



UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

Revised 2025-06-18

Family Medicine Clerkship

MDCN 502

PRECEPTOR MANUAL

****NEW for the Class of 2026****

UNDERGRADUATE MEDICAL EDUCATION
PRECEPTOR DOCUMENT

CLASS OF 2026

Academic Year: Jan 2025 – Apr 2026

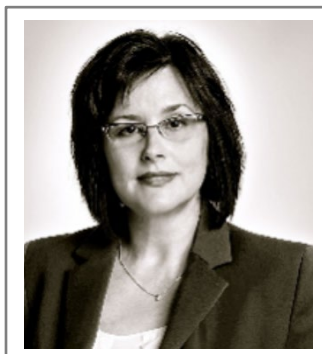
© 2024

Contents

1. WELCOME TO FAMILY MEDICINE CLERKSHIP	3
2. FM 4 + 4	5
3. GOAL OF THE FAMILY MEDICINE CLERKSHIP	6
4. SUPERVISION AND ASSESSMENTS.....	7
4.1 Supervision	7
4.2 Preceptor Assessments.....	7
4.3 Entrustable Professional Activities (EPAs)	8
4.4 EPA 0.....	8
4.4 Virtual Care	9
5. RURAL/REGIONAL.....	10
5.1 Clinical Time.....	10
5.1 Academic Sessions.....	11
5.3 Advance Care Planning/Goals of Care Discussions	12
5.4 SNAPS Sessions	12
5.5 Sample Timeline (RURAL/REGIONAL)	13
6. URBAN	14
6.1 Clinical Time.....	14
6.2 Academic Sessions.....	15
6.3 Patient-Centered Care Project (PCCP)	15
6.4 Planetary Health Workshop.....	17
6.5 Sample Timeline	18
7. ON-CALL ARRANGEMENTS	19
8. EXAMS	20
9. LOGBOOK.....	22
10. TEACHING RESOURCES FOR PRECEPTORS.....	23
10.1 Professional Development Sources	23
10.2 Feedback.....	23
10.3 Slow Clinic/Low Patient Volume - Strategies for Teaching	24
10.4 Patient Presentations	25
10.5 RIME Guide	25
11. AWARDS	26
12. CONFERENCE ABSTRACTS AND PRESENTATIONS CLERKS CAN APPLY FOR!	27
APPENDICES.....	28
A. CanMEDS Roles.....	28
B. Clinical Calendar (Rural/Regional)	27
C. Clinical Calendar (Urban)	28
D. Patient-Centred Care Project.....	29
E. Evaluation Form for Patient-Centered Care Project.....	32
F. SNAPS Presentations	34
G. Infographic Example	35
H. Supplemental Learning Resources.....	36
I. Learning Objectives and 27 Clinical Presentations	37
J. The Big 10 Educational Objectives.....	47
K. RIME Guide	48
L. Learning Objectives Overview	49
M. Twelve Points to Consider When Talking to a Medical Student	50
N. Role Conflict: Physicians as Care Providers and Teachers	52

1. WELCOME TO FAMILY MEDICINE CLERKSHIP

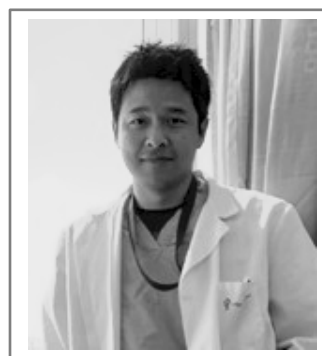
For scheduling queries, please email the UME Family Medicine Program Coordinator: Karishma Sutar: famclerk@ucalgary.ca.



Anila Ramaliu MD MSc CCFP

Family Medicine Clerkship Director aramaliu@ucalgary.ca

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



Jimmy Vantanajal BMBS CCFP

Family Medicine Evaluation Coordinator jsvantan@ucalgary.ca

FAMILY MEDICINE UNDERGRADUATE EDUCATION OFFICE

Clark Svrcek MD P.Eng M.Eng CCFP

Director, Family Medicine Undergraduate Education

Alexandra Thomas BA

Team Lead, Family Medicine Undergraduate Education

Christine Gray

Program Secretary, Family Medicine Undergraduate Education

ugfm@ucalgary.ca | T: 402-210-6318

Please welcome the Class of 2026! (Lunkaryas)



January 2025

Dear Valued Family Medicine Preceptor,

First, I want to express my sincere appreciation and Thank You for your commitment and dedication to teaching Cumming School of Medicine clerkship students. The DFM (Department of Family Medicine) deeply values your support in the success of the core Family Medicine Clerkship Rotations, which expose undergraduate medical students to our great profession!

Second, as I am new in my role, I would like to introduce myself to you. I am a family doctor and a physician with the DFM, and my name is Anila Ramaliu. As of December 1st, 2024, I have replaced Dr. Sonja Wicklum as Family Medicine Clerkship Director. Dr. Wicklum remains with the Cumming School of Medicine and has stepped into the new role of Director of Planetary Health.

*Third, the clerkship year we are about to begin is unique. The Class of 2026 (Lunkaryas) started their medical degree at the Cumming School of Medicine in 2023, a time that corresponds with the implementation of the new - **Re-Imagined Medical Education (RIME)** - curriculum in Undergraduate Medical Education. The key design principles of this new curriculum include spirality, generalism, patient-centering, and integration, where key concepts are presented repeatedly throughout classroom teaching with increasing layers of complexity. As RIME varies significantly from the previous Legacy curriculum, you may notice differences in the understanding or approaches to learning this cohort of clerks has compared to the ones you have worked with in the past. The following podcast provides more explanation about the [RIME](#) curriculum.*

Finally, I would like to reiterate a previous message with you. Family Medicine rotations are among the most highly valued and positively reviewed of the clerkship experience—thanks to you and your great work! The Family Medicine Core rotation exposes clerks to the challenges and joys of our specialty. The time spent with you impacts these students' career choices! Let's ensure this rotation is the best the students experience in their final year of medical school!

In closing, should you have any questions or concerns related to your role, please do not hesitate to reach out to me or the DFM undergraduate team.

Sincerely,

Anila Ramaliu MD MSc CCFP
Family Medicine Clerkship Director



2. FM 4 + 4

The Class of 2026 will complete 4 weeks of a rural/regional experience **and** 4 weeks of an urban experience. This will allow ALL clerkship students to have a Family Medicine experience before CaRMS. Of note, the 4-week blocks are not necessarily contiguous.

All clerks are expected to work full time: equivalent to a 40-50-hour work week. If you are not personally able to provide clerks this volume of clinical time, we hope that you will approach your colleagues to make up the time. **Clerks that fail to achieve the required clinical time will not pass the rotation.** Further, all absences need to be approved. Within the first few days of the rotation, clerks will engage you to create and review a work schedule. Clerks should not be expected to work more than a 55-hour week (not including call).

In this Preceptor Manual we have included information about both rural and urban experiences so that whether you are an urban or a rural/regional preceptor, you can understand the overall experience. We have also added an objectives list (Appendix I) that you can refer to. The clinical presentations in the Logbook, map on to these objectives.

We would like to highlight that **a mid-point ITER (MITER) needs to be completed** by the end of Week 2 of the 4-week block. Please remember that Drs. Anila Ramaliu and Jimmy Vantanajal can be reached at any time if you have concerns about a clerk.

Requirements to pass the Family Medicine rotation

Must Complete ¹	Logbook	2 nd FM block
Must Complete ¹	SNAPS presentation	Rural FM block
Must Complete ¹	Formative Midpoint Preceptor ITER	Both blocks
Must Complete ¹	Clinical Expectations	Both blocks
Must Complete ¹	Attendance and participation in teaching sessions	Both blocks
Must Complete ¹	Submit signed Clinical Calendar	Both blocks
Must Pass ²	Satisfactory Final Preceptor ITER	Both blocks
Must Pass ²	Patient-Centered Care Project	Urban FM block

¹ Must complete. Failure to do so will result in an overall evaluation of 'satisfactory with performance deficiency' for the rotation.

² Must pass. Failure to do so will result in an overall evaluation of 'unsatisfactory' for the rotation.

3. GOAL OF THE FAMILY MEDICINE CLERKSHIP

By the end of Family Medicine Clerkship, clerks will:

1. Have a better understanding of how family physicians think and do their work. A significant challenge in family medicine is dealing with **the undifferentiated patient**, someone with an issue or symptom, for which the diagnosis is not clear. Clerks will appreciate and develop skills in interviewing patients, determining management plans, and communicating these to the patient. They will recognize **the importance of shared decision making with patients and collaboration with a multitude of other healthcare providers** as they 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 cases and coming from patients. They 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. They 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. Clerks 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-centred approach**, the value patients add to the therapeutic process, and 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 J.

The [Department of Family Medicine](#) website has links to virtual care and teaching resources. This was created to provide easy access to helpful resources for preceptors to provide virtual care as well as teaching learners in a virtual environment. If you have any questions regarding virtual care, please contact the clerkship director or famclerk@ucalgary.ca.

4. SUPERVISION AND ASSESSMENTS

4.1 Supervision

As clerks are medical students, **the attending physician must directly see every patient**. Clerks must be appropriately supervised, but it is expected that they will be able to progress to a point where they can take an initial history and physical examination on their own*, synthesize the information and formulate a preliminary plan to review with you, before attending the patient together for further exploration/examination and wrap-up of the patient encounter. **Please teach the clerks any procedures that you do, including breast exams, pap smears and other sensitive exams, as FM clerkship is an important opportunity to learn and become skilled at these.**

**The mITER/ITER evaluations for clerks have a checkbox to record observing the clerk perform a history taking and physical examination. You do not need to observe the clerk every time to check this box. You need only observe the clerk one time, ideally during the first one or two days of the rotation so that you can gauge the clerk's competency at the onset. You may observe these procedures many times depending on the stage of the clerk and their skill level.*

Please facilitate the clerk's participation in any activity to which you are involved in as a family physician and which you deem appropriate. This may include attending home visits or long-term care or palliative care hospice visits, doing urgent care shifts or delivering babies.

There are no formal call requirements. **Please ensure that clerks do not exceed the PARA call rules of one-in-four in-house call.** In the attempt to balance daytime learning with post-call requirements, we would request that clerks only be called after midnight if there is an extraordinary learning opportunity so that they do not have to miss the clinical activities during the next day. For those in a rural site, we would ask that clerks be in town at least one weekend of the 4-week block and participate in weekend call activities as appropriate.

4.2 Preceptor Assessments

Midpoint ITER (mITER)

At the midpoint mark of the rotation (end of week 2), please provide your clerk with specific feedback (in addition to ongoing, continuous feedback) and fill out the mITER form on One45.

1. Review the clerk's Logbook to determine if any clinical presentations/procedures need to be completed. A total of one history and one physical must be observed.
2. Please note: 1) clerks must watch the Goals of Care/Advanced Care Planning videocast, 2) clerks must discuss the Green Sleeve with you, and if possible, with a patient. This is filling an important need in undergraduate medical education which may not be filled in any other rotation. We have emphasized that this be completed during the rural FM rotation, but it is acceptable for this to be completed during the urban FM rotation.

If you are concerned that the clerk is at risk of not meeting expectations for performance in the block, written documentation must be provided to that clerk at the rotation's midpoint and appropriate chance for remediation given. Please email the Clerkship Director aramali@ucalgary.ca and Family Medicine Evaluation Coordinator jsvantana@ucalgary.ca if you are concerned about a clerk's performance. The DFM is there to support you and ensure that the clerk has access to appropriate supports and interventions.

Evaluation of Patient-Centred Care Project (urban preceptors only).

Please see Section 6.3 and Appendix D for details. Ensure the clerk's project is patient centered. Projects not grounded in a patient encounter are not acceptable. The clerks have clear guidelines in the Core Document on how to complete the project. Please see 6.3 to review the project details.

Final ITER

At the end of the block, please provide clerks with feedback and complete and submit the final ITER on One45. **Please ensure the final ITER is submitted on One45 within 6 weeks of receiving it.**

4.3 Entrustable Professional Activities (EPAs)

A clerk can ask any preceptor, not just their primary preceptor, to complete an Entrustable Professional Activity (EPA), and this can happen during or after their block. Clerks have many opportunities to ask you to complete an EPA. If a clerk waits a long time and you are not comfortable completing the EPA then you can state this on One45.

For more information, please refer to the [Clerkship Handbook](#).

4.4 EPA 0

The Family Medicine Clerkship Program uses EPA 0 to assess and document medical students' professionalism throughout FM rotations.

"EPA 0" - "Learner demonstrates accountability to self, peers, and profession" will be used to record instances of both exceptional and concerning professional behaviors observed.

EPA 0 assessments will be completed situationally and based on observations by the FM clerkship team. Examples of professional behaviors documented through EPA 0 include:

- Active engagement: Punctual arrival, preparedness, active participation, and completion of assignments during Academic Day teaching sessions and clinic.
- Timely completion of requirements: Submission of required rotation materials (e.g., proposed calendar, signed calendar, logbook, PCCP and SNAP topic selections/assignments, make-up work) in the expected deadlines.
- Adherence to attendance policies: Prompt submission of absence requests via Osler, timely communication with preceptors and the scheduler regarding absences, avoidance of unapproved absences from clinics or mandatory sessions (in accordance with UME policies).

Completion of EPA 0 will take place only when notable instances of professional behavior are observed. As with all clerkship EPAs, EPA 0 assessments are not included in the Medical Student Performance Record (MSPR). However, they are reviewed by the Competency Committee to inform promotion and graduation recommendations.

EPA 0 is intended as a low-stakes formative assessment to provide timely feedback, reinforce positive professional behaviors and support improvement of those requiring development. For the Class of 2026, EPA 0 assessments will be completed exclusively by FM clerkship leads (Program Director or Evaluator).

4.4 Virtual Care

The [Department of Family Medicine](#) website has links to virtual care and teaching resources. This was created to provide easy access to helpful resources for preceptors to provide virtual care as well as teaching learners in a virtual environment. If you have any questions regarding virtual care, please contact the clerkship director or famclerk@ucalgary.ca.

5. RURAL/REGIONAL

5.1 Clinical Time

The expectation is that the clerks will work the equivalent of 5 full days per week for the 4 weeks of the block. Any absences will need to be approved through normal mechanisms in Osler and you, as their preceptor, should be notified.

Clerks 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 the clerk on call on the Sunday night before. However, if they cannot be accommodated and must be on call then their start day/time can be adjusted accordingly.

Clerks are expected to attend a mandatory virtual orientation for their rural FM rotation from 8:00 – 9:00 am on the first Monday of the rotation. This may delay their clinic start time.

The Undergraduate Medical Education Departmental Guidelines 'Attire – Medical Students' clearly outlines expectations regarding dress code and use of personal protective equipment in clinical settings. It is important for clerks to review this policy and comply with its expectations. UME policies are available at: <https://cumming.ucalgary.ca/mdprogram/about/governance/policies>.

A Clerkship Clinical Skills session may occur on a Friday afternoon during this block and if clerks are within 1 hour of the city, the expectation is that they attend Clerkship Clinical Skills in person. This should allow them to work in your clinic in the morning until 11:00 am. Clerks outside of the 1-hour travel time will be excused from attending Clerkship Clinical Skills. If a clerk wishes to attend the Clerkship Clinical Skills session, they must obtain consent from their preceptor.

During the first day, please orient the clerk to your clinic. Show them a safe place to store their belongings and the call room.

The clerk will ask to review their schedule for the block, including:

- a. clinical expectations
- b. time away for statutory holidays
- c. time away for the Clerkship Clinical Skills course (depending on location)
- d. SNAPS sessions during lunch hours so you can ensure you are excused from patients or wrapping up cases and can log on to Zoom on time (see next page for times)
- e. if necessary, travel time to write the ICE (Integrative Clerkship Exams)
- f. any previously approved absences

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

At the beginning of the block, clerks need to submit an unsigned proposed clinical calendar to ensure they will be working full time. The clerk needs to email the proposed calendar to famclerk@ucalgary.ca by 4pm on Friday of week 1. **Please help the clerk meet this deadline by reviewing the calendar with the clerk early in week 1.**

During this first discussion with the clerk and before orienting them to the clinic, we suggest that you ask:

- how they are feeling
- if they have any special needs that you and the clinic staff need to be aware of
- whether they have preferred pronouns

Clinic time is counted by the half day. A clinic is defined as 4-5 hours of patient contact and does not include academic sessions. One half day per 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 preceptors regarding counting clinical half days. Your schedule may not reflect a typical 4-5-hour half day and therefore please assist the clerk with ensuring they meet the 5-day workweek.**

At the end of the block, clerks need to submit a clinical calendar signed by their preceptor. The signed clinical calendar is due 4pm Wednesday of week 4.

Clinical calendars need to be signed weekly by preceptors. A copy of the calendar for the rural/regional block is in Appendix B. Clerks are instructed on this requirement and should bring this to your attention. We greatly appreciate your support with completing this requirement.

Clerks may have a **maximum of three flex days per clerkship year (not rotation)**. Clerks may take one flex day in each 4-week block. Flex days must be scheduled in advance (before the start of the rotation). Flex days must be approved by the clerkship director and will be tracked. More information is in the [Clerkship Handbook](#).

Clerks 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. Further, they may take one half day to prepare for their SNAPS session. All absences, except one (optional) half day for the SNAPS preparation during the rural FM block, must be approved at the UME level through Osler. A half day taken for SNAPS project preparation does not count towards clinical hours.

Please be aware that there is a **critical minimum number (30) of clinics for both the rural/regional and urban blocks**. Clerks cannot make up missed FM time in the other FM rotation or in any of the other clerkship rotations. Make-up time can only be made during breaks, e.g., fall, winter, CaRMS or at the end of the clerkship year. **TO BE VERY CLEAR, THIS IS NOT THE MINIMUM A CLERK MUST WORK. THE CLERKS SHOULD BE WORKING THE EQUIVALENT OF FULL-TIME AS WRITTEN ABOVE. THIS RULE IS ONLY IN PLACE FOR RARE CIRCUMSTANCES AND REFLECTS ABSOLUTE MINIMUMS.**

5.1 Academic Sessions

Academic sessions will be delivered by Zoom Video Conference. Clerks need access to the internet at your clinic and should have wrapped up clinical care to arrive at the sessions on time.

Week 1 - Monday (8:00 – 9:00 am)

Orientation – FM Clerkship Director

Week 2 - Thursday (12:00 - 1:00 pm)

SNAPS Session 1

Week 3 - Thursday (12:00 - 1:00 pm)

SNAPS Session 2

5.3 Advance Care Planning/Goals of Care Discussions

After learning about Advance Care Planning and Goals of Care Discussions (ACP/GCD) by reviewing the [video](#). Clerks are encouraged to engage a patient in the ACP/GCD process. Clerks need to discuss this with you early on so that you can consider a patient who may benefit from an ACP discussion. There is no formal reporting for this activity. Ideally clerks will complete the Green Sleeve document, but if they are unable to complete the Green Sleeve document, they should discuss the topic with you and ensure they are familiar with the Green Sleeve document. Doing this will be sufficient for clerks to log the encounter in their Logbook.

There are two Logbook entries for this topic: one is to confirm the clerk has reviewed the video presentation and the other is to confirm discussing ACP/GCD with you or a patient.

5.4 SNAPS Sessions

After frequent feedback from FM clinical clerks that there is not enough teaching of core family medicine during the FM Clerkship rotation, the FM undergraduate team introduced 'SNAPS' during the rural FM block to address this concern. SNAPS sessions will operate on the "flipped classroom" approach with clerks teaching their peers. Clerks will select one of the core family medicine presentations and present a brief synopsis of the topic including study materials to their peers.

SNAPS sessions will be moderated by rural family physicians, and they will run over the lunch hour on Thursday of week 2 and Thursday of week 3. **Please ensure the clerk is free from clinical duties at noon on these days.**

Clerks are being encouraged to consider submitting an abstract for their SNAPS projects to two family medicine conferences: Distributed Learning and Rural Initiative's Cabin Fever conference held in Kananaskis in February each year, and the Alberta College of Family Physicians Family Medicine Summit held in Banff in March each year. **Preceptors can be included as co-authors, so please discuss with your clerk if this is of interest to you.**

If you are interested in moderating these sessions, please contact the UME Program Coordinator: famclerk@ucalgary.ca.

5.5 Sample Timeline (RURAL/REGIONAL)

This is the sample timeline clerks receive in the Core Document. It has all the important rotation elements for which they are responsible.

<input type="checkbox"/> Laptop and access to Wi-Fi at the clinic required.					
<input type="checkbox"/> Contact the scheduler for the preceding rotation to confirm travel requirements for FM.					
WEEK 1					
<input type="checkbox"/> Academic Session: Orientation - Zoom - Monday 8:00 – 9:00 am. Attendance mandatory.					
<input type="checkbox"/> Clinic introduction and initial orientation. Discuss and review the following with your preceptor:					
a) clinical expectations	b) SNAPS sessions at lunch hours	c) Clerkship Clinical Skills course - time away (if required)	d) If necessary, travel time to write the ICE (Integrative Clerkship Exams) *	e) any approved absences	f) patient(s) for ACP/GCD.
<input type="checkbox"/> Logbook: Preceptor to observe complete Hx and PE.					
<input type="checkbox"/> MITER: Schedule time with your preceptor for the mid-point review.					
<input type="checkbox"/> Clinical Calendar: Email projected half-day totals to famclerk@ucalgary.ca by 4 pm Friday.					
<input type="checkbox"/> SNAPS: Email one of the 27 core FM presentations for your SNAPS to famclerk@ucalgary.ca .					
<input type="checkbox"/> Logbook: Start recording clinical presentations and procedural skills you see.					
WEEK 2					
<input type="checkbox"/> Logbook: Review ACP/GCD podcast and discuss with preceptor; discuss with a patient.					
<input type="checkbox"/> Academic Session: SNAPS Session #1 – Zoom – Thursday 12:00 - 1:00 pm. Attendance mandatory. Cameras on.					
<input type="checkbox"/> MITER: Mid-point review with your preceptor.					
WEEK 3					
<input type="checkbox"/> Academic Session: SNAPS Session #2 – Zoom – Thursday 12:00 – 1:00 pm. Attendance mandatory. Cameras on.					
<input type="checkbox"/> ITER: Schedule time with your preceptor for the final review.					
WEEK 4					
<input type="checkbox"/> ITER: Final review with your preceptor.					
<input type="checkbox"/> Clinical Calendar: Email signed calendar to famclerk@ucalgary.ca by 4:00 pm on Wednesday.					
<input type="checkbox"/> Finalized SNAPS materials submitted to UME FM Program coordinator by 4pm on Wednesday.					
2nd FM Block:					
<input type="checkbox"/> Logbook: Complete by 5:00 pm Sunday. (Final Sunday of the rotation).					

* The content of this Family Medicine clerkship rotation is a significant part of the Integrative Clerkship Exams.

6. URBAN

6.1 Clinical Time

The expectation is that clerks will work the equivalent of 5 full days per week for the 4 weeks of the block. Any absences will need to be approved through normal mechanisms in Osler and preceptors should be notified.

Clerks are expected to attend a mandatory virtual orientation for their urban FM rotation from 3:00 – 4:30 pm on the first Monday of the rotation. Please ensure that clerks are free from their clinical duties to attend. If clerks do not attend (for unforeseen circumstances or excused by FM leads) they must watch the orientation podcast and read the Core Document so that they are aware of the requirements to pass the rotation.

The Undergraduate Medical Education Departmental Guidelines 'Attire – Medical Students' clearly outlines expectations regarding dress code and use of personal protective equipment in clinical settings. It is important that clerks review this policy and comply with its expectations. UME policies are available at:

<https://cumming.ucalgary.ca/mdprogram/about/governance/policies>.

A Clerkship Clinical Skills session may occur on a Friday afternoon during this block. Clerks should be able to work until 11:30 am in the morning in your clinic and then travel back to campus for Clerkship Clinical Skills.

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

1. Clinical expectations – 5 days per week minus:
 - a) time away for statutory holidays,
 - b) time away for Clerkship Clinical Skills session (Friday afternoon only if required),
 - c) time away for Academic Day (Thursday, week 3)
 - d) if necessary, time away to write the Integrative Clerkship Exams
2. From (1) above minus any previously approved absences.
3. Clerks are permitted 1 day (2 clinics) for preparation of the Patient-Centred Care Project (PCCP). This time does not count towards clinical hours.

At the beginning of the block, clerks need to submit an unsigned proposed clinical calendar to ensure they will be working full time. The clerk needs to email the proposed calendar to famclerk@ucalgary.ca by 4pm on Friday of week 1. **Please help the clerk meet this deadline by reviewing the calendar with the clerk early in week 1.**

During this discussion we suggest you check in with the clerk and before orienting them to the clinic, please ask them:

- how they are feeling
- if they have any special needs that you and the clinic staff need to be aware of
- whether they have preferred pronouns
- their level of learning (which can be shared with the clinic staff)

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

Clinic time is counted by the half day. A clinic is defined as 4-5 hours of patient contact and does not include 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 the preceptors regarding counting clinical half days. Preceptor schedules may not reflect a typical 4-5-hour half day and therefore you may need to assist the clerk with ensuring they meet the 5-day workweek.**

At the end of the block clerks need to submit a clinical calendar signed by their preceptor. The signed clinical calendar is due 4pm Wednesday of week 4.

Clinical calendars need to be signed weekly by preceptors. A copy of the new calendar for the urban block is in Appendix C. Clerks are instructed on this requirement and should bring this to your attention. We greatly appreciate your support with completing this requirement.

Clerks may have a **maximum of three flex days per clerkship year (not rotation)**. Clerks may take one flex day in each 4-week block. Flex days must be scheduled in advance (before the start of the rotation). Flex days must be approved by the clerkship director and will be tracked. Please refer to the [Clerkship Handbook](#) for more information.

Clerks are also 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.

However, be aware that there is a **critical minimum number (30) of clinics for both the rural/regional and urban blocks**. TO BE VERY CLEAR, THIS IS NOT THE MINIMUM A CLERK MUST WORK. THE CLERKS SHOULD BE WORKING THE EQUIVALENT OF FULL-TIME AS WRITTEN ABOVE. THIS RULE IS ONLY IN PLACE FOR RARE CIRCUMSTANCES AND REFLECTS ABSOLUTE MINIMUMS.

6.2 Academic Sessions

Week 1 - Monday (3:00 – 4:30 pm)

Orientation and Health Screening – Zoom Video Conferencing

Orientation (3:00 – 3:30 pm)

Health Screening (3:30 – 4:30 pm)

Week 3 - Thursday (9:00 am – 4:30 pm)

Academic Day - in person at the Health Sciences Centre

- Multimorbidity session (9:00 – 10:00 am)
Break (10:00 – 10:15 am)
- PCCP Presentation (10:15 am – 12:15 pm)
- Planetary Health workshop (1:00 – 4:30 pm)

6.3 Patient-Centered Care Project (PCCP)

The purpose of this project is to apply patient-centred care to a patient with an unresolved health challenge (a question, concern, or issue) that requires a decision. The steps clerks will need to complete include:

- 1) Read the following article on shared-decision making:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445676/pdf/11606_2012_Article_2077.pdf

- 2) Identify a patient with a “Health Challenge” (**tip – try to do this early, during week 1 if possible)
 - a. disease screening questions: Should this person have apo-lipoproteins measured to determine her heart disease risk?
 - b. diagnostic work-up question: Will this x-ray help sort out this individual's particular back pain issue?
 - c. management question: Which medication might be best for this person to take to decrease their transmission of genital herpes to their new partner?
 - d. societal question: How is access to care impacting my patient and can I advocate for a change (such as gender reassignment surgery)?
- 3) Inform their patient that they need to do some homework/research and would like to follow-up with them virtually in one week to discuss the challenge further (ensure appropriate with your patient and preceptor)
- 4) Create a well-designed clinical question:
 - a. Is it a general knowledge question (about the forest) or specific (about the trees)? Specific questions are preferred (see below). The clerk is expected to understand the ‘general’ information on the subject, and this project is a chance to go deeper and tailor the question to their patient’s needs. General knowledge questions are only acceptable if the patient question is unique and therefore after developing a PICO statement and doing preliminary research the clerk becomes aware that there is very limited research in the field and must adapt their search or question.
 - b. Most projects should result in a specific question, they then develop a PICO statement:
 - i. **P = Population/Patient/Problem** - How would I describe the problem, or a group of patients like mine?
 - ii. **I = Intervention** - What main intervention, prognostic factor or exposure am I considering?
 - iii. **C = Comparison** - Is there an alternative to compare with the intervention?
 - iv. **O = Outcome** - What do I hope to accomplish, measure, improve or affect?
- 5) Complete a critical appraisal of the literature found during their search.
- 6) *Bring it all together for the patient, and with the patient.* Complete the follow-up visit and come to a shared decision.
- 7) Create their presentation - 10 minutes maximum.
- 8) Present their PCCP to you (their preceptor) and get your feedback (formative feedback). **This feedback is essential:** *Is their project based on an actual patient? Have they engaged the patient? Did they develop a good PICO statement? Did they complete a robust search? Did they evaluate the literature, and have they demonstrated that as part of their presentation?* The feedback form must be signed and handed in to the clerkship coordinator.
- 9) Give a presentation on the Patient-centered Care Project on Academic Day. This is a 10-minute presentation with 5 minutes for questions. They will present their project to a small group of their peers and an evaluator will provide a summative (final) assessment. This summative assessment must receive a ‘pass’.

By the end of this project, clerks will have:

- Carried out an in-depth study of an identified health challenge for a **specific patient**.
- Gone beyond a strictly biomedical approach to the 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 they went through in coming to a “common ground” with the patient that balanced the evidence of the recommendation/intervention, the dialogue that occurred between the clerk, their preceptor, and the patient, and how the patient’s values and wishes were incorporated into the decision.

Further details regarding this project, including the marking scheme, are in the appendix.

Clerks are being encouraged to consider submitting an abstract for their PCCP projects to two family medicine conferences: Distributed Learning and Rural Initiative’s Cabin Fever conference held in Kananaskis in February each year, and the Alberta College of Family Physicians Family Medicine Summit held in Banff in March each year. **Preceptors can be included as co-authors, so please discuss with your clerk if this is of interest to you.**

6.4 Planetary Health Workshop

A workshop exploring planetary health and the role of family physicians. An introduction to planetary health concepts followed by a flipped-classroom educational approach to collaboratively tackle planetary health challenges. Working in small teams, clerks will identify educational and actionable points for change relating to their challenge.

Teams will address challenges wearing three unique physician lenses:

1. *The physician visit with individual patients* (exploring concepts such as the benefits of plant-based diets or specific inhaler recommendations);
 2. *Clinic owners or community leaders* (exploring concepts of sustainable practices, eco-anxiety, and advocacy);
 3. *Medical educators* (exploring best practices, competencies, and collaboration).
- Clerks will learn about COM-B theory of behaviour change (Michie) and apply this to their educational and actionable points.

Learning objectives include summarizing the climate crisis in the context of planetary health and the medical system’s contributory role; obtaining foundational knowledge in planetary health including seminal resources and basics in carbon footprinting; understanding the COM-B framework in order to apply it to the planetary health challenges and describing and counselling patients about ‘co-benefits’: management actions that benefit both the patient and the planet.

6.5 Sample Timeline

The is a sample timeline clerks receive in the Core Document. It has all the important rotation elements for which clerks are responsible.

WEEK 1			
<input type="checkbox"/> Clinic introduction and initial orientation.			
<input type="checkbox"/> Academic Session: Orientation + Health Screening – Zoom - Monday 3:00 - 4:30 pm. Mandatory attendance.			
<input type="checkbox"/> Discuss and review with your preceptor:			
a) clinical expectations	b) Clerkship Clinical Skills course - time away (if required)	c) If necessary, time away to write the ICE (Integrative Clerkship Exams) *	d) time away for Academic Day.
<input type="checkbox"/> MITER: Arrange time with your preceptor for the mid-point review.			
<input type="checkbox"/> PCCP: Watch for an appropriate patient for the PCCP. Email PCCP topic to famclerk@ucalgary.ca by 4 pm Friday.			
<input type="checkbox"/> Clinical Calendar: Email projected half-day totals to famclerk@ucalgary.ca by 4 pm Friday.			
<input type="checkbox"/> Logbook: Start recording clinical presentations and procedural skills you see.			
WEEK 2			
<input type="checkbox"/> PCCP: Start your PCCP project!			
<input type="checkbox"/> MITER: Mid-point review with preceptor.			
WEEK 3			
<input type="checkbox"/> PCCP: Present and ask preceptor to complete the Evaluation Form (Appendix D).			
<input type="checkbox"/> PCCP: Email final PCCP to famclerk@ucalgary.ca by 1:00 pm on Wednesday.			
<input type="checkbox"/> Academic Day – Health Sciences Centre – Thursday 9:00 am - 4:30 pm. Mandatory attendance.			
<input type="checkbox"/> PCCP: Hand the PCCP Evaluation Form (completed by preceptor) to the Evaluator. Evaluators may complete online			
<input type="checkbox"/> ITER: Schedule time with preceptor for the final review.			
WEEK 4			
<input type="checkbox"/> ITER: Final review with preceptor.			
<input type="checkbox"/> Clinical Calendar: Email signed Calendar to famclerk@ucalgary.ca by 4 pm on Wednesday.			
2nd FM Block			
<input type="checkbox"/> Logbook: Complete by 5:00 pm Sunday. (Final Sunday of the rotation).			

* The content of this Family Medicine clerkship rotation is a significant part of the Integrative Clerkship Exams.

7. 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. Clerks on 'evening' call must be sent home by 2300h at the latest. Please refer to the [Clerkship Work Hours Policy](#) in the Clerkship Handbook.

8. EXAMS

Students will be evaluated with periodic multiple-choice exams that evaluate content knowledge across all clerkship rotations. Students will be expected to complete these evaluations successfully to graduate from the MD program. Further details regarding these evaluations can be found in the Clerkship Handbook (<https://cumming.ucalgary.ca/mdprogram/current-students/clerkship/student-handbook>).

A formative exam is part of the Family Medicine Clerkship Rotation. It aims to expose students to FM core objectives and assist them with learning and reviewing the FM content. Questions in the FM formative exam are of a similar format and content to the Mandatory Integrative Summative Clerkship Exams, and we encourage clerks to access the Formative FM Clerkship exam questions at <https://cards.ucalgary.ca/> on their own time.

Below are the dates for clerkship exams for class of 2026.

All clerks are expected to participate in clinic duties during the "am" (morning) of examination days. Clerks will be excused from the clinic in the afternoon to allow time to travel to and complete the exams. To ensure sufficient travel time to the examination site, clerks will be excused from clinical duties no later than:

- 1 hour prior to the examination, if the examination is at Foothills Medical Centre (FMC) or Alberta Children's Hospital (ACH).
- 2 hours prior to the examination, if the examination is at Rockyview General Hospital (RGH), Peter Lougheed Centre (PLC), South Health Campus (SHC), or other community sites within Calgary.

No call or shift work should be performed by the clerk the evening prior to an examination. All clinical duties should conclude by 5:00 PM the day before the examination.

If clerks are in the rural Family Medicine rotation, travel arrangements will vary based on the distance to the examination site. We advise the following:

- Travel time of < 3 hours: Travel to Calgary should commence no later than 1700h (5:00 PM) the day before the examination.
- Travel time of 3-5 hours: Travel to Calgary should commence no later than 1200h (12:00 PM) the day before the examination. An alternative option is to defer the examination (note the Deferral dates below).
- Travel time of > 5 hours: Deferral of the examination is strongly advised. Students should choose a deferral date for when they are rotating within Calgary and submit a deferral form to the Assistant Dean UME (kdbusche@ucalgary.ca) ume.exams@ucalgary.ca, indicating that they are on a rural rotation located more than 5 hours from Calgary.

	Class date	Deferral Date
Exam #1 – A (formative)	Jun 20/25 (3B)	Jul 18/25 (4B)
Exam #1 – B (formative)	Jun 27/25 (4A)	Jul 25/25 (5A)
Exam #2 – A (summative)	Oct 10/25 (7B)	Nov 14/25 (8B)
Exam #2 – B (summative)	Oct 24/25 (8A)	Dec 12/25 (9B)
Exam #3 – A (summative)	Feb 27/26 (10B)	Mar 27/26 (11B)

Exam #3 – B (summative)	Mar 13/26 (11A)	Apr 17/26 (12B)
----------------------------	--------------------	-----------------

9. LOGBOOK

Clerks have a logbook of clinical encounters they must complete. The logbooks will be assessed for completion at the end of their 2nd FM block only.

Clerks are required to log when they have completed all the listed clinical presentations and tasks. Please note that there are some clinical presentations that they will likely not see during their rotation as they are rare. The points of listing (and logging) them is to ensure that they read about these and/or discussed them with you, their preceptor. If they do not manage to see a case in relation to one of the problems listed, they can review the virtual patients on LearnFM. Once they have read around the topic and/or discussed this with you, they may log this as completed. Furthermore, if they have had that experience in another rotation then they may check off the activity.

The logbook MUST be completed by the end of day on the Wednesday of the week of the summative

e

Clinical Presentation / Objectives

1.	Abdominal pain
2.	Advanced Care Planning/Goals of Care video
3.	Blood pressure abnormal, hypertension
4.	Checkup
5.	Chest discomfort
6.	Contraception
7.	Cough, cough and/or abnormal x-ray
8.	Diabetes type II
9.	Diarrhea
10.	Dizziness/vertigo
11.	Ear pain
12.	Elderly – risk assessment
13.	Fatigue
14.	Headache
15.	Ischemic heart disease
16.	Joint pain
17.	Mood disorders, major depression, Adjust., Bipolar
18.	Obesity
19.	Pain - back
20.	Panic and anxiety
21.	Prenatal care
22.	Respiratory – upper - URTI
23.	Skin disorders
24.	Temperature abnormal/fever/chills
25.	Urinary frequency
26.	Vaginal discharge/STD
27.	Well-baby care
28.	Wheezing/respiratory difficulty/asthma

Procedures/Tasks

1.	Advanced Care Planning/Goals of Care discussion
2.	Blood glucose/glucometer
3.	Cryotherapy
4.	Intramuscular injections
5.	Joint injection (can be aspiration or injection)
6.	Papanicolaou smear
7.	Skin biopsy
8.	Syringe auditory canal
9.	Throat swab
10.	Urinalysis
11.	Vaginal smears/swab
12.	Wound swab
13.	Observed history
14.	Observed physical
15.	Complete the LearnFM Cards (cards.ucalgary.ca)
16.	Discuss “co-benefits” with a patient or preceptor (Planetary Health curriculum)

10. TEACHING RESOURCES FOR PRECEPTORS

The following are various resources and suggestions that will help you advance your skills as a preceptor. Please always feel free to reach out to the DFM if you are encountering any issues.

10.1 Professional Development Sources

The following are faculty development resources for teachers of medicine:

- Department of Family Medicine preceptor faculty development: Cabin Fever, Summer Spark, and Fall Together. You will receive email notifications of these events.
- TeachingPhysician.org: online resource. Get free access through our department (just email fmcpd@ucalgary.ca for access). Please let us know if you are not receiving these. This is an excellent resource of bit-size information that can help teachers expand their knowledge base and skill set.
- Office of Faculty Development: <https://cumming.ucalgary.ca/office/ofd> has free classes/ workshops for teachers, and some offer MainPro+ credits for attendance.
- Office of Faculty Development and Performance: [Learning and Instructional Design](#)
- National Conferences:
 - Family Medicine Forum (FMF)
 - Canadian Conference on Medical Education (CCME)
 - Society of Teachers of Family Medicine (STFM) – USA

10.2 Feedback

Giving Constructive Feedback

- Feedback should always include a suggestion for change – not just what was wrong but how things could have been managed differently.
- The sooner that feedback is given after the event, the better
- Provide feedback when there are clear indications that the receiver will be receptive.
- Give a clear report of specific facts, rather than generalities, assumptions, or value judgements.
- Be descriptive rather than judgmental – rather than stating that something went well or poorly, describe the behavior that made it go well or poorly.
- Discuss strengths first (prompts a safer, more supportive environment)
- Criticize the behavior not the individual.
- Encourage the speaker to be part of the discussion: let the receiver speak first as they often are realistic about their performance; show empathy and ask probing questions for their thoughts.
- Be sensitive to the person and be aware of any potential misunderstandings (particularly important if English is not the receiver's first language)
- Be specific and helpful in comments.
- Provide feedback about things that can be changed; be constructive by showing that the problem exists and encourage suggestions of improvements.
- Give the receiver time to digest the feedback rather than overwhelming them with discussion about multiple behaviors you would like to see changed.
- An excellent resource if there are **professionalism** concerns: [CFPC Recognizing Professionalism in Family Medicine](#).
- University of Calgary PGME: Feedback – [Helpful Hints for Medical Education](#)

Orsini C. et al. Common models and approaches for the clinical educator to plan effective feedback encounters. J Educ Eval Health Prof. 2022;19:35.

<https://doi.org/10.3352/jeehp.2022.19.35>

Receiving Feedback

- Look at feedback as an important part of development and an opportunity to learn and/or improve your skills.
- When receiving feedback, whether criticism or praise, do not let your feelings get in the way of what is being offered.
- Avoid interrupting with explanations or defense; listen to the feedback rather than immediately rejecting it or arguing with the giver.
- Pay attention to what is being said and ask for clarification so that you can be clear about the feedback; paraphrase what you have heard to ensure you understand.
- If the feedback is vague or generalized, ask the giver for specifics.
- Ask the giver for suggestions on what can be changed.
- Ask for feedback you want but didn't get.
- Reflect on the feedback and what you will incorporate into future actions.

10.3 Slow Clinic/Low Patient Volume - Strategies for Teaching

- Things to consider on slow days:
 - Complete other patient encounters with other preceptors in the office and allied health professionals
 - Pursue learning opportunities with support staff such as nurses, MOAs, or billing staff.
 - Review any of the following:
 - Learning objectives from Core Document
 - Cases from logbook
 - 99 Key Features - CFPC
 - Guidelines Review e.g., TOP, Canadian, NICE, etc.
 - Approach to PHE and Screening
 - Approach to Well Baby/Child Visit and Rourke Baby Guide
 - Immunizations Schedules
 - Therapeutics / Rx Files
 - Case Review / Reflection on Previous Case and Learning
 - Treatment Algorithms e.g., GI Pathway
 - Literature Review of Clinical Question
 - PBSG Cases
 - MSK Cases and MSK Exam
 - Task Review/Task Box/Annotate Results and Consults
 - INRs
 - X-rays Online
 - Suturing and Knot Tying (we have models in the procedure room)
 - Procedures (online resources, textbooks in procedure room)
 - Review Emergency Cart
 - Clinic Emergency Procedures
 - Slit Lamp
 - EKG Machine
 - Tympanometer
 - Other options:
 - Clerkship Project/Scholarship Project

- Review CanMEDS and Skill Dimensions (Assessment)
- Have one learner watch the other on computer and provide feedback.
- Have one learner review the other's note and provide feedback if note prepares them for the follow up visit.

10.4 Patient Presentations

Patient presentations can take up a lot of time when working with learners. When you are comfortable with your learner, there are several techniques that make these presentations more efficient and educational. "SNAPSPS" and "One-Minute Preceptor" are patient presentation techniques for learners that are useful for "teaching on the fly", making efficient use of limited time.

When encouraging learners to use "**SNAPSPS**", the following outline for patient presentations is followed. Students are encouraged to:

S – Summarize – *Briefly – history and findings*

N – Narrow the differential – *2 or 3 relevant possibilities*

A - Analyze the differential – *compare and contrast the possibilities*

P – Probe the preceptor – *ask about any uncertainties, difficulties or alternative approach*

P - Plan management

S - Select for self-directed learning – *not every case, be selective*

An educational video about using SNAPSPS is available at

<https://www.youtube.com/watch?v=cEZOjSyPhZ0>

The "**One-minute Preceptor**" approach follows the model below:

1. Get a commitment - What is going on with the patient? What do you want to do?
2. Probe for underlying reasoning/supportive evidence - Differential?
3. Provide positive feedback (what did they do right?)
4. Teach general rules - Key features are... In this type of situation...
5. Correct mistakes - *Next time try...*

An educational video about using One-minute Preceptor is available at

<https://www.youtube.com/watch?v=a3qiyniSaNg>

10.5 RIME Guide

The RIME Framework provides terminology for describing the professional growth of medical students. Essentially it describes a maturity that occurs as students develop to become both more competent and confident in their professional role. They move from the role of "reporter" to "interpreter" to "manager" and eventually "educator".

This guide can be very useful when providing feedback and goal setting for learners. It is also useful in final evaluations. Further description of the guide can be found at:

https://fid.medicine.arizona.edu/sites/default/files/u4/rae-2017_rime-kse.pdf

11. AWARDS

There are multiple awards for undergraduate students in Family Medicine. **If you encounter a learner that you feel is deserving, please strongly encourage them to consider applying for the following 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/awards/>
- 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/awards/>

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 a financial award to a medical student who has completed their clerkship Family Medicine rotations and 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 rotations 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 provides funds for selected third-year medical students from the University of Alberta and the University of Calgary who demonstrate a strong interest in developing a career in rural medicine. For more information please visit: <https://www.albertadoctors.org/about/awards/tarrant>

12. CONFERENCE ABSTRACTS AND PRESENTATIONS CLERKS CAN APPLY FOR!

Consider sharing your hard work and knowledge:

The DLRI (Distributed Learning and Rural Initiatives) Cabin Fever conference and ACFP (Alberta College of Family Physicians) Family Medicine Summit are great opportunities for clerks to submit an abstract to present their family medicine projects: PCCP and SNAPS. A preceptor can also be a co-author on a submission.

Cabin Fever is held the first weekend in February. Family Medicine Summit is the first weekend in March. Abstracts for both conferences are usually due in November.

For information on how to present a SNAPS infographic at Cabin Fever, clerks can email Distributed & Learning Initiatives at dlri@ucalgary.ca.

Clerks should also watch the Undergraduate Family Medicine notice board for dates or email ugfm@ucalgary.ca for information.

Please let us know at ugfm@ucalgary.ca if you do submit to either conference.

We would also like to display PCCP/SNAPS infographics on the Undergraduate notice board (opposite the medical bookstore). We will select random projects. Clerks must email famclerk@ucalgary.ca if they do not want their work to be displayed. When creating a SNAPS/PCCP, please consider its poster quality and pay attention to correct citing of information and any photos and images.



APPENDICES

A. CanMEDS Roles

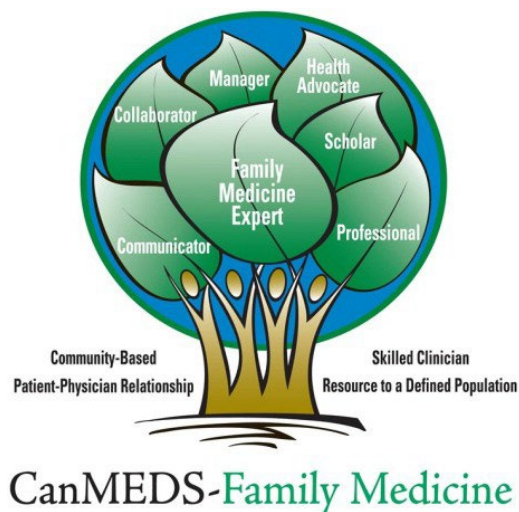


Image adapted from the CanMEDS Physician Competency Diagram with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2009.

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)

1. Complete every box: AM, PM, and EVE. All time must be accounted for (clinic, hospital, off, flex day, appointment, sick, Clerkship Clinical Skills session, SNAPS preparation, etc.). A half-day clinic = 4 to 5 hours. Minimum half days for rotation (for exceptional circumstances only) = 30.
2. Completed **unsigned** (proposed) calendar emailed to famclerk@ucalgary.ca by **4pm on Friday of week 1. This does not need preceptor signature.**
3. Completed **signed** (final) calendar emailed to famclerk@ucalgary.ca by **4pm on Wednesday of week 4. Every week signed by your preceptor.** Failure to complete this request will result in a mark of satisfactory with performance deficiency.

STUDENT NAME:										
		Orientation 8-9 AM	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	CLINIC 1/2 DAYS
	Week 1	AM								
		PM								
		EVE								
Preceptor Signature:										
	Week 2	AM								
		PM				SNAPS #1				
		EVE								
Preceptor Signature:										
	Week 3	AM								
		PM				SNAPS #2				
		EVE								
Preceptor Signature:										
	Week 4	AM								
		PM								
		EVE								
Preceptor Signature:										
										Total

Orientation: 8-9 AM on Zoom.

SNAPS #1 and SNAPS #2: 12-1 PM on Zoom

c. Clinical Calendar (Urban)

1. Complete every box: AM, PM, and EVE. All time must be accounted for (clinic, hospital, off, flex day, appointment, sick, Clerkship Clinical Skills session, PCCP preparation, etc.). A half-day clinic = 4 to 5 hours. Minimum half days for rotation (for exceptional circumstances only) = 30.
2. Completed **unsigned** (proposed) calendar emailed to famclerk@ucalgary.ca by **4pm on Friday of week 1. This does not need preceptor signature.**
3. Completed **signed** (final) calendar emailed to famclerk@ucalgary.ca by **4pm on Wednesday of week 4. Every week signed by your preceptor.**

STUDENT NAME:											
		Orientation 3:00-4:30 PM	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY		SATURDAY	SUNDAY	CLINIC 1/2 DAYS
	Week 1	AM									
		PM									
		EVE									
Preceptor Signature:											
	Week 2	AM									
		PM									
		EVE									
Preceptor Signature:											
	Week 3	AM									
		PM									
		EVE									
Preceptor Signature:											
	Week 4	AM									
		PM									
		EVE									
Preceptor Signature:											
										Total	

Orientation: 3:00-4:30 PM on Zoom.

Academic Day - in person - Health Sciences Centre: 9:00 AM - 4:30 PM

D. Patient-Centred Care Project

(Instructions for clerks taken from the FM Clerkship Core Document)

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 (Thursday of Week 3), 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: [Shared Decision Making: A Model for Clinical Practice.](#)

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 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 27 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 8-10 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 considering 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 must 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 the 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 on, 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. 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 the patient 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 PCCP presentation that you will give to your peers and an evaluator during the morning of the Thursday of 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 Thursday of Week 3 (your preceptor will need to complete a formative evaluation form).

✓**Tip:** Review the components of the evaluation form (Appendix E)

EMAIL the PCCP to famclerk@ucalgary.ca before the Family Medicine Clerkship Academic Day. To ensure clerks 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 1.

HAND IN the PCCP Evaluation (completed by your preceptor) to the evaluator on Family Medicine Clerkship 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.

E. Evaluation Form for Patient-Centered Care Project

Name: _____

Project Title: _____

Introduction	Poor <input type="checkbox"/>	Borderline <input type="checkbox"/>	Good <input type="checkbox"/>	Very Good <input type="checkbox"/>
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.				
<i>Poor</i> – title unclear, we don't understand why you chose this topic, problem unclear, context not explored, title confusing <i>Very Good</i> – 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 <input type="checkbox"/>	Borderline <input type="checkbox"/>	Good <input type="checkbox"/>	Very Good <input type="checkbox"/>
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.				
<i>Poor</i> – minimal or no explanation of search strategy or inappropriate strategy; cursory or no appraisal of the literature <i>Very Good</i> – 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 <input type="checkbox"/>	Borderline <input type="checkbox"/>	Good <input type="checkbox"/>	Very Good <input type="checkbox"/>
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.				
<i>Poor</i> – cursory or no explanation of why certain articles were chosen for inclusion. No mention of applicability to family medicine. <i>Very Good</i> – 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 <input type="checkbox"/>	Borderline <input type="checkbox"/>	Good <input type="checkbox"/>	Very Good <input type="checkbox"/>
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.				
<i>Poor</i> – 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 <input type="checkbox"/>	Borderline <input type="checkbox"/>	Good <input type="checkbox"/>	Very Good <input type="checkbox"/>
The student demonstrates appropriate presentation skills including time management, organization, and delivery (vocal pace and volume, slide preparation/clarity).				
<p><i>Poor</i> – 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.</p> <p><i>Very Good</i> – 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.</p>				

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:

F. SNAPS Presentations

(Instructions for clerks taken from the FM Clerkship Core Document)

During the 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 clerks 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 clerks on rotation.

For these sessions, you will choose a core topic from the 27 Clinical Presentations (EXCLUDING Periodic Health Exam) (Appendix I). **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 (Appendix I).** These sessions are intended to support the studying of your colleagues. An example of a SNAPS would be a 10-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. Clerks will be randomly assigned to each session.

You must submit your SNAPS topic 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 SNAPS.

The SNAPS 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 8 minutes, followed by 2 minutes for questions. This will challenge you to present the most important elements.

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 SNAPS 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 clerks on the rotation for use as study aids.

G. Infographic Example

CONSIDERATIONS WHEN YOU'VE MADE THE DECISION TO USE...

HORMONES IN MENOPAUSE

Sonja Wicklum MD CCFP FCFP

CHOOSE THE MODALITY

Vaginal - for vulvovaginal atrophy
Topical/Oral - for other postmenopausal symptoms

Hot flashes, night sweats, and mood disorders often require higher doses of estrogen delivered through a gel, patch or oral pill. There is a slightly lower risk of VTE with transdermal over oral administration (1).

ANSWER - DO WE NEED TO PROTECT THE UTERUS?

HRT can cause endometrial cancer.

Except for low-dose, intravaginal HRT you must protect the uterus by administering progesterone at the same time (1).

CHOOSE THE DOSE

Start low, use for as short a period as possible

Options: Vaginally: cream, tablet or ring e.g. estrin - changed q3months, vagifem 10 mg twice weekly
Transdermal: patches e.g. Estradot 0.025 2/week, gel e.g. EstroGel 1 pump (75ug estrace) QD.
Oral: premarin 0.3 - 0.625mg QD
Add progesterone if needed; e.g. prometrium 100mg QD.
If progesterone not tolerated consider estrogen plus bazedofexifene (SERM). (1,2,3)

DISCUSS THE RISKS

Stroke, MI, blood clots, gallbladder disease, invasive breast cancer

Combined estrogen/progesterone therapy increases risk of breast cancer when used for 5-5 years.

Contraindications to estrogen therapy: undiagnosed vaginal bleeding, history of breast cancer, VTE or severe liver disease (1,3).

CONSIDER ALTERNATIVES

Non-hormonal

Evidence based non-hormonal treatments for hot flashes include paroxetine, venlafaxine, gabapentin, soy products (some evidence to suggest it can help with vaginal dryness too), and clinical hypnosis. For vaginal dryness consider vaginal moisturizers and lubricants, and oral ospemifene (1,2,3).

REFERENCES:

1. HILL DA, CRIDER M, HILL SR. HORMONE THERAPY AND OTHER TREATMENTS FOR SYMPTOMS OF MENOPAUSE. AM FAM PHYSICIAN 2016, DEC 1, 94(11), 224-229.
2. [HTTPS://WWW.MENOPAUSE.ORG/DOCS/DEFAULT-SOURCE/PROFESSIONAL/NAMS-HY-TABLES.PDF](https://www.menopause.org/docs/default-source/professional/nams-hy-tables.pdf)
3. UPTODATE (R)

H. Supplemental Learning Resources

(Information for clerks taken from the FM Clerkship Core Document)

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 clerks 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)

I. Learning Objectives and 27 Clinical Presentations

(Information for clerks taken from the Clerkship Core Document)

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 27 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 Clerkship Clinical Skills.

Key features for each presentation are available via [LearnFM](#) and the '27 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

Fever
 Headache
 Cough; URI; Earache
 Abdominal pain; Diarrhea
 Back pain; Joint pain
 UTI/discharge
 Skin disorders

Stages of Life

Well baby
 Contraception
 Prenatal care
 Check-up – age appropriate
 Fail elderly

Chronic Disease

Hypertension
 Ischemic heart disease
 Diabetes
 Obesity
 Asthma
 Fatigue
 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

- i. 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

- ii. 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, consider 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 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 to rule out serious causes of dizziness, including assessment of orthostatic blood pressure, cerebellar & cranial nerve function, precordium, and cardiac rhythm.
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 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, to:
 - a. Make a determination as to whether a patient truly 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 headaches 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 hyperlipidemia 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. Uncomplicated 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.

27. Planetary Health

1. Summarize the climate crisis in the context of planetary health and the medical system's contributory role
2. Obtain foundational knowledge in planetary health including seminal resources and basics in carbon footprinting
3. Understand the COM-B framework in order to apply it to the planetary health challenges
4. Describe and counsel patients about 'co-benefits': management actions that benefit both the patient and the planet.

J. The Big 10 Educational Objectives

<https://cumming.ucalgary.ca/mdprogram/about/objectives-competencies#big-10>

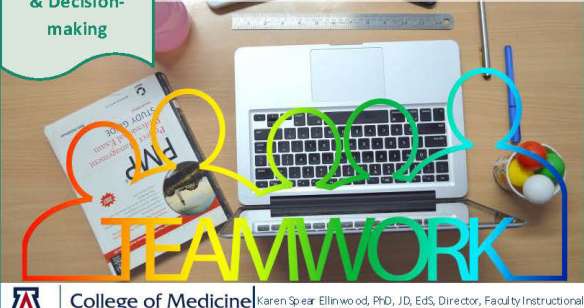

A student at the time of graduation will be able to:

1. 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.
2. Evaluate patients and properly manage their medical problems by:
 - Conducting a comprehensive medical history and thorough physical examination; reliably eliciting appropriate information in the history and detecting abnormal findings on the physical examination.
 - Correctly identifying the patient's diagnosis, differential diagnosis, and medical problems.
 - Applying an appropriate clinical reasoning process to the patient's problems.
 - Advocating for patients while formulating and implementing a resource-conscious management plan to deal effectively with patient problems.
 - 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.

K. RIME Guide

<p>REPORTER</p> <p>"Students must: (1) take ownership of the fact about their patients and accurately and independently gather information; (2) use appropriate terminology to clearly communicate their findings, both orally and in writing; (3) interact professionally with patients and staff; and (4) consistently and reliably carry out their responsibilities" (ACE 2015, 86).</p> <p>FOCUS → What, When, & Where</p>	<p>INTERPRETER</p> <p>"Students must: (1) take ownership of explaining their patients' findings, (2) demonstrate ability to identify and prioritize problems independently, and (3) offer ... reasonable explanations for new problems, generating and defending differential diagnoses" (ACE 2015, 86).</p> <p>FOCUS → Why</p>
<p>Attentive Fact Gathering & Reporting</p> <p>Encourage effective questioning & attentive fact gathering</p> 	<p>Insightful Data Interpretation & Knowledge Application</p> <p>Encourage critical analysis & creative problem-solving</p> 

Alliance for Clinical Education. Handbook on Medical Student Evaluation and Assessment. Pangaro LN & McGaghie WC (Eds.). Gegensatz Press: North Syracuse, NY; 2015.

<p>MANAGER</p> <p>"Students must be more 'proactive', taking ownership of solving their patient's problems, suggesting diagnostic and therapeutic plans that include reasonable diagnostic options and possible therapies. This level takes even greater knowledge, more confidence, and the skill to select interventions for an individual patient," moving toward patient-centered care and an understanding of how to engage in shared decision-making (ACE 2015, 86).</p> <p>FOCUS → How & What If</p>	<p>EDUCATOR</p> <p>"Students take ownership for getting to a higher level of expertise, and must identify questions related to their patients that cannot be answered from textbooks; they cite evidence that new or alternative therapies or tests are worthwhile, [and demonstrate] desire and ability to educate one's self and others ... and most importantly, to help the patient" (ACE 2015, 86).</p> <p>FOCUS → How, Why & What Next</p>
<p>Proactive Problem-solving & Decision-making</p> <p>Encourage engagement in decision-making & creative problem-solving</p> 	<p>Effective Self, Peer & Patient Education</p> <p>Encourage self-directed learning, patient education & action on constructive feedback</p> 

College of Medicine Tucson | Karen Spear-Ellinwood, PhD, JD, EdS, Director, Faculty Instructional Development
Resident as Educators Program | kse@med.admin.arizona.edu | 520.626.1743

Reference:

Alliance for Clinical Education. Handbook on Medical Student Evaluation and Assessment. Pangaro LN, McGaghie WC (Eds.). Gegensatz Press; North Syracuse, NY: 2015.

Content cannot be disseminated or distributed further without permission.

L. Learning Objectives Overview

Objective	Example	Sample Learning activity	Evaluated by
<u>CANMEDs Role: Expert</u> <u>CSM Big 10:</u> 1, 2, 3	<ul style="list-style-type: none"> Assess and generate an <i>appropriate</i> differential diagnosis in a patient presenting with a <i>new undifferentiated</i> 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 lifecycle 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
<u>CANMEDs Role: Manager</u> <u>CSM Big 10:</u> 1, 2, 3, 4, 5	Design a <i>comprehensive care plan</i> 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)
<u>CANMEDs Role: Communicator</u> <u>CSM Big 10:</u> 2,5,6	<ul style="list-style-type: none"> 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 <i>succinct</i> 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)
<u>CANMEDs Role: Advocate</u> <u>CSM Big 10: 2,3,4,6</u>	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)
<u>CANMEDs Role: Scholar</u> <u>CSM Big 10:</u> 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)
<u>CANMEDs Role: Collaborator</u> <u>CSM Big 10: 2,5</u>	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)
<u>CANMEDs Role: Professional</u> <u>CSM Big 10:</u> 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)

M. Twelve Points to Consider When Talking to a Medical Student

Available at: [Twelve Points to Consider When Talking to a Medical Student About a Career in Family Medicine \(cfpc.ca\)](https://www.cfpc.ca/twelve-points-to-consider-when-talking-to-a-medical-student-about-a-career-in-family-medicine)

BACKGROUND

The Undergraduate Education Committee (UGEC) of the College of Family Physicians of Canada (CFPC) has been exploring medical students' perceptions of family medicine and the messages they receive about our discipline. A striking trend that has been noticed is that medical students ask questions about "plus one" years of enhanced skills training even before they have been exposed to family medicine.

UGEC worked with the Section of Medical Students (SOMS), Section of Residents (SoR), and First Five Years in Family Practice (FFYP) Committee to disseminate surveys to students in 2016 and to residents and physicians in their first five years of practice in 2017. UGEC members also conducted two focus group-style workshops at Family Medicine Forum in 2016 and 2017 to inform their understanding of the issue and to generate solutions. Next steps include collaborating with the CFPC's Marketing and Membership Services Department to inform its branding strategy directed toward medical students.

While the strategy is being developed, this document outlines what family medicine educators and preceptors may want to consider when discussing a career in family medicine with a medical student. The College's Family Medicine Professional Profile (available at www.cfpc.ca/fmprofile) provides additional information that can be used to supplement these discussions.

The bottom line: We want to highlight the benefits of family medicine, dispel the myths, be honest about the challenges, and encourage medical students to reflect on whether family medicine is a good fit for them.

ACKNOWLEDGEMENTS

Dr. Kathleen Horrey and Dr. Amy Tan led this project on behalf of UGEC.

© 2019 The College of Family Physicians of Canada

All rights reserved. This material may be reproduced in full for educational, personal, and non-commercial use only, with attribution provided according to the citation information below. For all other uses permission must be acquired from the College of Family Physicians of Canada.

How to cite this document:


Horney K, Tan A. *Twelve Points to Consider When Talking to a Medical Student About a Career in Family Medicine*. Mississauga, ON: College of Family Physicians of Canada; 2019.



QUESTIONS?

Contact us at education@cfpc.ca.

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA







LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Twelve Points

to Consider When Talking to a Medical Student

About a Career in Family Medicine



12

TALKING POINTS

ABOUT A CAREER IN FAMILY MEDICINE

• 1 •

Emphasize that family medicine is a specialty.

In particular, explain that family physicians are skilled clinicians with generalist expertise. Family medicine is a career that is intellectually stimulating, challenging, and very rewarding. Talk about what a privilege it is to serve our patients and families. These meaningful longitudinal relationships enhance our own resiliency and well-being as physicians. It may be helpful to highlight the Four Principles of Family Medicine (www.cfpc.ca/Principles) as take-home points:

- » The family physician is a skilled clinician.
- » Family medicine is a community-based discipline.
- » The family physician is a resource to a defined practice population.
- » The patient-physician relationship is central to the role of the family physician.

• 2 •

Examine the notion of comprehensiveness with them and ask whether this seems overwhelming.

Explore embracing the mystery of the patient presentation and reject the perception of “knowing a little about a lot,” which devalues the intellectual rigour required for family medicine.

• 3 •

Discuss how we are trained to provide care that is community adaptive to meet local and emerging needs.

Medical students have a strong interest in social accountability. Build on this predisposition by exploring how family physicians working in comprehensive practices, practices with special interests, and focused practices all collectively meet the needs of our communities.

• 4 •

Point out that we do this work in teams, not in isolation.

We collaborate in teams with other family physicians and other health care providers, supporting each other in caring for patients.

• 5 •

Celebrate how family medicine offers variety and is never boring; each day brings new experiences.

Our work includes the comprehensive, continuous medical care of all people, ages, life stages, and presentations. It includes leadership, advocacy, scholarship, research, and quality improvement. As an example, if you are giving a lecture, teaching a small group session for medical students, or participating on a medical school committee (admissions, curriculum, etc.) alongside medical students, please be explicit that you are a family physician who has incorporated these roles as part of your work.

• 6 •

Describe how family medicine is the only medical specialty with such a diverse range of practice opportunities.

Emphasize **versatility** rather than the notion of flexibility, as the latter is interpreted by some as being centred on personal interests rather than community needs.

• 7 •

Highlight that family medicine is a career that adapts and grows with us.

We can tailor it to our stage of life and stage of practice, finding the best fit for us as individuals and the communities we serve.

• 8 •

Explain how this versatility allows us to strive to achieve work-life integration.

Avoid terms such as work-life balance, as medical students mistakenly perceive family medicine to be the “lifestyle” choice of specialties.

• 9 •

Dispel myths about “plus one” years of enhanced skills training.

Explore why students are asking about this. Some students have been misinformed and believe they require enhanced skills training to be able to provide palliative care, maternity care, urgent care, etc. to their patients as a family physician, even before they have been exposed to family medicine training. Other students find the thought of comprehensive practice overwhelming and want to be more focused; in this case, explore whether family medicine is the right fit/ route for them. We want to encourage students to select enhanced skills programs to meet community needs and to fulfill an interest to result in the best fit, not solely to fulfill personal interests. If they are selecting a specific area of medicine, is there a better route to that goal through the Royal College?

• 10 •

Ask whether they see family medicine as a “back-up” plan.

For some students it may be appropriate to select family medicine as one of their choices in CaRMS, but family medicine should not be considered a back-up for everyone. Encourage students to choose disciplines that they truly think would be a good fit for them and to rank them accordingly.

• 11 •

Address any fears they may have about the uncertainty of future practice conditions.

Talk openly about perceptions. The political climate and support for family medicine shift from time to time. If things look uncertain today, they will likely be better in the future. Acknowledge that there is uncertainty in all medical professions. However, there remains much more certainty regarding job opportunities in family medicine than in many other specialties.

• 12 •

Share stories about how patients appreciate your work.

Against the backdrop of systemic pressures on family physicians and the impression that that our profession is not valued, we may forget how much our patients appreciate our work and the importance patients place on the trusting relationship they have with us. Tell students how patients have demonstrated this to you.

N. Role Conflict: Physicians as Care Providers and Teachers

[Policy Information](#)



UNIVERSITY OF
CALGARY

CUMMING SCHOOL OF MEDICINE
UNDERGRADUATE MEDICAL EDUCATION

Role Conflict: Physicians as Care Providers and Teachers (MD PROGRAM)

Departmental Policy

Authorizing Unit Undergraduate Medical Education (UME) Management	<u>Table of Contents:</u> Purpose 1 Scope 2 Definitions 3 Policy Statement 4 Responsibilities 5 Procedures 6 History 7
Classification Operations	
Approval Authority Associate Dean, UME	
Implementation Authority Manager, Undergraduate Medical Education	
Effective Date May 1, 2015	
Last Revision November 2021	

- | | | |
|--------------------|----------|---|
| Purpose | 1 | Create a UME policy that specifies that providers of health and psychiatric/psychological services to a medical student will have no involvement in the academic assessment of or in decisions about the promotion of that student. |
| Scope | 2 | This policy applies to all students and preceptors in UME at the Cumming School of Medicine, University of Calgary. |
| Definitions | 3 | In this Policy
a. UME means the Undergraduate Medical Education program with the Cumming School of Medicine, University of Calgary.
b. "MD" means Doctor of Medicine.
c. Approval Authority means the office or officer responsible for approving Undergraduate Medical Education policy and procedures. |