



UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE
Department of Family Medicine

PRECEPTOR MANUAL

Family Medicine Clerkship

MDCN 502

UNDERGRADUATE MEDICAL EDUCATION
CORE DOCUMENT
CLASS OF **2022**
2021-2022 Academic Year

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1. WELCOME TO FAMILY MEDICINE CLERKSHIP



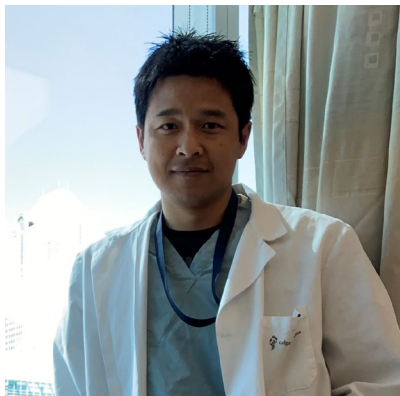
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For academic questions, please contact Dr Sonja Wicklum. Unless your email is of a sensitive or confidential nature, please cc famclerk@ucalgary.ca to ensure your email is addressed in a timely manner (2-3 business days).



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SECTION 1: Information Provided to Clerks

2. SAFETY

Clerkship – Student Involvement in Patient Care (classes of 2021, 2022)

(Updated January 26, 2021)

- Information provided to clerks -

These guidelines are intended to provide safety for patients, physicians and learners. A secondary goal is to avoid the unnecessary use of personal protective equipment (PPE) by individuals who are not essential to the care of an individual patient.

- Students will be subject to the daily screening process required for all health care workers
- Students will be expected to continuously wear a procedure mask at all times in all areas of any clinical setting
- Students will be expected to perform regular hand hygiene: alcohol-based hand rub (ABHR) is the preferred method for hand hygiene; however, there are times when handwashing with soap and water is required or availability of ABHR is limited. Ensure friction and wet time for a minimum of 20 seconds when using soap and water
- Students are expected to have completed both an online module (<https://ecme.ucalgary.ca/covid-19-cme-resources/topics/ppe/>) for training in the use of PPE and completed an observed practice session in the proper use of PPE
- **It should be recognized that students may require supervision in the use of PPE, particularly at the beginning of their return to clerkship and at the beginning of a new rotation**
- Students will comply with all requirements for PPE for an individual patient as directed by the most responsible physician or preceptor (e.g. protective eyewear)
- The most responsible physician or preceptor may choose to direct students to avoid caring for specific patients who are COVID positive
- Students may provide routine care to patients with known or suspected COVID only with the use of PPE as directed by the most responsible physician or preceptor
- Students should not be present during AGMPs with patients who are known to be COVID positive or patients where the likelihood of COVID is high (symptomatic, pending COVID testing results)
- Students will not be directly involved with any patient where caring for that patient would require the student to wear an N95 mask
 - exception of routine use in the OR setting during AGMPs (intubation, extubation, etc) as directed by the preceptor based on current local and provincial guidelines and requirements
 - exception of routine use in the ICU setting with patients during AGMPs
- Students may only wear N95 masks once they have been properly fit tested for the currently available mask at UME or through an AHS fit testing appointment
 - If a student is fit tested outside of UME, proof of fit testing must be emailed to immune@ucalgary.ca
- Students who are exposed to a patient with COVID-19 while not wearing appropriate PPE will complete the Healthcare Worker Self-Assessment form (<https://myhealth.alberta.ca/Journey/COVID-19/Pages/HWAssessLanding.aspx>) to determine if testing is required, to receive further information and to determine if self-isolation is required

- Students should contact Workplace Health and Safety (WHS) with specific COVID-related questions:

Andres Nino

Workplace Health & Safety Advisor -

Calgary Zone

Alberta Health Services

Office:587-774-7462

Andres.Nino@albertahealthservices.ca

- Guidelines for student involvement in patient care may change as the COVID situation evolves; communications will be directed via UCalgary email from UME to all students and clerkship leaders when changes occur. This includes updates about student attendance on hospital units on watch or outbreak status. Decisions about learner placements on watch/outbreak units will be determined via discussion among medical site leadership, Calgary ZEOC, UME leadership and relevant clerkship leaders.

Personal Protective Equipment – masks, if unavailable at your site, will be supplied by UME to ensure safety on family medicine rotations. Carmen Wong (famclerk@ucalgary.ca) will be communicating at a later time about this. We are also communicating with the sites in order to determine if they have adequate numbers of masks to ensure your protection. Carmen will let you know if there is a concern beforehand and arrangements made to pick up masks.

Additional Eye Protection Measures

General measure to be taken at all times:

- Masks and proper hand hygiene during patient encounters. **For encounters = or > 15 minutes, eye protection (safety glasses or face shield) is also needed if less than 2 metres from the contact.**
- Eye protection (safety glasses or face shield) have been recommended by Workplace Health and Safety if encounters are = or > 15 minutes and within 2 metres. If not used, then the individuals exposed will be asked to self-isolate. **Safety glasses have been provided by UME and clerks should have collected a pair.** Safety glasses can be cleaned with soap and water at the sink as needed or immediately after the exposure as indicated (e.g., the clerk and preceptor deem the patient at risk for COVID-19 and swab them then clean the glasses afterwards, the same as you would your hands) or daily if no high-risk exposures, but remember: if you take the glasses off, touch the glasses, set them somewhere, etc. they must be cleaned, and your hands cleaned.

Precautions for clerks coming from higher risk COVID-19 exposure rotations (from in-hospital care on wards with COVID-19 patients or on COVID-19 watch):

The following precautions should be considered for the first week at a minimum (clearly it is difficult to know for sure if the environment you came from was high risk and therefore this may apply after all hospital rotations. You may not find out for a few days if a unit you were on is now on some type of watch and that you need COVID testing.

- Clerk spends < 15 minutes with all patients that are within 2 m. If the clerk spends more than 15 minutes and then the clerk develops COVID-19 later that week, the patient will not have had eye protection on and therefore will be asked to self-isolate for 14 days (or longer depending on the variant).

- Clerk in general stays > 2 m apart from all clinic staff, brief, closer interactions by staff to, for example, get them set up on a computer may be needed but consider keeping these as short as possible.

3. TELEMEDICINE AND VIRTUAL CARE

It is essential that you review the document in APPENDIX A. You may want to print a copy to remind yourself how to set up your clinical day. APPENDIX B may become relevant to you because as much as you may not work in person with a patient with COVID-19, you may help monitor them via the telephone or virtually.

Below is a list of resources to help you with the task of providing virtual care to patients.

3.1 Virtual Clerkship and Telemedicine

APPENDIX A is a guide on the process of virtual care and will provide you with a clear understanding of what is expected while operating in this new clinical environment.

3.2 Alberta Health Service's Presumed/Confirmed COVID-19 Positive Primary Care Pathway.

Following the emergence of COVID-19, a team, including specialists from Respiriology and Infectious Disease, the AHS Primary Care team, Primary Care Networks, and members of the Calgary Specialist LINK task group developed this pathway to help support family physicians in caring for their patients (Page 1, and a link to full document can be found in APPENDIX B). This pathway was created with up-to-date knowledge at the time, but it will be reviewed on a consistent basis. Please refer to the AHS website for updates.

3.3 Virtual Care Playbook 2020

Canadian Medical Association, College of Family Physicians of Canada, and Royal College of Physicians and Surgeons of Canada. Virtual Care Playbook. 2020. This playbook was written to help Canadian physicians introduce telemedicine into their daily practices and focuses on video visits. It covers the key considerations to succeed at providing safe, effective and efficient care. Page 6, which contains a list of problems not currently amenable to virtual care, and a link to the full document, can be found in APPENDIX C.

3.4 Remote Assessment in Primary Care

Greenhalgh T, Choon Huat Koh G. Covid-19: a remote assessment in primary care. BMJ. 2020;368:m1182. This article addresses how to provide telemedicine and remotely assess a patient with symptoms of COVID-19. The article is available at:
<https://www.bmj.com/content/368/bmj.m1182>.

4. FM CLERKSHIP - GOALS

The following outlines the goals of the rotation. For specific exam preparation information refer to sections: 8. Exams, 9. Supplemental Learning Resources, and APPENDIX E - Learning Objectives and 26 Clinical Presentations.

By the end of the Family Medicine Clerkship, you will:

- Have a better understanding of how family physicians think and do their work. Unique to family medicine is the challenge of dealing with **the undifferentiated patient**, someone with an issue or symptom for which the diagnosis is not clear. You will appreciate and develop skills in interviewing patients, determining management plans and communicating these to the patient. You will recognize **the importance of shared-decision making with patients and collaboration with a multitude of other healthcare providers** as you follow patients through the course of their illness, providing **continuous and comprehensive care**.
- Understand the breadth of **medical expertise** required of a family physician and how they assimilate new knowledge, and address questions arising from medical cases and coming from their patients. You will be exposed to **all ages, life stages and types of presentations, along with both acute and chronic diseases**.
- Be responsible for integrating resources of all kinds for a patient, from diagnostic testing to mental health services. You will understand the **complexity** of patient management and the importance of the **Patient's Medical Home** in ensuring access to care and that care plans are executed. You will have had the chance to **advocate** on behalf of your patients.
- 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.
- 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 to the day-to-day lives of family physicians and their staff.

To learn more about the role of the family physician see:

https://www.cfpc.ca/uploadedFiles/About_Us/FM-Professional-Profile.pdf

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

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

5. FM CLERKSHIP - EXPECTATIONS

5.1 Clinical Time

The family medicine rotation will be a total of 6 weeks. This 6-weeks rotation will be split into blocks of 2 weeks and 4 weeks, and they may both be urban, both rural, or a mix. The blocks may or may not run consecutively.

You will be working full-time and we only accept absences from clinic for 1) exams, 2) mandatory academics (third Thursday afternoon of the 4 week block), 3) travel to/from rural site, 4) pre-arranged flex days (submitted on Osler), 5) sick day or other unscheduled leave (submitted on Osler). Some preceptors may work outside of traditional Monday - Friday day time hours and if this is the case you may discuss with your preceptor some time off during the week in lieu of these hours. Lastly, we accept that some preceptors may not work certain days of the week but in this case most have a colleague you can work with in their absence. If this is not the case please mark 'NO PRECEPTOR AVAILABLE' in the Clinical Calendar when reviewing it with your preceptor and have them initial the statement. Please work with your preceptor to complete the Clinical Calendars (APPENDICES H and I). Clinical Calendars will be reviewed to assess that all absences are explained. Remediation may be necessary if absences are not explained.

In extreme/unpredictable situations such as extended illness or absences of a student or preceptor we expect, for an adequate family medicine experience, the 2-week block should have not less than 7 clinical days, and the 4-week block not less than 16 clinical days. Remediation may be necessary if less than 7 + 16 = 23 days are completed.

At the beginning of the block, please review the Clinical Calendar with your preceptor and **submit** a *proposed* Clinical Calendar to Carmen Wong (famclerk@ucalgary.ca) during week 1. **Please submit the final Clinical Calendar, signed by you and your preceptor, to Carmen Wong by 11:59 pm on the Wednesday of week 2 (for the 2-week block) and Wednesday of week 4 (for the 4-week block).**

5.2 Absences

During the 6-week rotation, a total of 2 flex days is allowed. Only 1 flex day can be taken during the 2-week block. All flex days must be requested on Osler before the start of the block.

Sick days and medical appointments must be submitted on Osler.

All absences must be approved at the UME level through Osler.

5.3 Travel

For the rural block, one half-day at the beginning and the end of the block will be allowed for travel. An additional half-day travel will be allowed to complete the MCQ exam (if completing during the rural block). NB: additional travel time may be determined as valid based on a distance greater than 3 hours, or inclement weather. If able, travel should be completed on the Sunday afternoon before the rotation begins, so that clinic can be attended on the Monday morning.

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

5.4 Accommodation (Rural)

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

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

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

5.5 Attire

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 to review this policy and comply with its expectations. UME policies are available at: <https://cumming.ucalgary.ca/mdprogram/about/governance/policies>. Due to the pandemic, a number of students may prefer to wear scrubs and this should be allowed.

6. ACADEMIC SESSIONS

Before the start of the 2-week or 4-week block, please visit the UME office (G701) and collect a hardcopy of the LearnFM Canadian Family Medicine Clinical Card Booklet 2020.

6.1 Orientation

2-week block Podcasts: Orientation and Advanced Care Planning*	4-week block Podcasts: Orientation and Advanced Care Planning* Vaccine Hesitancy Addressed (part 1 + part 2) Multimorbidity and pre-reading
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*Review these at least once, at the start of either rotation.

For podcasts and pre-reading, please go to the Family Medicine page on Osler.

6.2 Advanced Care Planning (4-week block)

Review podcast

After completing the Introduction to ACP and learning how to engage in Advance Care Planning and Goals of Care Conversations (ACP/GCD) with patients, you are encouraged to engage a patient in the ACP process. Please discuss this with your preceptor early on so as to consider which patient(s) may benefit from a discussion. There is no formal reporting for this activity.

6.3 Vaccine Hesitancy Addressed (4-week block)

Mandatory Academic Session

Thursday, 12:15-1:00 pm, week 1 of the 4-week block

Review podcasts part 1 and part 2 (1-hour total)

Since the advent of vaccinations, the world is a safer and healthier place to live. Our way out of the current pandemic depends on the discovery and uptake of a vaccine. Yet, anti-vaccine sentiment has grown over the years. As health professionals, we have a responsibility to understand the reasons supporting such a trend. One patient at a time, building upon the trust that cements the patient-doctor relationship, we must also look to change it. A discussion of the above with a special focus on communication to address patients' fears, expose misinformation, and increase the uptake of vaccines will be learned in this session. **Mandatory** viewing of the podcasts please (this is essential for your participation in this session and lack of completing it without adequate reason will be considered unprofessional conduct).

6.4 Multimorbidity Case Discussion (4-week block)

Mandatory Academic Session

Thursday, 12:15-1:00 pm, week 2 of the 4-week block.

Review podcast and pre-reading

Dr Kristy Penner, Crowsnest Medical Clinic and Dr Martina Kelly, Sheldon M. Chumir Health Centre look forward to talking to you about how to approach caring for patients living with multiple illnesses (multi-morbidity) during a 45-minute lunchtime session. Dr Kelly and Dr Penner hope to make the session as interactive as possible. Please review the 15-minute podcast and the one-page 'multimorbidity tips' prior to the session. Also review the two cases (posted the week before) as these will be discussed during the session. You are also encouraged to reflect on your experiences to-date on how you, or your preceptors, have approached patients with two or more medical conditions - what strategies have you observed? Do you have tips you can share with your classmates? What would you like help with? If you have cases you

would like to discuss, even better! Sometimes, in practice it's helpful to share complex cases with colleagues, as we share new insights or suggestions to how we can work with patients.

6.5 Patient-Centred Care Project (4-week block)

Project will be presented at:

Mandatory Academic Session

Thursday, 1:00-2:30 pm, week 3 of the 4-week block

Students cannot choose the same topic. Carmen will email a sign-up sheet of topics on the first week of the block.

Submit PCCP and preceptor-signed evaluation by 4 pm, Wednesday week 3

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 goal of this project is to:

- Apply your critical appraisal skills to a specific patient problem (health challenge) from a family medicine perspective.
- Explore the process of shared decision making with your patient when applying the evidence you found, with the view to assist the patient, +/- their family, in the decision-making process.
- Reflect upon the process of shared decision making with your preceptor within your patient encounter.

By the end of this project, you will have:

- Carried out an in-depth study of an identified health challenge for a specific patient.
- Gone beyond a strictly biomedical approach to your patient's health challenge.
- Explored and critically appraised the available evidence and community resources, relevant to the identified health challenge.
- Used a collaborative, shared decision-making approach, by involving the patient +/- family in developing recommendations that will be feasible and acceptable to the patient +/- family.
- Reflected upon the process that you went through in coming to "common ground" with your patient that balanced the evidence of the recommendation/intervention, the dialogue that occurred between you, your preceptor, and the patient, and how your patient's values and wishes were incorporated into the decision.

** Before beginning, read the following article on shared-decision making:

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

Step 1: Health Challenge

Attempt to identify "the health challenge" 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 E 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.

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.

Step 3: Patient Follow-up and Patient-Centred Care Project (PCP) Presentation

Book a telephone follow-up review with the patient in week 3 of the block

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 (see the paper and apply the *choice, option* and *decision* three-step process). 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.

The above will form the basis of the content for the Patient-Centred Care Project (PCCP) presentation that you will give to your peers and an evaluator during the morning of the Thursday week 3 academic session (1:00-2:15 pm). You will have 7 minutes to present your project and five minutes for questions. Marks are awarded for presentation and content (Appendix F). Sample projects are available on OSLE.

Shared Decision Making is based on Social Cognitive Theory that states that **knowledge** forms the foundation of decision making. It implies that the physician (or you the clerk) can give all the relevant information to the patient and therefore empower them to make their own decision. The **knowledge** you give them gives 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.

Mandatory

SUBMIT: Email the Patient-Centred Care Project to famclerk@ucalgary.ca.

SUBMIT: Email the Patient-Centred Care Project Evaluation (completed by your preceptor) to famclerk@ucalgary.ca. **Submit both of these before 4:00 pm on Wednesday, week 3 of the 4-week block.**

6.6 Planetary Health Workshop (4-week block)

Mandatory Academic Session

Thursday, 2:45-4:45 pm, week 3 of the 4-week block.

No preparation required

Humanity has made tremendous gains in public health – by almost any measure, the health of much of the world is better now than at any time in history. Since the 1950s, life expectancy has increased by more than 30 years, and death rates in children younger than five have decreased from about 20% to about 6%. Yet at the same time, we have disrupted the Earth's natural systems. Have we mortgaged the health of future generations to realize economic and development gains in the present? In short: everything is connected: what we do to our environment comes back to affect us and not always in ways that we would expect. And to understand and act on these challenges, we need to collaborate across disciplines, across sectors, across countries, and across generations.

That's what we will focus on in today's session. We are going to split up into three groups based on the level of the role of the physician: physician as clinician, physician as clinic owner/hospital administrator, and physician as advocate/leader/educator/researcher. These reflect micro (in the context of an individual patient visit), miso (in the context of their clinic or hospital), and macro (in the greater community) levels of involvement by a physician. Within each group there are planetary health challenges – examples include changing infectious disease dynamics, changing food systems and nutrition, and declining mental health. Your group will have time to work together to respond to your health challenge, review articles and websites and then present your findings to your colleagues. As we will be working in small groups, we should be able to get through all of the challenges presented. **There is no preparation needed for this session.** Our goal is to expand upon your small group sessions on Climate Change and Health.

6.7 Academic Sessions - Timeline

✓ = required during this block / x = not required during this block

Week 1				
Action	Topic	2-week block	4-week block	Expectation
View	Podcasts: Orientation, Advanced Care Planning, Vaccine Hesitancy Addressed Part 1 and Part 2	✓ ¹	✓ ¹	Must complete
Submit	<i>Proposed</i> Clinical Calendar to famclerk@ucalgary.ca .	✓	✓	
Submit	Email PCCP topic to famclerk@ucalgary.ca by end of week 1 or start of week 2	x	✓	Must complete
Attend	<i>Academic Session</i> (Zoom) Vaccine Hesitancy Addressed Thursday, 12:15-1 pm	x	✓	Mandatory
Week 2				
Submit	<i>Final</i> Clinical Calendar to famclerk@ucalgary.ca . Wednesday, by 11:59 pm	✓	x	Must complete
Submit	Logbook to famclerk@ucalgary.ca . Wednesday, by 11:59 pm	✓ ²	x	Must complete
Attend	<i>Academic Session</i> (Zoom) Multimorbidity Thursday, 12:15-1 pm	x	✓	Mandatory
Complete (online)	Formative Examination Friday, before 3:59 pm	x	✓	Must complete
Complete (in person)	Summative Examination Friday	✓ ²	x	Must pass
Week 3				
Submit	PCCP project and PCCP evaluation (completed by preceptor) by 4 pm on Wednesday, week 3 to famclerk@ucalgary.ca before presenting PCCP project on Thursday, week 3.	x	✓	Must complete
Attend	<i>Academic Session</i> (Zoom) PCCP project presentation Thursday, 1-2:30 pm Planetary Health Workshop Thursday, 2:45-4:45 pm	x	✓	Mandatory
Week 4				
Submit	<i>Final</i> Clinical Calendar to famclerk@ucalgary.ca Wednesday, by 11:59 pm	x	✓	Must complete
Submit	Logbook to famclerk@ucalgary.ca Wednesday, by 11:59 pm	x	✓ ²	Must complete
Complete (in person)	Summative Examination Friday	x	✓ ²	Must pass

¹ We suggest watching the podcasts at the start of both blocks.

² If you are at the end of the 6-weeks' rotation.

7. LOGBOOK and LearnFM CLINICAL CARD BOOK 2020

7.1 Logbook

The logbook will be assessed for completion at the of the 6-week rotation.

You are required to log when you have completed all of the listed clinical presentations and tasks. Please note that there are some clinical presentations that you will likely not see during your rotation as they are rare. The point of listing (and logging) them is to ensure that you read about these and/or discuss them with one of your preceptors during your rotation. Ideally you should see patients with these problems in clinic and record them in your logbook. If you do not manage to see a case in relation to one of the problems listed, please refer to the virtual patients on LearnFM. Once you have read around the topic and/or discussed this with your preceptor, you may log this as completed. If you have had a particular experience in another rotation then you may check off the activity in your logbook but ensure that it was within the Family Medicine context. For example, management of cardiac disease post-MI in a family practice is different than in hospital.

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

Must complete: The logbook needs to be completed by 11:59PM on the Wednesday of the week in which you complete the summative examination.

7.2 The LearnFM Microcases

The LearnFM website contains brief patient scenarios and questions that allow you to test your clinical reasoning in family medicine situations. It is recommended that you go through them during the first week of your first FM block. **You can access them online through the link provided in the logbook.**

8. EXAMS AND EVALUATIONS

8.1 Exams

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

There are two exams in FM, a formative and a summative. **You must complete the formative exam before the end of your second week of the 4-week FM block** (see highlighted note below).

The formative exam is completed online. The formative exam can be accessed at <http://dolphin.ucalgary.ca>. Please use your CAS credentials to log into the exam. This exam is **mandatory**. The exam will NOT be re-opened once the deadline has passed. You MUST use the recommended web browsers (Safari or Chrome). Using any other browser will result in no record of exam completion.

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

To help you succeed, we suggest the following:

- Prepare early – Due to the numerous clinical presentations relevant to family medicine, we encourage you to read around the cases seen in your clinics, and those you may not have encountered, and do so early on. This will allow you to adequately address the depth and volume of information needed to be successful.
- Cover the basic information of the core clinical presentations – While the finer details are important and relevant, we want you to first establish a foundation of knowledge in each clinical presentation on which you can later build upon. What are the common differential diagnoses? What are the diagnostic criteria? What are the first-line treatments? This strategy will allow you to cover the multiple topics at the appropriate depth and position you well for your future studies.
- See the Learning Resources section. For example, there are Micro cases on the LearnFM (formerly SHARC-FM) website at: <https://sites.google.com/site/sharcfm/>.

Must complete: the formative examination by 3:59PM on the Friday of week 2 during the 4-week block. Note: the portal closes at 4:00 pm this day.

Must complete: the in-person summative examination on the last Friday of the 6-week rotation.

8.2 MITERS and ITERS (ITER = In-Training Evaluation Report)

2-week block

An ITER will be completed at the end of this block – **must pass**

4-week block

A MITER will be completed at the end of week 2 – **must complete**

An ITER will be completed at the end of week 4 – **must pass**

When completing your clinical calendar during the first few days also set up a time with your preceptor to review your progress. If it is the 2-week block please plan on reviewing progress at the end of the first week.

You must pass both ITERs and the Summative Exam, and submit a completed Clinical Calendar with preceptor signature to pass the block.

9. SUPPLEMENTAL LEARNING RESOURCES

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

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

E-resources

We encourage you to use these resources, just as you will use in other clerkships e.g. Up-to-date, 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: <https://learnfm.ucalgary.ca/> **The Shared Canadian Curriculum in Family Medicine**

- 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 are up to date and that questions are also 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.
- LearnFM micro cases - a question databank designed to help clerks test their knowledge. <https://sites.google.com/site/sharcfm/>.
- Clinical Cards - a series of clinical cards have been devised as part of the SHARC-FM initiative – these will be distributed during your orientation. They are also openly available at www.sharcfm.ca in PDF files for you to download.

Virtual Cases: <http://vp.openlabyrinth.ca>.

A suite of virtual patient cases is in development to compliment your learning when off-site.

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

- Anti-Infective Guidelines (MUMS) (low cost)
- Aspirin Guide (free)
- CND STI Guidelines (free)
- DynaMed
- GRC-RCMP Drugs Awareness (free)
- 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.
- RxTx - drug information, regular updates and Health Canada advisories, does not do drug interactions, there is a cost
- Spectrum
- Thrombosis Canada (free) - guidelines and algorithms
- UpToDate
- Visual Anatomy Lite (free)

10. ON-CALL ARRANGEMENTS

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

APPENDICES

A. Virtual Clerkship and Telemedicine

VIRTUAL CLERKSHIP AND TELEMEDICINE

Welcome to Family Medicine clerkship! This document has been created to help guide you through the process of virtual care and provide you with the expectations of you while operating in this new clinical environment. Please refer to the clerkship guide for complete details of timelines, objectives and requirements for this rotation.

Set up a time to talk with your preceptor, confirm what their current virtual care process and tools are (Zoom, three way calls etc.). Discuss your comfort level and reference the support links at the bottom of this document.

There are typically three categories of patients, work with your preceptor to review the days cases and confirm which ones are appropriate for your participating and for the virtual care setting:

- 1) With Covid19 and needing follow-up
- 2) Acute and Chronic Issues (typical visit)
- 3) High risk/vulnerable (not ill) support (HRVS)

AT THE START OF EACH DAY REVIEW ANY UPDATED GUIDELINES FROM HEALTH AUTHORITIES

1. WITH COVID19

- For high risk/vulnerable patients the Preceptor will call the patient, while you listen in if able. Once the patient has exited the call, discuss with the preceptor for 2-3 minutes.
- Medium/low risk – as per #2 – acute issues please see the definition of low and medium risk in the appendix document – ‘COVID Pathway’.

2. ACUTE ISSUES

You may be involved in every second or third patient. This is just a suggestion; your preceptor will decide the plan.

When appointments are booked the patient is advised of the timing: Clerk will call at 9:30, doctor/clerk together at 10:00AM.

- Clerk reviews chart (15 min)
 - special attention to age, GOC, medications, problem list
- Clerk calls patient 30 min before the time the preceptor will call.
 - Introduces themselves and tells the patient they will be getting some background information before the preceptor calls them in 30 minutes.
 - they complete HPI, med rec
 - avoid being conclusive about anything
- Clerk calls preceptors
 - 3-5 minute case review including A/P
 - scribe can be whomever, clerk if they have access, preceptor if clerk does not have access to chart
- Preceptor calls patient and asks if they can get the clerk back on the phone also (will likely be well-received). Preceptor reviews case with patient, clerk chimes in as needed.
- Preceptor then goes to next patient and students goes to the one after that.

3. HIGH RISK/VULNERABLE SUPPORT

Suggestions:

On Monday, preceptor identify 10 – 20 patients who are high risk/vulnerable that the clerk can call and check in on that week.

- The clerk can call and set a time or the MOA can do this (these could be afternoon appointments, leaving acute issues for the mornings)
- Your preceptor will run the list and pull out any information not highlighted in the visit notes. This is not meant to be an in-depth overview, but to provide you with some helpful information that may be relevant during the visit e.g. your preceptor shares with you that this patient's father passed away a month ago.
- Clerk calls patient and considers:
 - review present state of covid19 pandemic to ensure understanding
 - review patient safety: access to food, water, support by loved ones or friends, sanitizing agents and their use
 - discuss fears – careful to not offer advice/minimize/make statements that are not factual
 - review medications, problem list, goals of care (GOC)
 - clerk books follow-up call for preceptor for next day afternoon unless urgent or unsure and then states they will get back to the patient
- Clerk reviews with preceptor 3-5 minutes, preceptor/clerk scribes, A/P created, decision about:
 - Needs: medical, support, how to access, are extended health team needed, GOC on chart – Y/N, if no, can GOC be done at next visit?
 - Clerk calls patient to inform next steps, provides with handouts as appropriate e.g. Patient guide to Covid19 and palliative care (Dr. Tan's)

COMMUNICATION TIPS FOR PHONE AND VIDEO VISITS

1. Maintain full attention
2. Convey attention and interest
 - a. Warm tone of voice
 - b. Verbal listening acknowledgements
 - c. Periodically summarize
3. Pacing and language
 - a. Speak slowly and clearly
 - b. Avoid jargon
 - c. Pause after asking questions
 - d. Provide time for patient questions and elaborations more frequently
4. Explicit empathy
 - a. Listen/watch carefully for patient emotional cues
 - b. Increase explicit empathic statements

BEFORE THE VISIT

1. Chart review – review key interim history
2. Documentation – start the clinic note or add to the template started by the nursing staff. Create a mental agenda, if not written outline, in your HPI prior to calling
3. Self-preparation
 - a. Take a breath to ready yourself for the call
 - b. Make sure you are comfortably seated before calling the patient
 - c. If using video calling make sure the background of your video is not distracting
 - d. If possible be away from noisy/high traffic areas

BEGINNING THE CALL

1. Introductions
 - a. Identify patient and introduce self
 - b. Check if this is a good time for the patient to talk
 - c. Make certain that they are in a safe place and the conversation can be confidential
 - d. Offer a warm greeting
2. Initial check in
 - a. Can they hear/see you
 - b. Confirm how you will reconnect with the patient if disconnected
 - c. Build rapport
3. Orientation
 - a. Describe your understanding of the purpose of the visit, including if applicable the length of the visit.
 - b. If documenting let the patient know that you will be typing during the call.

DURING THE VISIT

1. Set the agenda
 - a. Elicit list of problems/concerns from the patient, negotiate what can and cannot be covered in the visit
2. Ask questions
3. Signpost
 - a. Identify when you are moving from one topic to another
4. Teach back to confirm that the patient understands, particularly around next steps and management options.
5. Orient the patient to the end of the encounter and review.
6. Notify the patient how or if information will be shared using MyChart or After-Visit Summary.
7. Discuss next steps and any follow up visits.
8. Note how long the conversation was.

AFTER THE VISIT

1. Take a moment after the first few appointments and review the process, was the information collected appropriate, how was your tone and flow of the conversation etc.
2. Prepare for the next appointment, ask any questions relevant for the next patient visit.

LOGISTICS

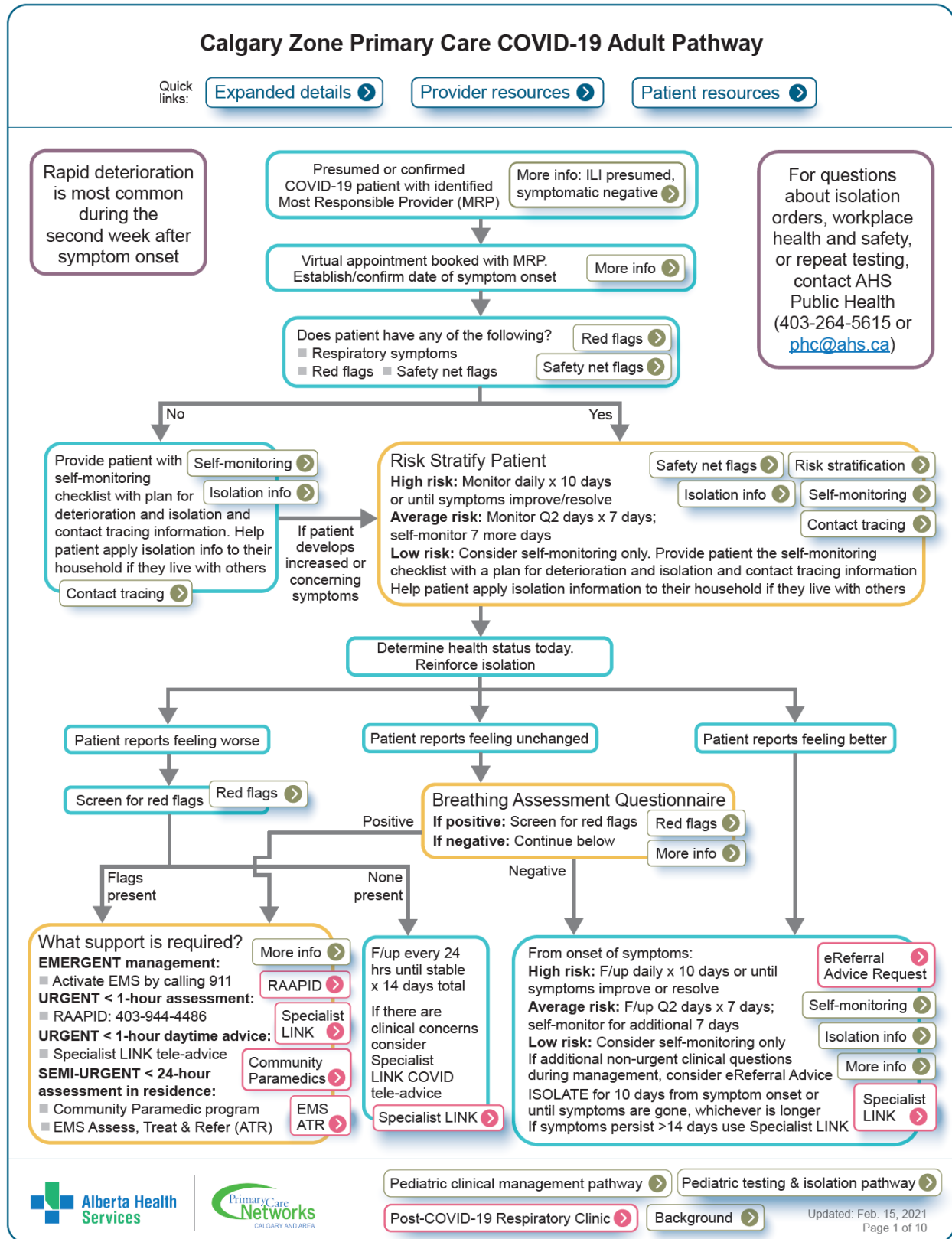
1. How to make a 3-way call. If no direct ability then get the student listening in through a second phone.

iPhone	<ol style="list-style-type: none"> 1. Make a normal phone call. 2. Touch the Add Call button to make another call. The person you're already on the line with will be put on hold. 3. After speaking to the second person, touch Merge Calls. You now have a three-way conference call where all parties can hear each other. 4. Repeat steps 2 and 3 to add more people. Up to 5 calls can be merged depending on your carrier.
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Android	<ol style="list-style-type: none">1. Phone the first person.2. After the call connects and you complete a few pleasantries, touch the Add Call icon. The Add Call icon is shown. ...3. Dial the second person. ...4. Touch the Merge or Merge Calls icon. ...5. Touch the End Call icon to end the conference call.
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2. How to chart remotely. Clinic and system specific, check with your preceptor at the beginning of the rotation.
3. Zoom
UCalgary Support - <http://elearn.ucalgary.ca/zoom/>

B. Alberta Health Service's Presumed/Confirmed COVID-19 Positive Primary Care Pathway.
https://www.specialistlink.ca/files/CZ_COVID_Adult_Pathway.pdf



C. Virtual Care Playbook 2020

https://www.cma.ca/sites/default/files/pdf/Virtual-Care-Playbook_mar2020_E.pdf

SCOPE OF PRACTICE

— WHAT PROBLEMS CAN BE SAFELY ASSESSED AND TREATED

Physician regulators all adhere to the same concept when it comes to virtual visits: a physician must not compromise the standard of care. That means that if a patient seen virtually provides a history that dictates a physical examination manoeuvre that cannot be executed remotely, the physician must redirect the patient to an in-person assessment.


For this reason, the scope of virtual practice is presently limited to encounters that require only history, gross inspection and/or data that patients can gather with cameras and common devices (e.g., glucometers, home blood pressure machines, thermometers and scales). **In practical terms, you can safely use virtual care to:**

- assess and treat mental health issues
- assess and treat many skin problems (photos submitted in advance provide resolution that is much better than the resolution of even a high-quality video camera)
- assess and treat urinary, sinus and minor skin infections (pharyngitis too if you can arrange throat swabs)
- provide sexual health care, including screening and treatment for sexually transmitted infections, and hormonal contraception
- provide travel medicine
- assess and treat conditions monitored with home devices and/or lab tests (e.g., hypertension, lipid management, thyroid conditions and some diabetes care; in-person consultations will still be needed for some exam elements)
- review lab, imaging and specialist reports
- conduct any other assessments that do not require palpation or auscultation

In contrast, the problems that are currently **not amenable to virtual care** include any new and significant emergency symptoms such as chest pain, shortness of breath and loss of neurologic function. They also include ear pain, cough, abdominal/gastrointestinal symptoms, musculoskeletal injuries or conditions, most neurological symptoms and congestive heart failure.



D. CanMEDS Roles

 <p>CanMEDS-Family Medicine</p> <p><small>Image adapted from the CanMEDS Physician Competency Diagram with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2009.</small></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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E. Learning Objectives and 26 Clinical Presentations

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

Resources/links to resources are also listed.

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.

<https://sites.google.com/site/sharcfm>.

Key features for each presentation are available via LearnFM and the '26 Clinical Presentations' folder in Osler.

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
Elderly Healthcare

Chronic Disease

Hypertension
Ischemic heart disease
Diabetes
Obesity
Asthma
Fatigue
Dizziness
Anxiety
Depression

Additional Resources

General

All of the following links are 'general' references because they may contain information regarding multiple different diseases. An example would be the link <https://actt.albertadoctors.org/CPGs> where you will find multiple topics covered.

<https://cep.health/clinical-products/low-back-pain/>

<https://osteoporosisdecisionaid.mayoclinic.org/>

<https://cep.health/>

<https://car.ca/>

<https://www.rxfiles.ca/rxfiles/>

<https://therapeuticseducation.org/>

<https://www.mycanceriq.ca/>

<https://canadiantaskforce.ca/>

<http://medstopper.com/>

<https://deprescribing.org/>

Clinical pharmacology in Clerkship

<https://core.ucalgary.ca/other/clinical-pharmacology/>.

Other Important Topics

Adolescent Health

<http://thehub.utoronto.ca/family/adolescent/>

Clinical Practice Guidelines

<https://www.nice.org.uk/>

<https://sporevidencealliance.ca/key-activities/cpg-asset-map/cpg-database/>

<https://www.cfpc.ca/en/education-professional-development/practice-tools-guidelines/tools-for-doctors/clinical-practice-guidelines>

CPG – Special Populations

<https://www.cmaj.ca/content/192/10/E240>

LGBTIQ2S

<http://thehub.utoronto.ca/family/lgbtiq2s/>

Mental Health

<https://www.porticonetwork.ca/web/psychiatry-primary-care/ppc-toolkit-mobile-app>

Pain Assessment and Management

<https://sites.google.com/site/sharcfm/sharc-fm-list-1/pain-assessment-management-clinical-cards>

Thyroid Disease

<https://canadiantaskforce.ca/screening-for-thyroid-dysfunction-do-not-routinely-order-tsh-in-all-patients/>

<http://thehub.utoronto.ca/family/thyroid-disease/>

26 Clinical Presentations

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.

Resources: <https://learnfm.ucalgary.ca/abdominal-pain/>
<http://thehub.utoronto.ca/family/abdominal-pain/>

2. Anxiety

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

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

Resources: <https://learnfm.ucalgary.ca/anxiety/>
<http://thehub.utoronto.ca/family/anxiety-3/>

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.

Resources: <https://learnfm.ucalgary.ca/asthma/>
<http://thehub.utoronto.ca/family/asthma/>

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.

Resources: <https://learnfm.ucalgary.ca/chest-pain/>

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

Resources: <https://learnfm.ucalgary.ca/contraception/>
<https://www.sexandu.ca>
<https://www.innovating-education.org>

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.

Resources: <https://learnfm.ucalgary.ca/cough/>
<https://goldcopd.org/gold-reports>
<http://thehub.utoronto.ca/family/cough-and-dyspnea>
http://emodules.med.utoronto.ca/FM/cough/story_html5.html (interactive)

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

Resources: <https://learnfm.ucalgary.ca/depression/>
<https://www.canmat.org/resources>
<http://thehub.utoronto.ca/family/depression>

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.

Resources: <http://guidelines.diabetes.ca/health-care-provider-tools>
<http://thehub.utoronto.ca/family/diabetes-mellitus-dm2>

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

Resources: <http://thehub.utoronto.ca/family/diarrhea/>

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.

Resources: <https://learnfm.ucalgary.ca/dizziness/>
<http://thehub.utoronto.ca/family/dizziness>

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 advanced 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, frontotemporal).

Resources: <https://learnfm.ucalgary.ca/elderly-health-care/>
<https://www.cmaj.ca/content/182/17/1864>

<https://www.cfp.ca/content/63/10/772>
<http://thehub.utoronto.ca/family/elderley-care>

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.

Resources: <https://learnfm.ucalgary.ca/fatigue/>
<https://sites.google.com/site/sharcfm/sharc-fm-home/fatigue-objectives>

13. Fever and Common Infections

1. Perform a focused history and physical exam to determine presence of fever, fever pattern, and associated symptoms & signs, so as to:
 - a. Make a determination as to whether a patient truly has/has had a fever, and whether it is acute versus chronic.
 - b. Identify patients with serious illness:
 - i. Demonstrate good understanding of the potential groups of cause of fever
 - ii. Infection, malignancy, drugs, environment (sun, heat)
 - iii. Important conditions not to miss: endocarditis, meningitis, septicemia
2. Recognize special groups where fever has different significance or impact (e.g. neonates, elderly, travel/immigrant issues, under-immunized groups, living conditions, cultural/religious groups, immune-compromised individuals).
3. Propose a plan for appropriate investigation of possible causes, based in the local context.
4. Propose a basic plan of management that includes:
 - a. Simple at home measures including antipyretics
 - b. guidance for patients/caregivers on how to access care depending on evolution of illness
5. Be familiar with causative agents and treatment options for:
 - a. Acute otitis media
 - b. Cellulitis
6. For patients presenting with ear pain:
 - a. Make the diagnosis of otitis media (OM) only after good visualization of the eardrum (i.e., wax must be removed), and when sufficient changes are present in the eardrum, such as bulging or distorted light reflex (i.e., not all red eardrums indicate OM).
 - b. Include pain referred from other sources in the differential diagnosis of an earache (e.g. tooth abscess, trigeminal Neuralgia, TMJ dysfunction, pharyngitis, etc.).

Resources: <https://learnfm.ucalgary.ca/fever-and-common-infections/>
<http://thehub.utoronto.ca/family/fever>

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

Resources: <https://learnfm.ucalgary.ca/headache/>
<http://thehub.utoronto.ca/family/headache-2>

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.

Resources: <https://learnfm.ucalgary.ca/hypertension/>
<http://thehub.utoronto.ca/family/hypertension>

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.

Resources: <https://learnfm.ucalgary.ca/ischemic-heart-disease/>
<http://thehub.utoronto.ca/family/chest-pain>

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.

Resources: <https://learnfm.ucalgary.ca/joint-pain/>
<http://thehub.utoronto.ca/family/jointlimb-pain>

18. Lower 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.

Resources: <https://learnfm.ucalgary.ca/low-back-pain/>
<http://thehub.utoronto.ca/family/back-pain>

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).

Resources: <https://obesitycanada.ca/resources>
<http://thehub.utoronto.ca/family/obesity>

20. Palliative Care

1. Explain the definition of the following terms and their application in palliative care settings and/or advanced 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.

Resources: <https://learnfm.ucalgary.ca/palliative-care/>
<http://thehub.utoronto.ca/family/palliative-care-2>

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)

Resources: <https://learnfm.ucalgary.ca/adult-female-preventive-care/>
<https://learnfm.ucalgary.ca/adult-male-preventive-care/>
<http://thehub.utoronto.ca/family/adult-preventive-health-care-2/>
<http://thehub.utoronto.ca/family/adult-preventive-health-care-2/>

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.

Resources: <https://learnfm.ucalgary.ca/prenatal-care/>
<http://thehub.utoronto.ca/family/pregnancy-and-prenatal-care>

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.

Resources: <https://learnfm.ucalgary.ca/skin-conditions/>
<https://dermnetnz.org/quizzes/>, <https://www.aad.org/member/education/residents/bdc>
<http://thehub.utoronto.ca/family/skin-concerns>

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]).

Resources: <http://thehub.utoronto.ca/family/common-infections/>

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

Resources: <https://open.alberta.ca/dataset/93a97f17-5210-487d-a9ae-a074c66ad678/resource/bc78159b-9cc4-454e-8dcd-cc85e0fcc435/download/sti-treatment-guidelines-alberta-2018.pdf>
<http://thehub.utoronto.ca/family/urogenital-concerns>
<http://thehub.utoronto.ca/family/genital-concerns-and-stis>

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.

Resources: https://www.caringforkids.cps.ca/handouts/your_childs_development
<http://thehub.utoronto.ca/family/well-child-visit-2>

F. Patient-Centred Care Project (PCCP) Evaluation Form

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.				

Poor – the student failed to consider the needs and characteristics of their patient or community when choosing a course of action. Minimal or no discussion of potential benefits and harms of chosen course of action is evident. No consideration or discussion of the patient’s values or concerns with regards to the decision to be made.

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

Presentation Skills	Poor <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:

G. The Big 10 Learning 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.

H. Clinical Calendar – 2-Week Block

✓ Attended or ✗ Not attended, and indicate travel time in the appropriate box. If ✗ Not Attended, provide reason: A (absent) / FD (Flex Day) / PA (Preceptor Absent) NPA (No Preceptor Available). **PA and NPA must be initialed by the preceptor.**

WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning	Podcasts: Orientation, Advanced Care Planning Podcast: Vaccine Hesitancy Addressed		Submit <i>proposed</i> Clinical Calendar (during this week) to famclerk@ucalgary.ca					# clinic days
	Afternoon	✓ or ✗							
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
2	Morning								# clinic days
	Afternoon			Submit <i>final</i> signed Clinical Calendar to famclerk@ucalgary.ca by 11:59 pm					
	Evening			Submit Logbook to famclerk@ucalgary.ca By 11:59 pm (if end of 6-weeks)		Summative Exam (if end of 6-weeks)			
TOTAL CLINIC DAYS									
Preceptor signature: _____ Student Name: _____ Signature: _____									

Please indicate time with Allied Health Professionals and specify type (pharmacist, RN, NP, etc.). Consider using this document to schedule midterm and final ITER review meetings with your preceptor. Include any travel time (write this in the appropriate box). 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).

I. Clinical Calendar – 4-Week Block

✓ Attended or ✗ Not attended and indicate travel time in the appropriate box. If ✗ Not Attended, provide reason: A (absent) / FD (Flex Day) / PA (Preceptor Absent) NPA (No Preceptor Available). **PA and NPA must be initialed by the preceptor.**

WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning	Podcasts: Orientation, Advanced Care Planning	Start PCCP (during this week) Email topic to famclerk@ucalgary.ca	Submit <i>proposed</i> Clinical Calendar to famclerk@ucalgary.ca (during this week)					
	Afternoon	✓ or ✗			Vaccine Hesitancy Addressed 12:15-1 pm				# clinic days
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
2	Morning								
	Afternoon				Multimorbidity 12:15-1 pm	Formative Exam Before 3:59 pm			# clinic days
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
3	Morning				Submit PCCP and evaluation to famclerk@ucalgary.ca				
	Afternoon				1:00 – 2:30 pm - PCCP 2:45-4:45 pm - Planetary Health				# clinic days
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
4	Morning			Submit <i>final</i> Clinical Calendar to famclerk@ucalgary.ca by 11:59 pm					
	Afternoon					Summative Exam (if end of 6-weeks)			# clinic days
	Evening			Submit Logbook to famclerk@ucalgary.ca By 11:59 pm (if end of 6-weeks)					
								TOTAL CLINIC DAYS	
Preceptor signature: _____ Student Name: _____ Signature: _____									

Please indicate time with Allied Health Professionals and specify type (pharmacist, RN, NP, etc.). Consider using this document to schedule midterm and final ITER review meetings with your preceptor. Include any travel time (write this in the appropriate box). 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).

J. 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 life-cycle that incorporates preventative healthcare e.g. well-child visit, antenatal care, periodic health check to an older patient 	Seeing and discussing patients in clinic Consider how your preceptor is a resource within your specific setting	ITER (mid-point & final) Certifying exam Logbook completion
CANMEDs Role: Manager CSM Big 10: 1, 2, 3, 4, 5	Design a <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)

SECTION 2: Information for Preceptors

1. SUPERVISION AND ASSESSMENTS

1.1 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 student's participation in any activity that 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 students 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 students 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, I ask that students be in town at least one weekend of the 4 week block and participate in weekend call activities as appropriate.**

SUPERVISION AND SCHEDULING TIPS:

#1. How should I structure my clinical day to accommodate a clerk?

During the first two days it is important that there is reciprocal observation. The clerk shadows you to understand how it is you like to run your clinic and visits, and see how you complete interviews and exams, AND you observe the clerk taking an interview, completing a focused exam, and developing a management plan. Once you have a good understanding of the clerk's strengths you will be able to schedule accordingly. A sample schedule is below:

	Clerk	Preceptor
0800 - 0815	✓	✓
0815 - 0830	X	✓
0830 - 0845	X	✓
0845 - 0900	✓	✓
0900 - 0915	X	✓
0915 - 0930	X	✓
0930 - 0945	✓	✓
0945 - 1000	X	✓

As the clerk's skills develop you may be able to move to one patient every 30 minutes.

A helpful rule can be to inform the clerk to interrupt you when they are fully ready to present their case (warn your patient that you may be interrupted) and then you briefly review their case and allow that

patient to get on their way. Being exposed to as many cases as possible during a day is important for their learning.

Another useful thing to do to help with organization is to **run through the day sheet before the day begins** so that you can specifically discuss patients with new presentations, such as NYD abdo pain, and assign them to the clerk, or you can identify presentations that they have not been exposed to yet, such as a prenatal visit, a newborn exam, etc., to ensure they have that learning opportunity, and/or you can ask the clerk to run through the day sheet the night before and prepare for some cases that interest them, or for which they will need significant time to review the patient's chart.

Please remember that the University of Calgary is a 3-year program but the clerks have extensive - typically science - backgrounds and are usually very ready and eager to see patients and to start applying their clinical reasoning skills. They should not be shadowing preceptors routinely, they should be given graded independence.

#2. How can I manage having two learners at a time?

Often, if there are two learners one is a clerk and one is a resident. The sample two-learner schedule below highlights that all three of you can have a patient booked at the top of each 90 minute period. The assumption would be that you see your patient and wrap them up in the 15 minutes allotted (by 8:15). The resident would be ready to review in the next time slot (by 8:30) and the clerk in the final time slot (by 8:45). Then you start the process over again.

	Clerk	Resident	Preceptor
0800 - 0815	✓	✓	✓
0815 - 0830	X	X	X
0830 - 0845	X	✓	X
0845 - 0900	✓	X	✓
0900 - 0915	X	✓	X
0915 - 0930	X	X	X
0930 - 0945	✓	✓	✓
0945 - 1000	X	X	X

As residents are further along in their training they can be engaged to teach the clerk; however, it is important that you have observed the clerk yourself before that transition happens. **When residents are involved in teaching clerks**, the lead preceptor should discuss the objectives of clerkship, and of the particular clerk they are teaching, with the resident first. And the residents should be given an opportunity to review the Preceptor Manual with particular emphasis on the objectives.

1.2 Assessments

1) Midpoint ITER – During 4-week long blocks

At the midpoint mark of the rotation (end of Week 2), please provide your student specific feedback (in addition to ongoing, continuous feedback) and fill out the mid-point ITER form on one45. Please also review the student's logbook to determine what clinical presentations/procedures, if any, still need to be sought out for the block.

If you are concerned that the student is at risk of not meeting expectations for performance in the block, written documentation must be provided to that student 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 and to support you as the preceptor by ensuring that the student can be contacted to see what supports or plan can be put in place to optimize learning and performance.

2) Final ITER -

At the end of the block, please provide students with feedback and complete and submit the Final ITER on one45.

Thank you again for your involvement in the teaching of our medical students at the Cumming School of Medicine. Should you have any questions, please contact the UME Program Coordinator at famclerk@ucalgary.ca who will be able to direct your question to the appropriate person.

For any academic concerns about a specific student, please do not hesitate to contact the Clerkship Director, Dr. Sonja Wicklum at sonja.wicklum@ucalgary.ca.

2. TEACHING RESOURCES

2.2 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.
- Dynamed: an electronic evidence-based, primary care database designed to provide the most useful point-of-care health information available. Dynamed can be accessed via the University of Calgary Health Sciences Library and the CMA.

Calgary Library Access

Step 1: Have UCID ready

Step 2: go to <https://itregport.ucalgary.ca/> and complete the online form to register for an IT account.

Step 3: go to <https://www-dynamed-com.ezproxy.lib.ucalgary.ca/> to set up your Dynamed account using your ucalgary email and password.

CMA Member Access

Step 1: Go to CMA website <https://www.cma.ca/>

Step 2: Click on 'Member Resources - All Clinical Tools' or go straight to <https://joulecma.ca/evidence>

Step 3: Click on 'Explore DynaMed'

Step 4: Enter personal CMA login details

- <https://library.ucalgary.ca/hsl> using your UCID login credentials. It is also possible to access Dynamed via the CMA, <https://joulecma.ca/evidence>. Click on Clinical Tools and selected Dynamed; login using your CMA login information.
- 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

2.3 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.

2.4 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.

2.5 SNAP

Masayasu Seki, Junji Otaki, Raoul Breugelmans, Takyuki Komoda, Shizuko Nagata-Kobayashi, Yu Akaishi, Jun Hiramoto, Iwao Ohno, Yoshimi Marada, Yoji Hirayama, Miki Izumi. How do case presentation teaching methods affect learning outcomes?-SNAP and the One-Minute preceptor. British Medical Journal. 2016;16:12. DOI 10.1186/s12909-016-0531-6.
<https://bmcmmededuc.biomedcentral.com/track/pdf/10.1186/s12909-016-0531-6>

2.6 RIME Guide

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

APPENDICES

A. Precepting Clerks Over Telemedicine

PRECEPTING CLERKS OVER TELEMEDICINE

Thank you for teaching the clerks during this difficult time, with so many changes we have prepared this document as a guide for teaching clerks while conducting telemedicine. Further resources are available on our website at <http://calgaryfamilymedicine.ca/undergrad/index.php/information-for-preceptors/information/20>. During the break from clinical activity the Clerks have been actively participating in 8 weeks of academic sessions designed to give them a base level of knowledge before entering your clinic, including instruction on proper donning and doffing should they be physically with you in your clinic. Clerkship started in January so the clerks have approximately 6 weeks of clinical clerkship training as of June 15, 2020.

During each day you can anticipate to see three categories of patients:

- 1) With Covid19 and needing follow-up
- 2) Acute or Chronic FM Issues (typical visit)
- 3) High risk/vulnerable (not ill) support (HRVS)

AT THE START OF EACH DAY REVIEW ANY UPDATED GUIDELINES FROM HEALTH AUTHORITIES.

1. WITH COVID19

- For high risk/vulnerable patients the Preceptor will call the patient, while you listen in if able. Once the patient has exited the call, discuss with the preceptor for 2-3 minutes.
- Medium/low risk – as per #2 – acute issues please see the definition of low and medium risk in the appendix document – ‘COVID Pathway’.

2. ACUTE OR CHRONIC FM ISSUES

Clerk is involved in approximately every second patient.

When appointments are booked the patient is advised of the timing: Clerk will call at 9:30, doctor/clerk together at 10:00AM.

- Clerk reviews chart (15 min)
 - special attention to age, GOC, medications, problem list
- Clerk calls patient 30 min before the time the preceptor will call.
 - Introduces themselves and tells the patient they will be getting some background information before the preceptor calls them in 30 minutes.
 - they complete HPI, med rec
 - avoid being conclusive about anything
- Clerk calls preceptors
 - 3-5 minute case review including A/P
 - scribe can be whomever, clerk if they have access, preceptor if clerk does not have access to chart
- Preceptor calls patient and asks if they can get the clerk back on the phone also (will likely be well-received). Preceptor reviews case with patient, clerk chimes in as needed.
- Preceptor then goes to next patient and students goes to the one after that.

3. HIGH RISK/VULNERABLE SUPPORT

Suggestions:

On Monday, preceptor identify 10 – 20 patients who are high risk/vulnerable that the clerk can call and check in on that week.

- The clerk can do the MOA work if needed and call and set a time (these could be afternoon appointments, leaving acute issues for the mornings)
- Run the list and pull out any information not highlighted in the visit notes. This is not meant to be an in-depth overview, but to provide the clerk with some helpful information that may be relevant during the visit e.g. you let the clerk know that this patient's father passed away a month ago, information which is not included in their chart.
- Clerk calls patient and considers:
 - review present state of covid19 pandemic to ensure understanding
 - review patient safety: access to food, water, support by loved ones or friends, sanitizing agents and their use
 - discuss fears – careful to not offer advice/minimize/make statements that are not factual
 - review medications, problem list, goals of care (GOC)
 - clerk books follow-up call for preceptor for next day afternoon unless urgent or unsure and then states they will get back to the patient
- Clerk reviews with preceptor 3-5 minutes, preceptor/clerk scribes, A/P created, decision about:
 - Needs: medical, support, how to access, are extended health team needed, GOC on chart – Y/N, if no, can GOC be done at next visit?
 - Clerk calls patient to inform next steps, provides with handouts as appropriate e.g. Patient guide to Covid19 and palliative care (Dr. Tan's)

COMMUNICATION TIPS FOR PHONE AND VIDEO VISITS

5. Maintain full attention
6. Convey attention and interest
 - a. Warm tone of voice
 - b. Verbal listening acknowledgements
 - c. Periodically summarize
7. Pacing and language
 - a. Speak slowly and clearly
 - b. Avoid jargon
 - c. Pause after asking questions
 - d. Provide time for patient questions and elaborations more frequently
8. Explicit empathy
 - a. Listen/watch carefully for patient emotional cues
 - b. Increase explicit empathic statements

BEFORE THE VISIT

4. Chart review – review key interim history
5. Documentation – start the clinic note or add to the template started by the nursing staff. Create a mental agenda, if not written outline, in your HPI prior to calling
6. Self-preparation
 - a. Take a breath to ready yourself for the call
 - b. Make sure you are comfortably seated before calling the patient
 - c. If using video calling make sure the background of your video is not distracting
 - d. If possible be away from noisy/high traffic areas

BEGINNING THE CALL

4. Introductions
 - a. Identify patient and introduce yourself
 - b. Check if this is a good time for the patient to talk

- c. Make certain that they are in a safe place and the conversation can be confidential
 - d. Offer a warm greeting
- 5. Initial check in
 - a. Can they hear/see you
 - b. Confirm how you will reconnect with the patient if disconnected
 - c. Build rapport
- 6. Orientation
 - a. Describe your understanding of the purpose of the visit, including if applicable the length of the visit.
 - b. If documenting let the patient know that you will be typing during the call.

DURING THE VISIT

- 9. Set the agenda
 - a. Elicit list of problems/concerns from the patient, negotiate what can and cannot be covered in the visit
- 10. Ask questions
- 11. Signpost
 - a. Identify when you are moving from one topic to another
- 12. Teach back to confirm that the patient understands, particularly around next steps and management options.
- 13. Orient the patient to the end of the encounter and review.
- 14. Notify the patient how or if information will be shared using MyChart or After-Visit Summary.
- 15. Discuss next steps and any follow up visits.
- 16. Note how long the conversation was.

AFTER THE VISIT

- 3. Take a moment after the first few appointments and review the process, was the information collected appropriate, how was the clerk's tone and flow of conversation etc. Provide feedback for them to expand on in subsequent visits.
- 4. Prepare for the next appointment, ask any questions relevant for the next patient visit.

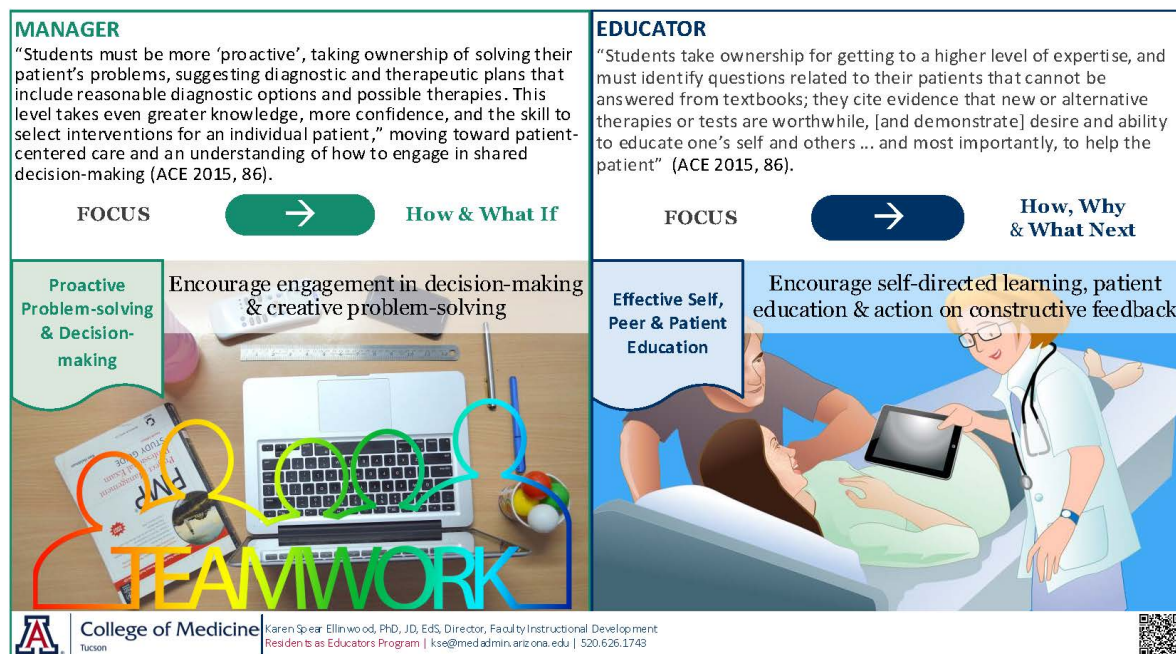
LOGISTICS

- 4. How to make a 3-way call. If no direct ability, then get the student listening in through a second phone.

iPhone	1. Make a normal phone call. 2. Touch the Add Call button to make another call. The person you're already on the line with will be put on hold. 3. After speaking to the second person, touch Merge Calls. You now have a three-way conference call where all parties can hear each other. 4. Repeat steps 2 and 3 to add more people. Up to 5 calls can be merged depending on your carrier.
Android	1. Phone the first person. 2. After the call connects and you complete a few pleasantries, touch the Add Call icon. The Add Call icon is shown. ... 3. Dial the second person. ... 4. Touch the Merge or Merge Calls icon. ... 5. Touch the End Call icon to end the conference call.

5. How to chart remotely. System specific for your clinic, please review with the clerk at the beginning of the rotation.
6. Zoom
UCalgary Support - <http://elearn.ucalgary.ca/zoom/>
AHS - http://meta.cche.net/clint/media/himhirex/14368/14368_frmFile2.pdf

B. RIME Guide



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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C. 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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QUESTIONS?

Contact us at education@cfpc.ca.

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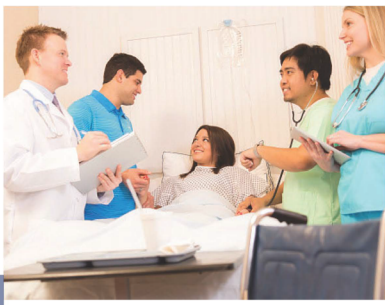

LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Twelve Points

to Consider When Talking to a Medical Student

About a Career in Family Medicine



12

TALKING POINTS

ABOUT A CAREER IN FAMILY MEDICINE

• 1 •

Emphasize that family medicine is a specialty.

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

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

• 2 •

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

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

• 3 •

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

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

• 4 •

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

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

• 5 •

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

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

• 6 •

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

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

• 7 •

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

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

• 8 •

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

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

• 9 •

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

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

• 10 •

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

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

• 11 •

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

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

• 12 •

Share stories about how patients appreciate your work.

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