The PIQUE

Welcome!

Sharing our teaching experiences together

Welcome Preceptors to our first edition of "The PIQUE"! The **P**receptor **I**nformative for **Qu**ality **E**ducation.

This quarterly newsletter will keep you connected to other local and regional preceptors, and inform you of faculty development and other resources and opportunities available through Queen's University.

Here you will find:

- ✓ Highlights of our educational programs
- ✓ Teaching tips and updates from the medical education literature
- ✓ Introductions to learners and preceptors
- ✓ Inspirational stories of education in our region
- ✓ FAQ and so much more!

We welcome your feedback and hope to create a platform tailored to your needs. Please email our information coordinator Trish Sherwin at pls1@queensu.ca with any of your questions and suggestions for future issues especially comments, stories, vignettes that showcase teaching successes and opportunities for improvements.

We look forward to highlighting you, the skilled clinician-educators of our region, in the near future.

The Longitudinal Integrated Clerkship Program-Lakeridge

The Longitudinal Integrated Clerkship (LIC) program at Lakeridge is an eight month learning experience combining community family medicine and hospital-based specialty and subspecialty rotations. Clinical Clerks learn at the Bowmanville Health Clinic as well as the Ajax-Pickering, Oshawa and Bowmanville Lakeridge Health sites. LIC clerks learn across multiple disciplines simultaneously and can immediately apply learning from one environment in another, for example: they can see a patient in hospital and apply that learning in an outpatient setting like emergency or family medicine. Through the LIC model, students experience continuity with patients, preceptors and learning environments for the bulk of their clerkship. They satisfy the same course requirements as their colleagues completing their clerkship in a traditional core-block model where they learn in one discipline at a time. This year we are welcoming six medical students to complete their clerkship rotations with us.

Student, you do not study to pass the test.
You study to prepare for the day when you are the only thing between a patient and the grave.

Quote from - Mark Reid

Faculty Development

The following are the upcoming virtual Faculty Development events:

Feedback Models

Wed Apr 28th 2021, 12:00pm-1:00 pm | Online, Queen's University | Faculty Development

Learn More

REGISTER FOR ZOOM LINK!

Initially from the West coast (West Vancouver and Tsawwassen to be precise), Dr. Schultz did her undergrad training on the East Coast (Halifax), medical school training and residency at Queen's and, after a few moves, has settled back in Kingston. She have been active in sports all my life, loves to do things with my family, like to travel, and really enjoys Family Medicine and working with our FM residents.

At the end of this session, participants will be able to:

- hear about the principles of feedback and understand where it fits with CBME
- discuss the challenges of giving feedback
- explore some practical solutions to giving effective feedback

Preparing your teaching dossier

Wed May 19th 2021, 12:00pm-1:00pm | Online, Queen's University | Faculty Development

Learn More

Use this link to find past modules and other learning tools: https://healthsci.queensu.ca/faculty-staff/opdes/about-us/faculty-development

Frequently Asked Questions

What is a clerk?
Clerks are undergraduate medical students in their third and fourth years of study. Unlike residents, clerks are medical students who are not yet physicians. Any orders written by clerks must be reviewed and approved (in writing or by telephone) by an attending or resident physician before implementation.

What is a clerkship?
A clerkship is an integral part of medical education in Canada. In a traditional core-block clerkship, medical students rotate through a series of, often isolated, learning experiences with preceptors. The Queen's Longitudinal Integrated Clerkship Program– Lakeridge (LIC-L) is an alternate approach in which students spend an extended period of time in a clinical setting or interlinked clinical settings such as a hospital and nearby family medicine clinic. Learning on LIC programs occurs in the context of continuity of relationship with preceptors, and patients in one area or region. LIC programs are preceptor-based learning experiences where students work directly with their attending physicians (and sometimes) residents) as opposed to the team-based learning in teaching hospitals where clerks are most directly supervised by a larger team of residents.

What is a preceptor?
Preceptors are Lakeridge Health staff or privileged staff members who actively supervise non-clinical, clinical or nursing students or medical or midwifery trainees. They share their skills and knowledge with students and trainees who become temporary members of the health care team. Preceptors are the backbone of student and trainee learning at Lakeridge Health. To explore the possibility of becoming a preceptor, please contact a member of the Academic Affairs team.

Why did Queen's University choose to partner with Lakeridge Health?
The LIC-Lakeridge program is a natural extension of the long-standing partnership between Queen's University and Lakeridge Health. Queen's already delivers numerous educational programs in partnership with the Lakeridge Health Education and Research Network (LHEARN). Currently, 70% of the medical trainees at Lakeridge Health come to us from Queen's University. Of these, approximately 70% are medical resident physicians and 30% are undergraduate medical student clerks. Since 2012, Lakeridge Health has been the site of a very successful family medicine residency training program affiliated with Queen's - QBOL. We have already matched our first LIC-Lakeridge clerk to this residency program!

How do I access the resources at Queen's University?
Queen's offers many resources for teaching and mentoring medical learners. In order to be able to access Elentra (the secure learning management system used by Queen's University) or the library, you will need to activate your Queen's NetID. You will, however, first need to obtain your staff number, which can be provided by telephone or via email, (with your permission to email it), from Kris Bowes kris.bowes@queensu.ca. Once you have your staff number and are ready to activate your NetID, please follow the instructions below.

Setting up your NetID and Password

Your NetID is your electronic fingerprint and gives you access to all things Queen's. You can find out more and get a NetID by following instructions here:

https://www.queensu.ca/its/netid/netid-activation

Once you have a NetID, you can get access to Queen's email and the Office 365 suite. The Office 365 suite is very handy, with 1TB of cloud storage, full service Office etc. It is strongly recommended that you forward your Queen's email to your hospital/professional email address. That way you won't miss any communication from the University and won't have to constantly check multiple email accounts.

Library Remote Access Information

Your Net ID also gives you full Queen's electronic library access from home.
https://library.queensu.ca/home
Click "off-campus access" at the top of the screen to log in.

Article of Interest

In this section of The PIQUE we will offer one or more education-oriented articles that may be of interest to you. This paper is authored by our very own – Dr. Mike Ward! Dr. Ward is a member of the LIC-Lakeridge leadership team, the heart and soul of the family medicine clerkship experience of our LIC students and an award-winning teacher!

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The "BETTER TEACHER" mnemonic: A Practical Guide for Busy Community-Based Clinical Teachers

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Abstract: The continued success and growth of distributed medical education into geographically dispersed communities has resulted in a dramatic increase in the number of community-based clinician teachers. We have created a simple mnemonic to help capture, translate and review classic and contemporary teaching concepts for the busy community preceptor. The "BETTER TEACHER" guide was designed to provide practical teaching tips for busy clinicians, and to act as a resource for those teachers looking to expand their own understanding of current concepts in medical education. Although presented from a Family Medicine teaching perspective, the fundamental concepts discussed here can be applied widely to include training in various Allied Health programs and beyond.

Introduction: Medical education has undergone a rather dramatic transformation of late with growing numbers of learners, graduate and undergraduate alike, moving into the community for some or all of their training (1). Indeed, many Family Medicine/General Practice residency programs are maintained fully in outlying communities with only short intermittent visits back to academic hubs (2). These changes stem from

a growing appreciation of the richness of community learning and the —whole patient‖ experience that accompanies it (3) as well as the importance of training in settings reflective of future practice. Learners may more fully understand the longitudinal patient experience and develop a sensitivity to culture and illness that may be more difficult to achieve in a more structured academic setting (4). Hence, we as community-based

primary care clinicians have been granted the privilege of helping to educate, teach, mentor, model, assess, and guide new learners. This is perhaps a daunting task given this skill set requires time and training to develop and that keeping up with new evidence-based education strategies requires more time than many community-based primary care clinicians have (5). Recognizing the global reality of workload issues, burnout, and financial constraints amongst others, there has been a realization that community preceptors need support and tools to continue to achieve excellence in patient care and maintain high standards in their educational responsibilities (6), Given this reality, there may be a need for a practical, evidence-based tool to help guide teaching experiences and improve the teaching process in a busy community setting. The "BETTER TEACHER" mnemonic (Figure #1) was designed to offer tips that may be of value, in particular, for newer community-based teachers as it attempts to explain and expand upon many of the fundamental/practical aspects of community-based medical education. This guide expands upon and extends two excellent recent reviews that provide additional advice on how to improve the teaching of learners and improve their educational experiences (7,8). This tool has emerged through the amalgamation of experience and insight from three main sources, including the author's reflections his own success' and failures in the trenches, from feedback based on comments and discussions from his lectures and seminars relating to community-based medical education, and from are view of the literature.

Figure #1

B – Become familiar with your learner
E – Exercise empathy and energy as your role model
T – Time your feedback to the teachable moment
T – Teaching tools – master the One Minute Preceptor
E – Entrust ownership to your learner
R – Reflect on your previous teaching experiences
T – Team approach – making use of support staff and allied health
E – Evidence based medicine and translation into practice
A – Act as a mentor
C – Create a mutual plan for the rotation
H – Home base – orient your learner to the clinic and local environment
E – Emulate scholarly thinking
R –Relaxed learning environment

Results

1 - Become Familiar with Your Learner

Many community teachers will host several learners in a single year (2 to 4 to 6 weeks rotations for example) while others may teach in systems that deliver them a single learner for 12 to 24 months. Developing a deeper appreciation for the individual learner's goals, fears, aspirations, insecurities, and needs will help you guide their clinical experiences and help promote their growing identities as physicians (9) as well as increase their competency through more effective feedback (10). Learners value the teaching and feedback from clinicians whom they feel connected to and whom they feel care and are invested in their personal/professional growth (11).

2 - Exercise empathy and energy as you role model

Students appreciate energetic/charismatic teachers (12). Role modeling this behavior creates higher learner satisfaction than when learning the same material with someone who is behaving less so. Similarly, learners appreciate and respond more attentively when they feel their teachers are empathetic towards their patients and towards their students (13). Role modeling is an age-old concept (14) that has been shown to guide choices and influence behavior in medical learners (15). We must all be aware of the subtle but powerful effect this informal teaching tool has on our learner's professional development and self-identity as their clinical precept matures (16).

3 - Time your feedback to the teachable moment

The rather imposing body of literature attempting to define and empower feedback has made one thing clear. This process is an immensely complicated multi-factorial web of relative unknowns. Some aspects of the process have been nicely clarified in a recent review by Bing-You at al. (17). It appears that the strength of the learner-teacher relationship lies at the heart of meaningful feedback of the type that will change a learner's focus and clinical behavior. Van Der Leeuw and Slootweg (18) suggest we prioritize this relationship, label feedback as feedback at the time it is delivered, and provide this valuable reflection in the moment when this is safe and appropriate. Labeling feedback helps make learners aware that the process is occurring. Much feedback is given by clinicians but can be mistaken by learners and its value lost (18). Keep feedback simple, timely and to the point. If the working day allows it consider reflecting on the one or two most important items you have discussed that day with your learner – they will realize you care and make you a more effective teacher moving forwards.

4 – Teaching tools: Master the One Minute Preceptor

The One Minute Preceptor model was established in 1992 as a practical teaching tool specifically designed for busy Family Medicine teachers in ambulatory care (19). The original model was built around five critical —micro skills‖ – and latter modified to add a sixth component. The micro skills are shown in Figure #2.

Figure #2

1. Get a Commitment
2. Probe for Supporting Evidence
3. Reinforce what was done well
4. Give Guidance about Errors and Omissions
5. Teach a General Principle
6. Plan for the Next Steps

In essence, the model asks that the learner commit to a diagnosis or plan. The preceptor then probes to understand how the learner arrived at that diagnosis while providing feedback as to what was done well in the assessment and what could have been done differently. Next the preceptor identifies a general principle to discuss, related to some aspect of the patient's care and then sets in motion a plan for the next learning goal relating to this case. It could be a guideline review, or a clinical question that remains unanswered and perhaps requires a literature search. The One Minute Preceptor framework has been shown to increase information uptake by learners and to help develop preceptor teaching skill and satisfaction (20). This is a Learner-centered model driven by a —patient‖ preceptor. Success lies in the preceptors' ability to refrain from taking over the case and resisting the temptation to fill in gaps in the history/physical exam. Rather, use this opportunity to assess your learner's understanding of key concepts and explore their developing —mind map‖ – the process by which students learn to process information to build plausible clinical frameworks via clinical reasoning (21).

5 - Entrust ownership to your learner

Perhaps the most difficult clinical delegation – the entrust able professional activity (?) or EPA (22). For many community-based primary care teachers this can be a difficult step. Trusting a learner to manage your patient's new onset atrial fibrillation, or break bad news, or see a sick asthmatic child in a busy out-patient clinic can be an anxiety provoking and daunting exercise. Yet the delegation of EPAs is essential to the maturation, clinical development and personal identity formulation of your learner as an individual physician (23). It is perhaps made easier as you gain confidence in your learner and as you understand their skill set more completely and contribute to it. Again, a strong learner-teacher relationship helps to build this confidence and is important for both sides. Consider what it is like being a learner at any level in this current era (24) and you may remember managing your first code STEMI and hoping a good teacher was there to help.

6 - Reflect on your previous teaching experiences

The ability to reflect on, assess and improve is an essential component of the Scholarship of Teaching as defined by Boyer (25). But much more than that for the clinician-teacher in all of us is the idea of improving and creating

a safe dialogue wherein your learners feel ―free‖ to question your approach, provide new information, pass on a new idea they have just learned from a consultant, or give constructive feedback. Learners want to give us something back and we should learn to accept it graciously. Reflecting on previous clinical experiences will also create a wealth of teaching topics and scenarios that you can use to highlight recent patient encounters or simply recall meaningful clinical vignettes. Successful preceptors often use this teaching tip to illustrate mistakes they have made hoping to reduce the risk of this happening to their learners. Humanizing their stories and admitting mistakes often makes their learners feel more at ease. Although the value of the clinical ―pearl‖ as a reliable evidence-based entity has recently been questioned (26), the reflective and personalized clinical vignette as a teaching vehicle is here to stay.

7 - Team approach – making use of support staff and allied health

For community teachers that have easy access to a multi- or pauci-disciplinary clinic this could represent a relative panacea of new learning opportunities. New models of care rely on several disciplines coming to bear on the, often times, multi-faceted needs of the patient, from specialized wound care delivered by community nursing, to nurse practitioners in the out-patient cardiology clinic to pharmacists liaising as diabetic educators in your local pharmacy. There is a wealth of local knowledge outside of your exam rooms to; tap into it if possible. Learners may elect to spend a morning or two with nurses practicing injections, taking phone calls and triaging to gain perspective and valuable experience. Students have spent a day in our local pharmacy, time with an out-patient physiotherapy clinic and visited our local chiropractor for more experiential learning. Making use of valuable allied health learning experiences may afford you time to get caught up on paper work and messages, while creating time to reflect and recharge.

8 - Evidence based medicine and translation into practice

Perhaps the most important piece of the modern educational puzzle is the teaching and translation of evidence-based medicine (EBM) (27). EBM is immensely difficult to fully comprehend its pragmatic nature yet so important to students and teachers alike. Changing practice patterns based on new evidence can be challenging (28) but rewarding (29). Students expect their teaching to be evidence-based whenever possible. We should make every attempt to rise to that expectation and deliver to the best of our abilities while recognizing always that science and trials are one thing, the person sitting next to you is another. It is this delicate balance that learners must come to understand because it is, after all, the fundamental business of our craft. Teaching the underlying principles of a guideline to a learner is as important as helping them understand why some patients should not be approached via a simple recipe. Put another way, we must guard our right to teach the art of medicine as diligently as we are expected to teach its new evidence-based dogma.

9 - Act as a mentor

Many of the topics discussed here already are intricately related to the concept of mentorship. A great mentor can affect a learner in many positive ways (30); a poor mentor less so (31). The value of a great mentor has recently been highlighted (32). It is difficult to think of an aspect of teaching that would not benefit from a positive mentorship experiences provided that professional boundaries are recognized, respected and maintained. We know that learners will seek career advice from good role models and great mentors, additionally, they will respond to and act on feedback in a more positive light, and will model professional growth and often clinical identity after positive mentorship experiences. Moreover, while teaching remains one of our great privileges as physicians, the opportunity to mentor colleagues should be accepted with great respect and privilege likewise.

10 - Create a mutual plan for the rotation

Rarely do learners come to the clinic unannounced. This means we have the opportunity to pre-book patients at a frequency that is directed to their level of training which leaves us time to catch up in case they are less efficient than had been anticipated. They will typically arrive early for their first day giving us lots of time for orientation (see below) and to plan their first week. A realistic needs assessment over a cup of tea and a review of some fundamental expectations on your part and the stage has been set. The working educational plan is of course iterative and reviewed as we progress. This plan can be easily modified by the student or preceptor such

that we both meet our end goal. I personally see many learners for 2 to 4 week rotations and this process has been successful for most, but not all learners, I must admit. I do not expect learners to see last minute —fit-in‖ patients as the learning is less seldom as rich as are the patient experiences that have been booked for them directly.

11 - Home base – orient your learner to the clinic and local environment

Day 1. —Hi my name is Mike and it's nice to meet you‖ A hand shake. —Thanks for coming to work with us‖ and the orientation to this rotation and the clinic has begun. Creating the first impression that you are happy the learner has decided to join you is critical as you set the stage for their experience and the development of the critical relationship. Next comes a tour of the physical space, including an introduction to your partners and the most important people they will meet that day – the clinic staff. Next, a tour of the kitchen complete with an open door policy to enjoy some tea, coffee or goodies. Then the rest room and a spot for their toothbrush should they desire. As we pass the booking desk, the student receives their EMR password (organized before arrival) and we are off to a short tutorial. I realize very soon that they know far more than I do about computers and we exchange telephone numbers and verify that the texting is functional. I make them aware that my schedule can change quickly and text is the most efficient way to communicate that change. They get a copy of my schedule for the time they are with us. I answer any questions and then we plan for the rotation as above.

12 - Emulate scholarly thinking

This is different than the practice of evidence-based medicine which I suggest is an important component of scholarly thinking. The broader umbrella includes teaching scholarly patterns of thinking relating to questions and answers (33) that can potentially affect all aspects of medicine and society at large. Remind learners who we are and what we represent to the patients we serve. Learning how to ask questions and use a search of the literature to try and answer them (34). Teaching the art of critical thinking when it comes pharmacotherapy, drug advertising, testing, guideline translation/interpretation and most importantly, people. Helping to guide students towards academic pursuits if this is their professional goal. Helping them understand some of the scholarly work that has gone into preparing their educational curricula (for the unusual student that wants to know). And finally, in the big picture, helping to create and support scholarship and a scholarly environment in a community-based Family Practice teaching environment.

13 - Relaxed learning environment

The critical component that underpins all of the above relies on creating and maintaining a safe, relaxed, supportive learning environment. Studies have made it clear that students at all levels and in all disciplines learn better when they feel comfortable, safe and supported (35). We were all students once and I suspect the majority of us would agree and support this concept. Sometimes the weather of the world makes the practice of medicine difficult. Some days it rains, some days it pours. This is an important learning opportunity for your students. Take advantage of the rainy days to model resilience and to let them see your human side – they are human too. The learning environment you create will have a significant impact on the teaching success of your office and the connections you form with your learners. Your success will continue to build and will serve you well should you occasionally come across a more difficult learner.

Conclusion The BETTER TEACHER mnemonic is a practical, easy-to-use guide to help community-based teachers and educators frame their learner's clinical experience. It is clearly and decisively learner-centered. It offers some evidentiary base where the evidence is available and offers practical tips for the busy clinician. It is a simple framework only, and is meant to be built upon as clinical teachers develop their own repertoire of teaching aides and ideals. It has been presented here from the perspective of a community teacher but certainly the general principles that lie at the foundation of the guide make it easily translatable to other disciplines whether it be a consolidation rotation in a nursing curriculum, a practicum in a physiotherapy block or an articling block from law school. Community and university-based clinician-teachers have all been tasked with the privilege of training the next generation of physicians, our colleagues. The medical literature and scientific

inquiry will continue to bloom. There will be challenges keeping up with the literature for many of us. Nevertheless, it's a great time to be a teacher and I wish you all great success.

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Thank you for reading this first edition of The PIQUE!

If you have an article you would like to share with other preceptors, please send it to Trish Sherwin our information coordinator at pls1@queensu.ca or psherwin@lh.ca

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