Undergraduate Medical Education Committee

APPROVED

Friday, February 1, 2019
Room G384
Health Sciences Centre

Attendees: Drs. Adam Bass, Heather Baxter, Kevin Busche, Sylvain Coderre (chair), Janeve Desy, Karen Fruetel, Martina Kelly, Kevin McLaughlin, Pam Veale, Richard Walker, Ms. Karen Chadbolt, Ms. Tabitha Hawes, Mr. William Kennedy, Ms. Shannon Leskosky, Mr. Arjun Maini, Mr. Mike Paget, Ms. Sarah Smith, Ms. Jane McNeill (minutes)

Regrets: Drs. Walla Al-Hertani, Luc Berthiaume, Ellen Burgess, Aliya Kassam, Charles Leduc, Chris Mody, Ms. Na'ama Avitzur, Ms. Kate Brockman, Ms. Shannon Leskosky, Ms. Kerri Martin

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Dr. Coderre introduced Dr. Richard Walker, a new UMEC Committee member, and in turn asked all UMEC members to introduce themselves.

1. Approval of Agenda **Dr. Sylvain Coderre**

The February 1, 2019 UMEC Agenda was approved.
- Motion: Mr. W. Kennedy Seconded: Dr. H. Baxter
  All In Favor

2. Approval of Minutes **Dr. Sylvain Coderre**

The November 23, 2018 UMEC Minutes were approved.
- Motion: Dr. H. Baxter Seconded: Ms. T. Hawes
  All In Favor

3. Report from Students

Class of 2019: Ms. S. Smith reported that February 1st was the last day of CaRMS interviews and that match day is Tuesday, February 26th. Dr. Coderre explained that this year CaRMS has allowed schools to contact unmatched students the day before the match. This system will be on an "opt in" basis – students will have the opportunity to participate in a survey link to indicate if they do want to be contacted if unmatched. If a student has indicated that they want to be notified if unmatched, they will be contacted by telephone on February 25th and invited to come to the UME and meet with an advisor. This will give an extra 24 hours to start planning the second iteration. Students will not be contacted if they are matched. Ms. Smith commented that this system is a much better way for students to find out if they are matched, or not.

Class of 2020: Mr. W. Kennedy reported that the class of 2020 just completed Course 7 (Psychiatry) and the Year 2

OSCE. The class will begin the Integrative Course on Monday, February 4th. He also informed members that the class is preparing for Clerkship Electives and that some electives require updated basic life support (BLS). Mr. Kennedy suggested that if this continues to be an ongoing elective requirement, it may be necessary to allocate class time to work on updating BLS. Dr. Busche suggested that the schedule (for the class of 2021) may have some flexibility and perhaps this could be included.

Class of 2021: Ms. T. Hawes reported that the class of 2021 is doing well and getting back into the "swing of things" after their winter break.

4. **New Business**

a. **Consent Agenda** – Dr. Coderre suggested that UMEC begin to utilize a consent agenda. This would be the first item to approve at each UMEC meeting (items would be circulated to members one week before the meeting). If a member has a concern about an item on the agenda, they are asked to bring that item forward.

Motion: That UMEC approves adoption of a Consent Agenda. This will entail "block approval" of the following items: a) meeting agenda, b) meeting minutes, c) reports to the committee for information, d) correspondence requiring no action and e) approval of new course/clerkship leaders.

Motion: Dr. S. Coderre **Seconded**: Dr. K. Fruetel
Motion Passed (all in favor, none opposed, none abstained)

b. **Well Man** – Dr. Busche explained that presently the Well Man teaching (genital and rectal exams) is not in line with accreditation standards, in that the standardized patients (SP) are acting as teachers as well as patients at the same time. The accreditation standards state that the clinical teachers have to be faculty members so they are able to both teach and evaluate the students. Dr. Busche proposed that he, Drs. Rosen and P. Lee are looking for approval fairly similar to the piloted teaching for the breast and gynecologic exams. He explained that there will be a single introductory lecture and video that will teach students how to do the exams (including some standardized patients that have done Well Man teaching in the past). Students will be in groups of eight with one preceptor and four task trainers (two male genitalia and two rectal and prostate). The students will be able to participate in multiple one-hour sessions with feedback from a preceptor in order to learn skills. Dr. Busche reported that there are a number of benefits for using task trainers such as it enables the opportunity to incorporate multiple different types of pathologies, as well students can practice as many times as they wish on their own.
Dr. Busche inquired whether the genital and rectal exams could be added to the Clerkship Logbook. Dr. Veale will check with Mr. M. Paget to see if the exam could be tracked in the logbook also noting which rotation the student was on.

Motion: For the class of 2021, to approve the proposal of moving to a model of teaching the male genital and rectal exam that uses expert teachers with task trainers and a lecture/video on how to perform the skills with hands on.

Motion: Dr. K. Busche **Seconded:** Dr. H. Baxter
Motion Passed (all in favor, none opposed, none abstained)

c. **Clerkship Work Hours Policy** – Dr. Veale explained that the Clerkship Work Hours Policy has been updated for the class of 2020. The updates include two significant changes: 1) to clarify what is expected for maximum work hours in a given day, for a student who is not on an evening shift, or evening/overnight call. The wording has been changed in hopes to make questionnaires more straightforward so that data can be tracked. The revised

paragraph may be found on the top of page two of the policy. 2) The second change is with regard to the Pediatric rotation, specifically rescheduling students doing their inpatient components at the ACH and PLC. Dr. Veale explained that during the three-week inpatient component at the ACH, there are two weeks of daytime shifts and one week of a nighttime shift. The nighttime shift has been shortened by two hours. The other component that has changed for that group is the weekend call, which was 24 hours and is now scheduled as 12 hours. The PLC component, which had been a three-week component, has been changed as follows: students are now going to do two weeks at the PLC (day time only – no call) and one week at the ACH doing admitting evening shift.

Motion: Approval of changes made to the Work Hours Policy as stated above.

Motion: Dr. P. Veale **Seconded:** Ms. K. Fruetel
Motion Passed (all in favor, none opposed, none abstained)

d. **CPSA Code of Conduct** – Dr. Coderre recommended that the CPSA Code of Conduct be used as a professional teaching and evaluative tool. He commented that the code of conduct applies to students, residents and faculty. Dr. Busche suggested that we invite the College of Physicians & Surgeons of Alberta to speak about values and professionalism to students.

Motion: UMEC endorses the use of the CPSA code of conduct as both an aspirational and evaluative tool in our program. (This does not exclude use of other Code of Conducts, such as: AHS, CMA, main campus calendar, and student code of conduct).

Motion: Dr. S. Coderre **Seconded:** Dr. R. Walker
Motion Passed (all in favor, none opposed, none abstained)

e. **Recruitment Process (Mr. Mike Paget)** – Mr. Paget gave an informative Power Point entitled “Preceptor Recruitment” (attached) with the goal of creating a mechanism for preceptors to search all available teaching opportunities, for all courses, without having to use sign-up genius. Preceptors could self confirm and select teaching opportunities based on payment model, performance and attendance. Discussion ensued with regard to this.

Motion: That the UME has the discretion to recruit teachers based on:

- Payment model (e.g. AMHSP/FTA)
- Evaluated performance (below 3.00 over 3 events with >5 evaluators)
- Consistent fulfillment of confirmed teaching events (Data to be collected around frequency and context)
- Specialist and Generalist (including Master teachers) exposure

Motion: Mr. M. Paget **Seconded**: Dr. H. Baxter

Motion Passed with the notion to return to UMEC with a specific set of criteria for recruitment, including the generalist/specialist dichotomy, Master Teacher allocation, proportions of fee for services/AMHSP teachers and evaluated performance. (all in favor, none opposed, one abstained)

f. **2018 UME Key Performance Indicators (attached)** – Dr. Coderre reported that as an accreditation standard, we annually review our Key Performance Indicators (power point presentation attached). Dr. Coderre commented that we continue to monitor mistreatment and more specifically the data in the End of Year surveys. The Task Force for Accreditation issued six recommendations for mistreatment and Dr. Coderre reported that we have fulfilled all of those recommendations. Dr. Coderre presented a slide from the Canadian Graduate

Questionnaire “Do you Believe that your Instruction in Each of the Following Areas was Inadequate, Appropriate or Excessive”. Topics included in the “inadequate” were discussed (end-of-life care, pain management, law and medicine, health promotion/disease prevention). For many of these areas, there are already strategies that have been initiated with a goal of improving their delivery and assessment.

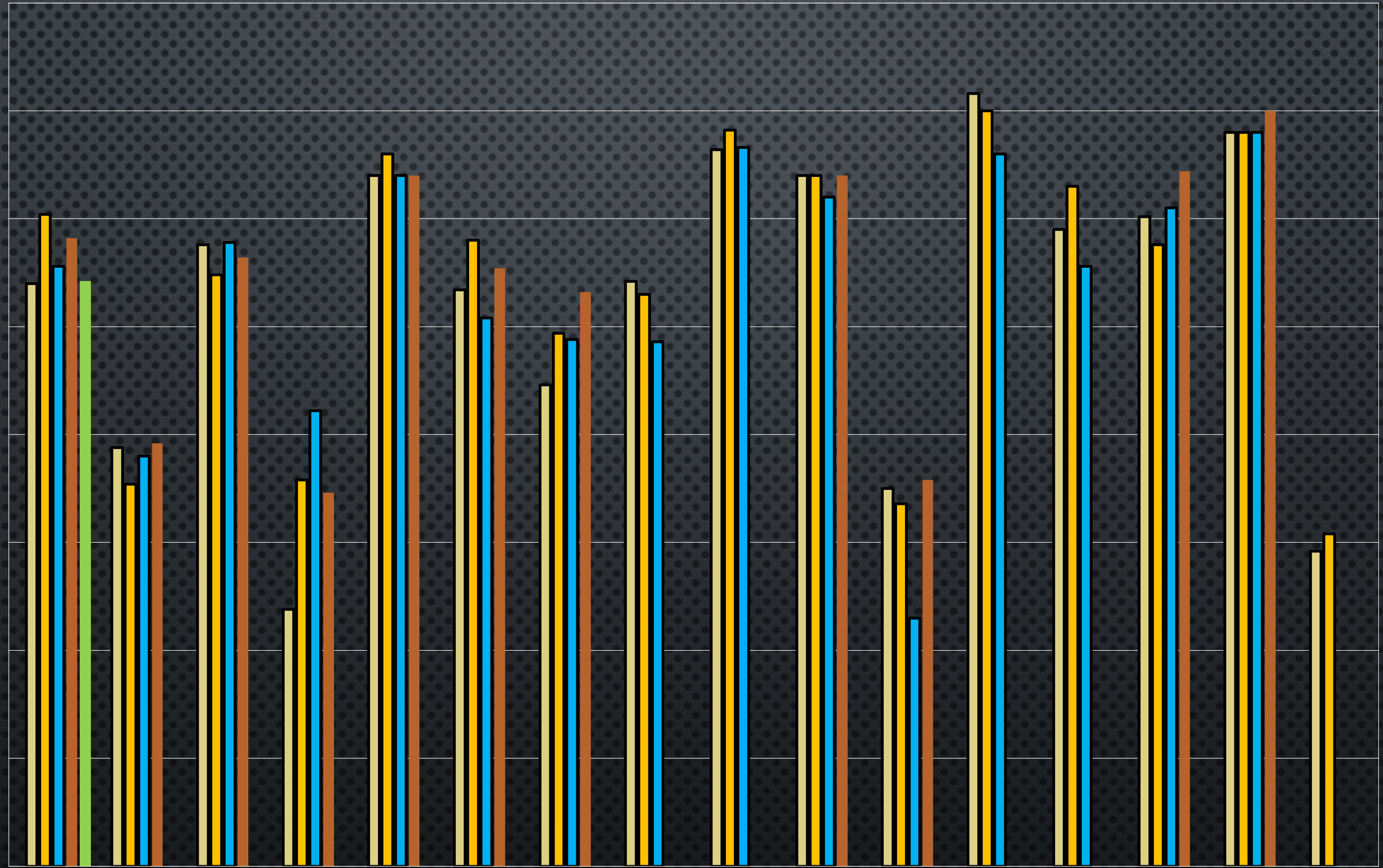
Meeting adjourned at 3:00 p.m.

Next Meeting: April 05, 2019 in Room G750 from 1:00 p.m. – 3:00 p.m.

2018 UME

Key Performance Indicators

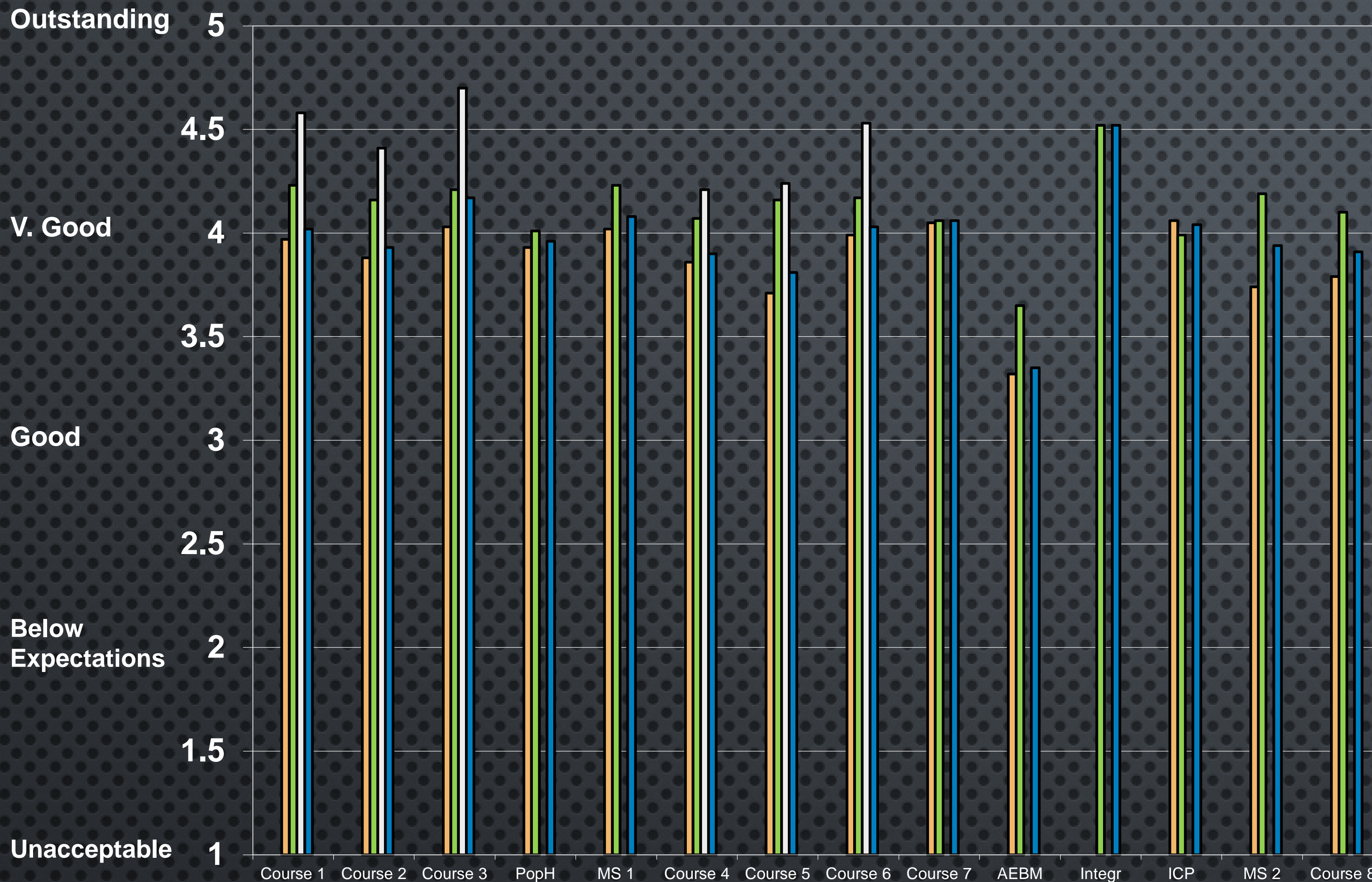
OVERALL RATING OF COURSES



Data Source: End of course survey

AGGREGATE TEACHING EVALUATIONS

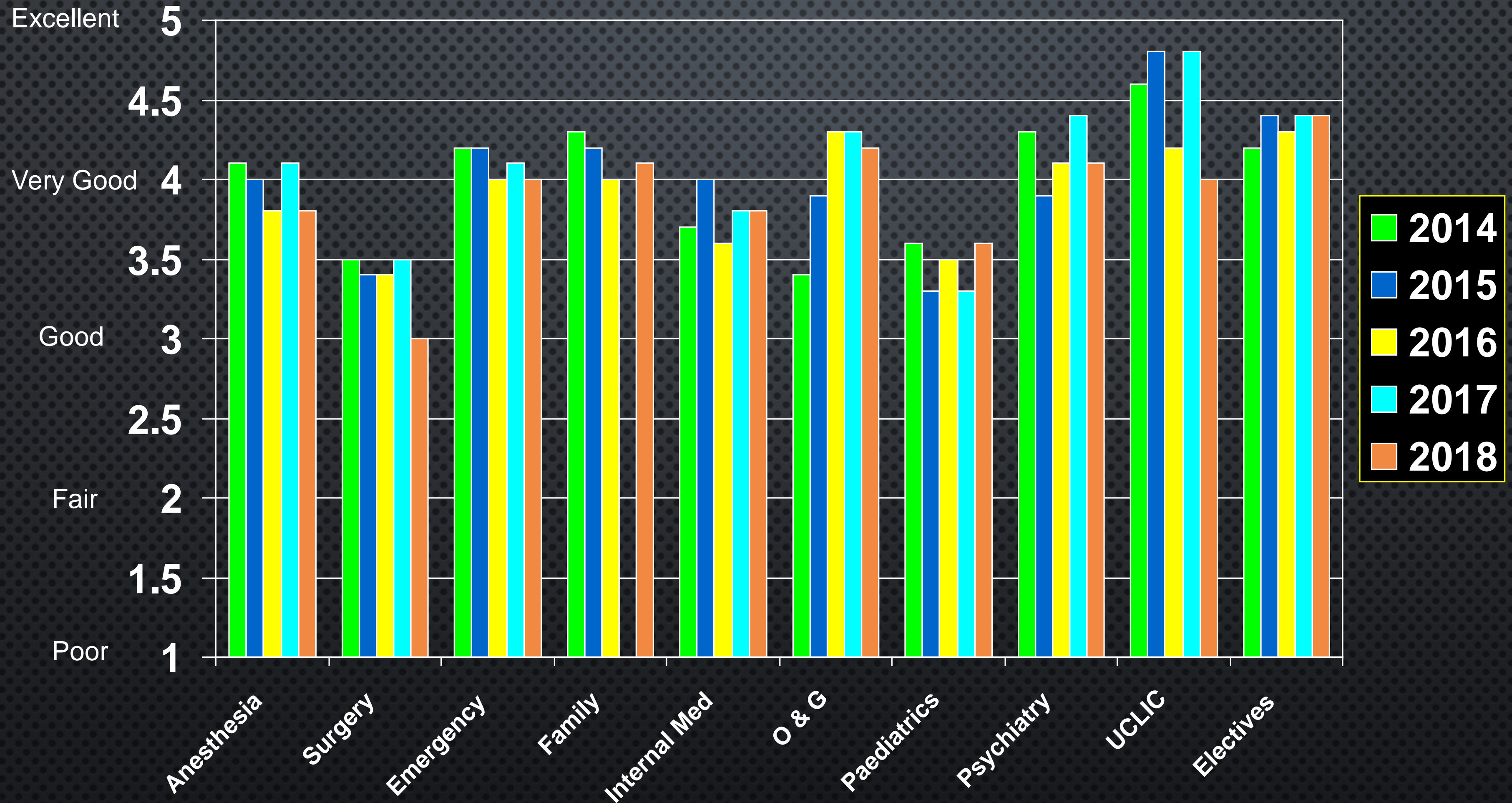
2017-18



Data Source: Daily Evaluations

Lecture | Small Group | Clin Core | Summary

OVERALL RATING OF CLERKSHIP ROTATIONS

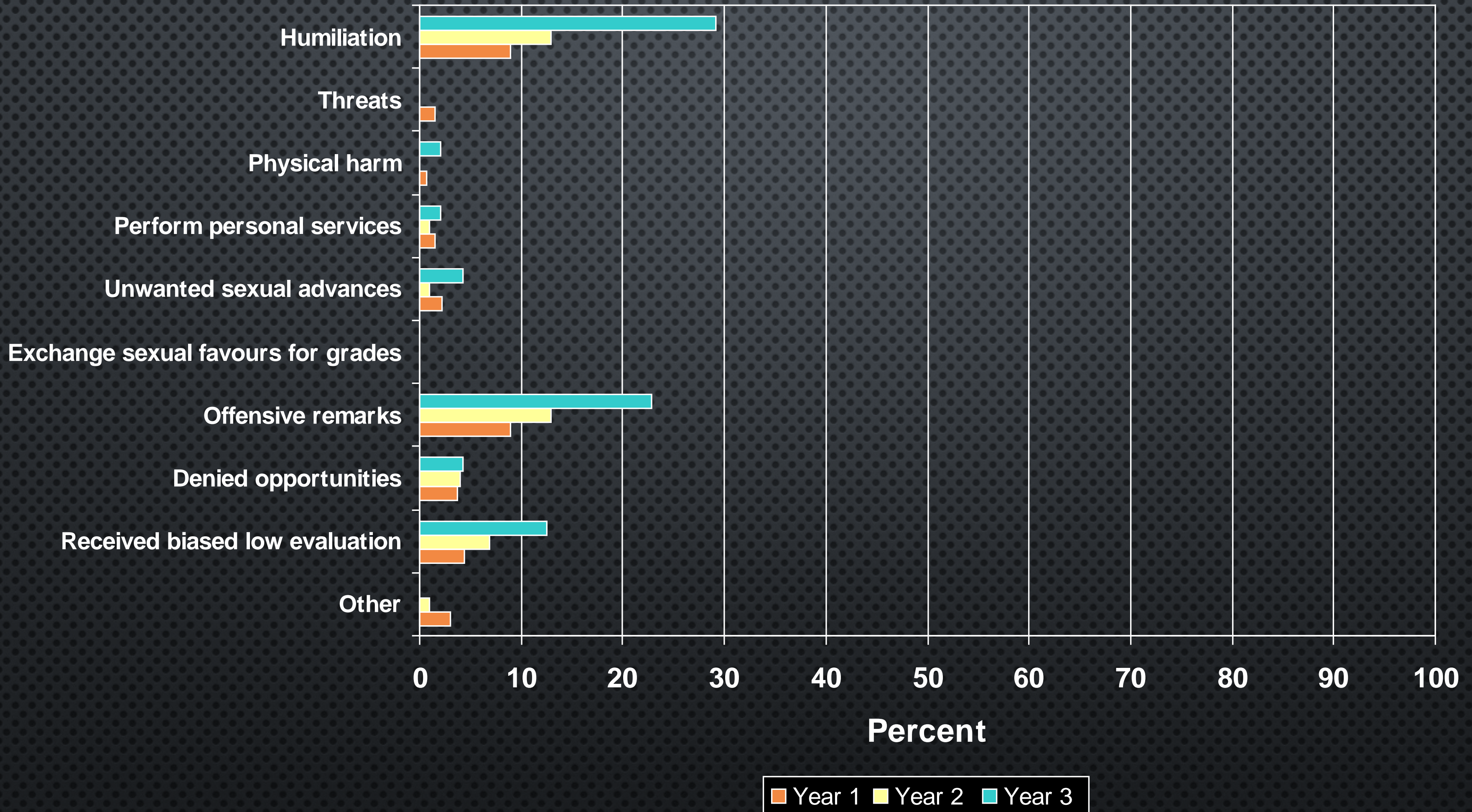


Data Source: End of rotation survey; Classes 2014-18; FM 2017 data unavailable

MISTREATMENT

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING FORMS OF MISTREATMENT WITHIN THE LAST YEAR?

SELECT ALL THAT APPLY



Data Source: end of year surveys – classes 2020 N=135 (80%); 2019 N=101 (60%); 2018 N=48 (31%)

STUDENT MISTREATMENT
END OF YEAR SURVEY DATA

Class	Survey respondents	Students reporting mistreatment	Forms of mistreatment total
2020 Yr 1	135 (80%)	28 (21%)	47
2019 Yr 2	101 (60%)	25 (25%)	40
2018 Yr 3	48 (31%)	24 (50%)	37

MISTREATMENT

IF YOU EXPERIENCED MISTREATMENT, DO YOU PERCEIVE THAT THIS MISTREATMENT WAS BASED ON ANY OF THE FOLLOWING CATEGORIES:

SELECT ALL THAT APPLY

Race or ethnicity

Gender

Gender identity

Sexual orientation

Religion

Physical appearance

Unknown/none of the above

Other

0 10 20 30 40 50 60 70 80 90 100

Percent

Unique Individuals
Yr 1 = **28** (21%)
Yr 2 = **25** (25%)
Yr 3 = **24** (50%)

Data Source: end of year surveys – classes 2020 (80%); 2019 (60%); 2018 (31%)

MISTREATMENT

WAS THE MISTREATMENT FROM:

SELECT ALL THAT APPLY

Students
Residents
Faculty
Staff
Patients/Std Patients
Other

0 10 20 30 40 50 60 70 80 90 100

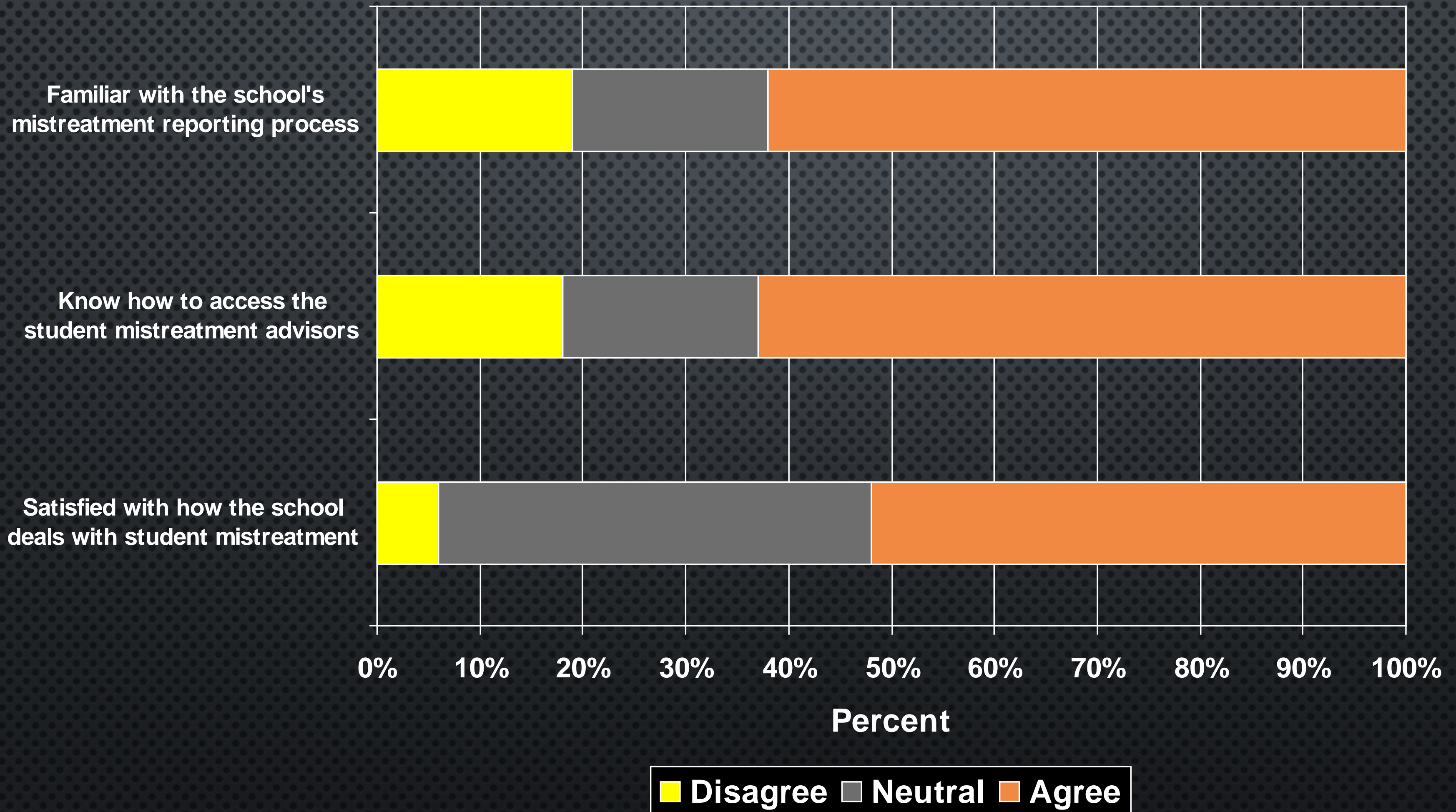
Percent

Unique Individuals
Yr 1 = **28** (21%)
Yr 2 = **25** (25%)
Yr 3 = **24** (50%)

Data Source: end of year surveys – classes 2020 (80%); 2019 (60%); 2018 (31%)

STUDENT MISTREATMENT – YEAR 1

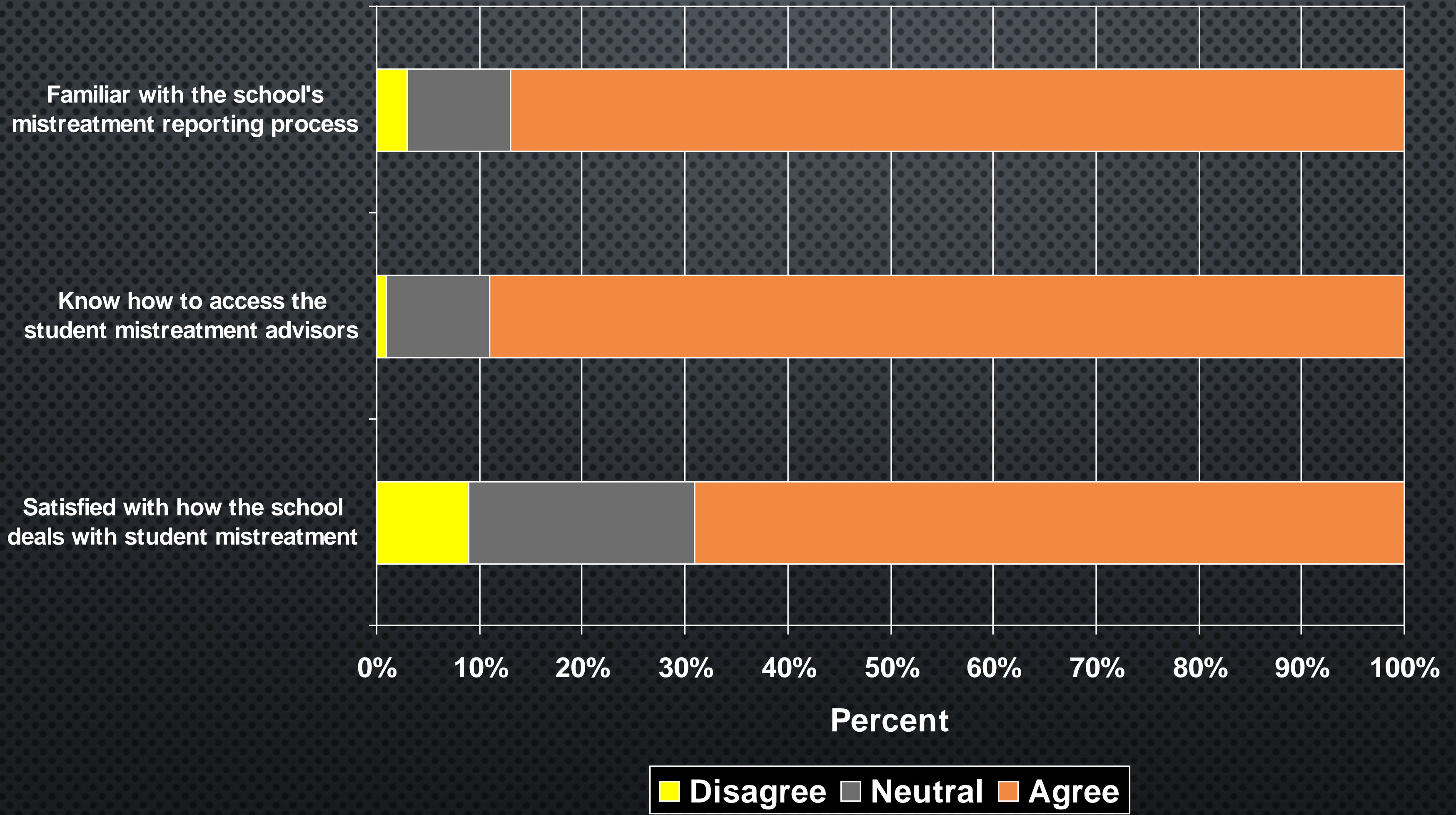
PERCENT OF RESPONDENTS THAT DISAGREE/NEUTRAL/AGREE WITH STATEMENTS



Data Source: End of 1st Yr curriculum survey to Class of 2020 (80% response)

STUDENT MISTREATMENT – YEAR 2

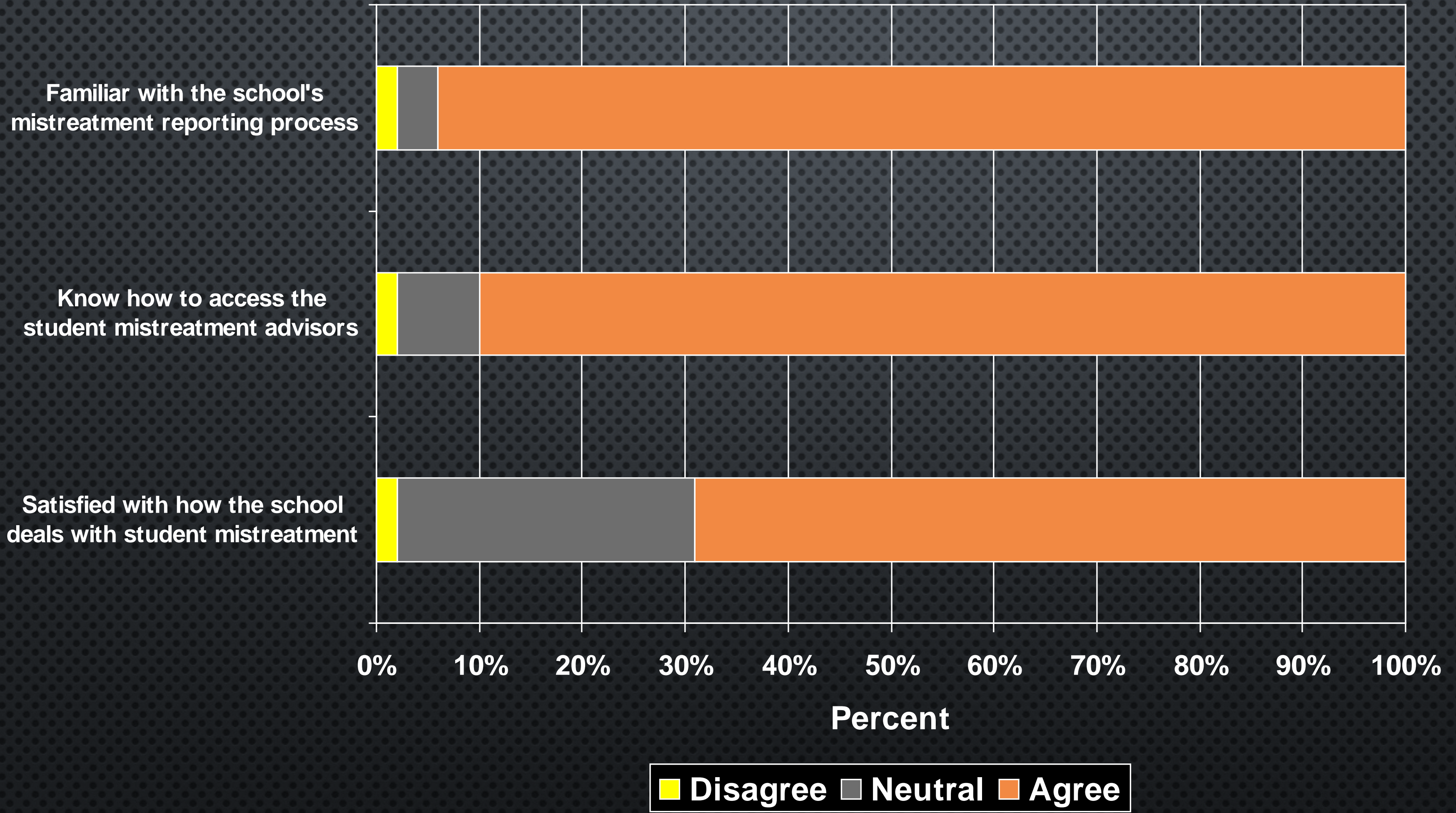
PERCENT OF RESPONDENTS THAT DISAGREE/NEUTRAL/AGREE WITH STATEMENTS



Data Source: End of 2nd Yr curriculum survey to Class of 2019 (60% response)

STUDENT MISTREATMENT – YEAR 3

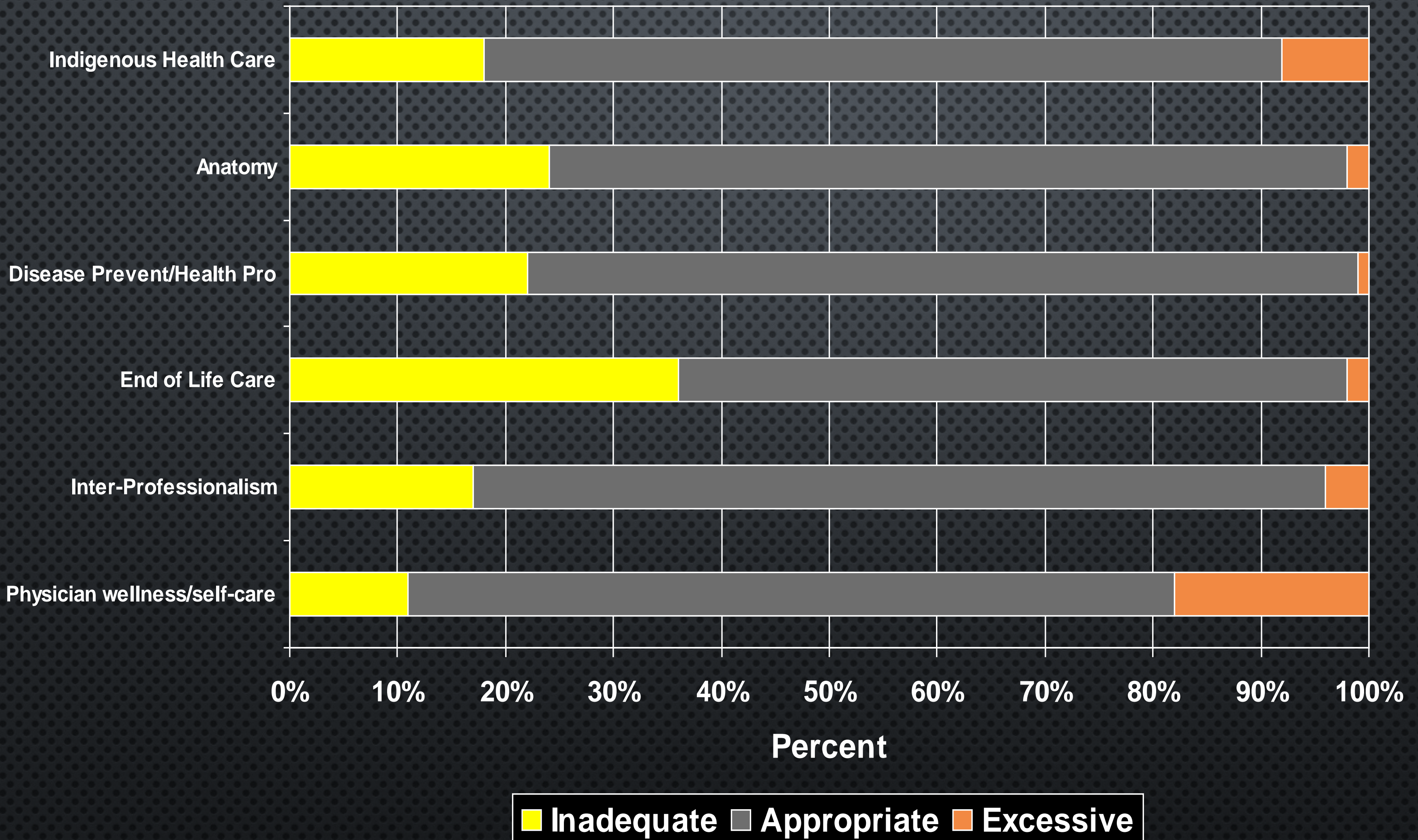
PERCENT OF RESPONDENTS THAT DISAGREE/NEUTRAL/AGREE WITH STATEMENTS



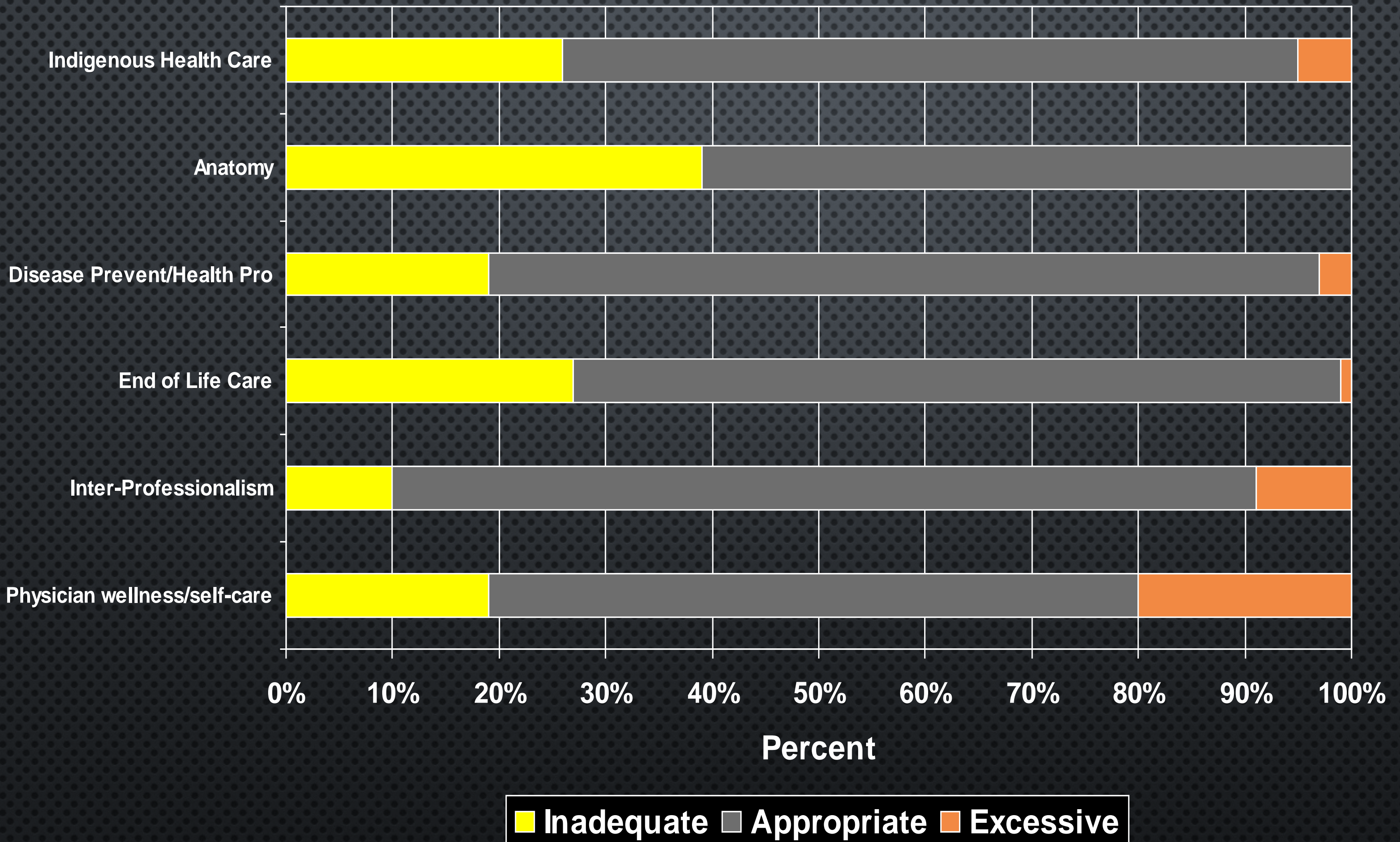
Data Source: End of 3rd Yr curriculum survey to Class of 2018 (31% response)

CONTENT AREAS - YEAR 1

PERCENT OF RESPONDENTS INDICATING INADEQUATE, APPROPRIATE OR EXCESSIVE



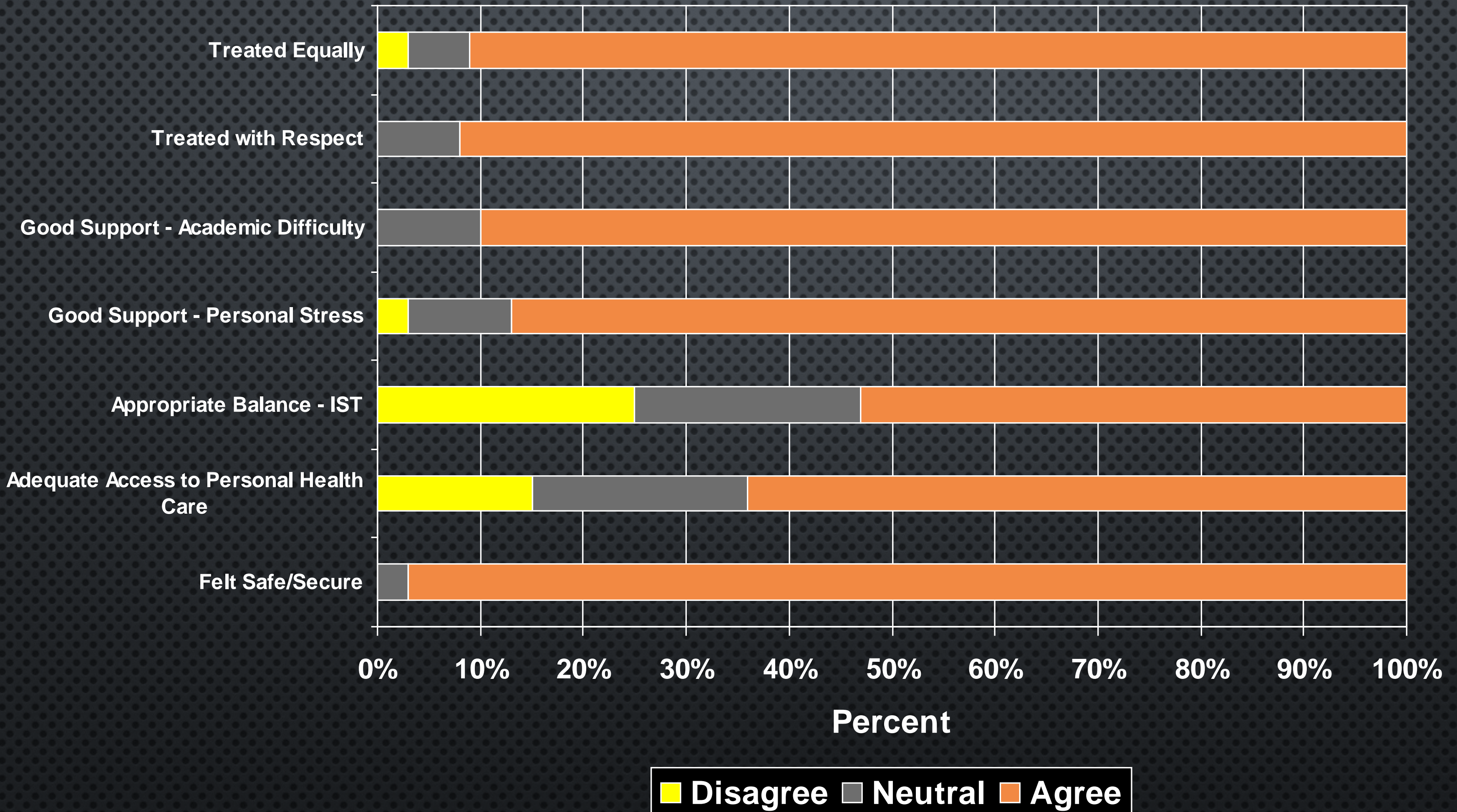
Data Source: End of 1st Yr curriculum survey to Class of 2020 (80% response)



Data Source: End of 2nd Yr curriculum survey to Class of 2019 (60% response)

LEARNING ENVIRONMENT- YEAR 1

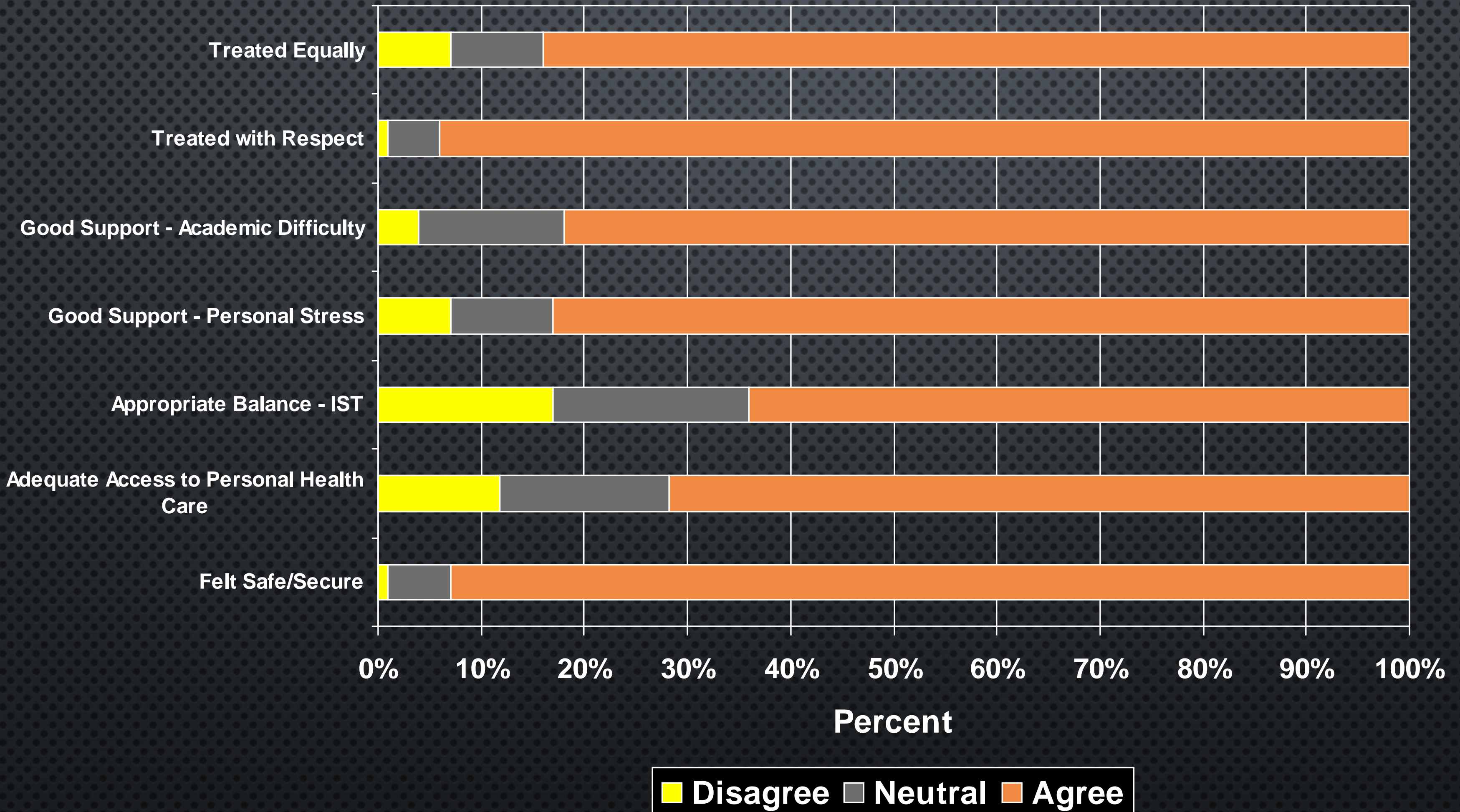
PERCENT OF RESPONDENTS THAT DISAGREE/NEUTRAL/AGREE WITH STATEMENTS



Data Source: End of 1st Yr curriculum survey to Class of 2020 (80% response)

LEARNING ENVIRONMENT- YEAR 2

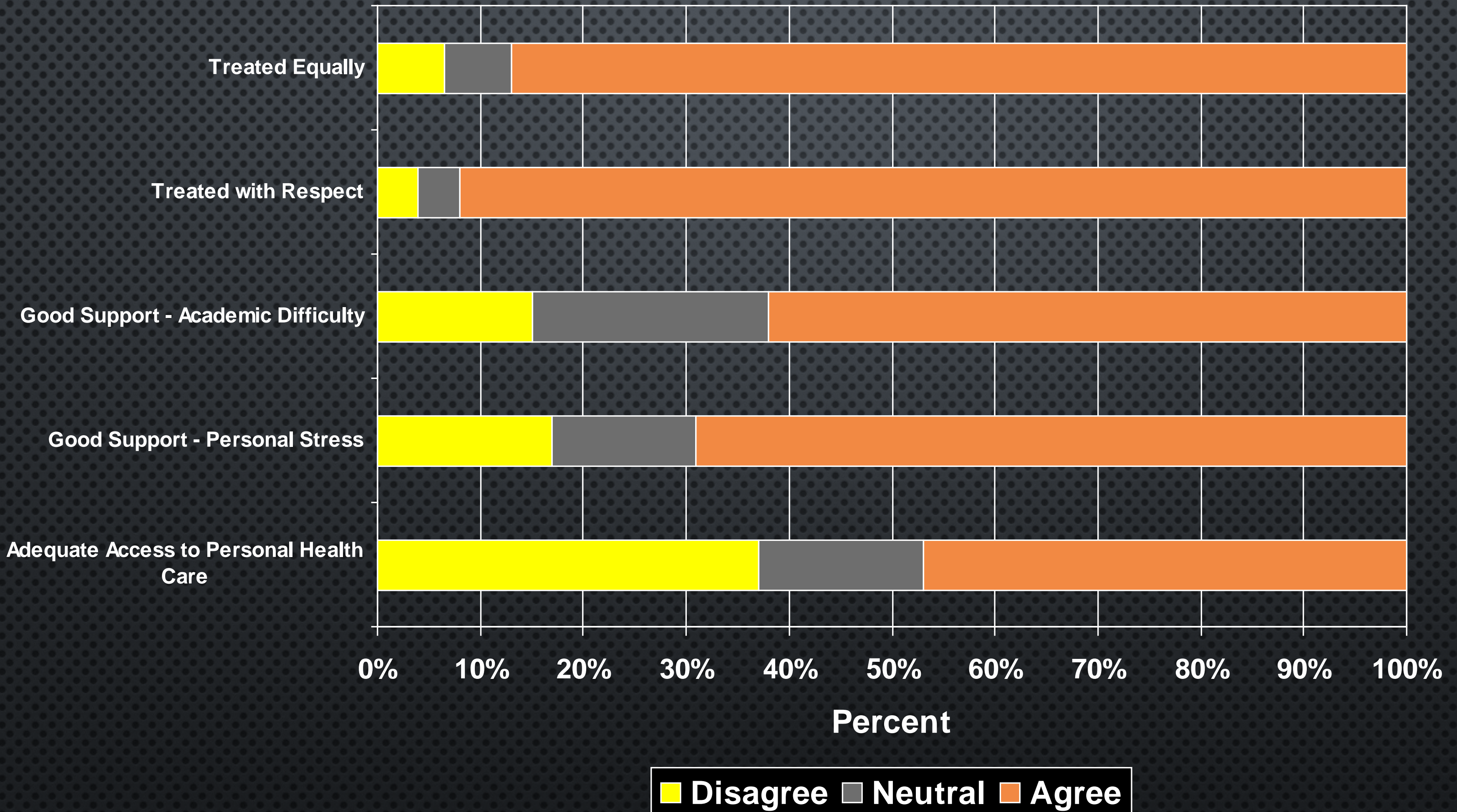
PERCENT OF RESPONDENTS THAT DISAGREE/NEUTRAL/AGREE WITH STATEMENTS



Data Source: End of 2nd Yr curriculum survey to Class of 2019 (60% response)

LEARNING ENVIRONMENT- YEAR 3

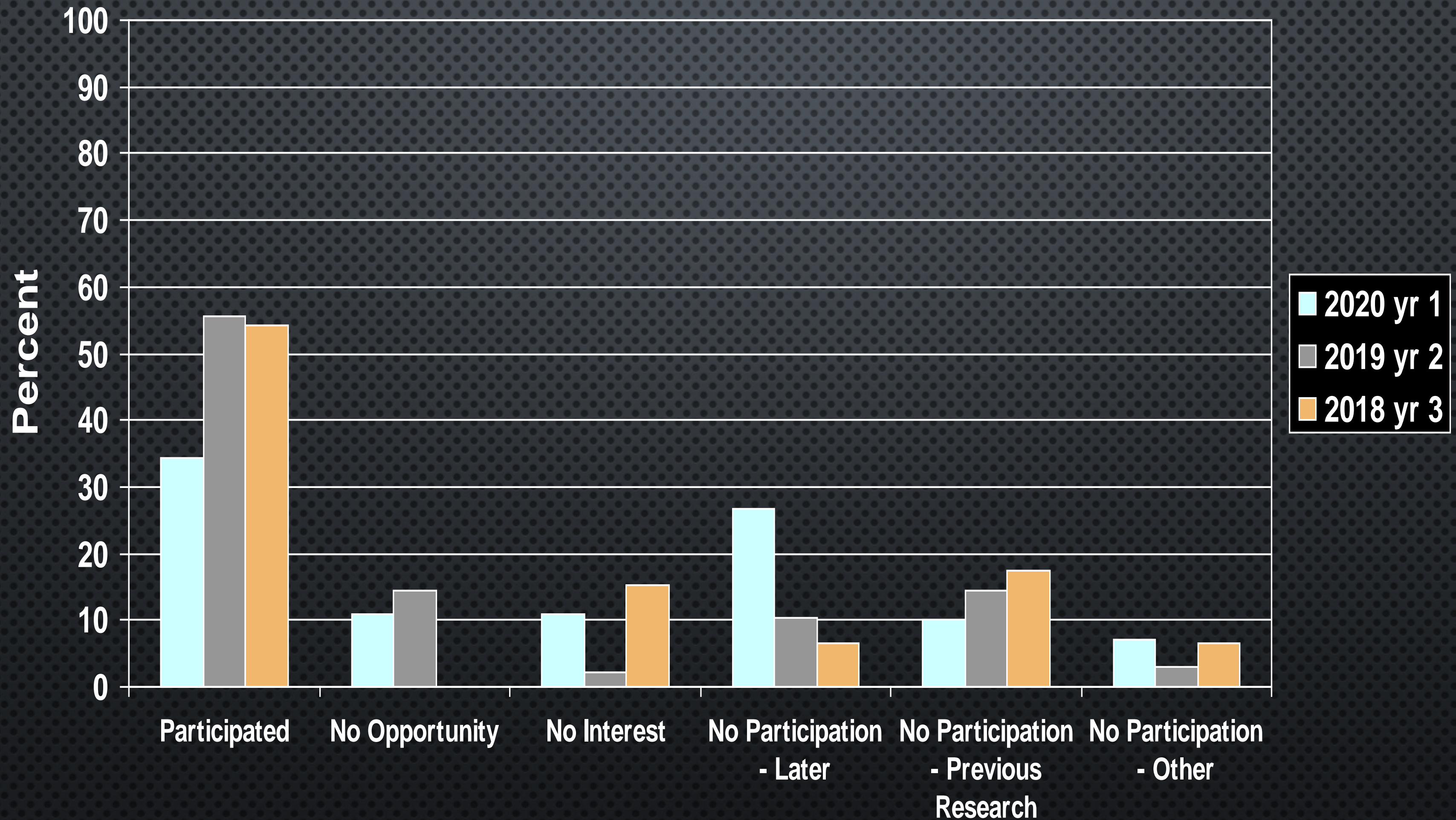
PERCENT OF RESPONDENTS THAT DISAGREE/NEUTRAL/AGREE WITH STATEMENTS



Data Source: End of 3rd Yr curriculum survey to Class of 2018 (31% response)

RESEARCH

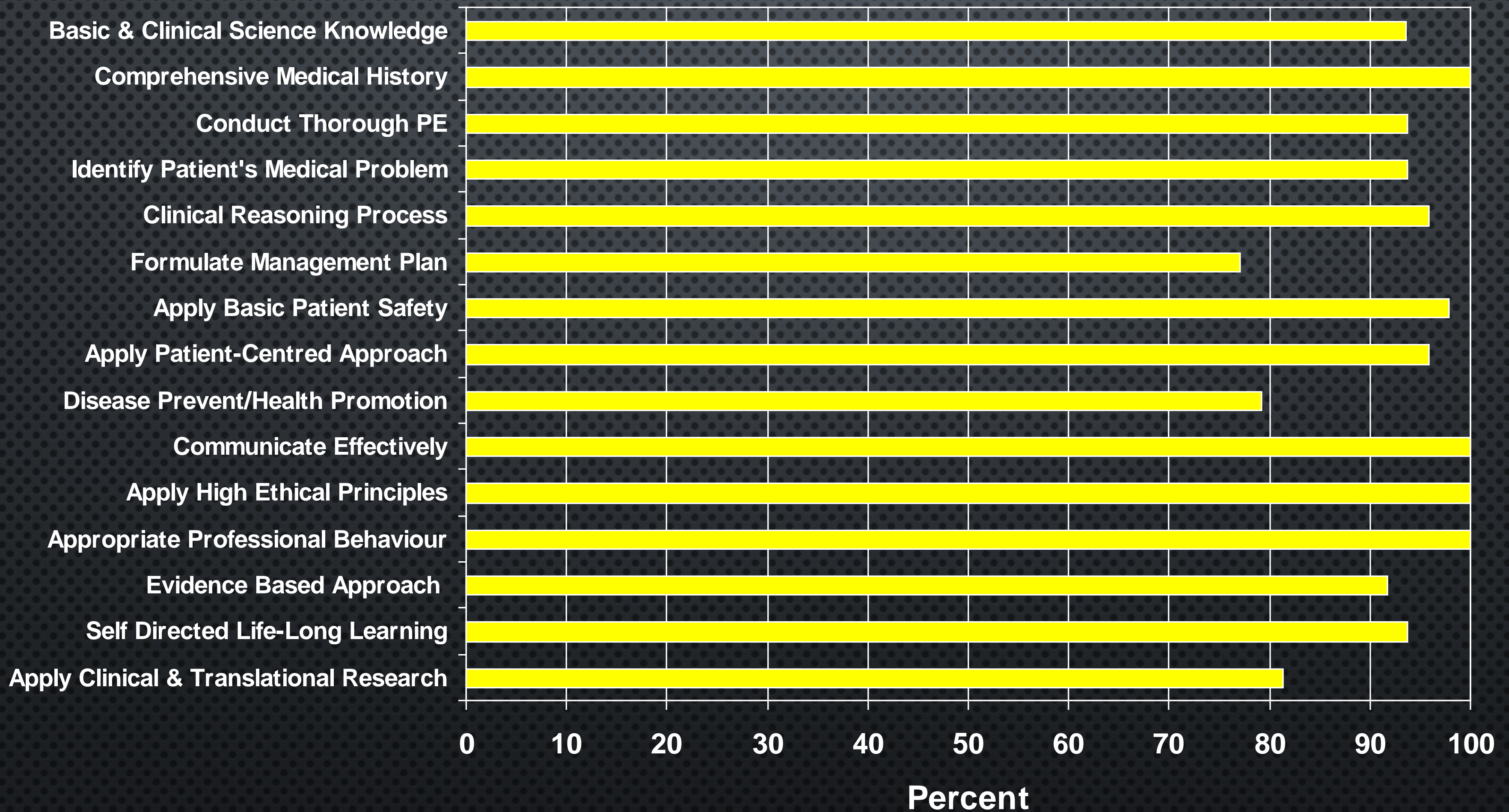
Aside from activities that are part of a course, how would you describe your participation in research/other scholarly activities while training as a medical student:



Data Source: Year-end surveys
Class 2020 (80%); Class 2019 (60%); Class 2018 (31%)

ACHIEVEMENT OF THE SCHOOL'S EDUCATIONAL OBJECTIVES

PERCENT (CLASS OF 2018) PREPARED/VERY PREPARED AT TIME OF GRADUATION



Data Source: End of 3rd Yr curriculum survey to Class of 2018 (31% response)

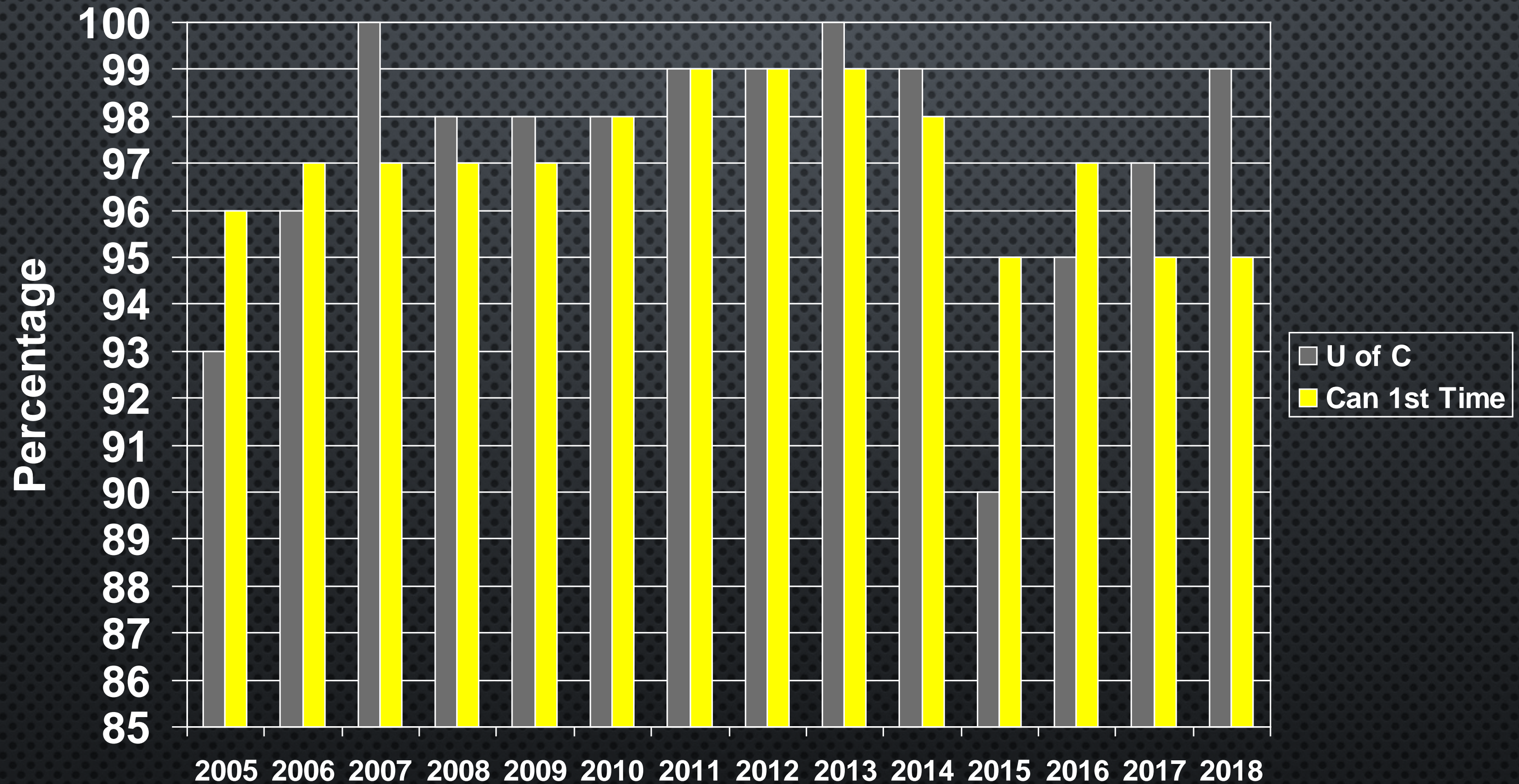
PASS RATE ON THE MCC - PART 1 EXAM

Class	Number of Examinees	Number Passing	Percentage Pass
2018	147	146	99.3
2017	159	154	96.9
2016	153	146	95.4
2015	167	150	89.8
2014	170	169	99.4
2013	157	157	100.0
2012	172	171	99.4
2011	147	146	99.3
2010	135	132	97.8
2009	122	120	98.4
2008	104	102	98.1
2007	101	101	100
2006	109	105	96.3
2005	101	94	93.1
2004	105	101	96.2
2003	91	88	96.7
2002	72	70	98.6*
2001	69	68	98.6

Data source: MCC

*In 2002, one examinee experienced computer problems which resulted in a “No standing” status for the exam. Percentage was calculated using 70/71.

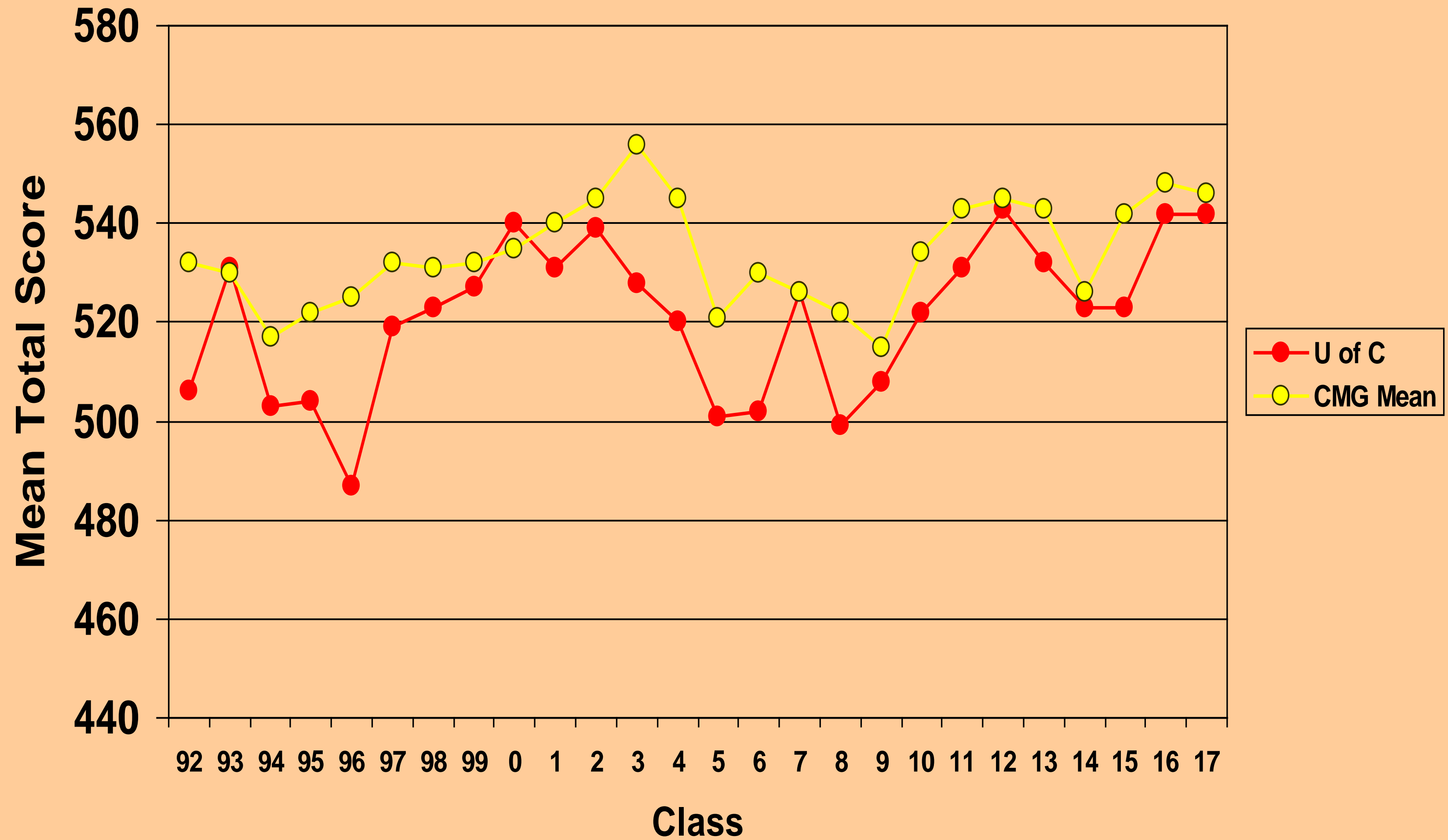
PASS RATE ON THE MCC PART 1 EXAM: CALGARY VS. CANADIAN FIRST-TIME TEST TAKERS



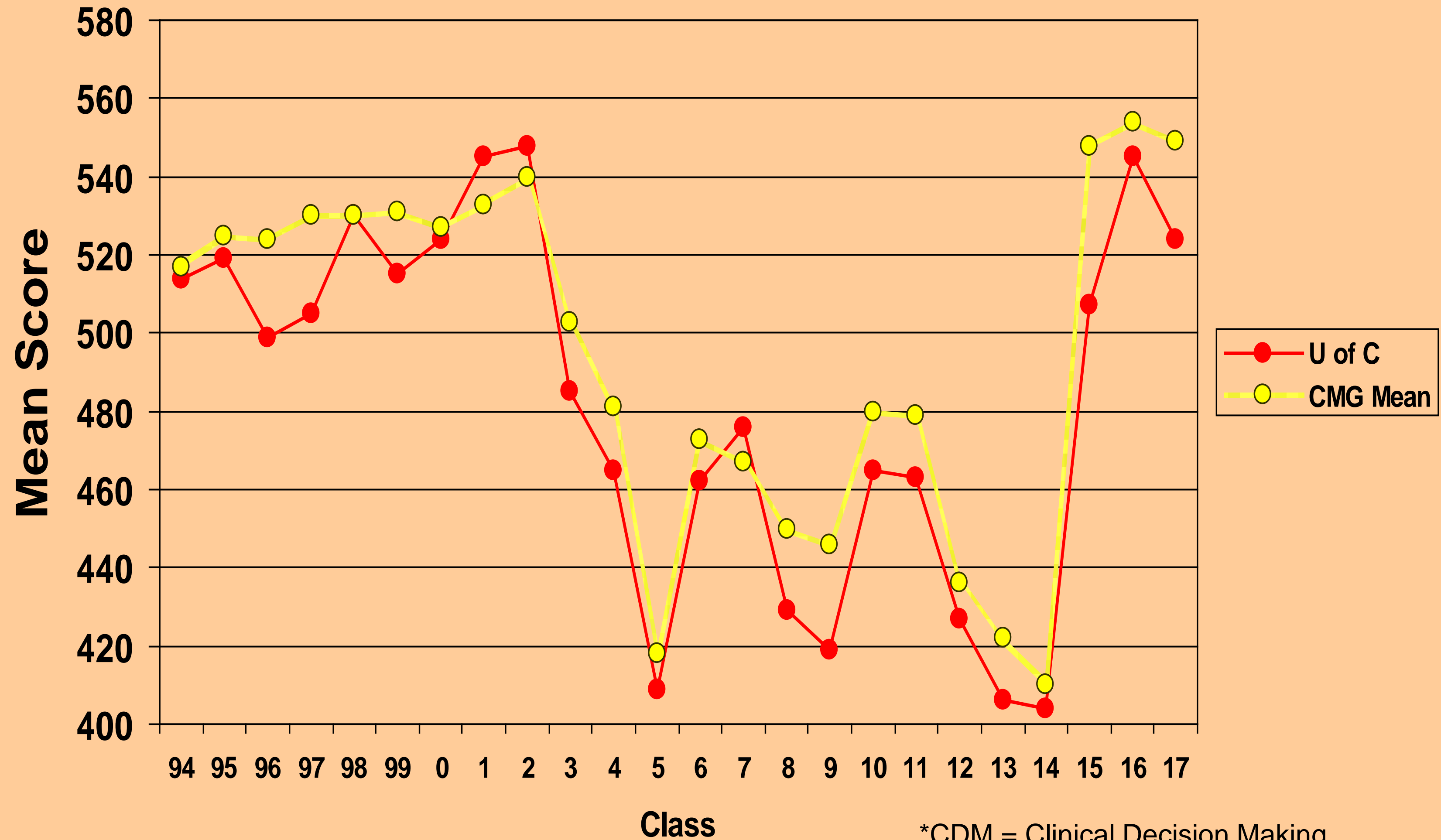
Data source: MCC

2015 pass score increased from 390 to 427; 2018 new exam/scoring format - pass score 226; M=250, SD 30

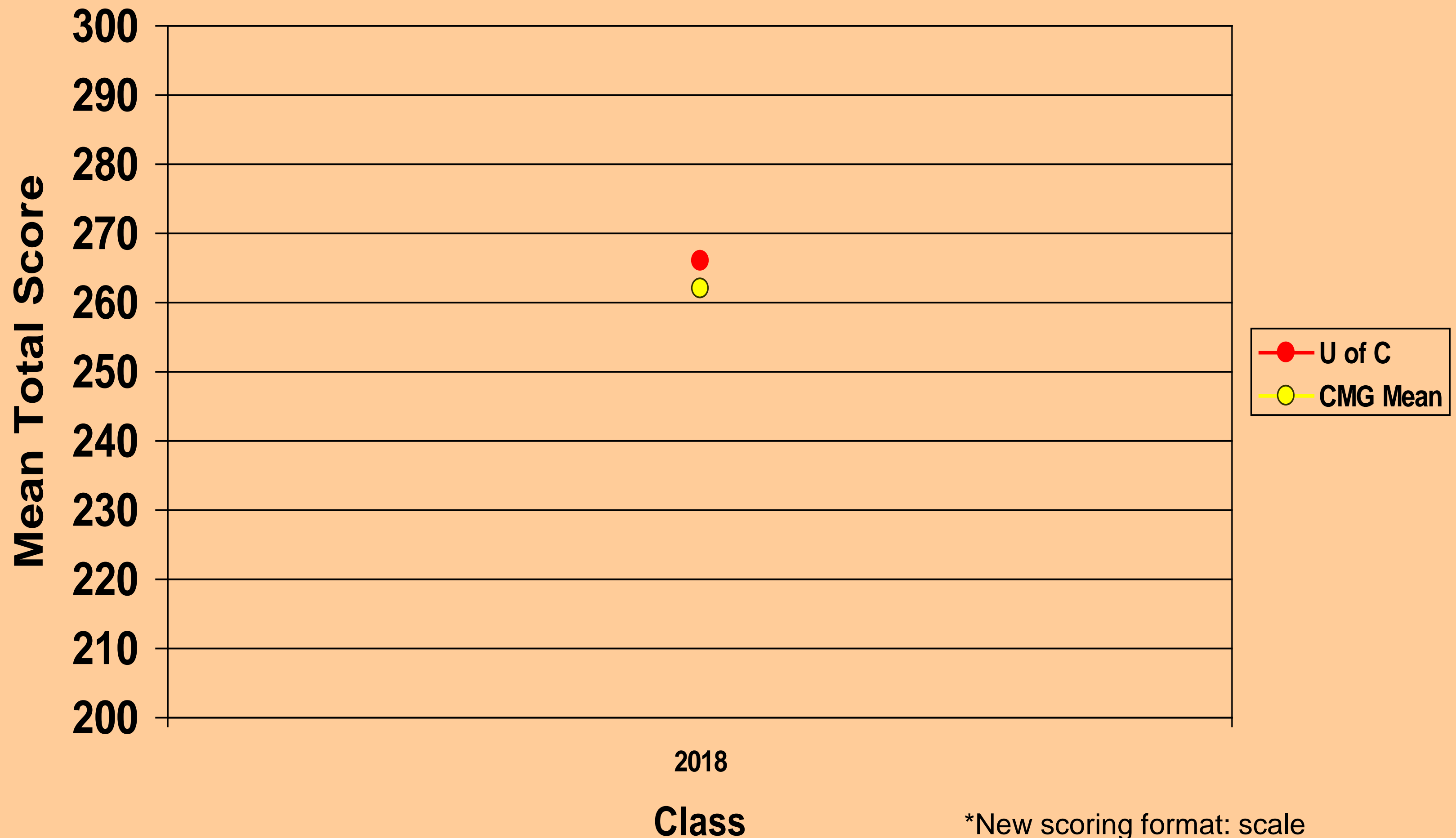
MCC Part I Exam - Total Score: 1992-2017



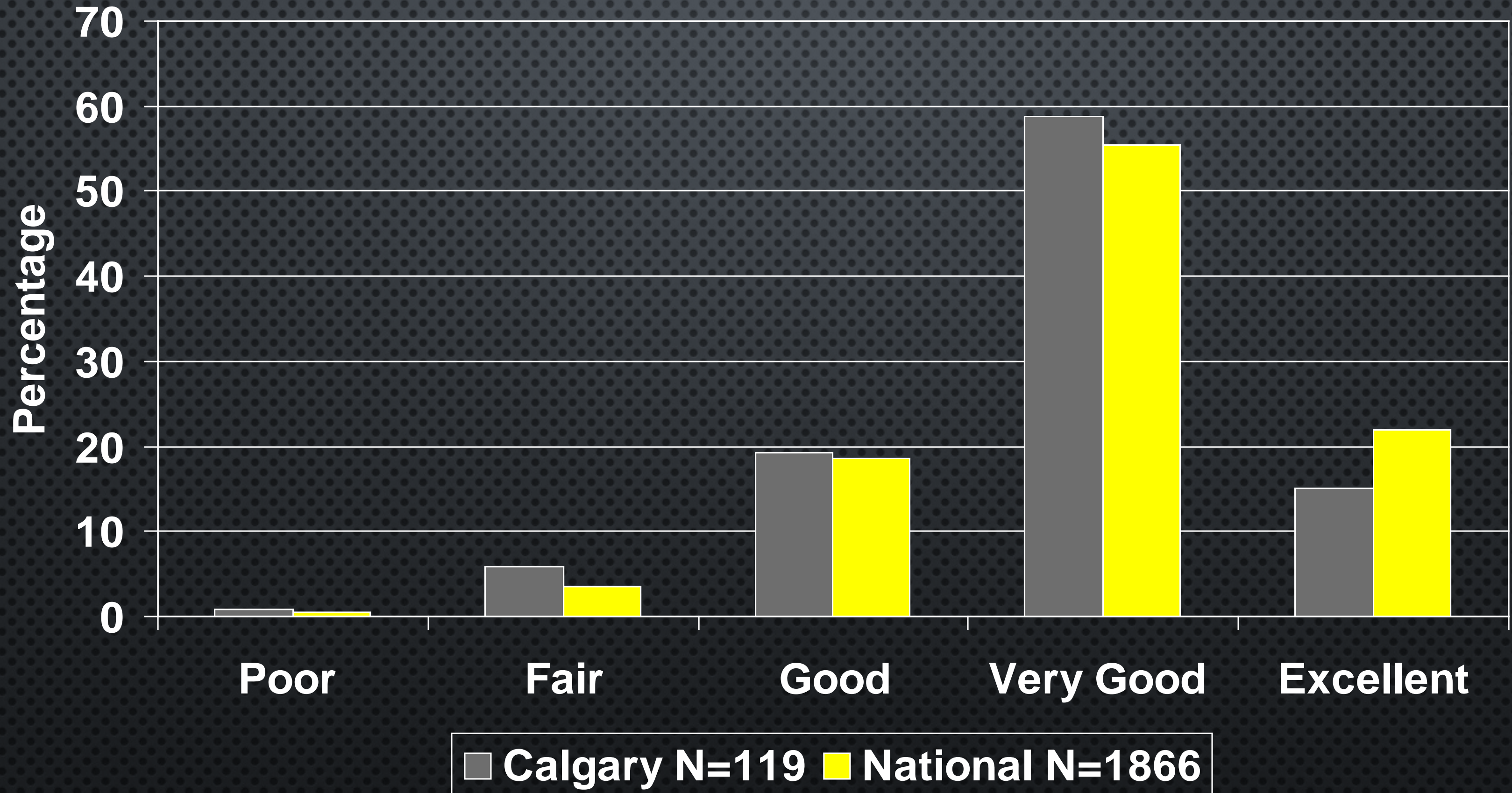
MCC Part I – CDM* Score: 1994-2017



*CDM = Clinical Decision Making constitutes 25% of the total score

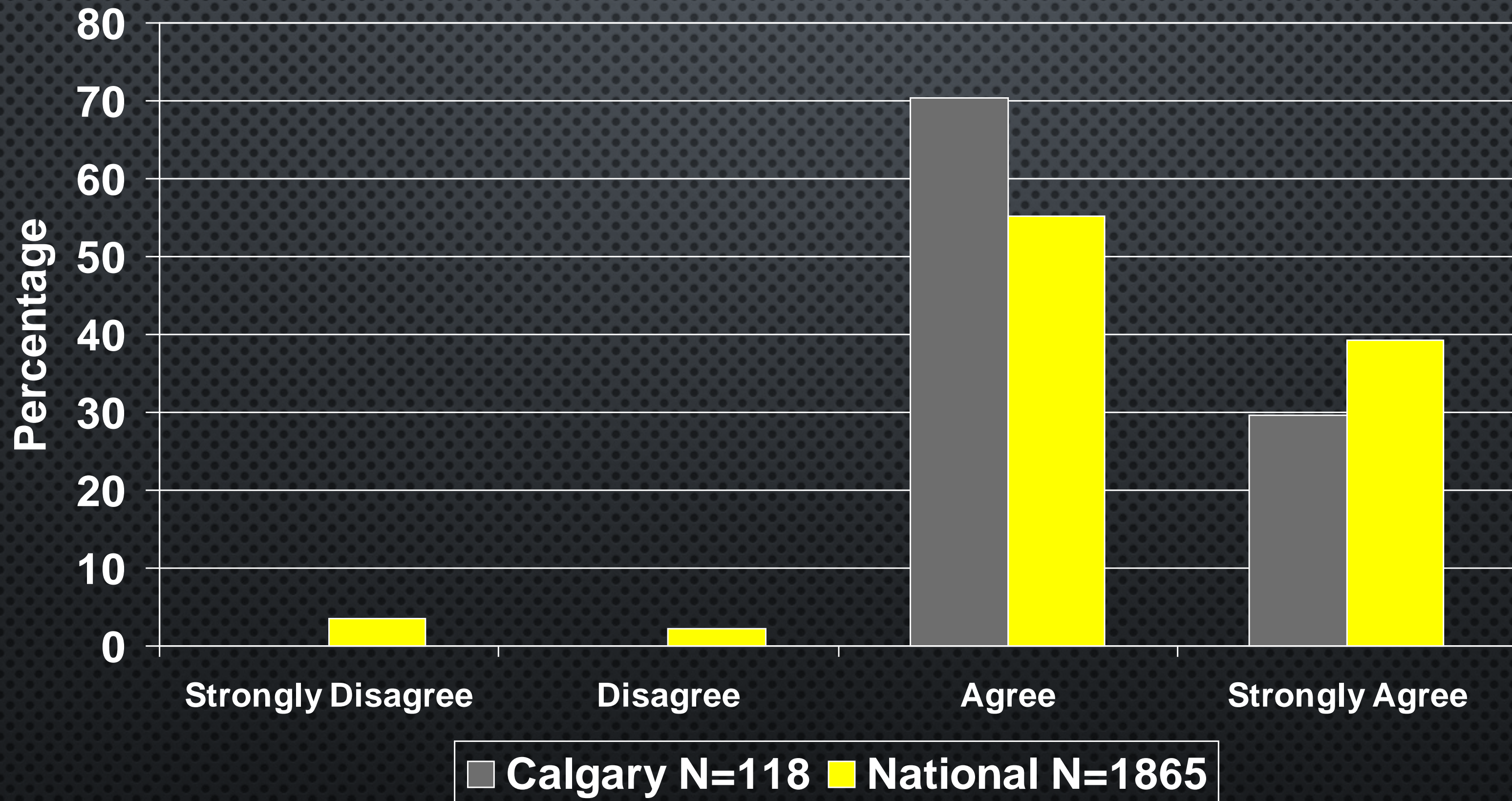

MCC Part I Exam - Total Score: 2018*
Mean Total Score
300
290
280
270
260
250
240
230
220
210
200
2018
Class
U of C
CMG Mean
*New scoring format: scale 100-400; M=250; SD=30; pass score = 226

QUALITY OF YOUR MEDICAL EDUCATION



Data Source: 2018 Canadian Graduate Questionnaire

I AM CONFIDENT THAT I HAVE DEVELOPED THE CLINICAL SKILLS REQUIRED TO BEGIN A RESIDENCY PROGRAM



Data Source: 2018 Canadian Graduate Questionnaire

What is the approximate amount of debt (in Canadian dollars) that you have accumulated directly related to your medical studies?

Calgary	2017 Count	2017 Percent	2018 Count	2018 Percent
Provided amount	86	72.9	85	72.6
Preferred not to provide	14	11.9	16	13.7
Did not know	3	2.5	6	5.1
None ($0)	15	12.7	10	8.5
Respondents:	118		117	

2018 Calgary Median = $100,000; 18.8% ≥ $200.000

National	2017 Count	2017 Percent	2018 Count	2018 Percent
Provided amount	1376	72	1282	69.1
Preferred not to provide	182	9.5	215	11.6
Did not know	68	3.6	122	6.6
None ($0)	286	15	237	12.8
Respondents:	1912		1856	

2018 National Median = $100,000; 13.1% ≥ $200,000

Data Source: 2018 Canadian Graduate Questionnaire

GRADUATION RATES

Class	New Students	Number (%) of Students Graduating with MD Degree	Of those who graduated, Number (%) Graduating in 3 Years (May or Nov)	Of Those Who Graduated, Number (%) Graduating ≥4 Years	Actual 3-Yr (May or Nov) Graduation rate of each class (based on new student entry for each class)
2021	164 (160 Can; 4 Int)				
2020	162 (158 Can; 4 Int)				
2019	160 (155 Can; 5 Int)				
2018	158 (Can)	137 (86.7%)	137 (100%)		137/158 (86.7%)
2017	158 (Can)	152 (96.2%)	144 (94.7%)	8 (5.3%)	144/158 (91.1%)
2016	157 (Can)	156 (99.4%)	139 (89.1%)	17 (10.9%) 1 LIM	139/157 (88.5%)
2015	170 (Can)	169 (99.4%)	150 (88.8%)	19 (11.2%) 2 LIM	150/170 (88.2%)
2014	173 (170 Can; 3 Int)	172 (99.4%)	157 (91.3%)	15 (8.7%)	157/173 (90.8%)
2013	169 (Can)	168 (99.4%)	152 (90.5%)	16 (9.5%) 1 LIM	152/169 (89.9%)
2012	177 (Can)	176 (99.4%)	164 (93.2%)	12 (6.8%) 5 LIM	164/177 (92.7%)
2011	152 (147 Can; 5 Int)	151 (99.3%)	144 (95.4%)	7 (4.6%)	144/152 (94.7%)
2010	148 (132 Can; 16 Int)	141 (95.3%)	131 (92.9%)	10 (7.1%) 2 LIM	131/148 (88.5%)
2009	140 (126 Can; 14 Int)	138 (98.6%)	127* (92.0%)	11 (8.0%)	127/140 (90.7%)

Class of 2019: I International student withdrew
Class of 2018: 21 students have not graduated – still enrolled ; 1 student transferred in for yr 3 – not included
Class of 2017: 6 students have not graduated – still enrolled
Class of 2016: 1 student has not graduated – still enrolled
Class of 2015: 1 student has not graduated – still enrolled
Class of 2014: 1 Canadian student withdrew
Class of 2013: 1 student has not graduated – still enrolled
Class of 2012: 1 student withdrew
Class of 2011: 1 Int student withdrew
Class of 2010: 2 Cdn students withdrawn (SARC TOR); 5 Int students withdrew
Class of 2009: 2 Int students withdrew; *one degree awarded posthumously

Updated November 2018

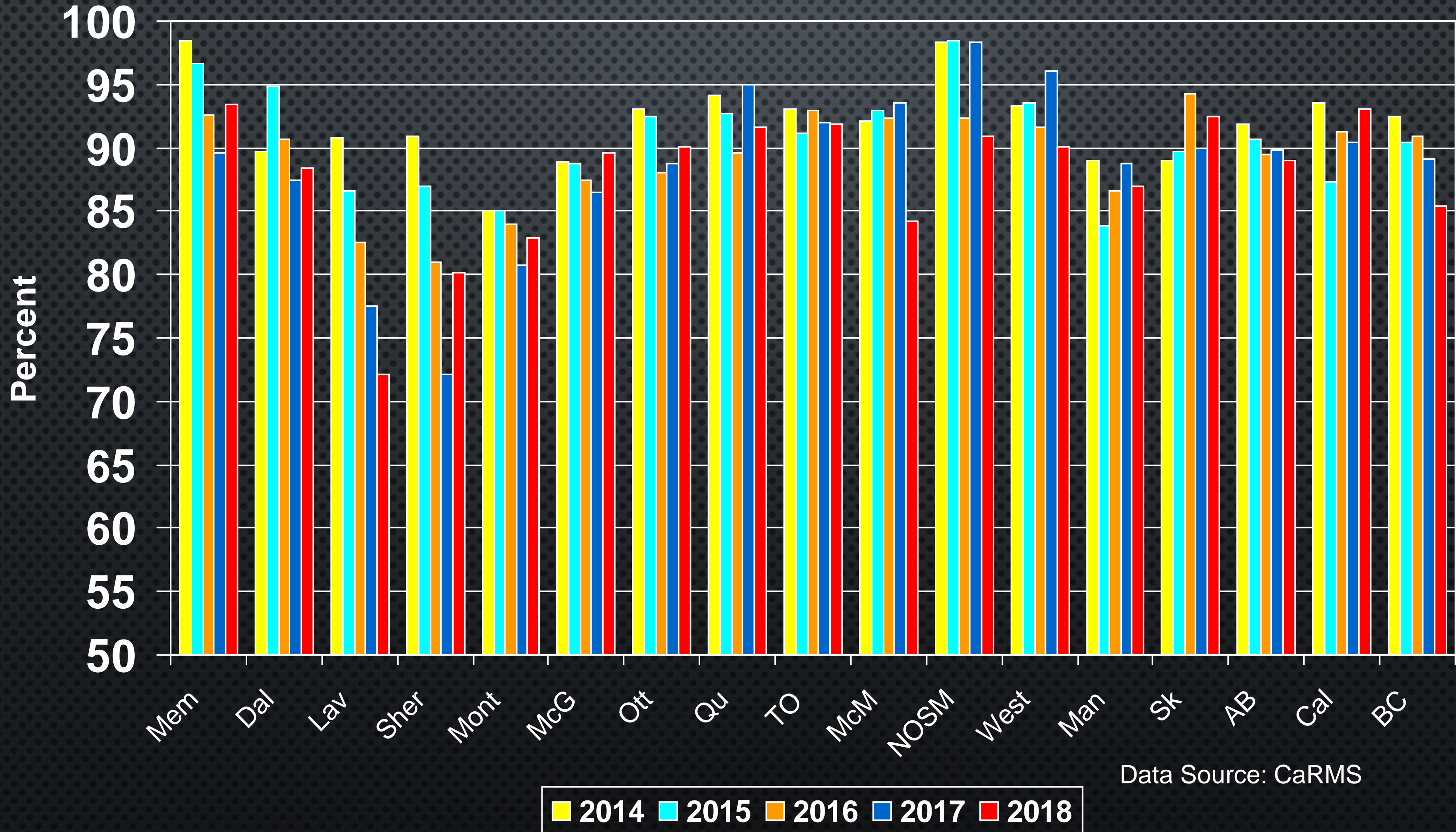
1st Round CaRMS match % for Canadian Medical Schools

Current year graduates only

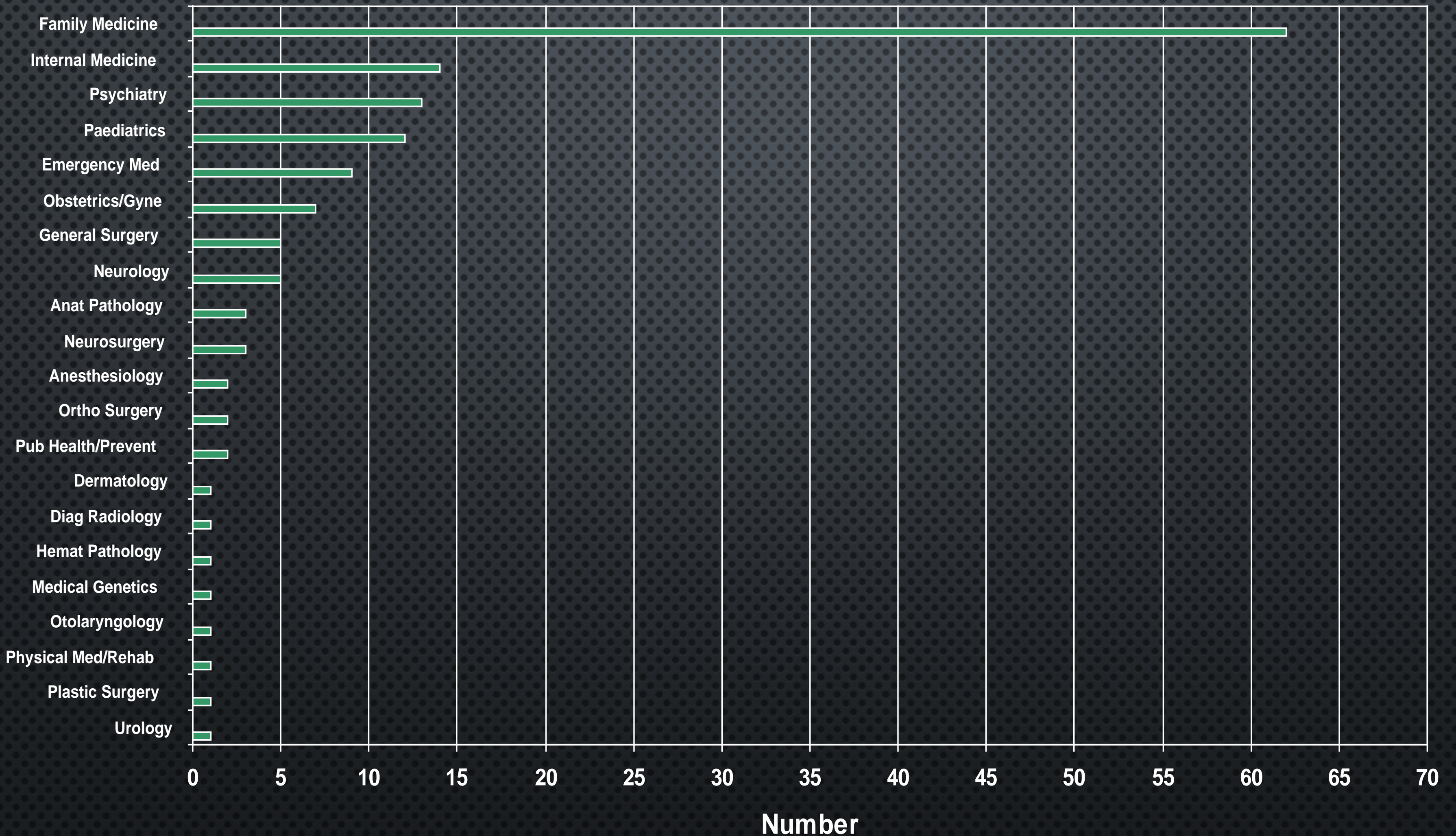
School	2013	2014	2015	2016	2017	2018	Mean
NOSM	98.2	98.4	98.4	100	96.8	95.6	97.9
Queens	96	99	98	96.9	98.1	95.9	97.3
Laval	96.2	97.8	96.5	95.7	98.2	97	96.9
Memorial	95.8	96.9	96.7	98.5	96.3	96.1	96.7
U of A	97.8	94.2	97	92.7	97	94.2	95.5
UBC	95.5	96.9	95.1	95.8	94.9	93.7	95.3
Calgary	95.7	96.5	94.8	96.9	95.1	92.3	95.2
McMaster	96.1	97.5	92.5	98.1	91.9	94.3	95.1
Ottawa	98	92.2	96.9	95.5	91.5	94.7	94.8
Sask	95.2	94	97.6	92.5	93.3	94.9	94.6
Montreal	93.4	94.6	96.8	93.1	94.6	92.2	94.1
Dalhousie	94.2	89.5	95.7	92.1	95.2	95.3	93.7
Toronto	96.7	93.4	95.6	92.9	93	89.8	93.6
Western	96.8	95.9	93.4	91.7	91.5	89.9	93.2
Sherbrooke	92.6	90	95.4	95.5	93.2	92.3	93.2
Manitoba	93.5	92.6	96.3	90.7	92.2	93.5	93.1
McGill	92.4	95.9	96.1	93.9	89.7	88.3	92.7
Canada*	**95.4**	**95.0**	**95.8**	**94.7**	**94.1**	**93.0**	**94.7**

Data Source: Carms.ca Table 2
*Based on raw data for all current year Canadian graduates

PERCENT OF MATCHED STUDENTS WHO MATCHED TO FIRST CHOICE DISCIPLINE IN 1ST ITERATION - CLASSES 2014 - 2018



SPECIALTY CHOICE - CLASS OF 2018*

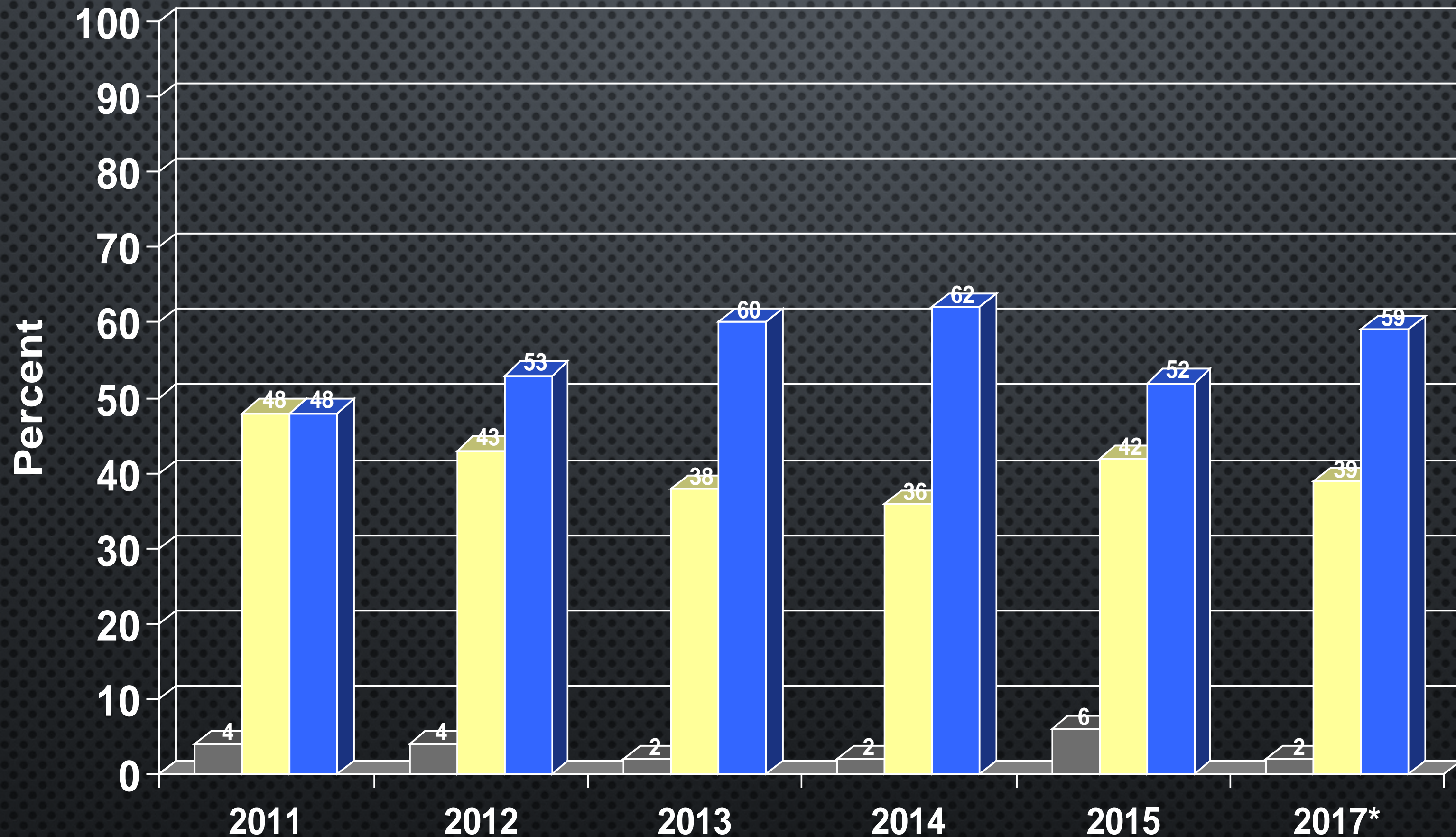


*Includes 1st and 2nd iteration; N=147 matched students - includes 4 students from 2017 that extended clerkship; 8 unmatched

Data Source: Canadian Resident Matching Service

RESIDENT DIRECTORS' ASSESSMENT OF U OF C GRADUATES AT THE END OF PGY1

"OVERALL PERFORMANCE - ABILITY TO FUNCTION AS A RESIDENT WITH A FULL WORKLOAD"



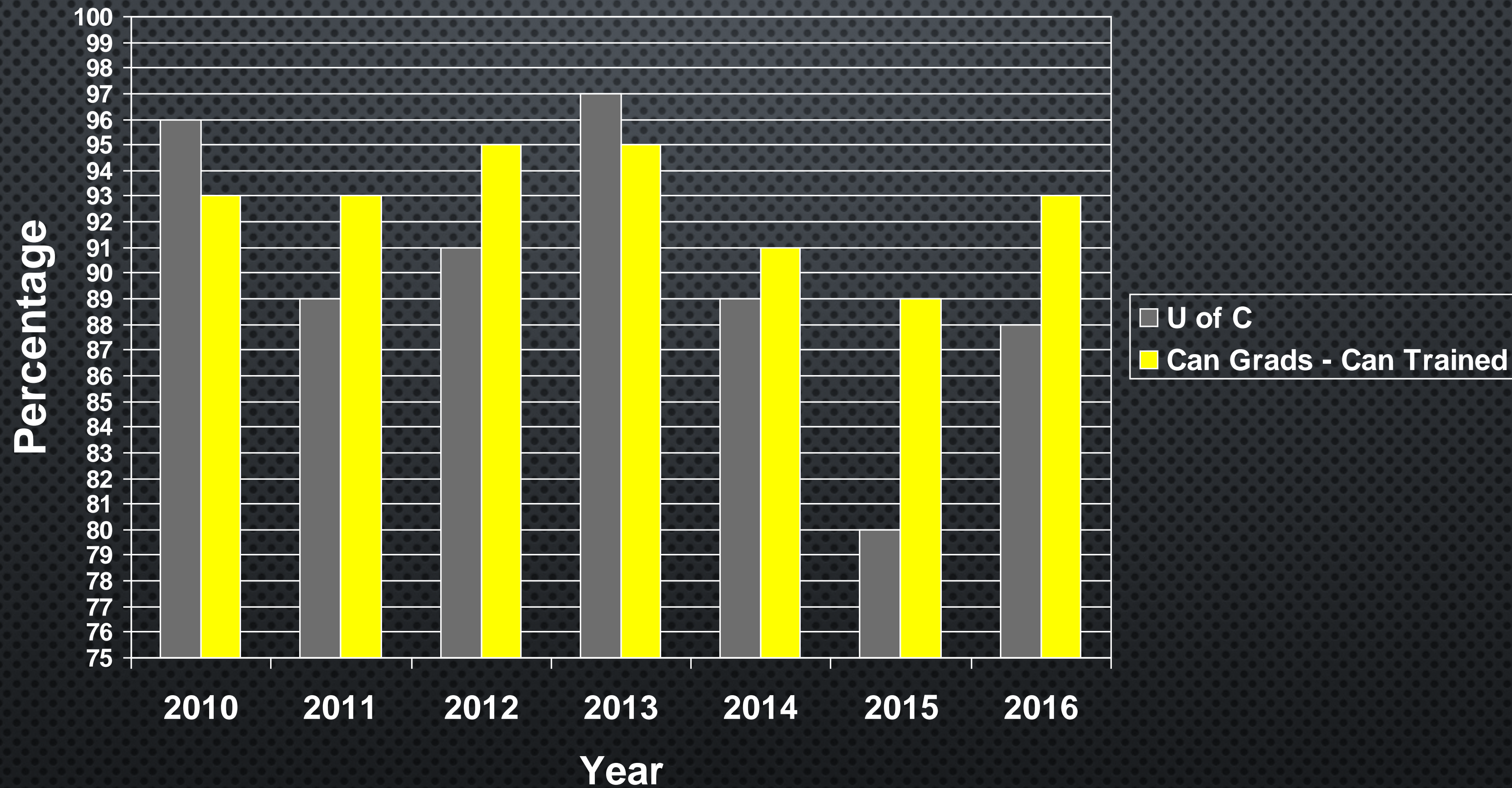
Class 2011 N=107 (75%); Class 2012 N = 118 (69%)
Class 2013 N = 104 (65%); Class 2014 N = 140 (83%)
Class 2015 N = 135 (81%); Class 2017 N = 125 (81%)

Source: Resident Program Directors' Survey; Classes 2011-2015; 2017. No data for 2016; 2017* - performance data was collected after 5 months rather than end of year

Weaker than most | Similar to most residents | Stronger than most

PASS RATE ON THE MCC PART 11 EXAM: CALGARY GRADUATES VS. CANADIAN GRADUATES – CANADIAN TRAINED

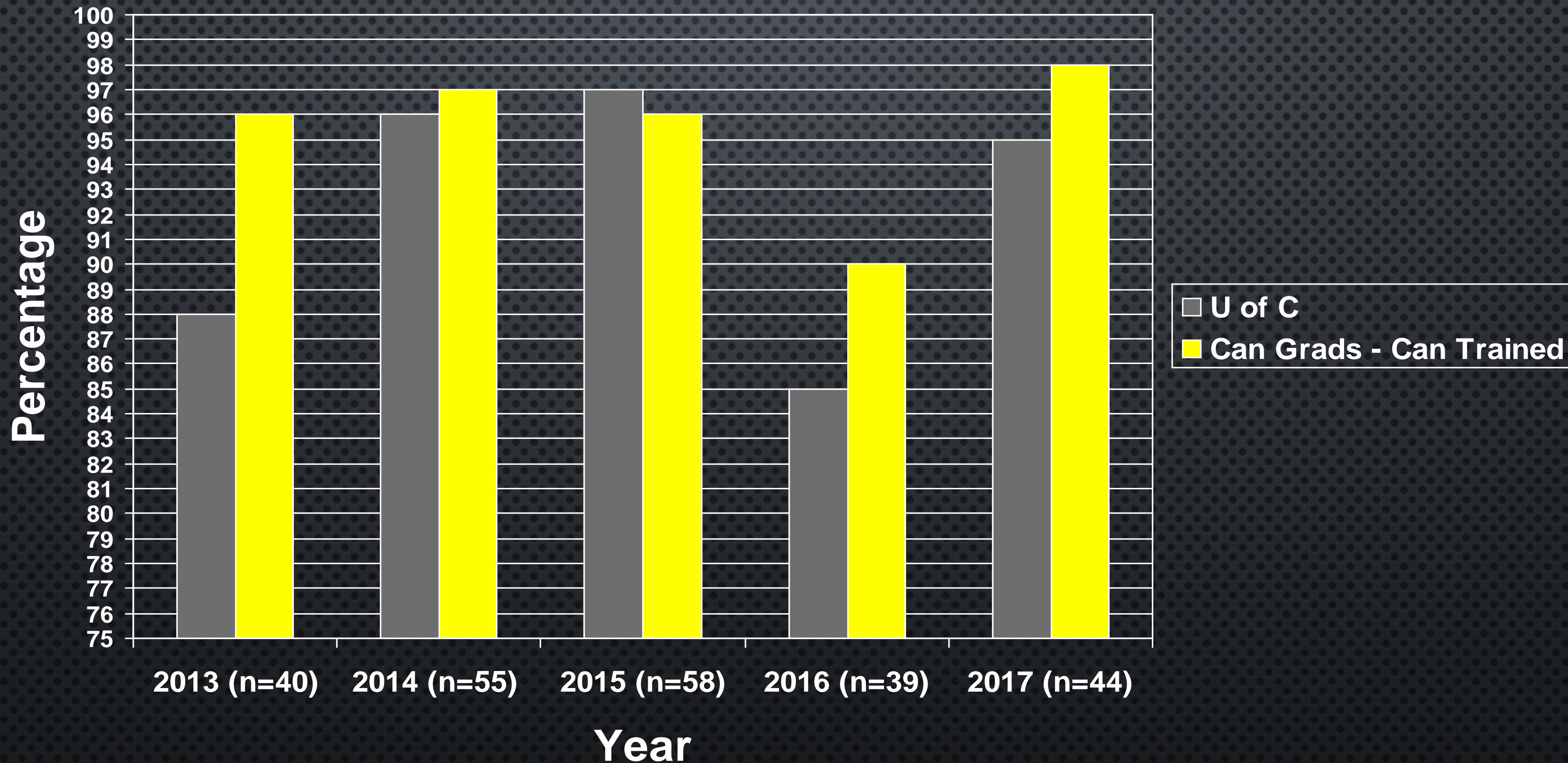
FALL ADMINISTRATION



Data source - MCC; beginning with the Spring 2015 administration the pass score increased from 475 (previous scale) to 509 (new scale).

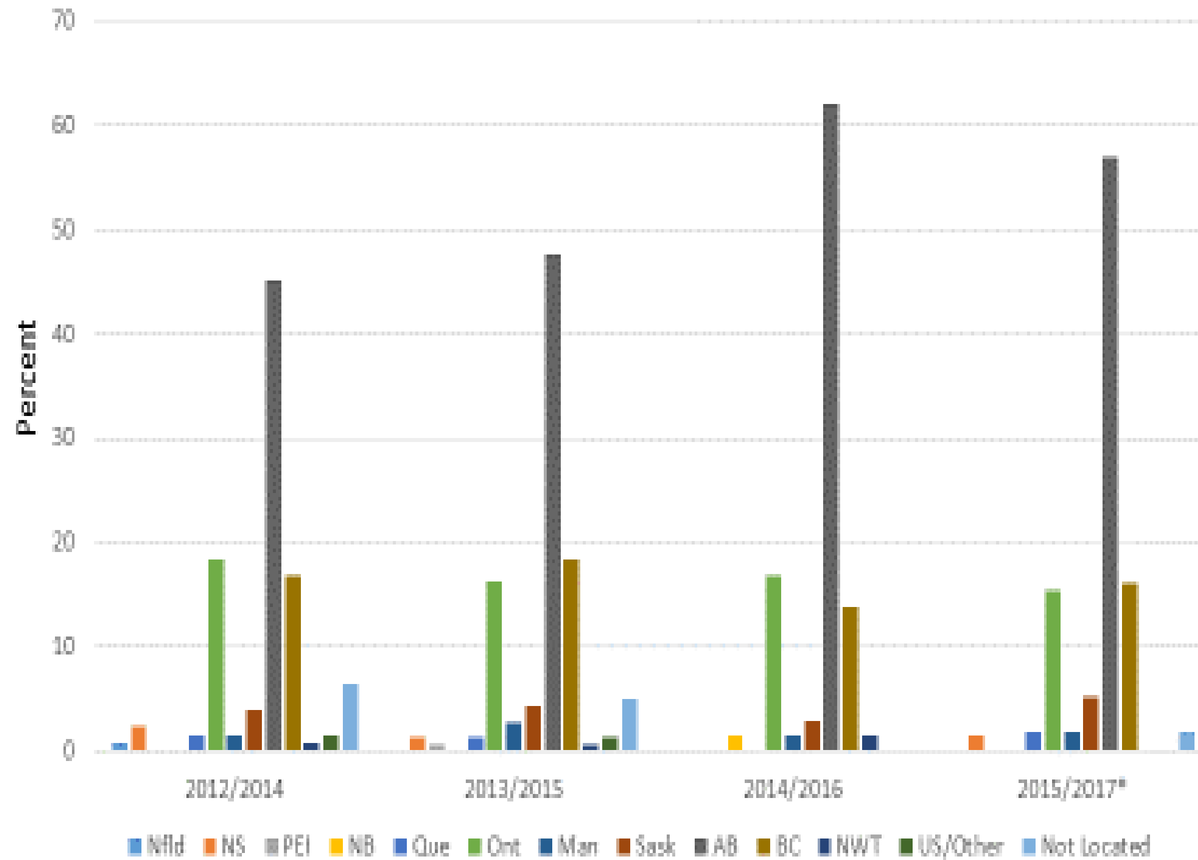
PASS RATE ON THE MCC PART 11 EXAM: CALGARY GRADUATES VS. CANADIAN GRADUATES – CANADIAN TRAINED

SPRING ADMINISTRATION



Data source - MCC: Spring exams are harmonized with CFPC; beginning with the 2015 Spring administration the pass score increased from 475 (previous scale) to 509 (new scale).

Practice Location of Calgary MD Graduates 2 years Following Post-Grad Training



*Year of exit from post-grad training (2015)/year practice location recorded (2017)

Data Source: Canadian Post-MD Education Registry

Technical Standards for Students in the MD program

The following standards were based on the recommendations of the AAMC Special Advisory Panel on Technical Standards for Medical School Admission, which was approved by the AAMC Executive Council on January 18, 1979, and on the Ontario Medical School Learning Policy. They are reviewed by the Undergraduate Medical Education Committee at regular intervals of not less than 5 years to ensure that they remain relevant to current curricular design.

These technical standards are essential to the completion of the educational program of the MD program at the University of Calgary. A candidate for the MD degree must demonstrate the following abilities:

Observation

A student must be able to participate in learning situations that require skills in observation. In particular, as student must be able to accurately observe a patient and acquire visual, auditory and tactile information.

Communication

A student must have a good (proficient, expressive and receptive) use of the English language. Examples of areas in which skillful English communication are required in the first 2 years include, but are not limited to, answering oral and written exam questions, presenting information in oral and written form, and participating in small group discussions/interactions. A student must be able to speak, hear, and observe patients in order to effectively and efficiently elicit information, describe mood, activity, and posture and perceive non-verbal communication. A student must be able to communicate effectively and sensitively with patients, families and any member of the health care team. A student must also be able to coherently summarize a patient’s condition and management plan verbally and in writing.

Motor / Tactile

A student must demonstrate sufficient motor function and tactile ability to safely perform a physical examination on a patient, including palpation, auscultation and percussion. The examination must be done independently and in a timely fashion. A student must be able to use common diagnostic aids or instruments either directly or in an adaptive form. (e.g. sphygmomanometer, stethoscope, otoscope and ophthalmoscope). A student must be able to execute motor movements that are required to provide general and emergency medical care to patients.

Intellectual-Conceptual, Integrative and Quantitative Abilities

A student must demonstrate the cognitive skills and memory necessary to measure, calculate, and reason in order to analyze, integrate, organize and synthesize information. In addition, the student must able to comprehend dimensional and spatial relationships. A student must be able to demonstrate these abilities in a manner consistent with the timely provision of general and emergency medical care to patients.

Behavioural and Social Attributes

A student must consistently demonstrate the emotional health required for full utilization of his or her intellectual abilities. The application of good judgment and the prompt completion of all responsibilities related to the diagnosis and care of patients are necessary. The development of mature, sensitive and effective relationships with patients, families and other members of the health care team are also required. The student must be able to tolerate the physical, emotional and mental demands of the program and function effectively under stress in order to maintain both physical and mental health. Adaptability to changing environments and the ability to function in the face of uncertainties that are inherent in the care of patients are both necessary. Finally, taking responsibility for themselves and their actions is expected.

Approved by UMEC, Jan 25th, 2013

CUMMING SCHOOL OF MEDICINE
UNDERGRADUATE MEDICAL EDUCATION (UME)

UNIVERSITY OF CALGARY

Departmental Policy

CLERKSHIP WORK HOURS

Classification Operations	Table of Contents
Approval Authority Associate Dean, UME	
Implementation Authority Manager, UME	
Effective Date November 21, 2014	
Latest Revision November 26, 2018	

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Purpose

1 Create an UME policy regarding the medical student work hours

Scope

2 This policy applies to Clerks as it pertains to their course rotations

Definitions

3 In this policy:

a. UME means the Undergraduate Medical Education program with the University of Calgary, Cumming School of Medicine
b. Approval Authority means the office or officer responsible for approving Undergraduate Medical Education policy and procedures
c. Implementing Authority means the office and officer responsible for implementing Undergraduate Medical Education policies and procedures.
d. Scheduled time means time students are expected to be at their clinical site (rounds, clinic, operating room, etc.) or in educational activities (bedside teaching, academic half-day, course 8, examinations etc.).
e. Clerks – 3rd year medical students
f. Professional Association of Resident Physicians of Alberta (PARA)

Policy Statement

4 Clerkship work hours

Special Situations

5 Students may be scheduled for an Emergency Medicine shift the day prior to a certifying examination provided that the shift ends a minimum of 14 hours before the scheduled examination.

Responsibilities

6 **UME will ensure adherence to this policy**

Procedures

8 This policy should not necessitate changes to current rotation scheduling. UME

will also track adherence to the policy.

Hours of daytime work on weekdays will vary by rotation. Unless scheduled for evening or overnight call, clerks should not be expected to work more than 11 hours per day on a regular basis, though this may occur on occasion.

Call may not exceed an average of 1:4 (7 calls maximum in 28 days) over the course of the rotation. No evening or night call is permitted the day prior to a certifying examination.

PARA (Professional Association of Resident Physicians of Alberta) sign over guidelines are to be followed. This means that students should be excused the morning after overnight call, once sign over is completed (24 hours +2).

On-call hours refer to those times the Clerks carries clinical responsibilities beyond the regular daytime hours. This typically includes evenings, overnight and weekends. When no call room is available, students should be dismissed no later than midnight and are expected to attend the following day. Dismissal prior to midnight is acceptable, at discretion of the rotation or preceptor.

Students should not be on call the last Sunday of any rotation past 2300 hours prior to starting a new block (Paediatrics, Family, etc.) or a new selective (Medical Teaching Unit, Clinical Teaching Unit, etc.).

If a student is assigned call on a statutory holiday, an in lieu day (or one less weekend call day) will also be assigned in order to assure fair scheduling for students. The in lieu day will be assigned taking into account needs for patient care and educational activities. It must be assigned during the rotation that includes the statutory holiday. If a student is “post-call” on a statutory holiday, NO in lieu day will be assigned.”

Special Cases:

Students may be scheduled for an Emergency Medicine shift the day prior to a certifying examination provided that the shift ends a minimum of 14 hours before the scheduled examination.

In rotations that require shift-work schedules, the usual work week and work hour maximums may be difficult to apply. In that case, rotations are asked to ensure that:

- in a two week period, there are a minimum of two 24 hour periods with no scheduled shifts
- shifts should not exceed 12 hours duration
- when moving "forward" in shift times, these may be scheduled on consecutive days [for example from day shift (8am-5pm) on Monday to evening shift (5 pm to 11 pm) on Tuesday]
- when moving "backward" in shift times, there should be a minimum of 10 hours between shifts [for example from evening shift (5pm to 11pm)

on Wednesday would not start shift on Thursday until after 9am]

- a student should not be scheduled for "split shifts" in a single day with the exception of time blocked for academic sessions.

The Pediatric rotation includes an inpatient rotation component that varies by sites. Students at ACH and PLC sites will be scheduled in shifts rather than 24 hour call. Students who complete this rotation component at ACH will do 2 weeks of daytime shifts and 1 week of night shifts (2100-0700). Students are not scheduled for night float shifts the night before examinations. Weekend coverage is scheduled in 12 hour shifts. Students who complete this rotation component at PLC will do 2 weeks of daytime shifts at PLC and 1 week of evening "admitting" shifts at ACH from 3-10pm Monday-Thursday and 8pm-8am on Friday/Saturday. Students who complete this component at a regional centre will do 1:4 call following the guidelines above.

Due to the nature of patient care in the ICU, students completing an ICU selective as a component of their Internal Medicine rotation may have long days (>11 hours) at times. In recognition of this, the number of required call in the 4 week selective has been reduced to 6 days instead of 7.

Similarly, due to the nature of patient care on the Hepatobiliary Service (HPB) during Surgery rotations, students completing a selective on this service may also have long days at times. As a result, one less call will be assigned during the Surgery rotation.

Pregnancy and Call: A Clerk will not be required to perform night call duties (after 2300 hours) once she has completed 27 weeks of gestation, or earlier if a valid medical reason, with medical documentation, is provided.

Instructions/Forms **9** UME will have conduct regular surveillance via the clerkship logbook.

The end of rotation surveys will include a question asking if there were breaches of the workload policy.

Standards **10**

History **15** *Approved:* Dr. Sylvain Coderre, Associate Dean
UME Management

Approved: UMEC (discussion regarding proposed changes Nov 23, 2018, approval date:_________

UMEC, June 29, 2017
UMEC, November 20, 2015
UMEC, November 21, 2014

Effective: **May 15, 2015 (Updates effective for Class 2020)**

College of Physicians & Surgeons of Alberta

CPSA Code of Conduct

Expectations of Professionalism for Alberta Physicians

Reissued: June 5, 2014[1]

Introduction

Integrity, trustworthiness, compassion and ethical conduct are the foundation of the practice of medicine. Patients, co-workers, learners and others in the healthcare workplace expect professional behavior from physicians; this behavior has an enormous impact on how health care is delivered and received.

The vast majority of physicians act professionally, and research shows this contributes to a healthier workplace and good patient outcomes. Alternatively, inappropriate physician behavior can lead to a number of issues in the healthcare environment, including:

- negative effects on patient safety and quality of care;
- erosion of relationships with staff, patients, learners and families;
- difficulty recruiting and retaining staff;
- reduced work attendance by co-workers and colleagues; and
- adverse impacts on a physician's health and/or reputation.

In order to address these issues, expectations of physicians must be clear.

The College of Physicians & Surgeons of Alberta ("CPSA") *Code of Conduct* was developed in response to requests from physicians for clarity and advice about professional behavior. It was written in consultation with physicians, other healthcare providers, healthcare organizations, regulatory bodies and post-secondary institutions.

The *Code of Conduct* is intended to:

- support a culture that aids and encourages effective care of patients and values professionalism, integrity, honesty, fairness and collegiality;
- promote an optimally caring environment of quality and safety for the health and well-being of patients and families, physicians, nurses, other healthcare providers, learners, teachers and others in the healthcare workplace;
- help physicians meet the principles outlined in the Canadian Medical Association (CMA) *Code of Ethics* and the CPSA *Standards of Practice;*
- help physicians model and teach professional behavior;
- encourage open and respectful discussion related to the delivery of health care; and
- support physicians and others in addressing physician behavior that does not meet professional expectations.

General Principles

The *Code of Conduct* is based on the following ethical and professional principles:

- Strive for high-quality patient care.
- Focus on safety.
- Treat others with respect.
- Maintain confidentiality.
- Do the right things for the right reasons.
- Be aware of your professional and ethical responsibilities.
- Be collaborative.
- Take action when inappropriate behavior occurs.
- Communicate clearly.

Scope of the *Code of Conduct*

The *Code of Conduct* applies in any environment where a physician interacts with patients, colleagues, co-workers, learners and others in the healthcare workplace, including physical workplace, telephone, videoconference and online. The *Code* also applies in any situation where a member can be identified by the public as a physician, such as public appearances, printed media and online networks where information may be shared.

The *Code of Conduct* clarifies the College's expectations of Alberta's physicians in all stages of their careers, in all facets of medicine, and in all methods of care delivery.

The *Code of Conduct* is consistent with the CMA's *Code of Ethics* and complements the CPSA *Standards of Practice.* Physicians are expected to know and abide by these rules; any breach of professional behavior will be judged against all three of these foundational documents.

While the *Code of Conduct* outlines expectations regarding professional behavior, when inappropriate behavior occurs the College will consider:

- the physician's fitness to practise, which must be addressed; and
- systemic issues within the healthcare system.

NOTE: Although these stressors must be identified and considered, they **cannot** be used as an excuse for inappropriate behavior.

Specific Expectations

Accountability

As a physician, I will:

(a) Act, speak, and otherwise behave in the healthcare workplace in a way that promotes safety, high quality patient care and effective collaboration with others on the healthcare team.

(b) Maintain high standards of personal and professional honesty and integrity.

(c) Take responsibility for my own behavior and ethical conduct regardless of the circumstances.

(d) Be accountable for my personal decisions, actions or non-actions in the workplace.

(e) Record and report accurately and in a timely fashion clinical information (history, physical findings and test results), research results, assessments and evaluations.

(f) Communicate with integrity and compassion.

(g) Accurately attribute ideas developed with others and credit work done by others.

(h) Deal with conflicts of interest, real or perceived, openly and honestly.

(i) Engage in lifelong learning.

Confidentiality

As a physician, I will:

(a) Regard the confidentiality and privacy of patients, research participants and educational participants, as well as their associated health records, as a primary obligation.

(b) Ensure confidentiality by limiting discussion of patient health issues to settings appropriate for clinical or educational purposes and to caregivers within the "circle of care". Discussion with others will occur only with explicit patient consent or as permitted by legal and ethical principles.

(c) Know and comply with applicable legislation regarding confidentiality and health information.

Respect for Others

As a physician, I will:

(a) Interact with patients and families, visitors, employees, physicians, volunteers, healthcare providers and others with courtesy, honesty, respect, and dignity.

(b) Refrain from conduct that may reasonably be considered offensive to others or disruptive to the workplace or patient care. Such conduct may be written, oral or behavioral, including inappropriate words and/or inappropriate actions or inactions.

(c) Respect patient autonomy at all times by appropriately discussing investigation and treatment options with the competent patient and, only with the patient's consent, identified other persons.

(d) Ensure appropriate consultation occurs when a patient lacks the capacity to make treatment decisions, except in emergency circumstances.

(e) Respect the personal boundaries of patients and their rights to privacy and confidentiality; refrain from physical contact outside the proper role of a physician, sexual overtures and behaviors or remarks of a sexual nature.

(f) Respect the personal boundaries of co-workers and their rights to privacy and confidentiality; refrain from unwanted physical contact, sexual overtures and behavior or remarks of a sexual nature.

(g) Avoid discrimination based on, but not limited to, age, gender, medical condition, race, color, ancestry, national or ethnic origin, appearance, political belief, religion, marital or family status, physical or mental disability, sexual orientation or socioeconomic status. (NOTE: In human rights legislation, this is known as "protected grounds".)

(h) Allow colleagues to disagree respectfully without fear of punishment, reprisal or retribution.

(i) Recognize the important contributions of colleagues, whether generalists or specialists.

Responsible Behavior

As a physician, I will:

(a) Ensure patient care and safety assume the highest priority in the clinical setting. The duty of physicians to advocate for patients does not excuse or justify unacceptable behavior; it must be done constructively.

(b) Attend to my health and well-being to enable attendance to professional responsibilities.

(c) Recognize limitations and seek consultation or help when personal knowledge, skills or physical/mental status is inadequate or compromised.

(d) Maintain professional boundaries:

- minimize self disclosure; and
- refrain from providing care to individuals where a dual relationship* exists and objectivity may be challenged; in circumstances where refraining is not reasonably possible, ensure care provided is transparent, objective and defensible.

(e) Supervise and assist others as appropriate to their needs and level of expertise.

(f) Participate in quality improvement initiatives and strategies to deal with errors, adverse events, close calls and disclosure.

(g) Express opinions on healthcare matters in a manner respectful of others' views and the individuals expressing those views.

(h) When conducting professional activities, abstain from exploitation of others for emotional, financial, research, educational or sexual purposes.

(i) Teach and model the concepts of professional behavior in research, clinical practice and educational encounters.

(j) Encourage and model language, appearance and demeanor appropriate to the professional healthcare setting.

(k) Endeavor to model professional behavior in all public settings, including online settings, particularly when there is limited ability to separate personal and professional identities.

(l) Avoid misuse of alcohol or drugs that could impair the ability to provide safe care to patients.

(m) Attend to other factors that could impair the ability to provide safe care to patients.

(n) Address breaches of professional conduct, scientific conduct or unskilled practice by another healthcare professional by discussion directly with that person or, if necessary, by reporting to the appropriate authorities using established procedures. Refrain from trivial or vexatious reports that unjustly discredit the healthcare system or the reputation of other members of the healthcare, research or academic team.

(o) Know and adhere to the CPSA *Standards of Practice.*

(p) Participate in professional development and assessment processes.

(q) Respect the authority of the law and understand professional and ethical obligations.

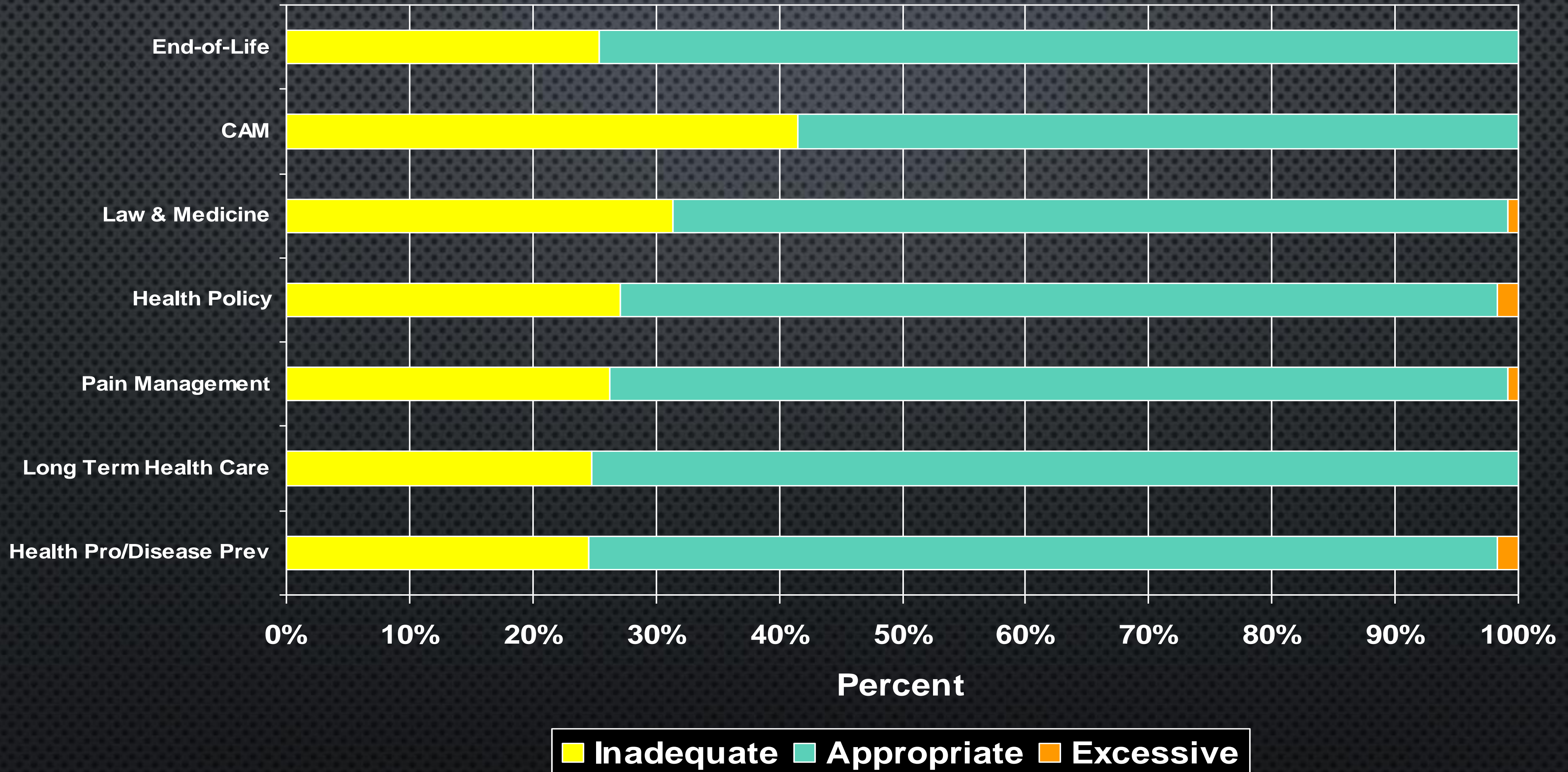
***** Dual relationship refers to when multiple roles (personal, professional, business or social) exist between a physician and a patient.

Acknowledgement

This document was developed with input from various health professions and using codes of conduct from other institutions and organizations. Particularly helpful were statements from the College of Physicians and Surgeons of Ontario, the University of Calgary Faculty of Medicine, the University of Alberta Office of Equity and Faculty Development, and the Medical Council of Canada.

[1] Replaces CPSA Code of Conduct; issued April 2010

DO YOU BELIEVE THAT YOUR INSTRUCTION IN EACH OF THE FOLLOWING AREAS WAS INADEQUATE, APPROPRIATE OR EXCESSIVE



Data Source: 2018 CGQ

Preceptor Recruitment

Mike Paget, Manager, Academic Technologies

UMEC, February 1st, 2019

Background

- This data is the result of three big initiatives
    - Osler, our Learning Management System, which facilitates our granular, event level details, led by Doug Hall
    - Vera, our CSM wide Preceptor Payment Eligibility system, which went live this week, developed by Scott Steil and Mike Cheshire. Thanks to all the finance teams from educational departments, Jonathan Nituch and Angela Coverdale from the Dean’s office.
    - Our Survey tool, which generates 5000+ event level evaluations annually developed by Chaoji Liu

Motion:

That UME has the discretion to recruit teachers based on:

- Payment model
- Evaluated performance
- Consistent fulfillment of confirmed teaching events

Our goal

- Creation of a mechanism for preceptors to browse all available openings
  - Across all courses
  - No more sign-up genius
- Self confirm and select teaching opportunities
  - No long loop to gain confirmation
- Filter opportunities based on payment model, performance and attendance

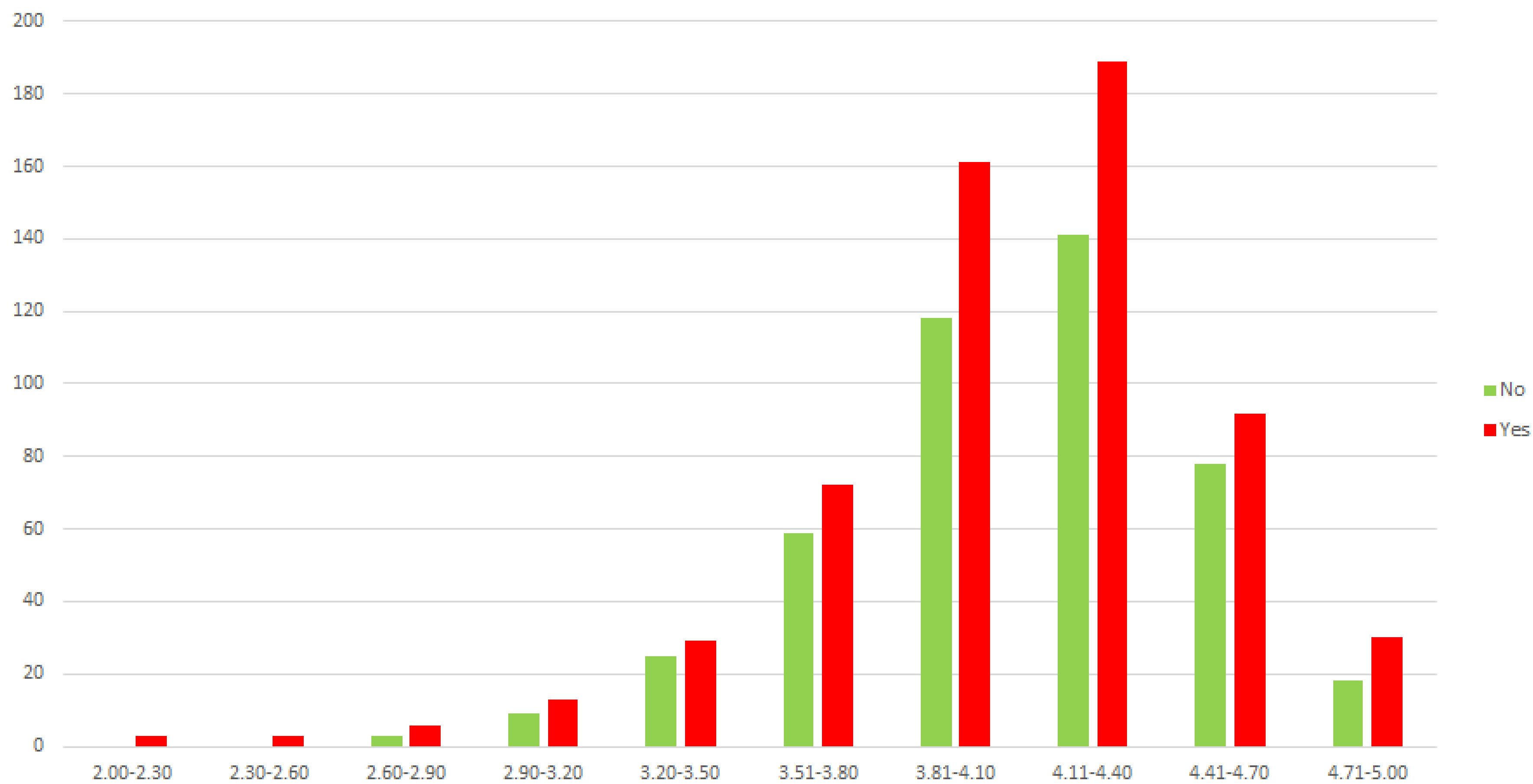
First concern:

Would an increase in AMHSP / FTA teaching via a new recruitment model have a global impact on the student's perception of the quality of teaching?

Slide for reference only

Payment Eligibility Reference

FTA	Resident	AMHSP FTE	AMHSP Education	Eligible for Payment
No	No	<0.4	0	Yes
No	No	<0.4	>0	No
No	No	>=0.4	0	No
No	No	>=0.4	>0	No
No	Yes	<0.4	0	No
No	Yes	<0.4	>0	No
No	Yes	>=0.4	0	No
No	Yes	>=0.4	>0	No
Yes	No	<0.4	0	No
Yes	No	<0.4	>0	No
Yes	No	>=0.4	0	No
Yes	No	>=0.4	>0	No
Yes	Yes	<0.4	0	No
Yes	Yes	<0.4	>0	No
Yes	Yes	>=0.4	0	No
Yes	Yes	>=0.4	>0	No



200
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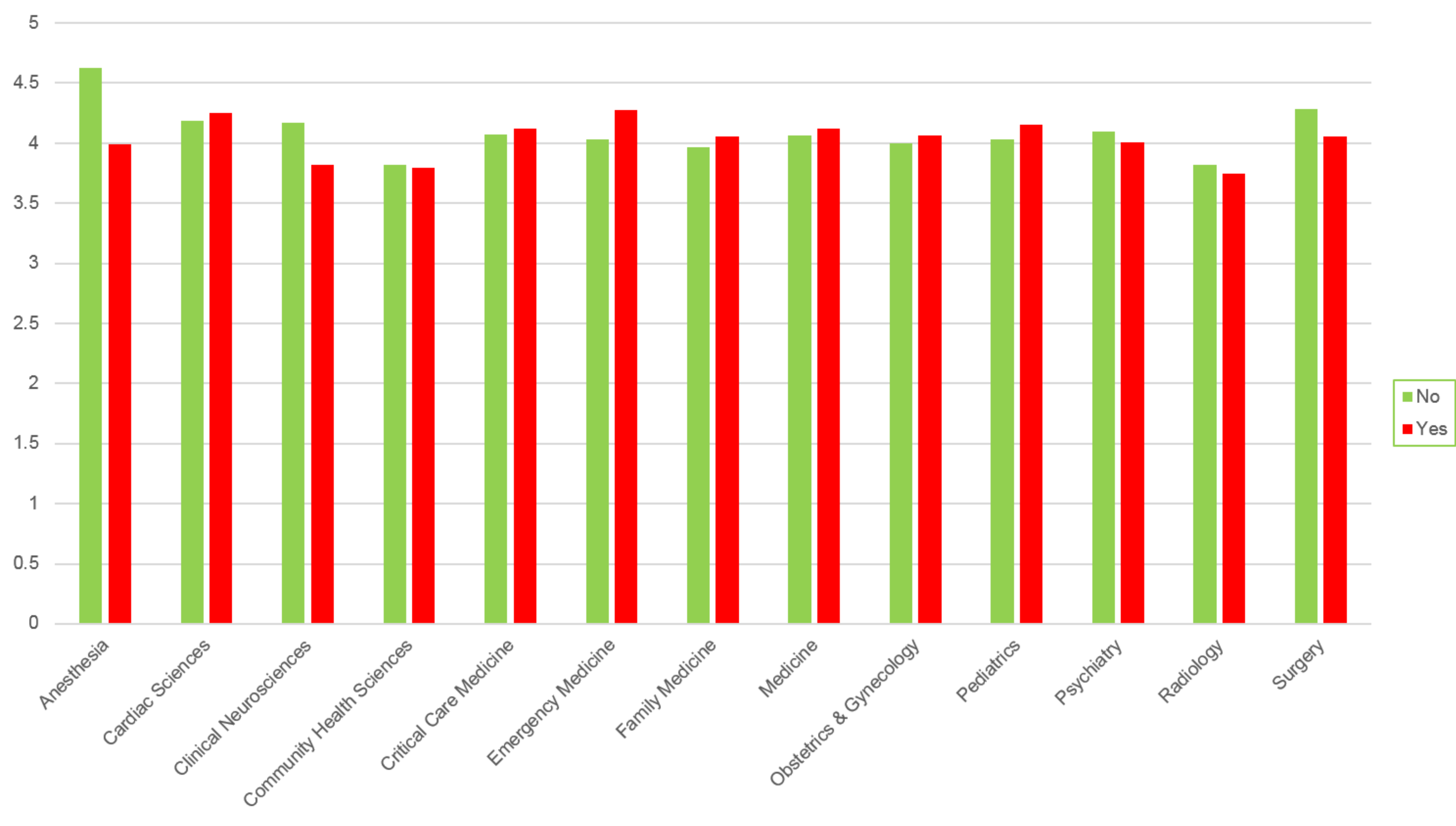
2.30-2.60
2.60-2.90
2.90-3.20
3.20-3.50
3.51-3.80
3.81-4.10
4.11-4.40
4.41-4.70
4.71-5.00
No
Yes

Second concern:

Would a specific department be at risk for negative exposure?



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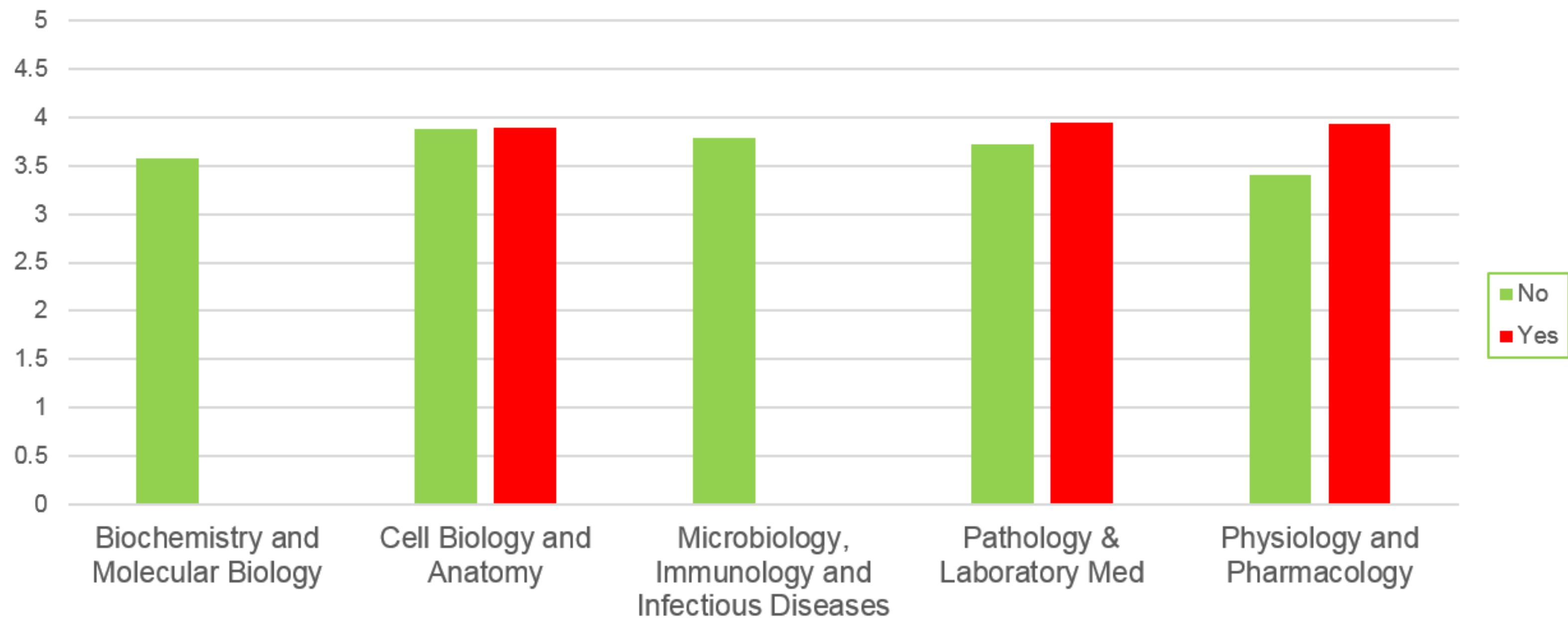
Anesthesia
Cardiac Sciences
Clinical Neurosciences
Community Health Sciences
Critical Care Medicine
Emergency Medicine
Family Medicine
Medicine
Obstetrics & Gynecology
Pediatrics
Psychiatry
Radiology
Surgery
No
Yes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Biochemistry and Molecular Biology
Cell Biology and Anatomy
Microbiology, Immunology and Infectious Diseases
Pathology & Laboratory Med
Physiology and Pharmacology
No
Yes

From the previous chart:

Anesthesia has better ratings by AMHSP/FTA faculty members vs. paid ones.
Only 6% of the Anesthesia department is AMHSP or FTA.

However, that AMHSP / FTA group is a positive outlier, not a negative one.

Discretion for: Payment Model

Priority given to booking faculty with AMHSP/FTA (or otherwise free) for a subset of events in a given course.

The subset of events would be defined by the Course Chair.

The remaining events would be hand selected faculty members, departments with primarily fee for service faculty.

Is there a rule for defining the size of the subset?

Discretion for: Evaluated performance

Evaluated performance (below 3.00 over 3 events with > 5 evaluators)

This would impact 9/1772 preceptors, 4 of whom we pay, from the last 5 years.

Discretion for: Cancellation

Preceptors who have cancelled 3 times with 2 weeks (or less) notice in the last 2 academic years*

*some details TBD, specifically, tracking mechanism, some room for valid excuses

*After a recent project looking at process in the UME, teaching cancellations flagged as a significant contributor to administrative workload

Motion:

That UME has the discretion to recruit teachers based on:

- Payment model (A subset of events would be open to AMHSP/FTA only)
    - Events specifically for Master Teachers
- Evaluated performance (below 3.00 over 3 events with > 5 evaluators)
- Consistent fulfillment of confirmed teaching events (Data to be collected around frequency and context)
- Specialist and Generalist exposure