Workshop abstracts
2007 Medical Education Conference
Victoria

W-01	**The Integration of Work-based Learning and Assessment** *Deborah Davis, Charlotte Ringsted, Rigshospitalet, Copenhagen, Denmark*

Many current assessment tools are based on a scholastic model in which learners demonstrate their knowledge and skills in written examinations and in checklists during simulated sessions. As well, clinical rotation evaluations are used to assess learners but are often inflated and subject to “the halo effect”. However, much of learning during medical education takes place in the workplace. This is especially true in postgraduate training, but undergraduate education is also now firmly rooted in clinical settings in North America. Thus, tools to assess authentic workplace activity are needed. Work-based learning and assessment must be integrated in a valid and reliable way. Competence is multidimensional and assessment tools should be designed to capture this. Tools should assess not only the traditional medical expert role, but should also include the desired outcomes within the other roles of the CanMEDS framework wherever possible. The development of such tools is best done with input from a variety of stakeholders. Those developing the tools must have a very clear idea of the tasks learners are expected to be able to perform, the expected standard for the performance, and the context in which learners should be able to do these tasks. Data from quality assurance studies can also be used to foster development of tools for learning and assessment. Because assessment drives learning, it can be appropriate to include assessment tools for both activities that are common and for activities that learners find challenging but are essential to the workplace. Studies have documented that these types of tools have an effect on learning and the educational environment. This workshop will highlight ways to design and implement authentic workplace assessment.

Objectives:

By the end of the workshop, participants will be able to: 1. Identify ways to define content of authentic workplace assessment tools 2. Discuss how to set standards for workplace assessment 3. Discuss implementation strategies for workplace assessment

W-02	**Using a Framework to Analyze Clinical Teaching: The Stanford Clinical Teaching Framework** *Dianne Delva, Queen’s University; Danny Panisko, University of Toronto*

The Stanford Faculty Development Program is the pre-eminent faculty development program in the country, according to Wendy Levinson, MD, vice chair of the Department of Medicine at the University of Toronto and past-president of the Society of General Internal Medicine. The Stanford Clinical Teaching Course developed by Kelly Skeff and Georgette Stratos, is based on a comprehensive framework that faculty can use to analyze their teaching. The full course, given over 8 eight sessions, addresses seven educational categories: Learning Climate, Control of Session , Communication of Goals, Promotion of Understanding & Retention , Evaluation, Feedback, and Promotion of Self-Directed Learning. Dianne Delva and Danny Panisko, both trained in Stanford, have successfully provided this course in their own institutions. Following last year’s successful seminar, they facilitators will provide participants with an overview of the Stanford course and an opportunity to practice using the framework by reviewing videotapes of clinical teaching encounters and participating in a role play. A different module will be presented this year to allow participants to build on a topic of the groups’ choice in more detail . Rationale: Clinical Teaching is too important a skill to be left to chance. The educational principles underlying traditional teaching are equally important in the clinical setting. Understanding and practicing these behaviours in the context of clinical teaching can help teachers enhance their versatility as teachers to better meet the needs of their learners.

Objectives:

Learning Objectives: The Goals of this workshop are to: • Enhance versatility as teachers • Improve ability to analyze clinical teaching using an educational framework Specific objectives: At the end of this session clinical teachers will: 1. Know a framework for analyzing clinical teaching 2. Be able to recognize specific teaching behaviours that enhance clinical teaching 3. Develop personalized goals for enhancing their own clinical teaching.

W-03	**Interprofessional Continuing Professional Development: Collaboration Through the Lens of the Humanities** *Pippa Hall, Susan Brajtman, Lynda Weaver, Kevin Barclay, Dawn Mullins, Enkenyelesh Bekele, University of Ottawa*

Through a partnership of SCO Health Service, the Élisabeth Bruyère Research Institute, the University of Ottawa, Saint Paul University, Algonquin College and La Cité collégiale, a series of Continuing Professional Development (CPD) workshops is being developed and piloted in Ottawa. The goal of these workshops is to enhance faculty members' and clinicians' understanding and appreciation of interprofessional collaborative person-centred practice (ICPCP), and to improve their abilities to teach ICPCP and to be role models for the learners with whom they interact. These workshops address ICPCP by having participants work on an aspect of humanity in health care. The Humanities framework consists of 4 pillars: Human Experience; Historical Perspectives; Ethics and Law; Professionalism. References: 1. D'Amour D, Oandasan I. Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. Journal of Interprofessional Care 2005; Supplement 1: 8-20. 2. Hall P. Interprofessional teamwork: Professional culture as barriers. Journal of Interprofessional Care 2005; Supplement 1: 188-196. 3. Dittrich LR. Preface. Academic Medicine 2003;78(10):951-952.

Objectives:

On completion of this workshop, participants will be able to: 1. Identify the 7 key elements of collaboration 2. Apply the elements of collaboration through the framework of the Humanities to case-based scenarios 3. Discuss and evaluate this approach in the context of their own experiences and learning environments.

W-04	**Ethics in the Trenches: Teaching Medical Ethics to Clerkship Students** *Naomi Lear, McGill University; Marcel D'Eon, University of Saskatchewan*

As a medical student, in an average day, I will be asked to see a patient who has not consented to student participation in care, to perform a procedure or exam for which I have not been adequately prepared, or to administer a treatment for which I cannot explain the risks. Like students at almost all Canadian medical schools, I received a brief introduction to ethics during pre-clinical training, but have received no formal support or teaching for the ethical issues I encounter in clerkship practice (1). On a daily basis, medical students like me, on the wards, are challenged by questions of learning versus serving, listening versus speaking out, and growing while presenting additional risks to patients (2). What can be done to ensure that students grow from the ethical challenges they face, rather than become callused in their training? In this workshop, co-presented by a medical student and medical educator, participants will explore ways to better teach ethics to students in their clerkship. They will review research on teaching ethics to students, discuss ways in which current teaching provided in pre-clerkship years could be adapted for use with clerkship students, and work together in small groups to develop a sample program, so that on returning to their universities they will be ready to begin supporting their students. In addition, participants will leave with a set of one hour case-based ethics and evidence presentations (prepared by the presenter) which complement the major core rotations in internal medicine, geriatrics, obstetrics, and paediatrics and have been well-received by McGill clerkship students. References: (1) Kidd, M. (October 2006) The History and Future of Humanities in Canadian Medical Education. CAME Newsletter. Turner, M., Jones, C., Ascai, M., Costescu, D., (2) Puente, S. & Wilson, T. (April 2006) Duty to Learn vs. Duty to Treat: The Medical Student's Professional Responsibility, Poster presented at the Canadian Medical Education Conference, London ON.

Objectives:

(1) Participants will be able to describe 3 key principles for teaching ethics based on current literature and a demonstration lesson. (2) Participants will be able to evaluate their current ethics program and plan modifications in light of the newly acquired principles. (3) Participants will develop an ethics workshop for clerkship students for one of the core rotations.

W-05	**Assessing Collaboration Competence** *Denyse Richardson, Ivy Oandasan, University of Toronto*

Now 11 years old, the CanMEDs initiative has recently be updated as the new CanMEDS 2005 Framework. This competency-based framework describes the principle generic abilities of physicians oriented to optimal health and healthcare outcomes, which is in line with our present era of accountability. While the familiarity of the Role constructs within the framework has seemingly steadily increased over the last several years, the level of understanding of the key competencies within the each of the roles and the comfort in assessing the competencies attributed to these roles seems to continue to be fairly low among faculty. Hence, continued faculty development in this area is required. Continued implementation of the CanMEDS framework requires clear understanding of the behavioural manifestations of each of the role constructs as well as practical tools for the assessment of physicians' competence in each of their professional roles. Fichtner CG, Hardy D, Patel M, Stout CE, Simpatico TA, Dove H, Cook LP, Grossman LS, Giffort DW. A self-assessment program for multidisciplinary mental health teams. Psychiatr.Serv. 2001 Oct;52(10):1352-1357. Parsell G, Bligh J. The development of a questionnaire to assess the readiness of health care students for interprofessional learning (RIPLS). Med.Educ. 1999 Feb;33(2):95-100 Singh R, Naughton B, Taylor JS, Koenigsberg MR, Anderson DR, McCausland LL, Wahler RG, Robinson A, Singh G. A comprehensive collaborative patient safety residency curriculum to address the ACGME core competencies. Med.Educ. 2005 Dec;39(12):1195-1204. Cullen L, Fraser D, Symonds I. Strategies for interprofessional education: the Interprofessional Team Objective Structured Clinical Examination for midwifery and medical students. Nurse Educ.Today 2003 Aug;23(6):427-433. Ritchie PD, Cameron PA. An evaluation of trauma team leader performance by video recording. Aust.N.Z.J.Surg. 1999 Mar;69(3):183-186.

Objectives:

Upon completion of this workshop, participants should be able to: 1) define and describe the behaviours associated with the CanMEDS Collaborator competencies 2) describe at least 3 different practical methods for explicitly evaluating collaboration in medicine and 3) integrate one new assessment strategy into a postgraduate residency program.

W-06	**Training in Cultural Competence: What We Want to Learn vs. What We Ought to Learn** *Saleem Razack, Mary Ellen Macdonald, Franco Carnevale, Pierre-Paul Tellier, Yvonne Steinert, McGill University*

Canadian society is becoming increasingly culturally diverse. The city of Toronto, for instance is estimated to have approximately 48% of its population belonging to visible minorities. For Canada as a whole, the percentage of visible minorities is approximately 11% (2001 data). In this context, the effective medical practitioner is likely to be one who has developed skills in cross-cultural interaction, and who sees diversity as a core value in the profession's accountability to society. Despite the best of intentions, there are pitfalls in cultural competence training; these are related to expectations on the part of the learner that may be different from what available cultural compentence curricula suggest ought to be the training focus. In this workshop, the authors hope to bring together medical educators from across the country who are interested in cultural training, in order to seek ways to address this gap and to share best practices. References: Lingard L., Tallett S. et al. Culture and Physician-Patient Communication: A Qualitative Analysis of Residents' Approaches to Bridging the Gap. Annals RCPSC, Sept 2002, 331-5. Razack S, Macdonald M, Carnevale F. Cultural Competence or Humility? Reflection Rather than Knowledge Acquisition as a Goal of Residency Training. Poster presented at CAME Conference, Saskatoon, May, 2005 Culhane-Pera K, et al. A Curriculum of Multicultural Education in Family Medicine. Family Medicne 1997 29(10):719-23.

Objectives:

At the end of this workshop, the participant will be able to: 1. Consider the gap between learners' expectations, and what curricula suggest ought to be taught as a potential barrier that must be addressed

in order to have effective cultural training. 2. Develop strategies to promote self-awareness and reflection on cross-cultural interactions as a means in skill-building for the culturally sensitive practitioner. 3. Share cultural training experiences with colleagues as a means to develop consensus on best practices.

W-07	**How to WOW Your Audience: A Workshop on Making Better Research Presentations** *Grant Russell, Clare Liddy, University of Ottawa*

Oral presentations matter. Whether it's a 10 minute talk to a faculty committee or a keynote address at an international conference, effective verbal communication is challenging. The difficulty increases when we are asked to present research data. This workshop has grown from years of watching peers struggle to translate complex research findings into a clear message. Months of planning can be lost in 10 minutes of jumbled delivery, crowded slides and poor time management. The presenters have spent a number of years trying to translate qualitative and quantitative research findings to local, national and international conferences. We've learnt from our successes and failures, and particularly from seeing, at first hand, the pre-presentation habits of some wonderful Canadian medical speakers. We hope our experiences, combined with information from a literature synthesis will give participants a chance to allow their conference performance to reflect the quality of the work that led to its original acceptance. The workshop should give experts and novices a framework for planning, practicing and performing a task that is for many, one of the more stressful parts of an academic career.

Objectives:

To provide skills in verbal, research presentations to health care audiences by 1) Understanding common pitfalls associated with these presentations. 2) Learning the habits of successful presenters. 3) Highlighting skills in voice, confidence, and body language. 4) Providing techniques for preparing and organising research presentations.

W-08	**Pandemics, Populations and Public Health: What Do Medical Students Need to Know?** *Ian Johnson, University of Toronto; Denise Donovan, Université de Sherbrooke; Jean Parboosingh, Association of Faculties of Medicine of Canada; Monica Hau, University of Toronto*

Concerns about pandemic flu, an epidemic of obesity, and the aging baby boom population all grab the newspaper headlines. The Medical Council of Canada has strengthened its requirements and the AFMC set specific targets for public health education as part of its initiative on social accountability. The College of Family Physicians of Canada has published a discussion paper on the role of family medicine with respect to public health and emergency preparedness. All these factors are pushing medical schools to strengthen their curriculum with respect to public health and emergency preparedness. On the other hand, results of focus group sessions with medical students have shown a general disinterest and lack of engagement in public health. This workshop will present the ongoing work of the AFMC Task Group on Public Health and stimulate discussion on these key issues. The goal is to assist participants to improve their respective curricula. Rationale – Why is this workshop of interest to medical educators? ? The increased interest of epidemics (both infectious and non-infectious) and concerns about pandemic flu have demonstrated that medical undergraduate curricula must respond to these new and emerging challenges with a population and systems based approach. ? The AFMC has made public health part of its initiative with respect to social accountability. The Task Group has presented a plan of action. This workshop will help faculty become more knowledgeable of these developments and the implications for curriculum. ? The Medical Council of Canada is raising its standards in the area of population health and has a new standard on outbreak management . ? The AAMC has called for increased teaching related to bioterrorism and other population health concerns. References: Paper by the AFMC Task Group on Public Health can be accessed at http://www.afmc.ca/docs/2006_april_afmc_public_health_vison_paper.pdf Paper by College of Family Physicians of Canada can be accesed at http://www.cfpc.ca/local/files/Communications/Role_Fam_Doc_Dec05.pdf Paper by Monica Hau and Ingrid Tyler on medical school focus groups with respct to public health is being submitted for publication.

Objectives:

Workshop objectives and learning outcomes: By the end of this session, participants will be able to: 1. Identify the main findings of the report on the AFMC Task Group on Public Health and the implications of these findings for curriculum development. 2. Discuss the challenges facing curriculum planners in enhancing the integration of these concepts into the existing curricula. 3. Propose a range of teaching activities to help engage students in public health as well as assist students acquire knowledge and skills in the areas of population health, public health and emergency preparedness.

W-09	**Professionalism in Action: Managing Conflict of Interest from UGME to CME** *Richard Handfield-Jones, Geneviève Moineau, Michelle Catton, University of Ottawa; Ford Bursey, Memorial University of Newfoundland*

One of the enabling competencies of the CanMEDS role of “Professional” is that “physicians are able to appropriately manage conflicts of interest”1. Dealing with COI is becoming a significant issue in research and education. Consider the following: • The federal research agencies, CIHR, NSERC and SSHRC, work as the Tri-Council to define common standards for funding. As an extension of its policy “Integrity in Research and Scholarship”2, the Tri-Council has declared that universities must have procedures for disclosure of COI in place by 2008 to remain eligible for funding.3 • In 2001, the CMA added to its policy on “Physicians and the Pharmaceutical Industry”, that COI must be disclosed as part of any CME activity4. This is now required by both national Colleges for CME accreditation so it is mandatory for the university CME offices. • A medical student in Ottawa reported that her classmates were shocked to discover that a teacher who had given a cardiology lecture had received financial support from a pharmaceutical company. She felt this should have been disclosed to the students. COI is defined as: “Activities or situations that create a real or potential conflict between personal, institutional or other interests (including, without limitation, financial interests) and the duties, commitments or responsibilities of a Member to the University (including, without limitation, those related to research)”.5 Conflicts of interest are not new. What is new is that, in the era of professionalism and social accountability, faculty members are being challenged to define acceptable ways to deal with them. Yet few Faculties of Medicine have formal policies. The goal of this workshop is to provide a forum to share stories about COI across the continuum of medical education and to generate ideas about how to manage them in ways that meet the profession’s obligations of ethical behaviour. 1. //rcpsc.medical.org/canmeds/CanMEDS2005/CanMEDS2005_e.pdf 2. www.nserc.gc.ca/professors_e.asp?nav=profnav&lbi=p9 3. www.nserc.ca/institution/coi/toc_e.htm#toc_e 4. //policybase.cma.ca/policypdf/PD01-10.pdf 5. University of Ottawa: Report from the Conflict of Interest Working Group. 2005.

Objectives:

By participating in this workshop, participants will be able to: • Identify some of the factors influencing university COI policies. • Explain issues relevant to COI disclosure in a medical school. • Compare and contrast COI issues at UGME, PGME and CME levels. • Formulate general strategies for implementing COI disclosure policies and procedures in a medical school.

W-10	**Strategies for Reflection Along the Continuum: Transforming Reflection Into Action** *Jocelyn Lockyer, University of Calgary; Joan Sargeant, Karen Mann, Dalhousie University*

Reflection is the mechanism by which we contemplate and try to understand relatively complex and sometimes troubling ideas for which there is not an obvious solution. Reflection allows us to transform current ideas and experiences into new knowledge and action. Several theorists contributing to understanding the mechanisms for reflection highlight the influence of emotions upon reflection (Boud), ways of dealing with ill-structured material (Moon), importance of deep vs. surface learning (Entwistle), and roles of experiential learning (Schon, Boud) and meta cognition (Flavell). We know that reflection requires time, discussion and feedback from and with others, and thoughtfulness to clarify ideas with intent towards new action. While personal experiences and faculty feedback may trigger reflection, there are educational strategies which can facilitate reflection; e.g., case-based discussion, log books, learning

portfolios, learning contracts, commitment to change agreements. These only become successful when reflection is transformed into new understanding or action. This workshop will examine several approaches to encourage reflection and discuss how these can be adapted for optimal learning and action.

Objectives:

Participants will: • Share experiences with promoting learner reflection; • Review briefly, approaches to and evolving thinking about reflection and its influence upon new knowledge and action • Apply their knowledge and experience to considering specific reflective approaches in their teaching. • Discuss barriers to incorporating

W-11	**Moving Towards a National Strategy on Community-based Faculty Development** *Thomas Lacroix, University of Western Ontario; Karl Stobbe, McMaster University; Elaine Van Melle, Danielle Blouin, Queen's University; Peter Wells, Rural Ontario Medical Program*

Canada has a need to develop materials for a large number of community-based preceptors who are taking on more active teaching roles. These preceptors may be distant to the University who is sending them learners, and in some districts, they may be taking learners from multiple Universities. A National strategy to develop training methods for core precepting skills that could be delivered in a wide variety of formats, and allow portablility of skills from centre to centre might help Universities share resources and novel teaching strategies.

Objectives:

After attending this session learners will be able to: *describe highlights of a large, multi-institutional faculty development survey of community-based preceptors *identify common or core faculty development needs for community-based preceptors *establish a mechanism for sharing materials that could be used toward developing a national faculty development repository

W-12	**Choosing a Career in Medical Education: Perspectives, Perils and Pathways** *Jason Frank, Royal College of Physicians and Surgeons of Canada; Meridith Marks, University of Ottawa; Brian Hodges, University of Toronto; Jerry Maniate, Canadian Association of Internes and Residents; Deborah Danoff, Royal College of Physicians and Surgeons of Canada*

This session is designed for anyone interested in developing a career in medical education, beyond being a medical teacher. How does one become a medical educator? Is that the same as being a clinical teacher? How does one get paid for this? Promoted? What role does advanced training such as M.Ed degrees play in such a career? This interactive panel discussion will highlight the reasons, the routes, the joys, and the pitfalls of becoming a leader in medical education in Canada.

Objectives:

Upon completion of this session, participants will be able to: 1. define medical educator and medical teacher; 2. describe several paths to a career in medical education, starting as a resident, junior faculty, or senior faculty; 3. describe the roles and options for further training in medical education.

W-13	**From Best Evidence to Practice: The Use of Research Findings in Medical Education** *Yvonne Steinert, McGill University; Karen Mann, Dalhousie University*

Medical educators increasingly appreciate the importance of evidence-based approaches to teaching and learning. However, locating and appraising the existing evidence has been challenging, as this literature is widely distributed across medical education, professional education, and discipline-specific journals.

Moreover, the existing evidence to justify educational interventions is of variable quality, and the research methods employed do not always conform to design approaches and standards of rigor familiar to those in the field. The Best Evidence Medical Education (BEME) Collaboration is an important vehicle through which to address the issues above. BEME reviews are systematic reviews of the literature in specific areas of medical education (e.g. use of simulations, faculty development, communication skills), to collect, appraise and synthesize the best existing evidence to inform our educational practice. As BEME reviews appear in the literature, it is important to consider what their findings mean, how they can be implemented into our practice, and what research questions remain. In short, the translation of the “best evidence” into practice requires facilitation and guided practice. The goal of this workshop is to utilize a completed BEME review of faculty development initiatives designed to improve teaching effectiveness in medical education (Steinert, Y., Mann, K., Centeno, A., Dolmans, D., Spencer, J., Gelula, M., and Prideaux, D., in press) to address these issues and the following learning objectives. Key References: Hammick, M. A BEME review: A little illumination. Medical Teacher, 2005, 27, 1-3. Reeves, S., Koppel, I., Barr, H., Freeth, D., and Hammick, M. Twelve tips for undertaking a systematic review. Medical Teacher, 2002, 24, 358-363. Steinert, Y., Mann, K., Centeno, A., Dolmans, D., Spencer, J., Gelula, M., and Prideaux, D. A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education. Medical Teacher, in press.

Objectives:

By the end of this workshop, participants will be able to: ? Define what is meant by “best evidence” in medical education. ? Summarize the key findings, strengths and limitations of the BEME review on Faculty Development ? Discuss the extent to which evidence guides our faculty development practices ? Identify common barriers to using evidence in medical education, using faculty development as a case study ? Describe how we can make further progress in translating research findings into educational practice

W-14	**Getting Started with Qualitative Research** *Elaine Van Melle, Queen's University*

Although quantitative methods tend to dominate research in health sciences education, it is anticipated that qualitative methods will become increasingly important over the next few years (Wolf, 2004). This workshop, combining theoretical and interactive approaches and examples, will provide participants with a basic introduction to qualitative research methods. Topics will include: developing a qualitative research question, methods for data collection and analysis of qualitative data. How to ensure analytic procedures are appropriately rigorous will be a featured focus of the workshop (Ziebland & McPherson, 2006). Also included will be the use of(software programs for qualitative data analysis such as NVivo and Atlas. The interactive activities of the workshop will provide the participants with an opportunity to deliberate and discuss the key issues involved in formulating and designing their own qualitative research project. References Ziebland, S,. & McPherson, A. (2006). Making sense of qualitative data analysis: an introduction with illustrations from DIPEx (personal experiences of health and illness). Medical Education, 40, 405-414. Wolf, F.M. (2004). Methodological quality, evidence, and research in medical education. Academic Medicine, 79, S68- S79.
Objectives:

As a result of this workshop participants will be able to: 1.Assess when it is most appropriate to employ qualitative research methods 2.Construct a qualitative research question 3.Choose appropriate qualitative research methods 4.Describe the basic process of qualitative data analysis 5.Determine whether or not qualitative research is an area worth further exploration

W-15	**Developing Postgraduate Curricula That Meet Real Needs** *Mark Goldszmidt, David Keegan, University of Western Ontario*

Background/Rationale: Many components of postgraduate training are descendants of earlier versions that have been remodelled, or sometimes just reworded, over time to meet current standards. However, having a curriculum on paper and achieving its objectives in real time are not always the same thing. Two key factors that sometimes get in the way are 1) faculty and resident buy-in to the curricular goals and 2)

curricular realities themselves (time, case-mix etc.). Referencing our own experiences in curriculum design in postgraduate education as well as the related literature, key topics addressed in this workshop will include: a general overview of curriculum development in postgraduate education, a focus on both qualitative and quantitative approaches to needs assessment for this setting and a novel strategy for increasing the relevance of rotation objectives for residents. Along the way we will also address how the process itself can be used to engender faculty buy-in. Depending on participant experience and current projects, there will also be opportunities for sharing and reflecting on participant initiatives.

Objectives:

Objectives: By the end of the workshop, participants will be able to: -Describe five key elements essential for curriculum development in postgraduate education -Discuss how to use both qualitative and quantitative methodologies to perform a curricular needs assessment and ensure the achievability of their objectives -Discuss strategies for using objectives to guide resident learning -Apply the above to their own curricular initiatives

W-16	**Building Distributed Medical Education Into Canada's Medical Education Databases: Workshop to Start the Action Plan** *Steve Slade, Association of Faculties of Medicine of Canada; Joanna Bates, University of British Columbia; Paul Grand'Maison, Université de Sherbrooke; Chris Lovato, University of British Columbia; Joshua Tepper, Ontario Ministry of Health and Long-term Care; Alain Vanasse, Université de Sherbrooke*

The phrase "distributed medical education" (DME) encompasses a wide variety of medical training that now goes on outside of downtown Canada. To address health care needs in rural, remote and northern places, Canada's faculties of medicine have literally pushed forward the frontiers of medical education. Rural rotations and electives have been commonplace for decades, but recent efforts have succeeded in establishing permanent training sites in regional and northern Canada. Undergraduate and postgraduate medical students can now pursue training entirely outside of large urban centres. Medical education databases managed by the Association of Faculties of Medicine of Canada (AFMC) do not reflect the growth in distributed medical education. The AFMCs undergraduate database tracks enrolment in medical schools, but it contains no further data on distributed learning. Possible data sets for tracking DME across faculties of medicine were established at an earlier Health Canada sponsored workshop and the Canadian Post-MD Education Registry recently launched a pilot study to evaluate the feasibility of gathering distributed learning information. Currently, the AFMC databases, including CAPER, are not yet adequately poised to gather the full range of data on medical education in Canada. This workshop will bring together medical educators, program directors and administrators, Deans, researchers and policy-makers with experience in studying and/or delivering distributed medical education. Participant input will build on previous work to refine and prioritize the specific aspects of DME that need to be measured (e.g., location and length of programs, medical disciplines covered, populations served, number of enrolees, practice location of enrolees after training is complete).The goal of the session will be to develop a set of research questions and indicators on DME that will guide AFMC and faculties of medicine in the collection of data and development of national databases to addresses the information needs of policy and decision-makers.

Objectives:

1. Learn about and contribute to development of core indicators and national medical education database development. 2. Develop an understanding of data definition and linked database development in medical education. 3. Discuss priorities for research and evaluation questions related to distributed medical education and strategies for collecting data.

W-17	**Disruptive Physician and Medical Student Behavior: Opportunities for Prevention, Intervention and Rehabilitation** *Derek Puddester, University of Ottawa; Lori Charvat, University of British Columbia; Paul Farnan, Physician Health Program of British Columbia*

This workshop will be of interest to medical educators because: - They have a unique opportunity to promote professional attitudes and behaviours in the education and training environment - Medical educators often are the first ones to identify a serious behavioural problem in medical trainees - Prevention strategies are best targeted at the undergraduate and postgraduate training environments

Objectives:

At the end of this workshop, participants will be able to: 1. Identify the major determinants of disruptive behaviour 2. Describe the impact of disruptive behaviour on patients, the health care team, and the teaching and learning environment 3. Summarize at least three strategies for identification, intervention, management, and monitoring of disruptive behaviour 4. List at least three resources to guide their future efforts in this area

W-18	**Social Accountability Learning Resource: A Collaboration of the 17 Canadian Medical Schools** *Kendall Ho, Denise Buote, University of British Columbia*

World Health Organization defined social accountability of medical schools as “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. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.” (1) In 2002, the Association of Faculties of Medicine proposed a set of key principles to guide medical schools in the context of social accountability. Central to these principles were the respectful involvement of the community in needs identification and priority setting, and the collaborative partnership with affiliated health care organizations, health professionals, policy makers and governments for innovation and evaluation of emerging models of engagement. (2) A group of faculty members from the 17 medical schools with experience in continuing professional development, faculty development, primary care, and medical training, obtained three year funding from Health Canada’s Primary Care Health Care Transition Program to pursue a national initiative called “Issues of Quality and Continuing Professional Development: Maintenance of Competence” (CPDiQ), (3). The CPDiQ initiative supported each medical school in the development of a regional and academic led project that animated community and transdisciplinary partnerships towards social accountability in continuing professional development (CPD) and faculty development (FD). Further to this, all schools collaborated on documenting best practices of social accountability by academia through an international literature review and the development of a Canadian inventory of best practices. An evaluation framework to guide and measure the initiative was articulated by a working group. CPDiQ documented these collective findings into a learning resource to promote dialogue on the privileges and obligations of medical schools in social accountability. This workshop proposal is to explore the utility, efficacy, and shortcomings of this learning resource in achieving its intended goals. References 1. Division of Development of Human Resources for Health, World Health Organization. Defining and Measuring the Social Accountability of Medical Schools. Geneva, Switzerland.1995. 2. AFMC Social Accountability Steering Committee. Social Accountability: A Vision for Canadian Medical Schools. 2002. Accessible at http://www.afmc.ca/docs/pdf_sa_vision_canadian_medical_schools_en.pdf 3. Project proposal. Issues of Quality and Continuing Professional Development: Maintenance of Competence. Submitted to Health Canada Primary Health Care Transition Fund. April 15, 2003.

Objectives:

• To affirm the vision and mission of inclusion of social accountability in medical schools • To highlight examples of social accountability of medical schools in action through selected school projects highlighted in the learning resource, and to illustrate how these cases can be used to stimulate dialogue and discussion on this topic with medical trainees and faculty members • To engage in a dialogue around the content of the learning resource addressing issues such as relevance to teaching issues of social accountability, key material that is critical to the teaching and material that would be beneficial to add to the learning resource • To encourage like-minded faculty members and individuals to help disseminate the concept and practice of social accountability using the examples highlighted in the learning resource

W-19	**Looking in the Mirror: Enhancing Self-assessment in Medical Education – A Learner-centred Model for International Medical Graduates** *Maureen Gottesman, Catherine Smith, David Tannenbaum, University of Toronto*

We have had the unique experience of designing and implementing the "Pre-Residency Program" (PRP) for international medical graduates (IMGs) entering family practice in Ontario. The goal of this intensive 8-week program, operated by IMG-Ontario, is to prepare IMGs for successful post-graduate training in family medicine. The curriculum focuses on communication skills, including the patient-centred clinical method, and understanding professional roles and responsibilities. The techniques used in teaching communication skills serve to enhance the IMG's ability to self-assess and reflect on their performance. These skills are often underdeveloped in some internationally trained professionals but necessary for successful learning and performance in the professions in Canada. Accuracy in self-assessment improves the ability of the learner to receive feedback positively and reduces defensive reactions. Self-assessment skills are also important for focusing one's lifelong learning needs. The workshop will help participants in teaching communication skills and providing feedback designed to enhance self-assessment in learners.
References 1. Bates J and Andrews R. (2001). Untangling the Roots of Some IMG's Poor Academic Performance. Academic Medicine. 76:43 2. Duffy FD and Holmboe ES. Self-Assessment in Lifelong Learning and Improving Performance in Practice: Physician Know Thyself. JAMA 2006;296(9):1137-1139 3. Eva KW and Regehr G. Self Evaluation in the Health Professions: A Reformulation and Research Agenda. Acad Med 2005;80(10);S46 4. Kruger J and Dunning. Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments. J Pers Soc Psych 1999;77(6):1121-1134 5. Steinert Y and Levitt C. Working with the "Problem" Resident: Guidelines for Definition and Intervention. Fam Med 1993: 25:627-32

Objectives:

Participants will: 1. Develop an understanding of how using a common language for Patient-Centred interviewing can be used to improve competence of medical learners 2. Appreciate how one's self assessment skills can be improved by observing others (benchmarking) 3. Practice giving learner-centred feedback as a means to assist the student in improving their self-assessment skills

W-20	**Writing OSCE Cases: Lessons Learned at the Medical Council of Canada** *Sydney Smee, Lise Martineau, Medical Council of Canada*

While there is widespread use of the OSCE at Canadian medical schools, writing valid cases and developing reliable scoring instruments remains a challenge. A good case is more than a patient problem, it is a test item with multiple components including instructions to test takers, information for standardized patients and scoring instruments. The case must be linked to assessment objectives and must be feasible within the constraints of the OSCE format. Without support, new authors struggle to produce quality cases that meet all of these criteria. Since the implementation of the Medical Council of Canada's (MCC) Qualifying Examination Part II in 1993, MCC staff and test committees have worked with several approaches for developing OSCE cases for a high stakes assessment. Along the way, some critical lessons have been learned about successful case development and the needs of authors. The purpose of this workshop is to share these lessons, including the value of a workshop format for authors.

Objectives:

1.Review common conceptual errors made by case developers. 2.Compare the use of checklists to the use of rating scales for scoring. 3.Discuss the impact of weighting items within a scoring instrument. 4.Discuss the effective use of computers and templates. 5.Discuss the advantages of a group-based approach to case development.

	An Interprofessional Approach to Remediation in Undergraduate Education: The

W-21	**Experience of the Medical Radiation Sciences Program, The Michener Institute of Applied Health Sciences/University of Toronto Faculty of Medicine** *Ewa Szumacher, Cathryne Palmer, Anna Jarvis, Marc Potvin, University of Toronto*

Academic difficulty requiring intensive, focused remediation is an uncommon but significant problem in many health professional programs. The Medical Radiation Sciences (MRS) Program, a collaborative program between the Department of Radiation Oncology at the University of Toronto, Faculty of Medicine, and the Michener Institute for Applied Health Sciences, was founded in 1999. Since the inception of the Program, a number of students have required remediation primarily in the clinical component of the Program, but also in the didactic or preclinical component. Not all remediation strategies have been successful, and a number of students have ultimately been dismissed. There is relatively sparse evidence in the educational literature regarding the nature of academic difficulties that health professional students encounter, and what constitutes appropriate remedial education. This workshop chiefly helps the participants to better understand the remediation process in undergraduate education based on the MRS Program's experience. Additionally, remedial strategies and interventions will be discussed, along with the interprofessional approach to the management and design of the remedial plan.

Objectives:

At the completion of this workshop, participants will be able to: 1. Determine common causes of academic difficulty for students in undergraduate professional medical education programs. 2. Differentiate between enablers and barriers to successful remedial education. 3. Appreciate the benefits of an interprofessional "student–based" approach to the development of remediation plans. 4. Determine the effectiveness of the remediation process and strategies implemented based on the experience of the MRS Program. 5. Novel approach using drama to improve communication skills and cultural awareness.

W-22	**Three Models of Distributed Medical Education - Urban, Rural, Inter-Provincial: Which Model Is Right for Your Institution?** *Joel Lanphear, Northern Ontario School of Medicine*; *Paul Grand'Maison, Université de Sherbrooke; Jay Rosenfield, University of Toronto*

RATIONALE As the pressure for education and training of more physicians increases nationally, Canadian medical schools have responded by creating and adopting new models of undergraduate medical education. Prompted by the need to increase class sizes and also to provide an educational context appropriate to the new demand, medical schools have looked to distributed models in urban, rural and inter-provincial environments. While these contexts have important cultural and environmental differences, the creation of distributed medical education programs requires systematic examination of a variety of factors. Among these are: 1. Defining clearly what is meant by distributed medical education in the context of a specific medical school; 2. Defining community and identifying stakeholders as they relate to the specific medical school context; 3. Identifying key educational principles essential to distributed medical education programs; 4. Identifying the criteria and role of the stakeholders in creating a distributed system; 5. Identifying methods and approaches to communicating with stakeholders. 6. Identifying suitable program evaluation methodology in order to provide feedback about program effectiveness; 7. Identifying ways in which students at various locations may have comparable learning opportunities; 8. Identifying the logistical components of planning and implementing a distributed experience; 9. Defining the parameters of the distributed educational model (i.e. course, clerkship, observation etc.); 10. Identifying student life issues and how they can be addressed; 11. Identifying the fiscal implications, limitations and funding sources for a distributed medical education model; 12. Defining the roles, rights, responsibility, and governance issues related to faculty in distributed sites. 13. Determining whether or not faculty development activities are required, and if so, what is the nature of those activities and how will faculty development programs be delivered. 14. Identifying an organizational structure to support the development and implementation of a distributed system. All of these issues and others need to be addressed in the process of deciding to create a distributed medical education model in new communities that may not have been involved in medical education in the past.

Objectives:

LEARNING OBJECTIVES At the end of the workshop the participants will: 1. Have identified a model of distributed medical education that best fits the needs of their institution; 2. Will have prioritized a list of action items and considerations as they move forward to create the distributed model; 3. Will have identified at least four key educational principles that will be essential in the development of their program; 4. Will have discussed in a small group format and reported out a summary of discussions held around the key concepts above in small group. 5. Will have identified an organizational structure to support the model.

W-23	**Improving Your In-training Evaluation** *Gary Cole, Royal College of Physicians and Surgeons of Canada; Brian Hodges, University of Toronto*

Increasingly, the medical education field is placing more and more emphasis on in training evaluation. Good in training evaluation is essential for effective medical education to take place. At both the graduate and undergraduate level, there are some fundamental principles that should be followed in setting up an effective in training evaluation system and, depending on your role, principles that should be followed in dealing with faculty, health care professionals, patients and family. Various evaluation tools are available and each has its strengths and weaknesses. Faculty development is important as well as the efficient collection and documentation of information. Both formative evaluation and summative evaluation are part of in training evaluation and require different approaches, skills and instruments. These issues and others present common challenges that are faced by faculty, program directors, at the undergraduate level as well as at the specialty level. In training evaluation is changing with new technologies and a better understanding of the techniques and principles of evaluation. Different conditions such as those presented by distributed learning may pose specific challenges. A sharing of information regarding the challenges and both old and new solutions to these challenges will enable program directors and faculty to conduct more effective in training evaluation.

Objectives:

understanding the common principles and specific challenges in effective in training evaluation at both in undergraduate and post graduate level of medical education and in different types of learning environments. understanding effective practices; old and new technologies for dealing with the challenges faced in in training evaluation

W-24	**'T5' – Teaching the Taught to Teach: Improving Medical Students' and Residents' Teaching Skills** *Linda Snell, Jeffrey Wiseman, McGill University; John Spencer, Newcastle University, Newcastle upon Tyne, UK*

Almost all residents and medical students will in due course have to teach future learners, their colleagues in CPD programs, their patients or other health professionals. Recent educational guidelines such as CanMEDS, ACGME, and 'Tomorrow's Doctors' (UK GMC) learning objectives include 'teaching skills' and 'learning about learning'. Medical students and residents with a better understanding of teaching and learning principles may be more effective communicators and better learners. In spite of these compelling factors, teaching skills improvement activities are not present in all residency programs, and these activities vary in content and format. As well, only a few programs are described that teach medical students how to teach. Content areas for a teaching skills improvement program could include, for example, adult learning principles for the clinical context, strategies for facilitating self-directed learning, planning a teaching session, large group, small group and one-one-one teaching strategies, giving feedback, assessment of learners, motivating learners etc. Successful formats for existing programs or activities have included workshops and half-days, seminar or lecture series, electives or student selectives; these may be targeted at specific levels of learners to address their current teaching roles. The success of teaching skills improvement programs should be assessed. This workshop will be of interest to those with teaching skills programs for students or residents, as well as those contemplating such a program. References 1. Snell L. Planning and implementing a teaching skills program for residents. Book chapter In Residents' Teaching Skills. Edwards JC, Friedland J, Bing-You R. New York NY Springer 2002,

p. 81-99. 2. Dandavino M, Snell L, Wiseman J. A teaching skills improvement program for medical students? Clinical Invest. Medicine, August 2004; 27(4):199. 3. Snell L & Friedland J. Residents as Teachers Guide to Planning and Implementing a Program. www.Welcome to the Residents' Teaching Skills Web Site, a collaboration with the Graduate Medical Education (GME) Section of the Association of American Medical Colleges (AAMC).htm 4. Busari JO, Scherpbier, Albert JJA. Why residents should teach: A literature review. J Postgrad. Me, 2004, 50(3) 205-19. 5. Wamsley M, Julian K, Wipf J. A Literature Review of Resident-as-Teacher Curricula Do Teaching Courses Make a Difference? J General Internal Medicine May 2004,19:574-81. 6. Bardach NS, Vedanthan R, Haber RJ. 'Teaching to Teach': enhancing fourth year medical students' teaching skills. Medical Education 2003; 37:1031-2.
Objectives:

At the end of the session the participants will: -be able to discuss reasons why learners should be taught how to teach -be able to outline the steps in designing a program to teach learners how to teach -have shared ideas for best practices -be prepared to implement or improve a program for their own context

W-25	**The Family Conference – A Forum for Teaching and Assessing Team Communication and Collaboration** *Sue Dojeiji, Anna Byszewski, Meridith Marks, University of Ottawa*

With the increasing complexity of patient care there is a need for effective inter-professional collaborative person-centered care. Health professionals need to develop skills to maximize how they coordinate their work and collaborate in a team setting, and how to optimize the transfer of complex information to the patient and their care providers. The family conference is the quintessential forum for interdisciplinary care. Family conferences include patients, their caregivers and the treating health-care team. They occur for many reasons: discussion of medical care and recommendations, discharge planning, and discussion of end of life issues. This forum for interaction is used regularly by health care teams ranging from acute medicine and surgery, to rehabilitation, and to palliative care. Literature supports the importance of family conferences, but there are limited and anecdotal guidelines on the essential content and process of these meetings. Some of the skills required in interprofessional work include effective communication between team members, mutual support, effective participation, joint decision making, clarifying goals, and showing respect for other health professionals and their respective roles. These skills are essential to be an effective contributor to family conferences. As a discrete interprofessional collaborative activity, the family conference provides an ideal forum for teaching and evaluating students and residents on the competencies related to communication and collaboration within a health care team. This workshop will provide one method for teaching and evaluating performance within the family conference. References: 1. Frank JR (Ed). 2005. The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada. 2. Headrick LA, Wilcox M, Batalden B, Interprofessional working and continuing medical education, BMJ 1998;316: 771- 774. 3. Hansen p, Cornish P, Kayser K, Family conferences as forums for decision making in hospital settings, Social Work in Health Care 1998; 27(3), 57-73. 4. Molloy W, Cranney A, Krajewski A, Lever J, Orange JB, Davidson W. The Family conference in Geriatrics. Canadian Family Physician 1992 ; 38, 585-8. 5. Taggar S, Brown T. Problem solving team behaviors. Small Group Research 2001; 32(6):698-726.

Objectives:

At the end of this workshop on family conferences, participants will be able to: 1. Compare and contrast multi-disciplinary and inter-disciplinary care. 2. Provide essential observable communication and collaboration behaviours that can be taught and evaluated within the context of a family conference.

W-26	**Teaching to Transform and Inspire: Seeking the Opportunity** *Sarah Jarmain, University of Western Ontario; Melissa Andrew, Queen's University; Lisa*

	VanBussel, University of Western Ontario

In our shifting healthcare environment, the leadership and educational paradigms that we are working within are changing at an unprecedented pace. With ongoing organizational and practice change, awareness is growing of the need for collaborative models of interaction, focusing on the differing needs of the learner or follower, and the context in which the interaction is occurring. Educators at all levels are beginning to attend to the need for trainees to acquire expertise across multiple physician roles, including Physician as Medical Expert, Scholar, Collaborator and Manager (CanMEDS 2005). However, methods to help trainees develop these roles are often unclear, and educators often feel ill prepared to teach in areas such as leadership or management. This workshop intends to help participants explore the concept that many of the skillsdeveloped as an educator can be applied to leadership and vice-versa. Through exploration of three theoretical models within leadership and education, participants will examine their own teaching and leadership styles, and develop some educational approaches to use in their own day-to-day teaching. 1. Bass, B.M. 1985. Leadership and Performance Beyond Expectations. Free Press. New York. 2. Burns, J. M. (1978). Leadership. New York: Harper & Row. 3. Collins, A., Brown, J. S., & Newman, S. E. (1989). Cognitive apprenticeship: Teaching the crafts of reading, writing, and mathematics. In L. B. Resnick (Ed.), Knowing, learning, and instruction: Essays in honor of Robert Glaser (pp. 453-494). Hillsdale, NJ: Lawrence Erlbaum. 4. Hersey, P. & Blanchard, K. 1969a. Life-cycle Theory of Leadership. Training and Development Journal, 23: 26-34. 5. Tichy, Noel, and Cohen, Eli. Building Leaders at Every Level. Plano, Texas: Pritchett Rummler-Brache, 1998.

Objectives:

- Describe three different models of leadership development, and list the specific methods each uses to facilitate development of leadership competencies - Compare and contrast the roles of leader and teacher - Effectively strategize about how they can ap

W-27	**Medical Humanities in Canada: A Developmental Workshop** *Marcel D'Eon, University of Saskatchewan; Monica Kidd, Memorial University of Newfoundland*

One commonly articulated purpose of medical humanities is to train compassionate and humanitarian doctors though there is some disagreement among Candian educators (Kidd, 2006). In the face of relentless depersonalization patients are in danger of being treated as no more than a collection of diseased organs and systems. Medical Humanities contribute to understanding the human condition: philosophy, ethics, history, anthropology, sociology, literature, and the visual and performing arts, to name a few and may slow or reverse this pressure. Furthermore, some claims have been made as to the efficacy of instruction in the humanities which are also disputed. The purpose of the workshop is to better (1) define medical humanities, (2) articulate the purpose(s) and scope of training in the humanities, (3) identify the challenges to humanities training, and (4) to consider ways to evaluate the outcomes of medical humanities training.

Objectives:

1. Define and describe medical humanities 2. Describe the purpose(s) of training in the medical humanities. 3. Describe ways to evaluate the outcomes of medical humanities. 4. Create ways to make the teaching of medical humanities more effective in Canada and in the home institutions of the participants.