UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE

UNDERGRADUATE MEDICAL EDUCATION (UME)
Medical Doctor Program (MD)

COURSE OUTLINE

Course Number:	MDCN 502.01
Course Name:	Family Medicine Clerkship
Dates:	Jan 15, 2024 – April 27, 2025 (Class of 2025)
Schedules and classroom locations:	Rotation schedule & location information will be emailed and posted to Osler.

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Course Description
Please refer to the University Calendar: http://www.ucalgary.ca/pubs/calendar/current/medicine.html#8554

Prerequisites
Please refer to the University Calendar: http://www.ucalgary.ca/pubs/calendar/current/medicine.html#8554

Supplementary Fees/Costs
• Lab Coat • Stethoscope

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

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

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

3. Asthma/Wheezing

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

4. Chest Pain

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

5. Contraception

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

6. Cough/Dyspnea

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

7. Depression

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

8. Diabetes Mellitus Type II

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

9. Diarrhea

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

10. Dizziness

1. Given a patient with “dizziness”, conduct a history so as to distinguish true vertigo from other types of dizziness.
2. Differentiate between psychiatric causes (depression, anxiety/panic, somatization, alcohol), disequilibrium (peripheral neuropathy, visual impairment, drug), and syncope/presyncope.
3. Identify likely causes of vertigo (e.g. benign paroxysmal positional vertigo, viral labyrinthitis, Meniere’s Disease) and other types of dizziness (e.g. anemia, vasovagal, hypovolemia).

4. Conduct a relevant physical exam so as to rule out serious causes of dizziness, including assessment of orthostatic blood pressure, cerebellar & cranial nerve function, precordium, and cardiac rhythm.
5. Identify patients with BPPV and be able to demonstrate the Epley maneuver for these patients.

11. Elderly Health Care

1. Assess the following for elderly patients:
    a. ADLs and IADLs (Katz 1983)
    b. Cognition (through validated tools)
    c. Medication/supplement safety
    d. Hearing and vision
    e. Mobility and fall risk
    f. Supports & environment
    g. Mood
    h. Presence and type of advance care planning documents
2. Identify community resources and other interventions to address concerns in these areas.
3. In the elderly patient taking multiple medications, avoid polypharmacy by: monitoring side effects, periodically reviewing medication (e.g., is the medication still indicated, is the dosage appropriate), and monitoring for interactions.
4. In the elderly patient, screen for modifiable risk factors (e.g., visual disturbance, impaired hearing) to promote safety and prolong independence.
5. In the elderly patient, assess functional status to: - anticipate and discuss the eventual need for changes in the living environment. - ensure that social support is adequate.
6. In older patients with diseases prone to atypical presentation, do not exclude these diseases without a thorough assessment (e.g., pneumonia, appendicitis, depression).
7. Be familiar with different forms of dementia (e.g. Alzheimer's, vascular, mixed, Lewy body, fronto-temporal).

12. Fatigue

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

13. Fever and Common Infections

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

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

14. Headache

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

15. Hypertension

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

16. Ischemic Heart Disease

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

17. Joint Pain

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

18. Low Back Pain

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

19. Obesity

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

8. In managing childhood obesity, challenge parents to make appropriate family-wide changes in diet and exercise, and to avoid counterproductive interventions (e.g., berating or singling out the obese child).

20. Palliative Care

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

21. Periodic Health Exam

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

Refer to core document on OSLER - https://osler.ucalgary.ca/ for learning objectives overview

Course Text(s)/Recommended Reading/Learning Resources
n/a

Evaluation and Course Requirements
FAMILY MEDICINE (Class of 2025) • Final Written MCQ (summative) = MP • Satisfactory Final Preceptor ITERS = MP • Formative Midpoint MCQ = MC* • Midpoint Formative ITERs = MC • Logbook = MC* • Clinical Expectations = MC • Patient-Centred Care Project = MP • SNAP Project = MC • Attendance and participation in teaching sessions = MC • Professionalism Expectation = MP • Meet all expectations outlined in Core Document = MC MP = must pass (failure to do so will result in overall evaluation of "Unsatisfactory" for rotation) MC = must complete (failure to do so will result in overall evaluation of "Satisfactory with Performance Deficiency" for rotation) MC* = must complete before rotation deadline (failure to do so will result in requirement to defer summative examination to the deferral/rewrite date) Please refer to Clerkship Student Handbook - https://cumming.ucalgary.ca/mdprogram/current-students/clerkship/student-handbook and core document on OSLER - https://osler.ucalgary.ca/.

Calculators for MCQ exam – simple calculators are allowed for your exams.

Assessment Dates
The assessment dates provided in the Evaluation and Course Requirements may be subject to change due to circumstances beyond the MD Program's control. In the event that an assessment date must be changed notification of the change will be emailed to the student by the evaluation team and posted on OSLER. Students will be given as much notice of the assessment date change as possible. The pre-clerkship schedule of all courses can be found on the timetable here https://cumming.ucalgary.ca/mdprogram/current-students/pre-clerkship-year-1-2/timetable The detailed day by day schedule is found on Osler. https://osler.ucalgary.ca/

Grading	
The University of Calgary Medical Doctor Program is a Pass/Fail program. The grading system that will appear on a student's legal transcript is as follows:	
Grade	Description
CR	Completed Requirements
RM	Remedial Work Required
F	Fail
I	Incomplete

W	Withdrawal
MT	Multi-Term (Used for Part A Courses that fall under 2 different terms in the calendar year.)

For Pre-Clerkship - A student's final grade for the course is the sum of the separate components. It is not necessary to pass each mandatory component separately in order to pass the course.

For Clerkship - A rotation signed off as "Satisfactory with Performance Deficiencies" will appear as a credit on a student's medical school transcript.

Assignments/Projects

The following criteria shall generally apply to all written assignments. Students are expected to submit all major assignments on or before the due dates. Unless prior arrangements have been made, major assignments worth marks submitted after the specified due date will be considered late. Late major assignments will receive a 0 % grade. Other assignments will not be accepted after the due date.

Timeliness

In general, dates listed in Core Documents are intended to act as guidelines for assisting students to complete their learning activities and assignments in a timely fashion. Students encountering difficulties completing assignments due to health or other serious factors must contact the Course Chair to arrange a deferral of term work. A Physician/Counsellor Statement to confirm an absence for health reasons may be required.

Professional Conduct

As members of the University community, students and staff are expected to demonstrate conduct that is consistent with the University of Calgary Calendar. The specific expectations cited in the Calendar include

- Respect for the dignity of all persons
- Fair and equitable treatment of individuals in our diverse community
- Personal integrity and trustworthiness
- Respect for academic freedom, and
- Respect for personal and University (or Host Institution) property.

Students and staff are expected to model behaviour in class that is consistent with our professional values and ethics. Students and staff are also expected to demonstrate professional behaviour in class that promotes and maintains a positive and productive learning environment. All students and staff are also expected to respect, appreciate, and encourage expression of diverse world views and perspectives. All members of the University community are expected to offer their fellow community members unconditional respect and constructive feedback. While critical thought and debate is valued in response to concepts and opinions shared in class, feedback must at all times be focused on the ideas or opinions shared and not on the person who has stated them.

Where a breach of an above-mentioned expectation occurs in class, the incident should be reported immediately to the Associate Dean or his/her designate. As stated in the University Calendar, students who seriously breach these guidelines may be subject to a range of penalties ranging from receiving a failing grade in an assignment to expulsion from the University.

University of Calgary Medical School – Student Code of Conduct
https://cumming.ucalgary.ca/mdprogram/current-students/pre-clerkship-year-1-2/student-code-conduct

Electronic Submission of Course Work
Most assignments will be submitted via email to the Program Coordinator, UME unless otherwise stated. Assignments may be submitted in MS Word or Rich Text formats. It is the student's responsibility to confirm with the Program Coordinator that the assignment has been received. This may be done through utilization of the return receipt function available on most email packages, or by a follow up confirmation email to the Program Coordinator. It is the Program Coordinator's responsibility to reply to any confirmation email from the student, and to inform the student promptly if there are any problems with the file (unable to open attachment, damaged data, etc.). In such cases, it is the responsibility of the student to promptly consult with the Program Coordinator regarding an alternate delivery method (e.g. courier, fax, etc.). It is the student's responsibility to retain a copy of the original document.

One45 Overview
The MD Program utilizes the One45 Software Program for assessment purposes for all evaluations in Year 1, 2 and 3. Students are able to view completed evaluations online through this software program. Evaluations and assessment data are collected at regular intervals. It is the student's responsibility to distribute their evaluations to preceptors during any given course and to follow up with preceptors if evaluations have not been completed by the deadline given out by the Undergraduate Medical Education (UME) Office. In addition to assessments and evaluations, One45 is also utilized to evaluate your preceptors and to gather information from students on their learning experiences. All students are provided training at the beginning of their program in Year 1. This would include a personal log in access code and password. One45 is used throughout your training in the MD Program (Undergrad) as well as Residency (PGME). Website Link to Access One45: https://calgary.one45.com/ Problems Accessing One45: Please contact the Academic Technologies at osler@ucalgary.ca

Course Evaluation/Feedback
Student feedback will be sought at the end of each learning session as well as at the end of each course through the electronic UME evaluation tool. At the end of each learning activity (ie. Lecture, small group, orientations, etc.), students will be asked to complete online evaluation forms to provide feedback to instructors regarding the effectiveness of their teaching and achievement of the learning objectives. An overall course evaluation will be completed following course completion. Students are welcome to discuss the process and content of the course at any time with the Course Chairs or Preceptors.

Clinical Core Overview (Pre-Clerkship Only)
Please refer to the Clinical Correlation Guidelines here: https://cumming.ucalgary.ca/mdprogram/about/governance/policies

Course specific learning objectives for Clinical Core in the setting of this course can be found in the course documents.

Clinical Correlation Rules of Conduct
Students and preceptors will not be used as patients for clinical correlation sessions. This means that students will not examine the preceptor, the preceptor will not examine the students and students will not examine one another.

UME Policies, Guidelines, Forms, & TORs
Please refer to the MD program website https://cumming.ucalgary.ca/mdprogram/about/governance

Reappraisals and Appeals
Please refer to the CSM Reappraisal of Graded Term Work and Academic Assessments and CSM UME Academic Assessment and Graded Term Work Procedures for details regarding reappraisals and appeals https://cumming.ucalgary.ca/mdprogram/about/governance/policies Please note by policy and terms of reference if you plan to request a reappraisal of the result(s) of this exam/course, a formal reappraisal request in writing needs to be submitted to md.reappraisals@ucalgary.ca within 10 days of receiving the result. If the student disagrees with the decision of the UME Student Evaluation Committee, the student may appeal that decision to the UME University Faculty Appeals Committee. Please refer to the CSM UME Academic Assessment and Graded Term Work Procedures for procedure for appeals. https://cumming.ucalgary.ca/mdprogram/about/governance

Academic Accommodation
Students needing an accommodation because of a disability or medical condition should contact Student Accessibility Services in accordance with the Procedure for Accommodations for Students with Disabilities available https://live-ucalgary.ucalgary.ca/student-services/access. Student Accessibility Services, please contact their office at (403) 220-8237, visit: MacEwan Student Centre room 452 or email: access@ucalgary.ca. Students who have not registered with the Student Accessibility Services are not eligible for formal academic accommodation.

Accommodations on Protected Grounds Other Than Disability
Students who require an accommodation in relation to their coursework or to fulfil requirements for a graduate degree, based on a protected ground other than disability, should communicate this need, preferably in writing, to the appropriate Assistant or Associate Dean Students who require an accommodation unrelated to their coursework, based on a protected ground other than disability, should communicate this need, preferably in writing, to the Vice-Provost (Student Experience). For additional information on support services and accommodations for students with disabilities, visit https://live-ucalgary.ucalgary.ca/student-services/access

Academic Integrity
The University of Calgary is committed to the highest standards of academic integrity and honesty. Students are expected to be familiar with these standards regarding academic honesty and to uphold the policies of the University in this respect. It is expected that all work submitted in assignments should be the student's own work, written expressly by the student for this particular course. Students are referred to the section on academic integrity in the University Calendar (https://www.ucalgary.ca/pubs/calendar/current/k-3.html) and are reminded that plagiarism is an extremely serious academic offence.

Student Misconduct
A single offence of cheating, plagiarism, or other academic misconduct, on term work, tests, or final examinations, etc., may lead to disciplinary probation or a student's suspension or expulsion from the faculty by the Dean, if it is determined that the offence warrants such action. A student is defined as any person registered at the University for credit or non-credit courses.

Freedom of Information and Protection of Privacy
The Freedom of Information and Protection of Privacy (FOIP) Act indicates that assignments given by you to your course instructor will remain confidential, unless otherwise stated, before submission. The assignment cannot be returned to anyone else without your express permission. Similarly, any information about yourself that you share with your course instructor will not be given to anyone else without your permission.

Emergency Evacuations and Assembly Points
Assembly points for emergencies have been identified across campus. The primary assembly point for the Health Sciences Centre (HSC) building is HRIC - Atrium. For more information, see the University of Calgary's Emergency Management website: https://www.ucalgary.ca/risk/emergency-management/evac-drills-assembly-points/assembly-points Emergency Evacuation Procedures - https://www.ucalgary.ca/risk/emergency-management/plans-and-procedures. In the case of an emergency during exam, immediately stop writing the examination and follow the direction of the invigilator and go to the nearest exit. Students should not gather personal belongings.

Internet and electronic device information and responsible use:
Students are welcome to use laptops and other electronic note-taking devices in this course unless otherwise stated. Please be considerate of others when using these devices.

Supports for student learning, success, and safety
Student Advocacy & Wellness Hub (SAWH): https://cumming.ucalgary.ca/student-advocacy-wellness-hub/home AMA Physician and Family Support Program: https://www.albertadoctors.org/services/physicians/pfsp Student Union Wellness Centre: https://www.ucalgary.ca/wellnesscentre/ Safewalk: http://www.ucalgary.ca/security/safewalk

Campus security - call (403) 220-5333

Student Success Centre: https://www.ucalgary.ca/ssc/

Library Resources: http://library.ucalgary.ca/

Student Union (https://www.su.ucalgary.ca/about/who-we-are/elected-officials/) or Graduate Student's Association (https://gsa.ucalgary.ca/about-the-gsa/gsa-executive-board/) representative contact information

Student Ombudsman: http://www.ucalgary.ca/ombuds/role

Copyright

All students are required to read the University of Calgary policy on Acceptable Use of Material Protected by Copyright (https://www.ucalgary.ca/legal-services/university-policies-procedures/acceptable-use-material-protected-copyright-policy) and requirements of the copyright act (https://laws-lois.justice.gc.ca/eng/acts/C-42/index.html) to ensure they are aware of the consequences of unauthorized sharing of course materials (including instructor notes, electronic versions of textbooks etc.). Students who use material protected by copyright in violation of this policy may be disciplined under the Non-Academic Misconduct Policy.

Wellness and Mental Health Resources

The University of Calgary recognizes the pivotal role that student mental health plays in physical health, social connectedness, and academic success, and aspires to create a caring and supportive campus community where individuals can freely talk about mental health and receive supports when needed. We encourage you to explore the excellent mental health resources available throughout the University community such as counselling, self-help resources, peer support, or skills-building available through the SU Wellness Centre (Room 370, MacEwan Student Centre, https://www.ucalgary.ca/wellnesscentre/services/mental-health-services) and the Campus Mental Health Strategy website (http://www.ucalgary.ca/mentalhealth).

Research Ethics

If a student is interested in undertaking an assignment that will involve collecting information from members of the public, he or she should speak with the Assistant Dean, Research (UME) and consult the CHREB ethics website (https://ucalgary.ca/research/researchers/ethics-compliance/chreb) before beginning the assignment.

ATSSL Guidelines

Please refer to the ATSSL Web Lab PPE Requirement:

http://www.ucalgary.ca/mdprogram/about-us/ume-policies-guidelines-forms-terms-reference