Revised: May 2020

UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

Family Medicine Clerkship

MDCN 502

PRECEPTOR MANUAL

UNDERGRADUATE MEDICAL EDUCATION
PRECEPTOR DOCUMENT
CLASS OF 2021
Jan, 2020 - May, 2021 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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INFORMATION SENT TO CLERKS

2 SAFETY

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 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 in all patient care areas and any other areas where physical distancing requirements cannot be achieved.
- Students will be expected to perform regular hand hygiene. Alcohol-based hand rub 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 will comply with all requirements for PPE as posted for an individual patient.
- 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.

- **Students will not be involved with any patient during a procedure that requires the use of an N95 mask (AGMP list: https://www.albertahealthservices.ca/topics/Page17091.aspx).**
- **Students will not be involved with any patient who is confirmed, probable or possible COVID (case definitions/criteria as defined on page two of the document found at: https://www.departmentofmedicine.com/meoc/covid_pandemic_admission_flowsheet.pdf.**
- **Students may be involved in all routine care of patients who are known COVID negative or in whom COVID is unlikely or very unlikely (case definitions/criteria as defined on page two of the document found at: https://www.departmentofmedicine.com/meoc/covid_pandemic_admission_flowsheet.pdf).**

- Students who are exposed to COVID 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

***Guidelines for student involvement in patient care may change as the COVID situation evolves; communications will be directed from UME to all students and clerkship leaders when changes occur.*

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.

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 COVD-19, a team, including specialists from Respirology 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 link to full document can be found in Appendix B). This pathway was created with up-to-date knowledge at the time (April 6, 2020), 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 in Appendix B 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 F.

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; 2 or 4 weeks RURAL, and 2 or 4 weeks URBAN. The blocks may or may not run consecutively, so you might complete 2 weeks of the rural block, have a break for a few weeks, and then complete 4 weeks of the urban block, and vice versa.

Ideally, you will be working full-time, but we accept that many clinics are working less than that at the present time. Please work with your preceptor to complete the Clinical Calendars (**Appendices I and J**). We would 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. Clinical calendars will be reviewed to assess whether remediation is necessary if fewer 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. At the end of the block, please submit to a Clinical Calendar, signed by you and your preceptor. Please follow this process for the 2-week and 4-week blocks.

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

6.1 Advanced Care Planning

You have completed the academic sessions, with the exception of Advanced Care Planning and an extra Planetary Health session. Dr Amy Tan expects that you will watch the ACP podcast available on Osler during your first week and then she will be providing a Zoom session on the subject of Advanced Care Planning during the Thursday of Week 3 of the 4-week block. The ACP session will take place from 12-1 PM. This session is mandatory. These sessions have been marked on the Clinical Calendar. ***If you completed urban FM in block 1, Carmen Wong will try to schedule a time for you to attend an ACP session during your 2-week block or another rotation but it will not be mandatory if this simply does not work out for you.*

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 will be required to:

1. Discuss with your preceptor *at the beginning of the rotation* about identifying an appropriate patient in the practice with whom to engage in an Advance Care Planning/Goals of Care Conversation.
2. Attempt an Advance Care Planning/Goals of Care Conversation with the patient +/-family to a point where some decisions are made with the patient and documented in the AHS Goals of Care Tracking Record Form in the Goals of Care (Green Sleeve) package.
3. Document key elements of the conversation (summary of issues provided on Tracking Form) in a confidential and anonymous manner so as to protect the privacy of your patient +/-family, and preceptor.

Write a reflective assignment incorporating the following questions:

- What surprised you about having the conversation with the patient?
- What did you feel uncomfortable with during the conversation?
- What did you want to know more about or how to do in order to improve your ACP/GCD conversation?
- What would you do the same during your next ACP/GCD conversation with a patient?
- What would you want to try to do differently during your next ACP/GCD conversation with a patient?
- How many ACP/GCD conversations have you participated in thus far in Clerkship and during which rotations?

Submit the Advanced Care Planning reflective assignment to one45. It must be submitted by 11:59PM on the last Sunday of the 4-week block.

6.2 Planetary Health

Details will follow.

7. 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 points 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. Furthermore, if you have had that experience in another rotation then you may check off the activity.

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.

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

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 F. 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 first FM block**, whether it is the 2-week or 4-week block. You will receive a score for this within 1-2 weeks afterwards, and you will be reminded of this score at the start of your second FM block.

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.

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

To help you succeed, we suggest the following:

- Use the Excel document: *FM Clerkship Foundations Resource 2020*

- 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 Microcases 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 FM 4-week block. **Note the portal closes at 4:00PM this day.**
MUST COMPLETE: the in-person summative examination on the last Friday of the 6-week rotation.

8.2 Evaluations

During each block you should elicit a formative evaluation in the form of feedback, a check-in. Your preceptor will need to complete a Final ITER (In-Training Evaluation Report).

8.3 MITERS and ITERS

2-week block

An ITER will be completed at the end of this block

4-week block

A MITER will be completed at the end of week 2

An ITER will be completed at the end of week 4

6-week block (2-week and 4-week, or 4-week and 2-week consecutively)

A MITER will be completed at week 3

An ITER will be completed at week 6

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. UptoDate, Dynamed and Lexicomp and ebooks. All of these are available via the Health Sciences library - bookmark and/or set up a tablet shortcut to both: http://library.ucalgary.ca/hsl

LearnFM: www.cfpc.ca/sharcfm - **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 microcases - 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 form 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.

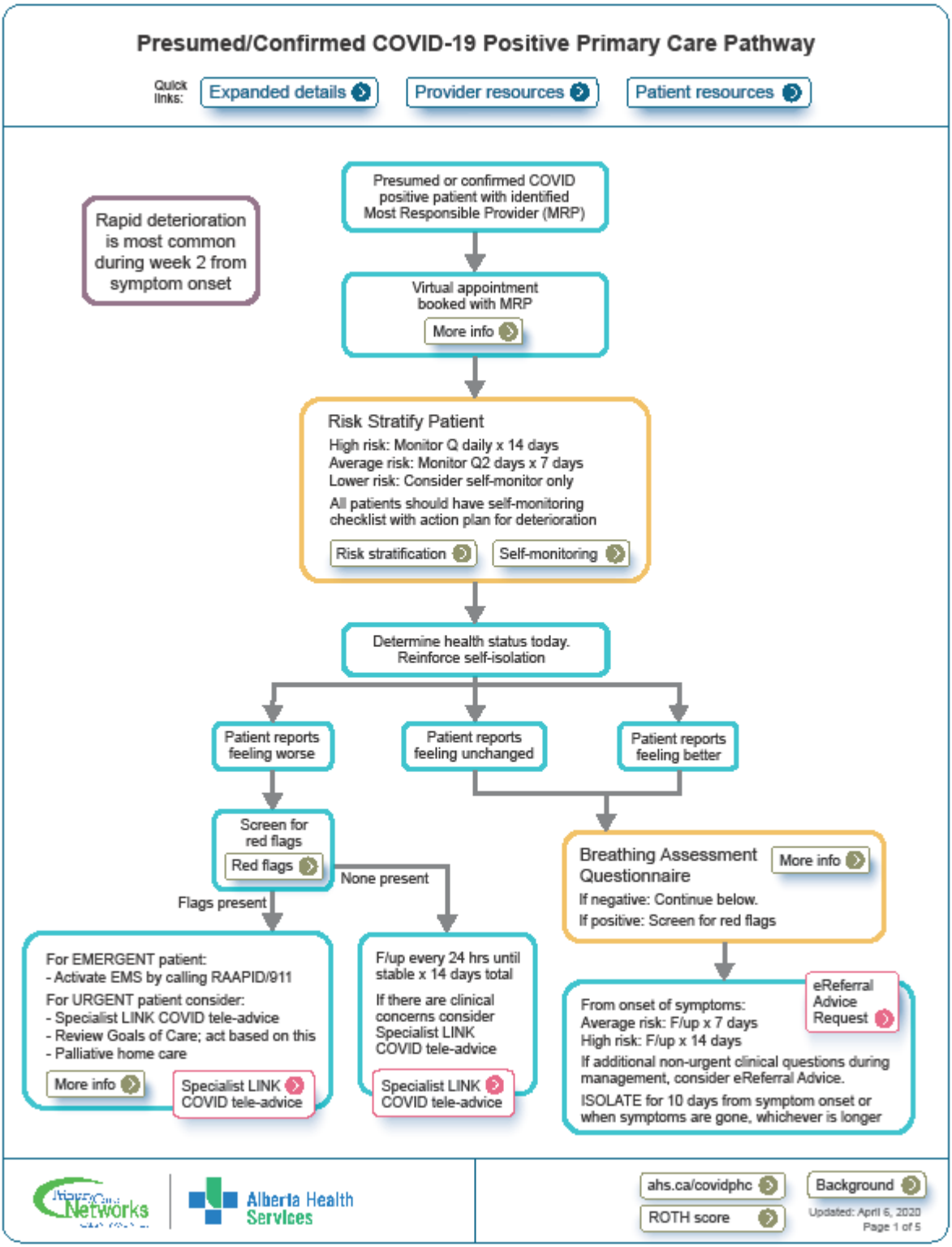
iPhone	1. Make a normal phone call. 2. Touch the Add Call button to make another call. The person you're already on the line with will be put on hold. 3. After speaking to the second person, touch Merge Calls. You now have a three-way conference call where all parties can hear each other. 4. Repeat steps 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.

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/COVID_PathwayV2_April62020.pdf



C. Virtual Care Playbook 2020

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

SCOPE OF PRACTICE

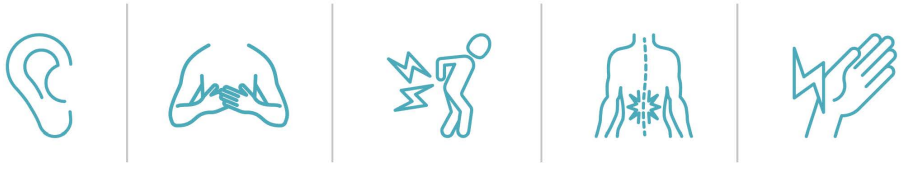
— WHAT PROBLEMS CAN BE SAFELY ASSESSED AND TREATED

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.

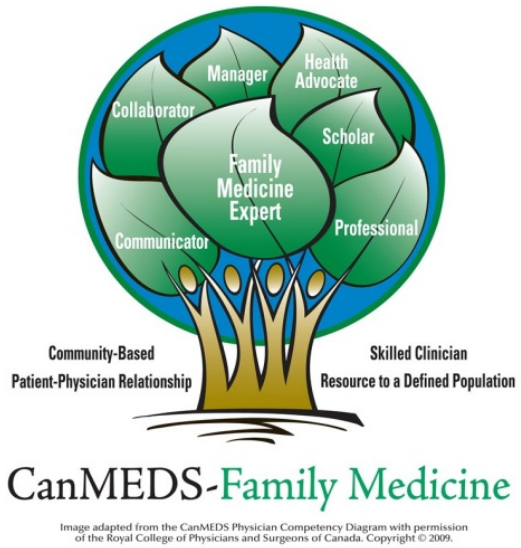
For this reason, the scope of virtual practice is presently limited to encounters that require only history, gross inspection and/or data that patients can gather with cameras and common devices (e.g., glucometers, home blood pressure machines, thermometers and scales). **In practical terms, you can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



The College of Family Physicians of Canada uses this diagram to illustrate the seven key roles of the Family Physician.

The foundational four principles of Family Medicine are linked to the Can-Meds roles by physicians in strong relationships with their patients providing ongoing care. Family physicians are skilled clinicians who are community-based and work in partnership with their patients and are a resource to that defined population.

Learning objectives for Family Medicine clerkship have been categorized according to the various roles of the Family Physician in the table on the next page as well as mapped to the Cumming School of Medicine's MD Program "The Big 10" Program Level Objectives.

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.

The following is a list of the 26 clinical presentations identified as important for Family Medicine. Ideally you should see patients with these problems in clinic and may record them in your logbook. If you do not manage to see a case in relation to one of the problems listed, please refer to the virtual patients on LearnFM (formerly SHARC-FM) or those available via Course 8.

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

Key Symptoms	**Stages of Life**	**Chronic Disease**
Fever	Well baby	Hypertension
Headache	Contraception	Ischemic heart disease
Cough; URI; Earache	Prenatal care	Diabetes
Abdominal pain; Diarrhea	Check-up – age appropriate	Obesity
Back pain; Joint pain	Fail elderly	Asthma
UTI/discharge		Fatigue
Skin disorders		Dizziness
		Anxiety
		Depression

1. Abdominal Pain

1. Given a patient presenting with abdominal pain, perform a patient-centered interview and focused physical exam, list and interpret clinical findings. Then:
    a. Identify signs and symptoms of a surgical abdomen
    b. Identify red flags of potential serious causes including referred pain from chest
    c. Identify psychosocial factors associated with chronic and recurrent abdominal pain.
    d. Propose a relevant differential diagnosis that includes common causes of abdominal pain and less common but important causes of abdominal pain.
2. For patients with acute abdominal pain, propose an initial management plan that includes appropriate and timely referral/investigation for potentially serious causes.
3. For patients with chronic/recurrent abdominal pain, propose a management plan that highlights initial investigations and basic management.

2. Anxiety

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

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

3. Asthma/Wheezing

1. Establish an accurate diagnosis of asthma through a focused history, physical exam, and spirometry
    a. Including family, occupational and environmental history
2. Including differentiating non-asthma causes of wheezing
3. Explain underlying pathophysiology of asthma to patients and/or family members
    a. In relation to acute & recurrent episodes and prophylaxis principles
    b. In relation to mechanism of action for relevant meds
4. In relation to red flags of impending asthma crisis
5. Assess asthma control at follow-up. Identify modifiable triggers for patients.
6. Describe the different medication delivery methods (and relevant compliance / educational issues).
7. Describe major medication categories
    a. Including mechanism of drug action, particularly SABA and ICS
    b. Benefits, risks, limitations
    c. Use patterns, compliance, device use
8. Propose a management plan for patients with acute exacerbations.
9. While designing an effective treatment plan, take into account the lifestyle of the patient, any potential issues with compliance, possible side effects of treatment, and available resources available in the community.

4. Chest Pain

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

5. Contraception

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

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

6. Cough/Dyspnea

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

7. Depression

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

8. Diabetes Mellitus Type II

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

9. Diarrhea

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

10. Dizziness

1. Given a patient with “dizziness”, conduct a history so as to distinguish true vertigo from other types of dizziness.
2. Differentiate between psychiatric causes (depression, anxiety/panic, somatization, alcohol), disequilibrium (peripheral neuropathy, visual impairment, drug), and syncope/presyncope.
3. Identify likely causes of vertigo (e.g. benign paroxysmal positional vertigo, viral labyrinthitis, Meniere’s Disease) and other types of dizziness (e.g. anemia, vasovagal, hypovolemia).
4. Conduct a relevant physical exam so as to rule out serious causes of dizziness, including assessment of orthostatic blood pressure, cerebellar & cranial nerve function, precordium, and cardiac rhythm.

5. Identify patients with BPPV and be able to demonstrate the Epley maneuver for these patients.

11. Elderly Health Care

1. Assess the following for elderly patients:
    a. ADLs and IADLs (Katz 1983)
    b. Cognition (through validated tools)
    c. Medication/supplement safety
    d. Hearing and vision
    e. Mobility and fall risk
    f. Supports & environment
    g. Mood
    h. Presence and type of 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, fronto-temporal).

12. Fatigue

1. Conduct a patient interview so as to:
    a. Define what the patient means by "fatigue" and distinguish from other concerns (e.g. mood concerns, muscle weakness, decreased exercise tolerance +/- SOB)
    b. Identify clinical symptoms/red flags that suggest a secondary etiology, e.g. depression, anemia, hypothyroidism, malignancy, sleep apnea, cardiac disease
    c. Identify context red flags that may suggest psychosocial concerns and impact differential diagnosis and/or management (e.g. homelessness, isolation, single parent, addiction, recent losses, sleep quality/shift work)
2. Conduct a relevant physical exam to refine DDx.
3. Include "watchful waiting" when appropriate as a diagnostic and/or management tool.
4. Propose and act on initial investigations based upon DDx and avoid over-investigation/"shot-gun" approach.

13. Fever and Common Infections

1. Perform a focused history and physical exam to determine presence of fever, fever pattern, and associated symptoms & signs, so as to:
    a. Make a determination as to whether a patient truly has/has had a fever, and whether it is acute versus chronic.
    b. Identify patients with serious illness:
        i. Demonstrate good understanding of the potential groups of cause of fever
        ii. Infection, malignancy, drugs, environment (sun, heat)
        iii. Important conditions not to miss: endocarditis, meningitis, septicemia

2. Recognize special groups where fever has different significance or impact (e.g. neonates, elderly, travel/immigrant issues, under-immunized groups, living conditions, cultural/religious groups, immune-compromised individuals).
3. Propose a plan for appropriate investigation of possible causes, based in the local context.
4. Propose a basic plan of management that includes:
    a. Simple at home measures including antipyretics
    b. guidance for patients/caregivers on how to access care depending on evolution of illness
5. Be familiar with causative agents and treatment options for:
    a. Acute otitis media
    b. Cellulitis
6. For patients presenting with ear pain:
    a. Make the diagnosis of otitis media (OM) only after good visualization of the eardrum (i.e., wax must be removed), and when sufficient changes are present in the eardrum, such as bulging or distorted light reflex (i.e., not all red eardrums indicate OM).
    b. Include pain referred from other sources in the differential diagnosis of an earache (e.g. tooth abscess, trigeminal Neuralgia, TMJ dysfunction, pharyngitis, etc.).

14. Headache

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

15. Hypertension

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

factors.

16. Ischemic Heart Disease

1. Identify patients at elevated risk for IHD and calculate their 10-year cardiovascular risk using the Framingham Risk Score.
2. Propose a patient-centered initial management plan for primary prevention of IHD.
3. Identify which patients require further investigation to confirm a diagnosis of IHD.
4. Describe an early post-ischemic event management plan including lifestyle changes, medications, psychosocial support, cardiac rehabilitation, etc.
5. Propose a surveillance and management plan for secondary prevention of cardiovascular events in patients with IHD.

17. Joint Pain

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

18. Low Back Pain

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

19. Obesity

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

7. As part of preventing childhood obesity, advise parents of healthy activity levels for their children.
8. In managing childhood obesity, challenge parents to make appropriate family-wide changes in diet and exercise, and to avoid counterproductive interventions (e.g., berating or singling out the obese child).

20. Palliative Care

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

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 hyperlidipemia screening, PSA testing)
4. Counsel patients on relevant health promotion/ disease prevention strategies (e.g. immunizations, exercise, diet, calcium/Vitamin D, smoking cessation)

22. Prenatal Care

1. Discuss key pre-conception considerations in healthy women of childbearing age. (e.g. folic acid supplementation, smoking, rubella immunity, etc.)
2. Date a pregnancy accurately.
3. Explore the patient's feelings and concerns about her pregnancy (e.g. supports, stressors, etc.).
4. Perform an adequate first prenatal visit including taking a history and performing an appropriate focused physical exam with the assistance of available antenatal tracking tools.
5. Screen for and identify pregnancies at risk (e.g. domestic violence, multiple gestation, maternal age, substance use, etc.).
6. Conduct a basic follow up visit, including BP measurement, weight, fetal heart rate (starting at 12 weeks), symphysis-fundal height (20wks and beyond), screening for concerns and complications.
7. Provide basic education and counseling regarding lifestyle, breastfeeding, and delivery planning.
8. Anticipate potential health problems during the pregnancy and provide rational health maintenance and disease prevention strategies.

23. Skin Conditions

1. Recognize acute life-threatening dermatologic conditions.

2. Recognize lesions that are at greater risk for malignancy using the ABCDE framework and recommend biopsy.
3. Describe morphology of skin lesions.
4. Identify and propose management plans for the following common skin conditions:
    a. Infections – viral (e.g. herpes, exanthems, warts), bacterial (e.g. impetigo, cellulitis), fungal (e.g. tinea, candida), parasitic (e.g. lice, scabies, bites)
    b. Dermatitis (irritant/contact, atopic, venous stasis)
    c. Psoriasis
    d. Acne
5. Counsel patients about sun/UV skin safety.

24. Upper Respiratory Tract Infection (URTI)

1. Given an appropriate history and/or physical examination:
    a. Differentiate life-threatening conditions (epiglottitis, retropharyngeal abscess) from benign conditions.
    b. Manage the condition appropriately.
2. Make the diagnosis of bacterial sinusitis by taking an adequate history and performing an appropriate physical examination, and prescribe appropriate antibiotics for the appropriate duration of therapy.
3. In a patient presenting with upper respiratory symptoms:
    a. Differentiate viral from bacterial infection (through history and physical examination).
    b. Diagnose a viral upper respiratory tract infection (URTI) (through the history and a physical examination).
    c. Manage the condition appropriately (e.g., do not give antibiotics without a clear indication for their use).
4. Through history and examination, make a clinical diagnosis of streptococcal tonsillo-pharyngitis.
5. Discuss the benefit of antibiotic treatment in group A streptococcal pharyngitis with respect to prevention of acute rheumatic fever and acute glomerulonephritis
6. Given a history compatible with otitis media, differentiate it from otitis externa and mastoiditis, according to the characteristic physical findings.
7. In high-risk patients (e.g. those who have human immunodeficiency virus infection, chronic obstructive pulmonary disease, or cancer) with upper respiratory infections: look for complications more aggressively and follow up more closely.
8. In a presentation of pharyngitis, look for mononucleosis.
9. In high-risk groups:
    a. Take preventive measures (e.g. use flu and pneumococcal vaccines).
    b. Treat early to decrease individual and population impact (e.g. with oseltamivir phosphate [Tamiflu]).

25. Urinary Symptoms/Genital Discharge

1. Conduct a focused history and physical exam (including genital/pelvic exam) that enables differentiation between:
    a. UTI uncomplicated (cystitis) vs complicated UTI (e.g. recurrent, pyelonephritis)
    b. Non-urinary tract infection including prostatitis, pelvic inflammatory disease, STI's, urinary retention, atrophic vaginitis, vulvovaginitis, urolithiasis, foreign body
2. Propose a focused investigation plan based upon the patient's features that may include
    a. Urinalysis (dip), c/s
    b. Genital swabs and other STI testing with informed consent re: notifiable diseases
    c. Other tests relevant to patient's condition
3. Identify patients with features suggestive of urgent conditions requiring immediate management and propose next steps including:

   a. Pelvic inflammatory disease
   b. Acute urinary retention
   c. Pyelonephritis with history of physical exam risk factors for serious disease
4. For the following nonurgent conditions, outline an initial management plan:
   a. Uncomplication UTI (cystitis), treat promptly without waiting for results of any ordered investigation
   b. Stable pyelonephritis or recurrent UTI- Identify causes of recurrent UTI's, including urinary retention, post-coital, urolithiasis, diabetes mellitus, atrophic vaginitis
   c. Atrophic vaginitis- local estrogen and/or moisturizers
   d. Prostatitis- prolonged duration of antibiotic treatment
   e. Vulvovaginitis- antifungal and risk factor avoidance
   f. Bacterial vaginosis/Trichomonas vaginalis - identify appropriate resources to guide treatment
   g. STI's-identify appropriate resources to guide therapy and risk reduction; contact Public Health re: notifiable diseases
   h. Urolithiasis- fluids, analgesia
   i. Child with pelvic foreign body or STI-screen for abuse- contact Child Protection Services
   j. Urinary incontinence (e.g. stress, urge, functional, overactive)
   k. Benign prostatic hyperplasia

26. Well-Baby/Child/Youth Preventive Care

1. Conduct an age-appropriate well child visit that includes physical exam, growth, nutrition and development.
2. Address parental concerns, social context, and safety and provide relevant anticipatory guidance (e.g. dental caries, family adjustment and sleeping position).
3. Assess vaccination status and counsel parents on the risks and benefits of vaccinations.
4. Be familiar with and use an evidence-based tool to help guide a well-child visit. (e.g. Rourke Baby Record)
5. Identify patients who require further assessment. 6. Inform caregivers of appropriate routine follow up intervals.

F. 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.

G. Clinical Calendar – 2-Week Block (✓Attended or × Not attended, and indicate travel time in the appropriate box)

WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning	✓or ×							
	Afternoon								
	Evening								# clinic days
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning								
	Afternoon								
	Evening								# clinic days
								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).

H. Clinical Calendar – 4-Week Block (✓Attended or × Not attended, and indicate travel time in the appropriate box)

WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning	Watch ACP Podcast ✓or ×							
	Afternoon								# clinic days
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning								
	Afternoon								# clinic days
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning								
	Afternoon				ACP Academic Session with Dr Amy Tan				# clinic days
	Evening								
WK		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
1	Morning								
	Afternoon								# clinic days
	Evening								
								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. Learning Objectives Overview

Objective	Example	Sample Learning activity	Evaluated by
CANMEDs Role: Expert **CSM Big 10:** 1, 2, 3	• Assess and generate an *appropriate* differential diagnosis in a patient presenting with a *new undifferentiated* 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 *comprehensive care plan* 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	• 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 *succinct* 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)

INFORMATION FOR PRECEPTORS

4. SUPERVISION AND ASSESSMENTS

4.1 Supervision

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

If possible, please facilitate your 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.

4.2 Assessments

1) Midpoint ITER

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.

8. TEACHING RESOURCES

8.2 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.
- 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

8.3 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.

8.4 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.

8.5 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://bmcmededuc.biomedcentral.com/track/pdf/10.1186/s12909-016-0531-6

8.6 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 form 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 clerks 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.

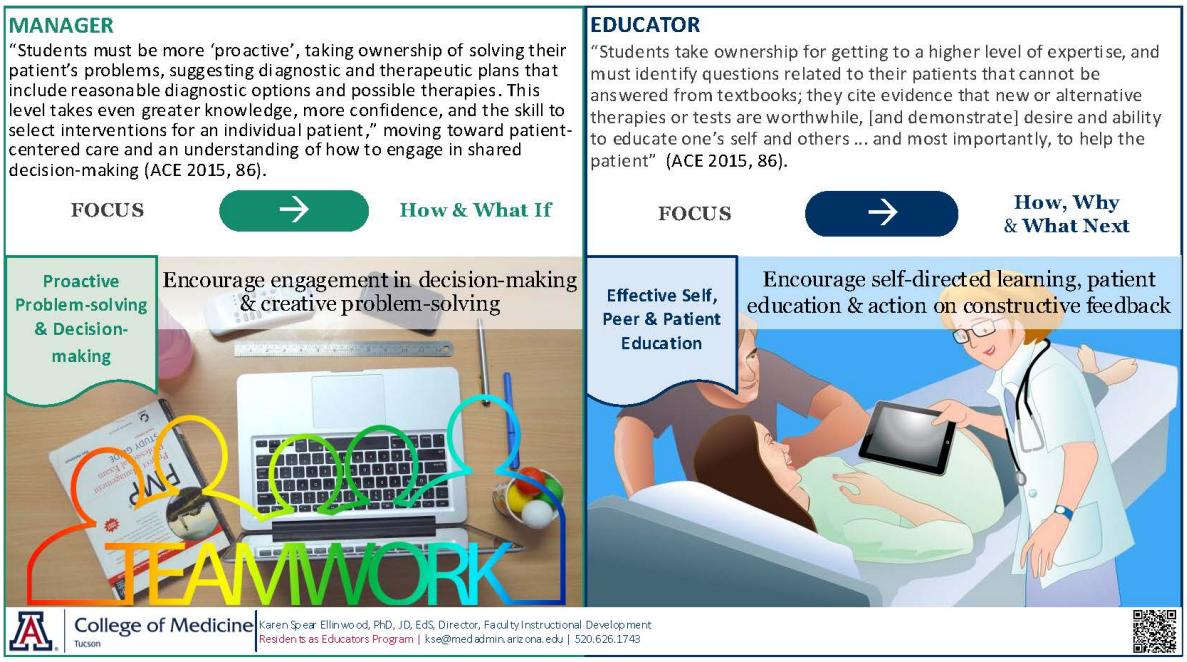
iPhone	1. Make a normal phone call. 2. Touch the Add Call button to make another call. The person you're already on the line with will be put on hold. 3. After speaking to the second person, touch Merge Calls. You now have a three-way conference call where all parties can hear each other. 4. Repeat steps 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

I 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.

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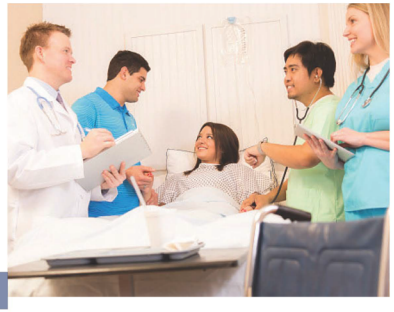
Horrey K, Tan A. *Twelve Points to Consider When Talking to a Medical Student About a Career in Family Medicine.* Mississauga, ON: College of Family Physicians of Canada; 2019.

QUESTIONS?
Contact us at **education@cfpc.ca**.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Twelve Points
to Consider When Talking to a Medical Student
About a Career in Family Medicine



12 TALKING POINTS

ABOUT A CAREER IN FAMILY MEDICINE

• 1 •

Emphasize that family medicine is a specialty.

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

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

• 2 •

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

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

• 3 •

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

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

• 4 •

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

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

• 5 •

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

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

• 6 •

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

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

• 7 •

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

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

• 8 •

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

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

• 9 •

Dispel myths about "plus one" years of enhanced skills training.

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

• 10 •

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

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

• 11 •

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

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

• 12 •

Share stories about how patients appreciate your work.

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