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Decisions for Regional Distributed Clinical Education
School of Medicine, Faculty of Health Sciences, Queen's University

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Executive Summary

Queen's School of Medicine (QSoM) delivery of clinical medical education in a "distributive format" requires decisions with respect to:

What is doable?
What is the experience?
What are the requirements?
What are the external influences?

The QSoM distributive regional model for clinical medical education was built on the mission statement of the school just prior to its 2004 sesquicentennial. A historical time line respecting the delivery of clinical medical education is presented. The present monthly activity of learners within the South Eastern Ontario (SEO) region and beyond is presented. The present arrangements and structure are outlined. Evaluations from the perspective of the learners, hospital communities and community teachers are summarized. Accreditation concerns of UG and PG programs are identified.

An environmental scan of Distributed Medical Education (DME) external to Queen's provides a background. The fragility of the present arrangements is highlighted. There is a need to develop a consistent effective regional strategy that addresses not only the education needs of the School of Medicine but also addresses regional input and health human resource planning. Planning for regional distributive education will need to consider a number of interlocking parameters such as clinical referral, patterns of practice, research opportunities, recruitment and retention of regional human health resources and the educational needs of the School of Nursing and Rehabilitation Therapy.

Three proposed models of architecture for QSoM DME in SEO are analyzed. Recommendations for decisions for Regional Education are provided. Delayed timelines for decisions on the most effective model and the requirements to support the model risks the permanent loss of community physician teachers at a time when our Kingston based clinical teaching resources cannot cope with the Undergraduate and Postgraduate clinical training requirements.

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1. Introduction

Our Queen's School of Medicine (QSoM) mission statement: "is to educate health professionals and students in the biomedical sciences by conducting research, by generating a spirit of enquiry, **and by serving the health needs of the people of southeastern Ontario,** drawing on Queen's learning environment to enable our graduates to become the leading health professionals for Canada's rural, northern, and urban communities and to provide researchers and educators for the nation's future."

The 2004 Mission & Strategic Objectives of the Queen's Faculty of Health Sciences concludes with the strategic direction in our Region and in the north: **"to develop and to sustain excellent and innovative care delivery systems integrated with educational and research programs in collaboration with our regional and northern partners by: reconstituting the academic health sciences centre, creating an academic health sciences network and serving the needs of regional and northern partners."** The final paragraph identifies that: "We are working with our principal teaching hospitals (in which our faculty are their medical staff) and regional partners to implement and devise further innovative programs of integrated care responding to the needs of the public in our region. It is our goal to continue to study the health of the population we serve, to measure the effectiveness of the programs we offer and to identify strategies and interventions that are effective. It is within these systems of care, and in conjunction with our many partners, that we are embedding a distributed medical school, and optimizing clinical education sites in Nursing and Rehabilitation Therapy." [See attachment 1]

QSoM Faculty Council joined with regional hospitals in a 2001 retreat to fashion a "distributive medical education" (DME) model for the clinical education delivery. A QSoM office of Regional Education Development was initiated in 2002.

The DME model for clinical medical education was to serve:

- the overwhelmed capacity for clinical education in Kingston hospitals
- the anticipated increase in numbers of MD students entering Clerkship in 2004
- the anticipated increase in numbers of residents entering training in 2006
- the interest and capacity of community hospitals and physicians in clinical educational roles

Since the initiation of the QSoM distributive model of education these key events have focused the attention of undergraduate, postgraduate and regional education programs:

- Undergraduate accreditation review
- Follow up undergraduate accreditation review
- Initiation of "curricular renewal" for the undergraduate MD program
- Preparation for PG accreditation ...Oct 2005
- Preparation for UG accreditation ...Jan 2007
- Further erosion of the regional human health resources within regional communities
- A substantial increase in the Postgraduate Family Medicine residency numbers requiring community rotations

After 3 years of Regional Education Development, it is appropriate to reflect on the present success and future uncertainties of the evolved distributive model in our QSoM. Since the initiative of DME in SEO there has been a number of pertinent changes to the medical education landscape in Ontario:

- Development of Queens-Ottawa Affiliation Agreement
- Opening of a new medical school "Northern School of Medicine"
- More than 30% increase in undergraduate MD enrollment
- Request for more training of International Medical Graduates
- Increase in number of postgraduate residents
- Further substantial increased enrollment of Undergraduate MD students for Sept 2005 in Ottawa and Toronto

The QSoM response to MTCU requests regarding Clinical Education -May 24, 2005 (See Attachment 2) and the 2005 Rae Recommendations pertaining to clinical education provide financial support for this increased output of UG and PG trainees in medicine.

The expectations of UG Accreditation and PG Accreditation (due 2007 and 2005 respectively) focus on the present successes and future uncertainties of DME at QSoM. The development of Med Tech, the initiation of Curriculum Renewal, the need for enhanced Faculty Development, the collaborative efforts of the Medical Education Advisory Committee, the enhanced numbers of presentations and leadership of Queen's faculty at Canadian Medical Education Conferences and the interdisciplinary cooperative efforts with the Schools of Nursing and Rehabilitation all point to the opportunity to define direction and process for DME in the QSoM and "distributed health education" (DHE) in the Queen's Faculty of Health Sciences

Two constant monitors of our health as a desirable medical school will be:

1. the success at the CARMS match by residency programs and
2. the admission selection by our medical school applicants.

Loss of past success in these venues will be hard to overcome. The decisions taken for Regional Education within our QSoM will affect not only the numbers but also the rank order that students and residents assign to our MD and residency programs.

2. Past Historic Time Lines in Medical Education Delivery

1854 - Queen's School of Medicine
1910 - Flexner Report – Undergraduate education to select medical schools
1960's - College of Family Physicians and Family Medicine Residency programs
- University based residencies in Canada
1970's - Community based Family Medicine Residency programs
1980's - reduction in output of medical schools
- reduction in active patient beds
-Development of regional education programs (reps) across Ontario

2002 - Regional Education Development - QSoM
2004 - expanded clerk numbers from 75 to 100

2005 - expanded Family Medicine numbers of residents
- further expanded expectations for numbers of undergraduate, postgraduates and IMGs
- expectation of "fast tracking" and proposals for 7th Medical School
- expectations of principles from DME-COFM [See attachment 3]
- expectations of distributive health education – M of H LTC
- expectations from LIHN's boundaries and terms of reference
- Primary Care Reform arrangements
- OMA – Mof HLTC Master Agreement
- May Ontario Provincial Government Rae Report findings and actions on Clinical Education needs
- Sept - opening of Northern School of Medicine
- Sept - increased intake of medical students in Toronto and Ottawa

3. Queen's School of Medicine Regional Education Activity – 2005

Three tables present:

3.1: Present activity outside SEO

3.2: Number of SEO learners per month at July 2005

3.3: Potential capacity for number of learners per month

3.1 Present QSoM Regional Education Activity Outside SEO

Location	PG
Markham	1.0 FM per month doing Paeds. starting July 2005
	1.0 Clerk per month doing Paeds. starting January 2006
Kingston Comm	5.0 FM residents per month
ROMP	3.0 FM clerks per month
Moose Factory	2.0 FM residents, 1 clerk
Ottawa	5.5 FM residents per month 3.5 FRCP residents per month
Hamilton	.4 FM residents
Toronto	.6 FM residents
Other Comm	2.0 FM residents per month
Outside Province	0.5 FM residents per month

* Electives for UG clerks not included
* Electives for PG residents in other Medical Schools not included

3.2 Number of SEO Learners per month at July 2005

Location	Discipline	FMPG	FMUG	FRCP	Clerks	Total
Belleville	Family					
	EM	0.3				
	OB/GYN	3.0				
	Sx	1.0		0.3		
	Ortho	1.0				
	Paeds			0.4	0.6	
	IM	3.0		1.0		
						10.6
Picton	Family	2.0				
						2.0
L&A	Family	0.6				
						0.6
Brockville	Psych			0.2	2.0	
						2.2
Oshawa	Paeds				1.1	
	Sx	1.0		0.3	2.0	
	Ortho	1.0				
	OB/GYN	3.3		0.4		
	Psych	1.0			2.0	
	IM			0.2		
						11.2
Bowmanville	Family					
Whitby/Brooklyn	Family					
Cobourg	Family					
Peterborough	Family					
	Sx	1.0				
	IM			0.2	2.0	
	Ortho	1.0				
	OB/GYN	0.6		0.4	2.0	
	Paeds			0.2	0.8	
	Urology			0.2		
	Anaesthesia			0.6		
						9.0
ERMEP	Family		6.0			6.0
Non SEO						10.0

* Avg. 60 learners per mth. * Comparison to 2001 - 10 learners per mth.

3.3 Potential extra capacity for number of learners each month

LOCATION	DISCIPLINE	INCREASE PER MONTH	
		CLERK	RESIDENT
Belleville	OBGYN	1	
	EM	0.5	0.7
	FAMILY	1	2
Brockville	OBGYN/Sx	1	0.5
	ANAES.		0.5
	PSYCH.		1
Oshawa	FAMILY		1
	Sx		2
	ORTHO		1
	OBYGYN	1 resident or 1 clerk	
	IM	1	1
Bowmanville	FAMILY	1	2
Whitby/Brooklyn	FAMILY	1	2
Cobourg	FAMILY	1	1
Peterborough	FAMILY	1	2
	IM		2
	PADS	1.2	.8
	ANAES.	1	0.6
ERMEP	FAMILY	4	2

REQUIRED ACTIONS TO ACHIEVE PROJECTED INCREASED CAPACITY:

- **Recruitment of new physicians to the community**
- **Paeds and OBGYN and Psychiatry are main deficits**
- **Integration of Family Medicine and FRCP postgraduate programs**
- **Integration of Family Medicine undergraduate and postgraduate programs in same communities**
- **Delivery of Faculty Development to community physician teachers**
- **Expansion of "Site Coordination"**

4. Projections of Future Needs for QSoM Regional Rotation

At the present number of UG clerks (100) there is no remaining capacity for UG clerks in any discipline. Each additional enrollment above 100 will require 4 blocks of 12 weeks (48 weeks or 12 months) within the present curriculum or as much as 60 weeks (15 months) in an expanded clerkship curriculum.

Eg 1 Increase enrollment to 103 for September 2005 will cause an increase of 3 x 12 = 36 months of community clerkship rotations beginning January 2008

Eg 2 Expansion of curriculum by one month will cause an increase of 103 x 1 = 103 months of community clerkship rotations

The latest proposal to increase UG enrollment by 6 positions will require 6x12 = 72 further months of Community rotations.

The undergraduate kingston rotations in a number of disciplines are being stretched beyond departmental capacity even with the present. use of regional rotations.

OBSGYN	needs to expand Regional rotations by 2 clerks per month
PAEDS	needs to expand Regional rotations by 2 clerks per month
PSYCH	needs to expand Regional rotations by 2 clerks per month
EMERGENCY MEDICINE	needs to expand Regional rotations by 2 clerks per month

Each of the above rotations (OBSGYN, PAEDS, PSYCH and EMERGENCY MEDICINE) will require the development of rotations that presently do not exist in the SEO Communities of Belleville, Brockville, Oshawa and Peterborough. Rotations in Communities outside of SEO will be needed over the next two to four years. Alternatively, the human physician resources for these specific disciplines in the SEO region need to be considerably augmented.

Community rotations that will likely see an expansion on a clerk and resident requested basis are:

- Anaesthesia
- Internal Medicine
- Surgery (General and Orthopedic)
- Emergency
- OBSGYN

Postgraduate rotations in Family Medicine are expanding extensively within SEO as of July 2005. However capacity in SEO does not meet the needs and a number of rotations outside SEO are now being utilized (Toronto, Markham, Ottawa). For each additional Family Medicine PG recruited resident the community rotations increase by 8 – 10 months per year.

Postgraduate rotations in FRCP specialties are expanding minimally and without a planned coordination. Most rotations go outside SEO and there is reluctance amongst program directors and residents to concentrate the regional rotations in communities where there are undergraduate learners in that specific discipline. For each additional FRCP recruited resident the community rotations increase by 4-6 months per year.

Integrated rotations of UG and PG learners and across disciplines have been successfully achieved in:

- Internal Medicine/ Family Medicine residents - Belleville Internal Medicine
- Psychiatry clerks and Family Medicine residents - Oshawa Psychiatry
- Surgery clerks and Family Medicine residents and Surgery residents - Oshawa Surgery
- OBGYN clerks and Family/Emergency residents – Peterborough OBGYN
- Internal Medicine Clerks and Residents – Peterborough Internal Medicine

Many community teachers who have only undergrad student learners or only Family Medicine PGY 1 & 2 residents without specialty specific residents feel that they are provided with an inordinate burden of teaching without corresponding benefits of workload reduction or ability to recruit learners to their discipline or to their community. In some rotations there are only clerks or only residents in a specific discipline. A few rotations have intermittent clerks scattered with residents.

Within the past year, there has been increased utilization of Ottawa based rotations for CCFP & FRCP resident training. This has occurred on a month by month basis with no coordination across programs and no coordination with respect to accommodations. Accommodations have become a limiting factor to resolve this years placements in Ottawa. A more significant concern is the likelihood of UofO Medical School placing restraints on Queen's School of Medicine access to these rotations.

At the present time clerks are expected to complete their 6 week rotation in Family Medicine outside of Kingston and are asked to exercise their option to do one (four or six week) rotation in General Sx/or/OBSGYN/or/PAEDS/or/Internal Medicine/or/Psychiatry in a community setting. With increased numbers there will need to be a clear statement that up to 8 weeks of clerkship beyond Family Medicine will be assigned to a community rotation.

5. Regional Education Office Arrangements for Community Rotations

Regional Education office arrangements for community rotations include:

- Affiliation agreements
- Site coordinators at Belleville, Peterborough, and Oshawa
- Lead Preceptors for Undergraduate and Postgraduate programs
- Learner pagers
- Accommodation allowance policy
- Telephone/cable access – upgrading the speed
- Travel allowances
- Preceptor reimbursement
- Reimbursement for medical administration
- Completed Needs Assessment with CPD office
- Videoconferencing - 23 sessions per week
- Web based access to necessary information for learners and teachers

The present apartment utilization (# of learners accommodated with "FM" identifying only Family Medicine Residents and "RE" identifying undergraduate clerks and FRCPS residents) in the communities is:

PICTON		3 FM
BELLEVILLE	3 RE	4 FM
OSHAWA	6 RE	3 FM
BROCKVILLE	4 RE	
PETERBOROUGH	6 RE	3 FM
MARKHAM		1 FM

Other communities with QSOM learners are….Ottawa, Dryden, Moose Factory, Napanee, Sharbot Lake, Smith Falls, Guelph, Toronto, Etobicoke, and Hamilton. Regional Education does not arrange accommodations in Ottawa or other medical schools. Clerks in Family Medicine are directed to ERMEP and ROMP regional programs to arrange preceptors and accommodations.

6. Evaluation by Learners

Evaluations by community learners have been uniformly positive with respect to welcoming, patient contact, patient access, and integration into clinical care teams. Family Medicine has experience with some long term (> 5 years) rotations. Clinical education opportunities **consistently surpass** those of their counterparts rotating at Kingston hospitals. Regional Education experience ranges from 2+ years to only a few months in some rotations. The preceptor model has some variances with respect to breath, style and enthusiasm of the teachers.

Some future concerns that the learners are likely to enunciate are:

- Frequency and choices of community rotations
- Length of community rotations
- On call rosters
- Preceptor vs. integrated teaching service
- Accommodations for family members

Present non-academic issues that are being addressed are:

- Expectations of time, location, frequency and duration of community rotations on admission to MD program and residency programs
- Fairness of choice and options available
- Local community travel
- Accommodations left in unacceptable squalor by cohorts
- Personal health needs
- Access to local health clubs
- Religious worship
- Sharing of accommodations
- Family and pets in accommodations

7. Evaluation of Hospital Communities

Past 3 years noted changes have occurred in leadership (CEO, COS) in the majority of SEO hospitals. There has been an exodus of family physicians and also specialists from hospital sites and declining hospital privileges. Much of the community hospital 24/7 clinical activity is dependent on Emergency Department and "hospitalist" physicians with varying models.

Retention and recruitment efforts see the potential positive complimentary role of learners in their community setting. New leaders are uniformly supportive of clinical learners. Planned recruitment is often stifled by fear of financial shortfalls in a fee for service individual physician arrangement.

Physical plant facilities are modern in most places with recent new construction in Cobourg, Markham, Oshawa, Brockville and a brand new hospital slated for 2007 in Peterborough. Lab/Imaging, electronic records, IT and VC are well advanced and often superior to Kingston teaching hospitals.

Medical and Professional Advisory Committees and hospital boards welcome the clinical education initiatives by QSoM and the Schools of Nursing and Rehabilitation Therapy.

The reality remains that there are many excellent community physicians who are independent practitioners and do not wish to be gathered into or for a collective purpose of educating young physicians.

Requests from community hospitals for enhancement of present funds for administration purposes are constant. Arrangements of all rotations through central RE office as opposed to multiple programs making different arrangements for rotations is preferred. They want one number or Email to call if they have a question for a specific learner, time period or rotation. Similarly, the majority of the active teaching community hospitals provide a single contact person that can efficiently and quickly provide direction, orientation and support to our academic programs and our learners.

8. Evaluation of Regional Education by Community Teachers

The positive experience of community teachers is removing some of the reluctance to teach. The students and residents do provide an enjoyable respite from the direct delivery of clinical care. Two distinct groups of teachers are evident:

1. Participant in Community Teaching Service:
   Eg. IM – Belleville, Family Medicine – Picton, OBGYN – Peterborough, Psych- Oshawa, Gen. Surgery – Oshawa

2. Lone preceptors

The first group share responsibilities and evaluations. Teaching is a part of the integrated team approach. These clinical teaching services are often hospitals based and office/ambulatory experience may be limited.

The second group (Lone preceptors) is interested in contributing and can be engaged but they do not want to have a continuous stream of learners. They are often difficult to contact for arrangements. They are excellent very busy practitioners on the edge of clinical overload. Although they will accept learners on an intermittent basis, they are opposed to a "learner-centered" model for community education.

Groups of teachers who are agreeable to have learners in their office setting plus the hospital setting needs to be developed. Office based teaching is more time consuming and often less efficient for the busy clinician. Teachers who cross cover their colleague's holidays and absences are also difficult to identify. Individual participants in a community teaching service can provide major or minor scheduled time commitments.

The community teachers pose four major reservations to teaching:

1. decrease in volume of patients, increase in workday hours

2. office facilities are too crowded and too busy

3. stipend is not nearly significant

4. lack of placements of resident physician of significant number and seniority

The generalist physician (FM, IM, PAEDS, OBS GYN, & PSYCH) do see importance and value for their efforts in education with respect to teacher and learner satisfaction and the possibility of recruitment of these same learners. Recruitment potential is minimal when the only purpose for the learner to be in a given community is to gain experience in a specific specialty.

Effective community physician role models are present but the pattern of individual practice arrangements does not assist recruitment strategies.

Each community has specific strengths in different spheres and different disciplines. There is a need to augment the strengths where possible in SEO communities. Moving beyond SEO (Markham, Scarborough, Barrie) is necessary but should not occur in lieu of shoring up the clinical education opportunities in SEO communities. The problems inherent in having learners (clerks and residents) beyond our SEO region are:

1. doesn't follow our 2004 mission and strategic objectives for the Faculty of Health Sciences
2. learners going farther from home
3. competition from learners from other schools
4. cause SEO communities and physicians to distance themselves from meeting QSoM clinical education needs.

Partnerships, primarily with ROMP & ERMEP will allow some flexibility over the next few years. [See Attachment 3]

9. Undergraduate Accreditation

The concerns of the undergraduate Accreditation team were that there is an onus to ensure that community rotations:

a) provide equivalent learning
b) provide student advisory capacity
c) do not disadvantage students financially

The above concerns have been addressed in terms of formal teaching, videoconferencing, connectivity, travel & accommodation arrangements, and site coordinates. Faculty Development needs have been formally assessed. Learner evaluations of (a, b, c) have been uniformly positive.

10. Postgraduate Accreditation

Family Medicine is the dominant program that uses community rotations. Family Medicine has more that a decade of experience using predominantly lone preceptors in many specialties. The factors that may come to discussion during accreditation are:

- influence of undergrad rotations in same community
- selection of rotation
- integration of rotations
- lack of family medicine rotations in the center where Family Medicine residents do specialty rotations
- lack of utilization of electronic teaching opportunities
- no integration of UG, Family Medicine clerks in communities with PG, Family Medicine residents.

The increase in FM resident pool is not containable within SEO without significant augmentation of community teacher resources and integration of learners. The RCPS specialty programs are using community rotations sparingly. There is continued resistance by individual program directors, departments and specialty disciplines to increase entry numbers in most programs because of Kingston's limited capacity. No or lack of growth of these RCPS programs will risk QSoM to become an "Undergraduate School" with Family Medicine being its only significantly sized postgraduate program.

11. Environmental Scan of DME in Canada

Experience with DME in Canadian medical Schools since the 1960's move of PG medical education from the hospital program setting to the University setting (Medical School) is sparse. The 1970 development of Family Medicine Residency Programs opened a new but singularly focused element. The 1980's reduction in PG number of trainees annihilated any further potential DME development. Even the schools that had offered significant blocks of discipline specific community rotations found the need to consolidate their program to achieve best education outcomes.

Ontario and other provinces in the 1990's identified community and rural centered initiatives of retention and recruitment and developed funding opportunities to have residents and medical students spend time in rural and small community based centers. The anticipation of enhanced recruitment of physicians for these "under serviced" communities was the operant logic for DME development. In Ontario the Regional Education programs (reps) took various nomenclatures (NOMEC, NOMP, SWORM & ROMP) with loose indistinct affiliations with one or more medical schools. ERMEP was the latest (2001) of these reps under a Queen's, University of Ottawa affiliation arrangement but with funding for only an undergraduate mandate. Essentially the reps focus on finding community preceptors who agree to take medical student or a resident for a defined time period. The student or resident applies directly to the rep electronically and selects from a menu of available community preceptors. The medical school program coordinator for the medical student and program director for the resident has little to no role to play but also has no preceptor or learner costs to bear. QSoM has used these rep arrangements exclusively for UG Family Medicine rotations and occasionally for elective PG specialty FRCPS rotations.

With the expansion of UG numbers, most Ontario and other Canadian medical schools found the need to develop community based "core rotations" outside their HSC. These core rotations were not easily accommodated with preceptor model of reps. The need for

defined and variable educational objectives, phased student evaluations and formal teaching sessions contributed to the medical schools' efforts to coordinate and select the community rotations. The medical schools are now dealing with - mandatory and continuous rotations as opposed to selective single preceptor rotations.

Each of UWO, Queens and later McMaster has attempted to select defined communities to achieve their rotations. The NSoM is now collaborating with NOMEC and NOMP to identify clinical placements for their UG needs but on an individual community preceptor model. Ottawa will loose some ability for placements when the NSoM begins clinical placement for clerks.

ROMP, the rep that is independent of a university affiliation is the rep that has the largest number of single preceptor community based physician teachers within its ranks. Queen's will need to work with ROMP, U of O, McMaster and U of T to share these available community-teaching resources.

COFM DME has outlined a position statement for a coordinated approach to DME in Ontario. [see attachment 4] This statement outlines:

1. medical schools primary and ultimate responsibility for :
   - all accredited activity
   - credentialing faculty
   - providing faculty development
   - evaluating practice setting
2. Needed collaboration between medical schools and MOHLTC funded DME programs
3. UE:COFM & DME:COFM in monitoring DME

The Ontario Ministry of Health and Long Term Care has highlighted a number of considerations for future funding of reps:

- Switch to distributed **health** education framework
- Exposure to setting **outside** academic health science centres
- Preparation of students for **interdisciplinary** nature of new models of care delivery
- Seamless **student access**
- **Multiple experiences** through UG and PG education
- **Collaborative** planning and accountability in reporting

[See Attachment 5]

Some Canadian Medical Schools are taking bold changes with respect to addressing their increased "output".

1. Separate Campuses – administratively & electronically linked
   Egs. UBC – Vancouver, Victoria, Port George,
   Sherbrooke – Sherbrooke, Moncton, Seguenay
   U of Montreal – Montreal, Trois Rivieres

2. Longitudinal Primary Care Clerkships with specialty exposure interspersed at specific days or portions of days each week
   Eg. UBC – Chilliwack
   Sherbrooke –
   U of Saskatchewan

12. Fragility of Present DME framework at Queen's School of Medicine

The fragility of the present arrangements at Queen's (see 2 ABC, 3 ABC) is directly related to:

- limited number of available teachers
- specific lack of some specialty teachers
- no shopping options within our SEO region
- any, a group or all teachers within a community or discipline could refuse to have learners.
- there are few substantive incentives for community physicians to teach
- community teachers that have accepted UG learners are not seeing influx of residents to their community.

Although the organizational components of learners rotations are no longer a burden to the teacher in the community, the continued voiced concerns of the community teacher are:

- Not enough money
- Not enough substantial fringe benefits
- No significant residents placements
- Not enough suitable office arrangements for teaching
- Decline in fee for service earnings
- Not committed on a constant basis to have learners
- Too many individuals to deal with
- University affiliation provides little tangible benefits for time savings
- University affiliation provides no meaningful ongoing discipline specific discussion forums.

There is some positive optimism in those community teaching rotations that have integrated learners within continuous clinical teaching service (critical number of community teachers working together):

Belleville - Internal Medicine
Oshawa – Psychiatry
Oshawa – Surgery
Peterborough – Obs Gyn

The single preceptor/single learner model works reasonably well in the UG arena for Family Medicine through the ERMEP & ROMP regional education programs. This also is available for PG elective community rotations in Family Medicine. The busy sole community FM teacher is an excellent teaching resource but is not the model that provides a strong foundation for anticipated future practice arrangements in Family Medicine.

The single community preceptor model does not effectively meet the needs the UG core rotations in non Family Medicine disciplines (OBS Gyn, Paeds, Psych, Internal Medicine, Surgery) other than for an occasional elective. Timing, consistency, continuity and arrangements need a critical mass of community teachers in a discipline in a specific location over the short and long term.

13. Regional Strategy Considerations

Our past and present experience with DME provides the background for focusing on the future. The future brings uncertain new organizational structures in the form of LIHN's and an ever-changing clinical referral patterns. Growth in population is decidedly only to the western border of SEO.

Our schools of Nursing and Rehabilitation therapy have enormous distributed learning needs and will continue to struggle with identifying suitable clinical placements. Interdisciplinary education will be expected by both the public and funding agencies. The term DME will likely be replaced by DHE (Distributed Health Education). The expectation by the public, funding agencies and the learners is that there will be provision of "team care".

Communities that can accommodate a continuous flow of one learner can usually accommodate learners from other disciplines or health professionals. Successful initiation of one educational program leads to positive evaluations from learners and teachers. Integration of community teachers to the educational milieu offers enrichment to the teaching fabric of Queen's School of Medicine. The success of Queen's Faculty of Health Sciences in achieving "QUIPPED" Queen's University Interprofessional Patient-centered Education Direction is identified in attachment 6.

14. Proposed models of Architecture for Distributed Clinical Education

1. **Multiple campuses (3 to 4**)

   1A: Students spend all or most of their time at these sites throughout their undergraduate years

   1B: Students spend all or most of their time at a specific site throughout clerkship

2. **Two defined campuses** (both with an urban and community base with one campus emphasizing

   2A: urban and community rotations and

   2B: the other campus emphasizing urban and rural rotations with students predominantly streamed to 2A or 2B throughout their clinical years and exclusively in clerkship

3. **Departmental Based Model of Distributed Clinical Education (DDCE)** that works to correct the present problems, takes advantage of the benefits of the critical mass in early undergraduate years and partners with our regional communities and other health disciplines to enhance human health resources of our SEO region.

Models 1 (A&B) & 2 (A&B) are not achievable in SEO and do not help to address the mission of the Queen's School of Medicine.

Model 3 – DDCE (**Departmental Based Model of Distributed Clinical Education)** requires a focused step by step approach for distributed medical (health) education in SEO. The needs for UG, PG, other health professions and the community physician teachers can be defined and the delivery of the educational rotations can be coordinated in a way that maximizes learner opportunity and teacher satisfaction. Such a model would enable and serve the necessary menu ingredients to a robust central and regional SEO faculty for QSoM through:

- Faculty Development,
- Continuous Medical (Health) Education,
- Interdisciplinary Education,
- Continuous professional Development,
- Retention and Recruitment

15. <u>Recommendations</u>

1. Each clinical department defines the placement of its Undergraduate and Postgraduate complement of learners in Kingston, other academic health science centres, and communities of SEO

2. Each clinical department reviews community health human resource augmentation required to achieve #1

3. Each clinical department defines the connectivity needs for maintenance of a distributed medical (health) program

4. Each clinical department defines the structure and staff that will be used to coordinate community rotations, community teacher appointments, faculty development, continuing education and interdisciplinary educational needs.

5. CPD with RE and Med Tech will work with each clinical department to effect CME & FD within the SEO region and across regional programs

6. CPD with RE and Med Tech will work with each clinical department to maximize interdisciplinary education opportunities

7. RE and department of Family Medicine will work to coordinate integration of community learning across disciplines

8. Department of Family Medicine will coordinate 2 or more community bases for continuous Family Medicine residents in Family Medicine

9. Resource allocation to community teachers:
    - Will be equivalent across discipline
    - Will be increased for Queen's regional faculty
    - Will be supplementally increased for undergrad teaching, faculty development attendance, office based teaching and lead roles for education

10. Site Coordinators will have a full expanded role for student affairs, CME & Faculty Development

11. Discipline specific community lead preceptors coordinate learner rotations with departments

12. Increase per learner stipend to each hospital administrative arrangement

13. Collaborative partnership with ROMP, ERMEP, U of Ottawa Medical School and other medical schools

14. Regional discipline specific videoconferenced "Grand and Specialty Rounds"

15. Regional and discipline specific access to rounds, presentations, CME, FD, through web casting

16. Adoption of each decision point (1 to 15) for Moose factory needs/resources.

17. Taking the DDCE model to communities (Disciplines, MAC & Boards)

18. Community physician invitation to undergraduate admission process and departmental/ discipline CARMs process.

19. Evaluation and Research in DHE and DDCE models of Distributive clinical education

20. Developing a process to define capacity and adaptability with a changing undergraduate curriculum and evolving Can Meds roles for Postgraduate residency programs.

21. Phase III Committee review and calculations to define for each incoming class (Meds 2007 onward) the required (out of Kingston) community rotations for each clerk.

22. PG Education Committee review and calculations to define for each residency program the out of Kingston mandatory community and out of Kingston mandatory other Health Science Centre rotations.

The acceptance of a Departmental Model of Distributed Clinical Education will require the defining of time lines, costing and definition of source of funds.

16. Attachments

1. 2004 Mission & Strategic Objectives of the Queen's Faculty of Health Sciences
2. QSoM response to MTCU requests regarding Clinical Education – May 24, 2005
3. Partnership Principles with ROMP
4. COFM:DME position statement
5. MHLTC Considerations for Future Funding Report
6. QUIPPED