from the patient, in cases of potential exposure to infectious disease.
(3) If the student is unable to speak for himself/herself:

a. Describe the incident to the health professionals who provide initial care to the student.
b. Inform the health professionals who provide initial care to the student that he/she is a medical student from the University of Toronto.
c. Contact at least one of the student's Academy Director, course director, or site director to inform them of the incident.

Introduction to Supervising FMLE Students

What do year two students already know?

Students participating in the FMLE will be in their second year of training in the Faculty of Medicine at the University of Toronto. Prior to beginning FMLE, students will have already completed courses covering anatomy, physiology, biochemistry, neuroanatomy, and some neuroscience. They will have also completed a course related to the determinants of health, and public health issues. In addition, they will have completed the first year of Clinical Skills, an introductory clinical skills course where students develop the fundamental skills of patient interviewing and the physical examination.

All students entering year two have developed a level of proficiency in the basic history-taking and physical examination skills taught in Clinical Skills. They will have practiced histories and physical examinations with standardized patients and some with 'real' patients as well.

All students have **already learned** the following specific skills during their first year of medical school in the ICE: Clinical Skills I Course:

1. How to take a **comprehensive history** with a new patient including chief concern, history of the present illness, past medical history, social and family history, and review of systems.

2. How to take a **focused history** based on a singular medical complaint.

3. How to do a **specialized history** for substance use history, spiritual history, male genitourinary system history, sexual history (basic; to be further expanded upon in year 2).

4. General physical examination skills including vital signs, and the examination of the following:
    a. JVP and volume assessment
    b. Precordium/heart sounds
    c. Peripheral vascular system
    d. Respiratory exam (anterior and posterior chest)
    e. Head and neck exam (thyroid and lymph nodes and Ear/Nose/Oropharynx exam)
    f. Abdominal exam and volume assessment
    g. Dermatology (one 4-hour session)
    h. Diabetic foot exam

5. How to write up a comprehensive case report.

Students in year II will have varied additional training depending on when in the year you connect.

From **September to January**, students are taught the following additional skills in their ICE: Clinical Skills II course:

1. Physical examination skills
    a. MSK exams (knee, hip, shoulder, back) – they refer to as GALS (gait, arms, legs, and spine) exam
    b. Neurological exam
    c. ENT exam (ears, nose, oral cavity, tonsils, and how to use an otoscope) (one 4-hour session)
    d. Ophthalmology – clinical theory only – did not include fundoscopy or slit lamp

2. Specialty Blocks

a. Psychiatry (online only; practice doing a Zoom history with psychiatric standardized patients)

From **January to May**, students are taught the following additional skills:

1. Specialized History Taking Skills
    a) Breast history
    b) Sexual history
    c) Palliative care interview

2. Physical Exam Skills
    a) Male Genital exam (including the DRE)
    b) Female Pelvic exam
    c) Breast exam
    d) Acute Abdomen (examining for guarding, rebound, cough/shake tenderness, signs for appendicitis, cholecystitis, etc.)

3. Specialty Blocks:
    a. Paediatrics
    b. Geriatrics

Each student will be taught these in a different order. Feel free to ask your student their particular schedule for learning these, and if you are able to book in a patient during their FMLE half day that lends themselves to practicing one of these shortly after they have learned it in Clinical Skills that would be a nice learning experience (but not expected or required).

You will find that your student is excited and enthusiastic about **any** opportunity to interact with patients and will welcome any chance to practice the skills learned in the clinical setting during patient encounters. Positive physical examination findings are a great source of excitement for our learners as they will often have read and learned about them in their classes but have not seen them in clinical encounters. Having the opportunity to share some "pearls of practice" or to help a student understand a physical examination finding is a great experience for both the learner and the teacher. It is a way of giving back to the medical community, sharing your expertise, and revitalizing your interest in clinical medicine.

Students are very anxious to practice their acquired clinical skills. They are also thrilled at the opportunity to acquire new clinical skills such as: **throat swabs, immunizations, pap smears, urine dips, ear syringing, punch biopsies, fungal scraping, venipuncture, plotting growth on WHO charts, and/or interpretation of lab results (e.g., Framingham score)**.

Clinical Skills Log

In the year 2 Clinical Skills curriculum, students are expected to complete the clinical skills log. This logbook contains a list of physical examination maneuvers that students are expected to demonstrate proficiency in by the end of year 2. As long as the tutor feels that the student did the maneuver correctly, that should be sufficient.

If a Clinical Skills or FMLE tutor observes a student performing any of the physical exam skills, the tutor can sign off the items in the logbook. The students have been asked to bring a copy of the logbook to each of their clinical skills or FMLE sessions. The logbook is due at the end of the academic year in May and students need to complete it in order to pass Clinical Skills.

Virtual Medicine

For any virtual encounters, students will be very limited in participating in a physical exam, especially for phone encounters. That's OK, this is a useful learning experience for them. They will get in-person exams during at least 4 of their in-person sessions with you. For phone encounters, you can simply ask the student what they would theoretically bring the patient in to examine. E.g., for this patient with heart failure now complaining of worsening shortness of breath, what systems would you examine? Highlight a clinical pearl like not forgetting vitals such as weight.

Some examinations that they could potentially try to practice over the phone with the patient's help (and your help!) are:

- Vitals: asking the patient to report vitals (where possible, e.g., for a patient with a home bp monitor, thermometer, scale)
- Derm exam (note, students do not have much experience with dermatology and would need your help): asking for patient's help in examining the rash e.g. asking about size -- in millimeters or perhaps just finger widths, colour or pigmentation and does it blanch, arrangement – solitary, grouped, linear…, morphology -- is it raised or flat, fluid filled, umbilication, crust, is the border distinct, distribution of the rash, palpation – e.g. is it warm to touch, etc. etc.
- Musculoskeletal exams
  - Back: range of motion, which movements cause pain (flexion, extension, rotation, side flexion…), saddle anaesthesia, etc.
  - Knee: obvious swelling, redness, antalgic gait, range of motion, palpation for temperature or joint line tenderness, etc.
  - Shoulder: palpation, range of motion of neck, range of motion of shoulder
- Abdo exam –asking patient to palpate
- Peripheral vascular exam (asking patient to inspect for hair loss, shiny skin, erosions or ulcers, skin colour, temperature, swelling and pitting edema assessment, etc.)
- CVA tenderness – asking patient to try to pound the area themself
- Psychiatric mental status examination (won't be able to do appearance, but most of the rest they might be able to ascertain over the phone e.g., attitude, speech, mood, affect, thought content, thought process, SI/HI, insight, judgement, gross cognition)

Foundations Core Curriculum

Many FMLE preceptors have asked that we provide them with a **bird's eye view of the main clinical topics students are learning about each week**. This would allow preceptors, if they choose to, to help the student preferentially see a patient with that chief complaint during clinic. Please see **Appendix 12 Foundations Curriculum Topics** for the most current student learning schedule.

This is not mandatory, but rather for your interest as an optional tool. It will likely be both informative as well as helpful in assisting you to stand out as a preceptor who takes an interest in consolidating their student's learning. For example, during the "Blood" week, students are learning about Interpreting CBC, approach to anemia, malignancies. If this is a week you have your student in clinic, wouldn't it be great to have your student see a patient who was already booked to review an abnormal CBC? Keep in mind, the student is NOT expected to be proficient in this new topic, they have only just been introduced to it or may not have the actual lecture until after they see you! The point of the exercise isn't to quiz them, but rather take it as a teaching opportunity to supplement their teaching with a real-life case and spark an interest in what they are learning.

Practical Tips for Organization and Time Management

Preparing your office for a student does assist with the integration of the learner into your daily routine. **Advance notification to patients** that you have a learner working with you helps facilitate the transition to incorporating a student into your office. Many offices will have a notice posted in their waiting room indicating that they are a University of Toronto affiliated teaching practice and the role of the student in the encounter. **We have sent you a Wall sign with your welcome package** that you can post in your clinic waiting room to indicate your involvement in this important medical education program. The administrative assistant(s) at your office can also play an important role in integrating the learner into the clinic by advising patients in advance that you will have a student working with you.

Introducing the Student and Consent

Introducing patients to the student and explaining their role in the clinic before you start the encounter also gives the patient the opportunity to advise you if they feel uncomfortable with having a learner present during the visit. Please refrain from introducing the student as a "doctor", as they are not. At the same time, try not to diminish the medical student's significant skills or to be overly apologetic to the patient. One way to introduce the student would be *"X is a senior medical student from the University of Toronto and is working with me today. I would like X to speak with you for a few minutes to get the initial*

history while I finish with the previous patient, and when I am finished, I will join you to review what you have discussed, and we can finalize a plan together. Is that OK?". As preceptors become more comfortable, many will delegate this to the student to do their own introduction and consent taking.

Seeking permission from the patient for the student to be present is essential, as in some circumstances a patient will wish to see their physician alone. Many patients are happy to have students observe or participate in their visits when an effort is made to explain that the student is working with you to gain an exposure to clinical medicine and to understand what a career in Family Medicine is like. Fortunately, most patients are acutely aware of the lack of family physicians in Canada and are eager to be involved in teaching a student who may go on to be a future family physician. Many patients also like to hear that their participation will help with the training of a future doctor, and that their feedback is important to that process. With your welcome package email we have included an adapted version of **Why You May See a Student**, shared with us by one of our FMLE Preceptors, for you to use in your clinic or on your website if you find helpful!

For those rare occasions that a patient requests that the student not take part in the encounter, you can direct the student to see a different patient, have them try to interpret some lab results that have come in, see a patient with one of your allied health professional colleagues, have them write up a S.O.A.P. note for you to give feedback on, or do some reading around a case that they saw earlier that day in the clinic setting.

How and What to Teach

To maximize the learning experience that the student has during the FMLE you may wish to consider having a brief discussion about specific learning objectives that the student may have when you first meet. We have developed the **FMLE Individual Learning Objectives Form (Appendix 8)** to aid you, and students are recommended to bring this to their first FMLE session.

To effectively direct your teaching, consider asking your student about their previous education/work (do they have a PhD in neuroscience? Were they previously a pharmacist?), their interests (clinical, research, teaching, other?), their clinical exposures to date (have they done any shadowing?), their clinical knowledge and examination skills (what are they learning this week/month? Would be a bonus if they can see that in clinic!).

Teaching in the FMLE is based upon a **mixed observership/participatory model**. Specifically, students will work with you in your clinics first shadowing you and then **quickly progressing** to increased responsibility by completing patient encounters on their own, for you to observe and/or then review. **ALL students should have interviewed AT LEAST ONE patient independently by the end of session 2** and conducted any relevant physical exam associated with the encounter. Allow the student to conduct the FULL interview to completion before you jump in. Students should not just be observing. **Aim for AT LEAST 1-3 student-led patient interviews per half day**, with progression over the course of the FMLE. Even if the student has low confidence, the preceptor should still gently push the student to lead patient interviews.

To optimize efficiency, remember to **PRIME the student on the patient they are about to see** – what do they need to know about this patient, what you want them to accomplish by the end of the visit, and how much time they have to do it?

Some helpful feedback we have gotten from a few students, is their confusion on why preceptors mention certain aspects of a patient's social circumstances in describing them when not immediately connected to their presenting complaint, in particular things like addictions and mental health. They worry that this kind of priming may inadvertently lead to undermining the validity of the patient's chief complaint, leading to poorer care. For example, when a preceptor tells a student "You are about to see a 23 year old IV drug user who is complaining of back pain". Although we are used to these kinds of descriptors in case vignettes, some students wonder about the intent behind this priming. They think – is the preceptor suggesting that this type of patient is lying about their pain? They then quietly wonder about professionalism. In order to avoid any unintended confusion, consider whether this aspect of the priming is helpful or relevant for that particular encounter, and if so, also explain to the student why you are

telling them what you are telling them. For example, you might say I'm mentioning this because I want you to look out for any signs of an infection or abscess. Upon completion of the clinical encounter or at the end of the half-day of clinic, providing an opportunity to discuss your approach to cases and your rationale for your decisions will enable the student to gain an understanding of how family physicians formulate differential diagnoses and devise their comprehensive management plans. **Focus on bite-sized pearls or general concepts, rather than minutiae. The One Minute Preceptor Model (Appendix 11) is very useful to facilitate this process.**

History Skills

Most students will have reasonable proficiency in history-taking and are eager and enthusiastic to participate. We encourage you to facilitate students' practice of these skills, commensurate with your comfort level. If you are in the room at the time that the learner is interviewing, this provides you with an **excellent opportunity to offer feedback on their skill set**. Furthermore, it also facilitates an important exchange and discussion around **clinical pearls** and key questions that you find helpful in differentiating the patient's concern. As you get to know your student you may choose to have the student interview the patient, while you see another patient in a different room, then review the history and together determine the management plan and disposition.

Physical Examination Skills

As with history-taking skills, students in the FMLE will have had the opportunity to work with real and standardized patients on their physical examination skills. **Any opportunity to practice physical examination skills will also be highly received by the student.** Sharing positive findings with students provides them with real life experience that helps reinforce the theoretical knowledge base they have already developed during their training. See the **What do year two students already know** subsection in the Introduction to Supervising FMLE Students section above for a summary.

Procedures

Depending on your scope of practice, your student may have the opportunity to observe and/or participate in office-based procedures. Something as simple as providing an immunization can be very exciting for students and is a useful learning opportunity. Along with immunizations, other common "procedures" that a student would love the opportunity to participate in would include **throat swabs, pap smears, urine dips, ear syringing, and fungal scraping. Some preceptors may be able to offer additional opportunities to observe or participate to a limited extent in things like TB skin tests, punch biopsies, joint injections, IUD insertions, venipuncture, etc.**

Continuity of Care

Another fundamental goal of the FMLE is to demonstrate continuity of care to our learners. Students rarely have the opportunity to see patients they have previously seen in follow-up visits given the short duration of our rotations. Given the longer duration of the FMLE, we hope that students will have the opportunity to understand how we provide ongoing care to our patients for chronic illnesses and how we use the "tincture of time" as a diagnostic tool in determining the underlying issue when patients present with undifferentiated illnesses.

Should a patient require a follow-up visit, organizing this visit, where possible, at a time that the learner is back in the clinic setting will be **very valuable** for demonstrating continuity of care. **Our goal is for all learners to have at least one opportunity to see the same patient twice during their FMLE.** Another way to help achieve continuity of care would be to show the student the results of investigations your ordered together, and allowing the student (under your direct supervision) to relay the results to a patient over a phone follow-up appointment if they are not coming in.

Multidisciplinary Teaching

Many of you are fortunate to work with other health care professionals in the clinical setting. Students can be involved in teaching with all members of the health care team, including dietitians, pharmacists, nurses and social workers etc. There is a strong focus at the University of Toronto on inter-professional education and Family Medicine is an excellent example of the provision of collaborative care. Demonstration of this type of care to the student will enable them to develop a greater understanding of primary care and the

roles of the members of the health care team. **However, the bulk of their time in FMLE should be working with you as the physician preceptor.**

Medical Records

All students have learned to document a complete case report; however they have little experience with the S.O.A.P. format used by family physicians and will welcome learning about this format of record-keeping. **The new skill introduced to students through the FMLE is the completion of the S.O.A.P. note.** You will have the opportunity to teach them about the Family Medicine based S.O.A.P. note which students will then use to complete their assignments (see below).

Most of you already have EMR records in your office. In the context of this evolution, the student assignments utilize an EMR type format for documenting the S.O.A.P. note.

The S.O.A.P Note (Excerpted from the FMLE Student Handbook)

Record keeping in Family Medicine reflects the unique, complex and longitudinal relationships that exist between family doctors and their patients. At the beginning of most paper-based Family Medicine records, you will find the Cumulative Patient Profile (C.P.P.). This is a separate document, which records what students have previously learned (in Clinical Skills) to document: Demographics, PMHx, FHx, SHx, Meds, Allergies, etc. Due to the ongoing doctor-patient relationship, family physicians needn't review this information each visit but rather they update the C.P.P. on an "as needed" basis. The C.P.P. is usually reviewed in depth during a periodic health examination.

For physicians using Electronic Medical Records, the C.P.P also exists usually either at the top or side of the screen in the patient's chart depending on the EMR platform.

To document patient encounters, family doctors (and some other clinicians) use a "S.O.A.P." format. This is very similar to a "progress note" used when rounding on patients in the hospital but **differs from the comprehensive Clinical Skills case report** you have been learning to date.

S.O.A.P. = Subjective, Objective, Assessment, and Plan, and provides a focused record of the office visit. This note provides the necessary information to reflect the history and relevant data to support the diagnosis or differential diagnosis for a particular patient encounter, and also documents the management plan for the patient including plans for follow-up.

The S.O.A.P. note is a stand-alone entry that should provide the reader enough information to understand the presenting problem and its subsequent management. This becomes particularly important as primary care is increasingly occurring in multidisciplinary/group settings. A good S.O.A.P. note provides all the necessary and relevant information, in a concise format and may be presented in sentences, point-form or a mixture of both formats.

During Family Medicine encounters, patients often present with more than one 'chief complaint' or 'problem'. In the S.O.A.P. note, each presenting problem (S.) should be numbered and then the corresponding information relating to each problem documented in the remaining sections (O.A.P.).

The components of the S.O.A.P. note are as follows:

(S) Subjective:

This includes information/history provided by the patient and/or other history providers (caregiver, relative, etc.). In this section include the presenting problem(s) and relevant history. This is not unlike the chief complaint (CC) and history of the present illness (HPI). In this section, it is also important to include any **relevant (not all known information)** data from the Past Medical History, Medications, Allergies, Social and Family Histories and Functional Enquiry. Remember to consider and include any relevant information related to risk factors. As this reflects the history obtained, some physicians may also record pertinent prior test results in this section.

In a good, patient-centered interview, it is important to ascertain the F.I.F.E. of the clinical experience. The marking scheme does include marks for documenting this in your report.

F = Feelings/Fears	The patient's concerns or worries about the present symptoms
I = Ideas	The patient's ideas about the cause of their symptoms
F = Function	The impact that this illness/these symptoms have on the patient, their lives, work, family, etc.
E = Expectations	What the patient is hoping will happen during the office visit

(O) Objective Information:

This includes objective, observed data. General observations about the patient, in addition to vital signs and physical findings, are documented here. Some physicians choose to document lab data in this section rather than in the Subjective section.

(A) Assessment:

For each presenting problem, a working/provisional diagnosis is provided **and a list of other possible diagnoses to be considered**. A full differential diagnosis is not required.

(P) Plan:

Management of the presenting problem(s) may include both medical and non-medical interventions. In this section include tests or investigations ordered, medication prescribed, other treatments or recommendations, referrals, instructions to patients and planned follow-up.[1]

A video describing the construction of the S.O.A.P. note can be found at the following link: http://youtu.be/NSWoZtYUdWQ. As well, a sample video of an EMR encounter can be found at the following link: http://youtu.be/gFhWemVuY8w. Both videos are also available on Elentra.

An example of a typical S.O.A.P note is as follows:

S:

- Abdo pain x 3 weeks.
- Epigastric burning sensation, 5/10, starts 2 hrs. after a meal. Started 2/week and now occurring daily.
- No radiation. Noticed increased gas and bloating x 2 weeks. No nausea/vomit/constipation/diarrhea/black stools/ fever.
- Worse after dinner, after eating spicy food, or coffee. Advil makes the pain worse. Pt has been drinking more coffee and drinking ETOH nightly x one month. 14 drinks/week. CAGE negative.
- Tried Tums no relief.
- Has had prior episodes of heartburn lasting a few days at a time; had a more prolonged episode in 2009. Upper GI series at the time was negative
- Father had gastric ulcer.
- The patient attributes pain to recent stress at work. He is worried he may have an ulcer.
- He has stopped business entertaining/dinners in last week due to pain

O:

- BP 120/80 R arm sitting 120/75 R arm standing, Hr 80 reg, no postural changes
- ENT: slight erythema throat, no nodes
- Chest: Clear IPPA
- Abdo: No bruit, normal bs, mild tender supra-umbilical area, no guarding, no rebound.
- Rectal: deferred

[1] In an EMR record, medications are often documented in a separate section within the Plan.

A:

- Provisional Dx: Peptic ulcer?
- Other possible diagnoses: Reflux, functional dyspepsia

P:

- Bland diet, discontinue coffee, ETOH, ASA, Advil
- BW: CBC, LFTs, H pylori breath test
- Stool O.B. x 3
- Rx: Omeprazole 40 mg OD x one month
- Refer to GI for possible endoscopy
- F/U 2 weeks, sooner if rectal bleed or black stools

Assignments

Both the First Assignment and Final Assignment are based on completing a S.O.A.P. note for a clinical encounter using an EMR type document, followed by short answer questions. **Please note that the questions in Part II of the First Assignment and Final Assignment are different**. When marking student reports, please ensure students have submitted the correct assignment.

Students have been asked to use **patient initials only** and general information (e.g., DD vs. Donald Duck…and "politician" vs. "Mayor of Toronto"). As the assignments are being emailed, we must take extra steps such as these to ensure patient confidentiality.

Students are to hand in their assignments to you directly; we ask that you provide them formative feedback (for the First Assignment) and officially mark them (for the Final Assignment) and return them to the students within one week.

Please report any late submissions, even if approved. On the MedSIS Final Assignment assessment form you will be required to answer a question about whether the student submitted the assignment on time. Please answer this truthfully – it will be a disservice to the student if we miss picking up on a pattern of difficulty across the program.

The marking schemes for the student reports can be found in **Appendices 3 and 4**.

Students are able to access examples of FMLE First Assignment and Final Assignment on the Student Elentra under the Assignments tab, however, students do not have access to a sample Part 2 of the assignment. **Preceptors can refer to a sample of a good report vs. a very good report to aid with marking** in **Appendix 9**.

Evaluation of the S.O.A.P. note is based on a four-point scale, namely Not Done, Inadequate, Adequate and N/A (Not Applicable). "Not done" refers to information that should be included in the report but is missing. "Inadequate" refers to information that is included in the note but is not thorough or detailed enough. "Adequate" refers to a note that reflects a second-year medical student ability. By marking "N/A", you are saying that piece of information is not relevant to the case and is rightly omitted by the student. For the First Assignment, you are not filling out the marking form, the student is. You are simply providing additional feedback on the S.O.A.P. note, short answer questions, and your thoughts on the student's self-evaluation. For the Final Assignment, you will be the one officially marking the assignment on MedSIS.

Please note that one of the short answer questions in the First Assignment asks the students to list references in citation format. We ask them to use the Vancouver Style of citation which they are taught in their Health Sciences Research curriculum. You do not need to be too concerned with double checking that they have done this style of citation exactly, but rather just a gestalt sense of it looking like a reasonable citation is fine. We have included links to how to do a citation both in the question itself as well as in the **Resources** section below if you want to review it.

ICE-PeRL (Personalized Resource List)

The ICE-PeRL (Personalized Resource List) is a student-maintained resource list that is introduced to students in their first year of the medical program. ICE-PeRL is a resource that each student will build up throughout year 2, containing information on health resources in the community that could potentially be used for collaboration and referral, as physicians do in real practice. There is no deadline associated with ICE-PeRL, and how students collect and store the information is up to them (i.e. electronic or paper list). It is their responsibility to add resources as they go through the different clinical courses. In FMLE, students will use this resource list to answer a short answer question in Part II of the Final Assignment. Below is the explanation of ICE-PeRL given to students in first year:

ICE-PeRL (Personalized Resource List)

Who are you gonna call?
As you go through your medical training, you will encounter physicians, colleagues, agencies, and community members who will be your resources in future practice. While you have access to vast amounts of resources via the internet, personal knowledge of various physicians, colleagues, agencies, and community members is even more powerful. You need to start collecting the contact information and details of these folks from day one. And these details need to be collected in an organized fashion which will be appropriate and sustained for future practice.

Making a list
Staff physicians collect lists of resources and contacts in various ways. Some will have a rolodex, others will use their mobile phone address book, Linked In, a professional Facebook page, Evernote/OneNote. You need to reflect on a good method for yourself and stick with it.

Checking it twice
This Personalized Resource List exercise spans multiple components in your medical education. You should continuously collect this information as you see patients, encounter lecturers, connect with community partners and agencies. Your ICE-CBSL tutors will help this process through an in-tutorial check-in. Your ICE-FMLE will consolidate this process through an in-experience assignment.

Special Information for Resident Preceptors

Most students are matched with Resident preceptors through a volunteer "opt-in" process. Many truly appreciate the opportunity for the near-peer learning that occurs. However resident preceptors do run into some challenges.

Often your schedules are lighter than other clinicians, limiting the clinical exposure for your student. **Consider collaborating with other physicians, residents, or allied health professionals in your unit during your teaching session to optimize clinical opportunities for your student, and/or utilizing the extra time to really give your student the chance to take the histories**. Scheduling can be challenging for resident FMLE preceptors. **Whenever possible try to use the dates set out by the University to set up your sessions.** Your students are aware they are not to be making other plans or commitments during those dedicated days until your sessions are scheduled and should make themselves available accordingly.

We recommend you try to settle your schedule with your student as early as possible. Your site administrator can assist you. **If you find that you are struggling to schedule all six sessions, please contact the FMLE Office for assistance.**

You are required to provide informal feedback on your student's First Assignment. You are also required to **formally mark their Final Assignment and Professionalism Form**. Students must submit their assignments to you by the noted deadlines. The FMLE Coordinator will email you a link to access your student's evaluation forms (Final Assignment and Professionalism Form) to complete online. Since you do not have a faculty appointment, **please ask your clinical supervisor to review your marking to make sure they agree** with the grading and comments, as per university policy. Note, within the

evaluation form you will be asked to attest to confirm you've reviewed the evaluation with your clinical supervisor. **Please ensure you mark your student's assignment within a week of receipt.**

It is especially important for resident preceptors to flag student absences, late assignments, or professionalism lapses to the FMLE office ASAP. It can be confusing for a resident on what to do if a student calls in sick, repeatedly arrives late, misses assignment deadlines, etc. Sometimes, as a near-peer, the student may feel more comfortable with informality and not meeting regular expectations when they have a resident preceptor. These lapses in professionalism may actually be a sign of a student facing serious difficulties in their personal or professional life. It is imperative that you reach out the FMLE Coordinator or the FMLE Director as soon as possible to flag these issues, so they can connect with both the student and the MD Program to ensure the student is doing OK across the program. Please keep the records of all communications with your student in case they are needed later.

Resources for Students (and Preceptors!)

Resource	Availability	Link/ISBN
"The Hub – Family Medicine"	Online	Online study guide for Family Medicine Clerkship (3rd year) students: http://thehub.utoronto.ca/family
Family Practice Notebook	Online	www.FPnotebook.com
DFCM Open	Online	The DFCM Open Website is a repository of peer-reviewed, evidence-based, family medicine focused tools and resources that are clinical, educational, or research-orientated in nature: http://dfcmopen.com
College of Family Physicians of Canada (CFPC)	Online	www.cfpc.ca (in particular, click on the publications link to go Canadian Family Physician or direct link https://www.cfp.ca)Canadian Family Physician has approaches to many topics and case presentations (try googling CFP and your topic). Similarly AAFP is the American version
HealthLinkBC	Online	Awesome Canadian (British Columbia) website with handouts on countless primary care topics. For example, if you are seeing a patient with plantar fasciitis, scroll down to the P section for handouts on what plantar fasciitis is and exercises to recommend https://www.healthlinkbc.ca/health-topics https://www.healthlinkbc.ca/services-and-resources/healthlinkbc-files Lots of patient handouts
Centre for Effective Practice – Clinical Tools	Online	https://cep.health/tools/ A useful database of clinical tools for issues ranging from insomnia to concussions to opioid management
Canadian Task Force on Preventative Health Care	Online	http://www.canadiantaskforce.ca Website for all preventative care related guidelines, e.g. screening guidelines for breast cancer, cervical cancer, colon cancer, etc. Click on Guidelines tab -> published guidelines Click on Tools and Resources tab -> for useful algorithms, shared decision making tools, FAQs, etc.

Alberta TOP (Toward Optimized Practice)	Online	http://www.topalbertadoctors.org user friendly clinical practice guidelines click on TOP CPG tab
Pediatric articles and handouts	Online	About Kids Health is the Sick Kids website for articles on paediatric health topics for patients and families https://www.aboutkidshealth.ca/ Caring for Kids is the Canadian Pediatric Society's version https://www.caringforkids.cps.ca/ healthychildren.org is the American Academy of Paediatrics' version https://healthychildren.org/English/Pages/default.aspx
Canadian Society Guidelines	Online	There are countless society guidelines websites e.g., SOGC (society of obstetrician and gynecologists for ob/gyn related guidelines), CCS (Canadian Cardiovascular Society for things like lipid guidelines), Hypertension Canada, Diabetes Canada, Canadian Pediatric Society guidelines, Canadian Urological Association guidelines etc. etc. etc.
Point of Care **Medication** Resources	Available through U of T Library	Lexicomp, RxTx, Micromedex
British Medical Journal: Point of Care	Online	http://group.bmj.com
UpToDate®	Available through U of T Library for Learners only; no access for staff MDs	http://main.library.utoronto.ca/eir/EIRdetail.cfm?Resources_ID=994895American and tends to be more expert-opinion based
DynaMed Plus	Available through U of T Library	Canadian evidence-based point of care tool
Mosby's Family Practice Sourcebook: An Evidence-based Approach to Care. Michael Evans. Toronto: Mosby Canada, 4th Edition	Available for purchase (completely optional and not required)	ISBN: 0779699068 Order from: www.amazon.ca
For Final Assignment: Part II, Question 5	CPPH	List of CPPH project agencies (you would have received a list from your academy office in late August of this year) www.211.ca The CPPH agency visit projects

Vancouver Style Citing (for First Assignment: Part II Question 5)	Online	Accessible online via HSR page https://guides.library.utoronto.ca/c.php?g=250657&p=5054120#s-lg-box-15896631 Sample References by the NLM https://www.nlm.nih.gov/bsd/uniform_requirements.html Citing & Referencing Guide by Monash University https://guides.lib.monash.edu/citing-referencing/vancouver (also has a PDF available for download)

Resources for Teachers

Communications

The **FMLE Preceptor Post,** our news digest, is usually published twice yearly. Please be sure to review this when you receive it, as we use this to keep our preceptors notified of important information and/or changes to the course. If you have not been receiving this newsletter, please contact the FMLE office to sign-up.

FMLE Preceptor Mentorship Program

If you are new to FMLE teaching, you will be offered to be paired up with a FMLE preceptor mentor - an experienced FMLE preceptor. We hope you will find this connection supportive and helpful as you integrate into our program. Any questions about our mentorship program can be directed to the FMLE Coordinator at fmle.recruit@utoronto.ca

The Hub

This is an extremely useful online study guide used by the third-year medical students at the University of Toronto. This online guide was created by UofT Faculty to address students' need for up to date, relevant and distilled resources for clinical reference and study during the Family and Community Medicine rotation. It is designed to provide references and resources for all core objectives for the official rotation in family medicine and complements the clinical experiences and seminars that students encounter during their rotation. That being said, staff preceptors will also find this useful for curated clinical information from the most up to date Canadian resources! http://thehub.utoronto.ca/family

Twitter

The Department of Family and Community Medicine has a Twitter account. Keep up to date with what is going on in the DFCM and live tweet events by following us at **@UofTFamilyMed**

Don't have a twitter account? You can still keep current with the DFCM Undergraduate Program by visiting our open Twitter page: https://twitter.com/UofTFamilyMed

The MD Program Student Assistance Link

If a health incident or concern occurs, or if a student has any concerns about their placement or professionalism issues around their preceptor's behavior, they can find helpful information and guidance through the Undergraduate Medical Education's ***Student Assistance Link***: www.md.utoronto.ca/student-assistance.

Vancouver Style Citing

Accessible online via HSR page
https://guides.library.utoronto.ca/c.php?g=250657&p=5054120#s-lg-box-15896631

Sample References by the NLM
https://www.nlm.nih.gov/bsd/uniform_requirements.html

Citing & Referencing Guide by Monash University
https://guides.lib.monash.edu/citing-referencing/vancouver (also has a PDF available for download)

Professional Development Resources for Teachers

A number of resources exist for department members who are interested in furthering their understanding of medical education and improving their teaching skills. Annual faculty development is provided at the DFCM Conference and Walter Rosser Day in the spring. General announcements regarding these workshops can be found on the **DFCM website** at http://www.dfcm.utoronto.ca/ on the main page in the News and Events sections as well as other resources under the Faculty tab. On the main page there is also a link to the **DFCM newsletter** – with your faculty appointment you should be getting this emailed to you once a month, and it keeps you up to date with the latest in medical education at the Department of Family and Community Medicine with news, events and updates. Please make sure to look out for the **DFCM listserv announcements**, as this is the way that most DFCM Professional Development activities and resources are announced.

You also have access to free workshops from the Centre for Faculty Development https://cfd.utoronto.ca/workshops. In addition, you have access to the University of Toronto library resources such as free access to journal articles, databases, some clinical tools (NB only students have access to UpToDate, not faculty, but faculty do have access to other clinical tools like Lexicomp, DynaMed Plus, etc), and assistance from librarians to do literature searches. Take a look at the Gerstein Library website, https://gerstein.library.utoronto.ca/, which is the largest academic health science library in Canada, for more links and information. All preceptors have access to a **Zoom Education account** as a UofT faculty member which has extra features compared to regular Zoom. Please use the following link to access your Zoom Education account: https://act.utoronto.ca/zoom-information/.

For those interested in more extensive faculty development on teaching skills, our department offers a course entitled Basics. The purpose of this three-day event is to equip new faculty to function optimally in their new role(s) and to build and strengthen collegial networks of learning within the Department of Family and Community Medicine (DFCM). For more information about Basics and other faculty development opportunities offered by the DFCM, please visit: http://www.dfcm.utoronto.ca/basics-workshop-series

If you would be interested in being provided an academic mentor through the Department of Family & Community Medicine, please visit: https://www.dfcm.utoronto.ca/mentorship

For more information on Faculty Development opportunities or for more information on the benefits of Faculty Appointment, contact our Physician Recruitment and Undergraduate Faculty Development Coordinator, Dr. Jane Chow at jane.chow@utoronto.ca

Appendix 1: FMLE Documented Absence Form

FMLE DOCUMENTED ABSENCE FORM

The following form needs to be completed in the event that the student misses a session.

Course: **Family Medicine Longitudinal Experience**

Date of Absence: ______________________________

Name of Student: ______________________________

Name of Preceptor: ______________________________

Choose one of:

__ Approval sought beforehand ("approved")
__ Notification provided afterwards ("notified')
__ No explanation, approval or notification provided ("none")

Reason given by student, if any:

____
____
____
____

Comments:

____
____
____
____

Appendix 2: Student Instructions for First Assignment and Final Assignment

Assignments

Both the First and Final assignments are composed of a Part I which is completing a S.O.A.P. note for a clinical encounter, using an EMR type document, followed by a Part II short answer section.

Please note that the FMLE reports differ from the Clinical Skills case report. Furthermore, the questions in Part II of the First and Assignments are different. Please use the correct form for each assignment to avoid receiving an "unsatisfactory" assessment.

For each report, choose a patient encounter related to a specific complaint (i.e., Do not use a visit for a periodic health exam or well-baby visit or new patient "meet and greet" visit). Your preceptor can assist you with the choice of a suitable encounter. You may use a visit that you have observed or participated in.

Due to the longitudinal nature of the family physician-patient relationship, some items such as past medical history or medications may not be reviewed in detail during the student's observed encounter. Therefore, in order to complete their assignment, students MAY need to review and obtain information from the patient's chart. We thank the preceptors in advance for facilitating this, should it be necessary.

You are encouraged to complete part of this EMR-based report form during the patient encounter, if at all possible. As EMR is gradually becoming mainstream in most family physicians' offices, this exercise will emulate what many family doctors are doing every day.

Students may achieve this in a number of ways:

I. By bringing the Word file on their own laptop to clinic
II. By bringing the Word file on a memory stick to be used on an office computer
III. By downloading the Word file from Elentra during the clinic, if their preceptor has computer/internet access, or
IV. If computer is not accessible, by bringing a printed copy of the form to clinic to complete.

A copy of the Word documents for completion of the First and Final assignments may be found on Elentra under "Assignments". **A copy of the assignments and the marking schemes may be found in Appendices 2 and 3.** Please read the marking scheme prior to doing the assignment to avoid surprises.

As the assignments are being emailed, we must take extra steps to ensure patient confidentiality. Please use patient initials only and general information (e.g., DD vs. Donald Duck…and "politician" vs. "Mayor of Toronto") in describing the patient's demographics.

Samples of reports can be found posted on ELENTRA under "Assignments".

First Assignment: Should be based on a patient encounter that occurred on Day 2 or 3 and must be submitted to the preceptor by the start (1:30pm) of the student's fourth clinic day, as well as emailed or faxed to the FMLE office: fmle.recruit@utoronto.ca or 416-978-3912. In addition to the assignment itself, the student should also be submitting a completed marking scheme done by them for self-assessment.

Final Assignment: Should be based on a patient encounter that occurred on Day 5 or 6 and must be submitted to the preceptor by 5:00pm, 2 weeks after the clinic Day 6, as well as emailed or faxed to the FMLE office: fmle.recruit@utoronto.ca or 416-978-3912.

Appendix 3a: FMLE Office Encounter (First Assignment)

FMLE First Assignment

Part I:

1. Identifying Data:

Initials:	Age:	Relationship Status:
Occupation:		Gender:

2. Subjective:

3. Objective:

Vital Signs

BP:	HR:	RR:	TEMP:

On Exam

4. Assessment:

Provisional Diagnosis:

Differential Diagnosis:

Notes:

5. Plan:

Medications:	Dosage/Directions:	Supply (Mitte):

PART II:

Please read around this case and answer the following:

1. What are the different diagnoses that you considered for this presentation? In the end, what was your presumed diagnosis and what evidence in the encounter led you to come to this conclusion?

2. Which of the treatments for this condition would you recommend for this patient and why? Did this patient require any particular modifications or accommodations to the treatment plan (e.g. due to contraindication to a first-line treatment, finances, side effects profile, medication interactions, previously tried treatments, patient preference, goals of care, etc.).

3. In a short paragraph, discuss something interesting or surprising which you discovered when reading around this case.

4. What is the one key point (take home message) which you will remember and apply when seeing a case like this in the future?

5. Please list, in citation format, 2 - 3 resources which you consulted to read around this case. What strength and/or weakness did the resource have? (for assistance with citations, please refer to the HSR page with various links for Vancouver Style Citation. In particular the links for Sample References by the NLM and Citing & Referencing Guide by Monash University may be most helpful).

Completed by:	**Date:**

Appendix 3b: FMLE Office Encounter (First Assignment) Marking Scheme

FMLE First Assignment Marking Scheme

Part I

Identifying Data (FM Communicator)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Notes patient's initials, age, gender, and any relevant social/ demographic data.				

Subjective (FM Communicator)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Chief Complaint				

History of Present Illness

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Gives the story in an accurate timeline (onset of symptoms, course over time)				
Characterizes the symptoms (i.e., quality, frequency, location, radiation, intensity				
Considers exacerbating and relieving factors				
Considers other associated symptoms				
Past experience of similar symptoms				
Fears/concerns about the symptoms/illness				
Ideas as to possible causality				
Function: how have symptoms impacted patient (life, work, family…)				
Expectations of the patient for this visit				
Considers risk factors appropriate to a year 2 student: (i.e., considers relevant family and social history, personal medical history, etc. E.g., hypertension in chest pain patient…)				

Objective (FM Medical Expert)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Accurately documents relevant physical findings				
Includes pertinent negatives				

Assessment (FM Medical Expert)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Provides a provisional diagnosis **AND** list of possible diagnoses				

Plan (FM Medical Expert)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Investigations				
Medications				
Non-medication management				
Use of outside resources/referrals				
Clearly indicates follow up plan				

Difficulty of Case

	Easy	Average	Difficult	Complex
Difficulty of Case				

List two areas of strength	
List two areas for development	

Part II

	Unsatisfactory Does not address the question (Fail)	Below Expectations (Borderline)	Meets expectations (Pass)	Exceeds Expectations (Pass)
1. What are the different diagnoses that you considered for this presentation? In the end, what was your presumed diagnosis and what evidence in the encounter led you to come to this conclusion?				
2. Which of the treatments for this condition would you recommend for this patient and why? Did this patient require any particular modifications or accommodations to the treatment plan (e.g. due to contraindication to a first-line treatment, finances, side effects profile, medication interactions, previously tried treatments, patient preference, goals of care, etc).				
3. In a short paragraph, discuss something interesting or surprising which you discovered when reading around this case.				
4. What is the one key point (take home message) which you will remember and apply when seeing a case like this in the future?				
5. Please list, in citation format, 2 - 3 resources which you consulted to read around this case. What strength and/or weakness did the resource have?				

Comments:

Was the assignment handed in on time by the beginning of the 4th FMLE session? Y / N
Was the assignment completed on the right form (first assignment vs final assignment)? Y / N
Has a Clinical Encounter Card been completed and reviewed with the student yet? Y / N

Appendix 4a: FMLE Office Encounter (Final Assignment)

FMLE Final Assignment

Part I:

1. Identifying Data:

Initials:	Age:	Relationship Status:
Occupation:		Gender:

2. Subjective:

3. Objective:

Vital Signs

BP:	HR:	RR:	TEMP:

On Exam

4. Assessment:

Provisional Diagnosis: **Differential Diagnosis:**

Notes:

5. Plan:

Medications:	Dosage/Directions:	Supply (Mitte):

PART II Roles/Principles:

For the following questions, please reflect back on your FMLE experience. You will need to answer FOUR questions in total, one from each of the CanMEDS roles below.

FM Manager: Please answer **EITHER** question 1 or 2

1. Describe a case/patient encounter in which the Family Physician connected the patient to the health care system. Remember to think broadly and include community agencies, specialists, investigations, etc.

2. All physicians will need to develop skills related to their practice management. Describe the challenges family physicians face in time management. Some of these challenges are inevitable. Are there any that could be addressed through a change in the health care system? How might physician wellness and resiliency be preserved?

FM Collaborator and FM Communicator: Please answer **EITHER** question 3 or 4

3. Family Physicians routinely collaborate with other health care professionals. Do you think this type of collaboration, including referrals to specialists, impacts the continuity of care between the Family Physician and the patient? Justify your answer.

4. Describe a time when you had to alter your communication style or use a mixture of techniques when conducting a patient history (for example in order to accurately obtain a history, to establish a therapeutic relationship with a patient or family with unique needs, etc.).

FM Advocate: Please answer **EITHER** question 5 or 6

5. Family physicians are a resource to the community. They need to be an expert in what resources are available to their patients. Think of a patient that you saw that would benefit from resources within the community. Using your ICE-PeRL (Personalized Resource List), list three or more resources that would be beneficial for your patient. If you don't have applicable resources on your list, find three applicable resources and add them to your ICE-PeRL. Explain why each resource was chosen.

6. How did public policy (ODSP/OW/EI/medication coverage/laws for refugees etc.) impact health and/or medical management of a patient you saw?

FM Expert: Please answer **EITHER** question 7 or 8

7. In all primary care settings, a physician must manage patients presenting with undifferentiated or ambiguous symptoms. Think of a patient you saw during your FMLE experience who presented this way. How did you feel as you were trying to come up with a differential diagnosis? What are some strategies you can use when you don't know what to make of a patient's presenting symptoms?

8. There is an expression in medicine "Guidelines are just guidelines". Think of a patient you saw during your FMLE experience for whom the official guidelines you learned in class/seminars were not completely suitable or practical. What were the considerations for that patient's individual needs that made it difficult to implement the guideline? How did you modify the usual recommendations?

Completed by:	**Date:**

Appendix 4b: FMLE Office Encounter (Final Assignment) Marking Scheme

FMLE Final Assignment Marking Scheme

Part I

Identifying Data (FM Communicator)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Notes patient's initials, age, gender, and any relevant social/ demographic data.				

Subjective (FM Communicator)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Chief Complaint				

History of Present Illness

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Gives the story in an accurate timeline (onset of symptoms, course over time)				
Characterizes the symptoms (i.e., quality, frequency, location, radiation, intensity				
Considers exacerbating and relieving factors				
Considers other associated symptoms				
Past experience of similar symptoms				
Fears/concerns about the symptoms/illness				
Ideas as to possible causality				
Function: how have symptoms impacted patient (life, work, family…)				
Expectations of the patient for this visit				
Considers risk factors appropriate to a year 2 student: (i.e., considers relevant family and social history, personal medical history, etc. E.g., hypertension in chest pain patient…)				

Objective (FM Medical Expert)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Accurately documents relevant physical findings				
Includes pertinent negatives				

Assessment (FM Medical Expert)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Provides a provisional diagnosis **AND** list of possible diagnoses				

Plan (FM Medical Expert)

	Not Done **(Fail)**	Inadequate **(Borderline)**	Adequate **(Good)**	N/A
Investigations				
Medications				
Non-medication management				
Use of outside resources/referrals				
Clearly indicates follow up plan				

Difficulty of Case

	Easy	Average	Difficult	Complex
Difficulty of Case				

List two areas of strength	
List two areas for development	

Part II

	Unsatisfactory Does not address the question (Fail)	Below Expectations (Borderline)	Meets expectations (Pass)	Exceeds Expectations (Pass)
FM Manager **1**. Describe a case/patient encounter in which the Family Physician connected the patient to the health care system. Remember to think broadly and include community agencies, specialists, investigations, etc. **OR**				

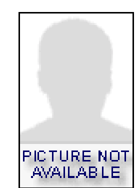
2. All physicians will need to develop skills related to their practice management. Describe the challenges family physicians face in time management. Some of these challenges are inevitable. Are there any that could be addressed through a change in the health care system? How might physician wellness and resiliency be preserved?				
FM Collaborator and FM Communicator **3**. Family Physicians routinely collaborate with other health care professionals. Do you think this type of collaboration, including referrals to specialists, impacts the continuity of care between the Family Physician and the patient? Justify your answer. **OR** **4.** Describe a time when you had to alter your communication style or use a mixture of techniques when conducting a patient history (for example in order to accurately obtain a history, to establish a therapeutic relationship with a patient or family with unique needs, etc.).				
FM Advocate **5.** Family physicians are a resource to the community. They need to be an expert in what resources are available to their patients. Think of a patient that you saw that would benefit from resources within the community. Using your ICE-PeRL (Personalized Resource List), list three or more resources that would be beneficial for your patient. If you don't have applicable resources on your list, find three applicable resources and add them to your ICE-PeRL. Explain why each resource was chosen. **OR** **6.** How did public policy (ODSP/OW/EI/medication coverage/laws for refugees etc.) impact health and/or medical management of a patient you saw?				
FM Expert **7.** In all primary care settings, a physician must manage patients presenting with undifferentiated or ambiguous symptoms. Think of a patient you saw during your FMLE experience who presented this way. How did you feel as you were trying to come up with a differential diagnosis? What are some strategies you can use when you don't know what to make of a patient's presenting symptoms? **OR**				

8. There is an expression in medicine "Guidelines are just guidelines". Think of a patient you saw during your FMLE experience for whom the official guidelines you learned in class/seminars were not completely suitable or practical. What were the considerations for that patient's individual needs that made it difficult to implement the guideline? How did you modify the usual recommendations?				

Comments:

Appendix 5: Professionalism Evaluation Form

Professionalism Evaluation Form



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.

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

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

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

Strengths:

Areas for improvement:

	No	Yes
Was this score based on a critical incident?	○	○

Save   Submit

Appendix 6: FMLE Learner Assessment of Clinical Teacher (LACT) Student Evaluation

FMLE Learner Assessment of Clinical Teacher (LACT)

About your assessment of teachers

- It should be based on the described encounter(s) only.
- The LACT form is to provide feedback and commentary on teaching performance.
- Feedback to teachers is an important professional obligation of learners.
- Your assessments are confidential - with only anonymized aggregated summaries reported.

How we will use the information

- Aggregated data is used to evaluate the teacher/faculty, rotation, and sites on a regular basis.
- Low scores are centrally monitored for needed confidential follow-up.
- Results of LACT scores are used to monitor, support and improve teaching practices for individual teachers, sites and clinical departments.

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

Serious Incidents (i.e. Discussing, Disclosing or Reporting Mistreatment)

- This LACT form is **not** designed as a rapid response mechanism for serious incidents.
- If you have **experienced or witnessed** learner mistreatment or a serious incident of unprofessionalism in the MD Program/PGME learning environment or the MD Program/PGME community, please use the following link to learn more about our supports and resources (**including an anonymous or confidential online tool designed to allow medical learners at the Temerty Faculty of Medicine at University of Toronto to disclose or report mistreatment**). For MD learners: see MD Learner Mistreatment ; For PGME learners: see PGME Learner Mistreatment

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

Would you like to nominate your Preceptor for a FMLE teaching award? (You may select one award)

- ○ I do not wish to nominate my Preceptor
- ○ FMLE Excellence in Teaching
- ◉ FMLE Role Modeling Clinical Excellence

Please provide a 3 line description of why your Preceptor is deserving of this award (should they win, we will use this descriptor at the award ceremony).

Save | Submit

Appendix 7: CPSO Guidelines on the Supervision of Medical Students

Copied from https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Medical-Education

PROFESSIONAL RESPONSIBILITIES IN MEDICAL EDUCATION

Approved by Council: June 2021

Companion Resource: Advice to the Profession

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Undergraduate medical students ("medical students"): Students enrolled in an undergraduate medical education program. They are not members of the College of Physicians and Surgeons of Ontario.[1]

Postgraduate trainees[2]: Physicians who hold a degree in medicine and are continuing in postgraduate medical education (commonly referred to as "residents" or "fellows" in most teaching sites). Postgraduate trainees often serve in the role of supervisors but do not act as the most responsible physician for patient care. If postgraduate trainees are supervisors, then the provisions of the policy regarding supervisors apply to them.

Most responsible physicians ("MRP"): Physicians who have overall responsibility for directing and coordinating the care and management of a patient at a specific point in time, regardless of the amount of involvement that a medical student or postgraduate trainee has in that patient's care.

Supervisors: Physicians who have taken on the responsibility to observe, teach, and evaluate medical students and/or postgraduate trainees. The supervisor of a medical student or postgraduate trainee who is involved in the care of a patient may or may not be the most responsible physician for that patient.

Policy

Supervision of Medical Students

1. MRPs and/or supervisors[3] **must** provide appropriate supervision to medical students which is proportionate to the medical student's level of training and experience. This includes:

a. assessing interactions (which may include observation) between medical students and patients to determine:
    i. whether a medical student has the ability and readiness to safely participate in a patient's care without compromising that care;
    ii. a medical student's performance, abilities, and educational needs; and
    iii. whether a medical student is capable of safely interacting with patients in circumstances where the supervisor is not present in the room;
b. meeting at appropriate intervals with a medical student to discuss their assessments of patients and any care provided to them;
c. ensuring that a medical student only engages in patient care based on previously agreed-upon arrangements with the MRP and/or supervisor;
d. reviewing and providing feedback on a medical student's documentation, including any progress notes written by a medical student;
e. subject to any institutional policies, using their professional judgment to determine whether to countersign a medical student's documentation;
f. countersigning all orders written under the supervision or direction of a physician;[4] and
g. managing and documenting patient care, regardless of the level of involvement of medical students.

Supervision of Postgraduate Trainees

2. MRPs and/or supervisors **must** provide appropriate supervision to postgraduate trainees. This includes:
    a. regularly assessing a postgraduate trainee's ability and learning needs, and assigning graduated responsibility accordingly;
    b. ensuring that relevant clinical information is made available to a postgraduate trainee;
    c. communicating regularly with a postgraduate trainee to discuss and review their patient assessments, management, and documentation of patient care in the medical record; and
    d. directly assessing the patient as appropriate.
3. Postgraduate trainees **must**:
    a. only take on clinical responsibility in a graduated manner, proportionate with their abilities, although never completely independent of appropriate supervision;
    b. communicate with a supervisor and/or MRP:
        i. in accordance with the guidelines of their postgraduate program and/or clinical placement setting;
        ii. about their clinical findings, investigations, and treatment plans;
        iii. in a timely manner, urgently if necessary, when there is a significant change in a patient's condition;
        iv. when the postgraduate trainee is considering a significant change in a patient's treatment plan or has a question about the proper treatment plan;
        v. about a patient discharge;
        vi. when a patient or family expresses concerns; or
        vii. in an emergency or when there is significant risk to the patient's well-being;
    c. document their clinical findings and treatment plans; and
    d. identify the MRP or supervisor who has reviewed their consultation reports and indicate the MRP's or supervisor's approval of the report.

Availability of MRP and/or Supervisor

4. MRPs and/or supervisors **must** ensure that that they are identified and available to assist medical students and/or postgraduate trainees when they are not directly supervising them (i.e., in the same room) or if unavailable, they **must** ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.
5. The degree of availability of an MRP and/or supervisor and the means of availability (by phone, pager or in-person) **must** be appropriate and reflective of the following factors:
    a. the patient's specific circumstances (e.g., clinical status, specific health-care needs);

   b. the setting where the care will be provided and the available resources and environmental supports in place; and
   c. the education, training and experience of the medical student and/or postgraduate trainee.

Involvement in Patient Care

Informing Patients about the Health-Care Team

6. MRPs or supervisors **must** ensure that patients[5] are informed of their name and roles, the fact that the MRP is ultimately responsible for their care, and that patient care often relies on a collaborative, team-based approach involving both medical students and postgraduate trainees.
   a. As medical students or postgraduate trainees are often the first point of contact with a patient, the information above can be provided by them where appropriate.

Obtaining Consent

Medical student and postgraduate trainee involvement in patient care are necessary elements of medical education and training, as well as essential components of how care is delivered in teaching hospitals and other affiliated sites. Respect for patient autonomy may warrant obtaining consent to the involvement of medical students and postgraduate trainees. Whether the consent is implied or express[6] will depend on the circumstances.

7. In situations where medical students or postgraduate trainees are involved in patient care solely for their own education (e.g., observation, examinations unrelated to the provision of patient care[7], etc.), physicians responsible for providing that care **must** ensure consent to medical student or postgraduate trainee participation is obtained, either by obtaining consent themselves or, where appropriate, by another member of the health care team (including the medical student or postgraduate trainee involved).
8. Where medical students provide care to patients, physicians responsible for that care **must** ensure that consent for the participation of the medical student is obtained in appropriate circumstances, and **must** determine who from the health-care team (including the medical student) will obtain it, taking into account the:
   a. type of examination, procedure or care that is being provided (e.g. complexity, intrusiveness, sensitivity);
   b. patient’s characteristics/attributes, including their vulnerability;
   c. increasing responsibilities medical students have in participating in patient care;
   d. level of involvement of the MRP/supervisor in the care being provided; and
   e. best interests of the patient.

Professional Behaviour

9. MRPs and supervisors **must** demonstrate a model of compassionate and ethical care while educating and training medical students and postgraduate trainees.
10. MRPs, supervisors, and postgraduate trainees **must** demonstrate professional behaviour in their interactions with:
    a. each other
    b. medical students,
    c. patients and their families,
    d. colleagues, and
    e. support staff.
11. MRPs, supervisors, and postgraduate trainees **must not** engage in disruptive behaviour that interferes with or is likely to interfere with quality health-care delivery or quality medical education (e.g., the use of inappropriate words, actions, or inactions that interfere with a physician’s ability to function well with others.[8])

Violence, Harassment, and Discrimination

12. Physicians (including MRPs, supervisors, and postgraduate trainees) involved in medical education and/or training **must not** engage in violence, harassment (including intimidation) or discrimination (e.g., racism, transphobia, sexism) against medical students and/or postgraduate trainees.
13. Physicians **must** take reasonable steps to stop violence, harassment or discrimination (e.g., racism, transphobia, sexism) against medical students and/or postgraduate trainees if they see it occurring in the learning environment and **must** take any other steps as may be required under applicable legislation[9], policies, institutional codes of conduct or by-laws.
14. MRPs and/or supervisors **must** provide medical students and/or postgraduate trainees with support and direction in addressing disruptive behaviour (including violence, harassment and discrimination) in the learning environment, including but not limited to taking any steps as may be required under applicable legislation[10], policies, institutional codes of conduct or by-laws.

Professional Relationships/Boundaries

15. MRPs and supervisors **must not**:
    a. enter into a sexual relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating the medical student and/or postgraduate trainee; or
    b. enter into a relationship[11] with a medical student and/or postgraduate trainee that could present a risk of bias, coercion, or actual or perceived conflict of interest, while responsible for mentoring, teaching, supervising or evaluating the medical student and/or postgraduate trainee.
16. MRPs and/or supervisors (including postgraduate trainees who are supervisors) **must**, subject to applicable privacy legislation[12], disclose any sexual or other relationship[13] between themselves and a medical student and/or postgraduate trainee which pre-dates the mentoring, teaching, supervising or evaluating role of the MRP and/or supervisor to the appropriate member of faculty (e.g., the department or division head or undergraduate/postgraduate program director) in order for the faculty member to decide whether alternate arrangements are warranted.

Reporting Responsibilities

17. Physicians (including MRPs, supervisors and postgraduate trainees) involved in the education and/or training of medical students and/or postgraduate trainees **must** report to the medical school and/or to the health-care institution, if applicable, when a medical student and/or postgraduate trainee:
    a. exhibits behaviours that would suggest incompetence, incapacity, or abuse of a patient;
    b. fails to behave professionally and ethically in interactions with patients and their families, supervisors, and/or colleagues; or
    c. otherwise engages in inappropriate behaviour.[14]
18. Physicians involved in administration at medical schools, or health-care institutions that train physicians **must** contribute to providing:
    a. a safe and supportive environment that allows medical students and/or postgraduate trainees to make a report if they believe the MRP and/or their supervisor:
        i. exhibits any behaviours that would suggest incompetence, incapacity, or abuse of a patient;
        ii. fails to behave professionally and ethically in interactions with patients and their families, supervisors or colleagues; or
        iii. otherwise engages in inappropriate behaviour, including violence, harassment, and discrimination against medical students and/or postgraduate trainees; and
    b. an environment where medical students and/or postgraduate trainees will not face intimidation or academic penalties for reporting such behaviours.

19. In addition to fulfilling the expectations set out above, physicians who choose to supervise medical students for educational experiences that are not part of an Ontario undergraduate medical education program **must**:
    a. comply with the *Delegation of Controlled Acts* policy,[15]
    b. ensure that they have liability protection for that student to be in the office,
    c. ensure that the student:
        i. is enrolled in and in good standing at an undergraduate medical education program at an acceptable medical school,[16]
        ii. has liability protection that provides coverage for the educational experience,
        iii. has personal health coverage in Ontario, and
        iv. has up-to-date immunizations.[17]
20. Where physicians do not have experience supervising medical students or are unable to fulfill the expectations outlined above, they **must** limit the activities of the medical student to the observation of patient care only.

Endnotes

1. The *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (*RHPA*) permits students to participate in the delivery of health care by allowing them to carry out controlled acts "while fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession".

2. The majority of postgraduate trainees in Ontario hold a certificate of registration authorizing postgraduate education, but regardless of the class of certificate of registration held, postgraduate trainees cannot practise independently in the discipline in which they are currently training.

3. A postgraduate trainee may also be a supervisor.

4. Prescriptions, telephone or other transmitted orders may be transcribed by the medical student but must be countersigned.

5. Throughout this policy, where "patient" is referred to, it should be interpreted as "patient or substitute decision-maker" where applicable.

6. Express consent is direct, explicit, and unequivocal, and can be given orally or in writing. Implied consent can be inferred from the words or behaviour of the patient, or the surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given. Obtaining consent for involvement of medical students and postgraduate trainees is different than that of obtaining consent in the context of the *Health Care Consent Act* regarding treatment decisions. More information is provided in the *Advice*.

7. See *Advice* for examples.

8. For more information, please refer to the College policy on *Physician Behaviour in the Professional Environment*, as well as the Guidebook for Managing Disruptive Physician Behaviour.

9. For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 ("*OHSA*") and the *Human Rights Code*, R.S.O. 1990, c. H.19 (the "*Code*").

10. Physicians may have other obligations under *OHSA* and the *Code* in regard to their own behaviour in the workplace, as well as specific obligations if they are employers as defined by *OHSA* or the *Code*.

[11.] Including but not limited to, family, dating, business, treating/clinical, and close personal relationships.

[12.] If the relevant information to be disclosed contains personal health information or is otherwise protected by privacy legislation, the MRP and/or supervisor may either obtain consent from the medical student and/or postgraduate trainee to disclose this information or state that alternate arrangements are warranted.

[13.] Including but not limited to family, dating, business, treating/clinical and close personal relationships.

[14.] The College's *Disclosure of Harm* policy also contains expectations which may be relevant to these circumstances.

[15.] The College's *Delegation of Controlled Acts* policy applies to any physician who supervises:

1. an Ontario medical student completing an extra rotation that is not part of their MD program, and
2. a student from outside Ontario completing an Ontario educational experience where the student will be performing controlled acts.

[16.] For the purposes of this policy, an "acceptable medical school" is a medical school that is accredited by the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America, or is listed in either the World Health Organization's Directory of Medical Schools, or the World Directory of Medical School's online registry.

[17.] Please refer to the Council of Ontario Faculties of Medicine's Immunization policy

Appendix 8: Individual Learning Objective Form

Family Medicine Longitudinal Experience (FMLE)

Individual Learning Objectives Form

Purpose:
To make the most of your six sessions, we ask that you complete this form and review it with your preceptor on the first day of your FMLE, as part of your clinic orientation. You may be as general or as specific to suit your comfort level. Although your preceptor **cannot guarantee you any specific experiences**, this information may help guide your preceptor in planning your activities in clinic.

Learning objectives:
(e.g.: take a history on an acute illness presentation, see an ante-natal visit, give a flu shot, perform physical exam maneuvers related to the respiratory system, do a pap test etc.)

1.

2.

3.

4.

Comfort with seeing patients:
The FMLE experience includes both shadowing and hands-on practice through interviewing/examining patients. Preceptors have a varying level of comfort in having students see their patients independently. In addition, some FMLE students are more comfortable than others in seeing patients on their own. Understanding your comfort level will be helpful to your preceptor. With that being said, students should quickly progress to leading encounters with each subsequent session.

Please rate your preference below:

Observe/ Shadow	**1**	**2**	**3**	**4**	**See Patients Alone**

Should this rating change as you progress through the FMLE and you become more comfortable in seeing patients on your own, it is important that you let your preceptor know!

Appendix 9: Sample Student Reports

Sample "Good" Report

Please note: Part 2, Questions 1 - 4 have changed from the sample below.

FMLE Office Encounter (FINAL Report)

PART I

1. Identifying Data:

Initials: A.B.	**Age: 80**	**Relationship Status: unknown**
Occupation: Retired		**Gender: Female**

2. Subjective:

Constant ache at base of R thumb x 2 months
No inciting injury; not getting worse or better
Occasional pins and needles base of R thumb and forearm,
Uses brace on/off and alternating cold and warm compresses - temporary relief
Taking Tylenol for pain – not working
Pt is frustrated b/c pain interferes with daily activities - writing, cleaning after bowel movements, opening jars, cooking
No problem with L wrist/hand
No past experience of similar symptoms
Pt has arthritis in hands, mostly L middle finger – pt can tolerate
ASA allergy – causes hives, blisters in mouth
Had cortisone shot for knee and shoulder in past and this helped

3. Objective:

Vital Signs

BP: n/a	**HR:** n/a	**RR:** n/a	**TEMP:** n/a

On exam

Swollen at base of R thumb,
ROM of thumb reduced, tender when abduct and adduct thumb
Pain shoots up arm during ulnar deviation and on flexion of wrist

4. Assessment:

#	**Diagnosis:** Provisional diagnosis: De Quervain's Tenosynovitis

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Notes:

DDx: Osteoarthritis , carpal tunnel syndrome,

5. Plan:

Patient refusing Advil.

Patient thinks steroid injection might help because has helped before for her (knee and shoulder), therefore:Referral to Dr. H for steroid injection

f/u after injection
Continue wearing brace

Medication	Dosage/Directions:	Supply (Mitte)
Tylenol	As required	60

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PART II Roles/Principles:

1) How has the ongoing doctor-patient relationship impacted the patient's care?

The ongoing relationship helps to develop trust between the patient and doctor, and the relationship in itself can be therapeutic. For example, the patient has developed trust of the doctor's clinical judgment, feels supported, and feels like her problem is acknowledged and that steps are being taken to resolve the problem.

2) In what way has the family doctor acted as manager for this patient's care?

The family doctor has acted as a manager for this patient's care by helping the patient navigate the health care system to receive the tests necessary to make a diagnosis and decide on the most appropriate treatment. The family doctor receives the various test results and then must manage these results by synthesizing the information to come to a conclusion.

3) Has the family doctor collaborated with other health care professionals to care for the patient? If so, in what way? If not, how could a physician utilize other health care professionals to advance the interests of this patient?

Yes, the patient was referred to a neurologist for nerve conduction studies to rule out Carpal Tunnel Syndrome, and the patient went to a radiologist for an ultrasound of her wrist. The patient will now be going to another physician for her steroid injection.

4) What other steps might a physician take with respect to this patient, in order to advance/promote their overall health?

A physician would want to follow-up with this patient to ensure that the pain subsides and that the patient is able to return to her usual daily activities and use her right hand (ie for writing and cooking).

In terms of overall health, a physician could screen the patient for problems common in the elderly to advance/promote her functioning. For instance, a physician might check vision, hearing, cognition/dementia, discuss fall prevention, screen for depression, etc.

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Sample "Very Good" Report

Please note: Part 2, Questions 1 - 4 have changed from the sample below.

PART I

1. Identifying Data:

Initials: . A.B.	Age: 51	Relationship Status: married
Occupation: teacher		Gender: female

2. Subjective:

-2 mos x bloating and LLQ pain
-worse after meals, slightly better after Colace
-pt c/o constipation x years
-nausea 2x day x years- no vomit, hematemesis, dysphagia, decreased appetite, melena, hematochezia or diarrhea or bloat
-pain in llq, no radiation; no similar hx in past,
-Mrs F has been experiencing acid reflux for the past ten years, and she is currently taking Nexium for this problem
- Two years ago, acid reflux and upper abdominal pain intensified, and she lost 30 pounds as a result of pain and discomfort in her upper abdomen.
- Mrs. F. noted that she recently had an OGD, which revealed a normal esophageal and gastric mucosa and no evidence of infection with H. pylori
- Mrs. F. did note, however, that a recent abdominal ultrasound revealed that she had a gallstone
- Mrs. F. also notes that she has iron deficiency anemia due to menorrhagia, and she takes iron pills. .
. There is no family history of gastrointestinal disease.
-pt. is a recreational ballet dancer and is finding the bloating and pain is interefering with her ability to dance. She is worried that this may be ovarian cancer.

3. Objective:

BP: 125/80 Right arm sitting HR: 80 bpm, regular RR: n/a Temp: n/a.
On exam

Gen: Mrs. F. appeared well and was in no apparent distress. She did not appear pale, and had no conjunctival pallor or scleral icterus

Abdo: No distension
- bowel sounds normal,

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-no organomegaly of the liver or spleen.
-no masses
-no local tenderness to palpation or deep palpation
-no guarding

4. Assessment:

1.	**Diagnosis:** Abdo pain/constipation/bloat, rule out: Irritable bowel syndrome Iatrogenic – side effect of Nexium and/or iron pills Colonic malignancy Ovarian malignancy

5. Plan:

-continue Nexium and Colace
-GI has suggested motility study
-scheduled for colonscopy in Feb
- Mrs. B. should also continue to be monitored by her family physician for worsening of symptoms or the development of any new concerning symptoms. Although Mrs. B. was found to have a gallstone on ultrasound, this was not thought to explain Mrs. B's symptoms. She was, however, instructed to seek medical attention should she experience symptoms of cholecystitis (severe upper right quadrant pain, fever, vomiting etc).

PART II Roles/Principles:

1) How has the ongoing doctor-patient relationship impacted the patient's care?

Mrs. B.'s trusting relationship with her family physician has allowed her to report the symptoms she has been experiencing and their impact on her daily life. Furthermore, Mrs. B. has been relying on her physician to prescribe medications and to monitor for an appropriate response to treatment and for potential medication side effects for a variety

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of medications she has been taking.

2) In what way has the family doctor acted as manager for this patient's care?

The family physician has acted as a manager of this patient's care in a number of ways. Firstly, the family physician has provided Mrs.B. with access to many diagnostic and laboratory tests over the course of many years, and the family physician has judiciously decided when these tests were necessary. The family doctor also managed this patient's care by deciding that it was appropriate to prescribe Mrs. F. medications for acid reflux and constipation. Additionally, the family physician acted as a manager of this patient's care by referring Mrs. F. to a gastroenterologist to further investigate her symptoms and to potentially recommend new treatments and by collaborating with the specialist to ensure the necessary tests are performed and followed up.

3) Has the family doctor collaborated with other health care professionals to care for the patient? If so, in what way? What community health and or social services resources might the physician use to help this patient now or in the future?[1]

The family doctor collaborated with a number of other health care professionals to provide optimal care for Mrs. B. To treat Mrs. F., the family doctor collaborated with pharmacists who dispensed medications to Mrs. B., medical imaging technicians and radiologists who performed and interpreted the results of Mrs. F.'s ultrasound studies, and gastroenterologists, who acted on the family physicians recommendations and performed an OGD on Mrs. B..

4) What other steps might a physician take with respect to this patient, in order to advance/promote their overall health?

(1) Mrs. B should continue to have regular checkups every year to monitor her symptoms and review her health status. Her immunization records should be reviewed and she should be counseled re need for mammogram and pap smear.
(2) Should there by no significant findings on Mrs. B.'s colonoscopy, her symptoms are likely multifactorial and are likely influenced by psychosocial factors.

[1] To answer this question you may refer to:
1. List of DOCH2 project agencies (you would have received a list from your academy office in late August of this year)
2. 211.ca
3. The DOCH1 agency visit projects

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Appendix 10a: Clinical Encounter Card (CEC) Preceptor (Mandatory)

Family Medicine Longitudinal Experience (FMLE)

Clinical Encounter Card (CEC): Preceptor*

This form is intended to provide formative feedback on elements of the Family Medicine based clinical encounter, with a focus on the patient-centered aspects of care. **A minimum of ONE FMLE CEC must be completed by the end of your FMLE sessions.**

Encounter Information:

Student Name:	
Student Number:	
Evaluator Name:	
Date:	

Done Well:	
Suggestions(s) for Improvement:	
Additional Comments:	

**Adapted from the ASCM I Clinical Encounter Card*

p

Global Ratings: Choose the rating which best reflects your judgement of the interviewer's performance on the following criteria

1. **Establishes rapport**

○	○	○
Below Expectations	Meets Expectations	Exceeds Expectations

2. **Explores patient's agenda & illness experience**

○	○	○
Below Expectations	Meets Expectations	Exceeds Expectations

3. **Response to patient's feelings, needs and values (empathy)**

○	○	○
Below Expectations	Meets Expectations	Exceeds Expectations

4. **Management of Interview**

○	○	○
Below Expectations	Meets Expectations	Exceeds Expectations

Preceptor Signature: ______________________________	**Date:** ___________________________
Student Signature: ________________________________	**I have reviewed this form with my preceptor** ☐

Appendix 10b: Clinical Encounter Self Reflection (Optional) Card

Family Medicine Longitudinal Experience (FMLE)

Self-Reflection Card:

This form is intended to give the student an opportunity to engage in self-reflection of their skills. It can also serve to facilitate a discussion with the preceptor regarding their thoughts and to further refine learning goals and objectives.

Encounter Information:

Student Name:	
Student Number:	
Date:	

Done Well:	
Suggestions(s) for Improvement:	
Additional Comments:	

**Adapted from the ASCM I Clinical Encounter Card*

Global Ratings: Choose the rating which best reflects your judgement of the interviewer's performance on the following criteria

1. **Establishes rapport**

○ Below Expectations ○ Meets Expectations ○ Exceeds Expectations

2. **Explores patient's agenda & illness experience**

○ Below Expectations ○ Meets Expectations ○ Exceeds Expectations

3. **Response to patient's feelings, needs and values (empathy)**

○ Below Expectations ○ Meets Expectations ○ Exceeds Expectations

4. **Management of Interview**

○ Below Expectations ○ Meets Expectations ○ Exceeds Expectations

Appendix 11: One Minute Preceptor

One-Minute Preceptor

1. **Get a commitment**
   "What do you think is going on?" or
   "What else did you consider?"
2. **Probe for supporting evidence**
   "What led you to this conclusion?" or
   "What else did you consider?"
3. **Teach general rules**
   "When you see this, always consider …"
   'The key features of this illness are …"
   "The natural progression of this disease is …"
4. **Provide positive feedback**
   "Specifically, you did a great job of …"
5. **Correct mistakes**
   "Next time this happens, try or consider …"

Copied from http://www.academicpeds.org/education/nutsandbolts/pdfs/irby.pdf

For a more detailed explanation of the One Minute Preceptor and each of the steps, simply google One Minute Preceptor and there are various websites going into depth, for example, https://www.gvsu.edu/cms4/asset/E6494549-9D1E-60EB-2FAF608662526253/the_one_minute_preceptor.pdf

Appendix 12: Foundations Curriculum Topics

2024-2025- Courses, key concepts/conditions covered in the Foundations Curriculum

Year	Course	Week		Key Concepts/Conditions Covered in TOPIC
Year 1				
1	Introduction to Medicine (8)	1	Embryology	Gametogenesis, implantation, development of placenta, congenital malformations and causes
		2	Medical Genetics	Genetic disorders, Inheritance of genetic disease, Dysmorphic features, Chromosomal disorders, Down Syndrome, Achondroplasia
		3	Histology	Tissue histology
		4	Immunology I	Introduction to the immune system - the basic science immunology
		5	Inflammation and Infection	Senescence, apoptosis, necrosis, inflammation, burns
		6	Cancer	Neoplasia, malignancy, screening, cancer prevention
		7	Drugs	Drug absorption and pharmacokinetics, how to find drug info
		8		Drug safety and efficacy, drug interactions
	Concepts, Patients, Communities 1 (17)	9	Pediatrics	Paediatric well child visits, growth, nutrition, development, vaccines
		10	Health Promotion	Nutrition, physical activity, sleep, health behaviour change, smoking cessation
		11	Microbiology	Bacterial infections, antibiotics (pneumonia especially)
		12	Microbiology	Viral infections, fungal infections
		13	Immunology II	Allergies, autoimmunity, immunodeficiencies (genetic and acquired)
		14	Blood I	Approach to anemia
		15	Blood II	Interpreting CBC, malignancies
		16	Deferred Assessments	
		17	Blood III	Thromboembolic disease, approach to platelets/WBC
		18	Dermatology	Psoriasis, rashes in kids, skin cancer, infections, cutaneous limited vasculitis
		19	Cardiovascular	Acute coronary syndromes
		20	Cardiovascular	Reading ECG,CHF
		21	Respiratory	Reading ECG, peripheral vascular disease, aneurysms
		22		Reading ECG, valvular disease, pericardial disease
		23		COPD
		24	Respiratory I	ILD, sleep apnea
		25	Respiratory II	Pleural disease, lung cancer
	Concepts, Patients, Communities 2 (11)	26	Endocrine (4)	Diabetes
		27		Thyroid, adrenal, pituitary
		28		Andrology, female reproductive cycle and menopause
		29		Osteoporosis, calcium disorders, thyroid nodules
		30	Gastrointestinal (4)	Peptic ulcer disease, upper GI symptoms

		31		Inflammatory bowel disease, diarrhea
		32		General surgery
		33		Liver (esp viral hepatitis, alcohol and liver disease)
		34	Kidney and Urinary Tract (3)	AKI, glomerulonephritis,
		35		Acid-base, electrolytes
		36		LUTS, hematuria, prostate, ED
Year 2				
2	Concepts, Patients, Communities 3 (16)	37	Musculoskeletal (3)	Common upper and lower limb fractures, describing fractures on x-ray, management and complications of fractures, compartment syndrome
		38		Gout, SLE, RA, other SARDs, monoarticular and polyarticular joint pain
		39		Back and neck pain, radiculopathy, spinal stenosis, osteoarthritis, joint replacement, inflammatory back disease, fibromyalgia/diffuse pain, shoulder pain, knee pain, meniscal tear
		40	Psychiatric (4)	Depression, bipolar, anxiety disorders Schizophrenia, psychosis, ADHD, personality disorders, self-harm Substance use disorders, smoking cessation, breaking bad news
		41		
		42		
		43		
		44	Neurologic (6)	Peripheral nervous system and spinal cord diseases.
		45		Extrapyramidal and cerebellar systems and their disorders.
		46		Motor and somatosensory systems*, the* cerebral vasculature*,* clinical diagnosis and management of stroke and intracerebral hemorrhage, lesion localization in the CNS.
		47		Epilepsy, headache/migraine, medication-overuse headaches, trigeminal neuralgia
		48		MS, vision loss, diplopia, vertigo, anisocoria, sleep disorders (OSA, RLS, insomnia, narcolepsy)
		49		Dementia (AD, DLB, FTD), aphasia, memory loss, cognitive assessment, coma, brain death
		50	Special Senses (3)	Red eye, anterior segment diseases: chalazion, conjunctivitis, uveitis, iritis, cataracts, acute glaucoma
		51		Posterior segment diseases: diabetic and hypertensive retinopathy, ARMD, retinal detachment, GCA, glaucoma
		52		Hearing loss, rhinosinusitis, hoarseness, neck mass, epistaxis, BPPV, Meniere's, labrynthitis
	Life cycle (9)	53	Gynecology I	Ectopic pregnancy, pelvic pain, amenorrhea and oligomenorrhea, infertility, abnormal uterine bleeding
		54	Sex and Gender Based Medicine, and Gynecology II	Post-menopausal bleeding, gyne oncology, sexual dysfunction, menopause, non-CA breast diseases, STIs, LGBTQ2S health
		55	Obstetrics I	Antenatal care, gestational diabetes, fetal hemolytic disease, fetal surveillance, teratogens, PROM, pre-eclampsia, ethics
		56	Obstetrics II	Labour and Delivery, postpartum fever and hemorrhage, breastfeeding

		57	Neonate and Infant	Jaundice, respiratory distress syndrome, prematurity, infectious diseases, failure to thrive, child abuse
		58	Child	Asthma, developmental delay, autism, abdominal pain, constipation, headache
		59	Adolescent	Adolescent development, eating disorders, substance abuse, teen pregnancy, street youth, PTSD
		60	Geriatric	Physiology and biology of aging, geriatric syndromes, falls, polypharmacy, atypical disease presentations
		61	Palliative Care	End of life care, pain and other symptom control, breaking bad news, end of life decision making, ethics
	Complexity and Chronicity (11)	62	Chronic Pain	Opioid management, neuropathic pain medications, acute and chronic pain management
		63	Surgery	Post-operative complications (fever, chest pain, oliguria, shortness of breath), common types of anesthesia, blood transfusions, DVT
		64	Trauma	ATLS, spinal trauma, airways including intubation, abdo/pelvic trauma, head trauma
		65	Social Medicine	Social determinants of health as applied to specific cases, indigenous health, black population health, LGBTQ2S health
		66	Public Health	Public health, mandatory reporting (conditions of public health significance)
		67	Complex Pediatrics & Transitions in Care	Intellectual and developmental disability, approach to care transitions (hospital to home, inpatient to inpatient, etc), patient self-management, role of caregiver including burnout
		68	Medical Psychiatry	Management of comorbid physical and mental health conditions, determining capacity, diagnostic ambiguity, conditions include bipolar disorder, depression, schizophrenia, hyperlipidemia, MI
		69	Complex Chronic Disease	Diabetes, hypertension, hyperlipidemia, diagnostic ambiguity, multimorbidity
		70	Cancer	Cancer screening (colon, cervical, lung), smoking cessation, cancer complications/emergencies (SVC syndrome, tumour lysis, etc), survivorship
		71	TTC-CIA (2)	TBD
		72		

Appendix 13: 6 Steps to Successful Virtual Supervision (optional)

6 STEPS TO SUCCESSFUL VIRTUAL SUPERVISION

STEP 1: PRE-READING

Here are some concise and helpful documents to help you prepare:

- Best Practices Supervising Learners While Providing Virtual Care (NOSM)
- Tips for supervising FM Learners Providing Virtual Care (CFPC)
- Pearls for Writing a Virtual Care Field Note (CFPC)

STEP 2: CHOOSE YOUR TECHNOLOGY

Get comfortable with the technology that best suits you/your practice/your learner. You might want to consider one platform for patient care and another to connect with your learners. Practice with family/friends first. Try out a stand up desk (table with a box/peripheral keyboard if using laptop) to help with posture and back pain. Here are a few suggested platforms:

For telemedicine visits:

- OTN - Sign Up
- Telus Virtual Visits for PSS - (1) (2) Costs 30$ per MD/month but learner can be added and attend appointments with their supervising MD
- Others - currently available free of charge and meets privacy standards: Novari evisit, doxy.me no downloads or apps needed.

For virtual supervision (these do not meet the privacy standards for patient encounters):

- Zoom
  - All U of T Faculty Members have access to licensed Zoom education accounts. Note these are education accounts and are not PHIPA compliant. Go to this link and you log in with your UTORID. Then open Zoom and log in via SSO and input utoronto as the domain. You will now have a licensed version of Zoom!
  - If you are not a faculty member you can still use Zoom free but will be limited to 40 min. meetings and <100 participants (!)
  - Note: Zoom has excellent and quick online tutorials about all things Zoom
- Microsoft Teams, GoogleMeets, WhatsApp, iPhones can conference 5 people, Skype - up to 10 people on video/25 on voice call, Viber - phone app for group chats of up to 5 people, FaceTime(Apple to Apple only)

Developed by: Risa Bordman MD CCFC(PC) FCFP Eleanor Colledge MD CCFP FCFP Susan Goldstein MD CCFP FCFP and Milena Markovski MD CCFP Faculty Development Committee, Department of Family and Community Medicine, University of Toronto June 2020

STEP 3: ORIENT THE LEARNER

Orient your learner to virtual care:

- Determine their prior experience (or lack of) with virtual care. The following handouts may be helpful for them to read:
  - » Telemedicine: The Essentials
  - » Virtual Visit Guidelines for Residents (University of Saskatchewan)

Note: All clerks receiving virtual care training through their medicine program prior to starting clerkship and the DFCM is developing e-modules for PGY-1 residents.

- Review the basics of virtual care:
  - » Webside manner
  - » Consent: How & Why? See OMA recommendations on virtual care
  - » Scope of Practice: Review what health care issues can/cannot be managed virtually
  - » Privacy: Ensure provider is providing virtual care from a private location, and also using a clinic number or a blocked number if using a personal phone

TIP: The CMA/CFPC/RCPSC Virtual Care Playbook (from page 6 onwards) is a quick read and provides a great summary of the items above including webside manner (pg. 7), scope of practice (pg. 6), templates for consent/virtual visits (pg. 10 - Appendix A).

STEP 4: DETERMINE TYPE OF SUPERVISION

Determine the best type of supervision depending on the level/competency of the learner.

For a CC/New PGY-1/Learner in difficulty

TIP: Ideally for these learners provide 1:1 supervision, prioritize for in-person assessments if possible until you have assessed level of competency.

For virtual supervision, use **synchronous supervision** whenever possible:

1. Phone - consider use of conference call technology
2. Video/phone - the following are options
   a. Use of OTN:
      i. You can invite up to 20 participants via guest feature (add your learner as a guest or add yourself as a guest to their encounter so you can observe them directly). After introductions mute your sound/video and then observe.
      ii. Learners can get their own accounts via One-ID email
   b. Use of other platforms listed above in Step 2.

For a seasoned PGY-1 OR 2

Use recommendations above and strategies listed in Step 5 below.

STEP 5: ESTABLISH CLINIC FLOW

Consider how virtual supervision and teaching will fit best into the flow of your clinic.

Ensure patient consent:

1. For clerks this will likely happen in the moment - by phone or if using OTN or similar, greet the patient first, confirm consent & have the learner as another "guest".
2. For residents it is typically easiest for front staff to inform the patient at time of booking that their appointment is with a resident.

Consider the following:

1. Connect with your learner in advance:
    a. Provide contact info and discuss the best ways to be in touch with you throughout the period of supervision (text, phone call, EMR messaging etc.)
2. Before Clinic:
    a. For early/in difficulty learners consider "priming" - reviewing cases (via a virtual platform or phone) the night before or just prior to clinic starting.
    b. For more experienced learners consider a quick meet up before clinic to assess for any specific learning needs they identify/anticipate issues.
3. During clinic:
    a. **Dedicated Supervision:** Consider starting a zoom meeting with all the residents you are supervising at the beginning of the clinic which you leave OPEN, residents can then come in and out the meeting over the course of their clinic to review with you as needed
    b. **1:1 Supervision:** If you are seeing patients at the same time as your learner consider setting up 15 minutes breaks every hour in your own and your learner's schedule. This can be scheduled as an appointment and then you can connect via OTN (with your learner as the "patient"), through Zoom or whatever platform you choose.
4. After Clinic:
    a. Set aside time in the learner's schedule for chart review, dedicated teaching.
    b. Meet with learners using virtual platforms such as zoom, conference call etc.
    c. Complete online assessment forms:
        i. Field notes for residents - click on Field Notes in top right hand corner
        ii. Clerkship assessment form

TIP: There is no need to reinvent the wheel - many of the supervision strategies you used before can easily be adapted to virtual supervision!

STEP 6: REACH OUT FOR HELP IF YOU NEED IT!

For U of T, DFCM faculty use the contacts below or contact your Faculty Development Representative:

- Postgraduate Representative
- Undergraduate Representative
- Clerkship Course Directors
- Preclerkship

Still have questions or concerns? Click here for additional resources.