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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 core rotation outside of the tertiary care hospital centers. 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 let Cathy know when she contacts you by email about this award.

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?
If you are incorporated we can pay you directly, if not we must pay the clinic. All we need is a Revenue Canada Business Number from either you or the clinic and we take care of all the paper work. 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 or email 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 checklist online for use throughout the rotation as a guide and self-evaluation tool. The preceptor and the student should review the list at the start of and at the mid point of the rotation, and midpoint evaluation forms (MITER) must be completed and submitted online 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 submitted online. This is then sent to be reviewed with the student. The student is responsible for submitting the final reviewed FITER online via OPAL.

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

Students are not currently required to sit this exam.

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). They must complete the ECP reflection exercise for each deficient subject. The ECP form must be reviewed and signed off by the end of the rotation. Students will be notified by the director or designate if any deficiencies are present after completion of rotation. Students must complete the assigned reading and reflection exercise within 14 days of end of 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 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. Periodically access OPAL and update Essential Clinical Presentation (ECP) form.
4. At the mid-point of the rotation, complete a mid-point rotation evaluation form (MITER) via OPAL and review it with his/her preceptor, along with his/her Essential Clinical Presentation form.
5. Submit completed MITER to the program administrator.
6. Complete and submit a final evaluation of the student’s experience at the debriefing sessions.
7. Review his/her completed final assessment (FITER) and Essential Clinical Presentation forms at the end of the rotation, and submit it via OPAL.

**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 cash 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).

We also ask the students to participate in selecting the Educator of the Year Award recipient by nominating their preceptor if they feel he/she has met or exceeded the requirements for the award. You will be contacted at the end of your 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 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. Describe limitations of health care resources available to the community
7. Discuss and apply an understanding of Continuous Quality improvement concepts as they apply to the family medicine setting.

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
7. Demonstrate responsibility through completing assigned tasks and meeting deadlines.

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 and translational research concepts as they apply to family medicine, 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
   d. Presentation of the above to faculty and fellow students
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**

Dependant  
Non-experiential  
Learns when teacher says  
Learn now, use later  
Motivated by grades

**Andragogy**

Self-Directed  
Experiential  
Learns when needs to learn  
Instant application  
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.

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
5)  Taylor: Family Medicine, Principles and Practice, Sixth Edition; Copyright Springer 2002.
Appendix A:
Preceptor Profile Information Sheet
PRECEPTOR PROFILE INFO SHEET

Preceptor(s):

____________________________________________________________________________________________________

____________________________________________________________________________________________________

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: 

Evaluation Forms - OPAL

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.

Midpoint Evaluations:

The student will independently complete and submit to UGME a self **Midpoint In-training Evaluation Report** (MITER). Once the student has submitted his completed MITER OPAL will generate an email to the preceptor letting him know that the student’s MITER is available for review and comments.

Final Evaluation:

At the end of the rotation the **preceptor** will complete a **Final In-training Evaluation Report** (FITER) together with the student. This evaluation is found on OPAL. 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.

The student will complete a **final independent evaluation** of the rotation and the preceptor. A report will be made available at yearend by UGME.

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.

**OPAL:**

**How to claim an OPAL account:**

Only Physicians that are registered preceptors are allowed access to an OPAL account. Access to the site [http://opal.med.umanitoba.ca/web/guest/home](http://opal.med.umanitoba.ca/web/guest/home) (A shortcut can be placed on your desktop by clicking on: File/send/shortcut to desktop). Go to Welcome/sign in (ignore the information about how to claim an account) click tab that says forgot password enter your email address click on Send New Password. It must be the same one that we have on file. A notice is sent instantly to your email account with a password. Go back to sign in and use your new password. Your password can be changed by going in to Welcome/My Account, scroll down and click on password tab.
Appendix C:
SAMPLE INVOICE
(WE CREATE AND SEND YOU A COPY FOR YOUR APPROVAL)

Department of Family Medicine
- Request for Payment

<table>
<thead>
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<th>FROM:</th>
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<th>Invoice #</th>
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<table>
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<tr>
<th>TO:</th>
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<tbody>
<tr>
<td>University of Manitoba Accounts Payable Department of Family Medicine T1S 0X2 770 Bannatyne Ave.</td>
</tr>
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</table>

Requests Payment for Family Medicine Clinic Time:

<table>
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<tr>
<th>Amount Payable</th>
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Cheque Payable to:

Mail to:
(if different from above)

Business Number

Instructions to Clinic Manager for Completion of Form: please make any changes needed to shaded areas of form and email or fax back to Cathy Higham email: higham@c.cumanitoba.ca or fax: 204 789-9917
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:

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
Copyright © 1996 The College of Family Physicians of Canada
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](http://www.aafp.org/afp/2008/0401/p971.html)

Diagnosis of Acute Abdominal Pain in Older Patients. [www.aafp.org/afp/20061101/1537.html](http://www.aafp.org/afp/20061101/1537.html)

Anxiety:


AAFP article from May 2009 when available

Asthma:


Chest pain:


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](http://www.aafp.org/afp/20040501/2159.html)


Depression:

Diagnosis and Management of Major Depressive Disorder. BC Guidelines and Protocols Advisory Committee. [http://www.bcguidelines.ca/gpac/guideline_mdd.html](http://www.bcguidelines.ca/gpac/guideline_mdd.html)
**Diabetes Type 2:**

Canadian Diabetes Association 2008 Clinical Practice Guidelines.  

**Dizziness:**

[http://www.aafp.org/afp/2006/0115/p244.html](http://www.aafp.org/afp/2006/0115/p244.html)

**Fatigue:**

[http://www.cmaj.ca/cgi/content/full/174/6/765](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  

**Headache:**

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

**Hypertension:**

2009 CHEP Recommendations for the Management of Hypertension.  

**Ischemic Heart Disease:**

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

**Low Back Pain:**


**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:**


**Well Baby Care:**


**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:**


**Family/Relationship Stressors:**


**Polypharmacy:**

**Poverty:**


**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](http://www.ccirh.uottawa.ca/eng/guideline_drafts.html)

**Same Sex Relationship:**


**Work Status:**


Appendix G: Leave of Absence from a Clerkship Rotation: Faculty of Medicine Guidelines and Procedures - 2012

1. PURPOSE

Undergraduate Medical Education asserts that student attendance and participation in all clerkship activities are necessary to the students’ academic and professional progress and ultimate success in medical school. However, there is a realization that periodic absence is unavoidable at times.

2. DEFINITIONS

2.1 Clinical Clerkship Rotations - A hospital and/or medical based practicing clinic that involves patient care for which students participate for a specified time period during their third and fourth year of undergraduate medical school.

2.2 LOA - Leave of Absence.

2.3 Approved Absence - An absence/leave that has been approved by the Director, Clerkship Curriculum and Clerkship Director of the affected rotation.

2.4 Anticipated Absence - Absence whereby the student has prior knowledge of an event or appointment that is happening in the future that the student wishes to attend.

2.5 Categories for Consideration of Anticipated Leaves of Absence:

- Personal: for example; student’s own marriage, medical appointments, academic advising/counseling, or representation at an elite level (provincial, national or international) of sports, arts or other activity. For maternity or parental leave please refer to extended leaves.
- Family (relates to immediate family members): for example; birth of a child, marriage, or illness.
- 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.
- CaRMS Interviews: the National Interview Period is in January/February, but there may be exceptions when attendance for an interview(s) is required during November/December.
- Observance of Religious Holy Days
- Other: Circumstances deemed to be exceptional by the UGME office and/or the clerkship Director of the rotation.

2.6 Unexpected Absence - Absence whereby the student does not have prior knowledge of the event or appointment which has occurred suddenly without notice. Unexpected absences include but are not limited to, absences due to illness, accident, family emergencies or inclement weather.

2.7 Extended Leave(s) - Approved leaves that extend beyond the maximum allowable absence/leave from an individual clinical clerkship rotation that will
require the student to defer the complete affected rotation(s) to a later date in their clerkship.

2.8 Categories for Consideration of Extended Leaves of Absence:
- Maternity/Parental Leave: will refer to the Professional Association of Residents & Interns of Manitoba (PARIM) contract for guidance [http://www.parim.org/66](http://www.parim.org/66).
- Medical Illness/Injury
- Bereavement Leave
- Other Crisis

2.9 Vacation Time -
- A two week scheduled vacation time at the end of Period 7 and prior to the start of Period 8.
- The Christmas break for Med 3 students normally beginning when Period 2 is complete and ending the Tuesday, prior to the first Wednesday in January, when Period 3 starts.
- The dates for the Med 4 students may vary slightly depending on their elective.

2.10 Maximum Allowable Absence/Leave from a Rotation - Time allowed to be absent from an individual clinical clerkship rotation, regardless of the reason, without penalty of repeating the rotation in whole.

2.11 Working Day - any day that the University of Manitoba is open for business.

3. POLICY STATEMENTS

General

3.1 A student may at anytime consult with the Associate Dean, Students for guidance as it relates to absence from the Clerkship component of the Undergraduate Medical Education program.

3.2 A course of study that is interrupted due to a leave of absence may be reflected on the Medical Student Performance Record (MSPR).

3.3 A student cannot be absent for more than 25% of an individual clinical clerkship rotation regardless of the reason, without penalty of repeating the rotation in whole.

3.4 A student may be required to make up missed time due to an absence.

3.5 A request for leave is not automatically granted and can be declined.

3.6 The Faculty of Medicine is not responsible for expenses incurred for a leave for which approval was not given.

3.7 A student failing to attend a scheduled Clerkship learning experience will be reported to the Associate Dean, Undergraduate Medical Education. If the
reason for the absence is inappropriate, then the student's attendance record will be considered by the Committee of Evaluation (Clinical) and the student may be deemed to have failed the rotation.

**Appeal**

3.8 A student disagreeing with a decision related to attendance has the right to appeal, in writing, to the Director, Clerkship Curriculum and/or Associate Dean, UGME.

3.9 Should the student not accept the final decision, the student has a right of appeal to the Undergraduate Medical Education Student Appeals Committee.

**Requests for Anticipated Leaves/Absences**

3.10 A student with a scheduled appointment for preventive, diagnostic, therapeutic health services or academic support must have verbal approval from the preceptor of the affected rotation with follow-up written communication to the preceptor, copied to the affected rotation Director.

3.11 A student with recurring scheduled appointments must complete and submit the Request for Leave from a Clerkship Rotation form (Appendix 1) including supporting documentation.

3.12 A student can apply for a maximum of two (2) days leave from a six week rotation and a maximum of six (6) days leave during the entire clerkship program.

3.13 A student who has been approved for a leave 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 the leave as determined by the rotation Clerkship Director.

3.14 A student is not permitted to make-up missed time during another subsequent clerkship rotation and not normally during scheduled vacation time.

3.15 A student who has been approved for a leave is responsible for making alternate arrangements for examinations and/or on-call shifts that may be affected within the rotation.

**Unexpected Absences**

3.16 A student absent from a clinical rotation without notice must follow-up in a timely manner with designated staff within the rotation, Undergraduate Medical Education Office and/or Student Affairs (Medicine).

3.17 Clinical rotation personnel are responsible for following up on a student who has not reported for clinical duties within a reasonable period of time.
3.18 **Unexpected absences exceeding two days within a six-week clerkship rotation or in excess of six days throughout the clerkship program will be reported to the Director, Clerkship Curriculum and the Associate Dean, Students.**

**Extended Leaves of Absence**

3.19 A student seeking an extended leave of absence from a rotation must meet with either the Associate Dean, UGME or Student Affairs (Medicine).

3.20 A student must complete and submit the Request for Leave from a Clerkship Rotation form (Appendix 1) including supporting documentation.

3.21 A recommendation/decision related to such leaves must be provided by either the Associate Dean, UGME and/or Student Affairs (Medicine).

4. **PROCEDURES – ANTICIPATED ABSENCES**

**Responsibilities of Student:**

4.1 For a **scheduled appointment**, seek verbal approval from the preceptor of the affected rotation. Follow up with written communication to the preceptor, copied to the affected rotation Director.

4.2 For **reoccurring scheduled appointments**, complete and submit the Request for Leave from a Clerkship Rotation form (Appendix 1) including supporting documentation as soon as feasibly possible to the UGME Clerkship Administrator.

4.3 For **anticipated absences**, complete and submit the Request for Leave from a Clerkship Rotation form (Appendix 1) including supporting documentation at least six (6) weeks prior to the start date of the requested leave to the UGME Clerkship Administrator.

4.4 Ensure all required information is submitted on each Request for Leave from a Clerkship Rotation form. Failure to do so will result in the request not being processed until all required information is received.

4.5 Appeal in writing within 2 working days of receiving an unfavorable decision to the Director, Clerkship Curriculum.

**Responsibilities of UGME Clerkship Administrator:**

4.6 Date stamp each Request for Leave from a Clerkship Rotation form upon receipt and record in the tracking database.

4.7 Review each Request for Leave from a Clerkship Rotation form for completeness.

4.8 Inform the student if additional information or clarity is required.
4.9 Advise the Director, Clerkship Curriculum of the student’s request via email, including the total number of days absent for which the student has already received approval.

4.10 Inform the affected rotation if the Director, Clerkship Curriculum approves the student’s request for absence to determine if the department can accommodate the approved request.

4.11 Notify the student in writing of the decision(s) and record the outcome on a tracking database.

4.12 Submit appeal documents to the Director, Clerkship Curriculum for review.

4.13 File all completed Request for Leave from a Clerkship Rotation forms whether approved or denied, in the student’s academic file.

**Responsibilities of Director, Clerkship Curriculum:**

4.14 Review and approve or deny the student’s request for absence based on submitted information.

4.15 Review each appeal and issue a final decision within 2 working days of receiving the student’s request appealing the initial decision.

4.16 Submit a copy of the decision to the UGME Clerkship Administrator and the Clerkship Director of the affected rotation.

**Responsibilities of Department/Rotation Clerkship Director:**

4.17 Inform the UGME Clerkship Administrator of the rotation’s ability to accommodate each approved request.

5. **PROCEDURES – UNEXPECTED ABSENCES**

**Responsibilities of Student:**

5.1 Inform the UGME Clerkship Administrator and/or the Department Administrator of the affected rotation as soon as feasibly possible, generally within one working day.

**Responsibilities of the Clerkship Rotation Preceptor:**

5.2 Contact the student by pager.

5.3 Notify the department Clerkship Administrator of the student’s absence.

**Responsibilities of the UGME Clerkship Administrator and the Department Administrator of Affected Rotation:**

5.4 Attempt to reach the student by pager and/or telephone upon notification by the preceptor of the student’s absence.
5.5 Send an e-mail to the student, copying the Clerkship Director and Associate Dean, Students, if no response to page or telephone is received within one hour.

5.6 Communicate with each other in writing of the notification received in regard to the student’s absence.

5.7 Record all information in the tracking database.

5.8 File written communication to and from the student in the student’s academic folder.

6. PROCEDURES – EXTENDED LEAVES

Responsibilities of Student

6.1 Meet with the Associate Dean, UGME and/or the Associate Dean, Students to discuss the request for an extended leave.

6.2 Complete the Request for Leave from a Clerkship Rotation form (Appendix 1) including supporting documentation a minimum of one week following the meeting with the Associate Dean, UGME and/or the Associate Dean, Students.

6.3 Ensure all required information is submitted on the Request for Leave from a Clerkship Rotation form. Failure to do so will result in the request not being processed until all required information is received.

6.4 Submit the completed documentation to the UGME Clerkship Administrator.

6.5 Confirm the date of return to clerkship program upon receipt of related information from the UGME Clerkship Administrator.

Responsibilities of UGME Clerkship Administrator

6.6 Date stamp each Request for Leave from a Clerkship Rotation form upon receipt and record in the tracking database.

6.7 Review each Request for Leave from a Clerkship Rotation form for completeness.

6.8 Inform the student if additional information or clarity is required.

6.9 Advise the Director, Clerkship Curriculum, in writing, of the student’s approved request for extended leave.

6.10 Inform the affected rotation, in writing, of the student’s approved request for extended leave.

6.11 Inform the student, in writing, of the anticipated scheduled return to clerkship program.
6.12 Notify, in writing, the clerkship department(s) of the student’s anticipated return to the Clerkship program.

6.13 File each Request for Leave from a Clerkship Rotation form with accompanying documentation in the student’s academic file.

**Responsibilities of Associate Dean, UGME and/or Associate Dean, Students**

6.14 Meet with the student and advise the student of the appropriate course of action.

6.15 Communicate in writing the decision to approve the student’s request to the following:
- Student
- Director, Clerkship Curriculum
- UGME Clerkship Administrator
- Admissions & Enrolment Services Administrator
- Clerkship Evaluations Administrator
Appendix H:
Clerkship Duty Hours

Preamble
Clinical medicine is best learned by active experience in the care of patients at the hospital bedside or in the office. This experience should include on-call, often overnight duty. But the inevitable service demands of patient care should not routinely replace educational sessions.

In order to provide adequate service and care to patients and to enhance the medical education of students, duty hours must be scheduled to provide a balance of clinical experience, patient service and academics. Duty Hours shall consist of both Regular Duty Hours and On-Call Duty Hours.

Definitions:
PARIM: Professional Association of Residents and Interns of Manitoba

Statutory Holidays: As defined by the PARIM Contract (July 1, 2008 to June 30, 2011) are Canada Day, August Civic Holiday, Labour Day, Thanksgiving Day, Remembrance Day, Good Friday, Easter Monday, and Victoria Day and any other holiday proclaimed by Federal or Provincial statute during the life of this Collective Agreement then such additional holiday(s) shall also be recognized.

Regular Duty Hours, in general, are between 0700-1700 hours Monday through Friday. Such Regular Duty Hours may vary for some clinical services. As future professionals, clerks should view these hours as guidelines and understand that patients, staff and colleagues should not be compromised by the letter of the law.

On-Call Duty Hours refers to those times the student carries clinical responsibilities beyond the Regular Duty Hours. This usually includes evenings/overnight Monday to Friday, weekends and designated recognized holidays. Weekday (Monday through Friday) On-Call Duty Hours commence at the end of Regular Duty Hours and are 14-17 hours in duration. Weekend and designated recognized holiday On-Call Duty Hours are twenty-four (24) hours (with a maximum of two (2) hours for transfer of care).

Policy Statements

A. On-Call Duty Hours
Two types of On-Call Duty Hours are recognized (obtained from the 2008 to 2011 PARIM contract)

1. Home Call
Home call refers to clinical service, or immediate availability for such service, provided by the student where the student is not required to remain in the hospital. Home call may result in the student returning to the hospital. Home call is not to be more frequent on average than one (1) in three (3) and should not exceed ten (10) home call days in 28 days. In-Hospital call should average one (1) in four (4), averaged over a six week rotation.

Where a clerk was required to work in the hospital during the home call for more than four (4) hours, of which more than one (1) full hour is after midnight and before 0600 hours the
entire Home call duty hours shall be included in calculating consecutive hours worked. Where Home call is included in calculating consecutive hours worked the student may, at their option, elect to work on the post-call day.

2. In-Hospital Call
In-Hospital call refers to clinical service, or immediate availability for such service, where the student is required to remain in the hospital for that time period. A student shall not be scheduled for In-Hospital call more than seven (7) times over a four (4) week period. In-Hospital Call should average no more than one (1) in four (4) over a clinical rotation.

The student must have two (2) weekends off in four (4). A weekend is defined as Friday from 1700 until Monday at 0700 hours.

Students must not be on hospital service duty for more than 26 hours continuously (24 hours of call and 2 hours of transfer care). Thus the clinical clerk who has spent an on-call night in the hospital must sign over their cases to the next on-call person during the morning work round.

3. Education Responsibility
Clinical clerks who have been on-call may wish to stay for educational purposes but they must not be expected to respond to service duties or on-calls on their patients. Clerks who do not stay for academic educational sessions are responsible for obtaining the missed information from their fellow clerks.

B. PREGNANCY AND CALL REQUIREMENTS

A clinical clerk who is pregnant shall not be required to take overnight call after 31 weeks of gestation. The affected clerkship rotations should be given as much notice as possible to prepare the call schedules accordingly.

C. STATUTORY HOLIDAYS

When a student is on call on a Statutory Holiday as recognized by the PARIM Contract, they must be given a day off during the rotation in which the statutory holiday occurred. Statutory holiday substituted days off may not be carried over to another rotation. A student is entitled to a day off in lieu of the statutory holiday if they are on call for at least eight (8) hours of the holiday (i.e. is scheduled to be on call for at least eight (8) hours between the time 0000 and 2400 on a recognized holiday)

D. GENERAL REGULATIONS

Students will NOT be placed on-call the night prior to their National Board examination. Students will NOT be placed on-call the last evening/night of their rotation. The rotation does not end with the exam and students are expected to return to their rotation after the exam unless their supervisor specifically tells them otherwise.
E. APPEAL PROCEDURES FOR STUDENTS

Should there be a violation of the on-call policy statements described above; the student can initiate the following appeal procedures:

1. The student should first approach the Clerkship Director for the affected rotation to try to rectify the inequity.
2. If the student is unable to come to a resolution with the Clerkship Director, then the Faculty of Medicine Clerkship Coordinator should be contacted.
3. If the student remains dissatisfied or does not feel comfortable approaching either the Clerkship Director of the affected rotation or the UGME Clerkship Coordinator, then the student should contact the Associate Dean, Students.