UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

Family Medicine Clinical Experience (FMCE)

Core Document

UNDERGRADUATE MEDICAL EDUCATION
Class of 2028
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2. Overview

As part of the Professional Role course, the Family Medicine Clinical Experience (FMCE) provides medical students with an opportunity to see, experience, and participate in the delivery of rural and urban Family Medicine across southern Alberta.

Our family physician preceptors 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.

In Professional Role - FMCE, students will experience the breadth, depth, and variety of community Family Medicine. Whether in a rural, urban or satellite location, all students will experience 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 are 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's experience 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 for 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. Students will see patients for conditions of which they have some, 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.

The first year is an exciting time to appreciate the unpredictability and diversity of Family Medicine. Students enjoy taking patient histories 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. The preceptor is ultimately responsible for patient care and formal documentation.

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 (e.g., 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.

History taking may be independent. If the student and preceptor first choose to take histories together, this should progress to independent history-taking with subsequent preceptor discussion. Preceptors and students may discuss the patient's 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.

In Clinic*: to help with time management, the student and the preceptor should chat about expectations and any other relevant information pertaining to the patient and their presentation prior to seeing the patient.*

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

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.

S Subjective
O Objective
A Assessment
P Plan

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.

In Clinic*: all physical examinations done by students must be with in-room physician (preceptor or resident) or staff guidance and patient consent.*

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 day.

In Clinic*: review expectations that at least two (2) SOAP notes are completed with preceptor review and feedback per Block. SOAP notes without patient identifying data can be sent electronically if time is tight to review in clinic.*

> **Note**: the SOAP notes do not need to be formally submitted, but their completion will be tracked through One45 assessments via the FMCE Daily (see below for further details on this process).

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

The Patient's Medical Home (PMH) 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 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. A card deck is also available to practice and further clarify these concepts.

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 placements occur longitudinally in Block 1 (September to December) and Block 2 (January to June). For each Block, you will be placed with a different preceptor.

The UME Coordinator will send out a survey at the beginning of each Block to identify your preference for placements, e.g., rural vs urban and any special circumstances that we need to take into consideration. We will do our best to accommodate these preferences.

Block 1 clinic requirements:

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 clinic requirements:

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)

Large and / or Small Group Sessions:

Orientation: start of Block 1
Midpoint: start of Block 2
Debrief: start of Block 3

Refer to Osler and Fresh Sheet for exact dates for the above in-person sessions.

Clinic Scheduling
Except for 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 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 throughout 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 throughout the Block. Each half-day clinic should be at least 3.5 hours.

Scheduling in the academic teaching clinics will be provided by each clinic's 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 throughout 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) reduce travel time and ensure 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 circumstances, 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
Large and small group sessions and all clinical experiences are mandatory and require an excused absence if missed. Clinical experiences must be rescheduled and completed before the end of the Block.

Please refer to the specific deadlines for each Block within the Professional Role Course Outline.

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 professionally.

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).

SOAP Notes
Students must review a minimum of 2 x SOAP notes with their preceptor per Block. The SOAP notes do not need to be formally submitted, but their completion will be tracked through One45 assessments via the FMCE Daily.

Entrustable Professional Activities (EPAs)
Students will be assessed using EPAs. At least 2 EPAs must be completed per Block, approximately one for each clinical day/half-day.

FMCE Daily
Students will be responsible for sending their preceptors a FMCE Daily through One45 at the end of each clinic day. The FMCE Daily will track attendance, SOAP note completion and EPAs. When possible, preceptors and students should review feedback the same day to ensure timely completion of their FMCE Daily.

Reflective Writing Exercise
Students will write and submit one 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.

Please refer to the specific deadline for the Reflective Writing Exercise within the Professional Role Course Outline.

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 that EPA.

A “Concerns Identified” in an EPA 0 for “Learner demonstrated accountability to self, peers, and profession” will trigger a conversation with UME leadership.

Remediation of any missed FMCE requirements and the timeline for its completion will be at the discretion of UME leadership and evaluated on a case-by-case basis.

6. Evaluation and Assessment

Please refer to the Professional Role Course Outline for the evaluation requirements for all parts of the Professional Role course, which includes FMCE.

7. Roles and Responsibilities

Pre-Clinic Preparation for Students

- Contact your assigned preceptor as soon as possible to confirm clinic dates and times (unless scheduled at an academic clinic as these dates will be scheduled for you).
- Confirm expectations with your preceptor: arrival time and location, attire, participation in patient care including history-taking and supervised patient examination.
- There is a card deck available for your reference that highlights all the key information you need to prepare for a successful FMCE experience.

In-Clinic Expectations for Students and Preceptors

- Students may take histories independently before the patient is seen by the preceptor. Direct observation of student history-taking is also encouraged as this provides the opportunity for direct feedback to the student.
- Students may ask for a brief verbal summary by the preceptor prior to seeing the patient. If the student has access to the EMR, they may review the patient's chart 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.
- Consider the appropriateness of junior student involvement with patients that have a history of challenging patient-provider interactions or behaviours. If the preceptor decides to have the student interact with these patients, then the student should be directly observed throughout the interaction.
- For many reasons students may be asked to observe during the visit. If this occurs, request preceptors to include you in discussions and plans to help understand clinical reasoning.
- If students work with a resident, ensure the resident is aware of preceptor expectations.
- Preceptors are responsible for care and all formal charting. Pre-clerkship students are not autonomous; however, this is also not meant to be a shadowing experience.
- FMCE is an opportunity to practice history-taking and physical exam skills.

Troubleshooting

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.

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.
- Always act in a professional manner.

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."

Reporting FMCE Concerns

You will quickly learn that no two clinical experiences are alike, and there is a wide variation in family medicine clinical settings and practice styles. We encourage you to take these opportunities to reflect on the type of physician you would like to be and focus on refining your professional identity as you progress through your medical training.

If you encounter any negative experiences, we encourage you to debrief these as this is part of the learning process.

The FMCE Co-Leads are a great resource and here to support you. You can find their contact information at the beginning of this document and you may directly email them with any concerns. It is especially important to notify the Co-Leads if you have experienced any negative interactions with your preceptor as this feedback is crucial to ensuring a safe learning environment for all students. Please note that disclosure of any concerns will not be reflected in any of your student assessments.

The Student Advocacy and Wellness Hub is a great impartial support if you feel uncomfortable coming forward to UME leadership directly.

The Cumming School of Medicine also has a formalized reporting process for any mistreatment and you can find all of the information on how to report a mistreatment concern here.

8. Appendices

A. Telemedicine and Virtual Care Resources

The COVID-19 pandemic has rapidly shifted the acceptance of virtual care in healthcare. This has implications for 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.

CMA, CFPC, RCPSC. 2021. Virtual Care Playbook.

B. SOAP Note Template

SOAP Note #_____

Student:	Preceptor:
Class of:	Date:

Subjective

What the patient says or feels. Listen, then try to organize by issue. If you have some possible diagnoses in mind, ask and include relevant pertinent negative or positive information. Include any relevant patient context/issues that might influence your care for this patient –ie. frail elderly needs help at home, difficulty taking time off to see you, limited funds for medications.

Objective

What you notice. Include observations even if you may not have touched or physically examined the patient. Include relevant vital signs, lab or imaging.

Assessment

What is the diagnosis? If unsure about the diagnosis list the possible other diagnoses but identify most likely first. If more than one diagnosis list in order and use the same order for your plan.

Plan

Make reasoning explicit. Organize by issue if more than one issue. For each issue, what is the intervention or Medication? Why was that choice made? Was PREVENTION part of the plan? If so, what? When is the patient to return? Why?