Academic Support Process
Department of Family Medicine

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ACADEMIC SUPPORT PROCESS – SUPPORT PLAN

LEARNER: Dr Adam Hugh ☐ IMG ☒ CMG ☐ MILITARY	PRECEPTOR: Dr Jane Doe ☒ PGY1 ☐ PGY2 ☐ PGY3
EXPECTED GRADUATION: June 30th, 2014	SUPPORT PLAN START DATE: November 15th, 2012
SITE: HolyOaks Hospital	DURATION OF SUPPORT PLAN: 12 weeks

REASON FOR SUPPORT PLAN (INCLUDE CONTEXT):

In his CTU ITER, Dr Hugh was identified as having difficulties in his Internal Medicine rotation by Dr Cameron, the on-service internist during his CTU rotation. Dr Hugh was found to be "aggressive and disrespectful" by the nursing staff. Patients have also expressed concerns and two patients have asked to be switched to another resident because they did not feel "listened to". Supervisors have noted that Dr Hugh "cuts patients off" when they are talking to him and does not take their concerns into account when planning their management. On half-days back, Dr Hugh has shown variable performance in his patient-centred approach. He has received feedback regarding similar concerns on two occasions over the last two blocks (Sept 12th and Oct 23rd, 2012.

WHAT SOURCE OF INFORMATION WAS USED TO IDENTIFY ISSUES?

- ☒ ITERS
- ☒ DIRECT OBSERVATION: FORMAL
- ☒ MULTI-SOURCE FEEDBACK: WRITTEN
- ☐ OSCES
- ☐ STANDARDIZED EXAMS
- ☒ DIRECT OBSERVATION: INFORMAL
- ☒ MULTI-SOURCE FEEDBACK: INFORMAL
- ☐ OTHER (SPECIFY): Click here to enter text.

HAS THE PROGRAM DONE A FULL ASSESSMENT OF ISSUES AFFECTING RESIDENT'S PERFORMANCE (RESIDENT, PRECEPTOR, & ENVIRONMENT)? (SEE https://www.academicsupportplan.com/open/OverComingChallenge.aspx FOR GUIDELINES)

Dr Hugh had many overnight call shifts while on CTU and concerns about his behaviour were usually temporally related to times of sleep deprivation or stress. However, some of this behaviour did persist through his FM in-unit blocks that did not involve the same physical/emotional demands.

STRENGTHS:

Dr Hugh appears to have up-to-date "book knowledge" and is quite evidence-based in his approach to clinical problems. He is very proficient at seeking out current resources to support his approach and supplement his knowledge. He is quite skilled at performing an appropriate physical exam and is very complete and concise in his record taking. He has mastered time management strategies and remains focused throughout his assessments/clinics.

	ISSUE IDENTIFIED (INCLUDE CANMEDS ROLE)	LEARNING OBJECTIVE	LEARNING STRATEGIES (STRATEGY, FREQUENCY, INDIVIDUAL RESPONSIBLE)	DESIRED OUTCOME (ASSESSMENT METHOD(S), FREQUENCY, PERFORMANCE STANDARD USED TO EVALUATE OUTCOME)	OUTCOME ACHIEVED (FULLY / PARTIALLY / NO)
1.	Communicator Has ineffective interviewing skills: does not use open-ended questions, does not FIFE, does not check for understanding.	The resident will consistently show a patient-centred approach in all interactions. He will use open-ended questions until he is at the point of confirming his differential	Role modelling/shadowing: 1 ½-day 1st wk (Dr Primus) observe for patient-centred interviewing techniques. Debrief at end of ½-day on his observations	Will be able to list and describe communication techniques that improve patient-centred care by the end of the 3 blocks of the learning plan (to be presented to Dr. Primus).	☐ ☐ ☐

		diagnosis. He will use FIFE in all encounters so as to elicit the patient's feelings, ideas, function, and expectations.	Role play and review of patient-centred approach: 2/wk with Behavioural Medicine specialist, with increasing complexity (Dr Outbright)	Will consistently (80%) use patient-centred approach in encounters as evaluated on field notes.	☐☐☐
			Direct observation (with field notes): 2x/day (Dr Primus) on patient-centred interviewing	Will rank moderately competent or better for communication skills on field notes in at least 85% of encounters.	☐☐☐
			Video Review: (pre self-assessment, followed by guided review and post self-assessment) on one of the above DOs chosen by Dr Primus or Dr Doe using the patient-centred interviewing tool	Will visibly use FIFE and Context Integration in ALL encounters by the last block of his learning plan and be able to explain, when asked, how these are relevant in every case he sees.	☐☐☐
				Dr Doe and Dr Primus will comment on depth of understanding and insight displayed during video review.	☐☐☐
			Patient feedback using patient survey tool: 1x/week. Reviewed and debriefed by supervising preceptor	80% of patient survey will rank the care by this resident provided as good and above. Any lower will be reviewed with preceptor.	☐☐☐
2.	Professional Does not demonstrate humility and compassion. At times, appears aggressive and challenging with patients, medical staff, and interdisciplinary team members.	The resident will in all situations behave in a respectful manner with patients, staff, and team members. He will recognise and take into account others' ideas, suggestions, and wishes in his clinical decision-making. In the clinical setting, he will solicit and assimilate input from the interdisciplinary team in treatment plans.	Reflective exercises: 1. Professional focus: Read and reflect on uOttawa Standards of Ethical and Professional Behaviour http://www.med.uottawa.ca/students/md/professionalism/assets/documents/Standards_of_Ethical_and_Professional_Behaviour.pdf and the College of Family Physician article *Defining competency-based evaluation objectives in family medicine Professionalism* http://www.cfp.ca/content/58/10/e596.full.pdf Guided discussion with Dr Primus 2. Reflective debriefs: 1/wk (guided by Dr Doe). Reflect on difficult situations that occurred during the week to identify areas of increased personal and interpersonal challenges.	Discussions and debriefs graded as pass/fail by supervisor based on level of engagement and openness to feedback in the activity and sense there was ownership, insight, and depth to the work. The work must make the link between the theoretical and the learner's own issues. There must be a plan for ongoing reflection and improvement.	☐☐☐
			Direct observation (+/- audiovisual review): 2x/wk, unless case warrants more, focusing on professionalism (Dr Doe using P-MEX)		☐☐☐
			Multisource feedback survey: Mid and final; reviewed with resident at		☐☐☐

			mid/final face-to-face sessions (Dr Doe) Role play: Learner-specific professionalism scenario 1/block (Dr Outbright, Behav Med)		☐☐☐

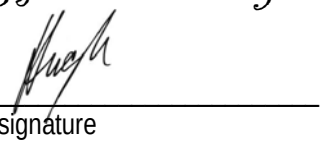
HAVE THE LOGISTICS FOR THIS LEARNING PLAN BEEN ARRANGED? ☒ YES ☐ No

SUPPORT TEAM: Preceptor: Dr Jane Doe
Unit Program Director: Dr Derek Mart
Director of Postgraduate Education: Dr Sue Stanley
Director of Academic Support and Remediation: Dr Rona Crane
IMG Director: Click here to enter text.
Others: Dr John Primus, Dr Karen Outbright

SCHEDULED MID-POINT EVALUATION: January 5th, 2013, with weekly check-ins	NB: Meet with learner face-to-face for both evaluations
SCHEDULED FINAL EVALUATION: February 15th, 2013	

PRECEPTOR COMMENTS:

LEARNER COMMENTS: *I am not in agreement with Dr Cameron's evaluation from CTU. I do not believe I was "aggressive and disrespectful". These comments were never conveyed to me during the rotation and there are no examples given in my Internal Medicine Evaluation of where this was the case. However, in discussion with my preceptor and when we reviewed a few encounters on video, I do see that my style might be misinterpreted at times. I agree to this learning plan and will try to soften my approach for the more sensitive patients.*



Learner's signature

Preceptor's signature

10th November, 2012
Date

10th November, 2012
Date

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