* Please note when navigating through the document the Appendices are hyperlinked.

The most current version of this manual is on the Family Medicine Postgraduate Website. Please refer to the website version for the most updated information.

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</table>
Welcome to the Family Medicine Residency at the University of Manitoba. In this manual you will find useful information on:

- this Department of Family Medicine
- Rotations – Guidelines for both Family Medicine Block Time (FMBT) and Off-Services
- Scholarly / Academic Activity
- Where to find Policies and Procedures relevant to your training
- Where to find Objectives and Evaluation Instruments for all your rotations

This manual will be available on the Department of Family Medicine website. Each unit / program has a Program Assistant who will be able to answer questions you may have. Your unit may have its own specific resident manual for issues related to your unit. Please see your Program Assistant for information you cannot find in this manual.

The manual is a constant work in progress. If you find items that you find useful to you during your training please pass them along to the Postgraduate Coordinator.

DEPARTMENT OF FAMILY MEDICINE CONTACT INFORMATION

Bannatyne Campus Offices

Health Sciences Centre
Department Head Office Phone 204-318-3655
P219-770 Bannatyne Ave
Winnipeg MB R3E 0W3

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Northern Connection Medical Centre (NCMC)

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Family Medical Centre (FMC)

St. Boniface General Hospital
500 – 400 Taché Avenue
Winnipeg MB R2H 3E1

**FMC Unit Director** – Dr. Gerald Konrad 204-237-2863
**FMC Education Director** – Dr. Mary Jane Jamieson 204-237-2863
**Program Assistant** – Susan Snusher 204-237-2893

Kildonan Medical Centre (KMC)

Seven Oaks General Hospital
2300 McPhillips Street
Winnipeg MB R2V 3M3

**KMC Unit Director** – Dr. Tunji Fatoye 204-632-3203
**KMC Education Director** – Dr. Iain MacGregor 204-632-3203
**Program Assistant** – Audrey Golondrina 204-632-3207

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Centre de Sante
Room D-1048 St. Boniface Hospital
Fax (204) 233-3053

**Director** – Dr. Chantal Frechette 204-422-8811
**Program Assistant** – Collette Philippe 204-237-2883

Rural Parkland Stream

Dauphin Regional Health Centre
625 Third Street S.W.
Dauphin MB R7N 1R7

**Acting Director** - Dr. Scott Kish (204) 638-6445
**Asst. Education Director** - Dr. Scott Kish (204) 638-6445
**Program Assistant** - Michelle Jubenvill (204) 629-3023
### Rural Boundary Trails Stream – Boundary Trails Clinical Teaching Unit (CTU)

Boundary Trails Health Centre  
Box 2000, Stn. Main  
Winkler MB R6W 1N2  
Phone 204-331-8987  
Fax 204-331-8804

**Site Lead -** Dr. R.J. Menzies  
**Phone** (204) 822-4474  
**Program Assistant –** Patti Rach  
**Fax** (204) 331-8987

### Rural Brandon Stream

Brandon Regional Health Centre  
N404, 150 McTavish Ave. East  
Brandon MB R7A 2B3  
Phone 204-578-4215  
Fax 204-578-4969

**Site Lead -** Dr. Joanne Maier  
**Program Assistant –** Jocelyn Beever  
**Phone** (204) 727-6451  
**Fax** (204) 578-4215

### Rural Steinbach Stream

Steinbach Family Medical Centre  
10 – 333 Loewen Blvd.  
Steinbach MB R5G 0C3  
Phone (204) 326-3401  
Fax (204) 326-3899

**Site Lead -** Dr. Karen Toews  
**Clinic Manager –** Fred Pauls  
**Program Assistant -** Darlene Hildebrandt  
**Program Assistant –**  
**Phone** (204) 326-8870  
**Fax** (204) 326-8859  
**Phone** (204) 326-8888

### Enhanced Skills Programs

- FM Anaesthesia
- Care of the Elderly
- Sports and Exercise Medicine
- Palliative Medicine
- Emergency Medicine
- Oncology

**Enhanced Skills Program Lead –** Dr. Colin McFee  
**Program Assistant –** Kate Smith  
**Phone** 204-237-2883  
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<table>
<thead>
<tr>
<th>Location</th>
<th>Name</th>
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<tbody>
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<td>Jessica Allen</td>
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Goal of the University of Manitoba Family Medicine Residency Program

The broad knowledge base and clinical skill sets enable the family physician to work in diverse settings such as patients’ homes, outpatient clinics, emergency departments, labour and delivery suites, hospital wards and nursing home. Family medicine often serves as the main entry point to the health care system and the hub that provides continuity of care throughout the life cycle. As such, family medicine is the central medical discipline. The importance of primary care in quality of health and the value Canadian society places on family physicians in the delivery of this care are well known. 1, 2

The goal of the University of Manitoba’s Family Medicine Residency Program is to train family physicians who are able to provide comprehensive, high quality, continuous care in urban, rural or remote settings.

On completion of their program, family physicians trained by our residency program will:

- Respond to the needs of their communities by providing comprehensive, high quality, continuous health care to their patients and families across the lifecycle, in a variety of care settings, to a broad base of patients including those from underserved and marginalized populations.
- Recognize that patient-physician relationship is central to their practice and strive to communicate effectively with patients.
- Collaborate with other physicians, health professionals, patients, and their families to optimize patient care.
- Mobilize the resources of the community to improve the health care delivery system
- Take an active role in improving the safety and quality of health care
- Engage in lifelong learning
- Demonstrate professional behaviors in all aspects of practice

The College of Family Physicians of Canada (CFPC) has adopted a competency approach to the accreditation of training of family physicians in Canada. The model is referred to as the CanMEDS-FM framework, which is modified from the CanMEDS model of the Royal College of Physicians and Surgeons of Canada (RCPSC).

In response to changes in accreditation standards in Family Medicine, the program has engaged in a process to review and modify its curriculum to ensure it meets the goals of the CFPC’s Triple C Curriculum – a competency-based curriculum that is:

- Comprehensive
- Focused on Continuity of education and patient care
- Centred in Family Medicine


Four Principles of Family Medicine

The family physician is a skilled clinician
Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients’ experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients’ lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to “take charge” of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best evidence available.

Family medicine is a community-based discipline
Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people’s changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients’ needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex bio-psycho-social problems. Finally, the family physician may provide palliative care to people with terminal diseases.

The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

The family physician is a resource to a defined practice population
The family physician views his or her practice as a “population at risk,” and organizes the practice to ensure that patients’ health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients’ health.

Family physicians have the responsibility to advocate public policy that promotes their patients’ health. They accept their responsibility in the health care system for wise stewardship of scarce resources.

The patient-physician relationship is central to the role of the family physician
Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients’ response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family physicians respect the privacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients’ well-being, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.

Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.
PROFESSIONALISM in the PROGRAM

One of the CanMEDS FM goals is to be professional. In your endeavor to become a true professional, we provide the following guidelines:

1) Dress appropriately. Guidelines from the Faculty of Medicine can be found at [http://umanitoba.ca/faculties/medicine/policies_procedures.html](http://umanitoba.ca/faculties/medicine/policies_procedures.html)
2) Be punctual.
3) Speak professionally. Use words that reflect who you are speaking with. Listen carefully.
4) Be supportive, patient, and respect others
5) Follow through on commitments
6) Respond to e-mails from administrative staff within 24 hours. Respond to pages by the administrative staff the day of. Not responding in a timely fashion impedes their ability to help your program run smoothly.

PROFESSIONALISM ACCORDING TO THE CFPC

Twelve Themes that Define Professionalism in Family Medicine

1. Day-to-day behaviour reassures one that the physician is responsible, reliable, and trustworthy.
2. The physician knows his or her limits of clinical competence and seeks help appropriately.
3. The physician demonstrates a flexible, open-minded approach that is resourceful and deals with uncertainty.
4. The physician evokes confidence without arrogance, and does so even when needing to obtain further information or assistance.
5. The physician demonstrates a caring and compassionate manner.
6. The physician demonstrates respect for patients in all ways, maintains appropriate boundaries, and is committed to patient well-being. This includes time management, availability, and a willingness to assess performance.
7. The physician demonstrates respect for colleagues and team members.
8. Day-to-day behaviour and discussion reassure one that the physician is ethical and honest.
9. The physician practices evidence-based medicine skillfully. This implies not only critical appraisal and information-management capabilities, but incorporates appropriate learning from colleagues and patients.
10. The physician displays a commitment to societal and community well-being.
11. The physician displays a commitment to personal health and seeks balance between personal life and professional responsibilities.
12. The physician demonstrates a mindful approach to practice by maintaining composure / equanimity, even in difficult situations, and by engaging in thoughtful dialogue about values and motives.
POLICIES

***As a resident, you are responsible for knowing all policies related to your residency training.***

PROGRAM POLICIES

Please see the policies on the Family Medicine website for the most up-to-date policies. Postgrad policies can be accessed through this link: http://umanitoba.ca/faculties/medicine/units/family_medicine/8195.html

POSTGRADUATE MEDICAL EDUCATION OFFICE POLICIES

General PGME policies can be found via the link below:

http://umanitoba.ca/faculties/medicine/education/pgme/policies.html

Please ensure you are familiar with these policies.

RESIDENT SAFETY

According to the University of Manitoba Health and Safety Policy and Procedure, students/residents are to immediately report any unsafe conditions to the appropriate supervisor. Please see more details about the policy:

http://umanitoba.ca/admin/governance/governing_documents/staff/551.html

about the procedure:

http://umanitoba.ca/admin/governance/governing_documents/staff/1196.html

Also, as mentioned above, please note the Resident Safety policy from the PGME office:

http://umanitoba.ca/faculties/medicine/education/pgme/policies.html

RESIDENT TRAVEL

Travel is a mandatory expectation of ALL residents in the Family Medicine Residency at the University of Manitoba. The amount of travel will be dependent on the stream and a resident’s location.

Residents’ primary home location is determined by the Program Director at the outset of each academic year. Generally, the location where a resident trains for Family Medicine Block Time determines the home location. In occasional instances, home location may be re-allocated during the academic year.
RESIDENT WELL-BEING

We recognize that residency is an intense experience. We encourage all residents to look after themselves during their training. Some resources you may find helpful are:

- fellow residents
- PARIM - see “Resident Well-being” on the PARIM website for more resources; [www.parim.org](http://www.parim.org)
- http://www.ephysicianhealth.com/
- Canadian Medical Protective Association (CMPA) – for concerns with ethical / boundary issues
- College of Physicians and Surgeons of Manitoba (CPSM) – for concerns about ethical conduct, concerns about a colleague or attending
- Student Affairs 204-789-3213
- Faculty Counseling Services 204-789-3328 – Free confidential consultation and treatment for students experiencing emotional stress by Drs Prober or Perlov from the Department of Psychiatry. Service is available to Faculty of Medicine students, their spouses and immediate family.

SELF-CARE

- take care of yourself – eat, sleep, take time for yourself, a walk, etc.
- maintain personal relationships outside of Medicine
- recognize signs of burnout and seek support, both for yourself and your resident peers

Intimidation, Harassment, and Discrimination

The University of Manitoba and all healthcare workers share a commitment to advance a safe working environment for all, learners, staff and patients alike. There are multiple avenues for redress if you experience or witness intimidation, harassment or discrimination (IHD). You are encouraged to contact any of the following: your Chiefs, Unit Director, or Program Director. Your “Speak Up” cards carry contact information for the Associate Dean of Students and the Associate Dean of Professionalism and Diversity. All of these individuals can provide you with guidance in reporting IHD.
RESIDENT CURRICULUM AND ASSESSMENT

CFPC COMPETENCIES

Triple C Competency-based Curriculum
Triple-C is the framework set out by the CFPC as a recommendation as how programs should organize their curriculum. Triple C stands for competency-based curriculum in Family Medicine that is Comprehensive, focused on Continuity, and Centred in Family Medicine. More information regarding Triple C can be found on the CFPC website at http://www.cfpc.ca/Triple_C/.

CanMEDS-FM
CanMEDS-Family Medicine (CanMEDS-FM) is a competency framework for medical education in Family Medicine. It is adapted from the Royal College 2005 CanMEDS. This framework addresses 7 categories in which a resident should be competent in by the completion of training. The seven categories are:

1) Family Medicine Expert
2) Communicator
3) Collaborator
4) Manager
5) Health Advocate
6) Scholar
7) Professional

Details for CanMEDS-FM and the seven competency areas can be found at www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf

6 Observable Behaviors
- 6 Skill Dimensions
  1) Patient-Centered Approach
  2) Communication Skills
  3) Clinical Reasoning Skills
  4) Selectivity
  5) Professionalism
  6) Procedure Skills

99 CORE TOPICS
By the end of their training, Family Medicine residents are expected to know the 99 Core Topics as set out by the CFPC.
http://www.cfpc.ca/uploadedFiles/Education/Priority%20Topics%20and%20KFs%20with%20skills%20and%20phases%20Jan%202011.pdf

PROCEDURAL SKILLS
There is also a list of procedural skills set out by the CFPC that we, as an education program, are confident our graduates are familiar with. http://www.cfpc.ca/EvaluationObjectives/
CLINICAL ROTATIONS

HOSPITAL / EDUCATIONAL SITES

<table>
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<tr>
<th>Acronym</th>
<th>Hospital/Educational Sites</th>
<th>Address</th>
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<tbody>
<tr>
<td>FMC</td>
<td>Family Medical Centre</td>
<td>400 Tache Avenue (across from SBGH)</td>
</tr>
<tr>
<td>GGH</td>
<td>Grace General Hospital</td>
<td>300 Booth Drive</td>
</tr>
<tr>
<td>HSC</td>
<td>Health Sciences Centre</td>
<td>T240, 770 Bannatyne Ave. (Northern/Remote office)</td>
</tr>
<tr>
<td>KMC</td>
<td>Kildonan Medical Centre</td>
<td>2300 McPhillips Street (located at SOGH)</td>
</tr>
<tr>
<td>NCMC</td>
<td>Northern Connection Medical Centre</td>
<td>425 Elgin Avenue</td>
</tr>
<tr>
<td>MIS</td>
<td>Misericoridia Health Centre</td>
<td>99 Cornish Avenue</td>
</tr>
<tr>
<td>RHC</td>
<td>Riverview Health Centre</td>
<td>1 Morley Avenue</td>
</tr>
<tr>
<td>SBGH</td>
<td>St. Boniface General Hospital</td>
<td>409 Tache Avenue (across from FMC)</td>
</tr>
<tr>
<td>SOGH</td>
<td>Seven Oaks General Hospital</td>
<td>2300 McPhillips Street (KMC location)</td>
</tr>
<tr>
<td>VGH</td>
<td>Victoria General Hospital</td>
<td>2340 Pembina Highway</td>
</tr>
</tbody>
</table>

PROFESSIONALISM IN ROTATIONS

- set your own goals for each rotation
- ensure consistent transfer of care – you are responsible for your patients until you transfer care to a fellow resident/attending
- be organized – keep a list of your patients and your responsibilities each day
- keep handy the pager numbers of your colleagues and attending.
- be a positive, professional resident

COMMUNICATION IN ROTATIONS

- be proactive about communication; meet with your supervisor early. Clarify your responsibilities. Let your supervisors know what your goals are.
- let your supervisors know (early) if you are uncomfortable with a situation or feel that the rotation is not meeting your needs
- address conflict/interpersonal problems
- note that some uncomfortable things are inevitable: long hours, stressful situations, learning while doing.....

Communication with Patients

Please see The Macy Model, a framework for effectively communicating with patients.

OFF-SERVICES

Off-Services are notified through VENTIS at the beginning of the year of dates that Family Medicine requests their residents be excused from service. Each resident is responsible for requesting to be off call the night prior to the date you’re being excused from service. Check VENTIS to find out these dates.

CONTACTS for OFF-SERVICES

For a list of Off-Services Contacts, please see
http://umanitoba.ca/faculties/health_sciences/medicine/education/pgme/postgrad.html

PGY1 FAMILY MEDICINE BLOCK TIME STRUCTURE

Family Medicine Block Time (FMBT) length differs by stream. Please check with your Program Assistant regarding FMBT details for your stream.

Residents are expected to be somewhat flexible as clinic hours may not be 9:00-5:00. Residents are expected to perform on-call duties. This will include attending at least 2 weekend on-calls. The exact nature and number of call shifts depends on the nature of the practice and will generally mirror the practice of the lead preceptor.

Block time residents are to be absent from the clinic for Academic Day and In-Unit Seminars. The time for In-Unit Seminars differs between streams and sites. Residents are expected to attend all in-unit seminars. Attendance will be taken. Times for In-Unit Seminars are provided by your Program Assistant.

For expectations on chart notes please see Appendix F.

EMR INFORMATION

You will have the opportunity to work with several different Electronic Medical Records (EMR) during your residency. Each teaching clinic will arrange for your orientation process. You will need to complete the WRHA EPR training prior to starting on your off-service/ward rotations.

ON-CALL PROCEDURES

Details regarding call can be found in the PARIM Collective Agreement. Please see Article 14 of the agreement.

- Residents generally follow on-call requirements of the site.
  - However, if the site has put you on call in excess of the usual PARIM guidelines (1 in 3 for home call and 1 in 4 for in-hospital call), you are able to decline some of the call shifts, knowing that you may miss out on learning opportunities by doing so.
  - NOTE that if you prefer to participate in all scheduled shifts, PARIM will only pay stipends for up to the usual number.
  - You are entitled to invoke the PARIM rule that if you are actively caring for patients for more than 4 hours in a row, one of which is after midnight, you are exempt from clinical duties the next day, after signing over your patients and ensuring continuity of care.
- You may not elect to take a call shift instead of working the usual clinic shift during the day.
Home Call vs. In-hospital Call:
- At remote sites, it may not be immediately obvious whether the call should be considered home call or in-hospital call. The location of the room that you live in is not the important factor, as they are often located in the hospital or hospital complex itself.
  - In-hospital Call – if a call shift entails being up most of the night actively caring for patients and the 1 in 4 PARIM limit applies to your call stipends.
  - Home Call – if you are primarily taking only phone calls, and are rarely needing to see a patient in person. This holds true for obstetric calls other than on core obstetric rotations.
  - Conversion - if you are called in and spend more than 4 hours involved in active patient care, one of which is after midnight, you can convert the call to In-Hospital Call and request the higher stipend. To convert Home to In-Hospital Call you need to use the PARIM home call conversion form online at [http://www.parim.org](http://www.parim.org)

Emergency shifts are not considered call shifts and stipends are not paid for these.

EVALUATIONS – Objectives and ITAR’s

ITAR
- In-Training Assessment Report – formal evaluation completed at the end of each rotation.
- Determines whether or not the resident has passed the rotation.
- Completed by the lead preceptor, reviewed with the resident.
- During Family Medicine Block Time an ITAR is required at the every two periods and at the end of a FMBT rotation.

End-of-Shift Trainee Feedback Form
- In some rotations, residents may be supervised by a number of preceptors, eg. Obstetrics and Emergency rotations. In order to capture feedback, we have developed End-of-Shift forms. These should be collected and submitted to the PA or Faculty Lead for these rotations for their use in generating the ITAR.
- The same form is used for short learning experiences (Misericordia Urgent Care, Cast Clinic, etc.) and should be returned to your PA.

Field Notes
- One field note to be completed per day on FMBT. More information on field notes can be found in Appendix G.
ELECTIVES

Time is set aside in the PGY2 year for electives. The amount of elective time available differs between streams. Most streams have 8 weeks of electives.

ALL Electives:
- Resident-directed; resident makes all arrangements independently
- Complete the Family Medicine residency's Mandatory Elective Agreement Form
  [http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/Elective_Agreement_Form_Nov3-14fillable.pdf](http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/Elective_Agreement_Form_Nov3-14fillable.pdf)
  Complete ALL Steps on the Mandatory Elective Agreement Form. An elective is not considered approved until Step 3 (Approval from your Education Director) has been provided.
- In all elective settings, you must be an active participant; observation electives will not be approved.
- During electives, residents expected to continue with clinical half-day backs.
- During electives, residents are expected to attend Academic Days if within the province.
- **All elective experiences are subject to the same evaluation criteria (and remedial/probation guidelines) as all other Family Medicine Residency program rotations.
- Our department must receive the following from your elective preceptor:
  - Confirmation of attendance
  - A completed ITAR

Process for setting up Elective in Setting with Established Rotations:
(e.g. Endocrinology at SBGH, Plastic Surgery at HSC)
- Contact the program assistant (PA) in that program to determine the availability of a training spot;
- Confirm the preceptor's name with that PA;
- Contact the preceptor to ensure he/she is willing to take you on for the elective rotation;
- Complete the Family Medicine residency's Mandatory Elective Agreement Form
  [http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/Elective_Agreement_Form_Nov3-14fillable.pdf](http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/Elective_Agreement_Form_Nov3-14fillable.pdf)

OUT-OF-PROVINCE ELECTIVE

An out-of-province elective is possible but conditions apply. This type of elective is not a right but a privilege. The Program Director retains the right not to grant permission for an out-of-province elective to any family medicine resident applicant. Please see the “Out-of-Province Electives” policy.

Process for setting up Out-of-Province Elective:
- Resident responsible for all costs for out-of-province elective
- Start preparation at least 3 months ahead of time
- Ensure elective preceptor is either CCRP or FRCPs(C) certified
- Obtain required medical licensure and insurance for the elective jurisdiction
  - It is recommended you ensure your license is in place at least 4 weeks prior to your scheduled elective. This will prevent any last-minute cancelations.
  - Ensure CMPA coverage extends to elective location. If not, take out additional coverage.
- Complete the Mandatory Elective Agreement Form [Appendix H](#) for approval.
- If host program requires documentation of your learner status in our program, please request this from the office of the Program Director and Program Coordinator.
- During electives, residents expected to continue with two full clinics per block (in lieu of clinical half-day backs)
Process for setting up Out-of-Country Elective:

- Resident responsible for all costs for out-of-province elective
- Start preparation at least 3 months ahead of time
- Ensure elective preceptor is either CCRP or FRCPS(C) certified (or equivalent in other countries). You may need to obtain their credentials and then check with the Education Director.
- Ensure you can practice to your full scope; seeing patients, working up their issues and managing them to your full capabilities. This has been an issue with electives in other countries where junior (R1 or R2) residents may not be given this degree of autonomy.
- Obtain required medical licensure and insurance for the elective jurisdiction
  - It is recommended you ensure your license is in place at least 4 weeks prior to your scheduled elective. This will prevent any last-minute cancelations.
  - CMPA will not cover you outside of Canada. Take out additional coverage and personal travel health insurance.
- Complete the Mandatory Elective Agreement Form for approval.
  
  http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/Elective_Agreement_Formal_Nov3-14fillable.pdf
- If host program requires documentation of your learner status in our program, please request this from the office of the Program Director and Program Coordinator.
- During electives, residents expected to continue with two full clinics per block (in lieu of clinical half-day backs)

RESEARCH ELECTIVE

The research elective is designed to provide residents an opportunity to perform a research study. It is also designed for faculty to participate in research projects and gain experience supervising research-related projects. Please see the policy on Research Electives for more information.

STUDY ELECTIVE

Residents have found it very helpful to devote part of their elective time in preparation for their Certification examination. Study electives are available, for a maximum of 2 weeks. For more information on a study elective, please discuss with your Education Director.

MOONLIGHTING – Work Outside of the Residency Program

Please see the FPGME Resident Moonlight Policy. All FPGME policies can be found at http://umanitoba.ca/faculties/medicine/education/pgme/policies.html
APPEALS
If you have concerns or complaints regarding an evaluation from a rotation you must submit a complaint in writing as soon as possible. Complaints/concerns not submitted in a timely manner may not be considered.

Please see the “Evaluation, Remediation, Probation, Dismissal” policy on the Postgraduate Medical Education website at http://umanitoba.ca/faculties/medicine/education/pgme/policies.html. If you have any questions regarding the appeals process, please contact the Program Director and/or your chief resident(s).

RESIDENT ASSESSMENTS
Stream Directors / Unit Directors meet with residents twice yearly for a resident progress meeting, to review ITARs, rotations completed, and overall progress. Scholarly activity and Academic Day attendance will be reviewed. At the end of year review a summative ITAR for Professionalism and Ethics will be completed.

PROGRAM ASSESSMENTS
The Associate Program Director or Education Director will meet with each resident annually to gather individual feedback on the program as a whole.

Chief residents meet annually with all residents in the stream to gather collective feedback on the strengths and weaknesses of the program, and convey their findings in their annual report.

FACULTY EVALUATION
Twice yearly, residents are provided the opportunity to provide feedback on faculty preceptors. Information is collated anonymously and forwarded to the Department Head’s office. Aggregate data is shared with the faculty by the Department Head. Every effort is taken to assure residents’ anonymity.

EDUCATIONAL SESSIONS and ACTIVITIES

ACADEMIC DAY
Each Family Medicine stream sets their academic curriculum delivered in Academic Days and/or Half Days. The timing of sessions and topics differs between streams. Please contact your Program Assistant for details on your Academic Days.

These mandatory sessions consist of didactic lectures, workshops and other activities designed to cover many of the content areas. The most up to date Academic Day schedules can be found on the Family Medicine website. Please check this weekly as changes occur frequently.

http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/8325.html

As sessions are mandatory, your attendance will be recorded through evaluations in VENTIS. Repeated late attendances may be reflected on your Professionalism ITER. Please see the Academic Day Attendance policy for more details.


If you are ill and unable to attend Academic Day you should notify your Program Assistant as soon as possible.
JOURNAL CLUB

Each teaching unit sets the date and location of their Family Medicine Journal Club. These are resident-led with support from a faculty physician. Normally an article related to the clinical topic is selected by the resident assigned to a particular journal club. Some units also use the McMaster-developed Problem-Based Small Group Learning Modules. All residents receive a login & password for the PBLP modules in July. See your PA for more details on how Journal Club is conducted in your unit.

RESIDENT’S RESEARCH DAY

Resident’s Research Day typically occurs annually after the CCFP exam. Exact dates for Research Day have not been set for the 2015-16 academic year.

PEARLS – Practical Evidence Applied to Real Life Situations

- a series of evidence-based practice reflection exercises designed to enhance your understanding and application of critical appraisal skills.
  - Evidence-Based Medicine (EBM), initially proposed by Dr. David Sackett and colleagues at McMaster University, is an important tool in the way physicians practice clinically, teach others, and do research. Dr. Sackett defines EBM as
    “....the conscientious explicit and judicious use of current best evidence in making decisions about the care of individual patients.”

- Residents are required to complete 3 PEARLS exercises during each academic year. Your Program Assistant will schedule your PEARLS sessions for you. Your preceptor will discuss your exercise with you and assign a pass/fail grade.

- PEARLS Exercise Reports, Critical Appraisal Worksheets, and more information on PEARLS and the series of steps used in this reflection process can be found on the CFPC website at www.cfpc.ca/Pearls_for_Residents/.

CLINICAL AUDIT (R1 + R2)

- the process whereby clinical charts are reviewed; reviewers look retrospectively for the presence or absence of specific predetermined criteria. This exercise will provide you with an opportunity to apply your critical appraisal skills to a clinical practice problem.
- Set a clinical standard based on a critical review of the literature; then evaluate the degree of attainment of that standard in a review of clinic charts.
- Being able to do a chart audit relies on accurate recording of all relevant information in the chart at the time of the clinical encounter. Information not recorded in the chart is not available for audit. The lack of information determined to be necessary for good clinical care is a reflection of the quality of care provided.
Clinical notes should be made to accurately and completely reflect the clinical visit as well as additional information required for good patient care (eg. problem lists, flow charts with test results).

Please see Appendix I for the Objectives and Processes involved in clinical (chart) audits.

PRESENTING ROUNDS

During many rotations, you will be expected to present rounds. The audience will typically consist of other learners (medical students and residents), faculty physicians, community physicians, and other health professionals.

You may be expected to prepare and present rounds either as an individual or in a group. All faculty members are willing to review and critique any presentation you are preparing. There are many skills for presentations, some of which include:

- Use of PowerPoint to develop and present your rounds
- Proper amount of information per slide – (remember the 7 X 7 rule where you should never have more than 7 words in a line and no more than 7 lines on a slide)
- Slides should not be your speaking notes – words on a slide should highlight the KEY points only
- Do not read your presentation from your slides – always face your audience and speak from your speaking notes.

COURSES and EXAMINATIONS

CORE CURRICULUM COURSES – PGME

You must register for the core curriculum courses so they are completed during your Family Medicine Block Time.

- mandatory courses organized by the PGME office with training in areas pertinent to residents of all specialties
- details and registration for the courses can be found on [http://umanitoba.ca/faculties/medicine/education/pgme/core_curriculum.html](http://umanitoba.ca/faculties/medicine/education/pgme/core_curriculum.html)
- Completion of the following core curriculum courses during your training is required:

<table>
<thead>
<tr>
<th>Core Curriculum Course List</th>
<th>When taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching Development Program 1 (TDP-1)</td>
<td>during PGY-1 year; online</td>
</tr>
<tr>
<td>Professional Boundaries</td>
<td>during PGY-1</td>
</tr>
<tr>
<td>Resident and the Learning Environment</td>
<td>during PGY-1</td>
</tr>
<tr>
<td>Conflict Management in Medicine</td>
<td>during PGY-1 or PGY-2; online</td>
</tr>
<tr>
<td>Practice Management</td>
<td>during PGY2 (done through our Academic Days)</td>
</tr>
<tr>
<td>Teaching Development Program 2 (TDP-2)</td>
<td>during PGY-2 year; online</td>
</tr>
</tbody>
</table>

Courses Required for Family Medicine

Please see the Mandatory Courses Policy on the Family Medicine Website.

Courses deemed mandatory for a stream must be successfully completed in order to graduate.

Further questions regarding FM courses not answered here or in the policy can be directed to Shannon Rankin, Postgraduate Coordinator in the main Family Medicine Department office.

**BLS – Basic Life Support**
- Mandatory for ALL Family Medicine residents PRIOR to starting residency
- Mandatory recertification for all “off-time” residents (those whose completion date extends beyond the expiration of their initial BLS and ACLS certifications).

**ACLS – Advanced Cardiac Life Support**
- Mandatory for ALL Family Medicine residents PRIOR to starting residency
- Mandatory recertification for all “off-time” residents (those whose completion date extends beyond the expiration of their initial BLS and ACLS certifications).
- Recertification optional for all other residents prior to end of training

**ALARM – Advanced Labour & Risk Management**
- Mandatory for ALL Family Medicine residents
- Offered in PGY1 and/or PGY2

**NRP – Neonatal Resuscitation Program**
- Mandatory for ALL Family Medicine residents
- Offered in PGY1 and/or PGY2

**ATLS – Advanced Trauma Life Support**
- Mandatory for Family Medicine residents in the following streams:
  - Northern/Remote
  - Rural (Bilingual, Boundary Trails, Brandon, Parkland, Portage la Prairie, Steinbach)
- Offered in PGY1
- Please note this is a challenging course with a significant failure rate. Thorough preparation is advised.

**Procedural Sedation**
- May be offered to Northern/Remote Family Medicine residents

**PALS – Pediatric Advanced Life Support**
- May be offered to Northern/Remote Family Medicine residents
Course Reimbursement by WRHA

Attendance at mandatory courses identified by your program must be approved by the program director (Course Reimbursement List). Course fees are reimbursed by the WRHA upon successful completion.

The resident is responsible for providing receipts when submitting any expense claim.

For all course tuition reimbursements please submit:

1) Course receipt

2) Copy of certificate of completion

Also provide PGME with a copy for VENTIS credit. Please send to pgme@umanitoba.ca

3) WRHA Expense claim form Please ensure that you sign.

Note** If the course was paid in US dollars a copy of the credit card receipt is also required.

If this is your first claim please submit:

1) Void cheque

2) Electronic Transfer funds form Please ensure that you sign.

Please send by mail, fax or email to:

Medical Staff Administrative Services
4-650 Main Street
Winnipeg, MB R3B 1E2

Email: msas-residents@wrha.mb.ca

or

Fax: (204) 943-1792

Course fees are reimbursed upon successful completion of the course.

If you have any questions, please contact
Medical Staff Administrative Services
at 204-926-1332
QUALIFYING EXAMINATION 1 – MCC

Please note that you are required to complete the QE1 exam during your PGY-1 year if you have not completed it prior to your entry into residency.

CCFP EXAM PREPARATION

Residents are strongly encouraged to begin exam preparation early in their second year. Past residents have used study groups to great success.

Family medicine candidates who are eligible to take the Certification Exam will need to take the MCCQE Part II separately as the CCFP exam has been de-harmonized.

SIMULATED OFFICE ORAL (SOO)

Residents practice simulated office oral exams (SOO’s) during their Family Medicine Block Time (FMBT). These mock exams are usually scheduled 5-6 times for PGY1’s and 2-3 times for PGY2s. Please see Appendix L for tips on conducting SOO’s. Exam preparation SOO sessions are offered late in second year, generally 1-2 months before the May CCFP exam.

SHORT-ANSWER MANAGEMENT PROBLEM (SAMP)

Short-Answer Management Problems (SAMPs) are done in preparation for the CCFP exam. Residents will develop an understanding of how to generate and answer SAMPs as part of their academic curriculum. A simulated SAMP mini-exam is offered several months before the May CCFP exam.

For SAMP Writing Guidelines, please see Appendix M.

Additional Exam Preparation

The chief residents typically organize examination preparation sessions for the CFPC certification exam. Chief Residents and Program Assistants at the units may have copies of resources used in previous years.
LEAVES

CONFERENCE/WORKSHOP LEAVE
Residents are encouraged to participate in conferences/workshops related to their education. Residents MUST seek approval to attend these events. **Approval must be sought 4 weeks prior to the event** and granted by the Unit’s Education Director.

Please see the Conference/Workshop Leave & Funding Policy. A “Resident Leave and Funding Request” form must be completed. This form addresses both your absence from clinic as well as your travel request.

Some Financial Support may be available to residents to attend conferences/workshops. Please see the Conference/Workshop Leave & Funding policy.


Policies can be found on the Postgraduate Family Medicine webpage.

SICK LEAVE
In the case of illness, residents should inform their Program Assistant or the respective PA in an off-service rotation should they be unable to fulfill training duties (coming to clinic, attending Academic Day, etc.). Please see the Unexpected Absence policy.

[http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/policy__Unexpected_Absences__FINAL_JS.pdf](http://umanitoba.ca/faculties/health_sciences/medicine/units/family_medicine/media/policy__Unexpected_Absences__FINAL_JS.pdf)

LEAVES OF ABSENCE FROM THE RESIDENCY
If you require a Leave of Absence from the Residency (ie. maternal, paternal, medical) you are required to request this leave through VENTIS. Please contact your Program Assistant if you require any further information.

YOUR CONTACT INFORMATION
It is important to keep your mailing address up to date with the program. This is necessary to receive all residency-related information from the program, the Postgraduate Medical office, as well as the WRHA (payroll). **Should your address change while in residency please update in VENTIS.**

***ALL email communication must be sent to your U of M student email address.***
MEETINGS

Department of Family Medicine Postgraduate Education Committee Meetings

Meetings are attended by the chief resident(s) of each unit. The chief residents are your representatives at these meetings. Please bring any residency-related concerns to their attention. He/she will bring forward your concerns at the meetings for discussion/resolution.

Chief Resident Meetings

Usually every one - two months chief residents will meet to discuss logistical and other issues pertaining to the residency. If you have questions or concerns, you should direct them to your chief resident(s) so they can be answered and/or addressed.

Resident Meetings

Meetings may be scheduled by the chief residents in unit to discuss important residency matters.

SENIOR ADMINISTRATIVE RESIDENTS

Chief and Senior Residents

The chief and senior residents in your stream have several responsibilities. They are required to attend meetings in order to represent the voice of the residents. Chief’s also organize the call schedule and help plan several annual events such as the resident retreat, post Welcome BBQ pub night and the CaRMS meet-and-greet event.

Chief residents can also act as resident advocates for residents who are experiencing educational or program difficulties and who need to meet with the Unit Director, Education Director, or Program Director. They can be a support and help clarify in difficult situations. Please contact your chief if you need this type of assistance.

RESIDENT FILES

An administrative file is maintained for each resident in the respective Program Assistant’s office. This file contains copies of rotation evaluations, etc.

A file is also kept in the general Family Medicine Postgraduate office for each resident. This file contains general training information and forms, correspondence with the resident, etc.

Residents are entitled to access their administrative files upon request.
COLLEGES, OFFICES, and AUTHORITIES

COLLEGE OF FAMILY PHYSICIANS OF CANADA - CFPC
The College of Family Physicians of Canada (CFPC) is the governing body that oversees all postgraduate family medicine residency programs in Canada. It is responsible for the accreditation of training, certification, and continued education of Canadian family physicians.

www.cfpc.ca

The Manitoba College of Family Physicians - MCFP
The MCFP is a chapter of the national CFPC. It offers the Annual Scientific Assembly, our major provincial Family Medicine CME event, held each spring. More information about the MCFP can be found on its website at http://mcfp.mb.ca/

COLLEGE OF PHYSICIANS and SURGEONS OF MANITOBA - CPSM

The CPSM is the governing body responsible for maintaining standards of medical practice in Manitoba. They are responsible for all resident licensing in the province.

The College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg MB R3J 3T7
PH: (204) 774-4344
Fax: (204) 774-0750
Toll Free (In Manitoba): (877) 774-4344
Email: cpsm@cpsm.mb.ca

PGME OFFICE

The website for the PGME office is at http://umanitoba.ca/faculties/medicine/education/pgme/index.html

The PGME office website provides information regarding postgraduate policies and procedures, core curriculum courses, and other resident matters relating to residents of all specialties, including Family Medicine.

PARIM

PARIM stands for the Professional Association of Resident and Interns of Manitoba. PARIM is a volunteer-run non-profit organization that represents resident physicians training in Manitoba. It advocates for resident well-being and professional issues.

A contract is negotiated between PARIM and your employer, the Winnipeg Regional Health Authority (WRHA). The current PARIM contract is available on the web at www.parim.org. Information pertaining to your salary and policies regarding your training can be found in the contract.
REGIONAL HEALTH AUTHORITIES

Until June 2012 there were 11 regional health authorities in Manitoba. These have now been merged into 5 regional health authorities. For more information on the RHA’s please see the following website - http://www.gov.mb.ca/health/rha/index.html.
ADDITIONAL RESOURCES

LIBRARY RESOURCES – Neil John Maclean Health Sciences Library
All residents have access to the U of M hospital libraries. In order to access the library resources you will need a U of M ID card. This ID/photo card can be obtained through staff at the Neil John Maclean library.

UP TO DATE
Library access to UptoDate from campus, hospital or home! UptoDate is clinical reference comprised of thousands of original topic reviews written by a recognized faculty of experts who each address a specific clinical issue and provide detailed recommendations.
UptoDate is currently available to all UM Medical Residents. It is available on-campus, from any computer in a Winnipeg area hospital or health centre (HSC, Seven Oaks, Misericordia, Deer Lodge, Riverview, St. Boniface, Concordia, Victoria, and Grace). It is also available by computer at home, or from any rural, northern, or remote location with an Internet connection.
To access UptoDate through the UM Health Sciences Libraries, visit http://libguides.lib.umanitoba.ca/health/
Click on UptoDate under Health Databases in the center part of the page. If you are off-campus, enter your student or staff ID number and PIN or your UM Library card number and PIN.

For more information, contact:
Information Centre, Neil John Maclean Health Sciences Library, njm_ref@umanitoba.ca Phone: 789-3464
Learn more about the value of UptoDate for clinical decision making:
http://www.utdol.com/home/about/research.html
Please check out the Family Medicine toolkit, a repository of great information and clinical decision-making tools at http://libguides.lib.umanitoba.ca/familymedicine?hs=a

WEBSITE LINKS
University of Manitoba
http://umanitoba.ca/
Department of Family Medicine:
http://www.umanitoba.ca/faculties/medicine/units/family_medicine/
Postgraduate Training in the Department of Family Medicine:
http://umanitoba.ca/faculties/medicine/units/family_medicine/postgrad/index.html
Professional Association of Residents and Interns of Manitoba (PARIM)
http://www.parim.org/
The College of Family Physicians of Canada (CFPC)
http://www.cfpc.ca/Home/
CFPC - Self learning: http://www.cfpc.ca/English/CFPC/CME/Selflearning/default.asp?s=1
Manitoba Physician’s Manual (Manitoba Billing Codes)
Medical Student/Resident Financial Assistance Program (MSRFAP)
www.gov.mb.ca/health/msrfap/index.html
ANNUAL EVENTS

**RESIDENT RETREAT**
An annual resident retreat usually takes place in the fall. The location and time of this retreat is determined annually. The planning committee for this retreat includes the chief residents as well as individuals from the Office of Rural and Northern Health (who provide financial support). The planning committee may select a Chair of the Planning Committee who is a resident with no other administrative commitments to the department. Chief residents will have more details on the planning of this event.

**CaRMS**
CaRMS interviews are held late January/early February each year. Residents in the program are involved in the CaRMS process. The chief residents organize a meet-and-greet social event for candidates to the program. Residents are involved in the social event and also meet with and/or interview candidates on interview days.

**FAMILY MEDICINE FORUM (FMF)**
The Family Medicine Forum is the premier family medicine conference in Canada. It happens annually, normally in November. It is held in a different Canadian city each year. More details can be found at [http://fmf.cfpc.ca/](http://fmf.cfpc.ca/)

**Annual Scientific Assembly**
The Annual Scientific Assembly (ASA) is an annual conference for Family Physicians in Manitoba. It is hosted by the Manitoba College of Family Physicians. It is usually held in April. More details can be found at [http://mcfp.mb.ca/asa/](http://mcfp.mb.ca/asa/)

**Research Day**
Please see the section on Resident’s Research Day in this manual.

**Resident’s Grad Farewell**
In late May or early June, the program holds a dinner for graduating residents who are completing their training. Details are announced in the spring of each year.
APPENDICES

APPENDIX A - EXPECTATIONS FOR CHART NOTES

FACULTY OF HEALTH SCIENCES
Department of Family Medicine

Key issues for outpatient and inpatient chart notes

- The patient’s medical record, often called a chart, is a legal document. Be bold in your oral presentations but conservative in your charting.
- Write fluently and legibly; do not leave blank lines in between your text.
- If dictating, do not speak in full sentences but in point form. Avoid extraneous words but make sure your meaning is clear.
- If you make a mistake, cross out the unwanted part, whether it is one word or several sentences, then write “error” beside the mistake and initial it. Those who read and examine medical records must be able to see mistakes and know who is responsible for crossing a word or sentence out. DO NOT SCRIBBLE WORDS OUT.
- For any handwritten note, always sign your name and then print your name, along with the proper credential i.e. John Smith - John Smith FMR1.
- For a dictated note where your name has been typed – you may initial your name
- Always work with an up-to-date problem list at the front of the chart

SOAP notes

- Done for patients seen in an ambulatory or clinic setting.
- Not necessary to use complete sentences. Be clear and to the point.
- If dictating or writing, the structure is always the same.
  - Start with the date – indicate the major reason (or reasons) for the visit in a title
  - SUBJECTIVE – (average length 2-3 lines) this section contains information you have learned from the patient or from people caring for the patient. Deal with patients’ symptoms. Include a description of concerns or complaints. When appropriate, your note should refer to onset, duration, location, severity, relieving or aggravating factors, associated symptoms, pertinent negatives gathered in the history. As well, comments on patients’ feelings, fears, impact on functioning and patient expectations could be noted. Include pertinent information contributed by family members.
  - OBJECTIVE – deals with clinical findings and patients’ signs. These include things you, as an observer, can: see, hear, touch, feel, or smell. Your note should refer applicable: important vital signs, physical examination findings (key normal and abnormal findings), mental status, observations (such as gait), lab data, imaging results, and procedure results. Limit physical exam findings to appropriate organ system(s). For patients on multiple medications, periodically summarize the medications they are receiving or refer to an updated medication list. You may refer to pertinent past diagnosis, as well as target values for lab tests. You may consider commenting on how the patient has responded to past treatments.
o **ASSESSMENT** – Your diagnosis / diagnoses of the patient’s condition(s); include what you feel is the patient’s differential diagnosis and why. You may find it easier, when there is more than one issue. Comment on any health maintenance issues that were addressed.

o **PLAN** – base your plan on your assessment. How will you treat each problem? List changes in existing management strategies as well as new medications, lab tests ordered, procedures you want done, and patient referrals to be made. Be specific with medication including, at the minimum, name and dose. Use generic names of drugs. Comment on recommendations for patient follow-up.

o **A/P** – *(when multiple problems exist, consider combining assessment and plan)* - discuss each problem with its specific plan sequentially.

- In summary, a SOAP note should briefly express the following:
  o Date and purpose of the visit
  o The patient’s own observations and concerns
  o Your objective observations and relevant measurements / tests
  o Your assessment of the data and the plan for the patient based on the assessment.

**Complete History and Physical**

- Use the following format:
  o Identifying Data & Entrance Complaint
  o History of Present Illness
  o Past Medical History
  o Current Medications
  o Social Supports and Social History
  o Family History
  o Review of Systems
  o Physical Examination
  o Key Laboratory and Imaging findings
  o Assessment
  o Discharge Planning Issues

Ensure problem list is generated / updated.

**Progress Notes**

- Done for in-patients cared for on hospital wards – use a focused history gathering technique and focused clinical examination.
- Progress notes are to be written daily except for long stay patients.
- Different from the comprehensive admission note (which is often called the History and Physical)
- Sums up the progress from the last note.
- Always work from an up-to-date problem list at the front of the chart and structure your progress note to address the active problems:
  o Changes in pertinent signs or symptoms
  o Current physical examination findings and significant changes
  o New laboratory data, imaging study results or procedure findings
The plan for the patient
Patient disposition or discharge planning issues
• The length of the note will vary with the specialty you are working with.
• Start your note right after the last note in the chart so it will be chronological.
• Date and time your note – it is helpful to start with the number of days the patient has spent in hospital so far.
• Comment on each active problem
• Always sign your name and then print your name along with the proper credential i.e. John Smith - John Smith FMR1

APPENDIX B - FIELD NOTES

OVERVIEW:
- Guided Self Reflection exercise
- Resident must write one daily and review with a preceptor
DFM policy
- Opportunity for specific feedback time
Do not be defensive
- Opportunity to fine tune and expand your skills
Venture beyond clinical reasoning as a feedback topic
- Give to your Education Director weekly (yellow copy)
Keeping a list of what you have covered identifies learning holes

GETTING STARTED:
- Every resident receives a personal field note pad
- Resident chooses a case, daily
Preceptor may direct this choice
- Choose your lens to limit discussion breadth
Phase of the encounter
Skill Dimension
Lens come from the CCFP evaluation document
- Reflect upon your performance in the phase/skill dimension
- Identify what you will do differently the next time
- Rx: Repeat daily

REFLECTION CONTENT:
- Continue:
  What you would like to keep doing
  We do not want to lose what we do well
- Suggestions for improvement:
  Often how to improve what you do well
Revisit what did not go well
Consider other approaches
Follow up:
  Often reading opportunities
Try approaches with subsequent patients

ASSESSMENT & TRACKING:
- Resident’s Global Impression: RIME
- Reporter Interpreter Manager Educator
- Change to CanMedsFM Roles likely in next iteration
- Competency Stack
- File by 99 Topic
- Track Phase of Encounter and Skill Dimension
- Put a check beside each element as you tear out your yellow sheet
  Identifies holes in your learning

PRECEPTOR INPUT:
- Preceptor Comments
  After a short discussion, usual comment will be Agree
  Encouragement if resident too hard on themselves
  Limits placed if resident is over confident

FUTURE PLANS FOR FIELD NOTES: Computerization planned in VENTIS.

APPENDIX C – Clinical Audits

Clinical Audit

INTRODUCTION
A chart audit is a quality improvement process where clinical charts are reviewed retrospectively looking at specific predetermined criteria or standard of care. This exercise provides an opportunity to apply critical appraisal skills to a clinical practice problem.

OBJECTIVES

At the completion of the audit, residents will:

1. Demonstrate critical appraisal of the literature
2. Demonstrate the application of critical appraisal to clinical practice via a chart audit.
3. Evaluate current practice as compared to a standard based on evaluation of the literature.
4. Demonstrate their self-assessment skills; and
5. Demonstrate their ability to present findings through oral and written presentations, which will be evaluated.

Examples of previous chart audit topics chosen by residents include the indications for and use of throat swabs, and investigation and treatment of cystitis.

PROCESS
1. Identify an important clinical or practice question
2. Critically appraise the available evidence.
3. Develop a tool for chart audit based on your appraisal of the appropriate evidence.
4. Present the results of the audit to your colleagues in both oral and written presentations.
5. Provide a written copy of your audit and your presentation to the Program Assistant for your file.

PROGRAM OUTLINE

1. The audit shall be a second year activity, initiated and completed during family medicine block time.
2. Residents will work in teams with their colleagues who are rotating through family medicine together with them.
3. The group will meet with a faculty advisor initially who will assist them in choosing an appropriate topic and be available throughout the activity as a resource to the group of residents.
4. Charts for the audit will be chosen randomly.
5. Each resident will be expected to audit a minimum of 20 charts.
6. The audit exercise is a mandatory component of the residency program.

PRESENTATIONS

The following must be included:

- Audit question
- Criteria for the evaluation of evidence
- Search strategy
- Method of identifying charts
- Tool used
- Results – grouped and anonymous (ie no physicians to be identifiable)
- Recommendations for clinic for improvement of clinical care related to your audit
- Individual practice data will be presented to each preceptor in writing
- Suggested follow-up process to track progress (if appropriate).

The following references are attached for your information.


APPENDIX D – Presentation Guidelines

Academic Project Presentations Guidelines

AVOIDING COMMON ERRORS WHEN PRESENTING RESEARCH
- Avoid using long complicated words to impress people -- it doesn’t!
- Avoid spurious accuracy.
- Percentages: if there are less than 100 in the sample, don’t give decimal places: 7 out of 11 is 64%, not 63.64%!
- Statistical values should only be quoted to 2 places, eg. p<0.05; r=0.94
- Give subject ages as mean (to one decimal place) and range, not standard deviation, for example: mean 43.1 years, range 29-68 (easy to understand) mean 43.148 years, s.d. 7.415 (hard to understand)
- When drawing charts, don’t let a computer design crazy scales for you, eg. 2.19, 5.38, 7.57 ...
- Don’t assume that everyone reading or listening to your paper is an expert in the field - make it clear enough for students, and for people from other disciplines.
- Understand that there may still be a real difference between two groups, even if the statistical test fails to support it (eg. because the sample was too small).
- Also understand that a statistically significant result may have no practical significance in the real world.
- Whether it is a written paper, an oral presentation or a poster, have someone else review it before you go public!

ORAL PRESENTATIONS Planning and Preparation
- Don’t simply read a paper that would be suitable for publication - an oral presentation is a totally different medium which requires a totally different approach.
- One picture is worth a thousand words.
- Humour is useful within limits - it can make a talk more interesting, but must not distract the audience from what you are trying to say. Sometimes a relevant cartoon will help get a point across, but a long irrelevant joke will detract from the talk.
- Avoid irrelevant sides - nature scenes, glamour pictures, etc. They may wake the audience up, but they may also distract or offend.
- Use only images that are licensed!
- Unless you are very experienced, do a dry run for timing. It is better to make it too short than too long - leave them begging for more, not begging you to stop!
- Look through the slides after loading the magazine, to make sure none are backwards or upside down.

Speaking - General
- Make a point of studying the technique of other speakers when you go to meetings - learn from both their good and their bad points.
- Preferably, talk off the cuff, using the slides as notes. If you can’t do this, use notes on file cards. If you are too frightened and must use a script, write it as a speech, not as a written paper.
- If you are using notes or a script, make sure there is enough light to read. If not, try and get a reading light of some sort.
- Find out how to use the pointer and control the slides before you go up to give the talk.
- Look at each slide as it goes up on the screen – don’t just plough ahead, oblivious of projection problems.
- Talk to the audience, not to the screen or your notes.
- Make sure you can be heard - allow for the deaf person in the back row! If using a microphone, stay about 12 inches from it and talk normally – don’t either stray away from it, or talk too closely into it.
• Point to relevant items on the slides. This is difficult if you are reading from a script or heavily dependent on notes.
• What is on the screen must relate to what you are talking about - if you want to talk about something different, you need another slide.
• Conversely, don’t put things on the slide that you don’t intend to talk about - make a simpler slide. Busy slides are a disaster!
• Stick to the time limit. No matter how interesting it may be, you will lose your audience’s attention if you over-run significantly. Rule of thumb -- Average one slide per minute, so for a ten minute talk use ten slides (maybe eleven or twelve), but certainly not fifteen, twenty or more!
• Tell your audience clearly when you have finished. Don’t say “Well, that’s about it..” or “any questions?” Thank them for their attention and wait for the applause!

PROJECTION AND SLIDES
• Always look at the screen to make sure the image is satisfactory.
• Don’t block the projector beam.
• Don’t block the audience’s view.

APPENDIX E – Simulated Office Oral (SOO)

PGY1s - Scheduled for 5 to 6 mock exams
PGY2s - Scheduled for 2 to 3 mock exams

Pointers for SOOers

1. Two problems, usually one medical and one psychosocial, sometimes both medical.
   a. First problem usually flows out of the opening statement.
   b. Two prompts (at 10 minutes and 7 minutes left), 1st prompt usually refers to 2nd problem, and 2nd prompt redirects to first problem – no penalty for prompts. Okay to redirect the conversation if a cue is given to finish what you are asking as long as you validate what you’ve heard and get permission to go back to it.
   c. Use first 12 minutes for information gathering only.
   d. Avoid educating the patient or managing the problems until after the 12 minute mark.

2. Ask about FIFE (feelings, ideas, function, expectations) for the 2 problems separately.
   a. May come out in conversation naturally, otherwise, need to ask!
   b. Equal weighting is given in marking for the problem identification and FIFE.

3. To address context identification, ask about their Living Situation, and do a Family and Social Hx. Ask about Social Supports and the Quality of all their Relationships. Ask about their WORK situation and their FINANCES. DO NOT MAKE ASSUMPTIONS!

4. Context integration (summary) statement should be given at around the 12-minute mark.
   a. Pause and make a distinct statement...“So, let me summarize what I’ve heard...
   b. Need to link the problem and not just parrot back what they have heard.
   c. Do not include management/teaching in this statement.
5. At 3-minute mark, actors cannot volunteer any new information and can only answer direct questions.

6. Manage problems separately. SPELL OUT each problem for examiners.
   a. Get old records/ER reports, if applicable.
   b. Consider PHE, labs, referrals.
   c. Be specific with all aspects of management plans and when to follow-up.

7. Negotiate plans with patients in depth. 50% of marks from management plan come from negotiating plans.

8. Process what you are thinking out loud. Examiners cannot give points for what they don’t hear.

9. Avoid leading and double barrelled questions. Do not interrupt patients. Use techniques such as responding to feelings, validation and reflection when appropriate.

10. Keep note-taking to a minimum.
A Blueprint for the SOO Examination

- How can I help you?
  - Let patient talk uninterrupted
  - Clarify the history of presented problems
- How have these problems affected how you function?
- Has anyone else been worried about how you are?
- Do you have any ideas of what would be most helpful to do now?
  - It seems like it would be helpful if we....
  - I wonder if we could start with those things and then deal with the...
  - Is that OK with you?
- Do you have any other ways that you have not been feeling well?
- Who lives with you?
  - Do you work outside the home?
- How has your health been in the past?
- I can see why you are looking for some help.
  - Let me summarize what I’ve heard is going on....
  - Is there anything else I should know about?
- Optimal: Was there anything else?
  - I’ll take care of... and would it be OK if we got back together in....?
SOO Flow Sheet

IDENTIFICATION OF ISSUE #1
- Medical History and Assessment
- Identify Cause / Connection

IDENTIFICATION OF ISSUE #2
- Medical History and Assessment
- Identify Cause / Connection

CONSIDER
1. Feelings / Fears about issue
2. Their ideas about what is wrong
3. Impact of issue on functioning
4. The client’s expectations

EXPLORE PATIENT’S SOCIAL & SUPPORT NETWORK
i.e.: family, relationships, employment, finances, school, friends, hobbies, interests, future aspirations.

CONTEXT INTEGRATION
i.e.: pull the entire situation together in a summative statement about what makes this person who is or she is.

MANAGEMENT OF ISSUE #1
- Explain issue to client
- Provide therapeutic options
- Discuss future investigations necessary

MANAGEMENT OF ISSUE #2
- Explain issue to client
- Provide therapeutic options
- Discuss future investigations necessary

FIND COMMON GROUND
Encourage discussion, feedback, and opportunities to ask questions
SOO Format

1. There are usually two problems in every SOO.
2. The actor will always provide the following:
   a. An opening Statement
   b. 2 prompts to cue the applicant to the problems
      - The 1st prompt typically refers to the second problem.
      - The 2nd prompt typically brings the applicant back to the first problem.
      - The prompts are typically at 10 minutes remaining and 7 minutes remaining.
3. At the 3 minute mark, the actor will state you have 3 minutes left. At this point, actors are instructed not to volunteer any new information. Information will now only be given if directly asked by the applicant.
4. For marking purposes, if the markers don’t hear it, they will not mark it!!! (i.e.: if you think the person is going through a mid-life crisis, make sure you state it; thinking it or making assumptions that this is understood will not get you marks!)

Finding Common Ground

Principled Negotiation

1. Separate the people from the problem. It is better to see the problem as being “out there” and the participants as working together to attack the problem, not each other.
2. Focus on interests, not positions. People tend to stake out a position and defend it as if it were personal territory. Often the underlying interests are forgotten in the battle.
3. Generate a variety of possibilities before deciding what to do. Having too much emotional investment in one approach inhibits creativity.
4. Use objective criteria to judge the solution, rather than pit one personal opinion against another.

The Process of Finding Common Ground

There is a need for doctor and patient to have some agreement about the nature of what is wrong. Even if the doctor does not believe the patient’s explanation for the disease, the doctor’s explanation and treatment plan must at least be consistent with the patient’s point of view and make sense in the patient’s world.

Doctors should not ignore their patient’s expectations because in doing so they risk misunderstanding their patient. Patients may be unwilling to hear the doctor’s ideas if they feel they have not been heard first. Timing of inquiries about patient’s expectations is important; neither too early in the interview, nor near the end.

When there is profound disagreement about the nature of the problem or treatment, it may help to look at the relationship between the doctor and patient and their expectations of each other’s roles. Avoiding blaming of the patient or themselves is usually the most effective attitude.

Specifically:
The physician clearly describes his/her definition of the problem, management goals, and potential roles for care.

For each phase above: the patient is given the opportunity to ask questions and raise concerns or issues; these concerns are mutually discussed; there is an explicit expression by both patient and physician on their agreement with problem definition, management etc. If there is disagreement a flexible response of the physician would enhance the finding of common ground.
APPENDIX F – SAMP WRITING GUIDELINES

Short Answer Management Problems will form the basis for one of your examination days for your CCFP Certification Exam. They should form the core of your studies for your CCFP exam. You will have 6 hours to answer 45-50 SAMPs. For this reason, we have identified SAMP-writing as an important skill to develop during your residency.

SAMPs should be generated as part of your Academic Half Day participation as the presenting resident. They are also required to remediate AHD attendance, should it drop below 75%.

General Principles

1. Your SAMP should be based on patients you and your colleagues are likely to see.
2. Your SAMP should be grounded in the 99 Priority Topics and draw upon the Key Features identified by the CFPC in the document “Defining Competences for the Purpose of Certification by the College of Family Physicians of Canada: the evaluation objectives in Family Medicine”, available at: http://www.cfpc.ca/uploadedFiles/Education/Certification_in_Family_Medicine_Examination/Definition%20of%20Competence%20Complete%20Document%20with%20skills%20and%20phases.pdf
3. SAMP-writing is a scholarly activity and information you use should be drawn from current academic resources. Up-to-Date, Toronto Notes and Wikipedia are not appropriate resources.
4. All resources must be appropriately referenced. Please review the document on Academic Integrity, available at: http://umanitoba.ca/student/resource/student_advocacy/cheating_plagiarism_fraud.html. There are some interesting on-line tutorials at the U of M Virtual Commons which you might find helpful (Hint: check out the Academic Integrity tutorial at http://www.umanitoba.ca/virtuallearningcommons/index.php?action=page&headingId=104)

Step-by-step instructions

1. Select your topic
2. Locate the corresponding topic in the 99 Priority Topic list
3. Review the Key Features
4. Search the literature for Guidelines, Reviews, Systematic Reviews, Meta-analyses, Research articles; you need a minimum of three references
5. Appropriate journals would include: CFP, CMAJ, AFP, BMJ, JAMA, NEJM, primary care research journals...
6. Include references at end of SAMP
7. Read each article to identify the three or four key concepts of the article.
8. Generate a patient problem. This could be either a common presentation or an atypical presentation.
9. Develop two scenarios. This should ideally be an initial presentation with a follow-up visit set after a period of time. Alternatively, you could select the same problem with two separate patient scenarios, which expand upon some variability in management.
10. Each scenario requires three or four questions, which require evidence-based answers, demonstrate continuity of care and be related to the issues of the case and important concepts from the evidence.
11. Your questions should ask for several possible options as answers. Indicate how many answers you need for each questions. Yes/No options generally indicate weak questions.
12. Develop an answer guide for your questions. If you have asked for 3 answers, you should provide 5-6 acceptable answers. If you asked for 4 responses, you should provide 6-8 acceptable answers.
13. Please avoid “What am I thinking” questions.
14. Please avoid questions that can be answered by reading the scenario.
15. Consider including a few confounders in your scenarios, but not so many that it completely distracts your participants.