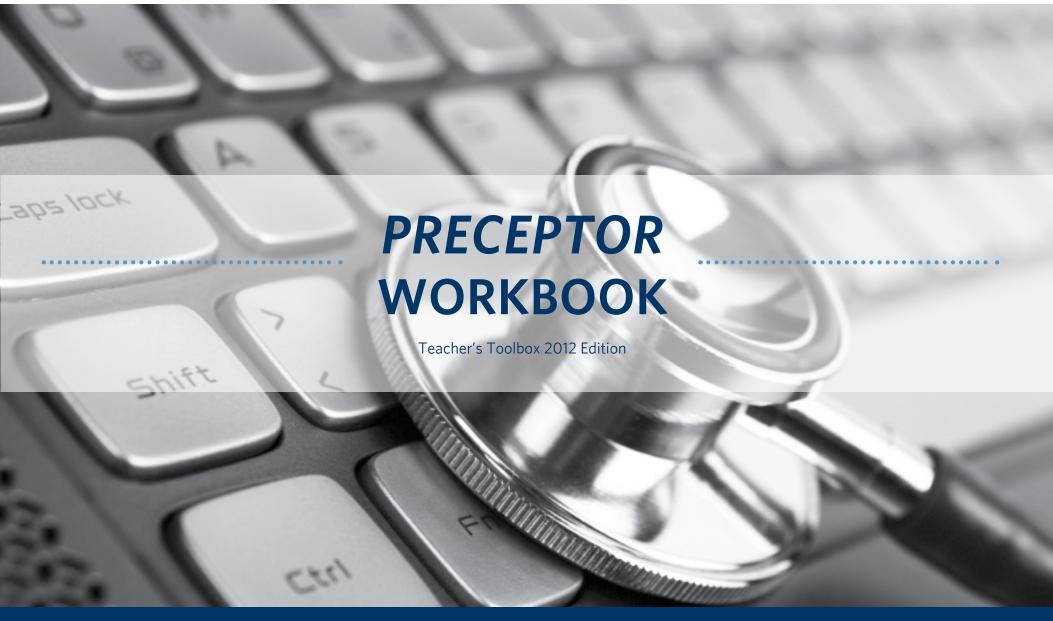
# UBC Department of Family Practice RESIDENCY PROGRAM



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## SECTION I: TIPS FOR PRECEPTORS

## **Short Tips/Pearls**

(Source: Internal Communication{Abbotsford}, UBC - "Teaching Skills", Teacher's Toolbox 2010)

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  - How to prepare you Patients for Teaching?
  - The Learning Cycle
  - How do we apply the Learning Cycle to Teaching?
  - "Random Chart Teaching"
  - Teacher's Toolbox workshop Summary
  - Goals for the Second 6 months of the Residency Program
- 2. This is "Work in Process/Progress" Lead and Site Faculty should add to this list current topics are a "How to get started" list.

## SECTION II: RESIDENT BENCHMARKS

## Goals for every 6 months of Residency

(Source: <a href="http://facdev.familymed.ubc.ca/professional-development/faculty-development/resources-for-evaluating-residents-3/">http://facdev.familymed.ubc.ca/professional-development/faculty-development/resources-for-evaluating-residents-3/</a>)

The Benchmarks have been organized into five stages:

Stage I: Beginning of First Year Residency

Stage II: End of First Six Months

Stage III: End of First Year

Stage IV: End of Eighteen Months

Stage V: End of Two Years Residency

Note: Be aware of the required skill levels at the end of each stage. Discuss with the Resident and frequently refer back to the document to check progress.

## SECTION III: GUIDE TO CERTIFICATION

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(Source: CCFP Website - <a href="http://www.cfpc.ca/FMExam/">http://www.cfpc.ca/FMExam/</a>)

- 3. Examination Description
- 4. Short Answer Management Problems (SAMPS)
- 5. 3. Simulated Office Oral (SOOs)

## SECTION IV: PRIORITY TOPICS

### **List of Topics/Description**

(Source: CCFP Website - <a href="http://www.cfpc.ca/uploadedFiles/Education/Priority%20Topics%20and%20Key%20Features.pdf">http://www.cfpc.ca/uploadedFiles/Education/Priority%20Topics%20and%20Key%20Features.pdf</a>)

- 1. A List of the 99 Key Topics
- 2. A detailed description of the Required Knowledge/Skills for the Assessment of each Key Topic
- 3. UBC Family Practice Residency Program Domains of Care diagram

Most of the Key Topics will be covered in Formal Lectures or during Clinical/Case Discussions.

Residents should be encouraged to review the requirements for each topic before every lecture and also use this information to direct their questions during case discussions.

## SECTION V: CANMEDS ROLES

# Description/Definitions, Concepts vs. Competencies/Curriculum Objectives

(Source: <a href="http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf">http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf</a>)

- 1. Description of CanMeds Roles
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(Source: http://postgrad.familymed.ubc.ca/residency/assessment/)

- 1. Field Notes
- 2. In Training Assessment Report (ITAR)

## Section I: Tips for Preceptors .....

## HOW TO PREPARE YOUR OFFICE FOR TEACHING

At this stage it is important to inform your office manager/staff that you will have a learner/resident in your office from July. Invite all of them to be active participants in the program. They need to be aware that the residents are young doctors and that they will be seeing patients under your supervision.

Most physicians use a "wave" schedule: They continue to see patients and will see 2-3 or more patients while the learner has more time with one patient. The teacher and learner will then have a brief discussion. This can be in front of the patient with the patient participating in providing more information or to confirm physical findings. Focus on one aspect and identify topics for more detailed discussion later. Keep the "wave" moving.

The learner can initially see 1-2 patients per hour with (identified by the teacher) with waiting time to do some reading on the case for later more detailed discussion. Be specific in your instructions and make clear your expectations. "Take a complete history". "Take a past medical and surgical history only". "Examine the shoulder". "Examine the ENT system". Or, "This is a short case: Find out what is wrong with this patient". As the learners gain more experience they will be able to see more patients per hour and you can expect a more detailed management plan.

It is easier for the learner to use a spare examination room. This will cause the least disruption to the teacher's schedule.

Make sure the office staff is made aware of these arrangements and ask for their input at this stage on how it will work best in your office situation to maximize efficiency and minimize disruption.

### HOW TO PREPARE YOUR PATIENTS FOR TEACHING

"Our Patients are our best Teachers".

Our patients will be valuable partners to us as teachers. We need to ask their permission to involve them in teaching. Most of them will be excited to be involved. Invite them to give feedback to the learner. Make sure they are reassured that you are still in charge of their care.

Select patients that are appropriate and receptive to involving a learner. Their problems should be common and straightforward. Select friendly patients who are good communicators.

The following is a sample office sign:

#### THANK YOU!

This practice serves as a teaching site for Family Practice Residents at the University of British Columbia School of Medicine.

As a patient of this practice, you are helping to educate new doctors in the skills necessary to be competent and caring Family Physicians.

**UBC Family Practice Program Preceptor** 

Ask your resident to write a short letter of introduction for your patients to be posted in the examination rooms or to be handed to the patient before the visit.

## THE LEARNING CYCLE

The following is a Competency Based Model of Learning.

- A learner may feel s/he could easily do a procedure = Unconsciously Incompetent.
- 2. Given the opportunity to try to do the procedure, s/he realises it is not as easy as they thought = Consciously Incompetent.
- --> they now realise the learning need and are now motivated to learn
- 3. By focusing on every step of a technique/skill, repeating the steps, rehearsing and reading, the learner becomes Consciously Competent.
- 4. The learner stops thinking about the steps and rely on experience rather than textbook knowledge = Unconsciously Competent doing things without thinking.

Key concept: Learners need to DO things.

HOW DO WE APPLY THE LEARNING CYCLE TO TEACHING?

"Learners need to DO things"

As experienced clinicians, we are Unconsciously Competent. We make many clinical decisions without thinking, based upon our experience.

But, how do we become good teachers?

The best teachers are Consciously Competent, they can see and teach the steps. By teaching the steps repeatedly to our learners, they will over time transition from Consciously Incompetent to Consciously Competent and with more experience eventually become Unconsciously Competent.

#### Key points:

- As experienced clinicians (Unconsciously Competent), we need to take a step back and think through the steps of clinical decision-making (Consciously Competent) to be good teachers.
- We need to understand where our learners are in this process (Unconsciously Incompetent/Consciously Incompetent) and how they will become Consciously Competent.
- 3. Our learners need to do things repeatedly to learn/gain experience.
- 4. Our learners will make mistakes and that is okay. The learning cycle is a process.
- 5. Our learners deserve feedback on their progress.

## TEACHER'S TOOLBOX WORKSHOP SUMMARY

The following is a summary of useful tips given at the Teacher's Toolbox workshop at UBC (2010). These were contributions from a wide range of very experienced preceptors.

1. Benchmark Document: This document can be found at www.familymed.ubc.ca/residency - check under Resources for Evaluating Residents. This document is essential to manage resident and preceptor expectations. It gives clear targets for every 6 months regarding skills level to be achieved. This document is most useful if you discuss it with the resident and keep a copy in your office and frequently referring back to it to check whether you are on track. All the experienced preceptors at the workshop referred to this document as a most useful guideline for progress. I have used it over the last month and can testify to the same.

- 2. Objectives: This document can be found on the same website as above check under Residency Program and Curriculum Objectives. This is a very comprehensive document, but it is quite easy to find the information you are looking for. It has very clear headings to guide you through the topics. For example: You may be interested to know which ethical issues need to be discussed with the resident. Use this as an example and check under "Ethics" and you will find a comprehensive list of the issues we are faced with every week as FPs. Note: In one of my previous e-mails I have discussed a topic "Random Chart Teaching" please review this. This is a great technique to cover a wide range of topics in a relatively short time very time-effective teaching technique.
- 3. Feedback: Set aside time for feedback every week. Example: Give the resident 15 minutes and yourself 15 minutes. Note: Feedback is not the same as evaluation. This is more a "How are we doing?" discussion.
- 4. Observation: This is an essential part of evaluation. It does not need to be the full history or physical examination, can be more focused on one aspect. A chart review is also a form of observation. Note: On the above website under Resources you will find a PowerPoint presentation on Observation for 1.5 Mainpro credits. This gives very practical ideas and tips on observation.
- 5. "Free the Reporter": Encourage the Resident to give a diagnosis/differential diagnosis and then ask: Why? they need to be able to back it up with symptoms/signs.
- 6. "Don't tell it all": Identify a pearl, a take home message. Teach approach. Give homework: This is the lipid profile of this patient (chart). What should the target LDL be for this specific patient and why?

#### "RANDOM CHART TEACHING"

You may find the following teaching technique useful. It is widely used by the Royal New Zealand College of Family Physicians. FPs in NZ meet monthly in small groups and use this tool as a self-directed CME tool.

Preparation: The teacher/preceptor asks his/her MOA to keep out all incoming mail for a specific day and attach it to the individual patient charts. The mail will include blood test results, imaging results, specialist reports, ER visit reports, requests from LTC facilities etc.

Method: You will set aside a fixed time for this learning activity.

- 1. The learner will pick a chart at random.
- 2. The teacher will present the case to the learner.
- The teacher will hand over the result/report to the learner for comments.
- 4. The teacher will facilitate discussion by asking questions:
  - How do you interpret this report?
  - Was the test appropriate?
  - Will the result change management?
  - Did the result confirm the diagnosis or was there a more appropriate test?
  - Should further tests be done?
  - Should this patient be seen for discussion and how soon? What advice will you give the patient?
  - Why was the specialist's findings that much different from mine?
  - Why did this patient go to the ER?
  - Could I have done something to prevent this ER visit, like being more accessible to my patients? Etc.

You will notice that you can cover a wide range of topics in a short space of time. It will also help the teacher to identify patients for the learner to follow-up. This is an excellent tool to teach clinical decision-making skills.

## **GOALS** for the second 6 months of the Residency Program

(From the "Residents Benchmark Document")

- 1. Residents still need to discuss each patient case with the preceptor discussions should be more brief and focused.
- Ongoing relationship between residents and patients should be patient driven. Patients should still maintain a connection with the family physician, while residents are encouraged to be involved with continuity of care.
- 3. Increasing share in decision-making regarding patient care full spectrum of cases/diseases seen by preceptor.
- 4. Look for gaps in knowledge (refer to the "Priority Topics") and encour-

- age the resident to read and consult treatment guidelines.
- 5. Discuss preventative care in patient management in addition to disease management.
- 6. Review examination techniques and observe interviews with patients.
- 7. Emphasize psycho-social aspects of patients' experience of illness.
- 8. Resident to review all tests ordered by them and arrange for follow-up discussions with patients.
- 9. Residents need to understand billing procedures and start billing for patients seen by them.
- 10. Review record keeping. Residents need to sign all entries and it should still be counter-signed by the preceptor.

## Section II: Benchmarks ...

## STAGE I: BEGINNING OF FIRST YEAR RESIDENCY

## Resident Abilities (Bordage I or II):

- Able to take a history and perform an examination. However, hospital-based style; prolonged, mechanical, unfocussed and takes up to an hour to conclude.
- Large gaps in knowledge base especially in relation to commonly seen family practice problems. Unable to differentiate common symptoms from uncommon ones since those seen in hospital practice are skewed.
- Little deductive ability since symptoms are common and disease is not.
- Scant knowledge of therapeutics including drugs and therapies let alone knowing what therapies are likely to influence outcomes.
- Often does not articulate awareness of psychosocial or contextual issues of patients.
- Conversely, medical school education may have focused on the psycho-social approach to the neglect of other competencies.
- Responsibilities & Goals Of Resident:
- Need to familiarize themselves with family practice type of problems.
- Consult with preceptor on each case.
- Constantly review how investigations help to determine the management of current problems. Not all investigations need to be done at once; learning concept of step-wise approach.
- Learn to recognize that problems are undifferentiated and often are not solved at first or even subsequent visits.
- Getting comfortable with uncertainty.
- Becoming aware of the long-term relationship with patients and the importance of family relationships.
- Acquiring effective communication skills, including both verbal and non-verbal cues given by the patient.

- Learning how to give succinct and accurate precis of the pertinent clinical findings to the preceptor.
- Response of Preceptor Over First Six Months of Residency:
- Early, observe complete history and examination until comfortable those resident shows appropriate and consistent skills.
- Observe resident doing several pelvic exams.
- Thereafter, observe at least part of the histories and selected examinations once daily or more often if warranted at this level of training.
- There must be a formal viewing of the resident interacting with a patient once a week and a log or note of this encounter kept.
- Look for the resident becoming at ease in greeting patient and being able to initiate the interview.
- Allow lots of time for interviewing, half to three-quarters of an hour.
- Encourage resident to explain thinking patterns and how differential diagnoses are entertained. Ask "What else did you consider"
- Encourage resident to make a most likely diagnosis in each case and the reasons, i.e., make a commitment. Ask "What do you think is going on".
- Emphasize the merits of the SOAP record keeping, with particular stress on the Assessment so you can see the resident's pattern of thinking.
- Emphasize common and most likely diagnoses.
- Tell them what they did right and how that impacts the patient.
- Correct mistakes.
- Encourage resident to read around cases and use the Internet, then report back to you the results of their enquiries.
- Stress the acquisition of a professional approach, appropriate boundary setting and when and where revealing personal information is helpful therapeutically

## STAGE II: END OF FIRST SIX MONTHS

#### Resident Abilities. (Bordage II):

- Histories are crisper and better use is made of the patient record and the resident is more comfortable with focused examinations.
- Growing comfort with the patient population and the recognition of people as people, warts and all and the fact that everyone needs professional long-term health care.
- Better appreciation of range of common problems seen in family practice.
- Less likely to consider esoteric diagnoses at first contact.
- Increased ability to demonstrate empathy and active listening.
- More rational use of investigations.
- More familiarity with pharmaco-therapeutics but still large gaps in knowledge and often irrational choice of drugs for family practice.
- Responsibilities & Goals of Resident:
- Increased understanding of range of problems dealt with in family practice.
- Building up a group of patients who have been seen on several occasions and who are happy to see the resident on a long-term basis.
- Early understanding of disease and illness patterns in family practice.
- Better understanding of psychosocial issues in illness presentation.
- Beginning to see opportunities for counseling on preventative strategies.
- Still uncertain of own ability to manage family practice problems but less intimidated than six months previously.
- Still dependent on preceptor to make decisions.
- Response Of Preceptor Six Months to One Year into Residency:
- Still need to discuss each case with resident but inter-actions briefer and more focused.
- Acknowledgment that relationship with resident still often patient
  -driven and most patients want to maintain their connection to you,
  their family doctor.

- Allow resident an increasing share in decision-making re patient care.
- Remain vigilant for gaps in knowledge and encourage resident to read and consult guidelines. Do they know how to do this quickly and efficiently? Don't assume all residents are highly computer literate.
- Spend time in discussing preventative care and indicate where resident can take the initiative in broaching the topic.
- Review exam technique and watch resident interview intermittently.
   Formal weekly sessions are still required.
- Probe for understanding and appreciation of psychosocial aspects of patients' experience of illness/experiences.
- Have a system in place whereby resident reviews all tests ordered by them and handles phone calls by patients they have seen.
- Resident needs to understand billing procedures and be billing for patients seen by them.
- Watch for some residents becoming over-confident and over-estimating ability.
- Review record keeping. It should be exemplary by this stage. To
  protect yourself legally, residents should sign all entries and have it
  counter-signed by you. Alternatively, have the resident write that the
  case was discussed and with whom.
- Preceptor should have a good appreciation of a resident's ability.
   Any misgivings should be discussed with the resident's educational advisor or the program director.

#### STAGE III: END OF FIRST YEAR

#### Resident Abilities (Bordage II-III):

- Very comfortable with the family practice setting.
- Good rapport with patients.
- Able to conduct an interview within half an hour.
- Listens well and able to prioritize patient needs/issues.
- Cues into "Red Flag" signs and symptoms.
- Able to formulate a reasonable management plan.

Source: <a href="http://facdev.familymed.ubc.ca/professional-development/faculty-development/resources-for-evaluating-residents-3/#Benchmarks">http://facdev.familymed.ubc.ca/professional-development/faculty-development/resources-for-evaluating-residents-3/#Benchmarks</a>

- Still tends to over-investigate.
- Much better grasp of therapeutics, but still needs lots of mentoring.
- Should have respectful relationships with office staff and recognize them as a resource to the physician and the patients.
- Able to confidently and reliably deal with lab results, consultations with specialists, phone calls and requests for medication refills.
- Growing awareness of community resources.
- Responsibilities & Goals of Resident for Next Six Months:
- More aware of weaknesses in the knowledge base and beginning to organize electives to remedy them.
- Recognition that one person cannot carry all the knowledge needed to be effective. Must have an organized approach to accessing knowledge and information.
- Now feels can accept increasing responsibility for patient care.
- Wants increasing autonomy from preceptor in handling patients.
- Still reliant on preceptor in many cases for help with patient care.
- Preceptor Response One Year to Eighteen Months into Residency:
- Gradual relinquishing of teacher/learner role and increasing collegial relationship as resident matures. Period of consolidation.
- Should now be fully integrated into the practice on-call system.
- Allowing resident increasing autonomy in interview situation and less supervision as merited.
- Allows resident to make some decisions regarding patient care even if preceptor is not in full agreement, so long as patient well-being is not compromised.
- Maintains regular feedback both positive and negative.
- Keeps time available for resident to discuss cases and soliciting help.
- Regular review of cases at end of day especially the problematic cases and where more detailed discussion is needed.

## STAGE IV: END OF EIGHTEEN MONTHS

## Resident Abilities (Bordage III):

- Should be seeing patients at a comfortable rate every fifteen minutes and no more than 20 minutes for a regular appointment.
- Where it is not possible to deal with all the patients concerns, able to prioritize and arrange to see patient at another appointment without patient feeling short-changed.
- Able to see patients alone and make therapeutic decisions in most cases.
- Still needs to consult preceptor over more difficult problems.
- Good appreciation of limitations.
- More comfortable in challenging preceptor over diagnosis and management.
- Manages challenging interactions with effective communication skills and self-awareness.
- Responsibilities & Goals of Resident:
- Eager to be well prepared for the CCFP exam.
- Seeking skills in areas of Family Medicine that are deficient or where there is a particular interest.
- Spending more time to complete research project.
- Increasingly aware of the business aspects of entering practice.
   Spends more time with practice manager or MOAs to see how they do their job.
- Wants to assume responsibility for decision-making for patients' visits as much as possible.
- Preceptor's Response Eighteen Months to Two Years of Residency:
- Comfortable in allowing resident to manage care of patient in office.
- Ensuring resident manages time effectively and copes with pressures of day to day practice.
- Increasingly, contact with some patients limited to ensuring that the patient knows that you are still their doctor and will maintain continuity of care.
- Most of the interaction with the resident is on a collegial basis.
- Comfortable with asking resident's advice on difficult cases.

## STAGE V: END OF TWO YEARS RESIDENCY

## Resident Abilities (Bordage IV, but at least II):

- Resident has demonstrated competency through practicum.
- Able to manage office practice, lab and other paperwork, on-call and in-patient responsibilities.
- Interacts with patients and colleagues at the level of a new locum
- Resident has been asked to do a locum for you.
- Preceptor looking forward and prepared to do the whole thing over again with another resident.
- Sadness at seeing resident leave your practice

## Section III: Guide to Certification.

## **EXAMINATION DESCRIPTION**

The responsibility for the design and content of the certification examination has been entrusted to the College's Committee on Examinations. The examination is designed to assess the knowledge and skills of candidates in relation to the four principles of family medicine (see appendix A):

The family physician is a skilled clinician.

Family medicine is a community-based discipline.

The family physician is a resource to a defined practice population.

Patient/physician relationship

Defining competence for the purposes of certification by the College of Family Physicians of Canada: The evaluation objectives in family medicine.

The evaluation objectives, including topics and key features which guide the College's Committee on Examinations in the development of the test items for the Certification Examination in Family Medicine, is available on the CFPC website. These materials / documents will serve to ensure that the examination maintains acceptable validity and reliability. To do this the evaluation objectives have been designed to clearly describe the domain of competence to be tested within each topic area. The majority of cases will be based on these evaluation objectives.

## THE WRITTEN EXAMINATION (SAMPS)

The written examination is comprised short answer management problems (SAMPs) designed to test a candidate's recall of factual knowledge and problem solving abilities in the area of definition of health problems, management of health problems, and critical appraisal.

This portion of the examination will be delivered using computer-based technology, will be approximately six hours in length and will involve approximately 40 to 45 clinical scenarios.

SAMPs are intended to measure a candidate's problem solving skills and knowledge in the context of a clinical situation. Basic information regarding the presentation of the patient will be provided and a series of three or four

questions will follow for each scenario. When answering questions in this examination please read the question carefully and provide only the information that is requested.

The following are some points to remember when answering SAMPs:

- When relevant, the setting in which you are practicing will be described.
- You can answer most questions in ten words or less.
- When ordering laboratory investigations be SPECIFIC.
- When ordering other investigations, be SPECIFIC. For example, ultrasound is not acceptable, you must specify abdominal ultrasound.
- When listing medications, the use of generic names or trade names will be accepted.
- Give details about procedures ONLY IF DIRECTED TO DO SO.
- When providing values or measures only Systeme Internationale (SI) units will be accepted.
- Avoid abbreviations which are not commonly used and which may not be clear to an examiner.
- Put one answer per box, subsequent answers in the same box will not be considered.

Please refer to the CFPC website for an online demonstration of the SAMP examination

## THE ORAL EXAMINATION (SOOS)

The oral examination is comprised of five simulated office orals (SOOs) each 15 minutes in length. They are designed to duplicate, insofar as possible, the actual "setting" in which the family physician conducts a practice. Family physician examiners are trained to role-play patients presenting with specific complaints. The physician playing the role of the patient notes the management of the case by the candidate and he or she will score the candidate according to pre-defined criteria. This examination will assess both the definition and management of health problems. The scoring system has

been devised to focus on the candidate's approach to dealing with patients -- including their ability to understand the patient's unique experience and to establish a positive doctor-patient relationship. Getting the "right diagnosis" plays only a minor role in the scoring. There are no hidden agendas.

A video demonstration of a SOO is available for download from the CFPC website www.cfpc.ca. It is also available on DVD, upon request, for candidates who do not have access to the Internet.

# Section IV: Priority Topics + Key Features .....

### PRIORITY TOPICS AND KEY FEATURES

Diabetes

Infertility Diarrhea Prostate **Abdominal Pain** 

**Difficult Patient** Rape/Sexual Assault Insomnia **Advanced Cardiac Life Support** 

Ischemic Heart Disease Disability Red Eye Allergy

Dizziness Joint Disorder Schizophrenia Anemia

Domestic Violence Lacerations Seizures **Antibiotics** 

Learning (Patients/Self) Dyspepsia Sex Anxiety

Dysuria Lifestyle Sexually Transmitted Infections Asthma

Loss of Consciousness Earache Skin Disorder Atrial Fibrillation

**Eating Disorders** Loss of Weight **Smoking Cessation Bad News** 

Low-back Pain Elderly Somatization **Behavioural Problems** 

Meningitis **Epistaxis** Stress **Breast Lump** Family Issues Menopause Stroke Cancer

Mental Competency **Fatigue** Substance Abuse

**Chest Pain** Fever Multiple Medical Problems Suicide

Chronic Disease **Fractures Neck Pain** Thyroid **Chronic Obstructive Pulmonary** 

Gastro-Intestinal Bleed Newborn Trauma Disease

Contraception **Gender Specific Issues** Obesity Travel Medicine

Cough Grief Osteoporosis **Upper Respiratory Tract Infection** 

Counselling Headache Palliative Care **Urinary Tract Infection** 

**Hepatitis Parkinsonism** Vaginal Bleeding Crisis

Periodic Health Assessment/ Hyperlipidemia Croup **Vaginitis** 

Screening Deep Venous Thrombosis Hypertension Violent/Aggressive Patient

Personality Disorder **Immigrants** Well-baby Care Dehydration

Pneumonia **Immunizations** Dementia

Poisoning In Children Depression Pregnancy

Infections

(Source: CCFP Website - http://www.cfpc.ca/uploadedFiles/Education/Exam Information/Priority%20Topics%20and%20Key%20Features%20with%20skills%20 and%20phases.pdf)

## KEY FEATURES/DESCRIPTION OF KEY TOPICS

## Tips:

- Discuss with Resident
- Rate discussion
- Resident and Preceptor to keep record

#### For a full description of the Key topics, visit the CFPC website:

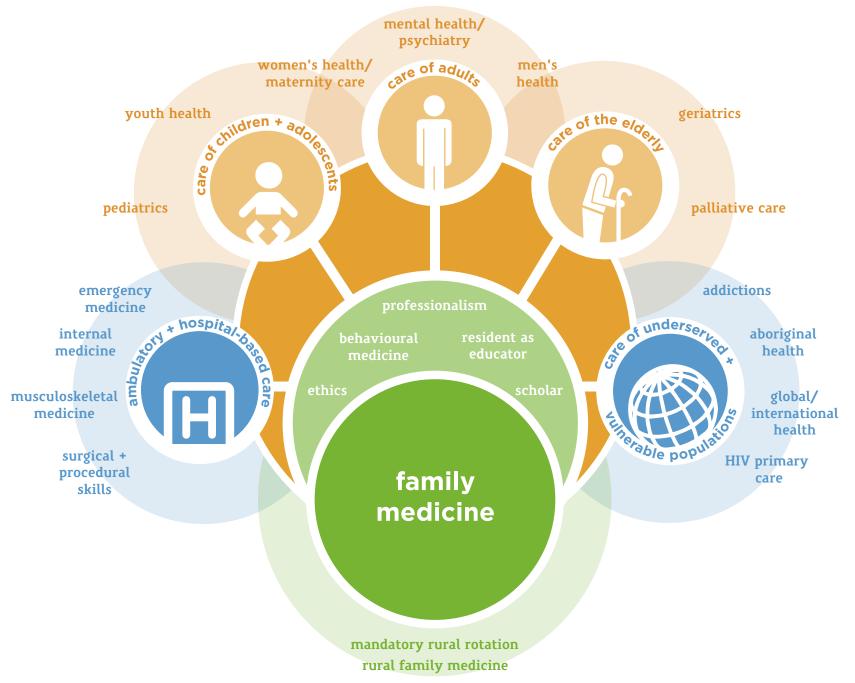
 $\frac{http://www.cfpc.ca/uploadedFiles/Education/Exam\_Information/Priority%20Topics%20and%20Key%20Features%20with%20skills%20and%20phases.pdf$ 

## **CURRICULUM OBJECTIVES**

For a full list of our curriculum objectives, visit our website:

http://postgrad.familymed.ubc.ca/residency/curriculum-objectives/

# **DOMAINS of CARE**



## Section V: CanMEDS-FM Roles

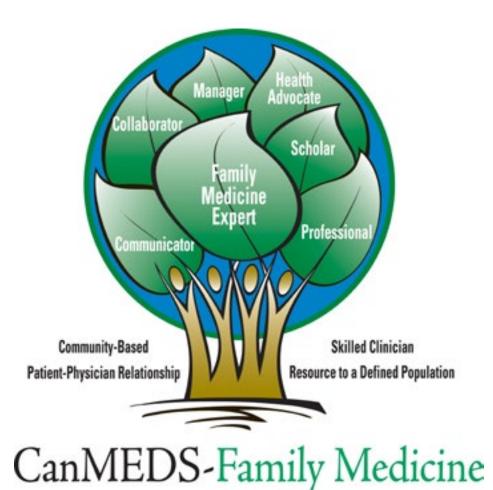


Image adapted by the College of Family Physicians of Canada in 2011 from the CanMEDS Physician Competency Diagram with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2009. Reproduced with permission of the CFPC.

### **DEFINITIONS**

#### THE FAMILY MEDICINE EXPERT

Family physicians are skilled clinicians who provide comprehensive, continuing care to patients and their families within a relationship of trust. Family physicians apply and integrate medical knowledge, clinical skills and professional attitudes in their provision of care. Their expertise includes knowledge of their patients and families in the context of their communities, and their ability to use the patient-centred clinical method effectively. As Family Medicine Experts they integrate all the CanMEDS-Family Medicine (CanMEDS-FM) roles in their daily work.

#### **COMMUNICATOR**

As Communicators, family physicians facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

#### **COLLABORATOR**

As Collaborators, family physicians work with patients, families, healthcare teams, other health professionals, and communities to achieve optimal patient care.

#### **MANAGER**

As Managers, family physicians are central to the primary health care team and integral participants in healthcare organizations. They use resources wisely and organize practices which are a resource to their patient population to sustain and improve health, coordinating care within the other members of the health care system.

#### **HEALTH ADVOCATE**

As health advocates, family physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.

#### **SCHOLAR**

As Scholars, family physicians demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of knowledge.

#### **PROFESSIONAL**

As Professionals, family physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

Source: <a href="http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf">http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf</a>

#### **RELATIONSHIP:** FOUR PRINCIPLES OF FM + CANMEDS-FM ROLES

Four Principles of Family Medicine (foundational concepts)	CanMeds-FM Roles (expected competencies)	
The Doctor Patient Relationship is Central to the Role of the Family Physician	2.Communicator 3.Collaborator 7.Professional	
The Family Physician is a Skilled Clinician	Family Medicine Expert     Communicator     Scholar	
Family Medicine is Community-Based	3.Collaborator 4.Manager 5.Health Advocate	
The Family Physician is a Resource to a Defined Practice	<ul><li>3.Collaborator</li><li>4.Manager</li><li>5.Health Advocate</li><li>6.Scholar</li></ul>	

#### THE FOUR PRINCIPLES OF FAMILY MEDICINE

The family physician is a skilled clinician - Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skilful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families. Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

2. Family medicine is a community-based discipline - Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex bio psychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.

The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or

Source: http://www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf

the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

3. The family physician is a resource to a defined practice population - The family physician views his or her practice as a "population at risk", and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients' health.

Family physicians have effective strategies for self-directed, lifelong learning.

Family physicians have the responsibility to advocate public policy that promotes their patients' health.

Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources. They consider the needs of both the individual and the community.

4. Patient/Physician relationship - Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family physicians respect the primacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients' well-being, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power. Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.

## Section VI: Assessment

#### LAUNCH OF COMPETENCY-BASED ASSESSMENT

Along with other Family Practice Residency programs across Canada, UBC is moving to improve Competency Based Assessment for our residents.

This means change, and while sometimes hard at first, we believe that this important initiative will substantially improve the quantity and quality of feedback for the residents by providing feedback that drives learning and progression to competency. We want it to be okay for residents to 'not know' and to learn from experience and constructive feedback. This will also enable preceptors to have more confidence in the quality of their assessment, both at the 'Point of Care' level and when filling in an In Training Assessment Report (ITAR).

Our overall goal is to provide the tools, continuity, and skills to create quality assessment for our residents. This will take time as we learn what works and what we can improve – and yes, we want your feedback, as this is how we improve our Assessment Program.

We are using new frameworks – the lenses through which we view what is important – of CanMEDS-FM and the Skill Dimensions. We wish to ensure good formative assessment across all the Domains of Clinical Care –those places in which we function as Family Physicians. We wish to cultivate the practice of reflection in assessment and provide good evidence for our young colleagues so that, by the end of their residency, they are competent to begin a practice.

### FIELD NOTES

Fast and easy method of documenting feedback and formulating a 'next step of learning' for residents. See our booklet 'Instructions for Completing a Field Note' for a user guide to our All Sites Pilot Field Note Project.

#### **Example of paper field note:**

UBC DEPARTMENT OF FAMILY PRACTICE			
FIELD NOTE			
Resident: Preceptor:			
Date:	Patient Age: Pati	ent Gender: M F	
Skill Observed:			
○ Continue (strength)			
Continue (Strength)			
Consider (for development)			
○ Stop (do less)			
Stop (do less)			
CANMEDS-FM	SKILL DIMENSIONS	DOMAIN OF CARE	
○ FM Expert	O Patient Centred Approach	○ Maternity + Newborn	
	O Clinical Skill	O Children/Adolescents	
	O Procedural Skill	○ Care of Adults	
○ Scholar	○ Clinical Reasoning	○ Care of Elderly	
○ Manager	○ Selectivity (prioritize/deal	O Palliative Care	
○ Advocate	with complexity)	○ Care of Underserved	
○ Professional			
LEVEL OF COMPETENCY:			
○ Reporter ○ Interpreter ○ Manager ○ Educator			
Resident initials:	Resident initials: Preceptor initials:		

## *Guide to completing a field note:*

The Family Practice Program Office has created a guide to help preceptors and residents understand the process of filling out a field note. For a paper copy of the guide, please contact your site coordinator or visit the assessment portion of the website:

http://postgrad.familymed.ubc.ca/residency/assessment/

UBC DEPARTMENT OF FAMILY PRACTICE

FIELD NOTE

RESIDENCY PROGRAM

# INSTRUCTIONS for **Completing** a **FIELD NOTE**

- Think of a moment on which you wish to get or give feedback
- Discuss it with your resident or preceptor and jot it down
- Check the applicable Domain of Clinical Care and CanMEDS-FM roles or Skill Dimensions
- → Look inside for more instructions + helpful hints!

## THIS BOOKLET INCLUDES:

- → Overall guidelines for identifying, completing and providing feedback regarding a field note
- → Guide to frameworks that appear on the field note
- → Informational guide for residents on field note use + purpose

#### FIFI D NOTE PILOT PROJECT

This is an "all sites" pilot project. We anticipate much refinement in our use of field notes over the next year or two. We would appreciate your feedback on any aspect of the field note initiative, as this is how we learn too!

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# **FIELD NOTE** guidelines



#### IDENTIFYING THE FIFLD NOTE

- Add the resident's and preceptor's names, and the date
- Indicate the patient's age and gender
- List the skill observed, e.g. taking a history

#### PROVIDING BRIEF NARRATIVE FEEDBACK

Use this space to provide focused feedback based on what the resident should continue to do (his or her strengths), should consider doing in the future (areas that would benefit from development or attention), and things to stop doing (avoid doing) in the future. Please use language that is descriptive, specific, and constructive.

#### Examples

Effective feedback: You grasped Mrs Wright's situation well, and did a good context integration statment. Next time move a little closer to her - so she can hear you better!

Not as effective: Nice job on that exam.

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#### FRAMEWORKS THAT APPEAR ON THE FIELD NOTE

#### CanMEDS-FM

The CanMEDS-FM framework is similar to the Royal College CanMEDS and describes the various roles of the family physician. The roles are outlined in brief below.

#### Family Medicine Expert

What you know and how you apply your knowledge to patients and community in a patient-centered way.

#### Manager

Running your office, making a living, getting through a busy day efficiently!

#### Collaborator

Your inter/intraprofessional encounters and your ability to work in a team.

#### Communicator

How you communicate with your patients, their families, and your staff.

#### Health Advocate

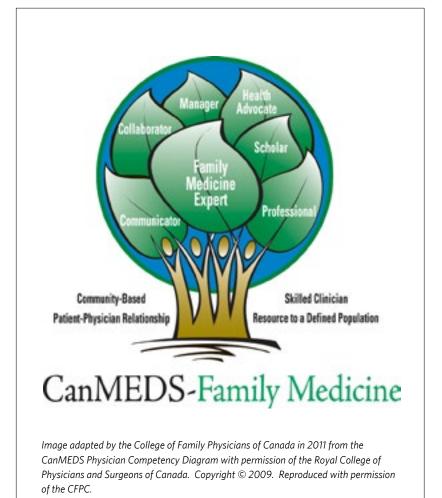
How you promote health and wellbeing for your patients and community.

#### Scholar

Your ability to practice evidence-based medicine and to answer important clinical questions.

#### Professional

Your behaviour, resilience, and wellbeing.



#### **Skill Dimensions**

Adapted from the Six Skill Dimensions, with two left off to avoid redundancy with CanMEDS-FM roles, and clinical examination skills added in for thoroughness.

#### Patient Centred Method

You employ this method when taking the patient's history.

#### Communication

You consistently use good communication skills (listening, reflection, verbal, non-verbal, written) in a culturally and situationally aware manner.

#### Clinical Reasoning Skills

Efficiently use the hypothetico-deductive model in a manner adapted to the patient's needs, the problem at hand and the context of the encounter.

#### Selectivity

Among the many facets of selectivity — sets priorities and focuses on the most important.

#### Clinical Skills

You employ best practice in your appropriate examination of the patient.

#### **Domains of Care**

Developed by the College of Family Physicians of Canada (CFPC), the Domains of Care framework addresses the need for

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graduates to be competent in providing care across the lifecycle (including prevention and acute and chronic illness management), in a variety of care settings (urban, rural, home, ambulatory, as well as emergency, hospital, and long-term care facilities) and to a broad base of patients including those from underserved and marginalized populations.

Care of Children and Adolescents Care of Adults Care of Elderly Hospital and Ambulatory Care Care of the Underserved

#### **Level of Competency**

Some preceptors may be familiar with this as RIME. This framework addresses the resident's level of competency, with the Reporter level as the starting point for competency.

#### Reporter

The resident can report back to you the details of patient history.

#### Interpreter

The resident can provide an interpretation and diagnose.

#### Manager

The resident is able to manage their patients, time, and practice effectively.

#### Educator

The resident can effectively educate patients, his or her community, and peers.

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# Informational **FIELD NOTE guidelines** for *RESIDENTS*

#### **Our Philosophy**

Field notes are a safe venue for constructive feedback. You are encouraged to acknowledge the things that you do not know so that you can focus on them and work to improve your level of competency. Use field notes to document your starting point and subsequent progress, and to make plans to maximize your learning. Collectively, your field notes should show overall progress, not perfection.

#### When to use

A field note may capture any of your activities as a resident. Have your preceptor directly observe you interacting with a patient in any setting.

These include, but are not limited to:

- Reviewing a case with your preceptor
- Delivering bad news to a patient
- Managing a family conference

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- Filling out a form for a patient
- Interacting with any allied health professional in person or on the telephone
- Writing a referral letter
- Doing a procedure
- Giving a presentation at your clinic
- Doing a literature search to answer a clinical question
- ... and many more!

Do this often in the early stages of your residency to ensure your clinical examination skills are solid. You will not know unless you ask to be observed.

Show that you both "know how" and can "do". If you need to improve in an area – it's good for you to know this – do so and get a 'follow up' field note!

#### Where do your field notes go, and how are they used?

- **1.** Field notes are primarily for your use as a resident.
- **2.** Use field notes to demonstrate that feedback has occurred and that you are learning from it.
- 3. Please organize, reflect upon, and bring all your field notes both those that you and others initiate to your '4 month review' meeting with your Site Director as evidence of your

- progress. Use the Field Note Stack Cover Card for each set on a specific theme, e.g. Domain of Care.
- **4.** Your Family Practice preceptor will get to know you well and want to initiate field notes to document your progress. He or she may ask to use these to inform the In Training Assessment Report (ITAR). This is your choice. Share copies of your field notes if you wish.
- 5. When you have multiple preceptors on a rotation or learning experience this is more complex. We want you to be well and fairly represented on the ITAR. One preceptor is identified as your Rotation Coordinator.

  If your site has an End of Shift or End of Week reporting form in place, your preceptors will use this to inform your Rotation Coordinator as s/he fills in your ITAR. If not, field notes initiated by your preceptors may be used for this purpose. Your multiple preceptors will be asked to do field notes and forward a copy to the Rotation Coordinator. You will keep the original. Your Rotation Coordinator is also asked to get verbal
- **6.** Your Residency Program is interested in ensuring a broad base of exposure for you across all the Domains of Clinical Care.

feedback from all your preceptors on your progress.

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## IN TRAINING ASSESSMENT REPORT (ITAR):

New three part form uses a CanMEDS-FM framework and asks that the process of setting goals for assessment – knowing the journey ahead, checking in at the halfway mark or periodically for the 'horizontal rotation', and deciding if the goals were met at the end – become the key to quality assessment for all learning experiences. Continuity is the hallmark. Narrative is essential. The new ITAR includes web links to our Curriculum Objectives.

The New ITAR Informational Page, July 2012:

# The New ITAR

Why change the WebEval Form?

#### What is changing?

The In Training Assessment Report (ITAR) form on WebEval (One45) that you are asked to fill in at the middle and end of each rotation is being renovated!

#### Why change?

UBC Family Practice Residency Program, like all the other programs across Canada, is moving to Competency Based Assessment, where we define the competencies – the outcomes – and look for our residents to progress towards these competencies during their training. This is a departure from the time-based 'tea steeping' method of exposing residents to a learning experience and ticking items off a checklist: Yup, they saw that... they did this... without having any concrete evidence of competence. We need to answer a couple of key questions: Are they gaining competence in this area? And at the end of the program: Are they competent to begin a practice?

#### How is this better?

When we put the emphasis on connecting assessment to learning by using formative (feedback) assessment, and linking assessment to our curricular objectives (competencies) we are more able to see the progress to competency. We create a continuity of assessment by starting at the beginning of the rotation with the First Day form (setting goals and expectations), check in at the Mid-Point (how are we doing to date) and set some new goals. At the End of Rotation we check in again and summarize – were these goals achieved? There is lots of opportunity to change what needs to be changed well before the end of the rotation or learning experience – with no surprises!

#### How would this change affect me?

The appearance of the new WebEval ITAR has changed. Gone are the 10 point Likert scales! Instead, you are asked to make a brief comment about the resident's performance looking through the lenses of the Can–MEDS-FM roles. You will need a passing familiarity with these 7 roles: Family Medicine Expert, Communicator, Collaborator, Health Advocate, Professional, Manager, and Scholar. The new form provides a quick guide to each, and a link to the original CFPC CanMEDS-FM document for your reference. You may, if the resident provides them, use his or her Field Notes to remind you of specific moments that relate to each role. The preceptors at the pilot sites for this new form found this to be easy and do-able.

#### Who was involved in this change?

The Assessment & Evaluation committee, made up of the Lead Faculty for Assessment & Evaluation and the Assessment & Evaluation Faculty from each teaching site, did most of the work in creating and testing this form. Your Site Faculty was involved. Special thanks to the residents on the Assessment & Evaluation Committee for their contribution to this process. The pilot sites were Chilliwack, Surrey, and Terrace.

#### When is this change occurring and why?

We are implementing this change across all sites, for all rotations, at the beginning of the next academic year. This works best for communications with a new cohort of residents. The start date is July 1, 2012.

#### What if I have questions?

Please contact your Site Faculty for Assessment & Evaluation for more information on the form itself, and how to fill it out. Please contact your Site Coordinator if you are having technological difficulties with the One45 system or gaining access to this new three part form.

Source: http://postgrad.familymed.ubc.ca/residency/assessment/

# The New ITAR

How to use the new In Training Assessment Report (ITAR)

In July 2012 there will be a new trio of assessment forms on WebEval(One45) for all rotations: First day of Rotation/Learning Experience Form; Mid Rotation/Learning Experience Form; and End of Rotation/Learning Experience form.

These 3 forms make up the new ITAR, which is guided by the following principles:

- → **Instructive**: Forms start with instructions and web links to facilitate quality assessment.
- → CanMEDS-FM Framework: Links to each CanMEDS-FM role are right on the forms.
- → **Narrative based**: Brief, thoughtful comments are requested for each of the roles.
- → **Promotes continuity of assessment**: The ITAR is one form with three parts First day, Mid, and End for each rotation. The last two forms are very similar.

#### Administrative Processes for the ITAR:

#### → TIPS

**Save** your preceptor expectations to the desktop, then simply copy and paste them for your next ITAR.

**Encourage** the Resident to have their goals thought out and written down prior to the first meeting!

Best practice: Open

WebEval (One45) in 2 browsers to view the Mid Rotation/ Learning Experience form as you fill in the End of Rotation/ Learning Experience form and compare the goals set at mid-term with the final outcomes.

#### FIRST DAY OF ROTATION/LEARNING EXPERIENCE FORM:

- **a.** Site Coordinators send the form well in advance of need (e.g. a week before the start date).
- **b.** Resident and Preceptor meet and complete this form prior to the start date to:
  - i. Review the <u>Curriculum Objectives</u>.
  - **II.** Enter your Preceptor expectations for this rotation.
  - iii. Enter Resident goals.

## MID ROTATION/LEARNING EXPERIENCE FORM:

- **a.** Site Coordinators send the form no later than one day before the mid point of the rotation/learning experience.
- **b.** Halfway through a rotation of 4 weeks or more, or every 3 months during a horizontal rotation, Resident and Preceptor meet and complete this form. For each CanMEDS-FM role:
  - i. Identify and comment on strengths, weaknesses, and suggestions for improvement. Be brief.
  - **ii.** Choose the appropriate summative statement: "meets expectations" or "does not fully meet expectations".

#### END OF ROTATION/LEARNING EXPERIENCE FORM:

- **a.** Site Coordinators send the form no later than one week before the end date.
- **b.** At the end of the rotation, meet and complete this form.
- **c.** Provide a brief summative statement about the achievement of objectives, expectations, and goals for each role.
- **d.** Select either "meets expectations" or "does not fully meet expectations" and add further comments as needed.



# UBC Department of Family Practice RESIDENCY PROGRAM

