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**A QUEEN'S DEPARTMENT OF FAMILY MEDICINE  
FACULTY DEVELOPMENT RESOURCE**

# Clinical Teaching

A Toolkit for Family Medicine  
Clinical Preceptors

Dr. Matt Simpson, MD, MSc, CCFP, CD

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# **Clinical Teaching**

A Resource Handbook for Family Medicine  
Preceptors

**Dr. Matt Simpson, MD, MSc, CCFP, CD and the  
Queen's DFM Faculty Development Team**

3 March, 2019

There are many excellent teaching manuals out there focussing on a variety of different clinical teaching skills. Having searched through many I sensed a gap. Queen's needed something more specific; something summarizing and encapsulating information our teachers need right here, right now. I'm hoping this manual fills that gap.

We are privileged to have a great community of dedicated preceptors who navigate this complex array of material and engage and develop their skills in their own way. I've tried to simplify that process. This is an attempt to bring together a collated collection of resources into one handy guide. It's best viewed 'online' so the hyperlinks are useful. And it is meant to be a living document updated regularly, so please check back often.

Hoping you find some utility here. Whether you are a new preceptor or one of our much loved seasoned veterans. Thanks for stopping by.

Acknowledgements and thanks to all those who helped in the development and creation of this guide.

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*“Education is not something you can finish.” – Isaac Asimov*

# Prologue

Every physician starts practice with a great deal of teaching and learning experience. We often have a sense that teaching is easy; not something we need to think about. The truth is, *mediocre* teaching is easy for most physicians. Many of us have good communication skills, a pleasant demeanour, relevant experience, intelligence and a strong knowledge base which bodes well for our learners. *Good* teaching even comes naturally to a few. But *great* teaching is always a product of time, energy, and study. This is your call to action: be a great teacher.

Despite the imposter syndrome that inflicts us all at times, *you* are capable of both doing and teaching medicine. It is that utilitarian mantra: “see one, do one, teach one” that reinforces the myth that you don’t need to think about your teaching. No one wants to perpetuate a culture of mediocrity in teaching, so don’t do this. Be great. Your teaching will get better with experience and study. Doing the job with an audience is only the first step. I challenge you to examine your ‘teaching knowledge’ and learn from past thinkers and experts. This is a worthwhile endeavour for the sake of your learners, our profession, and our health care system. Thank you for taking the first steps. I hope this booklet helps.

Sincerely,

Matt

Matthew T.W. Simpson, MD, CCFP, MSc, CD  
Faculty Development Director

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## Chapter 1 - Introduction

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**W**e are familiar with the way medicine is learned: a period of classroom and small group sessions progress through more hands on practice in a hospital setting. A supervised clerkship phase (with both service and learning components) is followed by a residency period with more and more independence under less and less scrutiny and supervision. This resembles an apprenticeship, but differs in that we have a multitude of different mentors along the way. You are one of those mentors.

Teaching is a two way street. You will benefit from having students or residents in ways you have not begun to imagine. Your learners will bring new vitality, new resources, and new approaches to your practice. In teaching them, you will solidify and hone your own skills. They will learn from your example. Simply doing your best



work and being open to change will set you well on your way.

## **CanMedsFM**

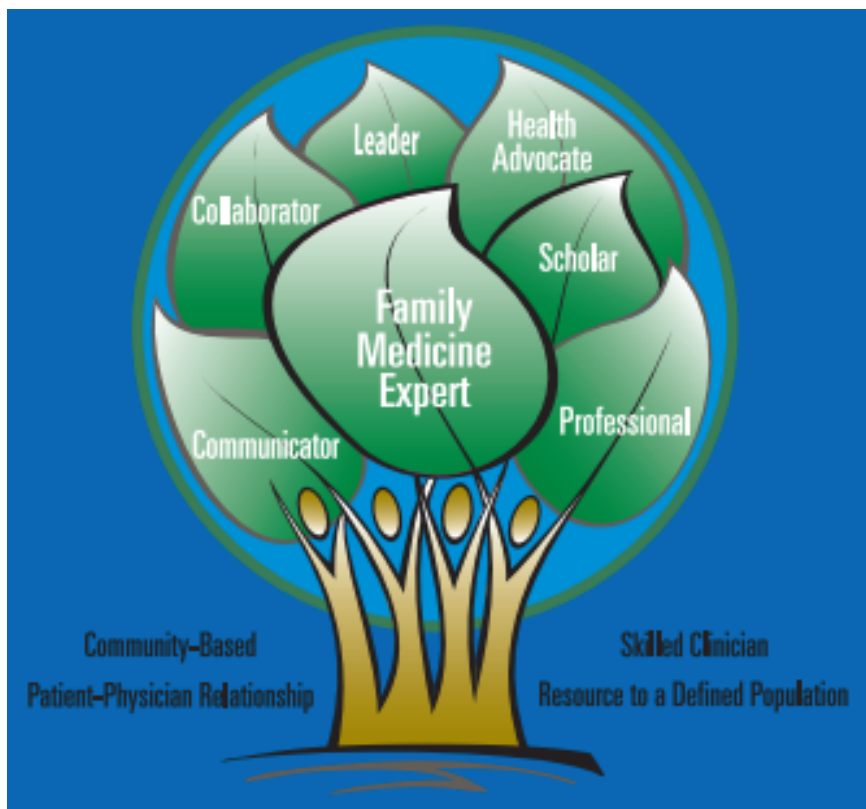
In 2017 the Canadian College of Family Physicians published their most recent document<sup>1</sup> outlining the competency framework for family physicians across the continuum. I encourage you to take a look at this document and familiarize yourself with it's content.

[https://portal.cfpc.ca/resourcesdocs/  
uploadedFiles/Resources/Resource\\_Items/  
Health\\_Professionals/CanMEDS-Family-  
Medicine-2017-ENG.pdf](https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Resources/Resource_Items/Health_Professionals/CanMEDS-Family-Medicine-2017-ENG.pdf)

Here you will recall the various 'roles' of the family physician including: Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional. You will re-familiarize yourself with the Four Principles of Family Medicine (fig.1: see the base of the tree.)

Grasp this document. Appreciating how it applies to all family physicians and captures the competency requirements. It defines the abilities needed across the educational continuum. This is a great place to start to your teaching journey.

Figure 1. CanMEDS-Family Medicine



## Competency Based Education

Trust that there is scrutiny on our education system, and Queen's curriculum, that ensure training and accreditation standards fit with our community needs. When you hear 'triple C' discussed, this refers to a Canadian concept of ensuring our curriculum is: **C**entred in family medicine, **C**omprehensive in scope, and **C**ontinuous across the life cycle. You contribute to this through clinical teaching at

your unique practice setting. More on the concept of ‘triple c’ and how it relates our work with college requirements can be found here:

[https://www.cfpc.ca/triple\\_c](https://www.cfpc.ca/triple_c)

This document emphasizes collecting evidence on a learner’s competency in small snippets over time within the various domains of clinical care to determine readiness for independence. This is directly opposed to the antiquated idea that a fixed period of time in residency determines competency and is why we ask for regular field notes from you (see below chapter on resident assessment).

## **Chapter 2 - Undergraduate Medicine**

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Teaching in the undergraduate medical program at Queen's University is a joy and privilege. We are always looking for new and keen educators to participate.

### **Opportunities for teaching**

Currently (in 2019) there are opportunities for preceptors to mentor undergraduate medical students at both the pre-clerkship and clerkship phase. Please contact the Undergraduate Program Director at the Department of Family Medicine if you are interested in participating. The Clinical Skills program and the Facilitated Small group case-based learning sessions (FSGL) that Queen's undergraduates attend throughout their pre-clerkship experience are great places to start your undergraduate teaching journey.

Mentorship is also an important part of the Queen's undergraduate medicine program. A formalized program exists that is meant to prepare students both personally and professionally by introducing them to practicing

physicians in a small group setting outside of the curriculum. Information on how to get involved in this can be found here:

<https://meds.queensu.ca/academics/undergraduate/student-wellness/mentorship-program>

In FSGL you have an opportunity to act as both a tutor and a mentor guiding junior medical students through case based modules linked to their block based curriculum.

In clinical skills they are introduced to physical examination and other clinical skills. This is hands on training sometimes with the aid of standardized patients.

Our family medicine program is always looking for new clinical experiences for placing our learners in clerkship.

The program provides orientation materials and tutor guides but it's your own preparation that enhances the experience. I encourage you to set time aside for active learning around practice, and lesson prep. Being more prepared with specific anecdotes and testimony can make these sessions resonate and come alive for your learners.

### **Notes on classroom teaching**

The opportunities for classroom teaching a somewhat more limited. Currently at Queen's our royal college specialist colleagues do the bulk of the pre-clerkship classroom teaching. Family medicine presence in the curriculum is limited by time and space. Occasionally we are asked to participate in a learning experience that would benefit from Family Medicine perspective. This usually

happens when a colleague teaching in the program reaches out directly to individuals. If this happens to you, do not hesitate to reach out to our Faculty Development team for support and advice. These can become great opportunities to participate and shine a light on our specialty.

Our flagship pre-clerkship family medicine course is a term one course that is both award winning and universally considered a favourite course of pre-clerkship. It is entitled “MEDS115 Introduction to Family Medicine” and it runs in the first term of year one at Queen’s. MEDS115 is designed to provide early medical learners approaches to common medical presentations but it is probably more accurately considered an ‘Introduction to Clinical Reasoning’ in the guise of a Family Medicine course. It was painstakingly developed with ‘constructive alignment’ (See John Bigg’s<sup>3</sup>), low cognitive load, and spaced repetition in mind. From there the professors use a flipped classroom design punctuated with small group learning, team assignments, and the occasional raucous class debate to deliver content. The students arrive prepared having reviewed pre-class material and having memorized a simple schema. The instructors confirm preparation in an initial review using ‘the randomizer’ to call on random students for answers. This is surprisingly and consistently the best loved component of the class and we are persistently entreated to convert other medical school classes to a similar format. Hopefully we will see more on that in the future. We are ready and willing to help facilitate going forward, and if it does, we will certainly need more keen classroom instructors, so please add your name to the list of interested participants if you so desire, by again contacting our DFM UGME Director.

The best way to get better at classroom teaching is to be honest with yourself about your preparation. It takes a great deal of time to distill your teaching concepts to digestible chunks. Teaching in the first year of Queen's medical school is really like teaching in the big leagues. These are excellent students who demand excellence. They deserve your best. You need to know exactly what point you are trying to make on each of your slides. If you aren't able to get that point across in two minutes or less then you haven't thought it through completely. You also need to think about what questions might arise at each slide, and have prepared answers at the ready. It is not so much about charisma or a cult of personality as it is about preparation. Experience in a classroom, dealing with students attempting to sidetrack the lesson, or fielding unusual irrelevant questions, can also help.

There is a great three part video series that gives the foundation of Bigg's theory of constructive alignment here:

<https://www.youtube.com/watch?v=iMZA80XpP6Y>

And here is a collated resources of teaching resources from Vanderbilt University that I have found helpful:

<https://cft.vanderbilt.edu/guides-sub-pages/teaching-statements/>

## Chapter 3 - Postgraduate Medicine

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The family medicine residency program at Queen's is currently based around a two year timetable. The different sites have slightly different formats and schedules but all responsibly cover the fundamental curriculum with some collaboration at the program level. If you are interested in learning more about the curriculum, information can be found here:

<https://familymedicine.queensu.ca/academics/core-residency>

As a clinical teacher you will be aware that the bulk of our learner's education takes place at the clinical hands-on 'coal face'. It is your supervision and assessment in these moments that impacts their progress most directly. Their individual progress depends on a variety of factors, including how long they have been in training, which experiences they have completed, their individual learning plan, and their intrinsic motivation. Learners will pick up



knowledge and clinical approaches as they go along, in a 'hands on the elephant' format... If you are not familiar with that metaphor, it is that of ten blind philosophers with hands on an elephant all describing what they feel: One might feel a leg and describe it as a tree; one on the trunk might describe a hose; yet another might feel the ear and describe a fan. In this metaphor, Medicine is the elephant and you are but one of the blind men for your learners. Your approach to any given clinical issue may be brand new to them, or it may be building on a great deal of prior learning. It all builds upon their understanding of Family Medicine as a whole and fills in a more complete picture. Each of these moments you spend with them, adds to the whole of their education.

I would encourage you to allow your learners to see your thinking process and to reflect on that from a meta-cognitive perspective. Encouraging them to reflect and think about their thinking will help them improve. Clinical problems very rarely have one right answer; one right course of action that trumps all others. Allowing them to make safe, sound decisions, and follow those through contributes profoundly to their growth.

Whether your learner is in their first or second year they will be expected to attend regularly scheduled academic days. These are program directed and set aside for specific curricular goals. You can expect your learners to be away from your clinical environment on these days. The dates for these events are published annually on the DFM intranet site.

Most preceptors will be very familiar with the CFPC guidance around the '99 topics'. These are a helpful guide for specific clinical questions that arise. There are a number of great archives for learning around these topics on the

web. I encourage you to also check our our chief resident blog here:

<https://www.qfmblog.com/resources>

This is updated regularly with links to learning resources. It can be helpful for both you and your learners. (please do direct your learners there if they are unfamiliar).

### **Milestones document**

It is also a great idea for clinical preceptors to have a look at the following “milestones document”:

<https://familymedicine.queensu.ca/sites/familymedicine/files/inline-files/Milestones.pdf>

This is a living document that was created a few years ago by our current Program Director, Dr. Brent Wolfrom. It is available as a link on the portfolio component of the intranet site as well. It is exceedingly useful when you are uncertain what performance level you should be expecting from your current learner. Of course it is prudent to make a habit of discussing learning objectives with your learner upon their arrival, and expecting them to be as specific as possible, but doing so with this document in mind can be very insightful.

# Chapter 4 - Faculty Development

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## Fundamental Teaching Activities Framework

It falls to you as a ‘teacher’ to work on your ‘teaching’. You should dedicate some time to think, read, and learn about how to be a better teacher. Knowing what bad teaching looks like is not enough. There are skills that can be acquired. There are thinkers who have distilled concepts for you in advance. Tips and Tricks that can be studied. I’m hoping that reviewing the contents of this handbook is a good first step, but be aware that teaching is also a skill that can be taught and improved.

It may feel sufficient to be clinically competent and able to handle clinical tasks but there are ways to make your learners experiences profoundly better. The following resource document defines the core competencies for clinical teaching, makes recommendations about strategies to develop these competencies, and provides a repository of resources and tools that you may find helpful. Please do take a moment to peruse the document:

[https://portal.cfpc.ca/resourcesdocs/  
uploadedFiles/Education/\\_PDFs/  
FTA\\_GUIDE\\_TM\\_ENG\\_Apr15\\_REV.pdf](https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Education/_PDFs/FTA_GUIDE_TM_ENG_Apr15_REV.pdf)

## **Preceptor Roles and Responsibilities**

A few useful definitions:

**GFT = Geographic Full Time.** This designation comes from the time of William Osler at John's Hopkins and was established when it became clear that universities needed a mechanism to compensate some for their teaching activities unrelated to clinical work. A small number of clinical faculty in the Queen's department of Family Medicine are funded this way through the south eastern academic medicine organization. These few faculty currently represent the majority of the educational and research leadership of the program. The department head, the program director, and the research director at our centre for studies in primary care, are examples of some of our GFT Faculty.

**Preceptor** - A teaching health professional (term somewhat unique to the medical profession, other terms often used in other professions).

**Clinical Preceptor** - A teacher working with learners in the clinical setting where patient care is being provided.

**Clinical Coach** - A supervisor of clinical activities who explicitly role models the competencies required in ways that inspire emulation. A coach uses the teaching program's

assessment materials to provide timely feedback on learner performance.

**Competency Coach** - Also called an **Academic Advisor** (or AA), facilitates the planning and career development of the medical learner. They work together with the learner on creating and facilitating work toward achievement of long term goals. At Queen's we call these regularly scheduled meetings "AA Meetings" (which is unfortunate).

## **Medico-Legal thoughts on teaching**

There are 14 "controlled acts" under the regulated health professions act (RHPA) (An Act of Parliament -1991). They are as follows:

### **CONTROLLED ACTS:**

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger, i. beyond the external ear canal, ii. beyond the point in the nasal passages where they normally narrow, iii. beyond the larynx, iv. beyond the opening of the urethra, v. beyond the labia majora, vi. beyond the anal verge, or vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the RHPA.

8. Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

As preceptors and independent clinicians, we are legally qualified to perform these due to the nature of our independent license (as regulated by the CPSO).

As professionals we can do these things because we can attest to having the “experience” and “skills” gained through our training. I.e. We cannot do them if we don't have the necessary experience and knowledge (e.g.#11)... and we are expected to abide by these rules as professionals. Part of what “proves” we have the “experience” and “know how” to do these things is that we have completed a medical degree. Still with me?

In undergrad medicine we learned and practiced some of these things prior to having a license of any kind; and in residency we learned and practiced some while in possession of a “restricted” license. Prior to independent licensure we certainly performed some of these delegated acts. (E.g. Used an otoscope (#6i). Or performing our first IM injection (#5).) How was this possible? Well this CPSO policy allowed it:

<http://www.cpsso.on.ca/Policies-Publications/Policy/Professional-Responsibilities-in-Undergraduate-Med>

This policy allows medical students (including ‘observers’) to “see one, do one”. It essentially places the responsibility and risk on YOU as the most responsible physician. You should *not* allow a medical learner do anything without watching them very closely and being certain you know they are capable and can do it. This usually by giving them some space and time prior to performance to demonstrate their knowledge. You can certainly watch a student use a needle or put on a cast as long as you abide by the guidance in this document. So read the document. It’s on you if anything goes wrong - not the university, not the program, you. (I think you knew that one already though!?)

### **Teaching around medical error**

Mistakes are inevitable in medicine. Most students will encounter some form of error during their training. Developing an approach to recognizing, acknowledging, and disclosing errors is key to becoming a great preceptor: One who is knowledgeable, kind, and reassuring, who knows how to model open and above-board handling of medical mistakes. I encourage you to develop your own approach to teaching this topic now, before it is required. There is a great resource here:

<https://depts.washington.edu/toolbox/errors.html>

You can also find some good guidance at the website of the Canadian Medical Protective Agency, here:

<https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2009/coping-with-an-adverse-event-complaint-or-litigation>

And finally, medicine can learn a lot from the philosophy behind ‘flight safety’ (see: <http://www.rcaf-arc.forces.gc.ca/en/flight-safety/index.page>). The RCAF has maintained a focus on quickly and objectively identifying effective measures to prevent or reduce the risk of the same mistake happening again. They benefit from free and open reporting and voluntary acknowledgement of errors and omissions because they do not assign blame. Their ‘just culture’ is based on decades of learning from mistakes in a manner that allows everyone to operate without fear of retribution.

This is a useful paradigm to frame your thinking about mistakes in medicine. Lay no blame and look for engineering and system controls that contribute to errors recognizing the line between actions that are acceptable and unacceptable (e.g. gross negligence / willful harm / deliberate deviations from standard of care – which are exceedingly rare).



## Teaching Professionalism

Professionalism is certainly the most multi-dimensional and subjective facet of competence. There is a body of knowledge that tries to codify ‘professional’ behaviours that our learners can certainly read and regurgitate, but as instructors we are much more interested in what we can observe; what professional behaviours a learner is demonstrating day to day.

We tend to teach professionalism best via a ‘discipline by example’ approach. As long as we carry on behaving with respect and integrity and showing up on time and getting the job done, we hope that rubs off on our learners. And for the most part it does. For the most part this is sufficient.

However, professionalism breaches do occur and they are one of the most difficult concerns encountered in medical education. These need to be handled with a ‘flight safety’ approach as it is never appropriate to assume an inherent character flaw or personality disorder is the reason for these transgressions. Always begin with an open mind and a ‘no fault’ position.

It is important to understand that behaviours don’t happen in a vacuum. They are influenced by the people and cultural environment around the learner. No one is expected to be perfect at all times. Any repeated unprofessional behaviour that cannot be justified or readily explained is a sign that your learner is not competent in this domain. All we ask is that you recognize these breaches as they happen and do your best to never never pass those faults: examining them professionally and documenting them appropriately (e.g. using field notes or ITERs). More information on this below in the chapter below on “The Learner in Difficulty”.

Our hope is that when an individual can say they are a graduate of our program, this carries with that the implication they are a competent family physician, which includes the idea that they can be trusted to act in a professional manner.

For detailed guidance on what is expected in the professionalism domain see the following college document:

[https://portal.cfpc.ca/resourcesdocs/  
uploadedFiles/Education/Professionalism.pdf](https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Education/Professionalism.pdf)

Also to be found in the above document (please do read it) are the following “Twelve Themes” that Define Professionalism in Family Medicine. (The document further elaborates on them with some specific observable behaviours to ponder):

1. Day-to-day behaviour reassures one that the physician is responsible, reliable, and trustworthy.
2. The physician knows his or her limits of clinical competence and seeks help appropriately.
3. The physician demonstrates a flexible, open-minded approach that is resourceful and deals with uncertainty.
4. The physician evokes confidence without arrogance, and does so even when needing to obtain further information or assistance.
5. The physician demonstrates a caring and compassionate manner.
6. The physician demonstrates respect for patients in all ways, maintains appropriate boundaries, and is committed to patient well-being. This includes time management, availability, and a willingness to assess performance.
7. The physician demonstrates respect for colleagues and team members.
8. Day-to-day behaviour and discussion reassure one that the physician is ethical and honest.
9. The physician practices evidence-based medicine skillfully. This implies not only critical appraisal and information-management capabilities, but incorporates appropriate learning from colleagues and patients.
10. The physician displays a commitment to societal and community well-being.
11. The physician displays a commitment to personal health and seeks balance between

personal life and professional responsibilities.  
12. The physician demonstrates a mindful approach to practice by maintaining composure/

equanimity, even in difficult situations, and by engaging in thoughtful dialogue about values and motives.

## **A Primer on Primary Care Research**

Each resident in our program completes a research project over the course of their two years. They receive some training on the format and expectations before the end of their first month (bootcamp) and should be thinking about their project right away. These projects, by virtue of the timeline, need to be somewhat limited in scope, but our hope is they each complete a short dissertation in the form of an article for publication. This may be a scoping review or critical appraisal of a topic of interest, or it may include some form of research, health advocacy, or ethics project of some kind. They receive some guidance as they go along from the faculty and staff at the Queen's Centre for Studies in Primary Care.

<https://www.queensu.ca/research/centres-institutes/centre-studies-primary-care>

Some learners may approach you about a topic or about being their research supervisor. There is a short faculty development session put together by our research team that will be helpful for you to attend but you may also reach out if you have any questions. Increasing the scholarly and research capacity in our region is always a key priority for your department of family medicine.

## **Chapter 5 - Preparing Your Practice for Clinical Teaching**

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As a new staff physician in any clinical setting it may take some time to feel settled into your routine let alone prepared for learners. Preparing your office for learners can be daunting and challenging on top of all of that... Here are some tips that may be helpful:

1. Ask yourself how best to welcome your learner into the office. What might they need? What changes might need to be made? Are there activities being performed by colleagues or staff they might benefit from observing?
2. Review the milestones document (above) and review the learner's personal objectives and learning plan (if they have one). If they haven't provided one, consider asking them for one in advance.
3. Prepare your colleagues and staff for the learner. Inform them of the learners goals. Staff may be able to help prepare patients for interacting with your learners.

4. When your learner arrives, take time to give them a tour and introduce them to key personal.
5. Provide them with a small workspace that is their own for the day, if at all possible.
6. Facilitate their access to your electronic medical record in advance of their first day, if possible, and give them their patient list in order for them to prepare.
7. Notify patients in advance, if possible while they are making their appointments, or, when they first arrive in the office.
8. Post signage in the waiting room and clinic spaces announcing the presence of the learner.
9. Introduce the learner formally where feasible.
10. Be sure to thank your patients for their participation in the learners education.
11. Save time for feedback and meta-cognition where possible.
12. Give Feedback. Label this as feedback. Ask them what was good about the day and what would they change for the next time.

It is helpful to think back to some of your best and worst experiences during your clinical learning phase and try to incorporate what you felt was helpful for you. Recall how learning happens and that, as an expert, much of your tacit knowledge and procedural skills have become automatic; consider taking a pause to break down your thinking and describe your steps wherever you can. Depending on the task, consider utilizing some form of scaffolding (removing individual support in a staged fashion once previous skills are mastered). Consider reading around the educational concepts of spaced repetition, intermittent reflection, and thoughtful testing and incorporate these wherever possible.

## **Chapter 6 - International Medical Graduates (IMGs)**

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Ontario offers about 200 entry level post-graduate training positions to IMGs annually. Family Medicine programs offer the bulk of these positions and our program currently offers 10. There are very strict entrance requirements, a return of service obligation, and some demanding hurdles to entry including multiple standardized test and strict language requirements. You can rest assured that the effort and scrutiny they have endured to get to be learning in your clinical environment has been thorough and exacting. You are expected to assess them the same way you would any other medical learner.

You should be aware of a few differences between IMGs and CMGs (Canadian Medical Graduates), specifically with respect to the initial portion of their training. Due to the need for assessment and verification of their readiness for residency, there is an increase in scrutiny in the first twelve weeks of their training program. In our program, all of this currently takes place at the KTI site at the Queen's Family Health team (QFHT).

IMGs also benefit from a short 'Pre-Residency Period' (PRP) of instruction. This includes a didactic

portion run by the touchstone institute in Toronto that includes a variety of topics related to the practicing medicine in Ontario. Information on this program can be found here:

<https://touchstoneinstitute.ca/learning/pre-residency-program-family-medicine/>

As well as a Part 2 portion of their PRP which takes place in June at the QFHT. Here they are introduced to their PGY1 learning environment in a three week observership that prepares them for entry into the program come July 1st. Recent experience has shown this portion puts them at ease and gives them some advantages over their CMG counterparts in terms of comfort and familiarity come July first. Our efforts to create a welcoming learning environment seem to be appreciated.

During their PRP they are considered ‘undergraduate medical learners’ and their activity is regulated by the CPSO policy on undergraduate medical education. They are aware they do not have a medical license to perform controlled acts. Any performance of controlled acts during PRP (e.g. placing a speculum in an external auditory canal) will only be performed under the direct supervision of a preceptor who is watching, is confident in their ability (which is up to them to gain, through the prior demonstration of knowledge and necessary skill).

After July 1st, they enter a 12 week period of daily assessment which is high stakes for them. During this AVP (Assessment and Verification Period), we are charged with determining their readiness for work at the PGY1 level (see above milestones document). At this stage they hold a

restricted medical license from the CPSO which doesn't really change much of our obligation as supervisors, but redistributes some of the medicolegal risk in that they can lose that license and be removed from training.

Overall a very high percentage of our IMGs are successful in their AVP and seamlessly migrate into the remainder of their 2 year family medicine residency program. After successful completion of AVP their program is indistinguishable from that of the other residents. More information can be found here:

[https://familymedicine.queensu.ca/academics/  
imgs](https://familymedicine.queensu.ca/academics/imgs)



## Chapter 7 - The Learner in Difficulty

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In general, difficulties affecting learner performance fall into three overarching categories: Academic (knowledge/skills), Environmental (learning conditions/situation/exposure to stressors/lack of available support or supervision/interpersonal conflict), and Professional (attitude/personality/workload/teacher/system).

It is important to keep an open mind and approach each occurrence of substandard performance with compassion, openness, and flexibility. Be ready and flexible to adjust your frame of reference, think broadly about causes, and be vigilant for signs and factors affecting your learner that may be other than your first inclination.

Sub-standard performance can quite rarely be assigned to such simple a cause as a disturbing lack of motivation, gross negligence, or a shortfall in professionalism. More often than not these relate to systems issues such as inconsistent supervision, overwhelming workload, personal stress outside of the workplace, or mental health concerns. It is important that you take a step-by-step approach to developing an understanding of your learning support, and seek out guidance if this needs to evolve. Start

by acquainting yourself with the learner resources available through learner wellness at Queens. The following is a useful resource to consider reviewing:

[https://healthsci.queensu.ca/source/Learners\\_In\\_Difficulty.pdf](https://healthsci.queensu.ca/source/Learners_In_Difficulty.pdf)

Having an understanding of how learners progress through challenges is also helpful. One useful model of learning to consider is the four stages of competence model:

*Stage 1: Unconsciously Incompetent. At this stage learners do not know what they do not know or what they might need to know. They may deny the usefulness of the skill. They must recognize their own incompetence and value the new skill before they can move to the next stage.*

*Stage 2: Consciously Incompetent. Here they recognize their own deficiencies, value their mistakes, and work to move to the next stage.*

*Stage 3. Consciously Competent. Here they understand and know how to complete the skill but they still require a great deal of focus and concentration and attention paid to the steps. A heavy conscious involvement is required to execute the new skill.*

*Stage 4. Unconsciously Competent. Here the experience and practice has led to a point where the skill is 'second nature' and performed with ease. They may be able to perform the skill while doing other things and thinking about other things and are prepared to teach the skill to others.*

Another useful model is used commonly in the internal medicine world is the RIME model, which stands for Reporter, Interpreter, Manage, and Educator. A detailed description of this model can be found here:

<https://deptmed.queensu.ca/sites/deptmed/files/inline-files/RIME%20Model%20for%20CBD%20in%20Internal%20Medicine.pdf>

## **Academic Support**

The residency program has a number of resources for academic support, both in person and online. At all times there is a faculty member assigned to the role of “Academic Support Person”. This person usually maintains an up to date list of clinical teaching resources for helping with residents in difficulty. They are also usually quite helpful in diagnosing the learning difficulty, which sometimes not very straight forward. They also usually have some time set aside for clinically observing in your practice if need be. You can request this assistance through your program site director.

## **Resident Assessment**

The scholarship and research behind competency based education is quite robust and growing. A great deal of work has gone into understanding how best to assess and maintain a portfolio on candidate learners. The white paper on assessment objectives for certification in family medicine can be found here:

<https://www.cfpc.ca/en/education-professional-development/educational-frameworks-and-reference-guides/evaluation-objectives-in-family-medicine>

At Queen's our learners use an 'ePortfolio' that compiles both objective and reflective assessments. Each resident has an 'academic advisor' (AA) (Still hoping this gets changed to 'clinical coach') whose role includes ensuring this ePortfolio is maintained and up to date. It is important to ensure residents are receiving regular objective feedback in the form of field notes.

As a new preceptor you will have been provided a login to the DFM Intranet at << [intranet.dfm.queensu.ca](http://intranet.dfm.queensu.ca) >> where you can find a link to the portfolio and assessment tab. Field notes can be accessed there. There is also a field note app under development that promises to streamline this process for you in the future. Please do familiarize yourself and take the short time to fill one or two out after each clinic. Not only will you learners appreciate it, but our model of assessment depends on it. Without regular formative assessments of the learner in the workplace we cannot pass or fail candidates in our program.

We encourage one 'field note' for every half day of clinical activity. Picking upon one item that was done particularly well, one item that was made as a suggestion for improvement, and/or one item that was done particularly badly requiring correction, and documenting those in a simple field note goes a long way to allowing the program to formulate a picture of progress.

You may also be asked to complete summative reports on progress in the form of ITERS (In-Training Evaluation

Reports). These are generally requested at the mid point and end points of a rotation. It is very important that they be completed on time and that the learner has an opportunity to receive this timely feedback about their progress. We rely heavily on you in this capacity to pay close attention to the timing and delivery of these ITERs as they are essential to maintaining a fair, equitable, and successful assessment process.

## **The Remediation Process**

Failure does happen. You as the clinical expert preceptor can determine that you do not feel your learner has met the standard for completion of their clinical rotation. You should be aware of the steps involved, in general, and seek more education in this area if you are to be involved in a remediation process.

Firstly, to reiterate, this process depends on regular, if not daily, formative assessments accompanied by regular performance reviews to allow reflection on progress and modify training as necessary. If this was not in place prior to and at the time of a ‘failed ITER’, the assessment committee invariably will not allow the ‘failure’ to stand on process concerns. This does not mean the candidate gets a pass. It usually means an extension of a training block is required, but funding concerns come into play here so it is imperative that we maintain our robust feedback processes. Extension is usually the outcome in these instances.

You should be aware that any field notes that are ‘flagged’ for program review, even prior to a failed ITER, are brought to the resident assessment committee which includes a small group of assessment and educational experts who will look at the incident objectively with an eye for what

may have been overlooked in the process and what may be put into place to support our learners. A wellness check and a check on the engineering controls and quality insurance process is invariably involved at that stage. Our goal is successful effective professional competent physicians at the end and these flags are helpful to ensuring all necessary supports are mobilized.

A failed ITER that meets appropriate process requirements will lead again to an assessment committee review involving both the resident and their clinical coach / academic advisor. If the failure goes forward a remediation process ensues that is somewhat higher risk for the learner in that a possible outcome is a failure of the program. A learning plan is put in place and supports are mobilized. Our program prides itself on having robust systems to support learners and their assessment in these situations. Much more information on this process can be found here:

[https://meds.queensu.ca/academics/  
postgraduate/current/policies/apa](https://meds.queensu.ca/academics/postgraduate/current/policies/apa)

# Chapter 8 - Queen's Department of Family Medicine

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## Department Structure

The department of family medicine is quite a complex organization with multiple departments that collectively provide leadership in family medicine education, research, advocacy and social accountability.

*“We are Family Medicine. For Learners. For Patients. For Communities”.*

Dr. Michael Green currently leads our department as head and oversees multiple divisions including administrative, clinical, research, education, and global health groups.

Department annual reports and strategic plan can be found [here](#):

<https://familymedicine.queensu.ca/familymedicine/familymedicine/familymedicine/familymedicine/familymedicine/familymedicine/administration/strategic-annual-reports>

## **Advancing your career**

All preceptors in the department of family medicine should hold an adjunct assistant professorship at Queen's University. Reach out to the program for support in applying for yours if you have not already.

A helpful overview of academic rank in Canada can be found on wikipedia, here:

[https://en.wikipedia.org/wiki/Academic\\_ranks\\_in\\_Canada](https://en.wikipedia.org/wiki/Academic_ranks_in_Canada)

Queen's specific information on adjunct academic staff and academic assistant appointments can be found here:

<https://www.queensu.ca/secretariat/policies/senate/statement-adjunct-academic-staff-and-academic-assistants>

The most recent policy guidelines for the faculty of health sciences at queen's can be found here:



[https://healthsci.queensu.ca/source/  
Academic\\_Appt\\_Guidelines.pdf](https://healthsci.queensu.ca/source/Academic_Appt_Guidelines.pdf)

The health sciences statement on promotion for GFT and Adjunct-1 appointees can be found here:

[https://www.queensu.ca/secretariat/policies/  
senate/health-sciences-statement-promotion-  
policy-geographically-full-time-and-adjunct-1](https://www.queensu.ca/secretariat/policies/senate/health-sciences-statement-promotion-policy-geographically-full-time-and-adjunct-1)

## **Teaching Dossier**

For those clinical preceptors intending to focus their medical careers on academics, having a teaching dossier is a must. This is a living document that exists to categorize ones teaching philosophy, strategies, experiences, and effectiveness (evaluations and feedback). It is useful for summarizing teaching activities when applying for academic appointment and or promotion. One useful resource on the development of a teaching dossier can be found here:

[https://www.queensu.ca/ctl/teaching-support/  
teaching-dossier](https://www.queensu.ca/ctl/teaching-support/teaching-dossier)

## Chapter 9 - Contacts

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Queen's Department of Family Medicine is located in Kingston at 115 Clarence St on the corner of Clarence and Bagot. Telephone: 613-533-9300.



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3. John Biggs. Constructive Alignment in University Teaching. Accessed at: [https://tru.ca/\\_shared/assets/herdsa33493.pdf](https://tru.ca/_shared/assets/herdsa33493.pdf) March 2020.
4. See also all of the links throughout the body of this text which were useful resources in the preparation of this booklet.