UNIVERSITY OF MANITOBA DEPARTMENT of FAMILY MEDICINE

Preceptor Handbook

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Undergrad Clerkship Program

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PRECEPTOR MANUAL – FAMILY MEDICINE

Introduction

The Department of Family Medicine at the University of Manitoba would like to welcome you as faculty to the Family Medicine & Community Medicine Clerkship Rotation. This is a unique experience for third and fourth year medical students as it is not only the only core rotation that they are under the supervision of family physicians but also the only outside core rotation outside of the tertiary care hospital center. The purpose of this manual is provide you with an overview of the rotation and offer some resources to refer to when teaching and evaluating your students.

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For the Busy Preceptor – Frequently Asked Questions

A student has contacted me and has asked if he could have his rotation at my site. What should I do?
Students are advised to approach our undergraduate office directly if they have a specific request for a site. Please ask the student to contact our office, and we will try to accommodate his request if you are in agreement. However, please don't tell the student his selection is guaranteed, as there may be other students who have requested your site without your knowledge.

My student has to return to Winnipeg for the day for a meeting. Is this okay?
As long as you are in agreement, and the student makes up the lost time in the evening or on weekend. For longer absences, please refer to the guidelines and policies on pages 8 and 27.

I have concerns that my student isn't performing up to par and might fail the rotation. What is the process I need to take?
Fortunately, this scenario doesn't occur very frequently, but when it does, can be stressful for all parties involved. Make sure the student is aware of your concerns as soon as they arise, give them specific objectives for improvement and a time frame for doing so. Most importantly – document, document, document. Please ensure that your evaluations are completed thoroughly and accurately, with examples if possible. If you are concerned that a student might fail the rotation, you must inform the student of this and indicate this in writing (with a copy to the undergrad office) prior to the midpoint of the rotation. Refer to page 7 for more information, and feel free to contact us if you've any questions.

I have a great student! How can I make sure she gets some acknowledgement?
If you haven't already done so, take her out for lunch! Beyond this, there are several awards given each year for students who demonstrate excellence in family medicine. In particular, the Paul Nehra award is given to the highest performing student in the family medicine rotation. If you think your "high performance" student might qualify for this award, please indicate this on your FITER form, with your reasons why.

I will be at a meeting for two days. Can I ask the student to spend his time with the public health office on those days?
Possibly, if everyone agrees, but not necessarily. The student is allowed to "book off" his or her community medicine exposure at any time during the rotation. This is dependant on the availability of the public health office, and their schedule may not always coincide with yours.

What are some "quick read" resources on teaching that I can use?
As a start, go to http://www.practicalprof.ab.ca/, which has a great selection of "on the fly" teaching materials to view and download.

How do I get paid?
Fill out an invoice (see page 23) and send it to our office. Any questions, give us a call!

Family Medicine Clerkship Program Outline

Introduction

The Family Medicine/Community Medicine Clerkship is administered jointly by the Department of Family Medicine and the Department of Community Health Sciences. We have developed a curriculum that combines seminars and community medicine experiences with clinical family practice 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 liability insurance policy that covers the student while being taught and supervised.

Student evaluation

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 of 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 Responsibilities

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

The student:

1. Is punctual and attends when expected.
2. Completes assigned tasks and duties.
3. Shall inform patients or appropriate staff when tasks or duties cannot be performed or completed. The student shall make alternate arrangements.
4. 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.

Absences/Post Call

Periodically students may be required to miss some time from their Family Medicine clerkship rotation due to illness or other exceptional circumstances. In the event of a student absence, please refer to Appendix F for the Faculty of Medicine's guidelines and procedures.

During the family medicine rotation:

- Students who are absent for two days or less are requested to make up the time missed on weekends or evenings.
- if a student is absent due to illness for more than two days then a medical certificate must be provided.
- In the case of absence greater than two days for any reason, the student is required to make up missed time as determined by the Director. If he or she is 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.

According to the MMSA agreement, if a student is taking call from home and is called back to hospital for four consecutive hours of active patient care, one hour of which is after midnight or before 7 am, the student has the option of relieving himself/herself from his/her clinical duties the next day.

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.

University Responsibilities

To the student:

1. The student will be provided with an experience which is consistent with the mission statements of the Department of Family Medicine, the Undergraduate Program and the objectives of the clerkship.
2. The Undergraduate Family Medicine Program will pay for the student's accommodations. However, the community is responsible for finding the accommodation site. The stipend is $500 per student per rotation.

To the preceptor:

The preceptor will be provided with:

1. Orientation materials and learning objectives for the learning experience
2. An appointment to the Department of Family Medicine, University of Manitoba
3. Access to the University of Manitoba Library Services including internet access
4. Ongoing feedback from the students and the Director
5. Opportunities for faculty development
6. An honorarium per student per clerkship rotation -$1250 per rotation as of 2010 (see appendix C)

Awards

Each year the Paul Nehra Prize in Family Medicine is awarded to the graduating student with the best evaluation during their family medicine rotation. The prize is a gift certificate for the University Book Store in the amount of approximately $500.00. Candidates must be nominated by their rotation preceptor, and as such all preceptors are encouraged to nominate deserving students for this award. Once all the nominations are received a committee is established in February of each year to select the successful candidate.

The College of Family Physicians of Canada also provides awards for students who demonstrate commitment and leadership in the discipline of family medicine during the clerkship. Students are asked to apply to the Office of Undergraduate Education, and a nomination is determined by committee based on the application documents (which frequently include preceptor reference letters).

Learning Objectives – Family Medicine Clinical Clerkship Rotation

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 centred 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 patients 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

Teaching Tips

Adapted from Dr. Risa Bordman and Douglas Scott 2002 Presentation, Montreal, Annual Meeting College of Physicians of Canada

Background

Why Teach?

Community based preceptors teach because of enjoyment of teaching and the opportunity to stay current.
Students rate community preceptors higher than in hospital attending or resident teachers.

Attributes of a Good Teacher

Enthusiasm: dynamic, energetic, enjoys teaching, interesting style, stimulates interest.
Clarity and Organization: clear explanations, summarizes, emphasizes important issues, and communicates learning objectives.
Clinical Competence: objectively defines patient problems, shows skill at data collection, uses consultants, interprets lab data, manages clinical emergencies, works effectively with others, maintains rapport with patients.
Modeling Professional Characteristics: self critical, self-confidant, responsible, recognizes own limitations, not arrogant, respectful of doctor-patient relationship, sensitive to others.
Group Instructional Skill: Encourages active participation, establishes rapport, respects students and shows personal interest, accessible, demonstrates problem solving skills, attentive listener, questions carefully, places non-threatening questions to students.
Clinical Supervision: Demonstrates clinical procedures, provides practice opportunities, offers professional support, observes student performance frequently, identifies strengths and limitations objectively, provides feedback and positive reinforcement, corrects student without belittling them.
Breadth of Medical Knowledge: Discusses current developments, reveals broad reading, discusses divergent points of view, relates to other disciplines, directs students to useful literature.

Characteristics of Today's Medical Student

1. Older student (average entry 24 years)
2. More educated (only 7% do not complete a bachelor's degree)
3. More visible minorities than Canadian population
4. Higher socioeconomic status families
5. Financial worries (85% report they will graduate with debt)
6. Computer literate
7. Comfortable with small group learning
8. Exposed to adult models of learning

Learning Styles

Understanding a student's learning styles will facilitate a positive learning experience. Observing a student's learning style and discussing it with them helps to facilitate learning more efficiently and effectively. One of the more common classifications in medical students learning styles is between a pedagogy and

andragogy. Many students are gradually making the transition to the latter style as they become adult learners.

Pedagogy	**Andragogy**
Dependant	Self-Directed
Non-experiential	Experiential
Learns when teacher says	Learns when needs to learn
Learn now, use later	Instant application
Motivated by grades	Motivated by self esteem, self confidence

Preparing for the Student

Before the Student Arrives

1. You should have received a letter from your prospective student.
2. Notify your clinic and hospital staff of the student's arrival.
3. Schedule time for student orientation
4. Possibly modify patient bookings to accommodate the student and plan for down time. For example: Wave Scheduling might include Phase 1: the preceptor sees patient 1 and the student sees patient 2 in the first time slot. Phase 2: the preceptor and the student see patient 2 together in the second time slot. Phase 3:the student charts on patient 2 and the preceptor sees patient 3 in the third time slot.
5. Organize room space for the student.

When the Student Arrives

Introduce your student to your clinic and hospital staff.
When the student arrives review your student's expectations, prior experiences, daily schedule, office organization, chart organization. Post the notice in the waiting room indicating that students will be participating in the care of your patients.

When the Patient Arrives

Review the chart with the student. Decide if you will see the patient together or if the student will see the patient first independently. Notify the patient of the student. The receptionist or nurse can do this. The student should introduce himself or herself as a medical student. Set appropriate time limits for the student's interview and examination.

Student-Patient Encounter

In general the student's autonomy will gradually increase. You may see the first few patients together with the student. Over time the student will become more independent and may eventually see the patient independently for both the history and physical examination depending on your confidence with the student.

The students use the SOAP format. The student is expected to have prepared an assessment and plan and discuss this with you. The students have been advised to record their assessment and plan in the chart in order to develop confidence in recording their thought processes. The students are aware that you may need to stroke out their assessment and plan if it is deemed incorrect. Have the student

observe special counseling sessions such as smoking cessation, nutritional, obesity, diabetes education counseling sessions.

Case Discussion

Many teaching opportunities involve the student conducting and interview and/or examination of the patient, followed by review of the case with the preceptor. In general, the following format is used:

1. Opening: Student presents the case
2. Patient Encounter: Triad with Patient-Learner-Teacher
3. Closing: Summary (case, plans), teaching points, reflection

Opening:

1. Create a learning climate.
2. Establish mutual goals & objectives.
3. Make a list of questions.
4. Master the case and supervise the quality of care.
5. Assess the learner's level of knowledge.
6. Active listening by thinking out loud. For example 'I was wondering if something else might be causing his symptoms…'
    a. Clarifying questions with an open-ended question. For example, "Explore the differential diagnosis for me." Avoid putting the student on the spot by having them guess what you are thinking. For example "What are the three possible diagnosis in his case."

Patient Encounter:

1. Role Model: Student observes teacher. You may ask the student "Would you like to see how I …" or Recognize the student by saying to the patient "I learned from Steven here that you … "
2. Coach: Preceptor observes the student. Set up learning agenda. You may ask the student to explore part of the history further.
3. Combination of role model and coach
4. Analysis/Management. Use probing questions, explanations, involve the marginalized players (student or patient), expand the case (What if…).

Closing:

Usually highlight one teaching point. You can have the student read up on the topic later. Review topics based on case experience, literature review etc…
Higher-level topics include doctor-patient communication skills, ethics, professionalism, and learner's experience in the office that day.

Additional questions:

Some examples of "One-Minute Preceptor" questions:

1. What do you think is going on with this patient?
2. What led you to that conclusion?

Other helpful questions might include:

1. Can you tell me why you made that recommendation/ diagnosis/ choice/ conclusion?
2. Was there something else that kept / led you to that choice?

3. Tell me more about your thinking concerning this patient.
4. What else do need to find out?
5. How could we obtain that information?
6. How do think that went?
7. Here's what I saw. What did you see?
8. What are you learning from working with these patients?
9. Can you tell me what you learnt today in the office?
10. What of the experience today is most helpful for your learning?

Giving Feedback

Adapted from the Faculty Development Workshop by Dr. Frank Martin

Feedback is the provision of information by the observer (preceptor) to performer (student) about the performance, without judgment about quality.

Feedback can also be defined as:

1. Information that let's people know where they are in relation to the goals toward which they are aiming.
2. Information that assists people in correcting their course.
3. Information about what the learner did that is shared with the learner.
4. A way of helping people learn how closely their behavior matches their intentions.

Levels of Feedback:

Level 1: What you saw the student do (acting as a human videotape recorder with no interpretation or judgment) For example "I noticed you examined the fundi", "I noticed that you checked for a hernia".

Level 2: Your personal reaction (not judgmental). For example: "I was not comfortable when you did not listen to the four areas for heart sounds", "I was worried that…", "I felt good when you assessed…".

Level 3: Your prediction of the likely outcome of the observed behavior. Judgment based on your experience about the appropriateness, correctness, or helpfulness of the observed behavior. For example: "When you do not listen to the four areas of the precordium for heart sounds you may not hear a heart murmur that may be present", "If you do not study this topic you may fail the exam".

Resources

Teaching Resources

The following teaching resources may provide suggestions and insights to help you in your teaching:

Neal John McClean Health Sciences Library
http://www.umanitoba.ca/libraries/health/
The entrance site for the Faculty of Medicine library. With your library card, you are able to access numerous databases, conduct PubMed searches, and access hundreds of online journals.

Mountain Area Education Center
http://www.mahec.net/pdp/busy_teaching_strategies.aspx
A pragmatic series of tips for busy preceptors from a medical education program based in North Carolina. Also, link to their resources page for more excellent teaching resources.

Practical Prof
http://www.practicalprof.ab.ca/
An excellent site from the Alberta Rural Physician Action Plan, with a number of useful teaching tools and instructional videos for busy community preceptors. Highly recommended!

Section of Teachers of Family Medicine
http://www.cfpc.ca/English/cfpc/education/section%20of%20teachers/general%20information/default.asp?s=1
An section of the College of Family Physicians of Canada, this site has a number of articles and links for new and experienced teachers. Also home to the Section of Teachers newsletter.

Society of Teachers of Family Medicine http://www.stfm.org/fmhub/fmhub.html
An American site, home of the free *Family Medicine* journal with some excellent full teach articles on teaching.

Clinical Resources

The following clinical resources are listed for students' reference in both the Family Medicine Student Handbook and the Undergraduate Clerkship Manual:

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 had 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 Livingston
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:
Preceptor Profile
Information Sheet

PRECEPTOR PROFILE INFO SHEET

Preceptor(s):

____
NAME DEGREE INSTITUTION DATE

____
NAME DEGREE INSTITUTION DATE

Work Address: ____
CLINIC STREET

____
CITY PROV POSTAL CODE

Phone: (____)_________________________________ Fax: (____)__________________________________

Office Practice

Number of physicians in clinic: _________

Names of Colleagues (not listed above): ____

____

Clinic Facilities: ____

____

No. of patients per day: _____

Patient Age Breakdown

Children _____% Middle Age _____%

Adolescent _____% Elderly _____%

Young Adult _ ____% No. of patients/day: _____

Types of procedures done in office: ____

____

Home Visits Done: (Yes (No How Often: ____

Hospital

Name: ____ No. of beds: ______________

Personal Care Home

Name: ____ No. of patients: ____________

How often visits made: ________________________

Obstetrics

Number of deliveries per year done by preceptor: ____

Surgery

When performed: ____

Types performed: ____

Student's role: ____

Allied Health Professionals Involved in Teaching:

(Pharmacist	(Optometrist	(Dentist
(Chiropractor	(Home Care Worker	(Social Worker
(Mental Health Worker	(Physiotherapist	(Public Health Nurse

(Other: (list)____

Visits made to:

First Nations Communities: ____
NAME HOW OFTEN

Hutterite colonies: ____
NAME HOW OFTEN

Other communities: ____
NAME HOW OFTEN

Accommodation arrangements:

____

____

Special Interests of Preceptor:

____

Additional Information of Interest to Students

____

____

Dr. _________________________ has been involved in the Family Medicine clerkship since ______._________

Please return form to Cathy Higham at T158 770 Bannatyne Avenue, Winnipeg, MB, R3E OW3 or fax to (204) 789-3917.

Appendix B:

Sample Evaluation Forms

The University of Manitoba has researched, revised as well as standardized the evaluation forms for the clerkship rotations. Please review and familiarize yourself with these forms, which should be included in the OPAL Curriculum Management System and on the Department of Family Medicine Website.

Educational Contract/Midpoint Evaluations:

At the midpoint of the rotation, the student will complete a **Midpoint Interview Form** (pink form). The student must review the form with his/her preceptor, have it cosigned by the preceptor and submit it to the Undergraduate Family Medicine office (fax number (204) 389-3917).

The student will also independently complete a self **Midpoint In-training Evaluation Report** (MITER-yellow form) that the student will FAX to the Undergraduate Family Medicine office.

Final Evaluation:

At the end of the rotation the preceptor will complete a **Final In-training Evaluation Report** (FITER) together with the student. Please give this to your student so that he/she can bring this form to the debriefing. *The student's rotation is considered incomplete until the Director of the Undergraduate program has received this form.* As there is no summative Family Medicine Exam it is imperative that this FITER be completed and returned. It is the only source of determining passage or failure of the student during his/her Family Medicine Clerkship rotation.

At the debriefing session the student will complete a **final independent evaluation** of the rotation and the preceptor. Copies of these evaluations are kept on file at the Undergraduate Family Medicine office for future students to review when selecting their sites. A copy is also sent back to the preceptor for feedback.

NOTE: As of September 2010, all MITERs and FITERs will be completed and submitted electronically using the OPAL Curriculum Management System. Further instructions will follow.

Appendix C: Sample Invoice

Clinic Name
Clinic Address
Clinic Telephone #

Attention: Ms. Cathy Higham
University of Manitoba-
Accounts Payable
Department of Family Medicine
T158-770 Bannatyne Ave.
Winnipeg, Manitoba

Student Name
Dates of Rotation
$1250.00

Please make cheque payable to the <u>clinic or preceptor</u>

Please mail your invoice to Cathy Higham at the above address.

Appendix D: The Four Principles of Family Medicine

Family physicians in Canada are guided by the following four principles, developed by the College of Family Physicians of Canada:

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
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Last modified: January 25, 2000

Appendix E: 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

Appendix F - Essential Clinical Presentations Resource List

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://ww1.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 counselling. 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

<u>Psychosocial Contexts:</u>

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/

Appendix G:
Leave of Absence from a Clerkship Rotation:
Faculty of Medicine Guidelines and Procedures

The following guidelines and procedures detail how the Faculty of Medicine, Undergraduate Medical Education (UGME) office will deal with requests for leave of absence from clinical clerkship rotations and arrangements for rescheduling missed time/rotations if required. These guidelines are made with the understanding that the Faculty agrees that student attendance and participation in all clerkship activities are necessary to the students' academic and professional progress and ultimate success in medical school.

A. REQUESTS FOR ANTICIPATED LEAVES OF ABSENCE

Guidelines

1. Requests for leave of absence are not automatically granted and can be declined. The Faculty will not be responsible for expenses incurred for leaves that did not have prior approval.
2. Students will be allowed to apply for a maximum of two (2) scheduled working days off from a rotation and a maximum of six (6) days off during the entire clerkship program.
3. A written request must be submitted to the UGME office – Clerkship Administrator, **at least six (6) weeks** prior to the start date of the requested leave for consideration.
4. The request for leave of absence form must be completed in full. All completed forms whether approved or denied will be filed in the student's evaluation folder that is held in the UGME office.
5. Students are responsible for re-arranging the dates of their NBME examinations with the Evaluation Program Administrator if applicable and all on-call shifts within the rotation.
6. Documentation acceptable to the UGME office is required to support the reason for the request.
7. Students will be expected, in conjunction with the rotation affected by the leave, to make alternative arrangements to complete any necessary requirements for the rotation that were missed during their leave as determined by the rotation department office. Missed time can not be made up during another subsequent clerkship rotation, and not normally during scheduled vacation time.
8. A course of study that is interrupted due to a leave of absence may be reflected on the Medical Students Performance Record (MSPR). All approved leaves may be reported to the Progress Committee for discussion.
9. Appeals for denied requests are to be made in writing jointly to the Associate Dean for UGME and the UGME Clerkship Coordinator.
10. In the case of an unexpected, single day absence (i.e. illness) students must notify the Clerkship Director or Administrator of the rotation. If the illness continues refer to section B: Requests for Extended Leaves of Absence. Appointments requiring less than two hours must be discussed at the start of the rotation and approved by the Clerkship Director or Administrator of the affected rotation. In either case, a completed request for leave of absence form will not normally be required.

Categories for Consideration of Anticipated Leaves of Absence

1. Personal: for example; student's own marriage, illness, or representation at an elite level (provincial, national or international) of sports, arts of other activity. For maternity or parental leave please refer to extended leaves.
2. Family (relates to immediate family members): for example; birth of a child, marriage, or illness.
3. Professional: for example; conference attendance, presentation of a paper, receiving of an award or a national/international organization meeting for which the student is a voting/invited member.
4. Observation of Religious Holy Days: Every effort will try to be made to accommodate a student's request for religious observance. Students on clinical rotations should understand that becoming a physician includes learning to accept responsibility for ones' patients 24 hours per day, 365 days per year, except when alternatives for coverage have been obtained. Although supervised, students have direct patient care responsibilities while on call, and cannot refuse the responsibility for religious reasons.
5. Other: Circumstances deemed to be exceptional by the UGME office and/or the clerkship Director of the rotation.

Procedure

1. Complete the Request for Leave of Absence form in full, attaching all relevant documentation.
2. Submit to the UGME office - Clerkship Administrator for approval to proceed.
3. UGME office and/or student to forward to the affected rotation for consideration of request.
4. Return completed form, whether approved or denied to the UGME office for recording and filing.
5. If denied, student may file an appeal (guideline #9 above).

B. REQUESTS FOR EXTENDED LEAVES OF ABSENCE

Guidelines

1. Students requesting leaves in excess of that indentified above from a rotation will have to seek approval from the Associate Dean of UGME and/or UGME Clerkship Coordinator.
2. Additional meetings with recommended faculty or professionals may also be recommended by the Associate Dean of UGME and/or UGME Clerkship Coordinator.
3. Students may also consult with the Associate Dean, Student Affairs (UGME) for guidance.

Categories for Consideration of Extended Leaves of Absence

1. Maternity/Parental Leave: will refer to the Professional Association of Residents & Interns of Manitoba (PARIM) contract for guidance http://www.parim.org/66 .
2. Medical Illness/Injury
3. Bereavement Leave
4. Other Crisis

Procedure

1. Complete the Request for Leave of Absence form in full, attaching all relevant documentation.
2. Contact the Associate Dean of UGME and/or UGME Clerkship Coordinator to meet and discuss the request.

3. If approved, the affected rotation's Clerkship Director will be contacted and arrangements made for the leave and subsequent make-up of missed time discussed.
4. If denied, student may file an appeal (guideline #9 above).

C. UNEXPECTED ABSENCES
1. Students requiring an unexpected emergency leave of absence must contact or have a designate on their behalf, contact the UGME office and/or the affected rotation office ASAP. Depending on the nature and length of the absence appropriate measures will be instituted in conjunction with the Associate Dean of UGME and the UGME Clerkship Coordinator. Affected rotations will be consulted in regard to fulfilling learning objectives for the rotation.
2. Students may also consult with the Associate Dean, Student Affairs (UGME) for guidance.
3. Not withstanding the above noted items, any student absence that has not received prior approval should be reported to the Associate Dean of UGME and the UGME Clerkship Coordinator.

APPEAL PROCESS
The Associate Dean of UGME and the UGME Clerkship Coordinator will review all submitted documentation from the student and discuss with the Clerkship Director of the affected rotation. A meeting may or may not be required with the student and the final decision will be issued in writing to the student and the Clerkship Director of the affected rotation. Students may also consult with the Associate Dean, Student Affairs (UGME) for guidance.

The above guidelines and procedures were constructed after careful review of fellow Canadian and international medical school policies on leaves from clerkship rotations and will be reviewed on annual basis by the Clerkship Curriculum Committee and the Undergraduate Medical Curriculum Committee.

(effective: August 25, 2008)