P-01	**A Full-Year Integrated Community-Based Clerkship** *Joan Fraser, Gordon Page, Jean Jamieson, Joanna Bates, University of British Columbia*

In 2004, UBC increased its medical class size from 128 to 200. In 2006 these 200 students will enter their clerkship program and will be accommodated through the development of new clerkship models and sites distributed throughout B.C. Pilot programs at new clerkship sites have been initiated. One progressive pilot program is in Chilliwack, a community of 80,000 people 120 km from Vancouver. In 2004-05, six third-year students will spend their entire clerkship year in Chilliwack in a community-based integrated program, modeled on the Parallel Rural Community Clerkship in South Australia. Four research initiatives have been carefully developed to study the comparative effects of the Chilliwack clerkship on: (1) student achievement, (2) student experiences, career choice, and study preferences, (3) clinical preceptors, and (4) other health professions and the community in general. This poster will describe the planning, design, implementation and evaluative research plans for the Chilliwack integrated clerkship.

P-02	**Learning Directed to Meeting Community Needs: Socially Accountable Educational Initiatives of the Department of Academic Family Medicine, University of Saskatchewan** *Alanna Danildewich, Meredith McKague, Katherine Lawrence, Sall Mahood, University of Saskatchewan*

The social accountability of medical schools refers to ".. the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve." (WHO 2000)
The Department of Academic Family Medicine at the University of Saskatchewan is involved in numerous activities that help to address priority health needs of underserved communities within Saskatchewan. This poster will outline the WHO and AFMCÆs Social Accountability framework, and will provide specific examples of how this framework is being applied through educational activities with which the Department is involved. Examples from our rural training initiatives, interdisciplinary collaborative primary health care sites, and urban health programs will be highlighted. The goal of this poster is to stimulate discussion about the myriad ways in which medical schools and their departments can participate with communities in responding to societal needs.

P-03	**Éducation médicale hors les murs : deux campus extérieurs pour Sherbrooke en 2006** **Distributed medical education: two outside campuses for Sherbrooke in 2006** *Paul Grand'Maison, Aurel Schofield, Mauril Gaudreault, Réjean Hébert, Université de Sherbrooke*

Faisant face à une augmentation de 100% de ses cohortes d'admission de 1999 à 2006 et prenant exemple sur des projets similaires au Canada, la Faculté de médecine de l'Université de Sherbrooke offrira l'ensemble de son programme MD dans deux campus extérieurs : l'un au Saguenay/Lac-St-Jean; l'autre à Moncton, Nouveau Brunswick. De 16 à 24 étudiants seront admis chaque année dans chacun des campus. Les responsabilités administratives et éducationnelles seront partagées entre les partenaires dont une université dans chaque région, un hôpital affilié universitaire, d'autres institutions de santé, des médecins et la communauté. Le soutien gouvernemental sera assuré. En plus de développer une compétence médicale générale, les gradués acquerront des compétences particulières pour le travail en régions rurales et périphériques. Cette approche permet de relever les défis d'une formation optimale pour les régions et du recrutement/rétention de médecins dans celles-ci. Elle représente un ultime exemple d'éducation médicale hors les murs et de partenariat.

In order to respond to a 100% increase in its admission positions from 1999 to 2006 and following similar examples in Canada, the Faculty of medicine, Université de Sherbrooke, will offer its entire undergraduate MD program in two outside campuses: one in Saguenay/Lac-St-Jean, the other one in Moncton, New Brunswick. From 16 to 24 students will be admitted each year in both campuses. Administrative and educational responsibilities will be shared among partners including one university in each region, a university affiliated hospital and other health care institutions, physicians and community. Governmental

support will be ensured. Further to the development of a general competence in medicine, graduates are expected to acquire the necessary competencies to work in peripheral and rural regions. This approach responds to the challenges of optimal education for these regions and of recruitment/retention of physicians in these. It represents an ultimate example of distributed medical education and partnership.

P-04	**Distributing a Medial Curriculum in BC: The Vancouver Island Perspective** *Mary Kay Nixon, Oscar Casiro, Catherine Gaul, Margaret Fonger, Steve Martin, University of British Columbia and University of Victoria; Gordon Page, University of British Columbia*

The Island Medical Program (IMP) at the University of Victoria is one of two distributed sites for the University of British Columbia Faculty of Medicine expanded medical program which was implemented in August 2004. The 24 IMP medical students spend their first term at UBC in Vancouver, and then complete the remainder of their four-year education on Vancouver Island.

The process of building a new team of leaders and educators and implementing a distributed medical curriculum in a new community presents unique challenges. The IMP directors for Foundations of Medicine, Clinical Skills, Family Practice, and Doctor Patient and Society courses, and other key players were surveyed. Expected and unexpected challenges that presented, and key strategies that were felt to be effective in overcoming these challenges will be discussed in the context of each individual's role and responsibilities in the pre implementation and early implementation phases of the IMP curriculum.

P-05	**Involving generalists in Biochemistry teaching for senior medical students: removing departmental barriers, easing curricular congestion, and much more** *Chris. Grant, University of Western Ontario*

At Western, the Department of Biochemistry introduced a Basic Science course that teams 4th Year medical students with volunteer Family Medicine residents and a faculty anchor person in a series of 50-minute case discussions highlighting molecular medicine issues. Participants examined clinical cases encountered in primary care, while considering their collective molecular diagnostic and therapeutic experiences in related situations. We hypothesized that such a course would interest Family Medicine oriented undergraduates and expose them to dynamic primary care role models. Interestingly, students who chose the course were found to comprise a disproportionately high representation from the graduating class' specialty-oriented members. Family Medicine residents were an eager and highly successful teaching resource; and the interdepartmental collaboration resulted in a summative resource base not available to either department on its own. Moreover new emerging issues in health care were readily incorporated into the curriculum alongside more traditional topics.

P-06	**The Decreased Interest in Family Medicine: What Medical Students Think** *Vishal Avinashi, Canadian Federation of Medical Students*

Recent trends show that fewer medical students are selecting family medicine as a career. As the number of people without a family doctor grows and as the age of the average family doctor approaches retirement age, the overall picture looks bleak. These frightening trends warrant immediate and appropriate attention, as the strength of our health care system is dependent on solid primary care. As young members of the healthcare workforce, the Canadian Federation of Medical Students (CFMS) would like to work towards attracting young minds to the evolving and exciting field of family medicine. In the poster, we identify commonly held perceptions and discuss stresses that likely affect medical students' career choices, such as early decision pressure and debt loads. More than just identifying barriers, the CFMS offers constructive recommendations on how to improve recruitment to the field of family medicine.

P-07	**Canadian Specialty Profiles - Data from the 2004 National Physician Survey: A Work in Progress** *June Harris, Memorial University of Newfoundland*

The 2004 National Physician Survey, recently conducted as a collaborative project by the CMA, CFPC, and RCPSC, has information that will be compiled to inform students about practice in the various

disciplines across Canada. Aspects of these specialty profiles include such parameters as work setting, practice profile, services provided, conditions treated, time allocations, and professional satisfaction. The aggregate data will be accessible to students who are members of the CMA. Students will be able to match their profiles with those of physicians in the various specialties. The data will strengthen the career guidance and planning resources available to Canadian medical students by helping them make better-informed decisions about their residency selection in advance of the CaRMS match. Having specific information on Canadian medical specialties that can be easily updated may have other benefits and allow for the tracking of trends across disciplines

P-08	**Personality Type and Medical Specialty Choice at the time of the Match [CaRMS]: A Review of Canadian Students** *June Harris, Memorial University of Newfoundland*

A prospective online survey will link Canadian personality typing data of current medical students with their future residency choice. First or second year Canadian medical students receive an access code to a web page and are asked to complete the online Keirsey Temperament Sorter II. A report is immediately generated for the student and the type result is e-mailed to the principal investigator. When the students are ultimately matched by CaRMS the anonymized personality type information will be linked with their respective specialty choice. At the end of the survey, the aggregate information will form a resource so that students applying for residency can match their personality type to those of residents in each of the various specialties. Currently, no data of this kind are available for Canadian students. This will broaden the career guidance resources available to Canadian medical students as they plan for residency in advance of the CaRMS match

P-09	**Evaluation of a Physical Examination Learning Aid - Linking Undergraduate Needs and Postgraduate Learning** *Anne PausJenssen, Sharon E. Card, Heather Ward, Lori Mamchur, Jill Newstead-Angel, Meredith McKague, University of Saskatchewan*

The University of Saskatchewan Professional Skills course employs clinical preceptors to teach fundamental clinical skills to first year medical students in small groups.

Past student feedback indicated a need for standardized and evidenced based objectives for physical examination techniques. Developing these objectives was seen as an important educational opportunity for 4th year general internal medicine (GIM) residents as it involved CanMeds competencies (communicator, collaborator, scholar and medical expert). Along with faculty, GIM residents developed a learning aid made up of two components: a document specifying objectives for each part of the physical examination, and a checklist for students to document mastery. The aid will be introduced in the 2004-2005 academic year.

This poster will review the results of the perceived effectiveness of this aid by both the 1st year students and the clinical preceptors. The perspectives of the impact on the education of the GIM residents will also be explored.

P-10	**Clinical Nurses as Tutors For Medical Students During Problem Based Learning at Université de Montréal.** *Marcel Julien. , S. Normand , J. Delorme, M. Sauvé, M.N. Bélanger, André Ferron , Raymond Lalande, Université de Montréal.*

Problem based learning (PBL) in medicine with a teacher/student ratio of 1/8 in small group sessions was implemented at Université de Montréal in 1993. Because of a planned increase in the number of medical students in the years to come, a trial was made to test the possibility of utilising clinical nurses with a bac degree, along with MDs, to supervise students during PBL sessions. Two nurses thus supervised two small groups of 8 students each (F=10, M=6) for 8 problems concerning the respiratory system.and were compared to 19 similar groups supervised by MDs At the end of the session, nurses were evaluated by a focus group of students from the 2 groups and from the rest of the class, also the knowledge and attitude scores of students in the two groups supervised by nurses were analysed and compared to the results

obtained by students from the rest of the class. Although the nurses involved in tutoring PBL activities for pregraduate students in medicine were apreciated for their inerest and motivation and although the knowledge and attitude scores of the students supervised by the nurses were not different than the rest of the class, students in general prefered being supervised by an MD.. We believe this is because of the "role-model" effect during the supervision of PBL activity.

P-11

Evaluation Study of Online Continuing Medical Education

Vernon Curran, Lisa Fleet, Fran Kirby, Memorial University of Newfoundland; Jocelyn Lockyer, University of Calgary; Joan Sargean, Dalhousie University

This poster will report on the preliminary findings of an evaluation of MDcme.ca – a Web portal which provides physicians with access to Web-based continuing medical education (CME) and resources. An evaluation research study, supported by the Atlantic Canada Opportunities Agency, Atlantic Innovation Fund, is underway to examine the effectiveness of these CME courses and to identify means for enhancing the quality of learning which is facilitated in online CME learning environments. Participant satisfaction and confidence, as well as self-reported changes in practice, are measured. Evaluation methodologies include the collection of registration data, pre-and post-confidence surveys, and course evaluation surveys, as well as participant and facilitator interviews. MDcme.ca is the main component of the Electronic Rural Medicine Strategy (TERMS), a national professional development strategy for enhancing the retention of rural and remote physicians. It is designed and developed in collaboration with a number of partners and university-based CME departments across Canada.

P-12

Faculty Development Programming: An Effective Developmental Framework

Ivan Silver, Amy Dionne, University of Toronto

The coordination and growth of an effective faculty development program requires support from administration, seamless integration of new and existing programs, a curriculum which targets a broad spectrum of faculty interest, as well as a means by which to measure outcome effectiveness.

Over the past two years, we have developed and refined an integrated instructional development and teaching scholarship framework to guide innovative and meaningful opportunities for an interprofessional Faculty û leading to the early application of theory to practice.

We are providing faculty with a tiered program grid ranging from stand-alone grand rounds presentations and workshops to certificate programs focused on instructional development, educational scholarship, and educational leadership and masters level education programs.

Informal feedback and early outcome measures indicate that faculty are sampling our programs, find them to be immediately relevant to practice, and are progressing through our tiered programming model.

P-13

Synthesizing the reports on teaching prevention and community health: is there common ground?

Ian Johnson, Niall Byrne, Katherine MacRury, University of Toronto

Faculties of medicine are being encouraged to make their undergraduate curricula based on community needs (Edinburgh Declaration, 1988), and be socially accountable (ACMC, 2004). The latter includes one component of being socially accountable in terms of medical education. In addition the outbreak of SARS in 2003 focussed attention on the need for training in public health, prevention and population health. The Association of Teachers in Preventive Medicine has established a set of standards for teaching clinical prevention. Recently the Institute of Medicine has recommended increased emphasis on the social and behaviour aspects of medicine (IOM, 2004). These concepts may not be clearly understood or articulated in terms of the practice of community health. In fact, many medical schools may feel pulled in different directions as a result of these various reports. In this poster presentation, the authors explore the meaning and application of these concepts to undergraduate medical education. The implications for undergraduate medicine curricula are discussed.

P-14	**Change in Scope of Practice: Evaluation of Scope of Practice and What Constitutes a Change in Scope** *Dale Mercer, Queen's University; William McCauley, University of Western Ontario; Elizabeth Wenghofer, Daniel Klass, College of Physicians and Surgeons of Ontario*

Physicians in Ontario must limit their scope of practice to areas in which they are trained and experienced. In November 2000 CPSO approved a Change in Scope Policy requiring physicians to notify CPSO of any intended change of scope. To implement this policy the Quality Assurance Committee must define and determine both scope of practice and change in scope of practice. The adopted process examines the background experience and training of physicians, the context of current practice data based upon types of patient encounters, and system factors such as practice locale and resource availability. The same factors are assessed for the proposed practice. The comparison allows the estimation of the degree the practices will differ in these dimensions. The difference is used to determine what form and degree of enhancement will be necessary to address any significant gaps and ensure the ongoing safety and efficacy of practice.

P-15	**Physician Registration By Assessment** *Daniel Faulkner, Elizabeth Wenghofer, Blair Ferguson, Daniel Klass, College of Physicians and Surgeons of Ontario*

The CPSO has embarked upon a pilot project to explore the use of performance assessments to supplement more traditional information when making decisions about applicants for medical licensure. Medical Regulatory Authorities have traditionally relied upon credentials to make decisions about candidates for licensure. But the question has always existed: when does a credential which gives evidence of having completed a training program or having passed a test of knowledge become stale? In the absence of alternatives, a certificate of good standing from a regulatory authority has been the proxy for continuing competence. In today's environment of heightened accountability, more convincing evidence is needed. Direct or indirect assessments of performance are of growing utility in medical education and training programs, and assessments of physician performance in practice are being used in a variety of practice settings. Using tools that have been validated in the assessment of practicing physicians in Ontario, CPSO is using direct practice performance assessments to provide evidence needed to assure the competence of physicians who otherwise might not meet the usual credentials based standard of entry to practice. We believe this to be the first systematic use of practice performance assessment to help make entry to practice decisions.

P-16	**Gender, Sex and Sexuality Education in Ontario Medical Schools** *Amy Andrews Alexander, McMaster University; Robin Williams, Aleks Mineyko, Queen's University*

Issues faced by people who identify as gay, lesbian, bisexual, trans-gendered/sexual, queer and intersexed (GLBTTQI) are rarely addressed by North American medical school curricula. The Gender, Sex and Sexuality web-based learning module outlined in this presentation is an effort to introduce Ontario medical students to the concepts they need to understand in order to provide quality care for GLBTTQI patients.

The goal of this module is to sensitize physicians to concepts of sex, gender and sexuality and the ways in which these interact with other social determinants of health. It uses a variety of methods (quizzes, case studies, interactive games) to encourage students to question their beliefs and to reflect on how biases affect the physician-patient relationship. The module was developed as a series of reusable learning tools that medical schools can incorporate into their curricula and that students can access, in whole or in part, to supplement classroom learning.

P-17	**Beyond cultural competence: Culture and diversity in medical education** *Ann MacLeod, Blye Frank, Dalhousie University*

Considering the wide diversity of the Canadian population and the current movement in Schools and Faculties of Medicine across Canada to become socially accountable institutions, well-intended

educational initiatives have been developed to prepare future physicians for practice with a diverse patient base. Most prevalent among these educational interventions has been training for ôcultural competence;ö however, this approach has been critiqued in medical education and educational literature, more broadly (Taylor, 2003; Wear, 2003; Nunez 2000) for being considered a curricular "add-on" often taking the form of "a half day workshop in sexuality" or "Cultural Diversity Day," for example, rather than being thoughtfully and thoroughly inter-woven into medical education curricula. This poster presentation will explore the present prevalence of the cultural competence method in medical education and offer possibilities for moving beyond this approach.

P-18	**Access to Library Subscriptions in a Distributive Model of Medical Education** *Benjamin Chen, Eugene Dagnone, Suzanne Maranda, Matthew Simpson, Queen's University*

As medical curricula distribute into distant sites, learners and teachers legitimately demand to have reliable, immediate, and ubiquitous access to online resources to support self-directed learning and evidence-based medicine. Access to a university's library subscription services can be especially problematic, since the access is generally restricted to local computers on the university network (as defined by IP addresses). We present an innovative, economical, and user-friendly solution that is superior to conventional solutions using proxy servers or virtual private networks.

P-19	**Standardized patients as assessors: reliability, validity and cost-effectiveness** *Phaedra Bennett, Sabine Clifford, George Pachev, Santiago Toro-Posada University of British Columbia.*

With the transition of the University of British Columbias (UBC) medical program to a distributed model, the feasibility of using standardized patients (SP) as assessors was explored as a means for alleviating costs and the burden on faculty time. Six additional standardized patients were recruited and trained, each for one of six history-taking stations of the third-year OSCE. These SP were then present in the room during the examination along with the faculty-examiner, and completed the same assessment form as the faculty-examiners. Results from SPs assessments were analyzed for internal consistency and for relation to the marks yielded by faculty-examiners. Costs for training and assessment were compared to the current costs for faculty examiners. Results are discussed in relation to improving the training program for SP assessors in order to achieve results comparable to those yielded by faculty-examiners.

P-20	**Evaluating the effects of changes to a clinical clerkship schedule** *George Pachev, Marc Broudo, Santiago Toro-Posada, Joan Fraser, University of British Columbia*

The proposed poster describes the results from analyses conducted to evaluate the effect of changes in the clerkship schedule at the University of British Columbia and the recommendations that followed these analyses.
Two main changes were introduced in the UBC clerkship schedule for year 2003-4: (i) two clerkships (Obstetrics/Gynaecology and Psychiatry) duration was reduced by two weeks in order add a new self-directed elective, and (ii) the flow of the rotations was altered, the 8 week rotations (Interrnal Medicine, Paediatrics, and Surgery) being back-to-back, creating a 6 month divide in the year. The effect of changes was evaluated by means of

1. A comparison of program evaluation results.within academic year and between (previous and current) academic years.
2. A comparison of student marks, between groups and with those of previous years.
3. An analysis of elective choices.

P-21	**Interprofessional Continuing Education as a Catalyst for Developing Rural Palliative Care Communities: a Ten Year Reflection** *Pippa Hall, Lynda Weaver, University of Ottawa*

The poster will demonstrate our evolutionary cycle of meeting two rural regions' educational needs in

palliative care and the catalysts that moved the education forward from 1994-2004. A 4-stage Systematic Educational Planning model was used: conduct a needs assessment, develop learning objectives, identify appropriate learning methods, and create an evaluation strategy. Traditional seminars and workshops no longer were appropriate after 1999. A progressively decentralized approach to local control and decision making for effective education methods was required. With guidance from our educational team in Ottawa, each of the 8 rural towns involved developed a Community Education Project (CEP). The significant common outcomes for the CEPs are:
1.Strong, interprofessional palliative care teams now exist in each community
2.CEP teams have learned from each other's successes and challenges, have adapted other CEPs for their own communities, and shared resources
3.Community awareness (professional and public) of palliative care services in each community has improved.

P-22	**Fanning the embers of interprofessional education: learning from each other.** *Pippa Hall, Susan Brajtman, Lynda Weaver, University of Ottawa*

The glowing embers of interprofessional (IP) education along the continuum of professional education are currently benefiting from a zephyr of enthusiasm, opening new opportunities for creative learning activities and educational research. The goal of effective IP learning is to enhance health care professionals' abilities to provide collaborative patient-centred practice. This workshop will provide a forum to share approaches being explored by educators for curriculum changes in professional degree faculties across the country.

At the end of this workshop, participants will be able to:
1.Discuss IP approaches to developing an IP curriculum
2.Exchange ideas for creative learning activities that can enhance IP learning
3.Discuss IP curriculum content
4.Explore barriers and enablers to curriculum changes and acceptance
5.Discuss approaches to the evaluation process of IP education

Rationale:
The recent call for proposals for the Health Canada Initiative, Interprofessional Education or Collaborative Patient-Centred Practice (IECPCP) has challenged each university to look at its curriculum for professional degree students and assess if health professional students are learning the knowledge, skills and attitudes that will be needed in our evolving health care system. There is an assumption, which still needs to be studied, that the provision of care by an effective interprofessional team is more effective and more cost-efficient than the current model being experienced in the community. By the time of the conference, awards for the first cycle of proposals will have been announced. This is a timely opportunity to share our ideas and experiences as the projects begin to evolve.

Format:Brief presentation, followed by small group work and large group discussion.

P-23	**From Innovation to Publication: Writing for Publication in Medical Education** *Yvonne Steinert, Peter McLeod, Stephen Liben, Linda Snell, McGill University*

Although educational innovations in medical education are increasing in number, many medical educators are not submitting reports of these initiatives for publication, and many good ideas are not being shared. This faculty development intervention, designed to assist medical teachers write about their innovations, consisted of three components: a half-day workshop on writing for publication in medical education; a follow-up peer-writing group; and independent study, guided by a self-instructional workbook. One year later, 4 of the 24 participants had submitted an article for publication; 8 were preparing a manuscript; and 6 had completed abstracts that were accepted for presentation at medical education meetings. In addition, participants highly valued the small group discussions, individual consultations, and self-study workbook, which they shared with colleagues. Based on early results, we conclude that a faculty development intervention, consisting of workshops and peer writing groups, is a useful approach to promote publication about educational innovations.

P-24	**Faculty Development: A tool for research capacity building** *Miriam Boillat, Laura Shea, Yvonne Steinert, McGill University*

Faculty Development in our Department has traditionally focused on teaching, learning and evaluation. It can also be used as a tool for research capacity building which encompasses the application of research knowledge to clinical practice, stimulation of new research and research methodology training.
Unique challenges inherent in designing Faculty Development to target research include: conducting a needs assessment that generates interest and optimizes response, finding strategies to promote faculty buy-in, and selecting appropriate educational methods and strategies.
This poster will present a work in progress in the McGill Department of Family Medicine, as we broaden the mandate of Faculty Development to include research training in primary care. It will be designed as an interactive poster in order to solicit participant input with the hope of providing a valuable forum for exchange of ideas, experiences and insights.

P-25	**Protecting curriculum integrity through a Faculty work disruption crisis: Lessons learned and remaining principles.** *Ramses Wassef, Raymond Lalande, André Ferron, Andrée Boucher, Christian Bourdy, Serge Quérin, Claire Béliveau, Jeannine Kassis, Laurence Masson-Coté. Université de Montréal*

In November 2002, medical specialists throughout Quebec initiated work disruption measures. Specialists were encouraged by their associations to forgo all teaching activities. This had a profound impact on our undergraduate curriculum. Despite various measures, several problems arose including heterogeneity in the teaching activities, inconsistent students' assessments and increased concern by the students about their evaluations and their impact on their career choices. An analysis of the events and how we handled them led us to the following conclusions: Direct communication with the students is essential during such a crisis; the clinical teachers' sense of belonging to the medical school must be examined and enhanced; their teaching contract should be defined explicitly; students need to know that all is being done to salvage their academic year and minimize the impact on their education; school administrators must keep an open mind towards different teaching methods and evaluation tools.

P-26	**Digital Video Common Currency: Lessons Learned** *D. Bruce Holmes, Wesley Robertson, Dalhousie University*

At last year's meeting we presented a workshop called Developing and Implementing a Digital Video Common Currency. In it we described our efforts to develop high-quality digital videos for learning procedural skills and anatomy, the goal being to make them shareable, and to promote the coordinated production of more such videos by other medical schools. Having now used them in our own medical education program, and having viewed and discussed them with a wide variety of physicians and educators both here and in Europe, we would like to present the lessons we have learned, and to premiere a new video that incorporates those lessons. The poster will outline the research we have done on the effectiveness of the original videos, will review the lessons learned and the ways these were incorporated into the new video, and will prominently display the website address of the new video, which is freely available (online or by download) to any medical school for use in their curriculum.

P-27	**Interprofessional Health Education: Undergraduate, Clinical and Continuing** *Sheila Harding, Sinead McGartland, University of Saskatchewan*

The University of Saskatchewan has created a sustainable environment to move interprofessional health education forward at the undergraduate, clinical, continuing and Aboriginal levels. Through the Health Science Deans Committee the vision has been identified for the programs to collaborate to achieve excellence in the education of health professionals by offering an encouraging environment for students, faculty and health professionals to engage in interprofessional initiatives.

The four subcommittees of the Health Science Deans Committee will collaborate to develop educational modules for the provinces of Saskatchewan with a focus on primary health care through interprofessional education.

This structure provides a model to share with all Medical Faculties in Canada to ensure that the structure is in place to move interprofessional education forward and ensure there are opportunities to learn from each other.

P-28	**With society's needs as a starting point, the review of a training program: the experience of the Université de Montréal** *Raymond Lalande, Caroline Béique, Carl Fournier, Denise Fréchette, Fabienne Grou, Claude Rajotte, Gilbert Sanche, Chi Anh Ta, Université de Montréal*

People often confuse program evaluation and review. Over the last few years, important progress was made in the field of learning and teaching evaluation. A range of useful and reliable tools were created. As for university program evaluation, various conceptual frameworks can be used to look for relevant information. In medicine, we rely more often than not on external audits to provide the relevant information that eventually leads to corrective action. Yet, is that adequate when one is trying to conduct a thorough and meaningful program review? How does one go about to create a new program? How does one identify and collect the relevant data that will help take the needed corrective action, thereby maintaining the program's relevancy with respect to the needs of society or establishing an adequate growth pattern for the student in a new program. Fundamentally, creating or reviewing a program must be in keeping with a broad-based exercise whose aim is to check if that program meets the needs of society and the prevailing scientific reality. Such an approach must be based on a thorough quality approach. The presentation is designed to describe the methodology used at Université de Montréal in the context of a family medicine residency program review and the development of a new residency program in emergency medicine. We will explain how we adapted the conceptual framework developed by Stufflebeam to meet the goals of the exercise and propose a method that leads to sound conclusions.

P-29	**Modern anatomy instruction methods: Do computer-based 3D anatomical models improve learning?** *Daren Nicholson, Oregon Health and Science University; Colin Chalk, McGill University*

There is only equivocal evidence that learning is enhanced by computer-based methods. We conducted a pilot study of an on-line ear anatomy tutorial based on computer-generated 3-D anatomical models of the middle and inner ear. Eighteen first-year McGill medical students were randomly assigned to intervention and control groups. The intervention group had access to the full tutorial, including text, 2-D images and 3-D models, while the control group had access to only text and 2-D images. Both groups were allowed 45 minutes to complete the tutorial, and then completed a 15-item quiz. The intervention group's mean quiz score was higher than that of the control group (72% compared to 61%), but the difference between the means did not reach statistical significance. Nevertheless, to avoid missing a potentially meaningful effect on learning, we are repeating the study with a larger sample size.

P-30	**Predictive Validity of the Medical College Admission Test Using Latent Variable Path Analysis** *Terri Collin, Claudio Violato, University of Calgary*

In the present study we employed multivariate statistics and latent variable path analysis to study the predictive validity of the Medical College Admissions Test for matriculating students across U.S. medical schools. The dependent variables were performance on the United States Medical Licensing Examination (USMLE) steps 1, 2, and 3.

Using multisampling procedures (Total N = 839, 710) significant between-group differences were found on achievement (UGPA), aptitude (MCAT) and performance (USMLE) variables. The latent variable path model postulated apriori fit the data very well with a Comparative Fit Index (CFI) = .928. The three latent variables, undergraduate achievement, aptitude for medicine and performance in medicine were identified and were all significantly intercorrelated.

We concluded that the path coefficient from aptitude (i.e., MCAT scores) to performance (i.e., USMLE measures) is large and indicates a direct causal link in the achievement-aptitude-performance system.

The findings provide evidence for the predictive validity of the MCAT.

P-31	**The incidence and severity of adverse events in patient populations: A meta-analysis of published studies across medical disciplines** *Terri Collin, Kent Hecker, University of Calgary*

Patient safety is one of the key markers of physician and health care competence in the delivery of optimum health service. Many studies document the detrimental nature of medical errors, particularly concerning physicians. Adverse events are one of the operational terms used to account for these medical errors that may cause injury or death to hospitalized patients. Although the seriousness of adverse events has been established the magnitude of the impact of adversity affecting hospitalized patients has yet to be clarified.

The present study collated over 40 studies, relating to medical errors and adverse events occurring in hospitalized patients. Analysis employed cohen's d to assess the magnitude of effect, as well, pertinent covariates such as, physician specialization, hospital type, etc., were analyzed for their possible moderating influence.

This study is organized in a way that addresses the significance of patient safety and augments directions in medical education that help support physicians.

P-32	**Taking and Giving Back: An analysis of donor funding and bursary support in medical education at the University of Saskatchewan** *Farrah Mateen, Kelly McInnes, University of Saskatchewan*

Medical education has become an increasing financial burden for many students today. This burden is alleviated by bursary support at the undergraduate level, which is thought to have long-term implications in the choice of specialization vs. general practice, future practice location, and recruitment of students from lower socioeconomic income levels. In addition to higher academic averages, increased financial need allows medical students to disproportionately access funding compared to students in other colleges, including the health science colleges.

An analysis of the current records at Student and Enrolment Services revealed that undergraduate medical students compose 1.74% of all undergraduates eligible for bursary funding (176/10112 persons); however, total bursary funding for undergraduate medical students accounted for 28% of the total operating budget for bursary expenditures ($148 500.00/$532 500.00).

We study whether this increased level of bursary funding was matched with increased donor support by currently practicing physicians to the University of Saskatchewan.

P-33	**Family Medicine Residents Research Skills Curriculum: Scholarly Activity Integrated with the Residency Training Program** *Vivian Ramsden, Keith Ogle, Peter Butt, Gill White, Mary Pat Dressler and members of the Department of Family Medicine, University of Saskatchewan*

In addition to the ability to learn and engage in clinical practice, scholarly activity must be maintained within the Residency Training Program. The College of Family Physicians of Canada states that:
1. this is maintained with: a funded research program; publications; residents' involvement in research; and participation on relevant committees.
2. there should be a faculty member whose is responsible to facilitate residents' involvement in research and other scholarly activities.

The Resident Research Program has become integral to the Residency Training Program. To successfully complete, the residents must participate in an ongoing research project or complete a research project and present the findings. The Resident Research Program is built upon a core curriculum that is enhanced to meet the needs of the residents.

At the University of Saskatchewan, scholarly activity has become more fully integrated into the Residency Training Program. Engaging in scholarly activity has many opportunities for transformative learning and building capacity.

P-34	**Academic Procrastination And The Achievement Fallacy: An Examination Of The Online Study Habits Of First Year Medical Students** *Tyrone Donnon, Jean-Gaston DesCôteaux, University of Calgary*

Purpose: To determine whether an online virtual information system would support consistency in study habits and enhance student achievement of a cohort of first year medical students.
Methods: The academic achievement and frequency of use of course based materials and resources online were monitored for 114 first year medical students (Class of 2006) on a continuous basis from August 15, 2003, to May 31, 2004.
Results: All first year medical students demonstrate routine academic procrastinate trends when confronted with regularly scheduled course examinations. What separates the top and bottom academic achievers has less to do with consistency in study habits then it does with students' potential to achieve academically in medical school.
Conclusion: The study habits of the first year medical students graphically reflect postponement patterns supportive of the general assumption that students respond more to the assessment process rather than the instructional expectations of consistent curriculum objectives.

P-35	**Why and how to include public health in training for clinical professions** *Denise Donovan, Université de Sherbrooke; Gladys Stewart, Verena Menec, University of Manitoba; Ian Johnson, University of Toronto*

Starting with Abraham Flexner in 1910, there have been calls to incorporate public health teaching in clinical curricula. The Edinburgh declaration on medical education, the Public Health and Medicine initiative and the Network: Towards Unity for Health are more recent manifestations of the recognition that public health knowledge and skills are important for quality clinical care, but are neglected in many curricula and much of medical practice. Those who work towards the integration of public health in clinical curricula face a number of obstacles including a diverse range of opinions on what constitutes public health, lack of definition of the objectives of integration, the challenge of integrating a body of knowledge and skills poorly adapted to the clinical situation and the challenge of ensuring rigorous evaluation of students attainment of relevant learning objectives. The poster addresses these issues and the authors present possible solutions.

P-36	**The teaching of public health in medicine: examples from a literature review** *Denise Donovan, Université de Sherbrooke*

Withdrawn / retirée

Objectives : Recognising the need to improve the integration of public health in medical education, we reviewed the literature to identify promising ways of teaching public health to medical undergraduates.
Results : Medical schools use a wide variety of public health teaching activities, depending on local circumstances, resources and strategic goals. Longitudinal activities include community placement, individual patient follow-up, voluntary work or vertically integrated modules. Other activities include joint family medicine and public health clerkships, public health learning objectives within organ-system teaching modules, community projects and specific public health exercises. Process evaluations indicate high satisfaction among teachers, students and community participants, but may be subject to publication bias. Outcomes are positive, but their validity is reduced by self-selection of students at entry to programs.
Conclusion : Schools can choose from a range of models for integration of public health. Methods for evaluation of integration projects are lacking.

P-37	**Interactive Case Design: Teaching Basic Hospital Skills to 2nd Year Medical Students** *Gustavo Duque, Ayanna Roberts, Joanne Hui, Nancy Posel, David Fleiszer, Wendy Chiu, McGill University*

BACKGROUND: Simulating clinical environments in the classroom is challenging. Interactive technologies complement clinical teaching by providing a preparatory and realistic supplementary learning environment to introduce medical students to clinical settings.
AIM: To use interactive web-based technology to teach basic hospital skills in preparation for the clinical setting.
METHOD: An interactive course design introduced students to the clinical setting and simulated a hands-on environment for practicing basic hospital skills. The two-part course included (1) instructor-led Flash presentation lectures featuring a clinical case and interactive hospital forms; and (2) web-based software to practice using hospital forms within the context of a geriatric case.
RESULTS: Assessment of results is ongoing. Current and past years will be compared using three measurements: tutor-led evaluation forms, overall clerkship scores and tutor survey responses. We expect this course to positively impact student performance of basic hospital skills and tutor perceptions of student clinical preparedness for clinical clerkships.

P-38	**Developing a Core Competency Model of Post-graduate Medical Education in Canada** *Pankaj Shrichand, Nadine Valk, Danielle Frechette, Royal College of Physicians and Surgeons of Canada*

The Royal College of Physicians and Surgeons of Canada (RCPSC) is currently in the process of developing a Core Competency Model for postgraduate medical education in Canada. This education-based response relates to a number of issues, including:

- The tensions between generalism versus superspecialization
- The pressure on medical students to make early career decisions
- The need for flexibility in training
- Overlapping competencies between the various specialties and subspecialties
- The exploration of interdisciplinary education, and other innovations such as Mastery Learning
- The role of Continuing Professional Development

The presentation will detail these issues, followed by a blueprint of the proposed new model and an analysis of how it will address these concerns.

P-39	**Alice in UWOnderland: an exploration of the ethical challenges faced by medical students** *Christine Palmay, Michael Charnish, Barbara Connolly, Nelvia Van Dorp, Jeff Nisker, University of Western Ontario*

UWO's medical curriculum includes an ethics and humanities project in which students explore a subject of their choice. Our project,"Alice in UWOnderland," deconstructs Lewis Carroll's story through images and text to explore ethical dilemmas encountered by medical students. Alice's journey starts as a premedical student. She travels through the looking glass of the admissions process into the curriculum and is challenged by the stresses of personal goals, losing identity, academic demands and expectations of medical culture. The looking glass threatens to distort the truth during the admissions process, during encounters with consultants (e.g. regarding previously performing lumbar puncture, episiotomy, vaginal delivery), her academic accomplishments for CaRMs, and other roles. Alice uses several moral lenses to navigate through UWOonderland, and slowly one by one quaint events were hammered-out and [by the time] the tale is done, she has explored many ethical issues to hone a set of personal moral standards.

P-40	**De l'utilisation rationnelle d'un laboratoire de simulation pour l'acquisition et le maintien des compétences procédurales en médecine** *Marcel Martin, D.Dorion, G.Bisson J. Langlois, Université de Sherbrooke; C. Frasson, VirtuelAge; R.Lemieux Université de Sherbrooke*

a)situation du probleme, volet technologique et rationnel pedagogique des laboratoires de simulation.Dr. M.Martin et Dr. G. Bisson
b)Challenge de l'attrition avec strategie nouvelle d'apprentissage. Dr. D. Dorion
c)Les controles de qualitelive de la pratique medicale ou l'education continue ciblee sur lacunes detectees. Dr. R. LemieuxPh.D.ing.de l'image
d)La realite virtuelle des milieux de pratique ou le laboratoire de simulation desuet. Dr. C. Frasson
e)L'importance du controle du stress ou le developpement d'automatismes. Dr.G.Bisson
f)Le developpement des aptitudes visuo-spatiales en pre-doctoral:vers la representation spatiale pour remplacer la simulation?Dr.J. Langlois
g)conclusions Dr.M. Martin

P-41	**Implementation of a curriculum on complementary and alternative medicine (CAM) in undergraduate medical education** *Marja Verhoef, University of Calgary; Alan Neville, McMaster University; Michael Epstein, University of Saskatchewan*

Over the past year, a team of medical faculty, students, and complementary and alternative medicine (CAM) practitioners from across Canada have intensified efforts to develop a comprehensive and flexible CAM curriculum for integration into Canadian UME programs. Given the breadth of CAM content and the complexity of our task, we have divided the curriculum into three large topic-based sections, and have constructed a unique two-component curriculum design. An invitational workshop of our project advisory committee will be held on March 12th, 2005 to review the content. The learning objectives for the proposed workshop will focus on issues of curriculum implementation. Using strategies to actively engage participant feedback, we will discuss (a) viable platforms for dissemination; and (b) successful approaches to advertise the curriculum. As in our 2004 ACMC workshop, it will be invaluable to garner feedback from those impacted by the project outcomes, but not intimately involved with its development.

P-42	**Introducing Reflection in the First Year of an Undergraduate MD Programme** *Ian Scott, David Kuhl, University of British Columbia; Douglas Cave, Providence Health Care; Patricia Boston, Eva Knell, University of British Columbia*

In an effort to provide entering MD students with skills and resources to become reflective medical students and reflective practitioners we have introduced three, 3 hour afternoon small group sessions wherein students explore the meaning of self and the relationship between self and others. We will review what has been done at some other medical schools and then briefly describe our program and experience. Attendees will then have the opportunity to begin designing a curriculum for their own program while consulting with other attendees as well as the facilitators

P-43	**Educating Future Physicians for Palliative/End of Life Care: A Unique Experiment in Educational Change** *S. Lawrence Librach, University of Toronto; Paul Daeninck, University of Manitoba; Alan Neville, McMaster University; Doreen Oneschuk, University of Alberta; Jose Pereira, University of Calgary; Hubert Marcoux, Université Laval; Gerard Yetman, Health Canada; Louise Hanvey, Project Manager; Sharon Baxter, Canadian Hospice Palliative Care Association; Susan Maskill, David Hawkins, Association of Faculties of Medicine of Canada*

The Association of Canadian Faculties of Medicine and the Canadian Hospice Palliative Care Association are embarking on a four-year Health Canada funded project in palliative and end-of-life care medical education. The overall goal of the project is that every medical student and every clinical resident will graduate with competencies in palliative/end of life care. The breadth of the project and the methods used make this project a unique experiment in trying to produce sustainable change in the area of end of life

care where deficiencies of knowledge, attitudes and skills deficits have been documented. The project will achieve its objectives by identifying and achieving national consensus among educators about end of life care competencies to be achieved, by facilitating the development of local teams at each of the Canadian medical schools who will provide local leadership in curriculum development, by establishing an annual symposium on end of life care education, by linking with similar projects in other health disciplines, by fostering interprofessional learning methods as appropriate and by developing an on-line resource package of articles, books, effective educational models, curricula and other resources.

P-44	**Training Generation X and Y: Challenges, strategies, and solutions to tune in to the needs of medical students and residents** *Derek Puddester, University of Ottawa; Catharine Robertson, Children's Hospital of Eastern Ontario; Clare Gray, University of Ottawa*

Canada has provided global leadership in the realm of postgraduate health and well being. Over the past few decades, significant revisions to the workplace and educational environments of medical students and residents have taken place, with the collaborative efforts of student and resident organizations, leaders in medical education, ACMC, the RCPSC, the CCFP, and teaching hospitals. In recent years, much attention has been paid to medical student and resident health and well-being, and many provinces have witnessed the development and implementation of programs to promote the resiliency of residents and decrease the burden of illness or burnout. These generations of physicians appear to have unique perspectives on a medical career, and literature suggests that the training and work environments will need to use particular strategies to promote their sustainability.

This workshop will help participants increase their understanding of the generational and cultural forces at play with the current cohort and incoming populations of medical students and residents, as well as give them a series of possible strategies to apply to their own program. Case scenarios and vignettes will be utilized, and participants will be invited to share their own challenges for group application of discussed strategies.

P-45	**Exploring Ethical Issues of Home Care through Film** *Jeff Nisker, Suzanne Chan, Shirley Chow, Betty Lee, Ernie Mak, University of Western Ontario*

Film has the capacity to bring us to the position of persons immersed in ethical dilemmas. It is currently being used in health-care ethics curricula. In this workshop, film will be used to facilitate the exploration of the ethical issues of home care.
Home care is being touted as the new mode of healthcare delivery, an efficient way to address health care's limited resources while providing care in the comfort of one's home. Several recent movies have focused on the impact of home care on families and caregivers, including: Marvin's Room; One True Thing; What's Eating Gilbert Grape?, and The Barbarian Invasions.
The proposed workshop plans to explore ethical issues in home care by presenting clips of the above films for discussion by the workshop participants. The use of film in general, as an effective teaching tool in a medical ethics curriculum will also be explored.

P-46	**The Transition From CME to CPD - Fostering Good Practice Through Education** Francine Lemire, Bernard Marlow, Susan Rock, College of Family Physicians of Canada

The College of Family Physicians of Canada is a voluntary organization of Family Physicians, which makes CME/CPD mandatory. Over ninety percent of members have obtained Certification, which is an indicator of special competence in the discipline of Family Medicine. In 1997, the CFPC introduced Mainpro-C activities, which aim to have more of an impact on practice than traditional CME, by encouraging physicians to reflect on the impact of the learning on their practice.

It is well recognized that the determinants of good practice go far beyond disease management and the role of clinical expert. We utilized eight identified physician roles: medical expert, communicator, collaborator, health advocate, learner, manager (gatekeeper), scholar, and “physician as person”, as a

model consistent with good practice and meeting societal needs.

Currently, Medical Regulatory authorities in Canada are reviewing the integration of a physician's CPD/CME portfolio as a component of revalidation of licensure. In this study, we will review the past Mainpro-C activities of our members based on the identified physician roles.

We will highlight the key elements of a practice reflection exercise and describe how Canadian Family Physicians are integrating the broader definition of CPD into their learning activities.

P-47	**Tutor Training for PBL: Investigation, Review and Redesign to Develop Best Practices in Tutoring** *Blye W. Frank, Patty Weld Viscount, D. Bruce Holmes, Dalhousie University*

The Faculty of Medicine PBL curriculum at Dalhousie requires well-trained and informed tutors. Since 1992, tutors have participated in a one and a half day orientation workshop prior to tutoring. Feedback from tutors and students indicated the need to review this tutor training process.

We conducted a qualitative study with former and current tutors, students, and stakeholders, and revised our Tutor Training Workshop. For example, tutors now have a more thorough orientation to tutorial group dynamics and management as well as tutor and student evaluation. A graduate of the PBL curriculum and current tutor now takes a lead in the tutor training workshop, offering valuable insight for new tutors.

In our presentation we will describe the research and the redesigned tutor training program implemented in 2004 as well as suggest implications for faculty development.

P-48	**Expanding Undergraduate Medical Education in British Columbia within a Socially Responsible Framework.** *Joanna Bates, Angela Towle, Joan Fraser, Dave Snadden, Oscar Casiro, Bruce Fleming, Vera Frinton, University of British Columbia*

In September 2004, University of British Columbia (UBC) implemented an expansion of medical undergraduate education using a distributed model involving two collaborating universities (University of Northern British Columbia (UNBC) in northern B.C. and University of Victoria (UVic) in the west), and six health authorities across B.C.
UBC determined to focus its expansion on addressing the identified underserved needs of rural and northern populations and an aging population, ensuring that medical students learn in the context of these populations. The development of the new partnerships and areas of focus such as admissions, student support, technology facilitated educational delivery, curriculum enrichment, and governance will be described. While the outcome for all streams is a generalist education that prepares the student for entry into any postgraduate program, we expect that the students in the two distributed sites will become both sensitized to and comfortable with the context in which they are educated.

P-49	**Case-Based Learning Distributed Over the World Wide Web** *Niamh Kelly, Brian Conway, Jennifer Shabbits, Barb Conway, University of British Columbia*

Bacterial Infection in Humans is an online case-based course delivered at UBC as an upper level science course. The learning occurs using a case-based approach in which students, working in small groups, are directed to acquire knowledge and understanding while working through case scenarios. The course is delivered over the World Wide Web, using the WebCT platform, with students and instructors all communicating online. Four years of experince with this online course willl be used as a jumping off point to enagage the participants in a discussion around:

- delivering case-based learning online;
- the role of the instructor online;
- student interactivity online;
- peer teaching and learning;

- using the library and other online resources;
- student assessment.

P-50	**Training in Social Responsibility: Design and Implementation of Rotation in Social Pediatrics** *Saleem Razack, Giosi DiMeglio, Gilles Julien, McGill University*

The Canadian Population of medical residents is diverse culturally but not socio-economically, coming overwhelmingly from the more privileged classes. Trainees' life experiences may pose a challenge to the understanding of the social determinants of health. We report on the design and implementation of social pediatrics rotation for pediatric residents in which exposure to the health problems of specific vulnerable populations (poverty, incarceration, street-youth, youth protection)is provided. The objective of this rotation is to gain appreciation of the importance of context in health outcomes (for all patients, not just socially vulnerable ones), and of the pediatrician's role as an advocate on behalf of such vulnerable populations. These diverse experiences are brought together through reflective practice sessions with the rotation supervisor. The training goals are to promote attitudinal shifts towards context sensitive practice and a more visceral understanding of the advocate role of the physician on behalf of vulnerable populations.

P-51	**How do residents view academic half-day?** *Colin Chalk, Sarkis Meterissian, Diana Tabatabai, McGill University*

The academic half-day (AHD) is ubiquitous in Canadian residency programs, but its impact has not been studied. We used focus groups to investigate perceptions of 17 McGill neurology, general surgery, and pediatrics residents about the AHD. Discussions were audio taped, transcribed, and coded for emergent themes. The 3 specialties had overall positive and notably similar views about the AHD. Residents felt personally responsible for the AHD's well-being, and often felt caught between obligations to patients and to their own learning at the AHD. The AHD was seen to symbolize the importance of teaching, and to be key for developing social cohesion and support networks among residents. Sessions in which clinicians model clinical reasoning or problem solving were the most valued. Barriers to attending the AHD included clinical work and the attitude of staff physicians (described as passive-aggressive by several residents). Our findings indicate ways that the AHD may be enhanced.

P-52	**Visa Trainees in Canadian Post-M.D. Training Programs in 2003 and Retention in Canada of Recent (exiting training in 1998) Visa Trainees 5 Years after Completion of Training** *Dianne Thurber, CAPER*

Data from the CAPER database and the CMA Masterfile were utilized to develop the data for this poster presentation concerning the final field of post-M.D. training and eventual practice location of physicians who held a temporary visa during their post-M.D. training in Canada.

In 2003, the 1862 Visa trainees registered in Canadian training programs represented 20% of the post-M.D. trainee population in Canada, with higher proportions in the medical and surgical specialties (23% and 25% respectively) than in Family Medicine (2%). Of the 378 Visa trainees who exited from post-M.D. training programs in 1998, 12% were located in Canada in 2003 (5 years after exit from training). The eventual province of practice in Canada and the range of specialties of this cohort of physicians will be compared to the Canadian citizen/permanent resident trainees who completed training at the same time. Implications for the Canadian physician workforce will be discussed.

P-53	**A New model for teaching the core competencies to PGY-1s in academic health science centres** *Leslie Flynn, Sarita Verma, Queen's University*

We designed a novel program for delivering a harmonized curriculum to all PGY-1s to address the core competencies arising from the CanMEDS roles, the 4 Principles of Family Medicine, and the MCC CLEO objectives. Having attempted a monthly series of academic half days, we redesigned the curriculum to be presented in two concentrated sessions and report the success of our experience. The unique features

of this program were that residents in all programs attended a common session (with the exception of those post-call or on rotations out of town) and sessions were provided over a two day period twice yearly in which residents were freed from clinical responsibilities. This model significantly diminished the demand on faculty resources while markedly increasing resident attendance (80% of all residents). This model may serve as a valuable template for other academic centres.

P-54	**Evaluating the Residency Experience - The Usefulness of Exit Surveys** *Leslie Flynn, Sarita Verma, Queen's University*

Postgraduate medical education benefits from feedback regarding the quality of the educational experience during residency. However, it is a challenge to solicit constructive criticism. Most residency surveys deal with aspects specific to a program. Internal reviews lack sufficient detail concerning global training issues. In order to address this gap, a resident exit survey was designed and administered at Queen's University to capture the opinion of all residents completing their training program. Items include feedback on the Program Director, Department Chair, Program Faculty, Preparation for Certification, Preparation for Practice, Quality of Life Throughout Residency, Educational Issues, Patient Care, Work Environment, and the Postgraduate Medical Education Office. Surveys were administered anonymously by email. In our three year experience the response rates have been 67%, 76% and 64% respectively. This tool has provided the postgraduate office with the means of identifying systemic issues which need to be addressed.

P-55	**Cultural Competence or Humility? Reflection Rather than Knowledge Acquisition as a Goal of Residency Cultural Training** *Saleem Razack, Mary Ellen Macdonald, Praco Carnevale, McGill University*

Effective medical practice in a multicultural environment requires an understanding the role of cultural identity in the clinical encounter. A needs assessment on resident cultural training was conducted among residents and faculty in a pediatric residency program. Participants identified mastery of a specific knowledge-base and the development of skills in dealing with clientele from different cultures as training priorities. Published cultural training curricula tend to emphasize such skill mastery/trait list approaches, but this may encourage stereotyping and unwitting discrimination. Alternative training models focus on the notion of humility, where the aim is to develop trainees' capacities to reflect on cultural encounters, rather than on the mastery of a finite body of knowledge and skills. We report on a pilot cultural training curriculum for residents that reconciles the learners' expectations for knowledge acquisition with a training goal that emphasizes the reflective process, shifting the focus from cultural "competence" to cultural "humility".

P-56	**Opportunities and Obstacles in Re-Entry Residency Training** *Kristin Sivertz, Eric Webber, Jean Jamieson, University of British Columbia*

In 2000 the BC Ministry of Health and Faculty of Medicine at UBC created new postgraduate positions open to practicing physicians who wished to undertake specialty training. The program sought to address a perceived desire among family physicians to enter residency training and the need to train more generalist specialists to work in regional and community settings. While there was anecdotal interest in these positions, this was not matched by applications to the program. To further evaluate this program and make recommendations regarding its future, a questionnaire survey of family physicians was undertaken. Over 50% of eligible family physicians in BC responded. We will present descriptive and qualitative data that include demographic characteristics of those interested in re-training; the specialties of interest; the reasons for considering re-training and barriers to participation in a re-entry training program. We will offer suggestions for development of re-entry training programs.

P-57	**A Qualitative Study of Medical Students' Well-Being, Coping Behaviours, and Ideas for Health Promoting Interventions** *Naomi Lear, Pierre-Paul Tellier, McGill University*

Introduction:An association between stress in medical school, stress related illness and risk behaviours among medical students has been documented. This study reports first-hand accounts of students' experience of stress, their coping mechanisms, and the interventions from which they would benefit.

Methods: Four focus groups, one with each medical class, at McGill University, were conducted over May and June of 2004. The concerns raised were grouped into categories.

Results: The comments included a) concerns common to all students and those specific to pre-clinical and clinical students, b) risk behaviours, c) coping mechanisms and d) suggested improvements.

Conclusions: Some stressors were common to all while others were unique to
the pre-clinical or clinical years. Thus directed interventions may be necessary. Students employed positive coping mechanisms, had few risk behaviours and made several suggestions to decrease stress.

P-58	**Medical Student Mistreatment Survey with Impact of Event Scale** *Maggie Morris, Cheryl Kristjanson, Wil Fleisher, Angela Tittle, University of Manitoba*

A medical school mistreatment survey based on the Association of American Medical Colleges Graduation Questionnaire(with permission)regarding student mistreatment was administered to the four medical school classes in 2003 at the University of Manitoba. Ethics approval was obtained. An additional question was included asking if students had been asked to do anything they considered to be unethhical during their training. An Impact of Event Survey was admisitered to students reporting a mistreatment event. 54% of first year students, 51% of second year student, 62% of third year students and 44% of fourth year students responded. Mistreatment rates were similar to previously reported rates in the literature, with the source of the abuse differing from pre-clinical to clinical years. Unethical behaviours requested of students were most likely to involve patient consent issues for procedures/examinations. Impact of Event Scores increased in clinical years compared to pre-clinical years.

P-59	**Mission-based Admissions: An Evaluation Instrument to Assess Rural and Remote Suitability for Education and Practice** *Joanna Bates, Don Voaklander, George Deagle, Dave Rutledge, Vera Frinton, Harvey Thommasen, University of British Columbia*

Rural students are under-represented in undergraduate medical education in Canada, and Canadian graduates locate primarily in urban areas of Canada. Rural areas of Canada are underserved in physician services, and the current physician shortages in rural areas are placing pressure on medical schools to be socially accountable in admitting students who are likely to locate their clinical practices in rural areas.
As a new admissions process for the distributed UBC campus, UNBC and UBC have collaborated to develop an instrument (Rural and Remote Suitability Score or RRSS) to evaluate applicants' suitability to be educated (and eventually practice) in a rural, northern, or remote setting.
The development process, inter-rater reliability, item factor analysis, and correlation to selection of educational site for the applicant pool of 1300 have identified the RRSS as a potential tool to address urban medical schools' social responsibility to admit and educate medical students in under-served areas.

P-60	**Development, implementation, and outcomes of a policy for aboriginal student admissions to an MD undergraduate program** *James Andrew, Rosalyn Ing, Joanna Bates, Vera Frinton, University of British Columbia*

Aboriginal students are underrepresented in medical programs in Canada. There have been national calls for processes and programs to reverse this statistic in Canada.
The UBC Faculty of Medicine developed in consultation with university and aboriginal groups a proposal for an admissions process to undergraduate medicine for aboriginal students. This policy was formally approved and implemented in 2002. This admissions track targets 5% of seats for well-qualified aboriginal students. The students can apply to both the regular and the aboriginal admissions track. The aboriginal student applications are reviewed by an aboriginal admissions committee comprised of aboriginal community leaders, physicians, residents, and students. Applicants are evaluated through standard

processes and according to criteria developed by the aboriginal selection committee. Early outcomes suggest that both the application and success rates of aboriginal students have increased. The aboriginal admissions policy represents a building block of the UBC aboriginal health pathway in medicine.

P-61	**Semi-structured panel interview for medical admissions at UBC.** *Carol-Ann Courneya, Vera Frinton, George Pachev, University of British Columbia*

March 2004 represented the debut of the semi-structured panel interview for medical admissions at UBC. Panels consisted of a clinician, an academic and a community member. Interviewers recorded scores on the criteria, first individually, and then collectively (consensus score). Interviews were conducted over four consecutive days, and consisted of standardized questions, coupled with panel-specific probing questions. Following the interview, applicants and interviewers completed a questionnaire which asked them to reflect on the panel interview experience by means of Likert scales and narrative comments. Presented analyses include: inter-interviewer reliability; intra-panel variability; relations of individual panelist scores to final consensus score; relationship of panel interview scores to admissions status; relationship between interview score and day of interview (day 1 to day 4). The results are interpreted in terms of the efficacy of having adopted the panel interview.