



UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

Family Medicine Clerkship MDCN 502

PRECEPTOR MANUAL

****NEW for the Class of 2024****

We have highlighted and marked in red font important NEW elements and elements that need reinforcing.

UNDERGRADUATE MEDICAL EDUCATION
PRECEPTOR DOCUMENT
CLASS OF 2024

Academic Year: Feb 2023 – Apr 2024

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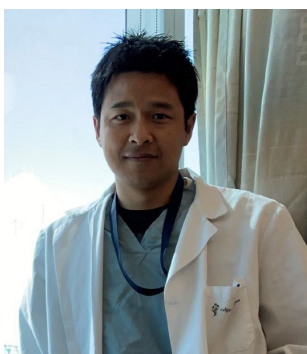
1. WELCOME TO FAMILY MEDICINE CLERKSHIP

For scheduling queries, please email famclerk@ucalgary.ca.
Present FM Clerkship Coordinator is JingChao Wang “Jing”. She replaced Nicolle Begert in January. She will be filling the role until approximately April 1.



Sonja Wicklum MD CCFP FCFP
Family Medicine Clerkship Director
sonja.wicklum@ucalgary.ca

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



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January, 2023

To Our Valued Family Medicine Preceptors,

First of all, thank you very much for your commitment to educating students in this unique environment. The Department of Family Medicine (DFM) greatly appreciates the time, effort, and attention you provide to learners. Because of you, we are able to successfully run the Family Medicine Clerkship Core rotations and expose undergraduate medical students to our amazing profession. We do not think you are thanked enough for what you do, so please accept our heartfelt gratitude!

Family Medicine rotations are constantly one of the most highly valued and positively reviewed rotations of the clerkship experience. This is all thanks to you! Having said that, we recognize that the past couple of years have been challenging (to say the least). We also acknowledge that asking for your time and expertise to teach our younger colleagues is a big ask. Within the DFM, we continue to advocate for our preceptors, and champion the incredible importance and value of generalists within the practice of medicine.

And we commit to continuing to do so.

We hope that you see the value of engaging with the “next generation”! The Family Medicine Core rotation is your opportunity to expose students to the challenges and joys of our specialty. The time spent with you can impact career decision making; let’s ensure our rotation is the best they experience in their final year of medical school.

Should you wish to, please do not hesitate to reach out to the DFM undergraduate team at any time.

Sincerely,

Sonja Wicklum
Family Medicine Clerkship Director

**Please meet the Bilbies!
Class of 2024**





2. FM 4 + 4

The Class of 2024 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 try 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. The clerks will engage you within the first two days 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 document 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, as do the written examination questions.

The clerks will write a formative examination at the end of their 1st 4-week block and a summative examination at the end of their 2nd 4-week block. They must pass the Final Exam and both Final ITERs; (Rural and Urban), along with meeting all of the requirements of the course in order to pass Family Medicine Clerkship.

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. Sonja Wicklum and Jimmy Vantanajal can be reached at any time if you have concerns about a clerk.

Formative Midpoint MCQ	Must Complete¹	1 st FM block
Formative Midpoint Preceptor ITER	Must Complete³	Both blocks
Logbook	Must Complete¹	2 nd FM block
Final Written MCQ (Summative)	Must Pass²	2 nd FM block
Satisfactory Final Preceptor ITER	Must Pass²	Both blocks
Patient-centered Care Project	Must Pass²	Urban FM block
SNAP presentation	Must Complete¹	Rural FM block
Professionalism Expectation	Must Pass²	Both blocks
Clinical Expectations	Must Complete³	Both blocks
Attendance and participation in teaching sessions	Must Complete³	Both blocks
Meet all expectations outlined in Core Document	Must Complete³	Both blocks

¹ **Must complete before rotation deadline (failure to do so will result in requirement to defer summative examination to the deferral/rewrite date).**

² **Must pass (failure to do so will result in an overall evaluation of "Unsatisfactory" for the rotation)**

³ **Must complete (failure to do so will result in an overall evaluation of "Satisfactory with Performance Deficiency" 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. Unique to family medicine is the challenge of dealing with **the undifferentiated patient**, someone with an issue or symptom, for which the diagnosis is not clear. 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 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.

4. SUPERVISION AND ASSESSMENTS

4.1 Supervision

As clerkship students are medical students, **the attending physician must directly see each and every patient.** Students must be appropriately supervised, but it is expected that students will be able to progress to a point where the student can take an initial history and physical examination on his/her 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 students 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.**

If possible, please facilitate your clerk's participation in any activity to which you are involved within your role as a family physician (as appropriate). This may include attending home visits, doing urgent care shifts, attending a long-term care or palliative care hospice, or delivering babies.

There are no formal call requirements. **Please ensure that clerks do not exceed the PARA call rules of 1 in 4 home call. In the attempt to balance daytime learning with post-call requirements, we would like to 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

At the midpoint mark of the rotation (end of Week 2):

1. Please provide your clerk with specific feedback (in addition to ongoing, continuous feedback) and fill out the mid-point ITER form on One45.
2. Review the clerk's Logbook to determine what clinical presentations/procedures, if any, still need to be completed for the book. One history and physical must be observed in totality.
3. NEW for Class of 2024, clerks have two new items in their logbook: 1) they must watch the Goals of Care/Advanced Care Planning videocast, 2) they must discuss the Greensleeve with yourself, 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 if it can be done during the urban FM rotation this is also acceptable.

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 mid-point of the rotation and appropriate chance for remediation be given.

Please email the Clerkship Director (sonja.wicklum@ucalgary.ca) to make her aware if you are concerned about a clerk's performance. The DFM is there to support you as the preceptor, 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 their project is patient-centred, projects not grounded in a patient encounter are not acceptable. The clerks have clear guidelines as to how to complete the project in their Core Document. See pg 14, 6.3. Please 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.

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. However, if a clerk waits a long time and you are not comfortable completing the EPA then you can state this on One45. The clerks have many opportunities to ask you to complete an EPA.

For more information please see Page 39 of the Class of 2023 Student Handbook:

<https://cumming.ucalgary.ca/mdprogram/current-students/clerkship/student-handbook>.

5. RURAL/REGIONAL

5.1 Clinical Time

The expectation is that the clerks will work the equivalent of 5 days per week for the 4 weeks of the block. Any absences will need to be approved through normal mechanisms in Osler and 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 08:00 – 09:00 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>.

Course 8 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 Course 8 in person. This should allow them to work in your clinic in the morning until 11 AM. If you are outside of the 1-hour travel time then clerks are expected to work in your clinic and review Course 8 material on their own time.

During the first clinical session the clerk should review their schedule for the block, including:

- clinical expectations
- teaching sessions during lunch hours (2nd and 3rd Thursday of block)
- travel time to return to Calgary to write the Final Exam (if second FM block)
- need to be away for Course 8 (as per above, depending on location)
- any previously approved absences

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

Expectation for clinic time is based on the block the clerks are in and 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 a week may be with a member of the inter-professional team who provides care to your patient population or may include a community-based medical experience, for example, a ride along with the local paramedics. **Of note, we respect the judgment of preceptors with regard to 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 are meeting the 5-day workweek.**

At the end of the block clerks need to submit a Clinical Calendar signed by their preceptor.

Clerks are allowed to take up to one flex day in each 4-week block. They 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. Further, they may take one half day to prepare for their

SNAP session. **All absences, except one (optional) half day for SNAP preparation during the Rural FM block, must be approved at the UME level through Osler.**

However, please be aware that there are a **critical minimum number of clinics for both Rural/Regional (30) and Urban (30) blocks**, below which clerks will not be permitted to sit the Final Exam, regardless of the block or the approved absences and they may be required to make up clinical time. Issues with respect to clinic time are reviewed by Dr. Vantanajal and the FM Clerkship Committee as needed.

Of note, if due to unforeseen illness or absence the clerk's total clinical time ends with less than 30 half days during the 4 weeks, they will not be permitted to sit the FM Final Exam and may be required to complete make-up time. 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.

5.2 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

(08:00-09:00) Orientation – FM Clerkship

Director

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

SNAP Session 1

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

SNAP Session 2

Week 4 - Friday

1st Block

Expected to be in clinic Formative Exam (on own time)

2nd Block

Travel* to write Final Examination (PM exam in Calgary) * travel the evening before the exam if within 2.5 hours of Calgary OR travel the afternoon beforehand if further away (or longer as needed for special travel requirements).

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:

<https://ucalgary.yuja.com/V/Video?v=34026&node=208519&a=1453025709&autoplay=1>

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 SNAP Sessions

There has been frequent feedback from FM clinical clerks that there is not enough teaching of core family medicine during the FM Clerkship rotation. To address this concern, the FM undergraduate team is introducing SNAP sessions during the Rural FM block. These sessions will operate on the “flipped classroom” approach – clerks teaching their peers. Clerks will select one of the “core” family medicine presentations (see Appendix G) and present to their peers a brief synopsis of the topic including study materials.

These sessions will be moderated by rural family physicians, and they will run over the lunch hour of the second and third Thursdays of the rotation. **Please ensure that your clerks are free from clinical duties at noon on these days.**

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

5.5 Sample Timeline (RURAL/REGIONAL)

The next page has a sample timeline clerks receive with all the important rotation elements for which they are responsible.

Sample Timeline for Clerks (RURAL/REGIONAL)

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

6. URBAN

6.1 Clinical Time

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

Clerks are expected to attend a mandatory virtual orientation for their Urban FM rotation from 3:00 – 4:00 pm on the first Monday of the rotation. Please ensure that clerks are free from their clinical duties in order to attend.

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>.

Course 8 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 Course 8.

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 stat holidays,
 - b) time away for course 8 (Friday afternoon only if required),
 - c) time away to write the Final Exam (if 2nd FM block), and
 - d) time away for Academic Day (Week 3, Thursday)
2. From (1) above minus any previously approved absences.
3. If felt necessary, clerks may also minus 1 day (2 clinics) for preparation of the Patient Centered Care Project (PCCP).

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

Expectation for clinic time is based on the block clerks are in and 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 with regard to 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 are meeting the 5-day workweek.**

At the end of the block the clerk submits a signed Clinical Calendar for the block (see Appendix C).

Clerks are allowed to take up to one flex day in each 4-week block. They 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 are a **critical minimum number of clinics for both Rural/Regional (30) and Urban (30) blocks**, below which clerks will not be permitted to sit the Final Exam, regardless of the block or the approved absences and they may be required to make up clinical time. Issues with respect to clinic time are reviewed by Dr. Vantanajal and the FM Clerkship Committee as needed.

Of note, if due to unforeseen illness or absence the clerk's total clinical time ends up less than 30 half days during these 4 weeks they will not be permitted to sit the FM Final Exam, and may be required to complete make-up time. 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 – 4:00 pm) via Zoom Video Conferencing Orientation – FM Clerkship Director

Week 3 - Thursday (9:00 am – 4:00 pm) Academic Day with:

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

Week 4 - Friday

1st Block

Expected to be in clinic Formative Exam (on own time) **2nd Block**

Final Examination in AM, expected to be in clinic in 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 they 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 in order 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 student 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 similar to 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 found in the appendix.

6.4 Sample Timeline

The next page has a sample timeline with all the important rotation elements for which clerks are responsible.

Sample Timeline for Clerks (URBAN)

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

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. Please refer to the Clerkship Work Hours Policy in the Clerkship Handbook.

8. EXAMS

Clerks must complete the **online formative exam** on their own time by the Friday of Week 4 of their 1st FM block. There are Microcases on the Learn-FM website at: <https://learnfm.ucalgary.ca/>. There is more information in the Supplemental Learning Resources section.

Clerks must complete the **summative examination** at the end of their 2nd FM block.

If they are working with you and it is their 1st FM block of clerkship then they will be able to work the final Friday afternoon (unless they have Course 8). If it is their 2nd FM block, they will write the exam on the final Friday afternoon. Clerks on Urban rotation should be released from clinic by 11am. Clerks on Rural rotation will be excused from clinic the final Friday morning to travel back to the medical school for the exam.

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 of 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 discuss 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. **Note the specific NEW element of learning about Goals of Care discussions discussed elsewhere in the manual.**

The logbook MUST be completed by the end of day on the Wednesday of the week of the summative exam or clerks will not be allowed to sit the exam.

10. TEACHING RESOURCES FOR PRECEPTORS

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

10.1 Professional Development Sources

The following are CPD resources for teachers of medicine:

- Department of Family Medicine preceptor CPD: include Cabin Fever, DFM Day, and Fall Together
– you will receive email notification of these events.
- TeachingPhysician.org: online resource, can 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.
<http://www.ucalgary.ca/ofd/workshops>.
<https://cumming.ucalgary.ca/office/ofd/faculty-resources/teaching-resources>.
- 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

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. “SNAPPS” 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 “**SNAPPS**”, 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 SNAPPS 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/h-a/opportunities-medical-students/#>

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

Chuck Carson Memorial Endowment

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

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

Selection of the awardee is made by a committee consisting of the Associate Dean of Undergraduate Medical Education, the Family Medicine Clerkship Director and a representative of the Class of 1977. To be considered for the award, students must have completed their clerkship rotation in family medicine. More information on the application process and deadline will be sent via email in March.

Michael Tarrant Scholarship (Rural Medicine)


Dr Michael Tarrant was a family physician from Calgary with a group practice at the Cambrian Medical Clinic. He was a staff member of the Foothills Medical Centre and served with the University of Calgary, Department of Family Medicine as residency program director and undergraduate coordinator.

Sponsored by the Alberta Medical Association's Section of Rural Medicine, the Tarrant Scholarship is one of Alberta's largest, unrestricted medical school undergraduate awards. Two \$12,500 awards are bestowed. There is one recipient from the University of Alberta and one from the University of Calgary.

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

APPENDICES

A. CanMEDS Roles

 <p>The diagram is a tree with a brown trunk and green leaves. The trunk is labeled 'Community-Based Patient-Physician Relationship' on the left and 'Skilled Clinician Resource to a Defined Population' on the right. The leaves are labeled with the seven roles: 'Collaborator', 'Manager', 'Health Advocate', 'Scholar', 'Professional', 'Communicator', and 'Family Medicine Expert' (in the center). Below the tree is the text 'CanMEDS-Family Medicine' and a small copyright notice: 'Image adapted from the CanMEDS Physician Competency Diagram with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2009.'</p>	<p>The College of Family Physicians of Canada uses this diagram to illustrate the seven key roles of the Family Physician.</p> <p>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.</p> <p>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.</p>
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B. Clinical Calendar (Rural/Regional)

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

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

C. Clinical Calendar (Urban)

WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	# of clinic half days
1	Morning	Orientation (3:00 – 4:00 pm) ZOOM							
	Afternoon								
	Evening								
2	Morning								
	Afternoon								
	Evening								
3	Morning				ACADEMIC DAY (9:00 – 4:00) PCCP Presentations Screening & Periodic Health Exam Multi-Morbidity Planetary Health				
	Afternoon								
	Evening								
4	Morning					(1 st FM block) In clinic (2 nd FM block) Summative Exam			
	Afternoon								
	Evening					(1 st FM block) Formative Exam on own time			

Preceptor signature: _____ Student Name: _____ Total number of clinic half days during 4 week block _____ Signature: _____

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

D. Patient-Centred Care Project (instructions for clerks taken from the FM Clerkship Core Document)

Step 1: Health Challenge

Attempt to identify “the health challenge – your ‘case’” within the first week of the rotation.

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

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

Step 2: Critical Appraisal of Evidence to address a specific health challenge for the patient

Find, review, and critically appraise relevant, peer-reviewed literature, and community resources. You may need to arrange further interviews with the patient to gather additional contextual or other patient information. Using these findings, as well as your understanding of the patient’s illness, experience, and context, you will develop options for your patient.

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

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

Step 3: Patient Follow-up Visit and preparation of the Patient-Centred Care Project (PCCP) Presentation

Attempt to meet and review with the patient, remember a phone call can be enough.

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

Shared Decision Making is based on Social Cognitive Theory that states that **knowledge** forms the foundation of decision-making. It implies 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 to them can give them the **confidence** they need to move forward. This **confidence** is essential for them to be **motivated** to take the next step (make a lifestyle change, take a medication).

Without their own **decision-making skills** enhanced they will not increase their confidence and will not be motivated to change.

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

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

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. SNAP Presentations (instructions for clerks taken from the FM Clerkship Core Document)

During your Rural rotation, you will have two lunch hour sessions in the second and third week where you and your peers will review selected core topics in family medicine. Rural family physicians will act as moderators for these sessions. They will be there to support and direct conversation as needed. Given the number of 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 26 Clinical Presentations (EXCLUDING Periodic Health Exam) (Appendix F). **The goal is not to cover the entire topic in depth, but to review the topic through the lens of primary care as outlined in the objectives (see Appendix F).** These sessions are intended to support the studying of your colleagues. An example of a SNAP would be a 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 SNAP topics to the UME FM Program Coordinator at famclerk@ucalgary.ca as soon as you decide on them (end of Week 1 at the latest) to ensure that another clerk is not doing the same topic. If there is overlap and you are the second person to submit the topic you will have to change yours, *SO SUBMIT AND THEN DO THE WORK!*

The SNAP presentation can be with or without slides. It can be a video, an Infographic (see sample instructions below), or any other creative, accessible format. The presentation should review the material you have developed. It should be no longer than 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 SNAP materials should be submitted to the Family Medicine UME Coordinator by Friday afternoon of the third week at the latest. They will be available to all 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 bazedofene (SERM). (1,2,3)

DISCUSS THE RISKS

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

Combined estrogen/progestogen therapy increases risk of breast cancer when used for 3-5 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). 334-339.
2. [HTTPS://WWW.MENOPAUSE.ORG/DOCS/DEFAULT-SOURCE/PROFESSIONAL/NAMS-HT-TABLES.PDF](https://www.menopause.org/docs/default-source/professional/nams-ht-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 26 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 26 clinical presentations identified as important for Family Medicine. Ideally you should see patients with these problems in clinic and may record them in your logbook. If you do not manage to see a case in relation to one of the problems listed, please refer to the virtual patients on LearnFM (formerly SHARC-FM) or those available via Course 8.

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

Key Symptoms

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, take into account the lifestyle of the patient, any potential issues with compliance, possible side effects of treatment, and available resources available in the community.

4. Chest Pain

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

5. Contraception

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

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

6. Cough/Dyspnea

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

7. Depression

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

8. Diabetes Mellitus Type II

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

9. Diarrhea

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

10. Dizziness

1. Given a patient with “dizziness”, conduct a history so as to distinguish true vertigo from other types of dizziness.
2. Differentiate between psychiatric causes (depression, anxiety/panic, somatization, alcohol), disequilibrium (peripheral neuropathy, visual impairment, drug), and syncope/presyncope.
3. Identify likely causes of vertigo (e.g., benign paroxysmal positional vertigo, viral labyrinthitis, Meniere’s Disease) and other types of dizziness (e.g., anemia, vasovagal, hypovolemia).
4. Conduct a relevant physical exam so as to rule out serious causes of dizziness, including assessment of orthostatic blood pressure, cerebellar & cranial nerve function, precordium, and 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 so as to:
 - a. Define what the patient means by "fatigue" and distinguish from other concerns (e.g., mood concerns, muscle weakness, decreased exercise tolerance +/- SOB)
 - b. Identify clinical symptoms/red flags that suggest a secondary etiology, e.g., depression, anemia, hypothyroidism, malignancy, sleep apnea, cardiac disease
 - c. Identify context red flags that may suggest psychosocial concerns and impact differential diagnosis and/or management (e.g., homelessness, isolation, single parent, addiction, recent losses, sleep quality/shift work)
2. Conduct a relevant physical exam to refine DDx.
3. Include "watchful waiting" when appropriate as a diagnostic and/or management tool.
4. Propose and act on initial investigations based upon DDx and avoid over-investigation/"shot-gun" approach.

13. Fever and Common Infections

1. Perform a focused history and physical exam to determine presence of fever, fever pattern, and associated symptoms & signs, so as to:
 - a. Make a determination as to whether a patient truly has/had a fever, and whether it is acute versus chronic.
 - b. Identify patients with serious illness:
 - i. Demonstrate good understanding of the potential groups of cause of fever
 - ii. Infection, malignancy, drugs, environment (sun, heat)
 - iii. Important conditions not to miss: endocarditis, meningitis, septicemia
2. Recognize special groups where fever has different significance or impact (e.g., neonates, elderly, travel/immigrant issues, under-immunized groups, living conditions, cultural/religious groups, immune-compromised individuals).
3. Propose a plan for appropriate investigation of possible causes, based in the local context.
4. Propose a basic plan of management that includes:

- a. Simple at home measures including antipyretics
 - b. guidance for patients/caregivers on how to access care depending on evolution of illness
- 5. Be familiar with causative agents and treatment options for:
 - a. Acute otitis media
 - b. Cellulitis
- 6. For patients presenting with ear pain:
 - a. Make the diagnosis of otitis media (OM) only after good visualization of the eardrum (i.e., wax must be removed), and when sufficient changes are present in the eardrum, such as bulging or distorted light reflex (i.e., not all red eardrums indicate OM).
 - b. Include pain referred from other sources in the differential diagnosis of an earache (e.g., tooth abscess, trigeminal Neuralgia, TMJ dysfunction, pharyngitis, etc.).

14. Headache

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

15. Hypertension

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

16. Ischemic Heart Disease

1. Identify patients at elevated risk for IHD and calculate their 10-year cardiovascular risk using the Framingham Risk Score.
2. Propose a patient-centered initial management plan for primary prevention of IHD.

3. Identify which patients require further investigation to confirm a diagnosis of IHD.
4. Describe an early post-ischemic event management plan including lifestyle changes, medications, psychosocial support, cardiac rehabilitation, etc.
5. Propose a surveillance and management plan for secondary prevention of cardiovascular events in patients with IHD.

17. Joint Pain

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

18. Low Back Pain

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

19. Obesity

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

20. Palliative Care

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

21. Periodic Health Exam

1. Conduct a patient interview so as to identify any significant age-, sex-, context-specific risk factors for health conditions (e.g., exercise, diet, substance use, immunizations, falls)
2. Conduct an age-, sex-, and context-specific evidence-informed physical exam (e.g., blood pressure, weight, waist circumference).
3. Discuss pertinent screening tests and explain their purposes & limitation (e.g., Pap testing, mammography, colorectal cancer screening, bone mineral density, diabetes and 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.

J. The Big 10 Educational Objectives



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:
 - a) Conducting a comprehensive medical history and thorough physical examination; reliably eliciting appropriate information in the history and detecting abnormal findings on the physical examination.
 - b) Correctly identifying the patient's diagnosis, differential diagnosis, and medical problems.
 - c) Applying an appropriate clinical reasoning process to the patient's problems.
 - d) Advocating for patients while formulating and implementing a resource-conscious management plan to deal effectively with patient problems.
 - e) Applying basic patient safety principles
3. Apply a comprehensive patient-centered approach in the evaluation and care of patients including sensitivity to differing: sexual orientation and gender identity, cultural and spiritual beliefs, attitudes and behaviours, economic situations.
4. Demonstrate knowledge of the fundamental concepts of disease prevention and health promotion for individual patients and populations and incorporate them into treatment plans as appropriate.
5. Communicate and interact effectively with patients, families, medical staff and others involved in the delivery of health services.
6. Describe and apply ethical principles and high standards in all aspects of medical practice.
7. Exhibit appropriate professional behaviour, including awareness of personal wellness and limitations.
8. Formulate clear clinical questions and apply an evidence-based approach to solving these questions.
9. Demonstrate educational initiative and self-directed life-long learning skills.
10. Describe the basic principles of clinical and translational research, including how such research is conducted, evaluated, explained to patients and applied to patient care.

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> 

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Reference:

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

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L. Learning Objectives Overview

Objective	Example	Sample Learning activity	Evaluated by
CANMEDs Role: Expert CSM Big 10: 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
CANMEDs Role: Manager CSM Big 10: 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)
CANMEDs Role: Communicator CSM Big 10: 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)
CANMEDs Role: Advocate CSM Big 10: 2,3,4,6	Identify the social needs of patients and where appropriate act to enable or facilitate these needs.	Explore your community Talk to different members of the health care teams	ITER (mid-point & final)
CANMEDs Role: Scholar CSM Big 10: 8, 10	Apply principles of evidence-based medicine to individualized patient care Use appropriate learning resources to support patient care	Determine the impact of your project in the practice / community Identify preferred resources and be able to defend your choices	Patient-centred Care Project ITER (mid-point & final)
CANMEDs Role: Collaborator CSM Big 10: 2,5	Demonstrate knowledge of the roles of members of the primary care team and be able to write an appropriate referral	Spend time with other health care professionals	ITER (mid-point & final)
CANMEDs Role: Professional CSM Big 10: 6,7	Act in a professional manner as exemplified by good communication with patients and your preceptors' team and the UME, take responsibility for fulfilling the requirements of the FM clerkship including the appropriate time commitment and submitting the relevant documentation.	Document your time commitment, progress and feedback received daily and include this tracing record as an appendix in your final submission.	Meets clinical expectations Participation in teaching sessions ITER (mid-point & final)

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

Available at: <https://www.cfpc.ca/uploadedFiles/Education/Twelve-Talking-Tips-ENG.pdf>

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.

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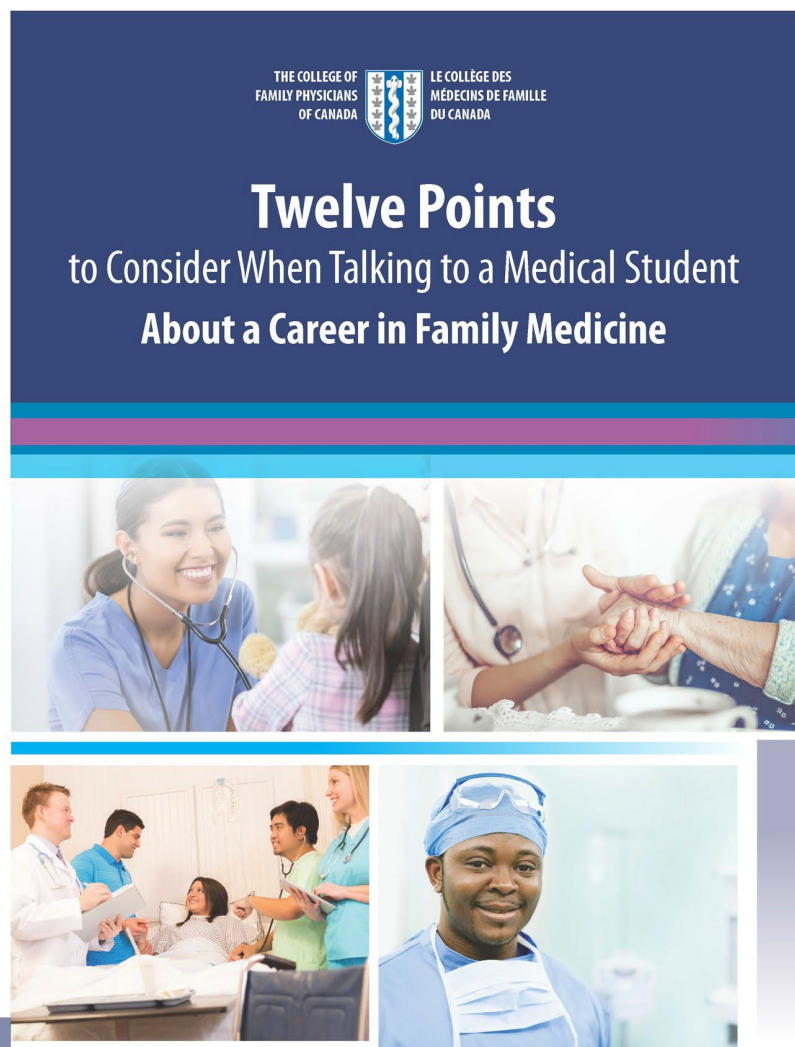
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QUESTIONS?

Contact us at education@cfpc.ca.





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.