UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

Family Medicine Clinical Experience (FMCE)

Core Document 2023
Blocks 1 and 2 of RIME

UNDERGRADUATE MEDICAL EDUCATION
Class of 2026
2023-2024 Academic Year

Contents

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2. Overview

With pride, we invite all of our first-year medical students to see, experience, and—with guidance—participate in the delivery of rural and urban Family Medicine across southern Alberta. Our preceptor physicians are skilled clinicians and educators who deliver community-based, generalist, continuity of care within a Patient's Medical Home (PMH). Year over year, students highly rate the quality of preceptor teaching. This includes teaching and learning within safe and supportive environments, providing the right amount of guidance and autonomy for students to safely participate in care, and being approachable, non-judgmental and taking time to ensure meaningful student participation in patient care. It takes considerable preceptor skill to provide supportive educational experiences for our very early, engaged, and enthusiastic learners, ensuring student participation while concurrently delivering high quality, timely patient care.

The value of family physicians to the healthcare system might seem intangible, but we can put some numbers to it. Family physicians form the largest part of Canada's medical workforce (Lemire and Slade 2022); they account for over 50% of all practicing physicians and surgeons (CMA 2019). Family physicians provide the overwhelming majority (~70% in Alberta) of all health care visits in Alberta and Canada (Stewart and Ryan 2015). Family physicians see more patients with multiple co-morbidities than specialists (Starfield et al 2003) and perform as well as specialists in managing common diseases such as diabetes, depression, and cardiovascular disease in the elderly (Harris et al 2008; Wisniewski et al. 2009; Stransberg et al. 2006). Patients who have a regular family physician report using emergency services less than half the time as those without a physician (4.3% vs 9.6%) and being admitted to hospital less than half the time (1.7% vs. 4%) (Fung et al 2015). Finally, adding family physicians to a population improves health outcomes greater than any other physician group: if you add one (1) family physician per 10,000 people there are 15 fewer deaths, 40 fewer hospitalizations, and an average increase in life expectancy by 52 days (Basu et al. 2019; Chang et al. 2017). In summary, access to a primary care workforce, which provides comprehensive patient care, improves patient outcomes (death) and decreases health care utilization (emergency room visits, hospitalizations and readmissions) and health care costs (Kolber et al. 2020).

In the Family Medicine Clinical Experience (FMCE), students will experience the breadth, depth, and variety of community Family Medicine. Whether a rural, urban or satellite location, all students will see practices that are Generalist Family Medicine (rather than specialized) and apply learning to a wide range of patients. Student experiences will be longitudinal, spacing visits over time.

Seeing patients over time (continuity) is highly valued by patients and physicians and contributes to strong doctor-patient relationships and enhanced outcomes. Most students thrive in this experience where a variety of patients are seen and student autonomy and responsibility is consistent with the learner level.

Depending upon the preceptor, students may join family physicians caring for patients in emergency departments, delivering babies, or attending other care locations in addition to the office. At least 50% of the student experience, however, will be in office care. Students may participate in team- based care with nurses, pharmacists, dieticians, mental health clinicians or others as available in the PMH clinic. Students will observe how family physicians and teams search up-to-date medical knowledge and shape it into a care plan based upon shared decision making with the patients' unique needs and context.

With preceptor and/or Resident physician support, students will use history-taking, communication, medical knowledge, and physical exam skills to participate in patient care delivery to increase skills and confidence. Almost certainly students will see patients for conditions of which they have lots, little, or no knowledge. Student experiences which offer the right amount of independence and guidance are most valued. All students and preceptors should discuss what feels best for both preceptor and student.

First year is an exciting time to appreciate the unpredictability and diversity of Family Medicine. Students enjoy taking the patient history and with increasing skills develop more comprehensive histories over time. With preceptor guidance students examine patients together and develop diagnoses and management plans while guiding student learning. At all times the preceptor is responsible for patient care and documentation.

Other questions about Family Medicine? Research? Teaching? The business side of Family Medicine? Certainly ask. Our family docs are pleased to chat.

Reference list:

Basu S, Berkowitz SA, Phillips RL et al. 2019. Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015. JAMA Intern Med, 179(4): 506-514.

Chang CH, O'Malley AJ, Goodman DC. 2017. Association between Temporal Changes in Primary Care Workforce and Patient Outcomes. Health Serv Res, 52(2): 634-655.

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Harris S, Yale J-F, Dempsey E. Can family physicians help patients initiate basal insulin therapy successfully? Can Fam Phys 2008; 54: 550-8.
Kolber, M, Korownyk, C, and Allan, GM. 2020. Re: Evidence pertaining to healthy primary care workforce. PEER (Patients Experience Evidence Research) team. Personal communication.

Lemire, F and Slade, S. 2022. Scope of work and the future of family practice. Canadian Family Physician, 68(8): 626. DOI: https://doi.org/10.46747/cfp.6808626

Starfield B, Lemke KW, Bernhardt T et al. Comorbidity: implications for the importance of primary care in 'case' management. Ann Fam Med 2003;1(1):8-14.

Stewart, M and Ryan B. 2015. Ecology of Health Care in Canada. Can Fam Phys, 61(5): 449-53.

Strandberg TE, Pitkala KH, Berglind S et al. Multifactorial intervention to prevent recurrent cardiovascular events in patients 75 years or older: Am Heart J 2006; 152:585292

Wisniewski SR, Rush AJ, Nierenberg AA et al. Can Phase III Trial Results of Antidepressant Medications Be Generalized to Clinical Practice? Am J Psychiatry 2009; 166: 599–607

3. Learning Objectives

Objective 1: Apply communication and history-taking skills in patient encounters

All students will apply relevant office practice communication and history-taking skills identified in the longitudinal Clinical Skills course. Skills include introducing self to the patient and building rapport, identification of presenting complaint(s), and eliciting further relevant pertinent positive or negative information to help with assessment. Note that these further details are only expected if related clinical approaches and course work have been completed.

Skilled history taking will enquire and document biopsychosocial contexts (patient feelings, ideas, fears, and expectations) and social contexts (low literacy, poverty, or abusive environments).

Use of open and closed questions, attentive listening, recognition of verbal and non-verbal cues, avoidance of jargon and clarification are all applicable communication skills to apply.

> **In Clinic:** To help with time management, chat with student/preceptor about expectations and time available to take the history prior to seeing patients.

History taking may be independent. If the student and preceptor initially choose to take histories together it is expected that this should progress to independent history taking with subsequent preceptor discussion. Preceptors and students may discuss the patient context prior to the visit; students may review medical records and related references before or after the visit. Students may accompany the preceptor in the exam room and participate in history taking, examinations, and discussions about diagnoses and planning. Students may also practice presenting the history verbally.

Objective 2: Record relevant details of a focused patient visit in a SOAP note

S Subjective
O Objective
A Assessment
P Plan

A SOAP note is written documentation to record the information and impression from a patient interaction. It should convey the information from an encounter that the writer feels is relevant for other healthcare professionals to provide appropriate care to the patient in the next encounter.

Subjective: Document the relevant history in **Subjective**. It is the STORY that you HEAR from the patient about their journey. Document the appropriate details you uncovered in your history-taking. With increasing experience students will organize by issue and prioritize issues.

Objective: Document relevant physical exam findings, vital signs, labs and investigations in **Objective**. This is what you MEASURE and OBSERVE. Ensure no history is recorded in Objective.

Assessment: Document what you think is going on in **Assessment**. It is your impression of the constellation of signs and symptoms before you.

Plan: Document what your course of action is to address each issue in **Plan**.

Both **Assessment** and **Plan** are informed by **Subjective** and **Objective** findings. We should consider when and why to return to care (continuity). At this early learner level preceptors most likely will have to make clinical reasoning overt to help learners understand how and why diagnoses and plans are developed.

As students progress through pre-clerkship RIME curriculum they are expected to incorporate more knowledge and practice more of their cumulative skills. There should be graduated responsibility based on student and preceptor comfort level after shared discussion of expectations for the clinic half-day.

In Clinic:

Review expectations that two (2) x SOAP notes are to be completed with preceptor review and feedback, one at the first clinic and another at a future clinic. SOAP notes without patient identifying data can be sent electronically if time is tight to review in clinic.

All physical examinations done by students must be with in-room physician (preceptor or Resident) or staff guidance and patient consent.

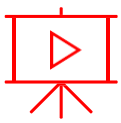
All students, whether in a rural or urban placement, must complete two (2) SOAP notes with preceptor review and feedback for each of Block 1 and Block 2 (i.e. 2 x SOAP notes per Block).

Objective 3: Demonstrate an awareness of the Patient's Medical Home

The Patient's Medical Home is the evolution of family medicine in Canada. In this vision for primary care, every family practice across Canada will offer the medical care that Canadians want – readily accessible, centered on patients' and families' needs, throughout all stages of life, and integrated with other services in the community and health care system.

As students are placed into Patient's Medical Home clinics, awareness may include discussions with preceptors about the PMH model of care, what makes a clinic a PMH, and any consideration of the 10 pillars. Awareness may also be demonstrated by including use of PMH health team members in SOAP note plans.

Watch the video "The Patient's Medical Home (PMH), the vision for Family Practice in Canada" at orientation or the link below:



https://patientsmedicalhome.ca/success-story/video-pmh-in-one-minute/

Objective 4: Demonstrate an awareness of Generalism in Medicine

Generalists are a specific set of physicians whose core abilities are characterized by broad scope of practice, able to respond to their patient and community needs. The Praxis of Generalism in Family Medicine involves the six (6) core concepts of (Kelly et al. 2021):

- Comprehensive Care
- Complexity
- Context
- Continuity of Care
- Collaboration
- Communication

These concepts will be both discussed and modelled in the Orientation and Midpoint sessions, the Small Groups, and in the Patient Medical Homes where you will have your clinical experiences.

Kelly, MA, Wicklum, S, Hubinette, M, and Power, L. 2021. The praxis of generalism in family medicine: Six concepts (6Cs) to inform teaching. Canadian Family Physician, 67 (10): 786-788. DOI: https://doi.org/10.46747/cfp.6710786

4. Schedule

FMCE is a longitudinal experience across Block 1 (Sept-Dec) and then Block 2 (Jan-June). Each Block will be a different clinical placement with a different preceptor.

Block 1:
Urban Clinic x 3 half-days (at least 3.5 hrs each)
OR
Rural Clinic x 2 clinic days (at least 5.5 hrs each)

Block 2:
Urban Clinic x 3 half-days (at least 3.5 hrs each)
OR
Rural Clinic x 2 clinic days (at least 5.5 hrs each)

University Sessions
Orientation: start of Block 1
Midpoint: start of Block 2
Debrief and Wrap-up: start of Block 3

Refer to Freshsheet for exact dates.

Clinic Scheduling
With the exception of the urban academic clinics, student-preceptor pairs are responsible for scheduling their FMCE in the Professional Role FMCE times or other asynchronous or unscheduled Professional Role time. If clinic scheduling changes must occur, the rescheduled clinic time must be made up in these same options of blocked time.

Urban Community Clinics
Urban community clinic students attend three (3) x half-day clinics per Block, ideally spaced out evenly over the Block. Each half-day clinic should be at least 3.5 hours.

Urban Academic Clinics (Sunridge, South Health Campus and the Central Teaching Clinic)
Urban academic clinic students attend three (3) x half-day clinics per Block, ideally spaced out evenly over the Block. Each half-day clinic should be at least 3.5 hours.

Scheduling in the academic teaching clinics will be provided by each clinics' scheduler to the student, based on the FMCE Professional Role blocks of time. If any of these half-days need to be rescheduled the student will reschedule with that academic clinic scheduler.

Rural Clinics
Rural students attend two (2) x clinic days per Block, ideally spaced out evenly over the Block. Each rural clinic day should be at least 5.5 hours in length.

Fewer clinic days and longer clinics (5.5 hours or greater) reduces travel time and ensures equivalent clinical hours to the urban experience. Students are expected to interact with patients and preceptors until the clinic is finished. ***Students may have to use asynchronous or unscheduled Professional Role time to ensure attendance at the longer rural clinic day. In exceptional circumstance, students may be able to apply for an excused absence from a small/large group session to meet FMCE rural attendance requirements.***

It may make sense to travel the night before and stay local to the rural community before the clinical experience. Contact the DLRI office at dlri@ucalgary.ca or rmexpenses@ucalgary.ca for all rural travel, accommodation, and funding inquiries.

5. Mandatory Requirements

Attendance
Student Orientation, Midpoint, and Debrief/Wrap-Up sessions and all clinical experiences are mandatory, unless UME has specifically waived a requirement.

Students will stay with patients and preceptor until the scheduled clinic/half-day finishes. Students are expected to be prepared, participate in clinical care, and behave in a professional manner.

In each of Block 1 and Block 2:
- Urban students must attend 3 x half-day clinics (at least 3.5 hrs each).
- Rural students must attend 2 x clinic days (at least 5.5 hrs each).

Reflective Writing Exercise
Upon completion of the clinical experiences at the end of Block 2, students will write and submit a 200 word reflection on Generalism in Medicine that they experienced during their time in clinic. This can be something they observed during their clinical time or an element of Generalism that

was discussed with their preceptor. The Reflective Writing Exercise can be submitted on One45 any time after the first clinical session up until the end of Block 2. **This Assignment is due June 30 of the year that their Block 2 ends.**

Assessment
Students must review 2 x SOAP notes with their preceptor per Block.

Students will be assessed using Entrustable Professional Activities (EPAs). **At least two (2) EPAs** must be completed **per Block**, approximately one for each clinical day/half-day. Students will be responsible for sending these EPAs to their preceptor via One45. These EPAs must be submitted and completed by the end of the respective Block with that preceptor and clinical experience.

To Pass
- Attendance at all sessions (clinical and Orientation/Midpoint/Debrief sessions)
- Review 2 x SOAP notes with preceptor per Block *(Must Complete)*
- Obtain at least 2 x EPAs per Block *(Must Complete)*
- Reflective Writing Exercise on Generalism in Medicine (due June 30 of the year that their Block 2 ends) *(Must Complete)*
- Act in a professional manner, including preparation and participation

Remediation
You will not need to remediate a "Concerns Identified" or a "Still developing towards minimum expectation" EPA – this is just an indication that you require additional experience in the area of that EPA. A "Concerns Identified" in an EPA 0 for "Learner demonstrated accountability to self, peers, and profession" will trigger a conversation with Course and/or UME leadership.

The need for remedial clinical experiences will be evaluated on a case-by-base basis. Any remedial clinical experiences are to be completed within 4 weeks of the end of that current Block.

6. Evaluation and Assessment

Student Assessment
As mentioned, students will be assessed using Entrustable Professional Activities (EPAs). The possible EPAs will be selected from those focused on professional accountabilities, communication skills, history and physical exam skills, or synthesis skills such as assessment and management plan development (in the later stages of the course). These will be available to select and submit to your preceptor from One45.

Course Evaluation
At the end of each Block 1 and 2, students will be able to evaluate their clinical experience for that Block using the Manchester Clinical Placement Index (MCPI). The MCPI is a better (and validated) representation of the teaching environment as rated by the student. Rather than focusing on assessing just the preceptor, it moves the analysis to the learning environment and teaching. It provides both quantitative and qualitative measures for the student to complete.

7. Roles and Responsibilities

Pre-Clinic Preparation for Students

- Contact/email preceptors to confirm dates and times.
- Confirm expectations: to arrive on time, attend all sessions, demonstrate professional manner including suitable attire, participation in patient care including history taking and supervised patient examination.
- Confirm completion of two SOAP notes with preceptor review and feedback.
- Students must ask for SOAP note review, if not offered. SOAP notes must be completed and reviewed to pass.

Preceptors

- Review summary sheet of course before student arrives.

In-Clinic Expectations

- Students may take histories independently before the patient is seen by thestudent and preceptor together.
- Students may ask for a brief verbal summary by the preceptor prior to seeing the patient or read up about the patient to understand patient context. Preceptors may ask about diagnoses and plans as skills develop. Presenting organized histories is not an expectation at this student level.
- All students are supervised when examining patients or doing procedures.
- Consider how students will be involved, if at all, when sensitive patient exams are indicated.
- For many reasons students may be asked to observe within the visit. If this occurs expect or request preceptors include you in discussions and plans to help understand clinical reasoning. Or pick a particular item to observe.
- If students work with a Resident Family Physician, ensure the Resident is aware of preceptor expectations.
- Preceptors are responsible for care and all enduring charting. Pre-clerkship students are not autonomous.

In Clinic: Participation even when the preceptor is busy

Students are to stay involved and engaged to ensure active learning and participation. This is not a shadowing experience, but students are not yet clerks, either.

Students: When your preceptor is busy or you are between patients

- Review the next patient chart.
- Read around issues of the patient you just saw.
- Introduce yourself to the next patient, identify reason for the visit and expectations.
- Work with staff to room patients, take vitals, heights and weights.
- Check in with other physicians or team members to see other patients.

Students: When you are in the room with the preceptor and patient

- Ask the patient further questions.
- Examine the patient with the preceptor.
- Assist with any procedures.
- Look up information for the patient on the computer.

Students: Managing Tricky Situations

Tricky Situation	Discussion	How to prevent and/or resolve it
The patient calls you "doctor".	This feels cool the first time you hear this. The problem is that the patient may think you're actually a trained doctor and may follow your advice which you're not qualified yet to give.	Prevention is the best route. If you are in position to introduce yourself, say "Hi," give your name and say, "I'm a medical student working with Dr. X." If the patient calls you "doctor," just say, "Thanks, but I'm not finished my training yet; I'm a medical student."
The doctor asks you to do something that is way beyond your skill.	A great part of working with a family doctor is being involved in direct patient care. You should never feel out of your depth or be asked to do things for which you are not trained.	Just say, "I haven't learned how to do this procedure (or whatever it is you've been asked to do). Can you do this with me so I can learn as we go?"

The doctor asks you to conduct a pelvic or rectal examination.	While this can be good learning, you are NOT allowed to do this unless the patient has given consent that (1) they know your examination is for education, and (2) that it's okay for you to do it. You must be certain that this consent has been given.	It is possible that your preceptor or resident preceptor does not know about this rule – this specific version is somewhat new. Just say, "Thanks for the opportunity. I'm not allowed to do this procedure unless the patient has given consent and they know my examination is for education and it's okay for me to do it."

Preceptors: Prepare your clinic for learners

- Share dates with colleagues and staff to ensure a welcoming experience for patients and students.
- Role model professional behaviour, wash hands between patients and highlight strong communication skills.
- Adjust patient schedule to allow for teaching time.
- Ensure UME/DFM has your up-to-date contact information.

Preceptors: Orient your student to your learning environment

- Introduce staff and colleagues to your student, familiarize your student with clinic layout and procedures.
- Prior to seeing patients discuss expectations of staff.
- Allow students independent history taking and reading around patients AND provide for supervised patient examinations and procedures as time allows.
- Include students in discussions and debriefs. Remember that these are pre-clerkship students. We hope that students will develop graduated skills in history taking and discussions.

Preceptors: What if you are unavailable on a clinic day?

- Ask a colleague to take your student on the scheduled day. They must have an Academic Appointment or appointment processing underway by the Academic Department of Family Medicine.
- Preceptors and students can reschedule to a mutually agreeable time.
- The rescheduled time must NOT be student class time, MAY be on a weekend, MAY be out of the office, MUST be a few weeks between the last experience to see patients over time and MUST ensure that at least half of the total student experience is office/clinic experience.

Preceptors: Who evaluates the student if a learner is shared?

- The primary preceptor remains responsible for student EPA evaluation. However, colleagues can complete an EPA in their absence.
- To ensure correct tracking please contact fmce.md@ucalgary.ca if an unscheduled preceptor has contributed to the teaching of your student.

Preceptors: What medical knowledge and exam skills can I expect from my learners at each session?

BLOCK 1 (July – December)		
	Approach to…	**Clinical Skill**
July	Arterial Disease	Communication Intro Building Rapport Agenda-setting Open/closed questions
August	Chest pain Dyspnea Anemia Obesity	Complete histories
September	Hypertension	BP/Vitals Peripheral vasc dz JVP, carotid Precordial/Resp exams Liver exam
October	Fever Infection	Intro to SOAP notes Focused history
November	Autoimmune Rashes	Telemedicine Intro
December	GI Organs that Bleed Liver	Case presentations
BLOCK 2 (January – June)		
	Approach to…	**Clinical Skill**
January	Weight loss – all causes	Crucial/challenging conversations.
February	Abdo Pain Pelvic Pain	Breaking bad news
March	Headache Breast	Genital exam Rectal exam Breast exam Newborn exam
April	Joint pain – articular vs trunk	MSK exam
May	Pregnancy Pediatric development	Handover
June	FM/ER workshops	Consults Sutures Airway

Preceptors: Assessment Requirements

- Review 2 x SOAP notes with preceptor per Block (may be done in-person at clinic or electronically)
- Complete at least 2 x EPAs per Block
- Student attendance at all clinical sessions
- Act in a professional manner, including preparation and participation.

Preceptors: Do I need a clinical appointment to take students?

Yes, preceptors need to have a clinical appointment through the University of Calgary in order to take medical students. If you require assistance with this we are happy to facilitate the process of application.

Preceptors: When are preceptors paid?

When all student EPA assessments are completed, the invoices are submitted for payment. Get paid promptly – complete your EPAs in a timely manner after the student submits them to you via email.

Preceptors: How is this course evaluated?

Students complete a post course evaluation. Items include learning environment, preceptor teaching strengths and impact of the experience on career choice. Results are used to improve the course. Aggregate results may be provided to preceptors to maintain student confidentiality.

8. Appendices

A. Safety

In light of the exceptional safety considerations during and because of the COVID-19 pandemic, 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 are expected to follow Medical Officer of Health safety requirements at the time of their clinical placements. This may include a daily symptom screeningprocess or mandatory masking as needed, or as required by the preceptor.
- 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 clinical experience.
- Whenever students are donning/doffing PPE they are encouraged to ask for observation and feedback (from any experienced health care provider).
- Students will comply with all requirements for PPE for an individual patient as directed by the most responsible physician or preceptor.

B. Telemedicine and Virtual Care Resources

The COVID-19 pandemic has rapidly shifted the acceptance of virtual care in the provision of healthcare. This has implication to the requirements of access to primary care, which affects family physicians, their community-based practices, and patients in their care (PMH 2021). Several resources around virtual or telemedicine care show how this sort of care complements rather than replaces in-person delivery of healthcare services. Support for virtual care must strive to add to the provision of continuous care rather than create a parallel system of episodic, disconnected access to care.

Two excellent virtual care playbooks are provided here for reference:

Patient Medical Home. 2021. Virtual care in the Patient's Medical Home. College of Family Physicians of Canada.
https://patientsmedicalhome.ca/files/uploads/PMH_Virtual-Care-Supplement_ENG_FINAL_REV.pdf

CMA, CFPC, RCPSC. 2021. Virtual Care Playbook.
https://www.cma.ca/sites/default/files/pdf/Virtual-Care-Playbook_mar2020_E.pdf

SCOPE OF PRACTICE

-WHATPROBLEMS CAN BE SAFELY ASSESSED ANDTREATED

> 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 t ransmit ted infections, and hormonal contraception
- provide travel medicine
- assess and treat conditions monitored with home devices and/or lab tests (e.g., hypertension, lipid managemen,tthyroid conditions and some diabetes care; in-person consultations will still beneeded 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.

C. SOAP Note Template

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SOA Note# Cima! D.ate

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