

FAMILY MEDICINE

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INTRODUCTION

Welcome to the undergraduate family medicine clerkship rotation - you are going to have an exciting and educational time. Family medicine will provide you with a broad range of medical experiences, incorporating urban, rural and northern medicine, emergency and internal medicine, obstetrics and gynecology, pediatrics, surgery, dermatology and psychiatry. You will also have experiences of other aspects of medical care, such as exposures to public health nurses, pharmacies, laboratory facilities and office management.

The Family Medicine/Community Medicine Clerkship is administered jointly by the Department of Family Medicine and the Department of Community Health Sciences.

THE FOUR PRINCIPLES OF FAMILY MEDICINE

While grounded in generalism, Family Medicine is now considered a specialty discipline with its own unique features and areas of expertise. Family physicians in Canada are guided by the following four principles, developed by the College of Family Physicians of Canada:

1. *The family physician is a skilled clinician.*

Family physicians demonstrate competence in the patient-centered 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 involving patients of all age groups. Their approach to health care is based on the best scientific evidence available.

2. *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-psychosocial 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.

3. 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 effective strategies for self-directed, lifelong learning.
- Family physicians have the responsibility to advocate public policy that promotes their patients' health.
- Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources.
- They consider the needs of both the individual and the community.

4. 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.

Quoted from the Postgraduate Family Medicine Curriculum: An Integrated Approach

http://www.cfpc.ca/vti_bin/shtml.dll/four.htm/map1

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Last modified: January 25, 2000

FAMILY MEDICINE CLERKSHIP PROGRAM OUTLINE

INTRODUCTION

The Departments of Family Medicine and Community Medicine have developed a curriculum that combines clinical family practice experiences with seminars and community medicine experiences in order to meet rotation's objectives (see below). The rotation is six weeks in total:

1. There are three days of seminars at the beginning and two days at the end of the rotation. These seminars provide a briefing and debriefing to the family medicine placement and introduce the core concepts of health care organization as applied in community medicine. In addition, concepts in quality improvement and evidence-based medicine shall be introduced both in seminars and with the student's presentation of a quality improvement project.
2. Five of these weeks (typically scheduled to begin on a Monday and end on a Friday) shall be spent in the rural family practice setting under the supervision of a family medicine preceptor. During this time it is expected that the student will be exposed to many aspects of clinical family practice. While in the community the student is expected to contact the regional medical officer of health and organize at least two days (and up to three days) of the public health component of this rural rotation.

GUIDE TO THE CLERKSHIP STUDENT PLACEMENTS

1. Fifteen weeks prior to the family medicine rotation the student will receive a letter from the department asking the student to submit any specific requests for the rotation. Attempts will be made to accommodate these requests, but no request is guaranteed. Students who must stay in or near Winnipeg may only do so under exceptional circumstances as determined by the Clerkship Director, Undergraduate Family Medicine.
2. The deadline for student requests is ten weeks prior to the beginning of the family medicine rotation. At this point the program assistant establishes educational contracts with specific family medicine preceptors/sites to receive students for the rotation.
3. Seven weeks prior to the rotation these contracts are confirmed, and students receive a list of the preceptors and sites available for the upcoming rotation. The students are expected to negotiate amongst themselves their individual placements. If the group cannot arrive at a consensus then the students must rank the sites in order of preference. This rank list is reviewed by the program assistant and the director. The students are placed in specific communities based on the requests submitted, as well as individual circumstances and needs.

PRECEPTOR/SITE SELECTION

Preceptors for the rotation must be family physicians and have a faculty appointment at the University of Manitoba. Communities and preceptors are chosen based on their ability to meet the objectives of the family medicine rotation (see below). Additionally, adequate accommodation must be available for the student. Student feedback regarding preceptors and rotation sites is solicited on an ongoing basis.

Students supervision models will vary from site to site. At sites designated as Family Medicine Enhanced Distributed Education Centers (FM EDECs), students will receive supervision and teaching by community preceptors and family medicine residents. At other sites, students will be supervised primarily by single community preceptor or a group of preceptors.

INITIAL STUDENT CONTACT

All students must write to their preceptors prior to the briefing meeting. The letter should include the following information:

1. Name of student
2. Address and phone number (home and present rotation) to facilitate contact.
3. Family commitments, health or social situations which may influence the student's participation in this rotation.
4. General background including family background, premedical undergraduate education, medical rotations completed to date, previous general experience, interests outside medicine.

5. Previous exposure to family practice
6. Expectations for this rotation.
7. Transportation arrangements while doing this rotation.

This letter will give the preceptor valuable information regarding the student and what his / her needs are during the rotation. Please provide a copy of the letter for the student file to the Clerkship Director. Your letter may be faxed from the undergraduate office.

THE STUDENT'S ROLE IN THE FAMILY PRACTICE

Students are expected to do many things that practicing family physicians do. These include interviewing and examining patients, charting, filling out various requisitions for investigations, writing orders and prescriptions, counseling patients and arranging follow up visits. The student will see patients in various settings such as the office, emergency department, personal care home, hospital and in the home. The student is expected to admit and follow patients in the hospital and personal care homes. The student is expected to observe and participate in surgical and obstetrical cases where applicable. Students are expected to participate in the "on call" schedule for the practice and emergency department.

Students should generally see the patient before the preceptor depending on the acuity of the medical problem. Students should review all patients seen with his/her preceptor at the time of the patient/student contact. Whether or not the preceptor then comes in to see the patient personally will depend on the problem itself and the confidence that the preceptor has in the student's clinical ability. Ultimately, the preceptor has responsibility for the patient and for all that the student does, regardless of whether he or she sees the patient. Students are generally allowed as much responsibility as they and their preceptor feel they are capable of handling. The degree of supervision required by students will depend upon the student's previous experience, competence, the structure of the practice and the needs perceived by both the preceptor and the student. The level of responsibility should increase as the rotation progresses.

Students are registered on the Education Register with the College of Physicians and Surgeons of Manitoba. The University has a liability insurance policy that covers the student while being taught and supervised.

STUDENT RESPONSIBILITIES

Professional responsibility includes the following behaviors and is expected at all times:

The student:

1. Is punctual and attends all clinics and rounds as required by the community preceptor.
2. Is expected to be on-call one night in four. Alternatively if the student is in an urban setting he/she must work six eight hour emergency shifts.
3. Completes assigned tasks and duties.
4. Shall inform patients or appropriate staff when tasks or duties cannot be performed or completed, and make alternate arrangements for their completion.
5. Shall work cooperatively with fellow students, staff and faculty.

The student must:

1. Write a letter to their preceptor prior to the family medicine rotation.
2. Attend all seminars and clinical sessions, briefing and debriefing sessions.
3. At the mid point of the rotation, complete a mid point rotation evaluation form (MITER) and review it with his/her preceptor, along with his/her Essential Clinical Presentation form
4. Fax a copy of the completed MITER to the program administrator.
5. Complete and submit a final evaluation of the student's experience at the debriefing sessions.
6. Review his/her completed final assessment (FITER) and Essential Clinical Presentation forms at the end of the rotation, and submit it at the debriefing session.

Periodically students may be required to miss time from their Family Medicine clerkship rotation due to illness or other exceptional circumstances. Under these circumstances, students are expected to adhere to faculty policies regarding leaves of absence (as described elsewhere in the course of study manual) under these circumstances.

If the student is absent from the family medicine rotation for more than two days the student is required to make up missed time as determined by the Director. If unable to make up this time the student may receive an incomplete evaluation at the discretion of the Director in consultation with the preceptor. Remediation could be required at a later date.

Students are referred to existing MMSA agreements for further information regarding acceptable post-home call responsibilities and expectations.

EVALUATION OF STUDENT

1. Assessment by the Preceptor

Students are provided with rotation objectives and an Essential Clinical Presentations booklet for use throughout the rotation as a guide and self-evaluation tool. The preceptor and the student should review the booklet at the start of and at the mid point of the rotation, and midpoint evaluation forms (MITER) must be completed and faxed by the student to the Family Medicine Undergraduate office.

Where appropriate, the evaluation should be undertaken in consultation with other preceptors and residents who have supervised the student during the rotation.

If, at the mid point of the rotation the preceptor feels that the student is not progressing satisfactorily (particularly if the preceptor anticipates the student might fail the rotation) the student must be informed and the deficiencies identified in narrative form. The preceptor and the student must contact the Clerkship Director at this point.

A final evaluation form (FITER) must be completed at the end of the rotation by the preceptor and reviewed with the student. The student is responsible for returning it to the Director at the debriefing session at the end of the rotation. As of September 2010, all MITERs and FITERs will be completed and submitted using the OPAL Curriculum Management System (instructions to follow).

2. Assessment by the Clerkship Director

All evaluation forms are reviewed by the Clerkship Director. Any concerns or recommendations will be addressed promptly by the Director with the student and preceptor.

3. National Board of Medical Examiners Exam

The student is required to sit the Family Medicine NBME exam at the end of the rotation. The results of this exam are for formative purposes only for the student and will not be used to determine passage or failure for the rotation. Interested students will be given the option of rewriting this exam at the end of the core clerkship year.

4. Criteria and Method of Assessment

In order to fulfill the requirements of this clerkship rotation the student must achieve a pass in each category:

- a. In training evaluation. The students must receive a pass in the clinical medicine component of the rotation as appraised by the preceptor.
- b. Essential Clinical Presentations. The student must have been exposed to all conditions documented on the Essential Clinical Presentations form for Family Medicine. If, at the midpoint of the rotation, this appears unlikely to occur by the end of the rotation, the student is expected to review the supplemental reading materials for this clinical presentation (See Appendix B). The ECP form must be reviewed and signed off by the end of the rotation.
- c. Professionalism. The student is expected to adhere to professional conduct and fulfill all his/her professional responsibilities, as defined in the previous section.

Should a student fail one of the components outlined the student shall fail the rotation. The Director will discuss the fail with the preceptor and student. The evaluation is forwarded to the Associate Dean for Undergraduate Medical Education and the Committee of Evaluators. Should the fail be upheld by the Associate Dean and the Committee of Evaluators then the student shall proceed to do appropriate remedial work. The student has the option to appeal the evaluation.

As the Family Medicine NBME examination is a course requirement, student failing to sit the exam will be marked as "incomplete" for the rotation.

Student Travel

Students at rural sites will receive remuneration for one trip to and from their site. In the event of inclement weather or poor road conditions, students are advised to defer travel until conditions improve.

Learning Objectives – Family Medicine Clinical Clerkship Rotation

A) Principles of Family Medicine

At the end of the rotation, the student will be able to:

1. Describe and explain the Four Principles of Family Medicine
2. Discuss the features unique to the specialty of family medicine
3. Describe the competencies and attributes specific to family physicians

B) Clinical Skills

At the end of the rotation, the student will be able to:

1. Demonstrate knowledge of clinical problems commonly seen in family medicine and their management (see Appendix A)
2. Demonstrate an ability to assess and manage patients seen within the family medicine setting, including:
 - a. Take an accurate and appropriate history
 - b. Perform a focused and accurate physical exam
 - c. Develop an appropriate differential diagnosis
 - d. Order investigations in a focused and appropriate manner
 - e. Develop and implement an appropriate management plan
3. Recognize "red flags" which might indicate an acutely ill patient or serious medical condition
4. Demonstrate and apply knowledge of the periodic health review
5. Demonstrate an approach to the assessment and management of patients with multiple medical problems
6. Apply the patient centered approach to patient encounters including:
 - a. Identifying the patient's ideas and feelings regarding his/her illness, the impact of the disease on his/her functioning and his/her expectations regarding treatment
 - b. Determining the psychosocial context of the patient's disease
 - c. Finding common ground with the patient in the development of a treatment plan
7. Demonstrate an understanding of the patient's life cycle in the context of their illness
8. Demonstrate skill in the assessment and management of patients with undifferentiated conditions and ambiguous presentations
9. Appreciate the value of continuity of care
10. Know the appropriate indications for referral to consultants and allied health professionals

C) Communication Skills

At the end of the rotation, the student will be able to:

1. Share information with patients, families and coworkers in a clear, coherent, respectful manner
2. Demonstrate an ability to adapt his/her communication techniques based on a patient's/family's age, cultural background and level of education
3. Write chart notes in a clear, thorough and efficient manner, using the SOAP format
4. Write clear and accurate orders for investigations and medications
5. Write clear and accurate prescriptions
6. Write a clear and effective consultation letter

D) Community Resource

At the end of the rotation, the student will be able to:

1. Recognize and discuss the role the family physician plays in his/her community
2. Demonstrate a basic knowledge of relevant social issues which may impact on a patient's health in his/her community
3. Understand the advocacy role family physicians play, where appropriate, on behalf of patients and families
4. Demonstrate a basic knowledge of health care resources in the community
5. Work collaboratively as part of the health care team
6. Understand and address limitations of health care resources available to the community

E) Professionalism

At the end of the rotation, the student will be able to:

1. Demonstrate professional and ethical behavior at all times
2. Respond to feedback in a constructive and professional manner
3. Demonstrate respect for the confidentiality of patients and their families
4. Recognize his/her limitations and ask for assistance when appropriate
5. Demonstrate integrity, honesty and respect for patients, their families and members of the health care team
6. Demonstrate an understanding of basic ethical and legal concepts as they apply to family medicine

F) Scholarly Activity

At the end of the rotation, the student will be able to:

1. Engage in self-directed learning
2. Demonstrate an understanding of evidence based medicine concepts, including:
 - a. Formulating an accurate and useful clinical question
 - b. Utilizing available resources to obtain reliable and accurate answers to clinical questions
 - c. Appraising information from the medical literature applying basic critical appraisal tools

RESOURCES

Evidence based guidelines are available to assist you in your professional career. These professional guidelines are designed to assist you in your medical profession. Continuing medical education is critical in order to maintain high standards of patient care using an evidence based approach and to facilitate efficient use of your time. In the following section you will find some Web sites relating to guidelines and evidence based medicine.

Web Sites

American Academy of Family Physicians <http://www.aafp.org>

While not always consistent with Canadian guidelines, this site provides a number of recommendations and guidelines on the periodic health review and common medical conditions.

Canadian Task Force on Preventive Health Care (CTFPHC) <http://www.ctfphc.org>

As described in the previous section, this website is designed to serve as a practical guide to health care providers, planners and consumers for determining the inclusion or exclusion, content and frequency of a wide variety of preventive health interventions, using the evidence-based recommendations of the Canadian Task Force on Preventive Health Care. The website also offers systematic reviews and a summary table of recommendations. As the CTFPHC has been temporarily disbanded (reconvening in April 2010), it has no new recommendations since 2005. However, it is still useful and relevant.

College of Family Physicians of Canada <http://www.cfpc.ca>

The Family Medicine Resources section has excellent memory aids and forms to provide evidence based guidance on the periodic health review.

Canadian Medical Association Infobase <http://www.cma.ca>

Using an excellent search interface, links to full text of hundreds of clinical practice guidelines produced or endorsed in Canada by a national, provincial or territorial medical or health organization, professional society, government agency or expert panel. Also provides access to Infopoems, a point of care database providing summaries and critiques of hundreds of recent research articles. Free registration required to access site.

Guidelines Advisory Committee <http://www.gacguidelines.ca/>

Produced by the Ontario Medical Association and the Ontario Ministry of Health. Another site with access to multiple guidelines, with ratings for each.

Procedures Consult

<http://app.proceduresconsult.com.proxy1.lib.umanitoba.ca/Learner/Default.aspx>

An excellent collection of video tutorials of common medical procedures. Available free to students and faculty through the NJM Library site.

Trip Database <http://www.tripdatabase.com>

Developed in the UK, a searchable database that provides quick, evidence based answers to clinical questions.

Therapeutics Initiative University of British Columbia <http://www.ti.ubc.ca/>

From the Department of Pharmacology and Therapeutics in cooperation with the Department of Family Practice at the University of British Columbia. Provides physicians and pharmacists with up to date, evidence based practical information on rational drug therapy. Full text of the Therapeutics Letter back to 1994.

Toward Optimized Practice <http://www.topalbertadoctors.org/TOP/CPG/>

Developed by the Alberta Medical Association. Links to full text of approximately 50 guidelines in 9 categories.

University of Western Ontario Undergraduate Family Medicine

<http://www.familymedicineuwo.ca/undergraduate/index.htm>

UWO has developed an excellent series of interactive multimedia family medicine cases which they have made available online. Free registration required.

Family Medicine Texts

- 1) Ferri: Ferri's Clinical Advisor 2011; Copyright 2011 Mosby, Inc.
- 2) Pfenninger: Procedures for Primary Care Physicians, Second Edition; Copyright 2003 Mosby
- 3) Sackett, David: Evidence Based Medicine; Copyright 2000 Churchill Livingstone
- 4) McWhinney, Ian: A Textbook of Family Medicine (1989 available at John MacLean Library; 1997 available at Seven Oaks Hospital Library) New York Oxford University Press
- 5) Taylor: Family Medicine, Principles and Practice, Sixth Edition; Copyright Springer 2002.
- 6) Tintanelli: Emergency Medicine: A Comprehensive Study Guide 6th edition; Copyright McGraw Hill 2003

Appendix A **Essential Clinical Presentations in Family Medicine**

Note: Due to its broad scope, it is impractical to include all relevant clinical problems and presentations seen in family medicine. This list documents those presentations, psychosocial contexts and skills which are considered mandatory for the student to see as part of his/her family medicine clerkship rotation.

Clinical scenarios:

- Abdominal Pain
- Anxiety
- Asthma
- Chest Pain
- Contraception
- Cough & Dyspnea
- Depression
- Dizziness
- Fatigue
- Fever
- Headache
- Hypertension
- Ischaemic Heart Disease
- Low Back Pain
- Palliative Care
- Prenatal Care
- Type 2 Diabetes Mellitus
- Well baby Care

Psychosocial contexts:

- Aboriginal
- Family/relationship stressors
- Polypharmacy
- Poverty
- Recent immigrant
- Same sex relationship
- Work status

Essential Clinical Presentations Resource List (Appendix B)

Clinical Scenarios

Abdominal pain:

Evaluation of Acute Abdominal Pain in Adults. www.aafp.org/afp/2008/0401/p971.html

Diagnosis of Acute Abdominal Pain in Older Patients. www.aafp.org/afp/20061101/1537.html

Anxiety:

Canadian Psychiatric Association. (2006, July). Clinical practice guidelines: Management of anxiety disorders. The Canadian Journal of Psychiatry, 51(Suppl 2). Retrieved October 11, 2007 from: http://www1.cpa-apc.org:8080/Publications/CJP/supplements/july2006/anxiety_guidelines_2006.pdf

AAFP article from May 2009 when available

Asthma:

Lemiere, C., Bai, T., Balter, M., Bayliff, C., Becker, A., Boulet, L.P. et al. (2004, May/June). Adult asthma consensus guidelines update 2003. Canadian Respiratory Journal, 11(Suppl A), 9A-33A. Retrieved January 24, 2007 from: http://www.asthme-quebec.ca/pdf/Consensus_asthme_2004_fr_eng.pdf

Chest pain:

Diagnosing the Cause of Chest Pain. www.aafp.org/afp/2005/1115/p2012.html

Top 10 differential diagnoses in family medicine: Chest pain
Can Fam Physician, December 2007; 53: 2146

Contraception:

Contraception in Canada: a review of method choices, characteristics, adherence and approaches to counseling. CMAJ, March 27, 2007, 176(7): 954

Cough/Dyspnea:

Evaluation of the Patient with Chronic Cough. www.aafp.org/afp/20040501/2159.html

Guidelines for Treating Adults with Acute Cough. www.aafp.org/afp/2007/0215/p476.html

[Tops Guidelines: Can Respir J V:15 Suppl A 2008](#)

Depression:

Diagnosis and Management of Major Depressive Disorder. BC Guidelines and Protocols Advisory Committee. http://www.bcguidelines.ca/gpac/guideline_mdd.html

Diabetes Type 2:

Canadian Diabetes Association 2008 Clinical Practice Guidelines. <http://www.diabetes.ca/for-professionals/resources/2008-cpg/>

Dizziness:

Initial Evaluation of Vertigo. Am Fam Physician 2006; 73:244–51, 254.
<http://www.aafp.org/afp/2006/0115/p244.html>

Fatigue:

Fatigue: a practical approach to diagnosis in primary care. CMAJ 2006; 174 (6):765-67.
<http://www.cmaj.ca/cgi/content/full/174/6/765>

Fever:

Top Alberta Guidelines for:

Acute Otitis Media

Acute Pharyngitis

Acute Sinusitis

Bronchitis

Pneumonia: Community Acquired-Adults

Pneumonia: Community Acquired-Pediatrics

http://www.topalbertadoctors.org/informed_practice/clinical_practice_guidelines.html

Headache:

Institute for Clinical Systems Improvement Care Guideline: Diagnosis and Treatment of Headache. March 2009.

http://www.icsi.org/headache/headache_diagnosis_and_treatment_of_2609.html

Hypertension:

2009 CHEP Recommendations for the Management of Hypertension.

<http://hypertension.ca/chep/recommendations-2009/>

Ischemic Heart Disease:

Towards Optimized Practice: Guideline for Management of Modifiable Risk Factors in Adults at High Risk for Cardiovascular Events. 2009.

http://www.topalbertadoctors.org/informed_practice/cpgs/cardiovascular_events.html

Low Back Pain:

Evaluation and Treatment of Acute Low Back Pain. Am Fam Physician 2007;75:1181–8, 1190–2.

<http://www.aafp.org/afp/2007/0415/p1181.html>

Top Alberta Doctors Guideline: Management of Low Back Pain. 2009.

http://www.topalbertadoctors.org/informed_practice/cpgs/low_back_pain.html

Palliative Care:

Palliative Care for the Cancer Patient. Prim Care December, 2009; 36(4); 781-810.

<http://www.mdconsult.com.proxy2.lib.umanitoba.ca/das/article/body/180686854-7/jorg=clinics&source=&sp=22686316&sid=0/N/723962/1.html?issn=0095-4543>

Prenatal Care:

Evidence-Based Prenatal Care: Part I. General Prenatal Care and Counseling Issues. Am Fam Physician 2005; 71:1307–16, 1321–2. <http://www.aafp.org/afp/2005/0401/p1307.html>

Evidence-Based Prenatal Care: Part II. Third-Trimester Care and Prevention of Infectious Diseases. Am Fam Physician 2005; 71:1555–60,1561–2. <http://www.aafp.org/afp/2005/0415/p1555.html>

Well Baby Care:

Rourke Baby Record. http://www.rourkebabyrecord.ca/rbr_national.html

Well Female Care:

Female Preventative Care Checklist Form.

<http://www.cfpc.ca/English/cfpc/communications/health%20policy/Preventive%20Care%20Checklist%20Forms/Intro/default.asp?s=1>

Well Male Care:

Male Preventative Care Checklist Form.

<http://www.cfpc.ca/English/cfpc/communications/health%20policy/Preventive%20Care%20Checklist%20Forms/Intro/default.asp?s=1>

Psychosocial Contexts:

Aboriginal Health:

A Guide for Health Professionals Working with Aboriginal Peoples (Part 2 Sociocultural Context). SOGC Guideline 2000. <http://www.sogc.org/guidelines/#aboriginal>

A Guide for Health Professionals Working with Aboriginal Peoples (Part 3 Health Issues). SOGC Guideline 2000. <http://www.sogc.org/guidelines/#aboriginal>

Family/Relationship Stressors:

Managing Family Dynamics. Fam Pract Manag. 2004 Jul-Aug;11(7):70. <http://www.aafp.org/fpm/2004/0700/p70.html>

Polypharmacy:

Minimizing Adverse Drug Events in Older Patients. Am Fam Physician 2007; 76:1837–44. <http://www.aafp.org/afp/2007/1215/p1837.html>

Poverty:

Peering down the vortex: Poverty and human health. Can Fam Physician, 2004 Jul; 50: 963 - 965. <http://www.cfp.ca>

Recent Immigrants:

An Approach to the Primary Care for Immigrants and Refugees: a primer for medical students, residents and nurse practitioner students. Dr. Kevin Pottie, University of Ottawa. (Search on Google Docs)

Canadian Clinical Preventive Guidelines for Primary Health Care of Immigrants and Refugees (Drafts). http://www.ccirh.uottawa.ca/eng/guideline_drafts.html

Same Sex Relationship:

Health Care Screening for Men Who Have Sex with Men. Am Fam Physician 2004; 69:2149–56. <http://www.aafp.org/afp/2004/0501/p2149.html>

Primary Care for Lesbians and Bisexual Women. Am Fam Physician 2006; 74:279–86, 287–8. <http://www.aafp.org/afp/2006/0715/p279.html>

Work Status:

Injury/Illness and Return to Work/Function: A Practical Guide for Physicians. WSIB Ontario Website. <http://www.wsib.on.ca/wsib/wsibsite.nsf/Public/HealthPhysiciansGuideRTW>

Return to work after occupational injury: Family physicians' perspectives on soft-tissue injuries. Can Fam Physician Guzman et al. 48 (12): 1912. <http://www.cfp.ca/>