UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

Family Medicine Clerkship

MDCN 502

UNDERGRADUATE MEDICAL EDUCATION
CORE DOCUMENT
CLASS OF 2024
2023-2024 Academic Year

Contents

1. WELCOME TO FAMILY MEDICINE CLERKSHIP

For scheduling queries or to submit course work, please email famclerk@ucalgary.ca

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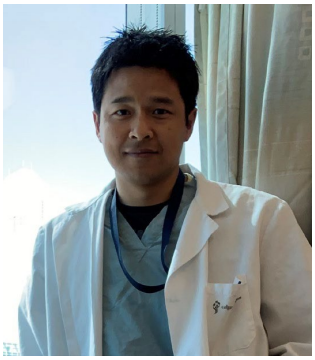
For academic questions, please contact Dr Sonja Wicklum. Unless your email is of a sensitive or confidential nature, please cc famclerk@ucalgary.ca to ensure your email is addressed in a timely manner (2-3 business days).



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Welcome Bilbies!

Class of 2024

Dear Clerkship Students,

We hope that you will enjoy your 8-week family medicine experience. We are thrilled to introduce you to the wonderful world of both rural and urban family medicine.

The next 4 weeks will be busy. Please read through the Core Document in advance to help you keep track of all the pieces of FM Clerkship. We have created Sample Guideline checklists for you so that you don't miss any important deadlines (see section 4.7 and 5.5 for Rural and Urban respectively). If you keep these guidelines in mind, you will do well!

Please read the emails from the UME FM Program Coordinator. She will be doing her level best to keep you on track and informed.

If you have concerns about your clerkship experience, please reach out to us!

Sonja Wicklum MD CCFP FCFP
Family Medicine Clerkship Director

2. GOALS OF THE FAMILY MEDICINE CLERKSHIP

The following outlines the goals of the rotation. For specific exam preparation information refer to sections: 6.1 Formative Exam, 7. Supplemental Learning Resources, and Appendix F, Learning Objectives and 26 Clinical Presentations.

By the end of Family Medicine Clerkship, you will:

1. Have a better understanding of how family physicians think and do their work. Unique to family medicine is the challenge of dealing with **the undifferentiated patient**, someone with an issue or symptom, for which the diagnosis is not clear. You will appreciate and develop skills in interviewing patients, determining management plans and communicating these to the patient. You will recognize **the importance of shared decision making with patients and collaboration with a multitude of other healthcare providers** as you follow patients through the course of their illness, providing **continuous and comprehensive care**.

2. Understand the breadth of **medical expertise** required of a family physician and how they assimilate new knowledge, and address questions arising from medical cases and coming from their patients. You will be exposed to **all ages, life stages and types of presentations, along with both acute and chronic diseases**.

3. Be responsible for integrating resources of all kinds for a patient, from diagnostic testing to mental health services. You will understand the **complexity** of patient management and the importance of the **Patient's Medical Home** in ensuring access to care and that care plans are executed. You will have had the chance to **advocate** on behalf of your patients.

4. Be exposed to the various roles that family physicians play in their communities; some may have health **advocacy or leadership roles**, others may have **research, teaching and/or diverse clinical roles** including hospital, obstetrical, emergency room or palliative care.

5. Gain an understanding of the importance of **long-term relationships** with patients and a **patient-centered approach**, the value patients add to the therapeutic process and to the day-to-day lives of family physicians and their staff.

To learn more about the role of the family physician see:
https://www.cfpc.ca/uploadedFiles/About_Us/FM-Professional-Profile.pdf

Visit the College of Family Physicians of Canada website for more information, including this link to the principles of Family Medicine: https://www.cfpc.ca/Principles/

"The Big 10" Program Objectives of the Cumming School of Medicine can be found in Appendix G.

3. LOGBOOK

Your logbook will be assessed for completion at the end of your 2nd FM block only.

You are required to log when you have completed all of the listed clinical presentations and tasks. Please note that there are some clinical presentations that you will likely not see during your rotation as they are rare. The points of listing (and logging) them is to ensure that you read about these and/or discuss them with one of your preceptors during your rotation. Ideally you should see patients with these problems in clinic and record them in your logbook. If you do not manage to see a case in relation to one of the problems listed, please refer to the virtual patients on LearnFM (https://cards.ucalgary.ca/institute/3). Once you have read around the topic and/or discussed this with your preceptor, you may log this as completed. Furthermore, if you have had that experience in another rotation then you may check off the activity.

If you have not completed the logbook by the deadline, you will be required to delay the summative examination to the deferral/rewrite period. In cases of delayed summative examination because of missed logbook, the rotation will be considered "incomplete" until all required elements have been completed.

The logbook needs to be completed by 11:59PM on the Wednesday of the week of the summative examination.

4. RURAL/REGIONAL

4.1 Clinical Time

The expectation is that you will work the equivalent of 5 days per week for the 4 weeks of the block. Any absences will need to be approved through normal mechanisms in Osler and your preceptor should be notified. For more information on absences refer to the Clerkship Student Handbook.

You are expected to travel on the Sunday in advance of the rotation to be ready to work on Monday morning. Of note, the other clerkship rotations are aware of this need to travel and will try to accommodate this by not placing you on call on the Sunday night before. However, ***it is important for you to contact the scheduler for your preceding block and inform them***. If you must be 'on call' then your start day/time can be adjusted accordingly.

A mandatory virtual orientation to the Rural FM Block will occur from 8-9 am the first Monday of the rotation. Please make sure that your preceptors are aware of the orientation and that they should not expect you in clinic until after the orientation is completed. You will be sent the details regarding this orientation in advance. ATTENDANCE is mandatory unless you have a prescheduled Flex/vacation day. If you do not attend due to vacation or flex day we will expect that you have watched the orientation podcast and read the Core Document so you are aware of all required activities to pass the rotation.

Course 8 may occur on a Friday afternoon during this block and if you are within 1 hour of the city the expectation is that you attend Course 8. This should allow you to work in your clinic in the morning until 11 AM and then travel back for the Course. If you are outside of the 1-hour travel time, then you are expected to work in your clinic and review Course 8 material on your own time.

During the first clinical session with your preceptor, please review your schedule for the block, including:

a. clinical expectations
b. teaching sessions at lunch hours so you can ensure you are excused from patients or wrapping up cases and can log on to the teaching sessions on time (see times below)
c. travel time to return to Calgary to write the summative exam (if second FM block)
d. need to be away for Course 8 (as per above, depends on location)
e. any previously approved absences

Any absences from a full 5-day (10 clinic) workweek beyond these must be approved through Osler.

Expectation for clinic time is based on the block you are in and is counted by the half day. A clinic is defined as 4 - 5 hours of patient contact and does not include your academic sessions. One half day a week may be with a member of the inter-professional team who provides care to your patient population or may include a community-based medical experience, for example, a ride along with the local paramedics. Of note, we respect the judgment of your preceptor with regard to counting clinical half days. Their schedules may not reflect a typical 4-5-hour half day and they will assist you with ensuring you are meeting the 5-day workweek.

At the end of Week 1 you need to submit a proposed Clinical Calendar (Appendix B) to the UME Program Coordinator, ensuring you have planned the weeks well and will not have any difficulty meeting clinical expectations.

At the end of the block, you need to submit a signed Clinical Calendar for the block (see Appendix B).

You are allowed to take up to one flex day in each 4-week block. You are allowed up to a maximum of 2 days of absence in each 4-week block for approved reasons such as illness, family issues, bereavement, or conference leave. **All absences, except one half day (optional) for SNAP project preparation during the Rural FM block, must be approved at the UME level through Osler**.

Of note, if due to unforeseen illness or absence your total clinical time ends with less than 30 half days during these 4 weeks, you will not be permitted to sit the FM summative exam and may be required to complete make-up time. Furthermore, you cannot make up missed time from one FM block in the other FM block.

4.2 Academic Sessions

Academic sessions will be delivered by Zoom. You will need to ensure you have access to the internet at your clinic and know how to connect to the videoconference (see 4.7) and that you have wrapped up with clinical care to arrive at the sessions on time.

Week 1 - Monday (**8:00 – 9:00 AM**) **Zoom Video Conference**
Orientation – Family Medicine Clerkship Director

Week 2 - Thursday (**12:00 - 1:00 PM**) **Zoom Video Conference**
SNAP SESSION #1

Week 3 - Thursday (**12:00 - 1:00 PM**) **Zoom Video Conference**
SNAP SESSION #2

Week 4 - Friday
1st Block
Expected to be in clinic
Formative exam (on own time)

2nd Block
Travel* to write summative examination (PM exam in Calgary)
* Travel the morning before the exam if within 2.5 hours of Calgary or travel the evening beforehand if further away (or longer as needed for special travel requirements).

4.2 Advance Care Planning

After learning about Advance Care Planning and Goals of Care Discussions (ACP/GCD) by reviewing the video: https://ucalgary.yuja.com/V/Video?v=34026&node=208519&a=1453025709&autoplay=1) you are encouraged to engage a patient in the ACP/GCD process. Please discuss this with your preceptor early on to consider which patient(s) may benefit from a discussion. There is no formal reporting for this activity. It is not required that you complete the Green Sleeve document, although this would be ideal if you have an opportunity. If you are unable to complete the Green Sleeve document, you should discuss the topic with your preceptor and familiarize yourself with the Green Sleeve document. Doing this will be sufficient to allow you to log the encounter in your logbook.

Please note: There are two logbook entries for this topic. One is to confirm that you have reviewed the video presentation and the other is to confirm discussing ACP/GCD with a patient/preceptor.

4.3 SNAP Presentations

During your Rural rotation, you will have two lunch hour sessions in the second and third week where you and your peers will review selected core topics in family medicine. Rural family physicians will act as moderators for these sessions. They will be there to support and direct conversation as needed. Given the number of students on rotation, the cohort may be divided in two for these sessions, but all materials that are developed by the cohort will be available to all students on rotation.

For these sessions, you will choose a core topic from the 26 Clinical Presentations (EXCLUDING Periodic Health Exam) (Appendix F). **The goal is not to cover the entire topic in depth, but to review the topic through the lens of primary care as outlined in the objectives (see Appendix F).** These sessions are intended to support the studying of your colleagues. An example of a SNAP would be a 5-minute synopsis on how cardiovascular disease risk is determined, or approach to abdominal pain in a primary care setting. There will be 5-6 presentations for each session over the lunch hour period on the Thursday of the second and third week. Students will be randomly assigned to present in each session.

You must submit your SNAP topics to the UME FM Program Coordinator at famclerk@ucalgary.ca as soon as you decide on them (end of Week 1 at the latest) to ensure that another clerk is not doing the same topic. If there is overlap and you are the second person to submit the topic you will have to change yours, *SO SUBMIT AND THEN DO THE WORK!*

You may take one half day out of clinic to prepare your SNAP.

The SNAP presentation can be with or without slides. It can be a video, an Infographic (see sample instructions below), or any other creative, accessible format. The presentation should review the material you have developed. It should be no longer than 5 minutes, followed by 2 minutes for questions. This will challenge you to present the most important elements. Please time yourself in advance to ensure that you DO NOT run overtime.

To make an Infographic you can use any tools you like. Consider using the Canva website which is a great graphic-design tool for creating and printing media designs and graphics. Sign-up and design (for free) at: https://www.canva.com

Steps:

- Outline your content: headings (how many you need) and content in a word doc.
- Search Canva Infographic Templates Educational: https://www.canva.com/templates/infographics/education/
- Scroll through the templates that appear or search another, choose one that is marked 'free'
- Click on one you prefer, consider if the number of headings match, can all your material fit?

- Click on “Use this Template” – top right.
- Get designing!
- Save as a PDF for Print

Name the file in the following way: YEAR_FIRST INITIAL_LAST NAME_TOPIC.pdf (do not save it as a PNG file as it does not show well in the room)

All finalized SNAP materials should be submitted to the Family Medicine UME Coordinator by Friday afternoon of the third week at the latest. They will be available to all students on the rotation for use as study aids.

4.4 Travel Reimbursement (RURAL)

You will generally be reimbursed for one round trip mileage to and from site. The rate of reimbursement is $.52/km. Mileage is calculated based on a fixed distance chart which can be found here: https://rhpap.ca/wp-content/uploads/2018/09/RhPAP-Mileage-Chart-5-Dec-2017-1.pdf. Additional trips for academic events are evaluated at the time of the event. There is no funding available for mileage reimbursement for commuter sites. If you have any questions regarding your reimbursement, please contact the Rural Office at rmexpenses@ucalgary.ca.

4.5 Accommodation (RURAL)

You will be placed in available accommodations approximately 2 weeks before the rotation begins. Accommodation preferences will be gathered by the Rural Office in advance of the clerkship year beginning. If you do not provide any preferences at that time, the rural office assumes that any accommodations are suitable to your preference.

Accommodations may be shared or room and board style. You will be provided with your own room and own bathroom. All accommodations are strictly no pets and no smoking.

If you have any questions regarding your accommodations, please contact the Rural Office at ruralmed@ucalgary.ca.

4.6 Video and Teleconferencing

Academic sessions will be streamed using Zoom Video Conference. You will need a laptop with Wi-Fi to connect to the academic session. The Zoom link and passcode will be provided to you by the UME FM Program Coordinator.

Please note: Academic sessions are MANDATORY. If you experience issues with your laptop or internet service, you must still attend by telephone using the dial-up number provided.

4.7 Sample Timeline (RURAL/REGIONAL)

☐	Ensure you have a laptop and access to WiFi at the clinic.
☐	Contact the scheduler for the rotation preceding this FM Rural/Regional block and inform them that you are expected to travel on the Sunday before the start of this block to be ready to work on Monday morning.
WEEK 1	
☐	**MONDAY (8:00-9:00 AM) *ACADEMIC SESSION* ORIENTATION** FM Clerkship Director to review rotation and answer and questions. **Logbook: Preceptor view complete Hx and PE.**
☐	Clinic introduction, initial orientation, clinical activities will start. Discuss and review with your preceptor: a) clinical expectations; b) teaching sessions at lunch hours; c) travel to write summative exam (if 2nd FM block); d) Course 8 time away (if required); e) any approved absences f) patient(s) for ACP/GCD.
☐	Schedule time with your preceptor for the mid-point review.
☐	**EMAIL** (by the end of Week 1) projected half-day totals (based on your draft clinical calendar) to the UME Coordinator (famclerk@ucalgary.ca).
☐	**EMAIL** UME Coordinator by the end of the first week which of the 26 core FM presentations you which to review for SNAP sessions (famclerk@ucalgary.ca).
☐	Start recording in your logbook the clinical presentations and procedural skills you see.
WEEK 2	
☐	Logbook: Review ACP/GCD podcast https://ucalgary.yuja.com/V/Video?v=34026&node=208519&a=1453025709&autoplay=1), discuss with preceptor, discuss with patient
☐	**THURSDAY (12:00 - 1:00 PM) *ACADEMIC SESSION* Zoom Video Conferencing** SNAP SESSION #1
☐	Mid-point review – mid-point ITER with your preceptor.
WEEK 3	
☐	**THURSDAY (12:00 - 1:00 PM) *ACADEMIC SESSION* Zoom Video Conferencing** SNAP SESSION #2
☐	Schedule time with your preceptor for the final review.
WEEK 4	
☐	Final review – final ITER with your preceptor
☐	**EMAIL** the signed Clinical Calendar to the UME Coordinator (famclerk@ucalgary.ca). It must be submitted by 11:59PM on the last Sunday of this FM block.
If 1st FM Block:	
☐	This week is a normal work week, but you must also complete the formative exam **by 3:59PM** on Friday of Week 4. **Note the portal closes at 4:00PM this day**. **If you fail to complete the formative examination by the deadline, you will be required to delay the summative examination to the deferral/rewrite period. The rotation will be considered incomplete until all required elements have been completed. For details, please refer to the Clerkship Student Handbook on Osler.**
If 2nd FM Block:	
☐ ☐	**COMPLETE** the logbook by 11:59PM on Wednesday of Week 4. **COMPLETE** the summative exam on Friday afternoon. ***travel the evening before the exam if within 2.5 hours of Calgary, or travel the afternoon before if further away (or longer as needed for special travel requirements).**

5. URBAN

5.1 Clinical Time

The expectation is that you will work the equivalent of 5 days per week for the 4 weeks of the block. Any absences will need to be approved through normal mechanisms in Osler and your preceptor should be notified. For more information on absences refer to the Clerkship Student Handbook.

Course 8 may occur on a Friday afternoon during this block. You should be able to work until 11:30AM in the morning in your clinic and then travel back to campus for Course 8.

During the first clinical session with your preceptor, please review your schedule for the block, including:

A. Clinical expectations – 5 days per week **minus**: a) time away for stat holidays, b) time away for course 8 (Friday afternoon only if required), c) time away to write the summative exam (if 2nd FM block), and d) time away for Academic Day (Week 3, Thursday)
B. From (A) above you then minus any previously approved absences.
C. If felt necessary, you may also minus 1 day (2 clinics) for preparation of the Patient Centered Care Project (PCCP)

Any absences from a full 5-day (10 clinic) workweek beyond these must be approved through Osler.

Expectation for clinic time is based on the block you are in and is counted by the half day. A clinic is defined as 4 - 5 hours of patient contact and does not include your Academic Day. One half day a week may be with a member of the inter-professional team who provides care to your patient population. Of note, we respect the judgment of your preceptor with regard to counting clinical half days. Their schedules may not reflect a typical 4-5-hour half day and they will assist you with ensuring you are meeting the 5-day workweek.

At the end of Week 1 you need to submit a proposed Clinical Calendar (Appendix C) to the UME FM Program Coordinator, ensuring you have planned the weeks well and will not have any difficulty meeting clinical expectations.

At the end of the block, you need to submit a signed Clinical Calendar for the block (see Appendix C).

You are allowed to take up to one flex day in each 4-week block. You are allowed up to a maximum of 2 days of absence in each 4-week block for approved reasons such as illness, family issues, bereavement, or conference leave. **All absences, except one (optional) day for project preparation during the Urban FM block, must be approved at the UME level through Osler**.

Of note, if due to unforeseen illness or absence your total clinical time was to end up less than 30 half days during these 4 weeks you will not be permitted to sit the FM summative exam and may be

required to complete make-up time. Remember, as previously stated, you cannot make up missed time from one FM block in the other FM block.

5.2 Academic Sessions

Week 1 - Monday (**3:00-4:00 PM**) **Zoom Video Conference**
Orientation – Family Medicine Clerkship Director

Week 3 - Thursday (**9:00 AM – 4:00 PM**) **HEALTH SCIENCES CENTRE**
Academic Day with:

- Multi-morbidity session
- Presentation of PCCP
- Screening and Periodic Health Exam
- Planetary Health workshop

Week 4 - Friday
1st Block
Expected to be in clinic
Formative Exam (on own time)

2nd Block
Summative Examination

5.3 Managing Multimorbidity

Managing multimorbidity is one of the greatest challenges to practicing good family medicine. It is the heterogeneous nature of the diseases impacting one patient at one time that can pose a challenge, with issues such as competing clinical guidelines, therapeutic dilemmas and negotiating patient priorities. In this academic session we will discuss these challenges and potential approaches. **Please bring a case example of a patient with multimorbidity and be prepared to briefly present the case and thoughts around the challenges and outcomes**. The session lead will also have a case for the group to discuss.

5.4 Patient-centered Care Project

The purpose of this project is to apply patient-centered care to a patient with an unresolved health challenge (a question, concern or issue that requires a decision). The presentation must be anchored on a patient case.

On Academic Day (Week 3, Thursday), you are required to:

1. Hand in a PCCP evaluation form that has been completed by your preceptor. This is a formative evaluation.
2. Give your PCCP presentation to a small group of your peers and an evaluator who will provide a summative (final) assessment, which must receive a 'pass'.

By the end of this project, you will have:

- Carried out an in-depth study of an identified health challenge for a specific patient.
- Gone beyond a strictly biomedical approach to your patient's health challenge.
- Explored and critically appraised the available evidence and community resources relevant to the identified health challenge.

- Used a collaborative, shared decision-making approach, by involving the patient +/- family in developing recommendations that will be feasible and acceptable to the patient +/- family.
- Reflected upon the process that you went through in coming to a "common ground" with your patient that balanced the evidence of the recommendation/intervention, the dialogue that occurred between you, your preceptor, and the patient, and how your patient's values and wishes were incorporated into the decision.

** Before beginning, read the following article on shared-decision making:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445676/pdf/11606_2012_Article_2077.pdf

Step 1: Health Challenge
Identify "the health challenge – your 'case'" within the first week of the rotation.
Once a patient is identified and interviewed, with assistance as needed from your preceptor, you will create a clear question for further exploration (**health challenge**). Using your own interviews with the patient, and the preceptor's knowledge from prior encounters, you will seek to understand the patient as a "whole person" and explore relevant context issues that might impact management of the health challenge. Examples of health challenges may be whether or not to take cholesterol-lowering medications with a modestly high LDL, to have triple screening or non-invasive prenatal testing when pregnant, or to trial medical marijuana for pain management. The 26 clinical presentations outlined in Appendix F can help guide your choice of topics (and health challenge within). It is our preference, but not mandatory, that your health challenge falls into one of these categories - they are there as a guide.

[TIP: CONSIDER 1-3 SLIDES TO PRESENT THE CASE AND SOME BACKGROUND INFORMATION]

Step 2: Critical Appraisal of Evidence to address a specific health challenge for the patient
Find, review, and critically appraise relevant, peer-reviewed literature, and community resources. You may need to arrange further interviews with the patient to gather additional contextual or other patient information. Using these findings, as well as your understanding of the patient's illness, experience, and context, you will develop options for your patient.

Use the literature to help create a plan for your patient, considering the pros and cons of different courses of action, and taking into account the patient's context, values and wishes. Share any anticipated concerns and reactions regarding the evidence on the part of the patient based on your initial interaction with the patient. We encourage using a method to design your question and evaluate the literature as appropriate. For example: A PICO statement can guide your literature search, and depending on the type of literature you find, its strengths and weaknesses should also be evaluated.

[TIP: CONSIDER 1 SLIDE FOR YOUR **PICO** STATEMENT OR OTHER QUESTION, 1-3 FOR LITERATURE AND 1 FOR EVALUATION OF THE LITERATURE. SOME HEALTH CHALLENGES AND PICO QUESTIONS WILL HAVE A LOT OF LITERATURE AND REVIEWS CAN BE RELIED UPON, OTHERS WILL HAVE VERY LITTLE LITERATURE, AND THE AVAILABLE LITERATURE WILL NEED TO BE ASSESSED TO DETERMINE IF IT IS APPLICABLE TO YOUR PATIENT'S SCENARIO, AND EXPERT OPINION MAY NEED TO BE SOUGHT TO HELP WITH THE DECISION MAKING.]

Step 3: Patient Follow-Up Visit and Preparation of the Patient-Centered Care Project (PCCP) Presentation
Meet and review with the patient, remember a phone call can be enough.

You should present your literature and context-based options in terms of defining the health challenge, establishing goals of management, and identifying roles for patient and doctor. The patient's values, wishes and context must be incorporated into any decisions made to help address the health challenge, at which point you can seek to reach common ground with the patient with regards to the next steps in the management of the health challenge in a collaborative manner. This is the process of shared decision-making with the patient.

Shared Decision Making is based on Social Cognitive Theory that states that **knowledge** forms the foundation of decision-making. It implies that the physician (or you the clerk) can give all the relevant information to the patient and therefore empower them to make their own decision. The **knowledge** you provide them with can give them the **confidence** they need to move forward. This **confidence** is essential for them to be **motivated** to take the next step (make a lifestyle change, take a medication). Without their own **decision-making skills** enhanced they will not increase their confidence and will not be motivated to change.

[TIP: CONSIDER 1 SLIDE TO REFLECT ON THE PATIENT'S DECISION]

The above will form the basis of the content for the Patient-Centered Care Project (PCCP) Presentation that you will give to your peers and an evaluator during the morning of the Thursday Week 3 Academic Session (10:30 – 12:00). You will have 10 minutes to present your project and 5 minutes for questions. Marks are awarded for presentation and content (Appendix D). Sample projects are available on Osler. **As needed, consider taking your 1-day (2 clinics) preparation time during Week 2 of the block.** Book a time to review your PCCP with your preceptor before Week 3 Thursday (they need to complete an evaluation form).

EMAIL the Patient-Centered Care Project to famclerk@ucalgary.ca before Academic Day. To ensure students do not present the same project subject, please contact the UME FM Program Coordinator @ famclerk@ucalgary.ca to confirm your chosen presentation topic by the end of Week 2.

HAND IN the Patient-Centered Care Project Evaluation (completed by your preceptor) to the evaluator on Academic Day.

Tips for Project presentations:

- Use images
- Rule of 8's for PowerPoint presentations – max 8 lines / slide and max 8 words/line; avoid clutter!
- Engage your audience – watch posture, eye contact, use humor
- Ensure you have prepared for the PCCP and have practiced your presentation. Most speakers run through their presentations on their own at least 5 times before presenting to a group.

5.5 Sample Timeline (URBAN)

WEEK 1	
	Clinic introduction, initial orientation, clinical activities will start.
☐	**MONDAY (3:00 – 4:00 PM) *ACADEMIC SESSION*** **Zoom Video Conferencing** Orientation with Family Medicine Clerkship Director
☐	Discuss and review with your preceptor, a) clinical expectations; b) Course 8 time away (if required); c) time away for summative examination (if 2nd FM block); d) time away for Academic Day.
☐	Arrange time with your preceptor for the midpoint-review (Week 2), and to present your PCCP project (Week 3, Monday, or Tuesday).
☐	Start to watch for an appropriate patient for your Patient-Centered Care Project.
☐	**EMAIL** (by the end of Week 1) projected half-day totals (based on your draft clinical calendar to the UME Coordinator (famclerk@ucalgary.ca).
☐	**EMAIL** (by the end of Week 1) any dietary restrictions or preferences to the Department of Family Medicine Undergraduate Program Secretary (ugfm@ucalgary.ca) for lunch on **ACADEMIC DAY.**
☐	Start recording in your logbook the clinical presentations and procedural skills that you see.
WEEK 2	
☐	By the end of Week 2 you need to have identified a patient and patient issue/problem for your Patient-Centered Care Project.
☐	**EMAIL** your chosen presentation topic to the UME Coordinator (famclerk@ucalgary.ca) **AND get a start on your project!**
☐	Mid-point review – mid-point ITER with your preceptor.
WEEK 3	
☐	Present the Patient-Centered Care Project and ask your preceptor to complete a formative assessment using the Evaluation Form (Appendix D).
☐	**EMAIL** the Patient-Centered Care Project to the UME Coordinator (famclerk@ucalgary.ca) by 1:00PM on Wednesday of Week 3.
	THURSDAY (9:00AM – 4:00PM) *ACADEMIC DAY* **HEALTH SCIENCES CENTRE**
☐	**HAND IN** the Patient-Centered Care Project Evaluation Form (completed by your preceptor) to the Evaluator on Academic Day. Evaluators may complete these online.
☐	Schedule time with your preceptor for the final review.
WEEK 4	
☐	Final review – final ITER with your preceptor.
☐	**EMAIL** the signed Clinical Calendar to the UME Coordinator (famclerk@ucalgary.ca). It must be submitted by 11:59PM on the last Sunday of this FM block.
If 1st FM Block	
☐	This week is a normal work week but you must also complete the formative exam **by 3:59PM** on Friday of Week 4. **Note the portal closes at 4:00PM this day**. **If you fail to complete the formative examination by the deadline, you will be required to delay the summative examination to the deferral/rewrite period. The rotation will be considered incomplete until all required elements have been completed. For details please refer to the Clerkship Student Handbook on Osler.**
If 2nd FM Block	
☐	**COMPLETE** the logbook by 11:59PM on Wednesday of Week 4.
☐	**COMPLETE** the summative exam on Friday afternoon.

6. EXAMS

Preparing for the exam in family medicine can be stressful and intimidating due to the breadth of topics you will be asked to cover, as well as the multiple resources you will need to utilize. The course is designed around the objectives found in Appendix F. The 26 Clinical Presentations support these objectives and therefore if you work at seeing or discussing each presentation in your logbook this will support your preparation. The exam questions reflect the objectives.

There are two exams in FM, a formative and a summative exam. **You MUST COMPLETE the formative exam before the end of your first FM block**, whether it is Urban or Rural/Regional. You will receive a score for this within 1-2 weeks afterwards.

The formative exam is completed online.

The summative exam is completed at the University, in person.

To help you succeed, we suggest the following:

1. Prepare early – Due to the numerous clinical presentations relevant to family medicine, we encourage you to read around the cases seen in your clinics, and those you may not have encountered, and do so early on. This will allow you to adequately address the depth and volume of information needed to be successful.

2. Cover the basic information of the core clinical presentations – While the finer details are important and relevant, we want you to first establish a foundation of knowledge in each clinical presentation on which you can later build upon. What are the common differential diagnoses? What are the diagnostic criteria? What are the first-line treatments? This strategy will allow you to cover the multiple topics at the appropriate depth and position you well for your future studies.

3. See the Learning Resources section. For example, there are Microcases on the LearnFM (https://learnfm.ucalgary.ca)

MUST COMPLETE: the online formative examination by 3:59PM on the Friday of week 4 of your 1st FM block, whether it is Urban or Rural/Regional. **Note the portal closes at 4:00PM this day.**
MUST COMPLETE: the in-person summative examination by the Friday of week 4 of your 2nd FM block, whether it is Urban or Rural/Regional.

7. SUPPLEMENTAL LEARNING RESOURCES

The breadth of family medicine can be overwhelming. Unfortunately, no single resource is available to answer all the questions you will encounter during your clerkship. One of the skills of being a family doctor is to access information.

Below is a list of supplemental resources to assist you with this rotation.

E-resources

We encourage you to use these resources, just as you will use in other clerkships e.g. UptoDate, Dynamed and Lexicomp and ebooks. All of these are available via the Health Sciences library -bookmark and/or set up a tablet shortcut to both: http://library.ucalgary.ca/hsl

LearnFM: The Shared Canadian Curriculum in Family Medicine: https://learnfm.ucalgary.ca/

- This is a shared national curriculum site for family medicine, supported by the College of Family Physicians of Canada. It **includes learning objectives, clinical cards, and sample cases**. All of the clerkship directors across Canada contribute to the development and maintenance of this site. We meet semi-annually and ensure the resources and questions are relevant and up to date. The material is open source and the only one of its kind. There are downloads by individuals and schools throughout the world. The course and tools were recently recognized by the United Nations, Sustainable Development Goals Partnerships Platform.

- **Microcases!** A question databank designed to help clerks test their knowledge: https://cards.ucalgary.ca/institute/3

- **Clinical Cards** - They are openly available at in PDF files for you to download. https://learnfm.ucalgary.ca/wp-content/uploads/2020/10/LearnFM-Clinical-Card-Book-2020.pdf

Textbooks

Guide to the Canadian Family Medicine Examination, 2nd edition, by Megan Dash and Angela Arnold. McGraw Hill Education, 2018– good for basics, available in the library.

Rx Files, Drug Comparison Charts, 9th Edition – copies should be available in your preceptor's office for you to use.

Case Files Family Medicine. Toy, Briscoe & Britton. McGraw Hill, 4th Ed. – uses case examples and questions. US focused so need to translate to Canadian setting, but easy to read – available via internet in library.

Swanson's Family Medicine Review: A Problem-Oriented Approach 8th ed. (2017). Tallia A, Scherger J, Dickey N. This is too comprehensive for FM clerkship and US focused but has the advantage of posing questions for quick study, it is available in the library.

Apps

- UpToDate
- DynaMed
- RxTx - drug information, regular updates and Health Canada advisories, does not do drug interactions, there is a cost
- Thrombosis Canada (free) - guidelines and algorithms
- INESSS Guides (free) - a guideline app developed by the Institut National d'Excellence en Sante et en Services Social and supported by the Quebec Government
- CND STI Guidelines (free)
- Anti-Infective Guidelines (MUMS) (low cost)
- Visual Anatomy Lite (free)
- GRC-RCMP Drugs Awareness (free)
- Aspirin Guide (free)

8. AWARDS

CFPC Student Awards

CFPC Medical Student Scholarship Award recognizes outstanding medical students who have demonstrated an interest in or commitment to a career in family medicine. For more information please visit: https://fafm.cfpc.ca/h-a/opportunities-medical-students/#

CFPC Indigenous Medical Student Scholarship Award recognizes a top First Nations, Metis, or Inuit medical student in Canada who has shown an interest in or commitment to a career in family medicine. For more information please visit: https://fafm.cfpc.ca/h-a/opportunities-medical-students/#

Chuck Carson Memorial Endowment

The Dr Chuck Carson Memorial Endowment was established through the generosity of the Carson Family and the many friends and colleagues of Dr Carson.

The Dr Chuck Carson Memorial Endowment provides an annual award of $1000 to a medical student who is in his/her Family Practice rotation, and who has demonstrated an interest in and a commitment to family medicine. The primary objective is to **recognize students who have demonstrated a real compassion to patients.**

To be considered for the award, students must have completed their clerkship rotation in family medicine. More information on the application process and deadline will be sent via email in March.

Michael Tarrant Scholarship (Rural Medicine)

Dr Michael Tarrant was a family physician from Calgary with a group practice at the Cambrian Medical Clinic. He was a staff member of the Foothills Medical Centre and served with the University of Calgary, Department of Family Medicine as residency program director and undergraduate coordinator. Sponsored by the Alberta Medical Association's Section of Rural Medicine, the Tarrant Scholarship is one of Alberta's largest, unrestricted medical school undergraduate awards. Two $12,500 awards are bestowed. There is one recipient from the University of Alberta and one from the University of Calgary.

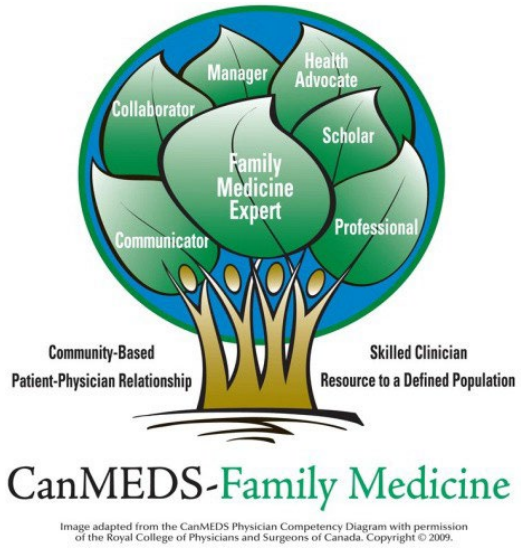
Specifics for these awards will be emailed - so remember to check for emails from UME! Also check the Undergraduate Family Medicine notice board (opposite the HSC bookstore).

9. ON-CALL ARRANGEMENTS

Maximum scheduled time 55 hours per week plus call. This includes required attendance in clinical settings and educational activities. Call may not exceed 1:4 (7 calls maximum in 28 days) and students are excused after sign-over is completed (24 hours +2). No evening or night call permitted the day prior to certifying examinations. Please refer to the Clerkship Work Hours Policy in the Clerkship Handbook.

APPENDICES

A. CanMEDS Roles



The College of Family Physicians of Canada uses this diagram to illustrate the seven key roles of the Family Physician.

The foundational four principles of Family Medicine are linked to the Can-Meds roles by physicians in strong relationships with their patients providing ongoing care. Family physicians are skilled clinicians who are community-based and work in partnership with their patients and are a resource to that defined population.

Learning objectives for Family Medicine clerkship have been categorized according to the various roles of the Family Physician in the table on the next page as well as mapped to the Cumming School of Medicine's MD Program "The Big 10" Program Level Objectives.

B. Clinical Calendar (RURAL/REGIONAL)

WK		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		# of clinic half days
1	Morning															
	Afternoon	Orientation (8:00 – 9:00 AM) Zoom Video Conference Logbook: Preceptor view complete Hx and PE														
	Evening															
2	Morning	Logbook: Review ACP/GCD podcast, discuss with preceptor, discuss with patient														
	Afternoon							SNAP SESSION #1 (12:00 – 1:00) Zoom Video Conference								
	Evening															
3	Morning															
	Afternoon							SNAP SESSION #2 (12:00 – 1:00) Zoom Video Conference								
	Evening															
4	Morning															
	Afternoon									(1st FM block) In clinic (2nd FM block) Summative Exam*						
	Evening									(1st FM block) Formative Exam on own time (by 3:59PM)						
Preceptor signature:_____ Student Name:_____ Total number of clinic half days during 4-week block Signature: _____																

Please indicate time with Allied Health Professionals and specify type (pharmacist, RN, NP, etc.). Consider using this document to book project time, project presentation to clinic, midterm and final ITER review meetings with your preceptor.*Travel morning of the exam if within 2.5 hours of Calgary, or travel the afternoon before if further away (or longer as needed for special travel requirements).

C. Clinical Calendar (URBAN)

WK		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		# of clinic half days
1	Morning															
	Afternoon	Orientation (3:00 – 4:00PM) Zoom Video Conference														
	Evening															
2	Morning															
	Afternoon															
	Evening															
3	Morning							ACADEMIC DAY (9:00 – 4:00PM) Multimorbidity PCCP Presentation Screening Planetary Health								
	Afternoon															
	Evening															
4	Morning															
	Afternoon									(1st FM block) In clinic (2nd FM block) Summative Exam						
	Evening									(1st FM block) Formative Exam on own time (by 3:59PM)						
Total number of clinic half days during 4-week block																

Preceptor signature:_____ Student Name:_____ Signature: _____

Please indicate time with Allied Health Professionals and specify type (pharmacist, RN, NP, etc.). Consider using this document/book project time, project presentation to clinic, midterm and final ITER review meetings with your preceptor.

D. Evaluation Form for PCCP

Name: _____

Project Title: _____

Introduction	Poor ☐	Borderline ☐	Good ☐	Very Good ☐
The identified health challenge, individual or community, is clearly explained and an appropriate title chosen. Why was this topic chosen? The context of the problem is explored.				
Poor – title unclear, we don't understand why you chose this topic, problem unclear, context not explored, title confusing *Very Good*– problem clearly outlined, understanding of patient or community is shown, context is explored fully including FIFE if applicable, enthusiasm and interest in the problem is shown				

Literature Search	Poor ☐	Borderline ☐	Good ☐	Very Good ☐
The student performs a thorough and appropriate literature search. The student comments on the quality and quantity of the literature in general relating to the topic.				
Poor – minimal or no explanation of search strategy or inappropriate strategy; cursory or no appraisal of the literature *Very Good* – clear and appropriate search strategy, multiple references examined including original research when available, appropriate level of appraisal of literature quantity and quality				

Narrowing Results of the Literature	Poor ☐	Borderline ☐	Good ☐	Very Good ☐
The student explained why certain articles were chosen for review, demonstrating an understanding of how to appraise both the quality of literature and its applicability to family medicine in the community.				
Poor – cursory or no explanation of why certain articles were chosen for inclusion. No mention of applicability to family medicine. *Very Good* – clear and appropriate explanation of why articles are chosen, appropriate level of appraisal of the quality of the literature, consideration of applicability to family medicine shown.				
Putting it Together & Shared Decision-making	Poor ☐	Borderline ☐	Good ☐	Very Good ☐
The student applies the results of their literature search directly to the patient or community. The student used the literature to create a plan for their patient or community, considering the pros and cons of different courses of action, including the patient's context, values and wishes into the plan.				
Poor – the student failed to consider the needs and characteristics of their patient or community when choosing a course of action. Minimal or no discussion of potential benefits and harms of chosen course of action is evident. No consideration or discussion of the patient's values or concerns with regards to the decision to be made.				

Very Good – in negotiating a course of action, the student demonstrates a clear understanding of the needs, context and characteristics of their patient or community, including such topics as access to care, time, beliefs, ethnicity, finances, etc. A full and nuanced discussion of potential benefits and harms is given and common ground is achieved through effective shared decision-making with the patient. A well thought-out and practical plan is suggested and / or implemented, taking into consideration what the student anticipates to be the concerns/values of the patient in the decision-making process.

Presentation Skills	Poor ☐	Borderline ☐	Good ☐	Very Good ☐
The student demonstrates appropriate presentation skills including time management, organization, and delivery (vocal pace and volume, slide preparation/clarity).				
Poor – The presentation is disorganized. Slides difficult to read. Information is excessive and required editing. The presentation went over the allotted time. The student does not maintain appropriate voice volume and pace, and/or does not maintain eye contact with the audience. *Very Good* – Presentation well organized and holds listener's interest. Slides well designed, appropriate in number, easy to read and understand. The student's voice is appropriate in volume and rate, and eye contact maintained. The student shows an engaging, entertaining style which is enjoyable to listen to.				

For project presentations, students receiving borderline in two or more categories will be asked to resubmit their project.

Date:

Student Name:	Signature:
Faculty Assessor Name:	Signature:

E. Infographic Example

F. Learning Objectives and 26 Clinical Presentations

The learning objectives are listed below the clinical presentations. The exam questions all map on to the learning objectives and the clinical presentations support the objectives.

The following is a list of the 26 clinical presentations identified as important for Family Medicine. Ideally you should see patients with these problems in clinic and may record them in your logbook. If you do not manage to see a case in relation to one of the problems listed, please refer to the virtual patients on LearnFM (formerly SHARC-FM) or those available via Course 8.

Key features for each presentation are available via LearnFM and the '26 Clinical Presentations' folder in Osler. PLEASE NOTE: The LEARN-FM website is sometimes under review and a link may not work, please contact them directly and let them know.

Key Symptoms	**Stages of Life**	**Chronic Disease**
Fever	Well baby	Hypertension
Headache	Contraception	Ischemic heart disease
Cough; URI; Earache	Prenatal care	Diabetes
Abdominal pain; Diarrhea	Check-up – age appropriate	Obesity
Back pain; Joint pain	Fail elderly	Asthma
UTI/discharge		Fatigue
Skin disorders		Dizziness
		Anxiety
		Depression

1. Abdominal Pain

1. Given a patient presenting with abdominal pain, perform a patient-centered interview and focused physical exam, list and interpret clinical findings. Then:
    a. Identify signs and symptoms of a surgical abdomen
    b. Identify red flags of potential serious causes including referred pain from chest
    c. Identify psychosocial factors associated with chronic and recurrent abdominal pain.
    d. Propose a relevant differential diagnosis that includes common causes of abdominal pain and less common but important causes of abdominal pain.
2. For patients with acute abdominal pain, propose an initial management plan that includes appropriate and timely referral/investigation for potentially serious causes.
3. For patients with chronic/recurrent abdominal pain, propose a management plan that highlights initial investigations and basic management.

2. Anxiety

1. Conduct a patient centered interview
    a. To elicit the common symptoms associated with anxiety (as per the most current DSM criteria (e.g. tenseness, fatigued, reduced concentration, irritability)
    b. To elicit the contextual and other factors contributing to the anxiety symptoms and probe for/describe impact of anxiety on patient's function.
    c. To differentiate between situational anxiety and anxiety disorders (e.g. GAD, OCD, phobias, PTSD)
    d. To identify other conditions that can present with anxiety, co-morbid or more serious conditions, e.g. substance abuse, dementia, delirium, hyperthyroidism, arrhythmias personality disorders
    e. To identify blended conditions i.e.: anxiety-depression, dual diagnosis

2. Identify high risk groups for anxiety disorder (e.g. post-trauma, bereavement, malignancy or other serious illness diagnosis (in self or family member), dysfunctional families (abuse, separation, etc.), family history)
    a. Propose non-pharmacologic and pharmacologic management options for patients with anxiety, including risks, benefits and limitations of the method(s) used.
    b. Identify locally available resources which can provide support or help with ongoing management of this chronic condition.

3. Asthma/Wheezing

1. Establish an accurate diagnosis of asthma through a focused history, physical exam, and spirometry
    a. Including family, occupational and environmental history
2. Including differentiating non-asthma causes of wheezing
3. Explain underlying pathophysiology of asthma to patients and/or family members
    a. In relation to acute & recurrent episodes and prophylaxis principles
    b. In relation to mechanism of action for relevant meds
4. In relation to red flags of impending asthma crisis
5. Assess asthma control at follow-up. Identify modifiable triggers for patients.
6. Describe the different medication delivery methods (and relevant compliance / educational issues).
7. Describe major medication categories
    a. Including mechanism of drug action, particularly SABA and ICS
    b. Benefits, risks, limitations
    c. Use patterns, compliance, device use
8. Propose a management plan for patients with acute exacerbations.
9. While designing an effective treatment plan, take into account the lifestyle of the patient, any potential issues with compliance, possible side effects of treatment, and available resources available in the community.

4. Chest Pain

1. Conduct a rapid assessment to identify patients requiring emergency care.
2. Describe the family physician's role in the stabilization and initial management of patients identified to require emergent care.
3. Conduct a focused history (including cardiac risk factors) and a relevant physical exam
4. Develop a concise differential diagnosis for patients with chest pain including cardiac (ischemic and non-ischemic) and non-cardiac causes (e.g. pulmonary/mediastinal, gastrointestinal, musculoskeletal, and psychogenic).
5. Describe the key clinical characteristics of the following chest pain etiologies: angina, embolism, gastroesophageal reflux, costochondritis, anxiety, pneumonia.

5. Contraception

1. Obtain an appropriate medical and sexual history (e.g. migraines, unprotected intercourse, smoking, depression, contraindications for common contraceptive methodologies)
2. Be able to list and explain the absolute contraindications for hormonal contraception.
3. Counsel patients on contraceptive options including:
    a. Patient preferences and values
    b. Risks and side effects
    c. Contraceptive methods and devices, both permanent and non-permanent
    d. Benefits & relative efficacy
    e. Barriers to access (e.g. cost)
    f. Proper use including initiation
    g. Potential drug interactions
    h. Emergency contraception

i. Counsel patients on STI prevention and screen when appropriate
j. Describe the role of family physicians in caring for patients with unintended pregnancy

6. Cough/Dyspnea

1. Conduct a patient interview and appropriate focused physical examination to identify the common and important causes of cough, particularly:
    a. Acute causes
        - Infectious (viral/bacterial)
        - Exacerbation of Asthma
        - Exacerbation of COPD
        - Post-viral cough
        - Exacerbation of CHF
        - Pulmonary embolus
        - Pneumothorax
        - Foreign body
    b. Chronic causes (including screening for red flags, e.g. weight loss, hemoptysis)
        - Post-nasal drip
        - GERD
        - Asthma (refer to Asthma Objectives)
        - COPD/Smoking
        - Infection (e.g. tuberculosis)
        - Medication (i.e. ACE Inhibitor)
        - Congestive Heart Failure
        - Neoplasm
2. Include an appropriate environmental, occupational, and travel history as part of the patient interview.
3. Propose a relevant initial investigation plan (e.g. chest x-ray, spirometry) for a patient with cough.
4. Recognize a patient with respiratory distress (e.g. hypoxia, tachypnea, etc.) and seek immediate help.
5. Suggest a preliminary/initial management plan for patients with cough, particularly for the acute and chronic causes listed above, avoiding unnecessary use of antibiotics.

7. Depression

1. To be able to screen for and diagnose depression including:
    a. using current criteria and other diagnostic and functional assessment tools
    b. Mental status exam, including assessment of suicide/homicidal risk, and take appropriate action where necessary
2. Identify high risk factors for depression and suicide.
3. Describe variant presentations of depressed patients.
4. Propose a differential diagnosis for patients with depressed mood to rule out important secondary causes and an initial plan for investigation & management
5. Describe non-pharmacologic and pharmacologic approaches to management, including risks, benefits and limitations of the method(s) used
    a. Pharmacologic
        - Mechanism of action
        - Medication classes & interactions
    b. Non-pharmacologic
        - Resources available in community
        - Effect of/on family & social supports

8. Diabetes Mellitus Type II

1. Identify patients at risk for T2DM and select an appropriate screening strategy.
2. Diagnose DM using current criteria.
3. Discuss with patients the importance of lifestyle in the management of diabetes and the prevention of complications, especially the role of exercise, nutrition and avoidance of tobacco.
4. Propose an initial therapeutic plan for patients with T2DM and identify major drug side effects.
5. Describe recommended targets (glycemic control, lipids, blood pressure) for specific diabetic patients.
6. Recognize potential complications (e.g. retinopathy, nephropathy, peripheral neuropathy, autonomic neuropathy)
7. Propose a surveillance plan for patients with T2DM including the role of flow sheets and/or electronic records, and identification of end-organ damage.

9. Diarrhea

1. Identify the dehydrated patient and propose a rehydration plan
2. Conduct a history and physical exam so as to identify patients with:
    a. Infectious diarrhea
    b. Non-infectious diarrhea including IBD, celiac, lactose intolerance, IBS, constipation, bowel CA
3. Order and interpret investigations to explore or confirm diagnoses identified in #2 above, potentially including the following:
    a. Fecal occult blood test
    b. Stool for c & s, ova & parasites, *C. difficile*
    c. CBC, ferritin
    d. Celiac serology
    e. Diagnostic imaging (abdominal plain films)
    f. Endoscopy
    g. Trials of food exclusions
4. Identify health information resources for patients travelling to international destinations (e.g. www.cdc.gov)
5. Based on findings and culture results, propose initial management plans for:
    a. Infectious
        - Consider hygiene and contact issues
        - Viral gastroenteritis – fluids, light diet (low fat)
        - Bacterial or parasitic diarrhea – identify appropriate treatment guideline
    b. Non-infectious
        - Celiac- dietary management
        - Lactose-intolerant- dietary management
        - Constipation
            i. Look for underlying causes
            ii. Develop bowel routine through use of diet change and laxatives as required
        - Irritable Bowel Syndrome - fiber, anti-spasmodics

10. Dizziness

1. Given a patient with “dizziness”, conduct a history so as to distinguish true vertigo from other types of dizziness.
2. Differentiate between psychiatric causes (depression, anxiety/panic, somatization, alcohol), disequilibrium (peripheral neuropathy, visual impairment, drug), and syncope/presyncope.
3. Identify likely causes of vertigo (e.g. benign paroxysmal positional vertigo, viral labyrinthitis, Meniere’s Disease) and other types of dizziness (e.g. anemia, vasovagal, hypovolemia).

4. Conduct a relevant physical exam so as to rule out serious causes of dizziness, including assessment of orthostatic blood pressure, cerebellar & cranial nerve function, precordium, and cardiacrhythm.
5. Identify patients with BPPV and be able to demonstrate the Epley maneuver for these patients.

11. Elderly Health Care

1. Assess the following for elderly patients:
    a. ADLs and IADLs (Katz 1983)
    b. Cognition (through validated tools)
    c. Medication/supplement safety
    d. Hearing and vision
    e. Mobility and fall risk
    f. Supports & environment
    g. Mood
    h. Presence and type of advance care planning documents
2. Identify community resources and other interventions to address concerns in these areas.
3. In the elderly patient taking multiple medications, avoid polypharmacy by: monitoring side effects, periodically reviewing medication (e.g., is the medication still indicated, is the dosage appropriate), and monitoring for interactions.
4. In the elderly patient, screen for modifiable risk factors (e.g., visual disturbance, impaired hearing) to promote safety and prolong independence.
5. In the elderly patient, assess functional status to: - anticipate and discuss the eventual need for changes in the living environment. - ensure that social support is adequate.
6. In older patients with diseases prone to atypical presentation, do not exclude these diseases without a thorough assessment (e.g., pneumonia, appendicitis, depression).
7. Be familiar with different forms of dementia (e.g. Alzheimer's, vascular, mixed, Lewy body, fronto-temporal).

12. Fatigue

1. Conduct a patient interview so as to:
    a. Define what the patient means by "fatigue" and distinguish from other concerns (e.g. mood concerns, muscle weakness, decreased exercise tolerance +/- SOB)
    b. Identify clinical symptoms/red flags that suggest a secondary etiology, e.g. depression, anemia, hypothyroidism, malignancy, sleep apnea, cardiac disease
    c. Identify context red flags that may suggest psychosocial concerns and impact differential diagnosis and/or management (e.g. homelessness, isolation, single parent, addiction, recent losses, sleep quality/shift work)
2. Conduct a relevant physical exam to refine DDx.
3. Include "watchful waiting" when appropriate as a diagnostic and/or management tool.
4. Propose and act on initial investigations based upon DDx and avoid over-investigation/"shot-gun" approach.

13. Fever and Common Infections

1. Perform a focused history and physical exam to determine presence of fever, fever pattern, and associated symptoms & signs, so as to:
    a. Make a determination as to whether a patient truly has/has had a fever, and whether it is acute versus chronic.
    b. Identify patients with serious illness:
        i. Demonstrate good understanding of the potential groups of cause of fever
        ii. Infection, malignancy, drugs, environment (sun, heat)
        iii. Important conditions not to miss: endocarditis, meningitis, septicemia

2. Recognize special groups where fever has different significance or impact (e.g. neonates, elderly, travel/immigrant issues, under-immunized groups, living conditions, cultural/religious groups, immune-compromised individuals).
3. Propose a plan for appropriate investigation of possible causes, based in the local context.
4. Propose a basic plan of management that includes:
    a. Simple at home measures including antipyretics
    b. guidance for patients/caregivers on how to access care depending on evolution of illness
5. Be familiar with causative agents and treatment options for:
    a. Acute otitis media
    b. Cellulitis
6. For patients presenting with ear pain:
    a. Make the diagnosis of otitis media (OM) only after good visualization of the eardrum (i.e., wax must be removed), and when sufficient changes are present in the eardrum, such as bulging or distorted light reflex (i.e., not all red eardrums indicate OM).
    b. Include pain referred from other sources in the differential diagnosis of an earache (e.g. tooth abscess, trigeminal Neuralgia, TMJ dysfunction, pharyngitis, etc.).

14. Headache

1. Perform a patient-centered interview that identifies:
    a. Symptoms of secondary headaches, including red flags of potentially serious causes: e.g. intracranial bleed, meningitis, etc.
    b. Features that may differentiate types of headache that commonly presents in primary care e.g. migraine, tension, cervicogenic, and medication over-use headaches.
2. Perform a focused physical exam that identifies signs of secondary causes, including potentially serious causes.
3. Use diagnostic criteria to diagnose a patient with migraine.
4. Propose a management plan that includes:
    a. Appropriate and timely investigation & disposition if a potentially serious secondary cause is suspected.
    b. Includes appropriate evidence-informed pharmacological and non-pharmacological modalities.
    c. Response to patient fears and expectations providing reassurance when appropriate

15. Hypertension

1. Describe and demonstrate the appropriate technique for blood pressure assessment.
2. Describe the operator and patient factors that can artificially raise and lower blood pressure.
3. Define how to diagnose hypertension in a family practice setting for different patient groups, and identify the blood pressure targets for these groups.
4. Describe the role of patient-determined blood pressure and 24-hour ambulatory blood pressure assessment in diagnosis and monitoring of HTN.
5. Describe the effects of hypertension on end-organs and how to assess a patient for these.
6. Propose an initial diagnostic workup for a patient with a new diagnosis of high blood pressure to determine if there is a secondary cause for hypertension (versus essential hypertension)
7. Define the diagnostic and treatment targets for various groups of patients with high blood pressure.
8. Suggest individualized lifestyle modifications to patients with hypertension. (e.g., weight loss, exercise, limit alcohol consumption, reduce NSAIDS, dietary changes).
9. Recognize and act on a hypertensive crisis
10. Treat the hypertension with appropriate pharmacologic therapy. Describe the various drug classes used to treat high blood pressure and their mechanisms of action, side effects, relative cost, and pharmacokinetics. Consider the patient's age, concomitant disorders, and other cardiovascular risk factors.

16. Ischemic Heart Disease

1. Identify patients at elevated risk for IHD and calculate their 10-year cardiovascular risk using the Framingham Risk Score.
2. Propose a patient-centered initial management plan for primary prevention of IHD.
3. Identify which patients require further investigation to confirm a diagnosis of IHD.
4. Describe an early post-ischemic event management plan including lifestyle changes, medications, psychosocial support, cardiac rehabilitation, etc.
5. Propose a surveillance and management plan for secondary prevention of cardiovascular events in patients with IHD.

17. Joint Pain

1. Recognize acute hot joints and propose next steps.
2. For joint/limb pain scenarios that commonly present in family medicine clinics:
    a. Diagnose intra- and extra-articular pathology based upon history and physical examination
    b. Identify the indications for and limitations of relevant investigations
    c. Interpret the findings of appropriate investigations
    d. Propose an initial management plan
3. For patients with arthritic symptoms, differentiate between osteoarthritis and inflammatory arthritides.
4. Describe the benefits and risks of acetaminophen, NSAIDs, and narcotics.

18. Low Back Pain

1. Perform a patient-centered interview that includes:
    a. Exploration of different causes of mechanical low back pain
    b. Probing for red flags of potentially serious causes
    c. Potential psychosocial risk factors for chronic disability (i.e. “yellow flags”)
2. Perform a focused physical exam that distinguishes different causes of mechanical low back pain and identifies signs of potentially serious secondary causes e.g. infection, pathological fracture, non-MSK referred pain
3. Propose initial management plan that includes:
    a. Appropriate and timely investigation of urgent potentially serious secondary causes
    b. Appropriate evidence-informed management of mechanical LBP, including pharmacological and non-pharmacological modalities, return to work, and secondary prevention.

19. Obesity

1. In patients who appear to be obese, make the diagnosis of obesity using a clear definition (i.e., currently body mass index) and inform them of the diagnosis.
2. Assess for treatable co-morbidities (e.g. hypertension, diabetes, coronary artery disease, sleep apnea, and osteoarthritis).
3. In patients diagnosed with obesity who have confirmed normal thyroid function, avoid repeated thyroid-stimulating hormone testing.
4. Inquire about the effect of obesity on the patient’s personal and social life to better understand its impact on the patient.
5. In a patient diagnosed with obesity, establish the patient’s readiness to make changes necessary to lose weight, as advice will differ, and reassess this readiness periodically.
6. Advise the obese patient seeking treatment that effective management will require appropriate diet, adequate exercise, and support (independent of any medical or surgical treatment), and facilitate the patient’s access to these as needed and as possible.
7. As part of preventing childhood obesity, advise parents of healthy activity levels for their children.

8. In managing childhood obesity, challenge parents to make appropriate family-wide changes in diet and exercise, and to avoid counterproductive interventions (e.g., berating or singling out the obese child).

20. Palliative Care

1. Explain the definition of the following terms and their application in palliative care settings and/or advance care planning:
    a. code status
    b. personal care directives
    c. substitute decision-makers
    d. power of attorney.
2. Propose a management plan for patients receiving palliative care with:
    a. Pain
    b. Nausea
    c. Constipation
    d. dyspnea
3. Identify local resources to support palliative patients & their families.
4. Recognize and seek assistance for the following palliative emergencies: opioid neurotoxicity, spinal cord compression, seizures, acute hemorrhage, and acute confusion/delirium.

21. Periodic Health Exam

1. Conduct a patient interview so as to identify any significant age-, sex-, context-specific risk factors for health conditions (e.g. exercise, diet, substance use, immunizations, falls)
2. Conduct an age-, sex-, and context-specific evidence-informed physical exam (e.g. blood pressure, weight, waist circumference).
3. Discuss pertinent screening tests and explain their purposes & limitation (e.g. Pap testing, mammography, colorectal cancer screening, bone mineral density, diabetes and hyperlidipemia screening, PSA testing)
4. Counsel patients on relevant health promotion/ disease prevention strategies (e.g. immunizations, exercise, diet, calcium/Vitamin D, smoking cessation)

22. Prenatal Care

1. Discuss key pre-conception considerations in healthy women of childbearing age. (e.g. folic acid supplementation, smoking, rubella immunity, etc.)
2. Date a pregnancy accurately.
3. Explore the patient's feelings and concerns about her pregnancy (e.g. supports, stressors, etc.).
4. Perform an adequate first prenatal visit including taking a history and performing an appropriate focused physical exam with the assistance of available antenatal tracking tools.
5. Screen for and identify pregnancies at risk (e.g. domestic violence, multiple gestation, maternal age, substance use, etc.).
6. Conduct a basic follow up visit, including BP measurement, weight, fetal heart rate (starting at 12 weeks), symphysis-fundal height (20wks and beyond), screening for concerns and complications.
7. Provide basic education and counseling regarding lifestyle, breastfeeding, and delivery planning.
8. Anticipate potential health problems during the pregnancy and provide rational health maintenance and disease prevention strategies.

23. Skin Conditions

1. Recognize acute life-threatening dermatologic conditions.
2. Recognize lesions that are at greater risk for malignancy using the ABCDE framework and recommend biopsy.
3. Describe morphology of skin lesions.

4. Identify and propose management plans for the following common skin conditions:
    a. Infections – viral (e.g. herpes, exanthems, warts), bacterial (e.g. impetigo, cellulitis), fungal (e.g. tinea, candida), parasitic (e.g. lice, scabies, bites)
    b. Dermatitis (irritant/contact, atopic, venous stasis)
    c. Psoriasis
    d. Acne
5. Counsel patients about sun/UV skin safety.

24. Upper Respiratory Tract Infection (URTI)

1. Given an appropriate history and/or physical examination:
    a. Differentiate life-threatening conditions (epiglottitis, retropharyngeal abscess) from benign conditions.
    b. Manage the condition appropriately.
2. Make the diagnosis of bacterial sinusitis by taking an adequate history and performing an appropriate physical examination, and prescribe appropriate antibiotics for the appropriate duration of therapy.
3. In a patient presenting with upper respiratory symptoms:
    a. Differentiate viral from bacterial infection (through history and physical examination).
    b. Diagnose a viral upper respiratory tract infection (URTI) (through the history and a physical examination).
    c. Manage the condition appropriately (e.g., do not give antibiotics without a clear indication for their use).
4. Through history and examination, make a clinical diagnosis of streptococcal tonsillo-pharyngitis.
5. Discuss the benefit of antibiotic treatment in group A streptococcal pharyngitis with respect to prevention of acute rheumatic fever and acute glomerulonephritis
6. Given a history compatible with otitis media, differentiate it from otitis externa and mastoiditis, according to the characteristic physical findings.
7. In high-risk patients (e.g. those who have human immunodeficiency virus infection, chronic obstructive pulmonary disease, or cancer) with upper respiratory infections: look for complications more aggressively and follow up more closely.
8. In a presentation of pharyngitis, look for mononucleosis.
9. In high-risk groups:
    a. Take preventive measures (e.g. use flu and pneumococcal vaccines).
    b. Treat early to decrease individual and population impact (e.g. with oseltamivir phosphate [Tamiflu]).

25. Urinary Symptoms/Genital Discharge

1. Conduct a focused history and physical exam (including genital/pelvic exam) that enables differentiation between:
    a. UTI uncomplicated (cystitis) vs complicated UTI (e.g. recurrent, pyelonephritis)
    b. Non-urinary tract infection including prostatitis, pelvic inflammatory disease, STI's, urinary retention, atrophic vaginitis, vulvovaginitis, urolithiasis, foreign body
2. Propose a focused investigation plan based upon the patient's features that may include
    a. Urinalysis (dip), c/s
    b. Genital swabs and other STI testing with informed consent re: notifiable diseases
    c. Other tests relevant to patient's condition
3. Identify patients with features suggestive of urgent conditions requiring immediate management and propose next steps including:
    a. Pelvic inflammatory disease
    b. Acute urinary retention
    c. Pyelonephritis with history of physical exam risk factors for serious disease

4. For the following nonurgent conditions, outline an initial management plan:
    a. Uncomplication UTI (cystitis), treat promptly without waiting for results of any ordered investigation
    b. Stable pyelonephritis or recurrent UTI- Identify causes of recurrent UTI's, including urinary retention, post-coital, urolithiasis, diabetes mellitus, atrophic vaginitis
    c. Atrophic vaginitis- local estrogen and/or moisturizers
    d. Prostatitis- prolonged duration of antibiotic treatment
    e. Vulvovaginitis- antifungal and risk factor avoidance
    f. Bacterial vaginosis/Trichomonas vaginalis - identify appropriate resources to guide treatment
    g. STI's-identify appropriate resources to guide therapy and risk reduction; contact Public Health re: notifiable diseases
    h. Urolithiasis- fluids, analgesia
    i. Child with pelvic foreign body or STI-screen for abuse- contact Child Protection Services
    j. Urinary incontinence (e.g. stress, urge, functional, overactive)
    k. Benign prostatic hyperplasia

26. Well-Baby/Child/Youth Preventive Care

1. Conduct an age-appropriate well child visit that includes physical exam, growth, nutrition and development.
2. Address parental concerns, social context, and safety and provide relevant anticipatory guidance (e.g. dental caries, family adjustment and sleeping position).
3. Assess vaccination status and counsel parents on the risks and benefits of vaccinations.
4. Be familiar with and use an evidence-based tool to help guide a well-child visit. (e.g. Rourke Baby Record)
5. Identify patients who require further assessment. 6. Inform caregivers of appropriate routine follow up intervals.

G. The Big 10 Learning Objectives

1. A student at the time of graduation will be able to:

2. Demonstrate the basic science and clinical science knowledge and skills necessary for the supervised practice of medicine and use knowledge efficiently in the analysis and solution of clinical presentations.

   Evaluate patients and properly manage their medical problems by:
   a) Conducting a comprehensive medical history and thorough physical examination; reliably eliciting appropriate information in the history and detecting abnormal findings on the physical examination.
   b) Correctly identifying the patient's diagnosis, differential diagnosis, and medical problems.
   c) Applying an appropriate clinical reasoning process to the patient's problems.
   d) Advocating for patients while formulating and implementing a resource-conscious management plan to deal effectively with patient problems.
   e) Applying basic patient safety principles

3. Apply a comprehensive patient-centered approach in the evaluation and care of patients including sensitivity to differing sexual orientation and gender identity, cultural and spiritual beliefs, attitudes and behaviours, economic situations.

4. Demonstrate knowledge of the fundamental concepts of disease prevention and health promotion for individual patients and populations and incorporate them into treatment plans as appropriate.

5. Communicate and interact effectively with patients, families, medical staff and others involved in the delivery of health services.

6. Describe and apply ethical principles and high standards in all aspects of medical practice.

7. Exhibit appropriate professional behaviour, including awareness of personal wellness and limitations.

8. Formulate clear clinical questions and apply an evidence-based approach to solving these questions.

9. Demonstrate educational initiative and self-directed life-long learning skills.

10. Describe the basic principles of clinical and translational research, including how such research is conducted, evaluated, explained to patients and applied to patient care.

H. Learning Objectives Overview

Objective	Example	Sample Learning activity	Evaluated by
CANMEDs Role: Expert **CSM Big 10:** 1, 2, 3	Assess and generate an *appropriate* differential diagnosis in a patient presenting with a *new undifferentiated* symptom Assess, generate an appropriate differential diagnosis and offer basic management for a patient presenting with common simple problems e.g. hypertension, upper respiratory tract infection, fever in a child Assess and offer tailored advice to a patient throughout the life-cycle that incorporates preventative healthcare e.g. well-child visit, antenatal care, periodic health check to an older patient	Seeing and discussing patients in clinic Consider how your preceptor is a resource within your specific setting	ITER (mid-point & final) Certifying exam Logbook completion
CANMEDs Role: Manager **CSM Big 10:** 1, 2, 3, 4, 5	Design a *comprehensive care plan* which incorporates bio-psycho-social aspects of care, within a team setting, relevant to the context of your preceptors practice	Attend a team meeting Do a home visit	ITER (mid-point & final)
CANMEDs Role: Communicator **CSM Big 10:** 2,5,6	Conduct a consultation in a patient-centered way which includes identifying the patient's perspective. Communicate effectively with other members of the team (written and phone) Document notes in a *succinct* manner Write a referral letter Write a prescription	Ask patients for feedback Ask team members for feedback Ask your preceptor to read a referral and prescription you have written	ITER (mid-point & final)
CANMEDs Role: Advocate **CSM Big 10: 2,3,4,6**	Identify the social needs of patients and where appropriate act to enable or facilitate these needs.	Explore your community Talk to different members of the health care teams	ITER (mid-point & final)
CANMEDs Role: Scholar **CSM Big 10:** 8, 10	Apply principles of evidence-based medicine to individualized patient care Use appropriate learning resources to support patient care	Determine the impact of your project in the practice / community Identify preferred resources and be able to defend your choices	Patient-centred Care Project ITER (mid-point & final)
CANMEDs Role: Collaborator **CSM Big 10: 2,5**	Demonstrate knowledge of the roles of members of the primary care team and be able to write an appropriate referral	Spend time with other health care professionals	ITER (mid-point & final)
CANMEDs Role: Professional **CSM Big 10:** 6,7	Act in a professional manner as exemplified by good communication with patients and your preceptors' team and the UME, take responsibility for fulfilling the requirements of the FM clerkship including the appropriate time commitment and submitting the relevant documentation.	Document your time commitment, progress and feedback received daily and include this tracing record as an appendix in your final submission.	Meets clinical expectations Participation in teaching sessions ITER (mid-point & final)