DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

Family Medicine
Resident Objective Book

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family.medicine.dal.ca

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PURPOSE

The residency program in Family Medicine at Dalhousie University is a Triple C Competency Based Curriculum.

This document contains everything you need to know regarding the Dalhousie Family Medicine Curriculum, Assessments and Resident Projects to act as a resource and help guide you through your Family Medicine residency training.

This document will introduce the core elements of the program's curriculum.
It will also give you information on:

- CanMEDS FM;
- The structure of the Academic Curriculum;
- The assessment process
- Guidelines around the Resident Project.

RESPONSIBILITY

Resident: To review the relevant objectives prior to each clinical learning experience and determine with the supervisor what can and should be achieved.

Supervisor/Preceptor**:** To review the relevant objectives prior to each clinical learning experience and determine with the resident what can and should be achieved.

Site and Program**:** To ensure that each site provides the learning opportunities and structured assessment stated in this document.

PREAMBLE TO THE CURRICULUM DOCUMENT FOR RESIDENTS

The delivery of the Dalhousie Family Medicine Residency Program is based on the provision of both strong clinical experiences and a focused academic curriculum. This delivery is in alignment with the *CFPC Residency Training Profile for Family Medicine and Enhanced Skills Programs Leading to Certificates of Added Competence* (Residency Training Profile) which details the aims of family medicine residency training across all the dimensions of professional practice. These dimensions include[1]:

- A unique professional identity and value system as described in the Four Principles of Family Medicine[2]
- Family medicine competence, described in the CanMEDS-FM 2017 Framework[3] and the Assessment Objectives for Certification in Family Medicine
- A comprehensive scope of practice enabled by a set of Core Professional Activities (CPAs)
- Participation in a collaborative work environment that enables the collective delivery of comprehensive and continuous care (*Patient's Medical Home)*

The Dalhousie Family Medicine program objectives are based on the CFPC's Triple C competency-based curriculum and the CanMEDS-FM 2017 roles. The program objectives were restructured in 2025 according to the Core Professional Activities (CPAs) outlined in the Residency Training Profile. The CFPC's Assessment Objectives for Certification in Family Medicine is the other document that has a major influence on the curriculum. It incorporates the Skill Dimensions of Competence, the Phases of the Clinical Encounter, the 105 Priority Topics with their Key Features, and the Themes of Communication and Professionalism with their Observable Behaviours.

It is important to differentiate *program* (*curriculum) objectives* and *assessment objectives*. It is the curriculum objectives that define the broad knowledge base that is expected for residents to gain over the training program. It is the assessment objectives that form the basis of assessment of competency in a *sampling* of these areas. Thus, it is appropriate that the Priority Topics drive our curriculum to a certain extent, but residents are expected to know more than what is included in the Priority Topics and corresponding Key Features.

The purpose of the academic curriculum at Dalhousie Family Medicine is to supplement the clinical curriculum in providing learning opportunities that support residents in accomplishing the competency-based program objectives. As noted above, these objectives encompass multiple documents that outline competence in family medicine. The components of the curriculum at Dalhousie Family Medicine have been deliberately designed to address the program objectives which are more comprehensive than what is outlined in the *CFPC Assessment Objectives for Family Medicine (105 Priority Topics).*

Residents are assessed in many facets of the program, including participation and presentation in seminars and workshops. Please see the Periodic Review document for a full list. Much of the assessment is accomplished in real clinical situations based on the clinical objectives in each clinical learning experience - this is known as workplace-based assessment (WBA). We focus on assessment *for* learning as well as assessment *of* learning. This means that we use all assessment tools to stimulate your learning and to see how you are doing at the same time. Documentation of the in-training assessment occurs with the use of Field Notes - which provide a narrative of what went well, with suggestions for improvement, with common reflection on multiple encounters from multiple observers. This information is summarized later to help populate the In-Training Assessment Reports (ITARs) for each clinical learning experience. Your preceptor

will help you create a personalized learning plan with the completion of each Narrative ITAR. This and other information, and with some of your reflections, will be used by your Site Director (or their designate) to complete the Periodic Resident Performance Review. A learning plan will also be developed to stimulate your learning and to help you achieve competence as quickly and efficiently as possible.

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1. Fowler N, Wyman R, eds. Residency Training Profile for Family Medicine and Enhanced Skills Programs Leading to Certificates of Added Competence. Mississauga, ON: College of Family Physicians of Canada; 2021.
2. The Four Principles of Family Medicine: the Family Physician is a skilled clinician; the Family Physician is community-based; the Family Physician is a resource to a defined community; and the doctor-patient relationship is central to the role of Family Physician.
3. The roles detailed by the CanMEDS-FM 2017 competency framework are: Family Medicine Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional.

CURRICULUM DELIVERY

Dalhousie Family Medicine strives to deliver the curriculum at each site in a comprehensive and equitable manner. To accomplish this in a distributed, multiple-site program such as Dalhousie's, a variety of methods are used to ensure that residents are provided adequate exposure to topics and have opportunities to achieve program objectives. Curriculum delivery will include, but not be limited to:

- Clinical Learning Experiences (both Family Medicine and other Specialty-based)
- Academic Curriculum (both on-site and distributed)
- The annual Family Medicine Education Event
- Practice-Based Learning Program (PBLP)
- Departmental/Hospital-based rounds
- Journal Club
- Dalhousie Postgraduate Medical Education (PGME) and other e-modules

The Dalhousie Family Medicine Academic Curriculum is primarily composed of a selection of topics that have been deemed essential to present to residents in an academic manner. These topics are termed Mandatory Academic Curriculum Topics (see below); the Curriculum sub-committee reviews and updates the topics and corresponding topic objectives on an ongoing basis. Each site determines how the mandatory topics and other topics will be covered in the academic curriculum based on resident learning needs and local resources and expertise. The academic curriculum also includes other program requirements such as (but not limited to) simulation-based learning, Residents as Professional Peer Educators (RAPPERs), Quality Improvement & Patient Safety (including a project), and Resident Resilience and Empathy Sessions.

Academic curriculum sessions may be virtual or recorded. Residents are encouraged to review relevant program policies and guidelines and inquire with their site administrator, faculty curriculum coordinator, or site director if further details are needed.

Dalhousie Family Medicine Postgraduate Program Objectives

PRIMARY CARE IN THE COMMUNITY/OFFICE SETTING

CPA 1: Provide first-contact access and relational continuity of care as part of an overall system of care to the practice

CPA 2: Manage the total care of patients to provide informational and management continuity

DFM Program Objectives	CanMEDS-FM Role
Document and share written and electronic information about the medical encounter to optimize clinical decision making, patient safety, confidentiality, and privacy.	Communicator
Become familiar with an effectively organized medical record.	Leader

CPA 3: Assess and plan for the care needs of the practice in the context of the local community

DFM Program Objectives	CanMEDS-FM Role
Contribute generalist abilities to address complex, unmet patient or community needs and emerging health issues, demonstrating community-adaptive expertise.	FM Expert
Contribute generalist abilities to address complex, unmet patient or community needs and emerging health issues, demonstrating community-adaptive expertise.	Leader
Engage in stewardship of health care resources	Leader
Recognize the need to balance the individual patient's concerns against the responsible use of public resources.	Leader
Recognize the impact of high-resource vs. low-resource public health interventions on population health	Leader
Demonstrate collaborative leadership in professional practice to enhance health care.	Leader
Contribute generalist abilities to address complex, unmet patient or community needs and emerging health issues, demonstrating community-adaptive expertise.	Health Advocate

CPA 4: Attend to career and practice administrative/business functions

DFM Program Objectives	CanMEDS-FM Role
Manage career planning, finances, and health human resources in a practice	Leader
Develop familiarity with different methods of compensation	Leader
Be aware of billing procedures and strategies	Leader
Develop familiarity with issues around commencing practice such as evaluating practice and locum opportunities, licensing, group versus solo practice, staffing issues, office equipment and layout	Leader
Be aware of personal and professional financial management principles, such as accounting, tax planning, budgeting and debt management, insurance	Leader

CPA 5: Participate in and engage with safety processes for patients, staff, and self

DFM Program Objectives	CanMEDS-FM Role
Actively facilitate continuous quality improvement for health care and patient safety, both individually and as part of a team.	FM Expert
Document and share written and electronic information about the medical encounter to optimize clinical decision making, patient safety, confidentiality, and privacy.	Communicator
Recognize and facilitate necessary transitions in care with other colleagues in the health professions, including but not limited to shared care, transfer of care and/or handover of care to enable continuity and safety	Collaborator
Demonstrate appropriate respect for the patient's safety and dignity, in particular appropriate boundaries, chaperoning and draping.	Professional
Demonstrate understanding of privacy legislation and physician confidentiality.	Professional
Demonstrate professional behaviour in the area of Patient Safety and Errors.	Professional

Develop awareness of cognitive biases, critical thinking and patterns of thought, and fatigue risk management; understand how these factors contribute to patient safety and medical error.	Professional
Develop and demonstrate skills in error/adverse event disclosure and apology	Professional
Demonstrate awareness of obligations to report patients at risk of harm to themselves or others.	Professional
Demonstrate awareness of obligations to report situations of abuse or neglect concerning children, the elderly and other vulnerable populations	Professional
Demonstrate awareness of the physician's role in prevention of iatrogenic infections and compliance with guidelines around hand washing.	Professional

CPA 6: Participate in collaborative and team-based care

DFM Program Objectives	CanMEDS-FM Role
Establish a plan for ongoing care and timely consultation when appropriate.	FM Expert
Work effectively with others in a collaborative team-based model for patient care	Collaborator
Collaborate in the care of the elderly through incorporating contributions from inter-professional team members into a thorough functional assessment	Collaborator
Recognize the role of the family physician as part of an inter-professional team in Long Term Care	Collaborator
Collaborate in the care of vulnerable and underserviced populations by working with other professionals, including cultural interpreters and translators, legal aid workers, CAS workers, social workers, and members of other community support groups.	Collaborator
Work collaboratively in different models of maternity care including team-based approaches.	Collaborator
Recognize and facilitate necessary transitions in care with other colleagues in the health professions, including but not limited to shared care, transfer of care and/or handover of care to enable continuity and safety.	Collaborator

CPA 7: Manage self-care to support personal well-being and a sustainable practice

DFM Program Objectives	CanMEDS-FM Role
Demonstrate a commitment to physician health and well-being to foster optimal patient care.	Professional
Demonstrate self-awareness and self-care while caring for their patients.	Professional
Display a commitment to personal health and balance between personal life and professional responsibilities.	Professional
Demonstrate a commitment to reflective practice.	Professional
Demonstrate a recognition of their own strengths and limitations, including the impact of fatigue, and ask for help when necessary.	Professional
Demonstrate a mindful approach to practice by maintaining composure and equanimity, even in difficult situations, and by engaging in thoughtful dialogue about values and motives.	Professional

CPA 8: Establish a therapeutic relationship and navigate ethical issues in everyday practice

DFM Program Objectives	CanMEDS-FM Role
Develop rapport, trust and ethical therapeutic relationships with patients and their families.	Communicator
Develop the confidence and skills to manage routine patient encounters.	Communicator
Develop the confidence and skills to manage difficult or emotionally intense situations or interactions	Communicator
When confronted with challenging patient interaction, seek out information about patient's life circumstances, current context, and functional status to better understand the patient's frame of reference.	Communicator
Identify one's own attitudes and beliefs which may be contributing to a challenging patient interaction.	Communicator

When faced with a challenging patient interaction, work towards establishing common ground and an atmosphere of safety and trust.	Communicator
Engage patients and their families in developing plans that reflect the patient's health care needs, values, and goals	Communicator
Demonstrate a commitment to patients through clinical excellence and high ethical standards.	Professional
Understand ethics as an integral part of every clinical encounter, not just when controversies arise.	Professional
Demonstrate understanding of privacy legislation and physician confidentiality.	Professional
Understand fundamental ethical principles of family medicine, including respect for patient dignity and beneficence-in-trust.	Professional
Understand and demonstrate specific professional qualities that stem from commitment to the good of their patients, such as effacement of self-interest, compassion, intellectual honesty, justice, and prudence.	Professional
In cases where there is ethical conflict between physician and patient, be prepared to transfer care to another physician if appropriate.	Professional
Demonstrate ethical decision making and valid consent, which includes a patient-centered approach to key ethical issues in clinical practice, such as informed consent, privacy/confidentiality, withholding and withdrawing medical interventions, surrogate decision making and advance directives.	Professional
Develop appreciation of their own roles and responsibilities in decision making as well as those of patients and respectfully discuss and manage value differences and conflicts.	Professional
Understand issues of allocation of scarce resources and prioritization of need and how these relate to the duty to the patient.	Professional
Define situations where there is an obligation to a third party that may conflict with the duty to the patient.	Professional
Understand issues that may arise in a physician's relationship with the pharmaceutical industry.	Professional
Take steps to end the physician-patient relationship when it is in a patient's best interests and do so according to accepted guidelines.	Professional
Demonstrate sensitivity to potential ethical issues in their collaborative relationships with nonmedical colleagues, institutions, professional associations, government bodies.	Professional
Demonstrate understanding of privacy legislation and physician confidentiality.	Professional

CPA 9: Provide medical care that challenges systemic racism and supports health equity with/for Indigenous peoples and other racialized or underserved patient communities

DFM Program Objectives	CanMEDS-FM Role
Establish an inclusive and culturally safe practice environment.	FM Expert
Acquire knowledge of the epidemiology of different underserviced and vulnerable groups in Canada, incorporating an understanding of the impact of the social determinants of health.	FM Expert
Be familiar with basic global burden of disease, including the major causes of mortality worldwide.	FM Expert
Demonstrate a basic understanding of the impact of migration, forced displacement, and war and armed conflict on the health of individuals.	FM Expert
Establish and maintain clinical knowledge, skills and attitudes required for global health and care of the vulnerable and underserviced	FM Expert
When caring for newcomers to Canada, provide evidence-based preventative care and screening that is informed by the person's regions or countries of origin and migration history.	FM Expert
Inquire about and maintain openness to the use of alternative healers, practices, and medications.	FM Expert
Understand the importance of the context of migration history and the potential impact on the health of newcomers to Canada.	FM Expert
Develop skill in the proper use of interpreters	Communicator

Demonstrate a working knowledge of the translation resources in the community.	Communicator
Recognize that patients have different communication needs (both verbal and written) depending on their level of literacy and primary language of communication.	Communicator
Provide materials appropriate to patient's literacy level and linguistic ability, when possible.	Communicator
Become aware of the concept of health as a human right and demonstrate knowledge of the Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights as they pertain to health.	Professional
Demonstrate a sense of cultural humility and understand the concept of cultural competence to enable constructive, helpful and professional provision of medical care to members of different cultural and socioeconomic groups.	Professional
Demonstrate an awareness and sensitivity to the patient's culture, beliefs values, gender and age.	Professional
Define one's own background, culture, beliefs, values and biases and the impact these may have on interactions with patients.	Professional
New Indigenous Health objectives when available	

CPA 10: Provide reproductive care

DFM Program Objectives	CanMEDS-FM Role
Obtain a detailed reproductive health history as part of a well woman visit – including history of risk factors for STIs.	FM Expert
Counsel a patient regarding reproductive and contraceptive choices.	FM Expert
Counsel a patient regarding safe sex.	FM Expert
Diagnose and manage menstrual disorders and irregularities throughout the life cycle.	FM Expert
Diagnose and manage specific reproductive tract infections and problems including STIs, cervicitis, PID, tubo-ovarian abscess, ovarian torsion, vaginitis, vulvar issues	FM Expert
Appropriately recognize and manage specific reproductive tract infections and problems such as urethritis, epididymitis, orchitis, prostatitis, BPH, penile anomalies, scrotal and testicular abnormalities, genital trauma, erectile/ejaculatory dysfunctions	FM Expert
Diagnose and undertake initial management of infertility.	FM Expert
Initiate evaluation and treatment of victims of rape and sexual assault (including psychosocial and legal issues).	FM Expert

CPA 11: Provide comprehensive primary care and continuity of care for children and youth

DFM Program Objectives	CanMEDS-FM Role
Establish and maintain clinical knowledge, skills and attitudes required to meet the needs of children and adolescents.	FM Expert
Evaluate and manage excessive crying and colic in infancy.	FM Expert
Evaluate and manage feeding problems in infancy and food-related behavioural issues in childhood.	FM Expert
Evaluate and manage bed wetting on an age-appropriate basis.	FM Expert
Recognize, diagnose using appropriate clinical tools, refer and collaboratively manage Attention Deficit/Hyperactivity Disorder.	FM Expert
Distinguish between benign and abnormal cardiac murmurs	FM Expert
Diagnose/manage and refer when appropriate: otitis externa, otitis media, sinusitis/pharyngitis	FM Expert
Diagnose/manage chronic GI conditions: GERD, diarrhea, constipation, lactose intolerance, chronic abdominal pain	FM Expert
Demonstrate knowledge of reportable disease and parameters for interim exclusion from school/activities	FM Expert

Evaluate and manage a child presenting with limp, intoeing, alignment abnormalities/scoliosis, joint instability, swelling, or pain	FM Expert
Evaluate fractures involving the growth plate and fractures/dislocations more common in children	FM Expert
Diagnose/manage headaches in children	FM Expert
Distinguish simple from complex febrile seizures and investigate/manage appropriately	FM Expert
Recognize the high prevalence of eating disorders in adolescents and manage appropriately	FM Expert
Diagnose/manage common respiratory conditions: croup, asthma	FM Expert
Recognize/manage common skin conditions: atopic dermatitis, acne, viral exanthems, candidiasis, impetigo, seborrheic dermatitis, and cellulitis	FM Expert
Recognize early signs of less common but serious problems	FM Expert
Recognize important rashes and investigate for possible serious underlying illness (petechiae, purpura, erythema nodosum, erythema migrans, café au lait spots).	FM Expert
Recognize potential anaphylaxis, educate parents and patients, and prescribe Medicalerts and EpiPen appropriately.	FM Expert
Evaluate severity of respiratory distress and manage respiratory emergencies (ex. epiglottitis, retropharyngeal abscess, anaphylaxis, foreign body aspiration, pneumonia, pneumothorax, and status asthmaticus).	FM Expert
Recognize/evaluate precocious puberty and primary amenorrhea	FM Expert
Recognize atypical presentations of common GI complaints (abdominal pain, vomiting, and constipation) that may suggest rare but serious complications.	FM Expert
Recognize the significance of dysmorphism, congenital anomalies or developmental delay and refer for assessment.	FM Expert
Employ case-finding as well as evidence-based surveillance and screening tools (e.g., Rourke Baby Record) to detect illness, deviation from normal growth and development and prevent injury and to provide suggestions to encourage motor, language, and social development.	FM Expert
Understand and counsel parents about normal nutritional needs at different ages. Effectively monitor growth and suggest intervention as necessary.	FM Expert
Learn to administrate an organized vaccination program within family practice including routine vaccinations and those for travel and special populations. Discuss benefits, safety, and side effects of vaccinations with parents.	FM Expert
Provide education and advice on injury prevention and common behavioural and family issues.	FM Expert
When caring for adolescents, review and counsel about substance abuse, peer issues, home environment, diet/eating disorders, academic performance, social stress/mental illness, and sexuality/STDs/contraception.	FM Expert
Have an approach to obesity in childhood including guidance on exercise and diet.	FM Expert
Communicate effectively with children	Communicator
Adapt communication methods based on the age of the child always attempting to maximize the child's participation in their medical care.	Communicator
Effectively evaluate the illness experience and influence on relationships for children and their families especially for children with chronic conditions or critical illness.	Communicator
Find common ground with children and adolescents as well as parents in managing medical or developmental issues cognizant of personal/cultural differences in parenting.	Communicator

CPA 12: Provide comprehensive primary care and continuity of care for adults

DFM Program Objectives	CanMEDS-FM Role
Perform a patient centred clinical assessment and establish a management plan.	FM Expert
Establish and maintain clinical knowledge, skills and attitudes required to meet the needs of adult patients.	FM Expert
Establish a plan for ongoing care and timely consultation when appropriate.	FM Expert

Develop effective motivational interviewing skills in counseling patients around lifestyle issues and prevention of disease.	Communicator

DFM Program Objectives	CanMEDS-FM Role
Address health promotion, screening, and disease prevention, while considering racial, cultural and gender differences, in the areas of:	
Well adult care:	
Perform a selectively adapted periodic health exam in a proactive or opportunistic manner	FM Expert
Address lack of physical activity with a structured approach including assessment and exercise prescription.	FM Expert
Inquire about alcohol consumption and screen for use of other substances.	FM Expert
Cardiovascular disease:	
Treat modifiable risk factors in patients at risk of stroke and other cardiovascular disease and offer antithrombotic treatment in appropriate populations.	FM Expert
Screen appropriate patients for hyperlipidemia. In patients with hyperlipidemia, establish target lipid levels, identify modifiable factors, give appropriate lifestyle advice, and periodically assess adherence.	FM Expert
Cancer	
Be opportunistic in giving cancer prevention advice and apply the periodic health examination where indicated.	FM Expert
Be opportunistic discussing skin cancer prevention	FM Expert
Endocrinology	
Screen appropriately for diabetes	FM Expert
Screen for and diagnose obesity, establish readiness to change and address with motivational interviewing and follow-up. Advise about treatment options.	FM Expert
Gastroenterology	
Counsel patients at high risk for hepatitis; vaccinate and offer post-exposure prophylaxis appropriately.	FM Expert
Infectious Disease	
Promote immunization as appropriate.	FM Expert
Respirology	
Take preventive measures in high-risk groups e.g., influenza and pneumococcal vaccination.	FM Expert
Regularly evaluate and document smoking status, continuously adopt a multiple strategy approach to facilitating smoking cessation.	FM Expert

DFM Program Objectives	CanMEDS-FM Role
Correctly diagnose and manage common problems in the following areas:	
Allergy	
Recognize potential allergic symptoms (skin, ophthalmologic, ENT, systemic) and manage using allergy testing, avoidance, pharmacotherapy, and desensitization where appropriate.	FM Expert

Document allergies to medication, environment, and food.	FM Expert
Cardiovascular Disorders	
Take an adequate history to make a specific diagnosis of life-threatening conditions in the patient with chest pain and begin timely treatment.	FM Expert
Have knowledge of the impact of valvular heart disease on long-term management including prognosis, appropriate medication, and follow-up.	FM Expert
Screen for hypertension, measure blood pressure correctly, and make a diagnosis on multiple visits, and investigate appropriately to rule out secondary causes. Be able to treat hypertension with pharmacological means. For patients with the diagnosis of hypertension assess periodically for end-organ complications.	FM Expert
Differentiate between hypertensive emergency and asymptomatic markedly elevated BP (formerly hypertensive urgency) and manage according to current evidence. Recognize when a workup for secondary hypertension is required.	FM Expert
Demonstrate the ability to diagnose ischemic heart disease that is classic or atypical and develop a plan in collaboration with the patient to reduce modifiable risk factors.	FM Expert
Manage a patient with stable ischemic heart disease in a timely manner according to the severity of the disease, and coordinate appropriate follow-up	FM Expert
Assess a patient who presents with a painful or swollen leg in terms of his/her risk for ischemic vascular disease or DVT, investigate appropriately and be aware of treatment options including outpatient management of DVT.	FM Expert
Assess cardiovascular function, determine the underlying cause, and appropriately treat patients with heart failure.	FM Expert
Have an approach to arrhythmia with emphasis on common arrhythmias such as Atrial Fibrillation and PVCs.	FM Expert
Cancer	
Be aware of and actively inquire about side effects or expected complications of cancer treatment.	FM Expert
Include recurrence or metastatic disease in the differential diagnosis in patients with a distant history of cancer who present with new symptoms.	FM Expert
Know the management of common medical complications of patients with malignancy, including effusions, pathological fractures, hypercalcemia, neutropenia, and infections.	FM Expert
Know how to manage cancer pain, including the use of narcotics and co-analgesics.	FM Expert
Understand the psychosocial issues facing cancer patients and how they might be addressed.	FM Expert
ENT	
Diagnose otitis media upon visualization of the TM and include pain referred from other sources in the differential diagnosis of an earache. Treat otitis media in an evidence-based fashion.	FM Expert
Consider serious causes in the differential diagnosis of an ongoing earache (e.g., tumors, temporal arteritis, mastoiditis).	FM Expert
Appropriately prescribe antibiotics when indicated for sinusitis and bronchitis.	FM Expert
Demonstrate an approach to vertigo with knowledge of benign and serious causes (BPV, stroke, labyrinthitis).	FM Expert
Endocrinology	
Manage diabetes both in and out of hospital appropriately using lifestyle, anti-hyperglycemic agents and insulin and provide patient and family education. Monitor for and manage complications.	FM Expert

Appropriately investigate and manage patients suspected with thyroid disease and limit testing for thyroid disease to patients with a significant pre-test probability of abnormal results. In patients with diagnosed hypothyroidism, check thyroid-stimulating hormone levels only at appropriate times.	FM Expert
GI	
Demonstrate the ability to diagnose and manage adult abdominal pain. Be able to distinguish between acute and chronic abdominal pain, generate a differential diagnosis and order appropriate investigations in a timely manner.	FM Expert
Appropriately investigate and manage a patient presenting with upper or lower gastrointestinal bleeding (non-life threatening).	FM Expert
Identify patients at high risk of GI bleed and modify treatment appropriately.	FM Expert
Recognize extra intestinal manifestations in a patient with a diagnosis of inflammatory bowel disease (IBD).	FM Expert
Include cardiac causes and other conditions as part of the differential diagnosis in patients presenting with dyspepsia and rule out serious conditions.	FM Expert
Diagnose and manage specific pathology commonly seen in primary care (e.g., gastroesophageal reflux disease, peptic ulcer disease, ulcerative colitis, Crohn's disease, diverticulitis, pancreatitis, irritable bowel syndrome, biliary disease).	FM Expert
Establish a diagnosis (e.g., infectious, malabsorption, immune, irritable bowel) and develop a management plan given a patient with acute or chronic diarrhea.	FM Expert
Have an approach to diagnosis in a patient with abnormal liver enzymes differentiating hepatocellular and obstructive.	FM Expert
In patients with Hepatitis B and C: be aware of treatment options, counsel regarding harm reduction, and monitor for complications. Screen for coexisting blood borne infectious diseases as appropriate.	FM Expert
Hematology	
Investigate the cause of low hemoglobin and classify the types of anemia, assess the risk of decompensation of anemic patients, determine the iron status and investigate the causes of iron deficiency if present.	FM Expert
In patients with macrocytic anemia consider the possibility of a vitamin B12 deficiency and look for other manifestations of the deficiency (e.g., neurologic symptoms).	FM Expert
Demonstrate some knowledge of common hematological malignancies (leukemia, lymphoma, myeloma) including the presenting symptoms, investigations, and basic management.	FM Expert
Be able to investigate and manage a patient presenting with a bleeding disorder or an acute coagulopathy (warfarin overdose, liver disease, sepsis, etc.).	FM Expert
ID	
Demonstrate an awareness of serious and common causes of fever. Investigate patients with fever of unknown origin appropriately and treat fever resulting from serious causes in a timely fashion (e.g., meningitis).	FM Expert
Recognize and triage serious infection (pyelonephritis, cellulitis, meningitis, osteomyelitis, sepsis, pneumonia) including antibiotic choice based on the patient's individual risk factors and a decision about hospital admission.	FM Expert
Use a selective approach in ordering cultures and make rational antibiotic choices in a timely fashion. In a febrile patient with a viral infection, do NOT prescribe antibiotics.	FM Expert
Recognize that infections in the elderly may present atypically.	FM Expert
Add HIV objectives	

MSK	
Use history and physical examination to rule out serious causes in a patient with low back or neck pain. Identify all red flag symptoms from history and physical that may indicate a serious cause.	FM Expert
Use conservative management for back and neck pain including exercise, lifestyle modifications, and pain medication when necessary.	FM Expert
Neurologic Disorders	
Diagnose stroke and differentiate, if possible, hemorrhagic from embolic/thrombotic stroke and assess patients presenting with neurological deficits in a timely fashion to determine eligibility for thrombolysis.	FM Expert
Involve the patient, the family, and other professionals as needed in decisions about intervention in patients with stroke. Evaluate the resources and support needed to improve function and include prevention of complications of stroke. Provide realistic prognostic advice.	FM Expert
Consider new objective on subacute/long term post stroke management	
Have an approach to diagnosis and management of the patient who presents with loss of consciousness, altered level of consciousness, or delirium, including recognition of reversible conditions (shock, hypoxia, hypoglycemia, drug overdose).	FM Expert
Differentiate delirium from dementia, drug intoxication/withdrawal, and psychotic disorders.	FM Expert
Distinguish between pre-syncope/syncope and vertigo in patients with dizziness, generate an appropriate differential diagnosis and rule out serious conditions, review medications, and investigate appropriately.	FM Expert
Differentiate different types of tremors, i.e., resting tremor, intention tremor.	FM Expert
Accurately distinguish between idiopathic and atypical Parkinson's disease, involve other health care professionals to enhance the patient's functional status, assess and anticipate side effects of anti-Parkinson medications, and look for other coexisting conditions.	FM Expert
Be able to recognize and appropriately investigate benign versus life-threatening causes of headaches (trauma, subarachnoid hemorrhage, meningitis).	FM Expert
Diagnose and manage the common causes of headaches (e.g., migraine, tension, cluster).	FM Expert
Ophthalmologic Disorders	
Distinguish serious from non-serious causes of a red eye always using a Snellen chart for visual acuity as well as fluorescein when necessary. Consider underlying systemic causes when the diagnosis is iritis	FM Expert
Distinguish allergic, viral, and bacterial conjunctivitis and provide pseudomonas coverage for those with bacterial conjunctivitis using contact lenses.	FM Expert
Diagnose and manage other common eye lesions such as hordeolum, chalazion, pterygium, pingueculum.	FM Expert
Renal/Urologic	
Have an approach to patients presenting with dysuria, identify high-risk patients (DM, underlying renal disease), and appropriately investigate for and manage UTI, STIs, prostatitis, vaginitis, etc.	FM Expert
Have an approach to acute renal failure, including identification of underlying cause. Understand management and monitoring of acute and chronic renal failure.	FM Expert
Understand presentation, investigations, and management (medical and surgical) of renal calculi.	FM Expert
Respirology	
Include asthma and COPD as part of the differential diagnosis in a patient with respiratory symptoms.	FM Expert

Objectively determine the severity of asthma or COPD (i.e., pulmonary function testing), and manage acute exacerbations appropriately including assessment for hospitalization.	FM Expert
Effectively use monitoring, pharmacotherapy and lifestyle change to manage COPD and asthma.	FM Expert
Generate a broad differential diagnosis for cough (i.e., GERD, asthma, rhinitis, presence of a foreign body, medications, malignancy, pertussis) in patients with an acute, persistent or recurrent cough.	FM Expert
Assess the patient with pneumonia with regard to: risks for unusual pathogens, underlying neoplasia, identification of the appropriate patient population for hospitalization, rational antibiotic choices and arranging contact tracing where appropriate.	FM Expert
Rheumatologic Disorders	
For patients presenting with joint pain, distinguish benign from serious pathology, using history and investigating appropriately.	FM Expert
In patients presenting with non-specific MSK complaints, consider the diagnosis of rheumatologic conditions, fibromyalgia, soft tissue injury and sources of referred pain.	FM Expert
Identify non-articular symptoms of rheumatic disease.	FM Expert
In patients experiencing musculoskeletal pain actively inquire about the impact of the pain, treat with appropriate analgesics, and consider aids and community resources.	FM Expert
Skin Disorders	
Distinguish benign from serious pathology (e.g., Melanoma, pemphigus, cutaneous T-cell lymphoma) by physical examination and appropriate investigations (e.g., Biopsy or excision).	FM Expert
Understand the cutaneous manifestations of systemic disease and be able to diagnose using history, physical and appropriate investigations.	FM Expert
Have an approach to diagnosis and management of other common primary care dermatologic problems such as eczema, acne, skin infections (viral, bacterial, fungal, parasitic), psoriasis, allergic/contact conditions, skin ulcers (vascular, pressure).	FM Expert
Undifferentiated and/or multiple	
Investigate and manage weakness appropriately, differentiating generalized and specific weakness and identifying neurologic and other causes.	FM Expert
When treating patients with disabilities, assess all spheres of function and offer a multifaceted approach to management as required (rehabilitation, community support, lifestyle modification).	FM Expert
In patients presenting with multiple medical problems take an appropriate history and prioritize to develop a mutually agreed agenda.	FM Expert
Develop a rational approach to investigation and management of fatigue.	FM Expert
Travel Medicine	
Advise a patient on appropriate immunizations prior to overseas travel	FM Expert
Make recommendations concerning malaria prophylaxis, and other health precautions including those around potable water and traveler's diarrhea	FM Expert
Demonstrate a basic clinical and epidemiological knowledge of diarrheal disease, HIV, malaria, and tuberculosis.	FM Expert
Demonstrate an approach to the management of fever in the returning traveler.	FM Expert
Men's Health	
Exhibit sensitivity in dealing with issues of sexual dysfunction. Ensure inclusiveness with regards to sexual orientation at all times but particularly when taking a sexual history.	FM Expert

Appropriately screen for, manage, and refer neoplastic disease of the male genital tract: penile, testicular, and prostate carcinoma	FM Expert
Appropriately recognize and manage reproductive tract infections and problems: urethritis, epididymitis, orchitis, prostatitis, BPH, penile anomalies, scrotal and testicular abnormalities, genital trauma, and erectile and ejaculatory dysfunctions.	FM Expert
Women's Health	
Be aware that many medical disorders manifest differently in women.	FM Expert
Be aware of the widespread and complex health effects of sexual abuse on women and resources available to assist affected women.	FM Expert
Be aware of effects on female patients regarding the public perception of women and body image.	FM Expert
Diagnose and manage menstrual disorders, and irregularities throughout the life cycle.	FM Expert
Diagnose and manage infection/inflammation of the reproductive tract and urinary tract, including STIs.	FM Expert
Diagnose and manage acute & chronic abdominal and pelvic pain, always considering pregnancy as a possible cause.	FM Expert
Diagnose and initiate management of endometriosis.	FM Expert
Diagnose and manage urinary incontinence & uterovaginal prolapse.	FM Expert
Screen for, detect and manage genital tract neoplasia.	FM Expert
Diagnose and undertake initial management of infertility.	FM Expert
Counsel a woman regarding normal physical and psychological changes to be expected at the menopause and options for management.	FM Expert
Counsel a woman with an unwanted pregnancy regarding the choices available to her.	FM Expert
Identify and counsel women with eating disorders.	FM Expert
Diagnose and manage breast lumps in women.	FM Expert
Counsel on recommendations and controversies in breast cancer screening using clinical examination, self-examinations, and imaging and genetic testing.	FM Expert
Refer and provide primary care follow-up for breast cancer patients.	FM Expert

CPA 13: Provide comprehensive primary care and continuity of care for older adults

DFM Program Objectives	CanMEDS-FM Role
Establish and maintain clinical knowledge, skills and attitudes required to meet the needs of elderly patients.	FM Expert
Discuss the aging process and the implications of the biological changes associated with aging, the concepts of successful aging and the importance of a comprehensive approach to care.	FM Expert
Focus on key determinants of health and their interrelationships in the elderly (e.g., biological, psychological, socioeconomic).	FM Expert
Differentiate between normal changes of aging and those changes that are pathological.	FM Expert
Describe the developmental challenges faced by the older person (e.g., dealing with loss, coping with chronic disease).	FM Expert
Demonstrate a functional approach to history taking and treatment planning.	FM Expert
Discuss the functional impact of illness in elderly patients including the fact that diagnoses often correlate poorly with function and functional impairment may be a first sign of illness.	FM Expert
Describe and be able to assess the concepts of Basic Activities of Daily Living (BADL's) and Instrumental Activities of Daily Living (IADL's).	FM Expert
Use functional assessment tools such as the Katz ADL Index and incorporate this information into a comprehensive geriatric assessment including: physical health, mental health (cognitive status, competency), socioeconomic status, environmental factors, level of care, and belief system.	FM Expert

Use functional rating scales in clinical situations.	FM Expert
Include an assessment of social support available to the elderly patient.	FM Expert
Obtain corroborative information where appropriate from families or caregivers.	FM Expert
Perform a comprehensive geriatric assessment that includes a comprehensive patient problem list, establishing diagnosis(es), identifying problem(s) associated with the diagnosis(es), and ranking of the impact and importance of each problem.	FM Expert
When performing a comprehensive geriatric assessment, be able to deal with multiple interacting problems.	FM Expert
When performing a comprehensive geriatric assessment, be able to identify the patient's perspective and establish realistic goals.	FM Expert
Recognize and describe the non-specific presentation of the disease in the elderly.	FM Expert
Demonstrate the ability to adapt their interviewing techniques to enable elderly people to understand and communicate with the resident.	FM Expert
Establish the expectations of the elderly person and reach common ground with regards to goals for management.	FM Expert
Help a patient establish and document their advance directives.	FM Expert
Describe the role and impact of the family or caregiver on the care of the elderly and be able to effectively recognize and manage problems that caregivers might encounter.	FM Expert
Describe the importance of corroborative information in providing effective care for elderly patients.	FM Expert
Discuss family dynamics (roles, conflict, role reversal) and their impact on the care provided to elderly patients.	FM Expert
Describe signs of caregiver stress and fully assess caregiver needs.	FM Expert
Manage and participate in family care conferences to see the value of information sharing, assessment of family supports, and the opportunity to provide education and comfort to families in need.	FM Expert
Discuss the major geriatric clinical problem areas: confusion or memory failure, falling or postural instability, reduced mobility, urinary incontinence, constipation and fecal incontinence, difficulties in activities of daily living.	FM Expert
Safely prescribe medications to elderly patients.	FM Expert
Understand pharmacodynamic and pharmacokinetic properties of commonly used medications in the elderly (e.g., antidepressants, beta blockers, oral hypoglycemics, NSAIDs, diuretics).	FM Expert
Develop safe approach to drug dosing in the elderly, including required adjustments in renal impairment.	FM Expert
Describe the importance of drug monitoring, as well as strategies for enhancing treatment adherence.	FM Expert
Understand the dangers of polypharmacy in the elderly and learn to effectively monitor for hazardous drug- drug interactions as well as adverse drug reactions.	FM Expert
Safely stop commonly used drugs, when appropriate, and monitor for signs of withdrawal (e.g., SSRIs, benzodiazepines).	FM Expert
Choose drugs within a class that offer the best balance between therapeutic benefit and adverse effects.	FM Expert
Use non-pharmacological alternatives to drug therapy in the elderly wherever appropriate.	FM Expert
Document over-the-counter drugs the patient may be using.	FM Expert
Recognize the potential for substance use disorder.	FM Expert
Undertake a Cognitive Assessment including: recognizing signs of declining cognitive function in elderly individuals and the use of cognitive assessment tools in appropriate situations and recognize their limitations in assessing cognition.	FM Expert
Undertake a capacity assessment.	FM Expert
Describe the fundamental aspects of a capacity assessment (e.g. capacity to make decisions about personal matters including housing, finances, medical treatment).	FM Expert

Describe the laws pertaining to competence and capacity (e.g., POA, Public Guardian and Trusteeship, the Mental Health Act).	FM Expert
Identify impaired and intact decision-making abilities as some may be retained in a given individual.	FM Expert
Demonstrate the ability to discuss advance care planning, including developing, revising and implementing advance directives with patients and families.	Communicator
Collaborate in the care of the elderly through incorporating contributions from inter-professional team members into a thorough functional assessment.	Collaborator
Recognize the role of the family physician as part of an inter-professional team in Long Term Care.	Collaborator

CPA 14: Provide palliative and end-of-life care

DFM Program Objectives	CanMEDS-FM Role
Establish and maintain clinical knowledge, skills and attitudes required in palliative care.	FM Expert
Assess and manage pain and symptoms effectively through history, appropriate physical exam, and relevant investigations.	FM Expert
Demonstrate knowledge of classification and neurophysiology of pain.	FM Expert
Prescribe opioids effectively including initiating dosage, titration, breakthrough dosing, prevention of side effects, monitoring, dose equivalency and opioid rotation.	FM Expert
Describe the clinical presentation of opioid neurotoxicity and be able to put a management plan in place to address the problem.	FM Expert
Prescribe adjuvant modalities and medications for pain and symptom relief.	FM Expert
Be aware of non-pharmacologic strategies for pain and symptom management.	FM Expert
Develop and implement management plans for other symptoms including: A) fatigue; B) anorexia and cachexia; C) constipation; D) dyspnea; E) nausea and vomiting; F) delirium; G) skin and mouth care; H) anxiety and depression.	FM Expert
Monitor the efficacy of symptom management plans.	FM Expert
Review and adjust management plans to accommodate the changes that may occur as the end-of-life approaches.	FM Expert
Describe a management plan for urgent/emergent problems in the palliative setting including spinal cord compression, hypercalcemia, superior vena cava syndrome and terminal agitation.	FM Expert
Distinguish between MAID, palliative sedation, withholding or withdrawing therapy in accordance with provincial/territorial/federal regulations and terminology.	FM Expert
Demonstrate an understanding of the personal, family, and social consequences of life-threatening illness.	FM Expert
When addressing end of life care, create an environment of cultural safety, demonstrating sensitivity to spiritual, religious, and cultural considerations, and to life context.	FM Expert
Demonstrate the ability to develop a management plan that appropriately balances disease-specific treatment and symptom management according to the individual needs of the patient and family.	FM Expert
Demonstrate the role of the family physician in assessing and managing grief in patients and families including normal and atypical grief.	FM Expert
Identify and assess spiritual issues in end-of-life care.	FM Expert
Develop skills in the unique challenges of communication in palliative care situations.	Communicator
Demonstrate the ability to provide supportive counselling and resources to those coping with loss.	Communicator
Demonstrate the ability to discuss advance care planning, including developing, revising and implementing advance directives with patients and families.	Communicator

CPA 15: Provide mental health and addiction care

DFM Program Objectives	CanMEDS-FM Role
Recognize and diagnose mental health problems commonly found in family practice including anxiety disorder), mood disorders, schizophrenia, personality disorders, post-traumatic stress disorder, phobic states, eating disorders, somatization disorders, chronic pain syndromes and substance use disorder.	FM Expert
Demonstrate familiarity with the DSM diagnostic criteria for these common disorders.	FM Expert
Demonstrate ability to appropriately screen for these disorders in high-risk groups.	FM Expert
Demonstrate ability to assess cognitive status with an appropriate instrument (MMSE or MOCA).	FM Expert
Take an appropriate history to generate differential diagnoses for symptoms, which also includes medical causes and contributors to rule out serious organic pathology.	FM Expert
Assess patient's suicide risk, homicide risk and judgment.	FM Expert
Identify comorbid psychiatric conditions.	FM Expert
Identify the functional impact of the symptoms to help guide and evaluate treatment.	FM Expert
Develop a management plan and provide appropriate follow up for mental health problems commonly found in family practice.	FM Expert
Offer appropriate treatment in a way that promotes full discussion of options and the patient's own decision-making.	FM Expert
Use a multidisciplinary approach to treatment and management and refer appropriately.	FM Expert
Use a multifaceted approach to treatment.	FM Expert
Include psychosocial support as part of the treatment plan.	FM Expert
Demonstrate knowledge of indications, side effect profile, common interactions, and monitoring requirements of psychopharmacological agents such as antidepressants, antianxiety medications, mood stabilizers, antipsychotics and other commonly used agents.	FM Expert
Demonstrate knowledge of different forms of therapy (including brief psychotherapy, couples and family therapy, behavior therapy, long-term psychotherapy) and the selection of patients for each modality.	FM Expert
Demonstrate ability to skillfully and appropriately counsel for behaviour change using techniques of motivational interviewing.	FM Expert
Monitor response to treatment using functional benchmarks, adjusting and augmenting as clinically indicated.	FM Expert
Diagnose and treat serious complications and side effects of medications.	FM Expert
Anticipate possible violent or aggressive behaviour and recognize the warning signs.	FM Expert
Develop a plan within your practice environment to deal with patients who are verbally or physically aggressive.	FM Expert
Develop a compassionate and effective approach to patients in crisis.	FM Expert
When caring for adolescents, review and counsel about substance use, peer issues, home environment, diet/eating disorders, academic performance, social stress/mental illness, and sexuality/STDs/contraception.	FM Expert
Demonstrate awareness of challenges associated with housing insecurity and the potential impact on mental health, substance use, and the ability to access routine medical and preventative care.	FM Expert
As part of routine preventative care, inquire about alcohol consumption and screen for use of other substances.	FM Expert
Develop the confidence and skills to manage difficult or emotionally intense situations or interactions.	Communicator
In a challenging patient encounter, look for and attempt to limit the impact of personal feelings [e.g., anger, frustration] and remain vigilant for new symptoms and physical findings to be sure they receive adequate attention.	Communicator
Demonstrate awareness of unique issues and responsibilities around prescribing controlled drugs.	Professional

Set clear boundaries with respect to appointment length, prescribing practices and accessibility.	Professional
Demonstrate awareness of obligations to report patients at risk of harm to themselves or others.	Professional

CPA 16: Perform medical procedures in all settings as per the Procedure Skills in Family Medicine

DFM Program Objectives	CanMEDS-FM Role
Plan and perform procedures and therapies for assessment and/or management.	FM Expert
Demonstrate the knowledge base required to effectively evaluate the indications for procedural and surgical procedures.	FM Expert
Demonstrate the ability to conduct a comprehensive pre-operative assessment and identify important peri-operative issues. This includes knowledge of testing required and indications for anaesthesia consultation.	FM Expert
Demonstrate awareness of the indications for and contraindications to each procedure.	FM Expert
Demonstrate the ability to mentally rehearse the landmarks, technical steps and potential complications of each procedure.	FM Expert
Demonstrate knowledge of normal postoperative healing and the ability to identify and manage post- operative complications, i.e., infection, wound dehiscence, keloid formation.	FM Expert
Demonstrate the ability to act effectively as a surgical assistant for major surgical procedure.	FM Expert
Technical objectives: DFM Procedure List	FM Expert

MATERNAL & NEWBORN CARE

CPA 17: Provide antenatal care

DFM Program Objectives	CanMEDS-FM Role
Conduct a first prenatal visit, discuss the rationale for all tests, explain routine prenatal visits.	FM Expert
Diagnose and manage complications of early pregnancy (1st trimester bleeding, spontaneous abortion, ectopic pregnancy, trophoblastic disease).	FM Expert
Screen all pregnant patients for intimate partner violence.	FM Expert
Conduct a prenatal visit in the first, second, and third trimester including maternal and fetal high-risk factors which influence prenatal morbidity and mortality.	FM Expert
Counsel a patient regarding indications for and timing of ultrasound.	FM Expert
Counsel a healthy patient who is planning a pregnancy.	FM Expert
Counsel patients with specific risks including: advanced age or with a family history of genetic abnormalities; VBAC; patients with specific medical diseases (diabetes, hypertension, multiple sclerosis, inflammatory bowel disease, etc.) during pregnancy; patients with complex obstetrical history i.e. (preterm labour, 2nd trimester pregnancy loss).	FM Expert
Ask the patient (and partner if applicable) open-ended questions about feelings, worries, and expectations at routine visits prenatally, intra-partum and post-partum.	FM Expert
Counsel a patient regarding expectations for labour and delivery: ambulation, different positions for delivery, early parent-infant contact.	FM Expert
Counsel a patient in the third trimester on the use of analgesia and anaesthesia in labour and effects on the patient and fetus.	FM Expert
Manage common pregnancy symptoms.	FM Expert
Counsel a patient regarding signs of labour.	FM Expert
Work collaboratively in different models of maternity care including team-based approaches.	Collaborator

CPA 18: Manage low-risk labour and delivery

DFM Program Objectives	CanMEDS-FM Role
Take a detailed history of a new patient presenting in labour.	FM Expert
Describe normal rate of progress in nulliparous and multiparous patients.	FM Expert
Describe indications for induction or augmentation of labour.	FM Expert

Describe indications, contraindications, and methods (external, scalp electrode, intrauterine pressure catheter) for continuous electronic fetal monitoring.	FM Expert
Manage a normal labour.	FM Expert
Counsel a patient regarding the potential for operative intervention such as forceps, caesarean section.	FM Expert
Demonstrate ability to interpret fetal heart rate patterns.	FM Expert
Describe the indications, risks, and prerequisites for low forceps, vacuum extraction.	FM Expert
Recognize and manage the adverse effects labour and delivery may have on full-term and preterm infants, i.e., asphyxia – (causes, prevention, detection, sequelae), trauma, drugs, especially analgesia and anaesthesia.	FM Expert
Judge uterine size in early pregnancy - differentiate 8, 10, 12-week size uterus.	FM Expert
Assess fetal presentation.	FM Expert
Auscultate fetal heart.	FM Expert
Diagnose small-for-dates, large-for-dates.	FM Expert
Recognize 3rd and 4th degree tears.	FM Expert
Recognize indications for episiotomy and understand how episiotomy is performed and repaired.	FM Expert
Describe the identification and management principles of shoulder dystocia.	FM Expert
Describe how to identify and manage cord prolapse and unexpected breech.	FM Expert
Describe how to identify and manage important complications of the third stage such as retained placenta, postpartum hemorrhage, and uterine inversion.	FM Expert
Understand how to recognize uterine rupture in VBAC.	FM Expert
Identify a neonate in need of resuscitation and describe the principles and procedures for neonatal resuscitation.	FM Expert
Perform core and recommended procedures related to management of low-risk labour and delivery as per the technical objectives detailed in the Dalhousie FM procedures list (CPA 16).	FM Expert
Work collaboratively in different models of maternity care including team-based approaches.	Collaborator

CPA 19: Provide postpartum care

DFM Program Objectives	CanMEDS-FM Role
Inform patients about common emotional experiences during and after pregnancy, such as body image, sexuality, ambivalent feelings about pregnancy and baby, fear of abnormalities, “baby blues,” intense attachment to baby, etc.	FM Expert
Discuss infant feeding with an evidence-based approach that incorporates patient and family preferences and appropriate interpretation and application of available data.	FM Expert
Counsel a breastfeeding patient regarding initiation of breast feeding.	FM Expert
Diagnose and manage common breastfeeding problems (i.e., sore nipples, engorgement, “not enough milk”, difficulties latching on).	FM Expert
Discuss circumcision.	FM Expert
Perform a 6-week postpartum exam.	FM Expert
Diagnose and manage endometritis, subinvolution, infected episiotomy.	FM Expert
Counsel a patient post C-section (e.g., activity, resuming intercourse, etc).	FM Expert

CPA 20: Provide newborn care in the hospital and community

DFM Program Objectives	CanMEDS-FM Role
Independently examine a newborn and recognize variants of normal.	FM Expert
Provide normal newborn care.	FM Expert
Describe current neonatal screening programs.	FM Expert
Recognize congenital anomalies and abnormalities, such as Down’s Syndrome.	FM Expert

Diagnose and manage common neonatal diseases and conditions: jaundice, sepsis, murmurs, hypoglycemia, respiratory distress, orthopedic abnormalities, IUGR.	FM Expert
Manage the issues surrounding the care of newborns of patients with medical/non-medical conditions (i.e., diabetes, substance use disorder, auto-immune diseases, medication use, social issues, AIDS, etc.).	FM Expert
Describe the nutritional needs and normal growth pattern in the first weeks following birth for premature and full-term infants.	FM Expert

EMERGENCY CARE

CPA 21: Manage all patients presenting to the emergency department

DFM Program Objectives	CanMEDS-FM Role
Recognize and appropriately manage acute, urgent and emergent presentations.	FM Expert
Recognize and appropriately manage anaphylaxis.	FM Expert
Appropriately manage acute presentations of chest pain.	FM Expert
Recognize and manage the acutely ill, new or diagnosed diabetic patient and manage appropriately, including management of hypoglycemia, DKA, and hyperglycemia.	FM Expert
Recognize and manage potentially life-threatening upper respiratory presentations such as epiglottitis and retropharyngeal abscess.	FM Expert
Appropriately manage epistaxis.	FM Expert
Appropriately manage the poisoned patient including recognition of important toxidromes.	FM Expert
Appropriately investigate and manage the febrile patient.	FM Expert
Appropriately assess, manage and, if necessary, refer patients presenting with potential fractures, lacerations, bite wounds and burns.	FM Expert
Appropriately assess, stabilize, manage, and refer patients presenting with multiple or complicated trauma.	FM Expert
Appropriately assess, manage, and disposition patients with acute abdominal pain and GI bleed.	FM Expert
Demonstrate knowledge of appropriate first line management of common infections.	FM Expert
Demonstrate appropriate investigation and management of dehydration and electrolyte disturbances.	FM Expert
Demonstrate appropriate investigation and management of delirium and loss of consciousness.	FM Expert
Demonstrate appropriate assessment and management of new-onset headache.	FM Expert
Demonstrate appropriate assessment, stabilization, investigation and management of an acute seizure episode.	FM Expert
Demonstrate appropriate recognition, assessment, management and referral of ophthalmologic emergencies such as acute visual loss, trauma, etc.	FM Expert
Develop a comprehensive approach to Domestic Violence.	FM Expert

CPA 22: Manage all patients presenting with emergent and urgent conditions in the office, home, and other community settings

CPA 23: Contribute to community-level emergency preparedness and response

DFM Program Objectives	CanMEDS-FM Role
Contribute generalist abilities to address complex, unmet patient or community needs and emerging health issues, demonstrating community-adaptive expertise.	FM Expert
Act as a resource to their community, assess and respond to the needs of the community by advocating with them as active partners for system-level change in a socially accountable manner.	Health Advocate

HOME & LONG TERM CARE

CPA 24: Provide primary care for patients with complex medical needs in their homes, long-term care facilities, and other community-based settings

DFM Program Objectives	CanMEDS-FM Role
Be aware of the unique medical needs of different underserviced and vulnerable groups in Canada, including indigenous populations, inner-city/unhoused populations, and Persons with Developmental Disabilities (PWDD).	FM Expert
Demonstrate knowledge of the unique health and social challenges faced by PWDD.	FM Expert
Manage and participate in family care conferences to see the value of information sharing, assessment of family supports, and the opportunity to provide education and comfort to families in need.	FM Expert
Help a patient establish and document their advance directives.	FM Expert
Engage patients and their families in developing plans that reflect the patient's health care needs, values and goals.	Communicator
Collaborate in the care of vulnerable and underserviced populations by working with other professionals, including cultural interpreters and translators, legal aid workers, CAS workers, social workers, and members of other community support groups.	Collaborator
Demonstrate awareness of obligations to report situations of abuse or neglect concerning children, the elderly and other vulnerable populations.	Professional

HOSPITAL CARE

CPA 25: Provide medical care in the hospital as the most responsible physician

DFM Program Objectives	CanMEDS-FM Role
Establish a plan for ongoing care and timely consultation when appropriate.	FM Expert
Share health care information and plans with patients and their families.	Communicator
Develop a common understanding of issues, problems and plans with patients and their families in order to develop, provide and follow-up on a shared plan of care.	Communicator
Document and share written and electronic information about the medical encounter to optimize clinical decision making, patient safety, confidentiality and privacy.	Communicator
Work effectively with others in a collaborative team-based model for patient care.	Collaborator
Recognize and facilitate necessary transitions in care with other colleagues in the health professions, including but not limited to shared care, transfer of care and/or handover of care to enable continuity and safety.	Collaborator

CPA 26: Provide surgical assistance in the operating room

DFM Program Objectives	CanMEDS-FM Role
Demonstrate the ability to act effectively as a surgical assistant for major surgical procedure.	FM Expert

ADVOCACY

CPA 27: Work with individual patients to secure their social and health care needs

DFM Program Objectives	CanMEDS-FM Role
Perform a patient centred clinical assessment and establish a management plan.	FM Expert
Develop a compassionate and effective approach to patient requests for Medical Assistance in Dying (MAID).	FM Expert
Understand the current ethical, legal and regulatory environment concerning MAID.	FM Expert
Understand and acknowledge the patient's request in the context of their experience of suffering and within the continuity of a palliative approach to end-of-life care.	FM Expert
Perform an appropriate assessment of issues which may compromise patient capacity.	FM Expert
Provide compassionate, non-judgmental support in their decision process.	FM Expert
When indicated, appropriately provide (or refer for provision) MAID according to accepted protocols.	FM Expert

Elicit and synthesize accurate and relevant information from, and perspectives of, patients and their families.	Communicator
Respond to an individual patient's health needs by advocating with the patient within and beyond the clinical environment.	Health Advocate
Recognize the role of Social Determinants of Health in the health of their patients and advocate with them as active partners for system-level change in a socially accountable manner.	Health Advocate
Identify patients who are vulnerable or marginalized and assist them in issues (e.g., housing, mobility, nutrition, access to financial resources etc.) that promote their health.	Health Advocate
Identify patients at risk because of social, family or other health situations; work appropriately with protective services when indicated.	Health Advocate

CPA 28: Speak up and take action to improve health equity, access to care, and the factors that affect health and safety at the practice or community level

DFM Program Objectives	CanMEDS-FM Role
Engage in stewardship of health care resources.	Leader
Contribute to the improvement of comprehensive, continuity-based, and patient-centred health care delivered in teams, organizations and systems.	Leader
Act as a resource to their community, assess and respond to the needs of the community by advocating with them as active partners for system-level change in a socially accountable manner.	Health Advocate
Demonstrate awareness of community resources to help patients in the community.	Health Advocate
Learn principles and strategies for effective advocacy.	Health Advocate
Become aware of important societal and geopolitical trends which will affect their patients' health such as climate change, global patterns of migration, economic globalization and patterns of income redistribution within Canada.	Health Advocate
Demonstrate a commitment to society by recognizing and responding to societal needs in health care.	Professional

HEALTH LEADERSHIP

CPA 29: Develop self to provide leadership in everyday practice

DFM Program Objectives	CanMEDS-FM Role
Explore leadership roles and the skills required for these roles.	Leader
Participate in activities that contribute to the effectiveness of their own program, primary practice, healthcare organizations and systems.	Leader
Participate in program, healthcare organization and/or community committees.	Leader
Demonstrate a commitment to physician health and well-being.	Professional
Demonstrate self-awareness and self-care while caring for their patients.	Professional
Display a commitment to personal health and balance between personal life and professional responsibilities.	Professional
Demonstrate a commitment to reflective practice.	Professional
Demonstrate a recognition of their own strengths and limitations and when to ask for help.	Professional
Demonstrate a mindful approach to practice by maintaining composure and equanimity, even in difficult situations, and by engaging in thoughtful dialogue about values and motives.	Professional
Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation.	Professional
Demonstrate appreciation of their own roles and responsibilities in decision making as well as those of patients, and respectfully discuss and manage value differences and conflicts.	Professional

CPA 30: Engage others in working toward practice-and/or system-level goals

DFM Program Objectives	CanMEDS-FM Role
Actively facilitate continuous quality improvement for health care and patient safety, both individually and as part of a team.	FM Expert
Establish an inclusive and culturally safe practice environment.	FM Expert
Demonstrate collaborative leadership in professional practice to enhance health care.	Leader
Contribute to the improvement of comprehensive, continuity-based, and patient-centred health care delivered in teams, organizations and systems.	Leader
Contribute to the activities of professional associations locally, provincially and nationally.	Professional

CPA 31: Assess, maintain, and enhance knowledge and skills to provide care that is evidence-informed and adapts to practice and community needs

DFM Program Objectives	CanMEDS-FM Role
Engage in the continuous enhancement of their professional activities through ongoing learning.	Scholar
Develop evidence-based practices for the medical care of their patients.	Scholar
Maintain and enhance their professional activities through ongoing self-directed learning based on reflective practice.	Scholar
Integrate best available evidence into practice considering context, epidemiology of disease, comorbidity, and the complexity of patients.	Scholar
Critically evaluate medical evidence and apply this evidence in the care of their patients.	Scholar
Develop skill at efficiently answering point of care questions using a variety of evidence-based strategies.	Scholar

CPA 32: Participate in quality improvement activities as part of practice improvement

DFM Program Objectives	CanMEDS-FM Role
Actively facilitate continuous quality improvement for health care and patient safety, both individually and as part of a team.	FM Expert
Engage in stewardship of health care resources.	Leader
Participate in and conduct quality improvement activities.	Scholar

CPA 33: Participate in research activities as part of advancing the discipline of family medicine

DFM Program Objectives	CanMEDS-FM Role
Contribute to the creation and dissemination of knowledge relevant to family medicine.	Scholar
Complete a research project and present it to their colleagues and department.	Scholar

CPA 34: Teach and supervise learners in everyday practice as a clinical coach

DFM Program Objectives	CanMEDS-FM Role
Teach students, residents, the public, and other health care professionals.	Scholar

Dalhousie Family Medicine Mandatory Academic Curriculum Topics 2025-2026

Abdominal Pain: Office Approach	Hypertension
Abnormal Uterine Bleeding	Indigenous Health
Abortion Care	Infertility
ADHD	Ischemic Heart Disease
Adolescent Health	LGBTQ+ Health
Allergies/Anaphylaxis	Low Back Pain
Anemia & Lower GI Bleed	Lifestyle Medicine
Antimicrobial Stewardship	MAID
Anxiety	Menopause
Arrhythmia/Atrial Fibrillation	Migrant Health
Arthritis: OA/RA/Gout	Newborn Care (1st 28 days)
Asthma	Obesity
Boundary Issues	Occupational Medicine
Breastfeeding & Feeding of Infants	Opioid Prescribing & Chronic Non-Cancer Pain
Capacity Assessment & Consent	Osteoporosis
Cerebrovascular Disease	Personality Disorders
Complex Chronic Conditions	Poisoning
Congestive Heart Failure	Population Health
Concussion	Poverty
Contraception	Preventative Health Screening & Assessment
COPD	Prostate Disease
Dementia	Quality Improvement/Patient Safety
Depression	Red Eye
Developmental Disabilities	Seizure Disorders
Diabetes	Sexually Transmitted Infections
Diarrhea & Inflammatory Bowel Disease	Skin Disorders
Dizziness	Substance Use Disorder
Domestic Violence	Syncope
Dyspepsia, GERD, Upper GI Bleed	Thyroid Disease
Ethics	Trauma & Persistent Trauma Related Disorders
Evidence Based Medicine	Ulcers and Wound Care
First Trimester Pregnancy Care	Vaginitis
Frailty	Venous Thromboembolism
Headache	

Sites may offer additional academic curriculum from the CFPC's 105 Priority topics (or other identified learning needs) to supplement clinical learning.

PROCEDURES

The CFPC has developed a list of core procedures for the practice of family medicine. This list was last updated in 2005. While awaiting an updated list, Dalhousie Family Medicine has reviewed this list and developed an internal list of program procedures.

Some procedures are considered by our procedures working group and site leads to be central to the practice of Comprehensive Family Medicine.

Residents ***should demonstrate competency in these Core Procedures***. If a site does not have access to clinical learning opportunities during which residents may develop these skills, simulated teaching approaches should be employed to ensure competencies.

Competencies may be evaluated in simulated settings when clinical experiences are not available. Residents are encouraged to request field notes from faculty outside of Family Medicine, when applicable, to document competency.

Residents should keep a log of these core skills as well as documenting competencies. When possible, residents should complete a procedural field note.

1. Core Procedural Skills

(Residents must demonstrate competency in clinical or simulated/workshop setting.

Competencies should be documented in field notes and ITARs. These procedures should also be documented in the procedures log on One45.

Skin Based Procedures:
Local anaesthetic infiltration and digital block
Abscess incision and drainage
Insertion of sutures--simple interrupted, vertical mattress, horizontal mattress and subcuticular
Laceration repair (suture and tissue adhesive)
Punch biopsy
Excisional biopsy
Cryotherapy of skin lesions (e.g., seborrheic keratoses, common and plantar warts)

Drainage paronychia:
Intradermal injection
Intramuscular injection
Subcutaneous injection
Wound debridement

Eye, Ear, Nose and Throat Procedural Skills
Instillation of fluorescein
Removal of cerumen

Gastrointestinal and Genitourinary Procedural Skills
Pap smear
Placement of transurethral catheter

Musculoskeletal Procedural Skills
Splinting of injured extremities
Reduction of minor dislocations/subluxations i.e. pulled elbow, finger dislocations
Corticosteroid injection of trochanteric bursa
Aspiration and injection knee joint
Aspiration and injection of the shoulder joint and subacromial bursa

Application of simple casts*:*
Forearm cast
Scaphoid cast
Ulnar gutter splint
Below knee walking cast

Resuscitative Procedural Skills
Intradermal, IV, IM and SC injections Venipuncture
Oral airway insertion
Bag-valve-mask ventilation
Cardiac defibrillation

Maternal and Newborn Care Procedural Skills
Skillfully perform a normal vaginal delivery
Repair second degree perineal tears
Recognize 3rd and 4th degree tears
Perform a neonatal resuscitation, including bagging, insertion of ET tube (insertion of umbilical vein catheter is optional)

2. Recommended Procedural Skills

(Residents are encouraged to seek out learning opportunities and exposure to these skills. Skills should be documented in their procedures logs, but they are NOT required to demonstrate competency in these skills). Residents are expected to complete 75% (i.e. 20 total) of these procedures:

Skin based procedures:
Shave biopsy
Excision of cystic and solid lesions i.e. epidermoid cysts and lipomas
Removal of foreign body
Surgical management of ingrown toenail
Pare skin callous
Skin scraping for fungus determination
Removal foreign body skin (fish hook, splinter, glass)
Release subungual hematoma

Eye, Ear, Nose and Throat Procedural Skills:
Removal of foreign body from nose or ear
Cautery for anterior epistaxis
Anterior nasal packing

Gastrointestinal and Genitourinary Procedural Skills
Cryotherapy or chemical therapy of genital warts
Insertion and removal of an intrauterine device
Endometrial aspiration/biopsy

Musculoskeletal Procedural Skills
Corticosteroid injection for epicondylitis
Trigger point injection

Resuscitative Procedural Skills
Peripheral intravenous line; adult and child
IO access
Nasogastric tube insertion

Maternal and Newborn Care Procedural Skills
Do ARM (artificial rupture of membrane)
Apply scalp electrode
Manage shoulder dystocia
Manage cord prolapsed, unexpected breech
Manage important complications of the third stage such as retained placenta and postpartum hemorrhage, uterine inversion
Recognize uterine rupture in TOLAC
Assist at a caesarean section

3. Optional Procedural Skills

(these procedures are relevant to the practice of comprehensive Family Medicine, however, clinical rotations and core teaching may not be available during the 2-year residency time frame). Residents are encouraged to seek out learning opportunities and exposure to these skills. Skills should be documented in their procedures logs, but they are ***NOT*** required to ***demonstrate competency*** in these skills).

Anoscopy

Arterial Line

Aspirate Breast Cyst

Central Line insertion

Chest Tube insertion

Corticosteroid injection for Plantar Fasciitis

Delivery: Use a vacuum extractor or low forceps for failure to progress in the second Stage

Diaphragm fitting and insertion

Electrocautery of skin lesion

Endotracheal Intubation

Incision and drainage of a thrombosed external hemorrhoid

Lumbar puncture

Measurement of intraocular pressure

Nasopharyngoscopy

Paracentesis

Point of Care Ultrasound

Reduce Dislocated shoulder

Removal of corneal or conjunctival foreign body

Slit lamp examination

Suprapubic catheter insertion

Thoracentesis

Use of Wood's lamp

PORTFOLIOS

Evidence shows that reflection on clinical experience improves and deepens learning. We use the Periodic Review to aid in this reflection. This process includes much of the data that would be in a portfolio. The Periodic Review involves resident reflection on their own, and with the Site Director or designate, to develop individualized learning plans. Evidence shows that guided self-reflection is best at promoting growth. Residents may also choose to construct their own individualized learning portfolios. With this in mind, residents are encouraged to consider documenting their learning throughout the residency. Help and guidance are available for residents who are constructing a portfolio. Some of the portfolio can be documented through One45.

Examples of items that could be included in a portfolio:

Procedures completed
Conferences attended
Seminars presented – with evaluations Clinical questions that have been researched
Chronic problems managed, deliveries completed, pregnant women followed
Learning plans, Benchmarking assessments
Self, peer, or observer assessments
Letters from patients
Worksheets, checklists, or logbooks of agreed upon activities, notes from meetings between the resident and their teachers, samples of work demonstrating clinical competence
Evidence of self-assessment and self-reflection
Narratives describing personal experience and critical incidents
Copies of summative evaluations.

QUALITY IMPROVEMENT PROJECT GUIDELINES

Each resident will undergo a quality improvement project. This purpose of this exercise is to apply the skills necessary to lead and guide a quality improvement initiative. You and your preceptor will identify an issue relevant to the practice for which a quality improvement initiative can be implemented. You will use QI tools to understand the root causes of the problem, make and implement an improvement plan, track data over time, and assess the impact.

The total expected time spent on this activity is 10-15h. You will be provided with a workshop to learn the QI process and tools, then use these tools to design and implement a project. Finally, you will share your findings with local residents and preceptors for group learning. The timeline for each site is individualized and will be provided to you by your site QI lead.

Tips to consider:

- Work with your preceptor and site QI Coordinator(s), starting early. This project should be something your preceptor identifies as beneficial.
- Select a relevant and achievable project. Choose something manageable and measurable. Individual or group projects are acceptable.
    - Ideas: Choosing Wisely, screening (BPs, Paps…), vaccinations, chronic disease care, finishing on time, evening paperwork, handover, Equality Diversity and Inclusion, environmental impact (paper in office, electricity consumption, medications + climate impact, Green Office Toolkit…), billing, resident feedback (Field notes frequency, time, specificity…) ……
    - Ideas to be cautious of as can be too large or unachievable: appointment availability, urgency availability, ER visits, no shows, refill requests…
    - Beware of flag fatigue: if flag is chosen, importance to preceptor is imperative.
- Work with office staff and other members of the health care team. Remember: those who touch the work should be involved in the improvement.
- You can join QI projects in progress or adopt new interventions to prior ones.
- Be sure to check in with your QI Project Coordinator(s) throughout your project and reach out if you have any questions along the way.
- QI Projects will be assessed according to the Quality Improvement Project Assessment Rubric.

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

Resident: _____

Date: _____

Quality Improvement Project Assessment

Residents are all expected to complete a project in Quality Improvement. This must include an analysis of the problem they wish to address, consideration of multiple interventions, then implementation of a chosen intervention through a full Plan, Do, Study, Act cycle. This cumulates in the sharing of their analysis, intervention, findings, and most importantly reflections for group learning with peers. Please assess the resident's QI project in the following four components:

Aim Statement: *("What are you trying to accomplish?")*

- Addresses an identified need or deficit
- Focuses on system change
- Uses SMART (Specific, Measurable, Achievable, Relevant, Timely) Goals
- Provides defined direction of change, amount, and time

☐ Meets ☐ Partially Meets ☐ Does Not Meet

Indicators: *("How can you measure the impact of your change?"*)

- Maintains relevance to the Aim
- Uses readily available data
- Captures key processes or outcomes
- Uses one Outcome Indicator plus one of either Balancing or Process Indicators

☐ Meets ☐ Partially Meets ☐ Does Not Meet

Change: *("What change is most do-able and likely to achieve your Aim?")*

- Uses 2+ of 3 root cause tools (Fishbone, 5 Whys, Process Map)
- Uses 1+ of 3 achievability tools (Force Field, Feasibility, Engagement)
- Links directly to Aim
- Places emphasis on existing resources
- Is sufficiently defined to initiate a test of change

☐ Meets ☐ Partially Meets ☐ Does Not Meet

Study and Act: *("What did you learn by implementing your change?")*

- Collects relevant data over an adequate observation period
- Uses appropriate analysis for data and project, with limitations understood
- Shares project for group learning in a constructive manner

☐ Meets ☐ Partially Meets ☐ Does Not Meet

Comments: (must provide comments if *Does Not Meet* or *Partially Meets* any of the above):

ASSESSMENT, EVALUATION and FEEDBACK

To ensure that residents are meeting curricular and program objectives, assessment of resident performance is conducted at regular intervals. The two main types of assessment are *formative* (providing timely feedback to help residents gauge their performance and take corrective action as necessary) and *summative* (ascertaining whether residents have met the stated objectives). Most assessment in the Dalhousie Family Medicine program is formative in nature.

Much formative feedback is delivered verbally during Clinical Learning Experiences (CLE). However, to help guide learning it is beneficial to document this feedback. In Family Medicine programs across the country, the documentation of this type of feedback typically occurs using 'field notes.' These daily feedback forms, be on paper or in electronic form, simply capture the output of the process of feedback that occurs between preceptor and resident.

Collected field notes help provide evidence of competence that is used to inform the program of your progress. Data collected on field notes is often used to back up statements of performance on your In-Training Assessment Reports (ITARs) that are completed for each of your rotations.

The remainder of this section summarizes the components of assessment and evaluation and is divided into the following:

- Assessment Tools and Tasks
- Policy on the Assessment Process
- Template for In-Training Assessment Process
- Easy to Follow Instructions for Using Field Notes
- Field Note Sample
- Characteristics of a Good Field Note
- Procedural Skills Field Note
- Clinical Feedback Form
- Quality Improvement Project Assessment Form
- Resident Feedback - Patient Feedback Form
- In-Training Assessment Report (ITAR) for Family Medicine
    - Professionalism
    - Selectivity
    - Clinical Reasoning
    - Patient-Centered Approach
    - Procedure Skills
    - Communication Skills
    - Overall Progress to Date
- Benchmarking
- Periodic Review Worksheets
    - Part A: Resident Reflection
    - Part B: Administrative
    - Part C: Program

If you have any questions about evaluation and assessment during residency, feel free to contact your site Assessment & Evaluation Coordinator or the Chair of the Assessment & Evaluation Sub-Committee, Dr. Keith Wilson (kwwilson@dal.ca).

Assessment Tools and Tasks

As mentioned above, much of your assessment in Family Medicine residency is formative in nature. However, in following a Programmatic Assessment model, formative/low-stakes assessments collectively are used to determine competence in learning objectives. The main components of the Dalhousie Family Medicine's assessment model include Field Notes, In-Training Assessment Reports (ITARs), Benchmarking, Periodic Review and Competence Committee. Briefly these concepts are outlined here, and further information can be found later in this document. Additionally, the Program's In-Training Assessment Processes table listed below summarizes the various assessment tasks and responsibilities.

Field Notes

Feedback and assessments are essential to your education. Feedback is most effective when it occurs immediately after an encounter, and with coaching. We suggest that you and your preceptor complete **a minimum of three field notes for each week of clinical experience**. This will give you a wealth of information on how to practice effectively and will encourage reflection and deeper learning on your part. However, it is most important to remember that the field note is simply **documentation of a process that is already taking place**: the feedback itself is the most important part.

Across the programme, during your core Family Medicine rotations and regularly at Integrated Sites, you will be primarily using electronic field notes. You will be provided login information to the "Narrly" field note system at your site. With this system, you will be able to track your progress and monitor for adequate sampling. Additionally, both you and your preceptor/supervisor can initiate field notes. More information on completing field notes is outlined below in this document. The Narrly electronic field note system has been expanded to allow field notes to be generated by residents and reviewed by off-service preceptors. We encourage you to use the electronic system where possible as it makes it easier for you to keep track of your progress and sampling across competencies.

Procedural Field Notes

These field notes are more detailed as they capture the numerous steps involved in doing procedures (for example, obtaining consent, follow-up). As discussed under the section on Procedures above, you are encouraged to complete a procedural field note when you are doing procedures. The procedural field note can be found further in this document.

Clinical Feedback Form

In some instances, you may be instructed to use the Clinical Feedback Form instead of field notes. This form allows for documentation of resident reflection on each case that was seen during a day and what was learned from it. It is formative/low-stakes in nature. These forms are typically used for clinical experiences that are of short duration (i.e., one or two days per month) including rotating clinics that are infrequent. The form is located later in this document for your reference.

Resident Feedback by Patient Form

Communication is vital to the physician-patient relationship. In addition to observations of your communication skills by your preceptor, you will be collecting feedback from patients that you encounter. The form you will be using is included later in this document.

In-Training Assessment Reports

Your preceptors will use observation and documentation from Field Notes to summarize your progress in the Skill Dimensions as outlined by the College of Family Physicians of Canada. A final/summative Family Medicine ITAR is shown later in this document.

Benchmarking

As part of the assessment of your overall progress, there are several key areas that may not fully capture your competence development using Field Notes. The Family Medicine Benchmarks are a way of capturing these concepts with

expectations leading to independent/unsupervised practice by the end of your residency programme. You will meet with your primary preceptor or designate twice annually (or more as necessary) to gauge your progress in the benchmarks using self-reflection and discussion. This is a formative exercise and is outlined in more detail later in this document. You will note in the information provided later in this document that there is a section on Expected Timelines related to the benchmarks.

Periodic Review

The Periodic Review is an opportunity for you to self-reflect on your progress thus far and to think about your own learning objectives going forward. This happens at least twice per year and requires self-reflection coupled with guidance from your Site Director, Assessment & Evaluation Coordinator or designate at your site. The outcome of this process is a co-created learning plan. The documents that are used to guide this process are included below for reference.

Competence Committee

To determine whether you are ready to progress to the next level of your residency, all of your assessment data is reviewed at least two times per year by your site's Competence Committee. The committee's goal is to ensure that all residents achieve the requirements of the Program, leading to successful completion of your residency. The Competence Committee allows for an informed decision-making process that looks at triangulating your assessment data to ascertain your progression towards competence. This approach ensures support for resident learning over time. The committee reports to the Residency Program Committee Executive and Postgraduate Medical Education (PGME) regularly. Additionally, if a Competence Committee identifies that a resident is not ready to progress to the next level of training, the Residency Program Committee Executive formulates decisions around the need for a Formal Enhanced Learning Plan to help the resident achieve the desired competencies.

Policy on the Assessment Process

The purpose of the assessment system in Family Medicine at Dalhousie University is to support residents in their learning and document their development of competence for entry into the independent practice of Family Medicine.

Requirements for Program Completion:

1. **Clinical Learning Experience (CLE) Assessment**

   For a resident to successfully complete the program and have their name submitted to the College of Family Physicians of Canada (CFPC) all the following documentation must be in order:
   - An In Training Assessment Report (ITAR) for each clinical learning experience (CLE) successfully completed.
     - In our integrated sites a Family Medicine an ITAR is completed at least four times in year 1 and three in year 2. These ITARs are to be supported by field notes from core family medicine preceptors and the consultant preceptors that provide longitudinal CLEs for the residents at these sites.
   - Evaluation of Service (EOS), Learner Assessment of Family Medicine Preceptor as well as Resident Assessment of Consultant Faculty for all CLEs.
   - The resident must demonstrate and document appropriate progress towards competence to enter unsupervised practice. This progress will be assessed by a detailed periodic review (held at least twice annually) at a meeting between the resident and the site director (or site directors' designate). Field notes will be a key component of this process as they provide written documentation of performance in the clinical environment.
   - Documentation that the resident is deemed ready for promotion by the Site Competence Committee.

2. **Non-Clinical Assessment Requirements**

   For a resident to successfully complete the program and have their name submitted to the College of Family Physicians of Canada (CFPC) they must also meet the following criteria:
   - Resident project must be completed, marked as acceptable and presented to peers and faculty

- Quality Improvement Project successful completion
- Completion of RAPPERs (Residents As Professional Peer Educators) module

(For the complete Policy on the Assessment Process see One45 Handouts and Links)

You will receive email notifications for all clinical learning experience assessments (mid-term, final and half-day back)

To log onto the electronic evaluation system, follow these steps:

- Go to: **www.med.dal.ca**
- Click on: One45 Web Eval (left side menu)
- You will receive an e-mail with your username and password and instructions on how to access the system once an evaluation has been sent out for you.

Evaluation of Service and Evaluation of Preceptor
According to University regulations your feedback on the Service and on your preceptor is mandatory for each Clinical Learning Experience (CLE) you complete. You will receive a notice and forms electronically through One45. We require **both** an evaluation of service and an evaluation of the supervisor(s).

Template for in-training assessment process

Dalhousie Family Medicine's In-Training Assessment Processes			
ITA Tasks/Steps	**Description**	**Learner Roles**	**Faculty/Staff Roles**
Observe, document, and provide feedback during daily clinical activities (Formative)	• Field notes (including procedural skills field notes) • Clinical Feedback Forms • Patient feedback forms	The learner will: • seek opportunities to be observed • seek feedback • participate in a process of reflective learning with documentation	Assessors in partnership with residents: • seek opportunities to observe performances • provide feedback • participate in reflection of the resident's clinical practice with documentation
Collect and organize documentation within a framework	• Resident portfolio (file) – a collection of evidence about performance, including field notes, ITARs and other performance assessments	The learners will organize documented observations according to: • learner's needs • objectives • program requirements	• Administrative staff compile and organize the resident's file with all relevant data for review minimum three times annually with the Site Director or designate (Periodic Review). • For paper field notes, one copy of the field note is retained by faculty for use in completing ITARs and after given to Site administrative staff for placement on the permanent file. • Electronic Field Notes are compiled through Narrly
Periodically review and reflect on progress based on all documents available	• Periodic Review • Benchmarking	In order to systematically develop competence in comprehensive full scope family medicine, the resident will: • use the CFPC Assessment Objectives to seek guidance for their self-assessment. • also participate in a process of guided self-assessment with the use of reflection during the periodic review process with their site director, program director or designate. • review and discuss benchmarking with their primary preceptor to assess their level of independence at least two times annually prior to their periodic review.	The assessor will: • Be familiar with the competency requirements (CFPC Assessment Objectives) with which they are required to assess the learner. • Site Director, Enhanced Skills Program Director or designate will review progress towards competence with the resident providing feedback and discussion with reflection to determine if the curriculum or learning plans require modification (at least two times annually). • Primary preceptor will review benchmarks with the resident to assess their level of independence (at least two times annually).

ITA Tasks/Steps	Description	Learner Roles	Faculty/Staff Roles
Adjust and adapt learning activities	• Identifying resources, modify curriculum, Identify target goals • Modifying/customizing assessment (formative and summative if needed) • Determine frequency and/or type of guided review given modifications in training	Become actively involved in implementing the adapted learning experiences needed to achieve the competencies required for their future practice. Collaborate with faculty: • to identify personal goals for development and/or remediation • to identify needed resources • to modify the curriculum • to customize the assessment	Primary Preceptor and/or the Site Director and/or the Program Director works with the resident to establish target goals. They will identify appropriate resources with the needed modification of the curriculum. As appropriate, the formative and summative assessments may be customized.
Update learning plans	• Plan who takes action and what is required for the next phase of training. • Discussion with the resident to clarify plan for daily activity and roles of clinical supervisors	Actively participates in developing the learning plan Review competencies necessary for their future practice to co-develop an appropriate series of learning plans with their preceptor throughout their residency by periodically reflecting on their: • learning needs • future career plans • personal objectives • community needs	• Primary Preceptor meets with the resident minimum two times annually to review their progress specific to Family Medicine and establishes their learning objectives with a co-developed learning plan. • The Site Director and/or designate meets with the resident minimum two times annually to review their overall progress and establishes their learning objectives with a co-developed learning plan.
Report	• Progress report to appropriate administrators • Documentation for accreditation or certification requirements	• Take ownership with reporting of the learning plan through discussion and documentation for implementation with appropriate faculty • Establish and document the necessary learning experiences to achieve the required competencies	The Primary Preceptor and/or the Site Director or their designate ensures: • both the resident and faculty have responded to the learning needs with appropriate documentation • progress reports are placed in resident's file by administrators • The Resident file will be a permanent record for review The Program Director reports to CCFP that resident is ready to sit the exam and when training is completed.

Easy to follow instructions for using field notes

This section explains the rationale for field notes as a method of assessment, instructions for completing a field note and provides a sample field note.

What the process should deliver:

- During daily clinical work, encourage the gathering and documentation of case-specific comments and feedback with reflection and coaching from preceptors to residents.
- Consistency across the program, with properly documented feedback to stimulate improvement in competence:
  - based on performance through a wide spectrum of skills
  - linked to the CFPC Evaluation Objectives (key features and observable behaviours)
- A guide to teachers and learners, with evidence that competence is developing by:
  - helping inform ITARs, periodic reports, performance reviews, and resident's portfolio
  - acting as an aide memoire for periodic discussions on resident progress

On the selected clinical sessions:

- Observe an encounter, part of an encounter, or simply discuss the case with the resident as close to the time of the encounter as possible (preferably the same day).
- It is very important that both the preceptor and the resident are engaged in the discussion reflecting on the clinical situation. This requires face-to-face dialogue, with input from both parties during completion. Often it is helpful to have the resident do some (or all) of the writing of the field note, noting the demographic information, the problem/situation discussed, and the feedback given. This facilitates guided self-reflection.
- Indicate on the note if there has been direct observation. We encourage residents and faculty to use direct observation wherever possible as it can elicit more meaningful, directed feedback.
- Use the "Guide to the CFPC Evaluation Objectives" found on the field note pad to choose **one** phase of the encounter and **one** competency of **one** skill to be discussed. This encourages specific feedback to reinforce the take home message. You may want to consider using the Priority Topics and Key Features as an area of focus. You can read more about these in the Assessment Objectives for Certification in Family Medicine on the CFPC website (https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf). Priority Topics and Key Features begin on page 57. Please note that Key Features are not an exhaustive list of what a resident should know, rather they are areas that are at times missed – this makes for a good area for assessment.
- The responsibility to initiate the discussion should be shared between faculty and resident.
- If completing a procedure, it is recommended to use the Procedural Skills Field Note (see later in this document).

Important Background Information

Click here to go to the CFPC's Assessment Objectives for Certification in Family Medicine

Or go to www.cfpc.ca and look under "Home > Exams, Education & CPD > Educational Frameworks and Reference Guides > Assessment Objectives for Certification in Family Medicine" for the Assessment Objectives for Certification in Family Medicine and other tools.

Feedback: To Be Shared, Specific and Focused

- Ensure the resident starts the discussion with their impressions.
- Together develop positive statements **"continue"** with shared **"suggestions for improvement"**.
- Common reflection is an important part of the process and facilitates deeper learning.
- On selected occasions explore with the resident the pertinent Key Feature or Observable Behaviour from the CFPC Evaluation Objectives.
- Reinforce the take home message/**coaching point**. It is recommended to stick with one pertinent and actionable point.

Mid and End of Clinical Learning Experience

- Ensure direct observations/discussions have covered a variety of phases, skills and topics.
- Review your copies of the field notes and electronic field notes prior to assessment discussions and ITAR completion with the resident. If you have copies of field notes, return them to the site administrator for storage in your resident file.
- The resident keeps the other copy for their file/portfolio to be used in discussion with their primary preceptor and/or Site Director for the ongoing demonstration of their progress towards competency.

Examples of Completed Field Notes:

Phase: History; **Skill Dimension:** Communication; **Competency:** Non-Verbal; **Domain:** Office/Care of Adults
Continue: Resident: "As we discussed the last time, I maintained good eye contact."
Suggestions for improvement: Preceptor: "I noticed you appeared to invade her personal space. If you try to stand back a little further, it may improve your patient's comfort."
Follow up: Preceptor: "Perhaps we could video you this afternoon so you could see for yourself."

Problem: Ectopic Pregnancy; **Phase:** Investigation; **Skill Dimension:** Selectivity; **Competency:** Establishes Priorities; **Domain:** Emergency/Women's Health Care
Continue: Resident: "I identified the GYN/OBS history and the possibility of an ectopic pregnancy." Preceptor: "Well done! It was great you used the key features for abdominal pain to help with this."
Suggestions for improvement: Preceptor: "Perhaps the next step is to understand the urgency for immediate further investigation and treatment and how to arrange for that in our community."
Follow up: Preceptor: "Tomorrow morning after rounds lets discuss how to best use the ER and X-ray in urgent situations."

Problem: Multiple Medical Problems; **Phase:** Management & Treatment; **Skill Dimension:** Clinical Reasoning; **Competency:** Set Goals/ Objectives; **Domain:** Office/Care of the Elderly
Continue: Resident: "I dealt with most of the problems she presented to me getting her flow sheets for diabetes and hypertension done."

Suggestions for improvement: Preceptor: "Thanks for going back when I noticed your description about her frequent falls was more limited than some of the notes on other less critical problems. With a patient like this I try to identify all the presenting problems early then put aside the less important today to deal properly with the more critical."

Follow up: Preceptor: "I think the Key Features on Multiple Medical Problems may help, please review them for discussion with me tomorrow morning."

Field note sample

Guide To The CFPC Evaluation Objectives
Phases Of The Clinical Encounter

A - History	D - Physical	G - Hypothesis
B - Diagnosis	E - Procedure	H - Investigation
C - Referral	F - Follow-Up	I - Management & Treatment

Selectivity
1. Appropriately Focused
2. Appropriately Thorough
3. Establishes Priorities
4. Urgent vs. Non-Urgent

Clinical Reasoning
5. Hypotheses / Diff. Dx
6. Gather Data **(Hx & Px)**
7. Interpret Data
8. Make Decisions
9. Set Goals/Objectives

Professionalism
10. Responsible/Reliable/ Trustworthy
11. Knows Limits
12. Flexible / Resourceful
13. Evokes Confidence
14. Caring / Compassionate
15. Respect/Boundaries/ Availability
16. Collegial
17. Ethical / Honest
18. Evidence Influence
19. Community Responsive
20. Good Balance
21. Mindful Approach

Patient Centered Approach
22. Explores Disease and Illness (**F**eelings, **I**deas, **F**unction & **E**xpectations)
23. Whole Person/Context
24. Common Ground
25. Builds Relationship
26. Health Promotion / Prevention
27. Being Realistic

Procedure Skills
28. Decision to Act
29. Informed Consent & Preparation
30. During Procedure (Comfort/Safety)
31. Technical Skills
32. If Problems: Reevaluate
33. After Care / Follow-Up

Communication with both Colleagues and Patients
34. Listening Skills

Language Skills
- 35. Verbal
- 36. Written
- 37. Charting

Non-Verbal Skills
- 38. Expressive
- 39. Receptive

40. Culture and Age Appropriateness
41. Attitudinal

Domains of Care	
Location of Care	**Lifecycle**
a. Office	g. Palliative Care
b. Emergency	h. Men's Health Care
c. Hospital	i. Women's Health Care
d. Home	j. Care of Adults
e. Long Term Care	k. Care of the Elderly
f. Community	l. Care of Children and Adolescents
	m. Maternal and Newborn Care

Field Note

Dalhousie University – Department of Family Medicine

Date: _____ Learner: _____

Supervisor: _____ Directly Observed Yes☐ No☐

Problem/Procedure: _____

Phase: _____

Skill: _____ Competency : _____

Domains: _____

Continue:

Suggestions for Improvement:

Follow Up: _____

Learner's Initials _____ Supervisor's Initials _____

Characteristics of a good field note

Purposes of a Field Note:

a. For the Learner: support further development
b. For the Clinical and Academic Coach: provide evidence to support assessment, judgement around competency development and a prescription for future growth
c. For the Program: document the learners' path to support program summative decisions concerning program extension, enrichment, completion, or termination

Principles:

a. Field Notes do not replace feedback*, they only document it.
b. In general terms, there are parts of clinical encounters that require thinking/problem solving (higher order skills**) beyond basic knowledge. Focusing on these areas better supports competency development and assessments.
c. Not all Field Notes require direct observation of the patient encounter, but all Field Notes do require direct involvement and reflective discussion with the resident. Think broadly for sources of feedback and Field Notes… i.e., a Field Note could be based on their clinical reasoning following a discussion and/or chart review, witnessing their collaboration with AHC, professional behaviours, leadership skills, etc. Having said this, we encourage as much direct observation as possible as it leads to more actionable feedback.
d. Competency-based assessment requires looking for patterns of performance and trajectory. If there is a previously identified area needing improvement, follow-up on this is essential to ensure that improvement/ growth has occurred.
e. Field Notes alone are not sufficient to ascertain competence. They must be part of an assessment system that collates, summarizes and interprets the data to make decisions. As such they should cover a broad range of identified desired competencies, pick up on past performance to follow trajectory and be numerous enough to provide a high- resolution picture of competency. To this end, the Dalhousie Family Medicine approach to assessment requires adequate sampling and co-developed learning plans in general.

Characteristics of a Good Field Note:

f. Has a date (for trajectory)
g. Identifies a topic and a competency
h. Is behaviourally specific and uses clear unambiguous language
i. Is detailed enough to paint a picture of the performance being commented on
j. Is focused on the individual (not a comparator to others)
k. Is focused on a manageable amount of information
l. Is focused on higher order skills
m. Includes an application of the assessment standards***
n. Has a judgement about the performance
o. Identifies things to continue doing, things for further growth
p. Promotes reflection

* The characteristics of good feedback include:

a. Ensuring the discussion is timely (at least the same day)
b. Ensuring it is frequent (at least daily)
c. Being specific and commenting on behaviours, not intentions or personal attributes
d. Having reflective discussions that focus on challenging/discerning case characteristics
e. Stimulating learning through making a judgement and documenting and discussing pertinent coaching points with each case
f. Focusing on one take-home message each for the behaviours to continue and the behaviours to modify
g. Making judgements based on standards, not comparators to others
h. Using the CFPC Evaluation Objectives to help identify key messages

** Higher Order Skills: Consider focusing on:

a. History vs Physical Exam
b. Diagnosis vs Treatment (although higher order skills could go into treatment decisions if the focus is on patient centeredness and/or acuity rather than just knowledge)
c. Data gathering vs Data interpretation

*** Assessment Objectives for Certification in Family Medicine (https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf)

Procedural Skills Field Note

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

Resident: _____ PGY: ☐ 1 ☐ 2 ☐ 3 **Supervisor:** _____

Setting: ☐ Outpatient ☐ Inpatient ☐ ER ☐ Patient's Home ☐ Other: _____ **Date:** _____

1. Procedural Skills Competencies

		Not Applicable	Close supervision	Distant supervision	In-dependent
Pre-Procedure	1. Correctly identified need for procedure				
	2. Describes procedure and possible outcomes				
	3. Obtains consent				
	4. Describes potential complications				
	5. Recognizes personal limitations				
Intra-Procedure	6. Adapts the procedure to the specific patient				
	7. Describes the technical approach to be used				
	8. Prepares for the procedure				
	9. Ensures patient comfort and safety always				
	10. Keeps patient informed to reduce anxiety				
	11. Responds to the unexpected				
Procedure	12. Uses proper technique (specify procedure)				
Post-Procedure	13. Provided post-procedure advice and plans				
	14. Documents properly				

2. Type of Observation ☐ Discussion only *(not directly observed)* ☐ Direct observation ☐ Complete procedure observed

3. Resident/Supervisor Comments

What has been done well/What could be done differently:

4. Overall Performance ☐ Close Supervision ☐ Distant Supervision ☐ Independent

5. Suggest a plan for next steps *(toward attainment of competence)*

6. Sign-Off

Supervisor: _____ Resident: _____ ☐ Flagged

Modelled after University of Ottawa Procedural Field Note. Version: 2023-1

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

Dalhousie University Clinical Feedback Form

Resident Name: _____ **Date:** _____

Patient Lifecycle: _____

Presenting Complaint: _____

Resident's Learning Objective (Pre): One specific learning objective achieved on shift.	**Resident's Learning Experience (Post):** 1. Area for focus and further development 2. Plan to achieve development goal

Essential Skill Dimension Competence

□ Selectivity □ Clinical Reasoning □ Professionalism □ Patient Centered Approach
□ Procedure Skills □ Communication with Colleagues □ Communication with Patients

Competency: _____ **(see over under skill dimension).**

Reflective Discussion with Preceptor:

What went well? (Competencies Demonstrated)

Suggestions for development. (Coaching Points)
Competency in this case: □ **Independent** □ **Distant Supervision** □ **Close Supervision**

Preceptor's Signature: _____ **Resident's signature:** _____

Preceptor Name (Print): _____

Essential Skill Dimension Competence Features Guide

Selectivity
- Appropriately Focused
- Appropriately Thorough
- Establishes Priorities
- Urgent vs. Non-Urgent

Clinical Reasoning
- Hypotheses/Diff. Dx
- Gather Data (Hx & Pt)
- Interpret Data
- Make Decisions
- Set Goals/Objectives

Professionalism
- Responsible/Reliable/Trustworthy
- Knows limits
- Flexible/Resourceful
- Evokes/Confidence
- Caring/Compassionate
- Respect/Boundaries/Availability
- Collegial
- Ethical/Honest
- Evidence Influence
- Community Responsive
- Good Balance
- Mindful Approach

Patient Centered Approach
- Explores Disease and Illness (Feelings, Ideas, Function & Expectations)
- Whole Person/Context
- Common Ground
- Builds Relationship
- Health Promotion/Prevention
- Being Realistic

Procedure Skills
- Decision to Act
- Informed Consent & Preparation
- During Procedure (Comfort/Safety)
- Technical Skills
- If Problems: Re-Evaluate
- After Care/Follow-Up

Communication with both Colleagues and Patients
- Listening Skills
- Language Skills
  - Verbal
  - Written
  - Charting
- Non-Verbal Skills
  - Expressive
  - Receptive
- Culture and Age Appropriateness
- Attitudinal

Patient Lifecycles
- Palliative Care
- Men's Health Care
- Women's Health Care
- Care of Adults
- Care of the Elderly
- Care of Children and Adolescents
- Maternal and Newborn Care

Competency
- **Close Supervision:** Still needs direct oversight
- **Distant Supervision:** Still may need some support/advice
- **Independent:** Is able to manage without supervision/is practice ready

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

Resident Feedback - Patient Form

Thank you for taking the time to complete this resident feedback form. Feedback is an essential part of the learning process for residents and feedback is valued from a variety of sources including the patients they care for. Communication with patients is a very important part of quality medical care. We would like to know how you feel about the way your resident communicated with you. Your answers are completely confidential, so please be as open and honest as you can. Thank you very much.

Resident Name: _____ **Date (dd/mm/yy):** _____

1	2	3	4	5
Poor	**Fair**	**Good**	**Very Good**	**Excellent**

Please use this scale to rate the way the resident communicated with you.
Circle your answer for each item below.

	The Resident:	**Poor**				**Excellent**
1	Greeted me in a way that made me feel comfortable	1	2	3	4	5
2	Treated me with respect	1	2	3	4	5
3	Showed interest in my ideas about my health	1	2	3	4	5
4	Understood my main health concerns	1	2	3	4	5
5	Paid attention to me (looked at me, listened carefully)	1	2	3	4	5
6	Let me talk without interruptions	1	2	3	4	5
7	Gave me as much information as I wanted	1	2	3	4	5
8	Talked in terms I could understand	1	2	3	4	5
9	Checked to be sure I understood everything	1	2	3	4	5
10	Encouraged me to ask questions	1	2	3	4	5
11	Involved me in decisions as much as I wanted	1	2	3	4	5
12	Discussed next steps, including any follow-up plans	1	2	3	4	5
13	Showed care and concern	1	2	3	4	5
14	Spent the right amount of time with me	1	2	3	4	5

Please identify one way that the resident communicated very well with you:
Please recommend at least one way this resident could improve his/her interactions with patients:

Dalhousie University Fam Med Postgrad	Evaluated By: evaluator's name Evaluating : person (role) or moment's name (if applicable) Dates : start date to end date	

* indicates a mandatory response

Final
In-Training Assessment Report (ITAR) for Family Medicine

The purpose of this in-training assessment report is to provide clear documentation of the resident's progress towards competence in the six essential family medicine skills. Each skill is defined. Please add specific comments about resident performance to outline where the resident has achieved competence, where they are progressing satisfactorily, areas to focus on for future development and any concerns. Please provide examples from field notes that support your narrative.

In order to document satisfactory progress, all six skill dimensions should be assessed in a **sampling** of the following content of comprehensive family medicine.

PGY1 - with readily available supervision **PGY2 - independently with back up**

Care of Children
- Newborn care
- Evidence-based health promotion and prevention from infant to child
- Acute illness in infants
- Acute illness in school-age children
- Chronic illness

Care of Adolescents
- Evidence-based health promotion and prevention
- Issues around sexuality and reproductive health
- Assessment of substance use/abuse
- Social problems
- Psychological/psychiatric problems
- Suicide risk
- Chronic illness (e.g., diabetes, asthma, IBD)

Care of Adults
- Evidence-based health promotion and prevention
- Chronic disease care (e.g., diabetes, CVD, arthritis, COPD etc)
- Complex patients with multiple diseases
- Benign self-limited illnesses
- Undifferentiated problems
- Acute serious illness in ambulatory setting
- Acute illness needing urgent care or hospitalization
- Care of hospitalized patients
- Behavioral Medicine
- Life stages and transitions
- Cancer care
- Palliative care
- Care of Women including Maternity Care
- Care of Men
- Emergency Medicine
- Care of Underserved populations
- Care of the Elderly

Uncommon but serious and treatable conditions (red flags)

Therapeutics

Procedure Skills

In order to be competent for the independent practice of Family Medicine, the resident should demonstrate the ability to practice in all of the above areas at the completion of residency training.

Professionalism

Definition
Professionalism means reliability, trustworthiness, respect and responsibility to patients, to colleagues, to oneself, to the profession, and to society at large; it deals with honesty, ethical issues, lifelong learning and the maintenance of the quality of care. Important attitudinal aspects such as caring and compassion fall under professionalism. It includes knowing and expanding one's limits of competence, dealing with uncertainty in a clinically appropriate and patient-centered manner and the ability to evoke confidence without arrogance. Professionalism implies attention to boundaries, commitment to patient well-being, respect for patients' culture and values (e.g. appropriate personal appearance) and willingness to assess one's own performance. It includes a commitment to reflective practice, evidence-based medicine and learning from colleagues and patients as well as a commitment to personal health and seeking balance between personal life and professional responsibilities. The ability to behave professionally and collegially in difficult situations is essential. Professionalism means doing the right thing even when no-one else may ever know.

Click here to view the CFPC themes with their observable behaviours for Professionalism.

*Describe aspects of competence achieved in PROFESSIONALISM and developing competence including examples from field notes

*Describe areas for focus and further development in PROFESSIONALISM including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

Selectivity

Definition

Residents who demonstrate selectivity are able to set priorities, focus on what is most important and avoid a routine or stereotypical approach (such as a medical student might use). They are selective and adapt to the situation and the patient. They gather the most useful information without losing time on less contributory data however they will explore a problem in detail when needed. They can distinguish urgent and non-urgent conditions and act appropriately for each.

Click here to view the CFPC priority topics and key features.

Click here to view the CFPC description for Selectivity.

*Describe aspects of competence achieved in SELECTIVITY and developing competence including examples from field notes

*Describe areas for focus and further development in SELECTIVITY including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

Clinical Reasoning

Definition

Residents who demonstrate good clinical reasoning gather **the right information at the right time and interpret and synthesize** the information systematically. They consistently consider common and red flag conditions and organize their thinking to come to a reasonable problem list with short and long term management plans. They make appropriate decisions and set appropriate goals.

Click here to view the CFPC priority topics and key features.

Click here to view the CFPC description for Clinical Reasoning.

*Describe aspects of competence achieved in CLINICAL REASONING and developing competence including examples from field notes

*Describe areas for focus and further development in CLINICAL REASONING including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

Patient-Centered Approach

Definition
Residents who are patient centred demonstrate exploration of both the disease and the patient's personal experience of illness (e.g. FIFE). They show an active interest in their patients and over time are able to describe important details of their lives. They work to enhance the relationship and gather day to day contextual information that will help guide them in making appropriate decisions with their patients. They work with their patients to come to agreement on the problems, the priorities, the goals and approach to management. They regularly address prevention and health promotion in clinical encounters. They manage time and resources effectively.

Click here to view the CFPC themes with their observable behaviours for Patient-Centred Approach.

*Describe aspects of competence achieved in PATIENT CENTERED APPROACH and developing competence including examples from field notes

*Describe areas for focus and further development in PATIENT CENTERED APPROACH including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

Procedure Skills

Definition
Residents who have an effective approach to procedures can decide if it is appropriate for **them** to do **this** procedure on **this** patient on **this** day. They prepare thoroughly for the procedure including patient consent. They attend to the patient's comfort and safety throughout the procedure. If difficulties arise they demonstrate the ability to reevaluate and stop or seek assistance. They organize appropriate after care and follow up.
They demonstrate appropriate technical skills.

Click here to view the CFPC general key features for Procedure Skills and a list of the core procedures.

*Describe aspects of competence achieved in PROCEDURE SKILLS and developing competence including examples from field notes

*Describe areas for focus and further development in PROCEDURE SKILLS including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

Communication Skills

With members of the health care team (colleagues)

Definition
Residents who communicate well with colleagues take enough time and demonstrate the ability to listen so they truly understand their colleague's point of view. They are able to communicate accurately and clearly, both verbally (face to face, over the phone, etc.) and in writing (e.g. chart notes, consult letters, orders, prescriptions etc.).They display effective non-verbal skills including attention to their own body language, responding to body language of a colleague, tone of voice, etc. They demonstrate respect for the opinions, values and ideas of their colleagues.

Click here to view the CFPC themes with their observable behaviours for Effective Communication with Colleagues.

*Describe aspects of competence achieved in COMMUNICATION SKILLS with colleagues and developing competence including examples from field notes

*Describe areas for focus and further development in COMMUNICATION SKILLS including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

Communication Skills

With patients

Definition
Residents who communicate well with patients demonstrate the ability to listen so that they truly understand the patient's needs. They are able to communicate clearly both verbally and in writing (e.g. letters, instructions). They display effective non-verbal skills including attention to their own body language, responding to the body language of a patient, use of silence, etc. Their communication is appropriate to the culture and age of the patient. They demonstrate a respectful, caring and compassionate attitude.

Click here to view the CFPC themes with their observable behaviours for Effective Communication with Patients.

*Describe aspects of competence achieved in COMMUNICATION SKILLS with patients and developing competence including examples from field notes

*Describe areas for focus and further development in COMMUNICATION SKILLS including examples from field notes

	Significant concerns about progress - site level or program level remediation plan required. May need program support	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

OVERALL PROGRESS TO DATE

	Significant concerns about progress - site level or program level remediation plan required (must be brought to Residency Training Committee Executive meeting for discussion).	Some concerns about progress. A plan has been established between the resident and the preceptor and will be implemented and assessed through ongoing clinical exposure	Progress as expected. No concerns.
*Rate:	○	○	○

For the CFPC Evaluation Objectives, with the observable behaviours of Professionalism and Communication Skills and priority topics with their key features please see One45 Handouts and Links

Please download this onto your desktop for use in clinical teaching.

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

Benchmarks for Family Medicine Residents

for academic year 2025-2026

Department of Family Medicine
1465 Brenton Street, Suite 402
Halifax, NS B3J 3T4

family.medicine.dal.ca

Benchmarks for Family Medicine Residents

Introduction & Background

Graduates of Dalhousie's Family Medicine programme should have the skills necessary to work in any undifferentiated family medicine practice. To this end, the Dalhousie approach to curricular design and assessment revolves around competency based medical education (CBME). The College of Family Physicians of Canada (CFPC) with its Triple-C curriculum utilizes a number of objectives to delineate the domain of competence. Currently Dalhousie Family Medicine uses data gathered from field notes and in-training assessment reports (ITARs) to determine success in a particular rotation. Periodic review, conducted twice per year, serves as a way to ensure the resident is meeting the overarching objectives of the programme and has a co-created learning plan.

A number of family medicine programmes across Canada have undertaken initiatives aimed to help residents benchmark their progress through their residency programme in light of local and national goals and objectives. Dalhousie has undertaken a similar approach using the Skill Dimensions framework. Residents, during their periodic reviews or at times designated by their Site, will be assessed using the benchmarks below to ascertain progress towards independent practice.

Each item is grouped by the Skill Dimensions. Residents are assessed on a scale from 1 to 5 delineating a range from needing close supervision to independent. It is expected that residents in the Dalhousie Family Medicine training programme will attain all benchmarks at the independent level by the time of completion of their residency training.

Residents and preceptors will assess attainment of benchmarks individually twice per year. However, this data will then be collated, and differences will be highlighted as a source of possible discussion. The purpose is to help inform an individualized learning plan, either as part of a rotation or more longitudinally at the bi-annual review.

		Close Supervision	Distant Supervision	Independent
SELECTIVITY	1. Sets appropriate priorities during patient encounters	Does not prioritize patient problems during encounter. Focuses on physician agenda for appointment.	With appropriate coaching, can set priorities during patient encounters. Needs ongoing coaching to reach a balance between patient and physician priorities.	Actively balances patient and physician priorities, reaching common ground in shared decision-making.
	2. Performs an appropriate, focused physical examination	Performs a physical examination in a thorough but stereotypical fashion; is unfocused, or sometimes not reproducible, may use incorrect or inappropriate technique. Does not interact with the patients during the examination.	Performs a thorough but relatively focused and reproducible physical examination. Common examination techniques performed correctly. Interacts with the patient during the examination.	Performs a focused and reliable physical examination, including specialized examination techniques when relevant. Comfortably interacts with the patient during the examination.
	3. Distinguishes the sick from the not sick	Fails to recognize serious urgent/ emergent conditions encountered in family medicine.	With appropriate coaching, recognizes and manages common urgent/ emergent conditions.	Spontaneously anticipates, recognizes & appropriately manages common urgent / emergent conditions
	4. Selects investigations and modifies treatment to fit patient need	Chooses inappropriate or generic/stereotyped investigations and treatments rather than tailoring them to patient's situation.	For common primary care complaints, identifies, with appropriate coaching, investigations and treatments tailored to the patient's situation.	For common primary care complaints, spontaneously identifies investigations and treatments tailored to the patient's situation.

		Close Supervision	Distant Supervision	Independent
CLINICAL REASONING	1. Practices generalist medicine	Shows little understanding in the breadth of family practice. Rarely incorporates health promotion and disease prevention in patient visits. Fails to recognize the complexity of medical practice.	With some coaching, practices full-scope family medicine including trying to promote health and disease prevention in patient visits.	Practices cradle-to-grave medicine through the spectrum of health promotion and disease prevention, recognizing the complexity, uncertainty, and ambiguity inherent in medical practice.
	2. Performs patient-centered clinical assessments	Assesses patients in an exhaustive but stereotyped way. May seem disorganized or unfocused, and may incompletely assess the problems. Misses key features. Does not adjust to cues arising during the interview. Performs physical examination lacking focus and reproducibility. May use incorrect or inappropriate technique. Interacts poorly with the patients during the examination.	Performs more or less focused patient assessment, defines problem well, but spends excessive time assessing less relevant information. Performs a thorough but relatively focused and reproducible physical examination. Common examination techniques performed correctly. Interacts with the patient during the examination.	Selectively adjusts patient assessment by focusing on relevant information. Performs a focused and reliable physical examination, including specialized examination techniques when relevant. Comfortably interacts with the patient during the examination.
	3. Establishes management plans	Management plans often lack detail and can be unfocused or disorganized. Unable to prioritize urgent issues in management plans.	With coaching, able to develop a comprehensive management plan and prioritize urgent issues.	Develops organized and comprehensive management plans for all clinicial situations. Prioritizes urgent issues first in management plans.
	4. Manages uncertainty	Shows a marked insecurity when facing uncertainty, or does not recognize a situation in which he/she should feel uncertain.	Manages clinical problems in a context of uncertainty mainly by consulting preceptors.	Manages clinical problems in a context of uncertainty not only by consulting preceptors, but also consulting other appropriate sources of information such as colleagues and by encouraging shared decision making with the patient.
	5. Uses appropriate clinical judgment	Makes clinical decisions where the proposed diagnosis and management are inconsistent with the symptoms and signs of the patient. Does not prioritize assessment or management in light of the urgency of a clinical situation.	With appropriate coaching, makes logical decisions linking the identified clinical signs and symptoms, the diagnosis and the proposed management. With supervisor's help, prioritizes work-up or management in light of the urgency of a clinical situation.	Makes logical decisions linking the identified clinical signs and symptoms, the diagnosis and the proposed management. Spontaneously prioritizes work-up or management in light of the urgency of a clinical situation.

	6. Has an evidence-informed practice	Rarely considers available evidence in the use of diagnostic and therapeutic tools.	With appropriate coaching, considers available evidence in the use of diagnostic and therapeutic tools. Tends to directly apply conclusions from critical appraisal without ensuring applicability to the patient on an individual basis.	Spontaneously considers available evidence in the use of diagnostic and therapeutic tools. Adjusts conclusions from critical appraisal to ensure applicability to the patient on an individual basis.
	7. Engages in the stewardship of health care resources	Minimally considers the consequences of his/her investigations / management decisions and associated costs for the health system.	With appropriate coaching, generally considers the consequences of his/her work-up / management decisions and associated costs for the health system.	Spontaneously considers the consequences of his/her work-up / management decisions and associated costs for the health system.

		Close Supervision	Distant Supervision	Independent
PROFESSIONALISM	1. Demonstrates a commitment to patients through clinical excellence and high ethical standards	Explains little or does not explain the benefits and risks of proposed interventions and the consequences of not intervening; reveals personal information against the expressed will of the patient or speaks of patients in public environment; does not respect patient decisions and autonomy.	Stereotypically explains the benefits and risks of proposed interventions and the consequences of not intervening; respects patient privacy, respects patient autonomy in their decision making.	Explains in a manner appropriate to the patient the benefits and risks of proposed interventions and the consequences of not intervening to allow a free and informed decision; respects the privacy of patients; respects and promotes patient autonomy in their decision making. Manages conflicts of interest and maintains professional boundaries.
	2. Demonstrates a commitment to society by recognizing and responding to societal needs in health care	Does not recognize their role in the context of society at large. Shows little insight into the recognition of societal needs. Does not consider patients' social context within encounters. Does not respond to societal needs when identified.	Recognizes their role in the context of society at large. At times considers patients' social context within encounters. With appropriate coaching, can come up with a plan to respond to identified societal needs.	Demonstrates accountability to patients and society by regularly considering elements of the patients' social context within encounters. Is able to identify societal needs independently and respond appropriately.
	3. Demonstrates a commitment to the profession by adhering to standards and participating in physician-led regulation	Demonstrates a lack of knowledge of codes of conduct and laws regarding the profession. Shows little insight into unprofessional and unethical behaviours of physicians and other practitioners and/or does not stay up to date with physician regulation documentation.	With appropriate coaching, recognizes the need for codes of conduct and recognizes unprofessional/unethical behaviours in physicians and other practitioners. Stays up to date with physician regulation documentation.	Adheres to professional ethical codes of conduct and laws governing practice resulting in a culture of respect and collegiality. Responds to unprofessional and unethical behaviours in physicians and other practitioners. Stays up to date with physician regulation documentation.
	4. Demonstrates a commitment to physician health and well-being to foster optimal patient care	Presents difficulty in prioritizing various professional obligations when facing multiple requirements. Takes too much or not enough time to meet his/her personal needs. When a conflict between professional and personal activities is brought to his/her attention, does not take it into account nor adjust accordingly.	With appropriate coaching, prioritizes various professional obligations when facing multiple requirements. Usually protects a suitable time to meet his/her personal needs. When a conflict between professional and personal activities is brought to his/her attention, discusses it on demand and adjusts accordingly.	Spontaneously prioritizes various professional obligations when facing multiple requirements. Protects a suitable time to meet his/her personal needs. When a conflict between professional and personal activities is brought to his/her attention, spontaneously discusses it and adjusts accordingly.

	5. Demonstrates a commitment to reflective practice	Does not recognize the factors that could have an impact on consultations. Does not take time to reflect on events and actions in clinical practice.	Recognizes the factors that could have an impact on consultations, but does not consider the implications for patient or self. With coaching, reflects on the events occurring in his/her practice, especially critical incidents, to refine knowledge of him/herself.	Recognizes the factors that could have an impact on consultations and works to resolve them before meeting with patients. Able to spontaneously reflect on the events occurring in his/her practice, especially critical incidents, to refine knowledge of him/herself.
	6. Cultivates and maintains positive working environments through promoting understanding, managing differences, minimizing misunderstandings, and mitigating conflicts	Is not consistently respectful of others in the team environment. May be confrontational with colleagues. Lacks skill in mitigating conflict.	With appropriate coaching, understands their role and the roles of their colleagues in shared decision-making. Requires some coaching to reflect on their own limitations and that of team function. Has some skill in mitigating conflict, may require coaching at times.	Actively maintains a respectful attitude towards others and engages in shared decision-making, minimizing conflict. Is able to mitigate conflicts in a professional manner when they occur. Reflects and recognizes one's own limitations and how this impacts team function.
	7. Seeks feedback regarding performance	Does not seek feedback. May be resistant to feedback given or does not respond to feedback.	Generally actively seeks feedback. Is able to make some appropriate changes or improvements based on feedback given/received.	Appropriately self reflects and self-evaluates. Makes appropriate changes based on self-reflection. Seeks feedback on appropriateness and accuracy of self-assessment.
	8. Teaches students, residents, the public, and other health care professionals	Teaches or supervises learners intuitively based on his/her past learning experience, without adjusting to learners' needs.	Incorporates some teaching strategies in small group teaching or clinical supervision in order to vary approaches, occasionally adjusting to learners' needs.	Uses varied teaching strategies in small group teaching or clinical supervision to encourage active learning most often adjusted with learners' needs.

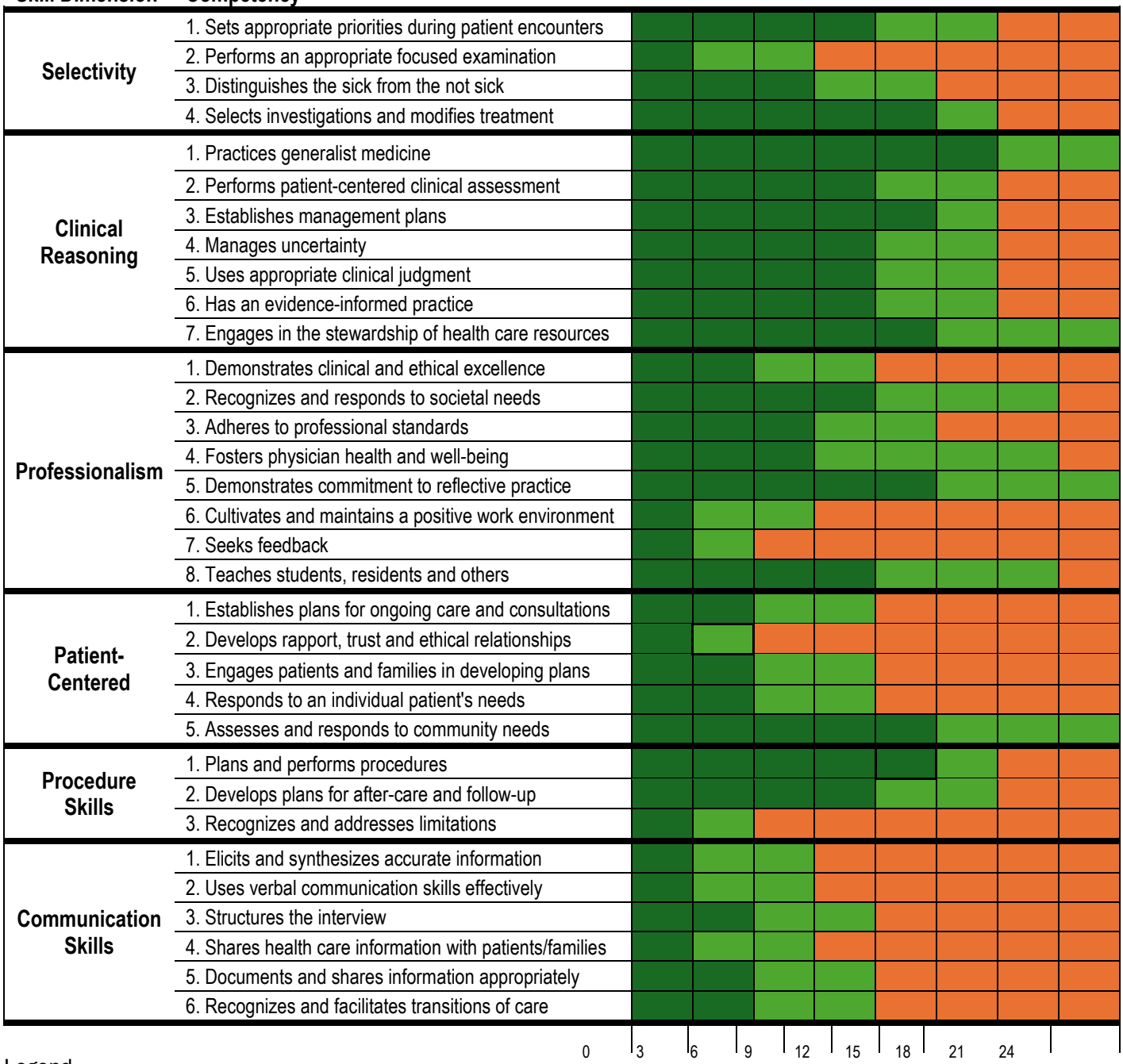
		Close Supervision	Distant Supervision	Independent
PATIENT-CENTERED	1. Establishes plans for ongoing care and timely consultation when appropriate	Adopts a rather unilateral and paternalistic discourse. Is rarely inclined to give patients and their families information about the problem and associated management.	Must be coached to encourage discussion, questions and feedback from patient. Teaches patients and their families generic information regarding the patient problem and associated management. When reminded, involves the patient to find common ground about management (shared decision making).	Utilizes consistently the patient-centered method to determine the plan of care including appropriate referral to other providers. Spontaneously encourages discussion, questions and feedback from patient. Sensitively adapts teaching to patients and their families. Usually involves patient spontaneously to find common ground about management (shared decision making).
	2. Develops rapport, trust, and ethical therapeutic relationships with patients and their families	Struggles with developing rapport with patients and families. Does not recognize the importance of respecting confidentiality, privacy and autonomy.	Requires ongoing feedback on developing rapport with patients. Respects confidentiality, privacy and autonomy.	Uses understanding, trust, respect, honesty, and compassion in establishing positive therapeutic relationships while respecting confidentiality, privacy and autonomy.
	3. Engages patients and their families in developing plans that reflect the patient's health care needs, values and goals	Rarely consults with patients, family members and / or caregivers (when relevant) to guide interventions.	When prompted, consults with patients, family members and / or caregivers (when relevant) to guide interventions.	Spontaneously seeks and incorporates patient and family perspectives in developing care plans based on needs, values and goals.
	4. Responds to an individual patient's needs by advocating with the patient within and beyond the clinical environment	Rarely discusses health promotion and disease prevention strategies with patients, or suggests inappropriate strategies not tailored to patient's need.	When prompted, discusses health promotion and disease prevention strategies with patients.	Spontaneously implements health promotion and disease prevention strategies suitably adapted to patient needs.
	5. As a resource to their community, assesses and responds to the needs of the communities or populations served by advocating with them as active partners for system-level change in a socially accountable manner	Rarely identifies or, declines to take care of some vulnerable (elderly, mental health, chronic illness, etc.) or marginalized (immigrant, homeless, indigenous, etc.) populations.	With appropriate coaching, responds appropriately to the needs of vulnerable (elderly, mental health, chronic illness, etc.) or marginalized (immigrant, homeless, indigenous, etc.) populations.	Responds appropriately to the needs of vulnerable (elderly, mental health, chronic illness, etc.) or marginalized (immigrant, homeless, indigenous, etc.) populations.

		Close Supervision	Distant Supervision	Independent
PROCEDURE SKILLS	1. Plans and performs procedures and therapies for assessment and/or management	Selects inappropriate intervention, does not obtain consent or obtains incomplete consent, improperly prepares for intervention, applies incorrect technical skills; unsafely discards hazardous materials; plans inappropriate follow-up.	Selects appropriate intervention, obtains consent based on correct information; prepares properly with appropriate coaching; demonstrates correct technical skills with appropriate coaching; safely discards hazardous materials; plans for appropriate follow-up.	Selects appropriate patient-centered intervention, obtains patient-centered consent; prepares properly; spontaneously demonstrates correct technical skills while paying attention to patient comfort; safely discards hazardous materials; tailors follow-up to patient needs.
	2. Develops plans for after-care and follow-up	Develops inappropriate after-care plans and follow-up. Fails to recognize need for timely follow-up.	With appropriate coaching, is able to develop a plan for after-care to give to the patient and arranges follow-up.	Spontaneously reaches common ground with patients regarding appropriate after-care treatment and arranges follow-up as appropriate.
	3. Recognizes and addresses limitations	Does not recognize limitations when performing procedures and may be unsafe. Rarely seeks feedback to remediate deficiencies.	Recognizes some limitations but still may miss significant ones. Seeks some feedback to correct deficiencies.	Spontaneously reviews potential knowledge gaps. Actively seeks feedback to address any limitations in knowledge and skill in procedures.

		Close Supervision	Distant Supervision	Independent
COMMUNICATION SKILLS	1. Elicits and synthesizes accurate and relevant information from, and perspectives of, patients and their families	Inattentive or distracted when taking a patient history; misses nonverbal cues provided by the patient.	Listens properly to patient answers and grasps nonverbal cues, without adjusting data collection and analysis accordingly.	Actively listens to patient answers and grasps nonverbal cues to adjust data collection and analysis accordingly.
	2. Uses verbal communication skills effectively	Seems to be misunderstood by the patient; often holds a conversation not well adapted to the patient; pays little attention to interview techniques. Does not use accepted approach to induce a change in behavior, break bad news or manage a difficult patient.	Sometimes, seems misunderstood by the patient; occasionally holds a conversation not well adapted to the patient; demonstrates appropriate use of some interview techniques. When prompted, uses accepted strategies / communication models to induce a change in behavior, break bad news or manage a difficult patient.	Seems well understood by the patient; holds a conversation well adapted to the patient; demonstrates appropriate interview techniques. Spontaneously uses accepted strategies / communication models to induce a change in behavior, break bad news or manage a difficult patient.
	3. Structures the interview	Does not list patient chief complaints or ignores them; does not contract with patient at the beginning of the interview, struggles to control the interview, or rigidly controls the interview.	With appropriate coaching, explores patient chief complaints early in the interview; when prompted, balances the agenda with that of the patient; needs some guidance to control the interview effectively.	Explores all patient chief complaints early in the interview and spontaneously balances the agenda with that of the patient; controls the interview with appropriate fluency.
	4. Shares health care information and plans with patients and their families	Shares little information with patient. Does not seek feedback to ensure patients and their families understand.	With appropriate coaching, provides patients with information that is accurate and timely. Sometimes seeks feedback from patients to ensure understanding.	Is able to share information with patients and families that is clear, accurate and timely, seeking feedback and addressing concerns as appropriate.
	5. Documents and shares written and electronic information about the medical encounter to optimize clinical decision making, patient safety, confidentiality, and privacy	Maintains unclear, inaccurate records, incompletely reflecting consultation, or inconsistent with professional regulations. Does not complete records in a timely manner.	With appropriate coaching, maintains clear and accurate records, consistent with professional regulations.	Spontaneously maintains clear and accurate records, consistent with professional regulations. Documents are focused.
	6. Facilitates necessary transitions in care with other colleagues in the health professions, including but not limited to shared care, transfer of care, and/or handover of care to enable continuity and safety	Communicates inappropriate consultation requests with a nonspecific question, insufficient or non-targeted clinical information, or uses confusing language.	With some coaching, communicates appropriate consultation requests and transitions in care with a clear question, relevant and targeted clinical information and appropriate language.	Communicates appropriate consultation requests and transitions in care with a clear question, relevant and targeted clinical information and appropriate language.

Expected Timeline to Achieve "Independent" Entrustment of Competencies

Skill Dimension	Competency
Selectivity	1. Sets appropriate priorities during patient encounters
	2. Performs an appropriate focused examination
	3. Distinguishes the sick from the not sick
	4. Selects investigations and modifies treatment
Clinical Reasoning	1. Practices generalist medicine
	2. Performs patient-centered clinical assessment
	3. Establishes management plans
	4. Manages uncertainty
	5. Uses appropriate clinical judgment
	6. Has an evidence-informed practice
	7. Engages in the stewardship of health care resources
Professionalism	1. Demonstrates clinical and ethical excellence
	2. Recognizes and responds to societal needs
	3. Adheres to professional standards
	4. Fosters physician health and well-being
	5. Demonstrates commitment to reflective practice
	6. Cultivates and maintains a positive work environment
	7. Seeks feedback
	8. Teaches students, residents and others
Patient-Centered	1. Establishes plans for ongoing care and consultations
	2. Develops rapport, trust and ethical relationships
	3. Engages patients and families in developing plans
	4. Responds to an individual patient's needs
	5. Assesses and responds to community needs
Procedure Skills	1. Plans and performs procedures
	2. Develops plans for after-care and follow-up
	3. Recognizes and addresses limitations
Communication Skills	1. Elicits and synthesizes accurate information
	2. Uses verbal communication skills effectively
	3. Structures the interview
	4. Shares health care information with patients/families
	5. Documents and shares information appropriately
	6. Recognizes and facilitates transitions of care



Legend

- Competency achieved at the expected timing
- Limit timing for achievement of competency
- Delay in competency achievement

Periodic review resident performance review

WORKSHEET

- The sections assigned to the resident MUST be completed and submitted **three weeks prior** to meeting with the Site Director or designate.
- The sections assigned to the administrator are expected to be completed upon receipt of the resident's submission and prior to the scheduled meeting between the resident and the Site Director or designate.
- The sections assigned to the Site Director or designate are expected to be completed at the time of the scheduled meeting with the resident.
- The periodic reviews are a great opportunity for you to define your short- and long- term personal learning objectives. The more thought you put into the process, the more you stand to gain from it! Please note that we have streamlined this process and that the following data points may change during your residency (although the timelines will remain the same)
- Additionally, you will also use the "benchmarks" during your periodic review process (or just prior to). The benchmarks outlined above are used to ensure that you are meeting certain broad competencies at the right point in your training.

Resident: _____

Introduction

The periodic review is an opportunity for you to 'check-in' regarding your progress through your residency. Guided self-reflection on your progress is key in helping you formulate a learning plan that meets your needs and ensures alignment with the College's learning requirements. The periodic review tends to be about 0.5-1h long. You should review your progress to date and come prepared to discuss various aspects of your progress as reflected on and outlined below. (https://www.cfpc.ca/CFPC/media/Resources/Communications/GIFT-2017_One-pager_ENG_RevMay18_Final_Web.pdf)
Please be thoughtful in your responses: this is not simply a 'hoop' to pass through rather an opportunity for you to chart the course of your learning in the remaining months of your residency. In addition to wanting to ensure your skillset meets the requirement of the College, we want to ensure that you are meeting your own individual goals for learning and have a personal career path and wellness in mind. Be prepared to lead the review as it is for your personal growth!
In terms of timelines, you will need to complete and submit this document at least a week in advance of your periodic review. Be sure to complete each section.

1. YOUR PRACTICE SITUATION

Comment on how you have had the opportunity to develop a panel of patients with whom you experience continuity. Are there specific areas of strength that you have noted and any areas that may need more exposure (e.g. children, adolescent, adult, elderly, palliative patients)?

2. PROGRESS TOWARDS INDEPENDENT PRACTICE

Consider the six skill dimensions under which you are progressing and assessed: Do you feel that you are progressing adequately in each? Do you feel that there are areas that you discovered gaps and that you may need more experience? Please use the space below to capture your self-assessed proficiency in each area (backing up your reflection with field notes, benchmarks and/or ITAR comments as appropriate) and any areas that may need some work. This should include any areas that may require additional learning experiences. You will likely want to use these thoughts to generate your own learning plan in section 4.

2.1. SELECTIVITY **Number of Field Notes: _**

(https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf#page=58)

2.2. PATIENT-CENTERED APPROACH **Number of Field Notes: _**

(https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf#page=35)

2.3. COMMUNICATION SKILLS (with patients and colleagues/team) **Number of Field Notes: _**

(https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf#page=37)

2.4. CLINICAL REASONING **Number of Field Notes: _**

(https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf#page=56)

2.5. PROCEDURES **Number of Field Notes: _**
Number of Procedures: _
Number of Deliveries: _____

(https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf#page=59)

2.6. PROFESSIONALISM **Number of Field Notes: _**

(https://www.cfpc.ca/CFPC/media/Resources/Examinations/Assessment-Objectives-for-Certification-in-FM-full-document.pdf#page=46

2.7. LOCATION OF CARE

Do you feel that you have had adequate exposure to the following environments: office, emergency, hospital, home, long-term care and community?

2.8. LIFECYCLES

Do you feel that you have had adequate exposure to the following lifecycles: palliative care, men's health care, women's health care, care of adults, care of the elderly, care of children and adolescents, maternal and newborn care?

3. OTHER ASPECTS

3.1. CAREER PLANNING

Consider your future goals as a family physician: what aspects of your residency have led you to shape your future career? Are there areas that you may need to prepare to help you transition to practice?

3.2. WELLNESS AND BALANCE

Reflect and comment on how you are trying to promote and maintain your own wellness in the programme.

3.3. SOCIAL ACCOUNTABILITY

Have you been involved with any committees or done community volunteer work?

3.4. EXAM PREPARATION

What efforts have you made to prepare for the CFPC Certification Examination (including whether you are part of a study group)? Have you completed practice SOOs or SAMPs?

3.5. CONTINUING PRACTICE DEVELOPMENT/COURSES

Please list any courses you have taken (e.g. ACLS, NRP, ALARM).

Course	Completion Date

3.6. PRESENTATIONS

Please list any presentations you have made.

Presentation	Date

3.7. RESIDENT PROJECT

Title	
Co-Authors	
Supervisor	

Please comment on your progression towards completion of your project and any challenges you have had or anticipate.

4. YOUR LEARNING PLAN

If this is not your first learning plan, please reflect on your last one(s) and indicate progress made.

Taking into account your answers to the above, please indicate below areas that you want to work on in the upcoming months. Your primary preceptor will receive a copy of your individualized learning plan (that you may want to modify at your biannual review after your discussion with your site director/assessment & evaluation coordinator) to help you attain your goals.

Resident Comments:

Assessment & Evaluation Coordinator/Site Director Comments:

Date Completed: _____

Resident Name: _____

Resident Signature: _____

Assessment & Evaluation Coordinator/Site Director Signature: _____

Program Director Signature: _____

Resident: _____

Please include completed benchmark worksheet(s), ITARs, procedure logs, leave request(s)/history.

Periodic Review Completion Dates and Comments

Timing		Date	Comments/Follow-Up
Year 1	First		
	Second		
Year 2	First		
	Second		
(Year 3)	First		
	Second		

1. CLINICAL LEARNING EXPERIENCES

1.1. **Completion of Clinical Learning Experiences** (include electives/selectives)

ITARs in PGY1 Year	Midpoint or Final	Completed YES/NO

ITARs in PGY2 Year	Midpoint or Final	Completed YES/NO

ITARs in PGY3 Year	Midpoint or Final	Completed YES/NO

Elective ITARs	Completed YES/NO

Selective ITARs	Completed YES/NO

2. ADMINISTRATIVE

2.1. Are the evaluations of educational activities and faculty up to date?

☐ Yes ☐ No – Comments below

2.2. Has there been vacation leave?

☐ Yes ☐ No – Comments below

2.3. Has the resident had other leave for any reason? (e.g. sick leave, conferences, etc)

☐ Yes ☐ No – Comments below

2.4. Has the resident had adequate attendance at academic curriculum? (Target: 70+%)
(for reference, here is the policy on minimal attendance
https://cdn.dal.ca/content/dam/dalhousie/pdf/faculty/medicine/departments/department-sites/family/Education%20Documents/Policies/Minimal_Attendance_Policy.pdf)

☐ Yes ☐ No – Comments below

2.5. Has the resident completed their quality improvement project?

☐ Yes ☐ No – Comments below

2.6. Has the primary preceptor log been completed since last review?

☐ Yes ☐ No – Comments below

2.7. CanMeds & Other Learning Modules

Module	Done	Module	Done
Indigenous Health (PGME) *		Infection Control	
Apology (FM) *		Patient Safety	
Critical Thinking		Resident Safety and Wellness	
Death Certificates (FM) *		Residents as Teachers (PGME) *	
Handover (FM) *		Residents as Professional Peer Educators (RAPPERs) (DFM) *	
Health Law (FM) *		Opioid Stewardship (PGME) *	
		NS Prescription Monitoring (FM)	

* indicates mandatory module

Date Completed: _____

Resident: _____

Please include completed benchmark worksheet(s), ITARs, procedure logs, leave request(s)/history.

1. ADEQUATE SAMPLING (with evidence from field notes, ITARs etc)

1.1. Is there adequate evidence that the resident had appropriate sampling across all **skill dimensions** (Selectivity, Clinical Reasoning, Professionalism, Patient Centered Approach, Procedure Skills, Communication Skills)?
☐ Yes ☐ No – Comments below

1.2. Is there adequate evidence that the resident had appropriate sampling across all **locations of care** (office, emergency, hospital, home, long-term care and community)?
☐ Yes ☐ No – Comments below

1.3. Is there adequate evidence that the resident had appropriate sampling across all **lifecycles** (palliative care, men's health care, women's health care, care of adults, care of the elderly, care of children and adolescents, maternal and newborn care)?
☐ Yes ☐ No – Comments below

1.4. Is there adequate evidence that the resident had appropriate sampling for primary care procedures?
☐ Yes ☐ No – Comments below

1.5. Is there adequate evidence that the resident had appropriate feedback from patients?
(Target: 10 per year)
☐ Yes ☐ No – Comments below

2. CLINICAL LEARNING EXPERIENCES

2.1. Are all ITARs complete and satisfactory for each Clinical Learning Experiences since last review?
☐ Yes ☐ No – Comments below

2.2. Has the resident shown appropriate progress with the family medicine benchmarks?
☐ Yes ☐ No – Comments below

3. ADMINISTRATIVE

3.1. Has there been adequate vacation leave or other wellness activities?

☐ Yes ☐ No – Comments below

3.2. Has the resident made adequate progress on their project? (e.g. have they defined their topic, met deadlines, etc)

☐ Yes ☐ No – Comments below

3.3. Is the resident aware that they have access to a faculty advisor and resident supports when needed?

☐ Yes ☐ No – Comments below

4. OVERALL PROGRESS

☐ Progress as Expected	☐ Some concerns about progress	☐ Not progressing as expected
Comments:		

Date Completed: _____

Resident Signature: _____

Assessment & Evaluation Coordinator/Site Director Signature: _____

Program Director Signature: _____

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

DALHOUSIE FAMILY MEDICINE RESIDENT PROJECT GUIDE

July 2025-2026

Department of Family Medicine
1465 Brenton Street, Suite 402
Halifax, NS B3J 3T4

family.medicine.dal.ca

Resident Project Guide Department of Family Medicine

Introduction

Family Medicine requires compassionate practice based on sound, reproducible evidence and critical thinking. Scholarly work in Family Medicine is promoted by the College of Family Physicians of Canada. The Dalhousie Family Medicine resident project program promotes the attainment of the four CanMeds roles: health advocate, medical expert, scholar and communicator.

The objectives for scholarly activity in Family Medicine are detailed by the College of Family Physicians of Canada. The project promotes the attainment of the four CanMeds roles: health advocate, medical expert, scholar and communicator.

All residents are required to complete a resident project as part of their residency program requirements. The resident project is an academic/scholarly one that must meet the standards described in this guide and must be completed successfully in order to fulfill the requirements of the residency training program.

The purpose of the resident project is to provide an opportunity for the resident to explore an area of personal interest in a scholarly manner. With guidance provided by their supervisor, the process involves finding answers to questions commonly encountered in primary care by critically reviewing the available literature. Where such answers are found lacking, the resident may choose to employ an appropriate methodology to design a study using proper scientific rigor to answer that question. By contributing to this scholarly activity there is an opportunity for residents to positively impact primary care and the wider community.
There is no requirement to conduct a research study; however, it is hoped that the resident project will provide the resident with the opportunity to develop or practice primary care research skills. For those with more in- depth research interests, primary care research electives are available and inquiries should go to the Site Director.

Goal:

- To contribute to the understanding and/or effectiveness of family practice.

Purpose:

- To develop skills that the resident can use to be a resource to a family practice;
- To provide an evaluation of these skills for the resident transcript.

Objectives:

- To ask a question relevant to Family Medicine
- To develop a way of answering the question using appropriate resources and timelines;
- To write up the project and present it orally prior to completion of the residency.

Project Goals:

- To develop skills in asking and answering questions that are important and relevant to the discipline of Family Medicine;
- To stimulate creative and original thought based on questions encountered in practice;
- To practice the fundamental of evidence-based care or other critical inquiry;
- To be able to communicate the results clearly to colleagues;
- To promote an interest in Family Medicine research.

How to Use the Resident Project Guide

The Resident Project Guide has been developed as a resource for residents, project supervisors and project/research coordinators. The guide contains information regarding project and project form deadlines, format requirements, tips and tricks, assessments, etc. The Resident Project Guide is reviewed by the Resident Project Sub-Committee on an annual basis and updated accordingly.

Residents may choose to follow the version of the Resident Project Guide released in their PGY1 year, or they may opt to follow the version released in the year in which they submit their project.

In order to ensure fairness in marking, residents are required to indicate on their project title/cover page which year's version of the Resident Project Guide they followed at the time when they submitted their final project.

Expectations

The resident project must be aimed at answering a question in the field of Family Medicine. It can be in the form of a research project, a practice quality improvement project, a position paper, clinical education tool, medical education tool, literature appraisal or a medical/health humanities project. The resident is expected to choose an area of interest to Family Medicine, propose a question, review the literature, and design a method of answering that question.

Family Medicine and Family Practice includes enhanced areas of expertise achieved and maintained by some family physicians, such as those recognized by the College of Family Physicians of Canada as Certificates of Added Competence (CACs). Approved CAC domains of care in Family Medicine include Care of the Elderly, Emergency Medicine, Family Practice Anesthesia, Palliative Care, Sport and Exercise Medicine, Addiction Medicine and Enhanced Surgical Skills.

PGY2 residents are expected to submit a written paper and give an oral presentation of their findings to their colleagues and faculty members at the Resident Project Presentation Day held at their Site Project Presentation event. The written documents will be graded and may be considered for various resident project awards.
PGY1 residents may be asked to give a 10-minute presentation discussing the progress of their projects. Residents are welcome to submit their completed resident project in their PGY1 year; however, they are not required to do so until their PGY2 year.

Completed resident projects will be stored and available to review for internal use by residents and faculty.

Ethics Issues

All residents who engage in research involving human beings, their biological samples, or their data are required to ensure that their projects are operating under an approved Research Ethics Board (REB) application and follow Canada's national Tri-Council Policy Statement: Ethical Conduct of Research. This applies also to any project considered "minimal risk", for example the examination of patient charts, patient/resident/physician surveys, etc. The resident should discuss this with their Project/Research Coordinator. If possible, it is advised that residents should consult with the Chair of the local Research Ethics Board (REB) regarding requirements for REB applications. If REB approval is necessary, it must be ensured that all requirements of the local REB are met for the resident project. If applied for, and REB approval is not required, residents are required to provide the appropriate REB documentation around that decision. To determine if a project falls under QI or Program Evaluation (and therefore exempt from REB review), it is suggested to use local guidelines (or connect with their local REB) to help in that decision, such as 'Dalhousie University's Guidelines for Differentiating Among Research, Program Evaluation and Quality Improvement' (https://cdn.dal.ca/content/dam/dalhousie/pdf/research-services/REB/Guidelines%20Research%20PE%20QI%20(28%20Nov%202013).pdf).

Projects with More than One Author

Residents are encouraged to collaborate when planning and completing Family Medicine projects. Collaboration with others must be acknowledged and explained in the manuscript. In most circumstances, residents will collaborate on a topic, but their project will ask a separate question; therefore, individual manuscripts and project forms will be submitted by the primary author.

In the event residents wish to co-author a project, we ask that this collaboration be approved by their site Project Coordinator(s) to ensure each author's contribution is substantial. Each author must outline, in a section entitled "Author Contribution", their individual contribution to the project. Each resident will be required to submit individual forms, project outline and final reports. There will be one assessment of the project. The project presentation may be collaborative if possible.

When collaborating as co-authors, it is important to recognize the four measures of authorship from the ICMJE:

- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or revising it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Further advice on authorship can be found at http://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html

Types of Projects

Because different marking rubrics are used for different project types, residents are asked to submit their project as a single project type. Projects may be submitted as one of the following with the project type clearly indicated on the cover page:

Research

This involves the posing of a question, reviewing the literature, selecting the methods needed to answer the research question, collecting original data, conducting the data analysis, and reporting the findings Residents are encouraged to engage in original research. It is important for residents to be aware that research projects require more steps to complete than other types of projects and therefore may take longer to complete. Most research projects require approval by the local Research Ethics Board (REB). Residents are advised to speak with their Project Coordinator about the need for ethical approval for their project. If REB approval is not required, residents are required to provide the appropriate REB documentation around that decision.

Practice Quality Improvement Project

This involves identifying a practice-based question (aim statement), constructing a method for measuring change, developing that change by finding evidence-based guidelines/recommendations to guide the approach to clinical care with respect to the question, reporting the results and recommendations to target population, along with reassessments after change has been initiated (PDSA cycle; Plan, Do, Study, Act). Ideally this will involve multiple PDSA cycles.

Please note, residents are not permitted to use the same question or data used in their QI curriculum exercise at their site.

Advocacy Project (*Formerly Position Paper Project)

In this project type, the resident takes a position on an issue of importance to family medicine and appraises evidence for and against the position. The resident either ***describes*** or ***undertakes*** an advocacy action related to the position. In either case, the report is to include a self-reflection component as described in "Tips and Tricks".

Clinical Education Tool

This involves developing a tool or resource useful for the education of physicians, other health care workers, patients or the public. The education tool needs to be accompanied by a description of how the topic was selected, a literature review and the reason for the need for the tool.

Medical Education Tool
This involves developing a tool or resource useful for undergraduate or postgraduate medical education, with accompanied reason for tool and literature review to support the tool. Examples include Problem Based Learning Cases, OSCE development, online curriculum modules, Self-Learning Question Writing Project, etc.

Literature Appraisal
This involves a detailed review of the literature on a specific topic pertinent to Family Medicine. Original research papers* should be reviewed and appraised using critical appraisal skills. (* primary sources, no systematic reviews)

Medical/Health Humanities
This project type requires residents to ask an important question relevant to Family Medicine. The resident will conduct a review of the evidence on the topic and the final project may include an arts-based piece, or use of art in the scholarly project, both clinical and humanities. This may take the form of writing, visual art, performance (e.g. dance, theatre), production or a musical composition, or other. While the health humanities may be considered a category of its own, it could also be a component of any of the above categories. For example, the resident may choose to conduct a literature review on the effect of the use of writing as a tool to prevent burnout among medical students. The paper could also go further to encompass project types such as a formal literature review, education tool, position paper/essay, research project, or practice quality assessment related to the art form.

*Please refer to the Tips and Tricks section of this Guide for more information on the above project types

Project Coordinator
Each site has a Project Coordinator, whose role is to discuss the project format and requirements with the resident on a regular basis and encourage the resident to adhere to the deadlines. In some cases, the Project Coordinator may also be the Project Supervisor.

Project Supervisor
Each resident must choose a Project Supervisor (or Project Supervisors) to counsel them on the content of their project. The Project Supervisor(s) may be a clinical supervisor, another family physician, a consultant or another individual with qualifications appropriate for the selected resident's project topic.

Each project requires a Project Supervisor with a faculty appointment in the Dalhousie University Department of Family Medicine. If the primary project supervisor is not a DFM faculty member, the resident is responsible to find a co-supervisor who has a faculty appointment with the Dalhousie University Department of Family Medicine.
Once the Project Supervisor has been identified, the resident is responsible to provide them with the Project Supervisor Information Kit. This can be found on Brightspace.

Budget
There are funds in each site's budget to cover some resident project expenses at that site. Each resident is allowed $50 for minor expenses, but it is also possible to apply for more funding. This issue should be discussed with the Project Coordinator at the appropriate site. For amounts over $50, a written budget must be submitted to the Project Coordinator at the appropriate site. All receipts must be submitted in order for expenses to be reimbursed. If funds are needed in advance, a written request can be submitted with receipts submitted at a later date.

Minimum Time Commitment
Residents should expect to commit at least 40 hours of work to their project, although the actual amount of time spent on the project will depend on a number of factors. The program may allow the resident to use some independent learning time to work on their project, however; the amount of time permitted depends largely on the nature and scope of the project and therefore residents will need to discuss this with either their Project Coordinator or Project Supervisor. Time away from half-days back and academic half-days is not generally permitted.

Academic Integrity, Plagiarism, and Artificial Intelligence

Academic integrity is the expectation that all members of the academic community act with honesty, trust, fairness, respect and responsibility. See http://www.dal.ca/dept/university_secretariat/academic-integrity/plagiarism-cheating.html

Dalhousie University defines plagiarism as the submission or presentation of the work of another as if it were one's own. Plagiarism is a serious academic offence and can lead to a failing grade or expulsion. See: https://www.dal.ca/about/leadership-governance/academic-integrity/plagiarism-and-cheating.html

Artificial intelligence (AI) potentially can assist authors by suggesting scholarly manuscript ideas and outlines. However, current AI technology creates the potential for breach of academic integrity or ethics in the production of scholarly projects. Current AI outputs can be erroneous, false, out of date, or lead to plagiarism. Residents must assume full responsibility for all content in their projects, including content generated by AI. They must ensure that the content is free from error, fabrication and plagiarism. Residents must use AI with caution and be transparent in their use of AI in developing their scholarly projects. Residents who use AI to assist them must disclose and detail such use in the methods section of their project reports. Artificial Intelligence sources cannot be used as references for projects, and cannot be listed as co-authors. Copying text into an artificial intelligence computer service risks exposing the content in ways that could breach privacy or ethics requirements.

To fulfill the competencies of resident projects, residents must conduct their own literature search (no third-party searches). However, residents are encouraged to seek assistance from hospital or university librarians.

For more information on AI in Scholarly Work at Dalhousie, please see 'Guidance for Use of Generative A.I. Tools in Research' (https://dalu.sharepoint.com/sites/research-innovation/SitePages/generative-ai-tools-research.aspx). Please keep in mind that this is an evolving practical tool.

Project Format

The project paper should be a minimum of 2500 words and a maximum of 4000 words, excluding tables and references. The project must be submitted as a single PDF. It is to be double spaced, 12 font, and cannot exceed 10MB. **Project products such as infographics, tools, artwork, essays, handbooks, DVDs, websites, apps and others are to be submitted as appendices to the paper.** Alternatives for the word count and format will be considered for special circumstances and must be approved by the Project Coordinator.

The format of the written work should follow a scientific lay-out, including: Cover Page, Abstract, Introduction/Background, Methods, Results, Discussion, Strengths and Limitations, Conclusions and References and Appendices (where required).

Abstracts should be structured to include the following layout as described by the CMAJ (excluding Trial Registration) (https://www.cmaj.ca/submission-guidelines#resarch): Introduction/Background, Methods, Results, Interpretation.

Below the Abstract, add 3-5 keywords reflecting the main topics of your project.

At least fifteen (15) references are recommended. Vancouver reference formatting preferred as is required by CMAJ. Use of a reference manager (such as Zotero) is recommended.

Please note that a full academic literature review is only required for the Literature Appraisal project type. Other project types are required to have a Background section with an abbreviated literature review relevant to project type.

Projects may only be submitted as a single project type. For example, a project may be submitted as a research project or a clinical education tool, not both.

Project Cover Page

Make sure that you include a cover page (title page) with your project.

The title page must include each contributing resident's name and site. For non-Dalhousie Family Medicine resident co-authors, there must be some sort of identification of who they are (e.g. physician from (name of clinic, hospital, etc.); pharmacist from (name of pharmacy, hospital, etc.), nurse practitioner from (name of clinic, etc.); PGY# resident from (name of program and institution)).

The cover page must include the following:

- Name(s)
- Title of project
- Site(s)
- Name of project supervisor(s)
- Type of project (research, literature appraisal, etc.) (NOTE: use only the heading used under "Type of Projects")
- Date
- Which year's version of the Resident Project Guide the resident(s) followed during project development

Project Assessment

It is the resident's responsibility to send the completed project for marking to the Department of Family Medicine Education Committee Assistant (fmcommittees@dal.ca) with copy to the Site Administrator and Project Coordinator, as a single PDF file by the 2nd Monday in February. The PDF document must be no larger than 10MB and formatted in such a way as can be easily emailed to, and opened by, project reviewers.

The Medical Education Committee Assistant will forward the completed resident projects to appropriate reviewers. Once accepted by the reviewer, the full project review process is to be completed within 4-6 weeks. It is recommended that project reviewers complete their evaluation within 2-3 weeks to allow time for revisions and administrative work if needed, in order to fulfil the 4-6 week timeline for full project review. A resident project must be deemed "Acceptable" or higher for the resident to successfully complete the residency program requirements.

If a project is assessed as "Requiring Revisions," the resident and the Project Supervisor and/or Project/Research Coordinator will be informed by the Education Committee Assistant. Once the resident has completed the required revisions, the revised project will be sent back to the Education Committee Assistant (ideally within 2 weeks) in a single PDF document that is no larger than 10MB and that has been formatted in such a way as can easily be emailed and opened by the project reviewer. The Education Committee Assistant will then forward the revised project to the original project reviewer, who will aim to have the review completed in 2-3 weeks to fulfil the 4-6 week timeline from the original project review acceptance date. If, after a second revision the project is still deemed as "Requiring Revisions" by the original reviewer, a second reviewer may be invited to review the project.

Late Projects

Residents who miss the final project submission date may face a delay in receiving their letter of program completion. Residents are encouraged to submit their final project by the appropriate deadline.

Non-Compliance

Non-compliance with the program requirements without approval and just cause may result in the inclusion of a professional misconduct note in the resident file.

Awards/Presentations

Projects submitted by the February deadline (according to project guidelines) that receive marks in the "Outstanding" range will be considered for award nominations. Select projects receiving a score in the 'Highly Acceptable' range may also be considered. Additionally, Project Supervisors and site Project/Research Coordinators may nominate for consideration any resident projects they consider to be exceptional. Award nominations include the following:

1. Dalhousie University Family Medicine: The Dr. Doug Mulholland Award for the best scholarly non- research project. The projects are judged on originality, relevance to family medicine and critical thinking.
2. Dalhousie University Family Medicine: The Dr. R. Wayne Putnam Award for the best research project.
3. Award competitions:
    a. Faculty of Medicine Research Award Competition: Up to ten projects are nominated from the Department of Family Medicine.
    b. College of Family Physicians of Canada research awards for Family Medicine Residents: Up to one project is nominated from the Dalhousie University Department of Family Medicine
    c. The College of Family Physicians of Canada scholarly activity award. Up to one project is nominated from the Dalhousie University Department of Family Medicine. This award aims to recognize outstanding family medicine scholarship performed by a resident.
    d. Nominee(s) for the Residency PBLP Scholarship Award

Resident Project Repository

A selection of completed and acceptable resident projects may be posted on Dalhousie University's Postgraduate Family Medicine Brightspace Page (under Resident Resources) for 2 years. This is to provide ideas and to serve as project examples for current Family Medicine Residents.

Dalhousie Family Medicine Website

The chair of the Resident Project Committee will seek consent from Residents and their Supervisors of the top projects to be published on the Dalhousie Family Medicine Website to share. The top projects are identified by numerical grade as evaluated by the Resident Project Awards Committee.

Questions

Questions regarding resident projects may be directed to:
Dr. Laura Sadler
Chair, Resident Project Sub-Committee Phone: 902-473-4700; Fax 902 417-1553
Email: LSadler@dal.ca

Timelines

PGY1 year:

- The resident must discuss the project topic with the Project Coordinator.
- The resident will select and discuss the content of the project with their Project Coordinator (and Project Supervisor if applicable) by the end of the three-month PGY1 Family Medicine clinical learning experience, but no later than the 1st Tuesday in November.
- The resident will complete Form 1 that they will submit to their Project Supervisor and their Project Coordinator. This proposal will state their research question/objective, a brief background literature review, the type of project and the methodology they will use to answer the research question.
- Residents must have their PGY1 Resident Project Proposal Form (Form I) initiated and submitted via One45 by the 1st Tuesday in November for their Project Coordinator to review/approve.
- Residents are required to distribute via One45 a Project Supervisor Agreement Form (Form II), which must be completed/signed by their Project Supervisor and submitted via One45 by the 1st Tuesday in December for their Project Coordinator to review.

- Residents whose projects are research projects, must apply for approval through their local Research Ethics Board (REB). It should be noted that this can at times be a lengthy process, and residents must plan accordingly in order to allow sufficient time for punctual project completion.
- If necessary, the resident should write out a budget and submit it to their Project Coordinator. (see below for budget guidelines)
- At some sites, PGY1 residents are required to present their proposal in a 10-minute oral format during their site's Resident Project Presentation Day (usually held in May), or at another venue, as determined by their site. PGY1 residents are to confirm details with their Project Coordinator.

PGY2 year:

- The resident will review their project progress and distribute the Project Progress Report (Form III) via One45 to their Project Supervisor. This form is to be submitted by their supervisor via One45 no later than the 1st Tuesday in September. The progress report will be reviewed by the Project Coordinator.
- Once the project is complete, the resident will distribute the Resident Project Final Approval for Assessment Form (Form IV) to their supervisor via One45 no later than the 1st Tuesday in January. It will be approved by their Project Supervisor as being ready to be sent out for assessment. Project Coordinators will review these forms.
- The Final Project must be submitted to the resident's site designate (named by each site), and from there forwarded to the Education Committee Assistant (fmcommittees@dal.ca) as a single PDF document by the 2nd Monday in February. The PDF document must not exceed a file size of 10MB and must be formatted in such a way as can easily be emailed and opened by project reviewers. The Education Committee Assistant will send the project to a project reviewer for assessment.
- A PowerPoint slide presentation (or appropriate alternative medium of presentation) of the project must be completed and submitted to the residents' site designate by the 1st Monday in May of their PGY2 year.
- PGY2 residents will present their projects orally during their Site Project Presentation event.
- If a resident is concluding the program four months or more beyond the usual program end-date, submission of the written project can be deferred to 2 months before their concluding date, and an oral presentation will be arranged separately.

See the attached worksheet for timeline summaries. Please note that these deadlines may be modified if the nature of the project is such that data collection or analysis cannot be completed by the required dates. In such case, the resident must discuss the new timelines in advance with their Project/Research Coordinator and new timelines will be formally established.

Residents in the three-year integrated FM/EM program may, with permission from their Project/Research Coordinator and Project Supervisor, extend their project timeline into the third year of their residency program.

Residents Completing Off-Cycle

Residents who will be completing off-cycle should contact their supervisor and project coordinator(s) to discuss timing of submission for forms and the final written project if they will not be following the above timelines.

Submission of the written project can be deferred if a resident is concluding the program four months or more beyond the usual program end-date. In this case, the project must be submitted a minimum of 2 months before their concluding date to allow for assessment and presentation. An oral presentation will be arranged separately based on availability of the resident, supervisor, and project coordinator(s). This should occur after submission of the final written project and prior to their concluding date but can occur before or after marking.

Worksheet and Dates for Completion of Resident Project

PGY1				
Form	Task	Timeline	Dates	Task Complete
	Meet with Project/Research Coordinator to begin formulating a type of project	July – September	Suggest by early September	
	Select Project Supervisor	July – October	Suggest complete by early October	
	Begin conducting literature review	September – December		
Project Proposal (Form I)	Residents must initiate and complete Form I (Resident Project Proposal) for Project Coordinators to review. Residents are responsible for ensuring the form is completed in a timely manner, in compliance with deadlines. Once the Project Supervisor has been named, the resident is responsible to provide them with the Project Supervisor Kit		1st Tuesday in November of the resident's PGY1 year	
Project Supervisor Agreement Form (Form II)	Residents are responsible for initiating Form II (Project Supervisor Agreement Form), to be completed and submitted by their Project Supervisor. Residents are responsible for ensuring the form is completed in a timely manner, in compliance with deadlines		1st Tuesday in December of the resident's PGY1 year	
	If the resident project is a research project, the resident must apply to their local Research Ethics Board (REB) for approval. (NOTE: This may be a lengthy process and residents must plan accordingly.)	September - February		
	At some sites, Proposal Presentation Day (10-minute presentation)		Usually in May (date to be determined by each site)	

Worksheet and Dates for Completion of Resident Project (Continued)				
PGY2				
Form	Task	Timeline	Dates	Task Complete
Resident Project Progress Report (Form III)	Resident must initiate Form III (Resident Project Progress Report) for their project supervisor to complete (in collaboration with resident) and submit. Residents are responsible for ensuring the form is completed in a timely manner, in compliance with deadlines.		1st Tuesday in September in PGY2 year	
Project Draft and Project Final Approval Form (Form IV)	Completed draft of project given to Project Supervisor for feedback. Residents must initiate Form IV (Project Final Approval for Assessment) for their project supervisor to complete (in collaboration with resident) and submit. Residents are responsible for ensuring the form is completed in a timely manner, in compliance with deadlines.		1st Tuesday in January of PGY2 year	
Final Project	Completed FINAL project to be submitted by the designated person(s) at each site to the Education Committee Assistant (fmcommittees@dal.ca)		2nd Monday in February of PGY2 year	
	Education Committee Assistant will distribute projects for assessment	As received		
	Residents will present their projects orally during their Site Project Presentation event.		Usually in May (date to be determined by each site)	

Dalhousie Family Medicine Resident Project Forms I-IV (one45 Tasks)

Beginning in the 2018/2019 academic year, resident Project Forms I-IV will now be completed via one45 Forms. The table below provides a description of how the Forms are to be completed and by whom. Please contact your site administrator if you have any further questions.

<table>
<tr><th>Form:</th><th>Due:</th><th>Resident's tasks:</th><th>Project Supervisor's tasks:</th><th>Project Coordinator's tasks:</th></tr>
<tr><td>Form I:
Resident Project Proposal.</td><td>PGY1 year:
1st Tuesday in Nov.</td><td>The resident initiates and completes Project Form I. The submitted Form is automatically sent directly to the Project Coordinator for review.
The Project Coordinator's comments and approval are automatically sent directly to the resident who is required to review and sign-off.</td><td>No responsibility for Form I</td><td rowspan="4">Blank Project Forms will be listed in the Project Coordinator's one45 ToDos.

As Project Forms are completed, a blue check marked box will appear next to the residents' Forms. Visual cues will appear under the Contributors' column to indicate that the Form is completed.

The Project Coordinator is to:
• Check one45 regularly for completed Project Forms;
• review completed Forms when indicated by a blue check marked box;
• provide comments directed to resident; and,
• approve/accept or decline the Form.</td></tr>
<tr><td>Form II:
Project Supervisor Agreement.</td><td>PGY1 year:
1st Tuesday in Dec.</td><td>Resident distributes (i.e. forwards) blank Project Form II, III, and IV to an approved Project Supervisor(s) who will complete it for the resident.</td><td rowspan="3">Project Supervisors receive blank Project Forms II, III, and IV from the resident.

Project Supervisor completes those Forms based on communication(s) from the resident and submits them before the Forms' due dates.

Completed Project Forms are automatically sent directly to the Project Coordinator for review.

Residents will also review and sign-off on Project Supervisor's and Project Coordinator's comments.</td></tr>
<tr><td>Form III:
Project Progress Report.</td><td>PGY2 year:
1st Tuesday in Sep.</td><td rowspan="2">The Project Supervisor's completed Forms are automatically sent directly to the Project Coordinator for approval/acceptance and response.</td></tr>
<tr><td>Form IV:
Project Final Approval for Assessment.</td><td>PGY2 year:
1st Tuesday in Jan.</td><td>The Project Coordinator's comments and approval are automatically sent directly to the resident who is required to review and sign-off.</td></tr>
</table>

Reminders for Project Coordinators

- Project Coordinators should check their one45 account regularly under the Summary Evaluations section for Project Forms that have been completed (indicated by a blue check marked box).
- Form IV is to be reviewed and only accepted after final edits have been completed. This confirms that the Project is ready to be sent out for marking.

Reminders for Residents

- The one45 Forms I-IV are designed to keep you on task. Please ensure you have ongoing communication with your Project Supervisor and Project Coordinator regarding the details surrounding the Forms.
- Once Form IV is approved and accepted by the Project Coordinator, the resident is to send the final written Project to the site designate for marking.

Dalhousie University Fam Med Postgrad	Evaluated By: evaluator's name Evaluating: person (role) or moment's name (if applicable) Dates: start date to end date	

* indicates a mandatory response

Form-1: Resident Project Proposal.

All family medicine residents are required to complete a resident project as part of their residency program requirements. The purpose of the resident project is to introduce the resident to the process of finding answers to questions commonly encountered in primary care. Residents are expected to submit a written paper and give an oral presentation at their site's project presentation event in their final year of residency.
Types of Projects:
Clinical Education Tool
Literature Appraisal
Medical / Health Humanities
Medical Education Tool
Advocacy Project
Research Project
Quality Improvement / Patient Safety

Please submit this one45 form no later than the first Tuesday in November of your PGY1 year.

*Proposed project supervisor's full name:

*Project supervisor's email address:

Proposed co-supervisor(s) full name:

Proposed co-supervisor(s) email address:

Once the project supervisor has been named, the resident is responsible to provide them with the Project Supervisor Information Kit.
*Working Title of Resident Project:
*Type of project:

- Clinical Education Tool
- Literature Appraisal
- Medical/Health Humanities
- Medical Education Tool
- Advocacy Project
- Research Project
- Quality Improvement/Patient Safety

Research Question/Objective

Brief background literature review Methodology
*Brief description:

*Brief timeline:
Resident's comments for project coordinator(s):

Research Ethics Board (REB) Application Status:

	n/a	No	Yes
*Will this project require REB approval?	○	○	○

If "No," please explain why:

Dalhousie University Fam Med Postgrad	Evaluated By: evaluator's name Evaluating: person (role) or moment's name (if applicable) Dates: start date to end date	

* indicates a mandatory response

Form-2: Project Supervisor Agreement.

*Please submit this one45 form no later than the first Tuesday in December of the PGY1 year.

Project Supervisor:
All residents should have a Project Supervisor and a Project Coordinator.

The Project Supervisor will counsel the resident on the content of the project. The Project Supervisor may be a clinical supervisor in the home base Family Medicine Unit, another family physician, a consultant or another appropriate individual. If someone other than a family physician is selected, it is important to obtain advice on the relevance of the project to Family Medicine from the Project Coordinator.
The Project Coordinator will discuss the project format and requirements with the resident on a regular basis and encourage the resident to adhere to the deadlines. In some cases the Project Coordinator may also be the Project Supervisor.
Click here to access our Project Supervisor Information Kit

Please submit this one45 form no later than the first Tuesday in December of the PGY1 year. I have agreed to be the Project Supervisor for this resident's project:
- ○ No
- ○ Yes

*Project Supervisor's full name:
Proposed co-supervisor(s) full name, if applicable:

*Are you, or one of the committee members for this resident project, a faculty member of Dalhousie's Department of Family Medicine?

- ○ No
- ○ Yes

*Type of project:
- ○ Clinical Education Tool
- ○ Literature Appraisal
- ○ Medical/Health Humanities
- ○ Medical Education Tool
- ○ Advocacy Project
- ○ Quality Improvement / Patient Safety
- ○ Research

Research Ethics Board (REB) Application Status:

	n/a	No	Yes
*Will this project require REB approval?	○	○	○

If "No," please explain why:

Dalhousie University Fam Med Postgrad	Evaluated By: evaluator's name Evaluating: person (role) or moment's name (if applicable) Dates: start date to end date	

* indicates a mandatory response

Form-3: Project Progress Report

Please submit this one45 form no later than the first Tuesday in September of the PGY2 year.

*Project title:

*Type of project:
- Clinical Education Tool
- Literature Appraisal
- Medical/Health Humanities
- Medical Education Tool
- Advocacy Project
- Quality Improvement / Patient Safety
- Research

Comments:

*As the Project Supervisor, I have reviewed the progress of the resident project.
- No
- Yes

As the Project Co-Supervisor (if applicable), I have reviewed the progress of the resident project.
- No
- Yes

Research Ethics Board (REB) Application Status:

	n/a	No	Yes
*Will this project require REB approval?	○	○	○

*Why, or why not?

	n/a	No	Yes
*If "Yes", has REB been obtained?	○	○	○

If "No", what is the status/plan?

* indicates a mandatory response

Form 4: Project Final Approval for Assessment.

Please submit this one45 form no later than the first Tuesday in January of the PGY2 year.
*Project Title:

*As the Project Supervisor, I have reviewed and approved the final draft copy of the resident project for assessment:
- No
- Yes

As the Project Co-supervisor (if applicable), I have reviewed and approved the final draft copy of the resident project for assessment:
- No
- Yes Comments:

Research Ethics Board (REB) Application Status:

	n/a	No	Yes
*Did this project require REB approval?			
*If yes, was REB obtained?			

Dalhousie Family Medicine Resident Project Assessment Rubrics

Dalhousie Family Medicine Resident Project Assessment Rubric: Clinical Education Tool

Resident: Assessor: Date:

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Identification of the need for a Medical Education tool	Problem/topic clearly identified Objectives for development of the project are richly stated Complete description of the need for this project and/or a description of existing/similar projects	Problem/topic clearly stated, originally, creativity Objectives less richly stated Clear description of the need for the tool and/or the value of existing/similar projects	Problem/topic stated Objectives not fully stated Brief description of the need for the project and/or the value of existing/similar projects	Problem/topic not defined Objectives not stated Need for the tool and/or the value of existing similar not stated	/20
Relevance to Family Medicine across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC	YES: Question appeals to or is of interest to the Family Medicine community across domains of care Relevance to Family Medicine is discussed or identified The project may be linked to the Principles of Family Medicine			NO: Question/problem is of no interest to the Family Medicine community Relevance to Family Medicine is not identified or approved	YES/NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Information Gathering: Literature review of the identified problem	Complete description of the literature on the value of existing tools Clear description of existing tools Critical evaluation of strength of evidence and certainty of conclusions	Some review of the literature Less clearly described existing tools Limited assessment of strength of evidence and certainty of conclusions	Sparse/basic literature description Minimal statement about strength of evidence and certainty of conclusions	Incomplete literature review to support the identified problem/topic No mention of strength of evidence and certainty of conclusions	/15
Methodology	Development of the tool clearly incorporates literature findings and formal tool design method Includes a thorough consideration of the applicability of the tool to the defined medical education setting to be utilized	Development of the tool incorporates literature findings and tool design method Includes consideration to the applicability of the tool to the defined medical education setting to be utilized	Partial incorporation of the literature findings and tool design method Some consideration to the applicability of the tool to the medical education setting to be utilized	Inadequate incorporation of the literature findings and no mention of tool design method Inadequate consideration to the applicability of the tool to the defined medical education setting to be utilized	/20
Achievement of Goals/Objectives	The tool is exceptional in meeting the stated objectives for the defined medical education setting	The tool highly achieves the stated objectives for the defined medical education setting	The tool meets the stated objectives for the defined medical education setting	The tool does not meet the stated objectives for the defined medical education setting	/10

Dalhousie Family Medicine Resident Project Assessment Rubric: Clinical Education Tool

Resident: Assessor: Date:

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Results and Discussion: The Completed Tool	The tool is of outstanding quality Practical application into practice and tool assessment is straightforward and well explained Discusses realistic implications for practice Suggests practical approach to evaluating the utility of the proposed tool	The tool is of high quality Explanation of application into practice and assessment Suggests some implications for practice and basic approach to evaluating the utility of the proposed tool	Tool is of average quality Some explanation of application into practice and assessment Mentions at least one implication for practice and mentions need to evaluate the utility of the proposed tool	Poor quality tool Minimal discussion of the practical application and assessment of the tool No or too little discussion of implications	/25
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately			NO: Word choices invite misunderstanding or may give offence Consistently poor grammar and spelling	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Organization	Organized thoughts Excellent layout of tool Appropriate education tool project components	Organized thoughts Appropriate education tool project components	Fairly organized thoughts Appropriate education tool project components	Missing key elements of education tool project components	/10
Proper citation and quality of references	YES Appropriate number of references (min. 15) The quality of references meets the expected standards.			NO Insufficient citations Does not meet desired standard of quality	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	/100
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. "Requires Revisions" must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required.

Dalhousie Family Medicine Resident Project Assessment Rubric: Medical/Health Humanities

Resident: Assessor: Date:

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Identification of the need for a Humanities Project	Problem/topic clearly identified Objectives for development of the project are richly stated Complete description of the need for this project and/or a description of existing/similar projects	Problem/topic clearly stated, originally, creativity Objectives less richly stated Clear description of the need for the tool and/or the value of existing/similar projects	Problem/topic stated Objectives not fully stated Brief description of the need for the project and/or the value of existing/similar projects	Problem/topic not defined Objectives not stated Need for the tool and/or the value of existing similar not stated	/20
Relevance to Family Medicine (across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC)	YES: Project/topic appeals to or is of interest to the Family Medicine community, student learned from experience, open to learning, independent worker, took initiative The project may be linked to the Principles of Family Medicine			NO: Problem/topic is of no interest to the Family Medicine community Relevance to Family Medicine is not identified or approved	YES/NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Methods:	Thorough description of methods used to review the literature, develop the art piece and answer the research questions.	Some description of methods used to review the literature, develop the art piece and answer the research question.	Sparce description of methods used to review the literature, develop the art piece and answer the research question.	No mention of methods used to review the literature, develop the art piece or answer the research question.	/15
Achievement of Goals/Objectives	The project is exceptional in meeting the stated objectives for the defined health setting	The project highly achieves the stated objectives for the defined health setting	The project meets the stated objectives for the defined health setting	The project does not meet the stated objectives for the defined health setting	/10

Results and Discussion	RESULTS The results were extremely well presented and of high quality The presentation was meaningful and engaging	RESULTS The results were well presented and of good quality	RESULTS The results were adequately presented and of adequate quality The presentation was less meaningful and engaging	RESULTS The results were inadequately presented and not of quality The presentation was not meaningful nor engaging	/25
	DISCUSSION Insightful, very detailed Rich discussion of how the project connects to the literature Identifies strengths and limitations A rigorous discussion of implications for practice and further development	DISCUSSION Insightful, less detailed Some discussion of how the project connects to the literature Identifies strengths and limitations Some discussion of implications for practice and further development	DISCUSSION Minimal insights and detail Limited discussion of how the project connects to the literature limited discussion of strengths and limitations limited discussion of implications for practice and further development	DISCUSSION Insufficient insights and detail Insufficient discussion of how the project connects to the literature Insufficient discussion of strengths and limitations Insufficient discussion of implications for practice and further development	/20
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately Cultural and identity sensitivity as appropriate			NO: Word choices invite misunderstanding or may give offence Consistently poor grammar and spelling Insensitive to culture and/or identity	YES / NO If “NO”, return project to resident for revisions. Do NOT grade until satisfactory
Organization	Exceptionally well-organized thoughts, Appropriate sections in the paper.	Organized thoughts, Appropriate sections in the paper.	Fairly organized thoughts Appropriate, appropriate sections in the paper.	Missing key elements of the paper.	/10
Proper citation and quality of references	YES Appropriate number of references (min. 15) The quality of references meets the expected standards.			NO Insufficient citations Does not meet desired standard of quality	YES / NO If “NO”, return project to resident for revisions. Do NOT grade until satisfactory
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	/100
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. “Requires Revisions” must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required.

Dalhousie Family Medicine Resident Project Assessment Rubric: Literature Appraisal

Resident: Assessor: Date:

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Define question/thesis or presenting case	Original question/thesis position presented Demonstrates the significance of the question with strong rationale Uses rich detail and identifies perceptively what is at issue	Clear question/thesis position presented Demonstrates judgement in the rationale for the importance of the question Identifies some significant points	Less clear definition of the topic and question Further discussion needed regarding the rationale for the importance of the topic	Vague topic presented Poorly thought-out rationale Does not match the project that was carried out	/20
Relevance to Family Medicine across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC)	YES: Question/problem appeals to or is potentially of interest to the Family Medicine community across domains of care Relevance to Family Medicine is discussed or identified The project may be linked to the Principles of Family Medicine			NO: Question/problem is of no interest to the Family Medicine community Relevance to Family Medicine is not identified or approved	YES/NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Researching/ Information Gathering	Conducted a comprehensive and recent review of the literature Clear and structured approach; inclusion/exclusion criteria identified Judiciously selected important sources to focus on; rejected or qualified less reliable sources	Variety of sources used Inclusion/exclusion criteria identified Well-chosen sources according to clear criteria as appropriate Balanced in perspectives; took into account strengths and limitations of sources	Did not present the most relevant sources Could be more balanced in the sources used Takes account of pitfalls in some sources	Fails to make use of appropriate literature Makes use of unreliable sources	/20
Presenting and evaluating sources/other perspectives	Summarized diverse literature views accurately and fairly Consistently focuses on the most central and significant ideas Critical evaluation of strength of evidence and certainty of conclusions using an established procedure or grading system	Summarized views of others fairly, with few errors Critical evaluation of strength of evidence and certainty of conclusions using less rigorous application of established procedures. Balanced detail with focus in summary and/or critique	Needs to be more fair in criticisms and summarizing the views of others Should be more judicious in honing in on what is important Minimal evaluation of strength of evidence and certainty of conclusions	Presented views of others in inaccurate or unfair ways No or too little discussion of strength of evidence and certainty of conclusions	/25

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Applying sources; reaching conclusions, resolving case, proving thesis	Successfully synthesized and weighed diverse kinds of evidence Provided a compelling argument/evidence for conclusion, and/or a conclusion that is appropriately qualified given the argument/evidence	Drew plausible conclusion from the evidence and arguments Demonstrated some ability to synthesize and/or evaluate diverse evidence	Should improve the argument(s) provided Recommend getting more comfortable in evaluating and synthesizing information/ reaching clear conclusion	Project fails to support views with evidence and arguments Poor synthesizing of information and reaching conclusions	/25
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately			NO: Word choices invite misunderstanding or may give offence Use consistently poor grammar and spelling	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Organization	Organized thoughts Smooth transitions Appropriate literature/ position paper project components	Organized thoughts Appropriate literature/ position paper project components	Fairly organized thoughts Appropriate literature review/ position paper project components	Missing key elements of literature review/position paper project components	/10
Proper citation and quality of references	YES: □ Proper citations □ Adequate number of references			NO: Improper citation	YES / NO
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. "Requires Revisions" must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					/100

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required.

Resident Name: Assessor: Date:

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Significance of the issue and advocacy objective	Demonstrates the significance of the issue with strong rationale Advocacy objective clearly explained and aligned with the issue	Demonstrates judgement in the rationale for the importance of the issue Advocacy objective identified	Further discussion needed regarding the rationale for the importance of the issue Advocacy objective could be clarified	Importance of the issue not established. Advocacy objective unclear	/20
Relevance to Family Medicine across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC.	YES: Issue is relevant to the Family Medicine community across domains of care. Relevance to Family Medicine is discussed or identified. The project may be linked to the principles of Family Medicine.			NO: Issue is of no interest to the Family Medicine community. Relevance to Family Medicine is not identified or approved.	YES/NO If "NO" return project to resident for revisions. Do NOT grade until satisfactory.
Researching the issue/Identifying allies	Conducted a comprehensive review of evidence including all relevant perspectives. Interest-holders (including affected communities and potential allies) comprehensively considered.	Includes a variety of sources, considering a range of relevant perspectives. Relevant interest-holders (including affected communities and potential allies) identified.	Some clearly relevant sources of evidence not considered. Highly relevant interest-holders (including affected communities and potential allies) not identified.	Incomplete or unreliable review of evidence. No consideration of interest-holders (including affected communities and potential allies)	/20
Presenting and evaluating perspectives/Advocacy strategy	Position clearly articulated and supported by relevant, high quality, evidence. Strength of evidence critically evaluated with attention to all relevant perspectives. Advocacy strategy described or undertaken with careful reflection on achievement of intended objective, strategies, and partnerships.	Position explained and supported with some relevant evidence. Strength of evidence considered, with consideration of some different perspectives. Advocacy strategy largely aligned with issues, objective and evidence.	Should improve the argument(s) provided. Minimal evaluation of strength of evidence and important perspectives overlooked. Objective unclear and strategy needing re-evaluation.	Project fails to support position with evidence and arguments. No discussion of strength of evidence. Presented some perspectives in inaccurate or unfair ways. Advocacy objective and strategy misaligned with issue, objective, and evidence.	/25

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Applying sources to written argument/implementation and reflection.	Advocacy strategy described or undertaken with careful reflection on achievement of intended objective, strategies and partnerships.	Advocacy strategy described or undertaken with some reflection of achievement of intended objective, strategies and partnerships.	Advocacy strategy described or undertaken with some reflection on achievement of intended objective, strategies and partnerships.	Advocacy strategy described or undertaken with little attention to achievement of intended objective, strategies and partnerships.	/25
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately			NO: Word choices invite misunderstanding or may give offence Use consistently poor grammar and spelling.	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Organization	Organized thoughts. Smooth transitions. Appropriate literature/position paper project components.	Organized thoughts. Appropriate literature/position paper project components.	Fairly organized thoughts. Appropriate literature review /position paper project components.	Missing key elements of literature/position paper project components.	/10
Proper citation and quality of references	YES: Proper Citations Adequate number of references			NO: Improper citation	YES/NO
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. "Requires Revisions" must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					/100

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required.

Resident:	Assessor:	Date:			
	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Identification of the need for a Medical Education tool	Problem/topic clearly identified Objectives for development of the project are richly stated Complete description of the need for this project and/or a description of existing/similar projects	Problem/topic clearly stated, originally, creativity Objectives less richly stated Clear description of the need for the tool and/or the value of existing/similar projects	Problem/topic stated Objectives not fully stated Brief description of the need for the project and/or the value of existing/similar projects	Problem/topic not defined Objectives not stated Need for the tool and/or the value of existing similar not stated	/20
Relevance to Family Medicine across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC	YES: Question appeals to or is of interest to the Family Medicine community across domains of care Relevance to Family Medicine is discussed or identified The project may be linked to the Principles of Family Medicine			NO: Question/problem is of no interest to the Family Medicine community Relevance to Family Medicine is not identified or approved	YES/NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Information Gathering: Literature review of the identified problem	Complete description of the literature on the value of existing tools Clear description of existing tools Critical evaluation of strength of evidence and certainty of conclusions	Some review of the literature Less clearly described existing tools Limited assessment of strength of evidence and certainty of conclusions	Sparse/basic literature description Minimal statement about strength of evidence and certainty of conclusions	Incomplete literature review to support the identified problem/topic No mention of strength of evidence and certainty of conclusions	/15
Methodology	Development of the tool clearly incorporates literature findings and formal tool design method Includes a thorough consideration of the applicability of the tool to the defined medical education setting to be utilized	Development of the tool incorporates literature findings and tool design method Includes consideration to the applicability of the tool to the defined medical education setting to be utilized	Partial incorporation of the literature findings and tool design method Some consideration to the applicability of the tool to the medical education setting to be utilized	Inadequate incorporation of the literature findings and tool design method Inadequate consideration to the applicability of the tool to the defined medical education setting to be utilized	/20
Achievement of Goals/Objectives	The tool is exceptional in meeting the stated objectives for the defined medical education setting	The tool highly achieves the stated objectives for the defined medical education setting	The tool meets the stated objectives for the defined medical education setting	The tool does not meet the stated objectives for the defined medical education setting	/10

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Results and Discussion: The Completed Tool	The tool is of outstanding quality Practical application into practice and tool assessment is straightforward and well explained Discusses realistic implications for practice Suggests practical approach to evaluating the utility of the proposed tool	The tool is of high quality Explanation of application into practice and assessment Suggests some implications for practice and basic approach to evaluating the utility of the proposed tool	Tool is of average quality Some explanation of application into practice and assessment Mentions at least one implication for practice and mentions need to evaluate the utility of the proposed tool	Poor quality tool Minimal discussion of the practical application and assessment of the tool No or too little discussion of implications	/25
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately			NO:Word choices invite misunderstanding or may give offence Consistently poor grammar and spelling	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Organization	Organized thoughts Excellent layout of tool Appropriate education tool project components	Organized thoughts Appropriate education tool project components	Fairly organized thoughts Appropriate education tool project components	Missing key elements of education tool project components	/10
Proper citation and quality of references	YES Appropriate number of references (min. 15) The quality of references meets the expected standards.			NO Insufficient citations Does not meet desired standard of quality	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	/100
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. "Requires Revisions" must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required

Resident:		Assessor:		Date:	
	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Identification of the need for self-learning questions tool	-Theme for the questions clearly identified - Complete description for the evidence gap in theme area selected -Objectives for development of the questions are richly stated	-Theme clearly stated -Clear description for the evidence gap in theme area selected -Objectives less richly stated	-Theme stated -Brief description for the evidence gap in theme area selected -Objectives sufficiently stated	-Theme not defined -Insufficient description for the evidence gap in theme area selected -Objectives not stated	/20
Relevance to Family Medicine across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC	YES: Theme and questions appeal to or are of interest to the Family Medicine community across domains of care Relevance to Family Medicine is discussed or identified The project may be linked to the Principles of Family Medicine			NO: Theme or questions of no interest to the Family Medicine community Relevance to Family Medicine is not identified or approved	YES/NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Information Gathering: Articles selection	-Complete description of each paper -Complete rationale for choosing each article -Complete assessment of the strength of evidence and certainty of conclusions for each article.	-Good description of the articles on which each question is based -Sound rationale for choosing each article -Good assessment of the strength of evidence and certainty of conclusions for each article.	-Minimal description of the articles on which each question is based. -Limited rationale for choosing each article -Limited assessment of the strength of evidence and certainty of conclusions for each article.	-Inappropriate papers or incomplete description of the articles on which each question is based -No rationale for choosing the articles -No assessment of the strength of evidence and certainty of conclusions for each article.	/15
Methodology	-Clear and thorough description of how the questions and educational points were written. -Attention to all the self-learning question-writing guidelines. ***(*see Lespérance S. 2025 Self-Learning Question Writing Guide*)**	-Good description of how the questions and educational points were written. -Good attention to the guidelines.	-Adequate description of how the questions and educational points were written. -Sufficient attention to the guidelines.	-Insufficient description of how the questions and educational points were written. -Insufficient attention to the guidelines.	/20
Achievement of Goals/Objectives	Fully achieves objective of enabling users to remain current with knowledge	Achieves objective of enabling users to remain current with knowledge	Sufficiently achieves objective of enabling users to remain current with knowledge	Does not sufficiently achieve objective of enabling users to remain current with knowledge	/10

Results and Discussion: The Completed Questions and Educational Points	-Six questions provided (including at least one Short-Answer Management Problem (SAMP) -The questions and educational points are of outstanding quality -For each question, practical application into practice is well explained and implications of the findings discussed	-Six questions provided -The questions and educational points are of very good quality -For each question, practical application into practice is explained and implications of the findings discussed	-Six questions provided -The questions and educational points are of sufficient quality -For each question, practical application into practice is somewhat explained and at least one implication of the findings discussed	-Less than six questions provided and or/ no SAMP -The questions educational points are of insufficient quality -Does not discuss practical applications and realistic implications for practice	/25
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately			NO: Word choices invite misunderstanding or may give offence Consistently poor grammar and spelling	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Organization	-Very well-organized thoughts -Excellent layout of questions and educational points -Appropriate education tool project components	-Organized thoughts -Good layout of questions and educational points -Appropriate education tool project components	-Fairly organized thoughts -Sufficient layout of questions and educational points -Appropriate education tool project components	-Thoughts insufficiently organized -Insufficient layout of questions and educational points -Missing key elements of education tool project components	/10
Proper citation and quality of references	YES One appropriate article for each question, and overall appropriate number of references (min. 15) The quality of references meets the expected standards.			NO Insufficient citations Does not meet desired standard of quality	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	/100
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. "Requires Revisions" must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required.

Dalhousie Family Medicine Resident Project Assessment Rubric *(check one)*: ☐ Research or ☐ Practice Quality Improvement

Resident: Assessor: Date:

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Define research question	Clear rationale for study question Clearly stated objectives Innovative nature of project	Clear rationale for study question only Clearly stated objective Study was somewhat innovative (question previously asked but interesting aspects of author's approach to the question)	Research question defined but not innovative Objectives stated	Research question not defined Objectives not stated	/10
Relevance to Family Medicine across domains of care (including domain specific competencies required for awarding Certificates of Added Competence (CAC) by the CFPC	YES: Study question appeal to the Family Medicine community across domains of care Relevance to Family Medicine is identified and/or discussed The project may be linked to the Principles of Family Medicine			NO: Study question is of no interest to the Family Medicine community Relevance to Family Medicine is not identified or approved	YES/NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Background literature review	Comprehensive literature review Recent evidence reviewed Critical evaluation of strength of evidence and certainty of conclusions	Adequate literature review Recent evidence reviewed Limited assessment of strength of evidence and certainty of conclusions	Brief/short literature review Limited but adequate sources used Minimal statement about strength of evidence and certainty of conclusions	Incomplete literature review Does not include recent evidence No mention of strength of evidence and certainty of conclusions	/15
Appropriateness of study design (to answer the research question)	Study design is scientifically sound and answers study question Methods are clearly described with appropriate citation	Study design answers study question Methods are clearly described	Study design answers the question, but more appropriate design exists Methods would benefit from further explanation	Study design does not adequately answer the study research question	/15
Appropriateness of data analysis	The analysis answers the study question appropriately Well described statistical analysis and rational for the approach chosen	The analysis answers the study question The rationale is explained	The analysis somewhat answers the study question but another statistical approach would be more appropriate	The analysis is not able to answer the study question Inappropriate statistical tests chosen	/15

	Outstanding	Highly Acceptable	Acceptable	Requires Revisions	
Results	Results included and clearly presented Tables/graphs were of high standard and appropriate for the type of project	Results included and clearly presented Tables/graphs appropriate for the type of project	Minimum level of results presented Basic tables/graphs presented	Results inadequately presented	/15
Discussion/ Conclusions	Proper discussion of key findings, including strengths and limitations Comparison to similar studies in the literature Conclusions drawn reflect the results Discussion of next research steps	Discussion of key findings included Some discussion of strengths/limitations Comparison to similar studies in the literature Conclusions drawn reflect the results	Brief discussion of key findings Less thorough understanding of strengths/limitations Less thorough comparison to similar studies in the literature Conclusions generally reflect the results	Lack of summary of key findings, strengths/ limitations Lack of comparison to similar studies in the literature Conclusions go beyond the limitation of the research conducted	/20
Quality of Language	YES: Clear and accurate word choice Selected appropriate academic vocabulary Well-structured sentences Minimal spelling mistakes and sentence structure concerns Proofread adequately			NO: Word choices invite misunderstanding or may give offence Use consistently poor grammar and spelling	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
Organization	Organized thoughts Smooth transitions Appropriate research project components	Organized thoughts Appropriate research project components	Fairly organized thoughts Appropriate research project components	Missing key elements of research project components	/10
Proper citation and quality of references	YES Appropriate number of references (min. 15) The quality of references meets the expected standards.			NO Insufficient citations Does not meet desired standard of quality	YES / NO If "NO", return project to resident for revisions. Do NOT grade until satisfactory
RESULTS	Outstanding (90-100)	Highly Acceptable (75-89)	Acceptable (60-74)	Requires Revisions (<59)	/100
INSTRUCTIONS: Judge level of achievement based on descriptors in the box and underline some descriptors for guidance or praise. "Requires Revisions" must include specific descriptors and comments to help the resident improve. Only provide a final grade for those in the Outstanding, Highly Acceptable and Acceptable range. Give grades to projects requiring revisions only after the revisions have been satisfactorily completed.					

FEEDBACK (Required): Please provide an explanation for your evaluation of the project. Please add additional pages if required.

Guide on How to Organize Resident Projects Based on Type of Project

	Research	Practice Quality Improvement/Audit	Advocacy Project	Education Tool	Literature Appraisal	Medical/Heath Humanities
Cover Page: 1 page	Must include project title, author's name, name(s) of co-author(s) (if applicable), site, name(s) of Project Supervisor(s), type of project, and date.					
Abstract: ½ page	Introduction, methods, results, interpretation, and 3-5 keywords.					
Introduction/Background: ½ to 1 page	Summary of background literature and state research question. State objective(s) or hypothesis(es)	Summary of background literature and state research question. State objective(s).	Summary of background literature and the position that will be taken. State objective(s).	Summary of background literature and provide evidence for relevance and indicate gaps. State objective(s).	Summary of background to topic for literature appraisal and state research question. State objective(s).	Summary of background literature and provide evidence for relevance and gaps. State objective(s).
Study Design / Method: 1 to 2 pages	Describe study methods.	Describe study methods, inclusion and exclusion criteria.	Provide brief description of evidence development to support position (literature review).	Provide methodology for education tool development, audience focus, visuals, language level, tool choice (paper, video), etc.	Describe how review was conducted, data-bases searched, terms used for searches and inclusion/ exclusion criteria used. Method applied for appraisal.	Provide methodology for project development, audience focus, visuals, language level, medium choice (paper, video) etc. Describing the art form that was chosen and why.
Results: 3 to 5 pages	Present findings from data.	Present findings from data and describe the strength of the findings.	Detail position in relation to literature/ evidence and, if appropriate, make recommendations or describe the meaning of the position and identify implications for practice.	Statements need to be grounded in the literature.	Summarize findings including evidence strength.	Inclusion of the humanities piece with a description.
Discussion: 2 to 3 pages	Synthesize/ interpret findings, link back to literature, identify implications for practice and research.	Synthesize the data and identify implications for practice and research.		Describe the tool and how to implement it. Provide the tool in appendix. Identify implications for research.	Synthesize the literature, create meaning, and identify implications for practice and research.	Synthesize/reflect on the piece, link back to literature, identify implication for practice and research.
Strengths/ Limitations: ½ page	Share limitations and highlight advantages and disadvantages of the data/literature					
Conclusion: ½ page	Summarize the results					
References	References should be appropriate, relevant, and the style should be consistent.					

Tips and Tricks When Doing a Family Medicine Resident Research Project

Conducting research for your resident project can be rewarding and challenging. The following is intended to provide guidance and suggest resources to help with the research endeavor so you can competently complete your project with the time and resources you are prepared to expend. This guide is divided into 5 Steps:
Step 1: Select a topic, identify the research problem, and state a clear research question.
Step 2: Choose a research method.
Step 3: Find an appropriate supervisor.
Step 4: Write a research proposal.
Step 5: Ask the expert.

Step 1: Select a topic, identify the research problem, and state a clear research question.
Topic requirements are:

- It needs a strong relationship to Family Medicine;
- You need to be curious/passionate about it;
- It needs to address a gap in the literature research;
- It needs to be doable within the allotted time and your skill set.

Identifying your research problem/research question
Selecting your research question can be one of the most agonizing and critical steps in developing a solid research study. It defines your whole process, from what background literature you need to read, guiding what method you should use, analysis required, and the findings to report in order to answer the question. Your question should be clear, focused, concise, complex and arguable. This will take time. Step away from your computer; consider what drew you to your topic. What about it animates and matters to you? Listen to yourself and start formulating your question by following your own interests. Remember, you will spend a lot of time researching and writing about the proposed project. If it does not interest you in the beginning, it will certainly become very difficult to write about in the end.

Next, extensively research your topic. What have experts published in peer reviewed journals? How have they framed their research? What gaps, contradictions or concerns arise for you as you read, talk to people, and visit places? Would doing a local project using existing studies enhance knowledge? Consult the literature! If you aren't sure how to do this, consult a subject librarian:

Formulating your research question
Conduct a preliminary literature review of the topic area to help frame the research question.
The question needs to be specific answerable within your time frame.
Is your question adding something new to what is already known? Is it addressing local relevance?
Formulate two or three research objectives that will answer the question.
Think, consider, and estimate
Be sure of the feasibility of your study.

Edit your writing

- Choose your words carefully.
- Rewrite, rewrite, rewrite!
- Keep your sentences short.

Too broad: How are doctors addressing diabetes in Canada?

Appropriately specific: What are common traits of those suffering from diabetes in Canada, and how can these commonalities be used to aid the medical community in prevention of the disease?

The simple version of this question can be looked up online and answered in a few factual sentences, and leaves no room for analysis. The more complex version is written in two parts; it is thought provoking and requires both significant investigation and evaluation from the writer. As a general rule of thumb, if a quick Google search can answer a research question, it's not very likely effective.

Step 2: Choose a research method

There are several methods to choose from for conducting research. They broadly group into qualitative studies, quantitative studies and evidence review. Mixed methods studies draw on both qualitative and quantitative methodologies because they are complementary.

Qualitative Research

- Qualitative research focuses on the interpretation of a situation, a set of behaviors, or a setting.
- Collects large amount of data from a small number of individuals, usually through interviews, analyzed to identify themes.
- Used to understand people's experiences in much greater depth than is possible with quantitative research.
- Qualitative data is analyzed using thematic techniques.
- Methodology examples include: ethnography, narrative, phenomenological, grounded theory and case studies.
- Examples include: interviewing patients to understand how they experience a disorder or health system approach, or interviewing health care providers to understand how they view a clinical tool or their experience of medical education, or describing a series of cases with a similar type of health issue.

Quantitative Research

- Quantitative research measures characteristics of a population or phenomenon of interest.
- Collects data from larger number of individuals through surveys or existing or prospectively collected data sets.
- Quantitative data is analyzed using statistical analyses with tests of statistical significance.
- Methodology examples include: population surveys to measure prevalence of a disorder or implementation of a clinical tool, observational studies using clinical or administrative data sets, or randomized controlled trials of the efficacy and safety of treatments.
- Examples include: identifying correlates of suicide, evaluating measures to prevent suicide, or determining the benefit/risk of a medication to treat a disorder.

Step 3: Find an appropriate supervisor

A supervisor should be interested in your project and be available to guide you. If you are having trouble finding one, talk to your site's Project/Research Coordinator.

Step 4: Write a research proposal. This will also be required for REB approval.

A research proposal is a study plan that is to be followed in the course of a research study. It is important for you to understand how your objectives, method, analysis plan, and any budgetary requirements, as well as how prepared you are to do the work required and if you have the needed skills. From this, you can identify where you will need assistance.

Research proposal sections:

1. One paragraph introduction to your research question/problem, including why this is important to study, and relevance to Family Medicine. A good first line of a research proposal begins, "The research objective of this proposal is… "

2. Write a more in-depth introduction. After you have identified a pertinent problem and framed a purpose statement, then you need to craft an introduction. Among other things, the introduction to the proposal will include:
   (a) The problem statement
   (b) A brief summary of the literature
   (c) A brief description of any gaps in the literature
   (d) A Purpose statement as to why you are proposing the study and why others should care about the subject matter of your research proposal

3. Background/literature review. Frame your project around the work of others. Remember that research builds on the extant knowledge base, that is, upon the peer reviewed published work of others. Be sure to frame your project appropriately, acknowledging the current limits of knowledge and making clear your contribution to the extension of these limits. Be sure that you include references to the work of others. Also frame your study in terms of its broader impact to the field and to society. (e.g., "If successful, the benefits of this research will be… ")

4. Methods. Determine the Method of Investigation. The method section is the second of the two main parts of the research proposal. In good academic writing it is important to include a method section that outlines the procedures you will follow to complete your proposed study. Many scholars have written about the different types of research methods in articles and textbooks. It is a good idea to site the method and provide a reference. The method section generally includes sections on the following:
   (a) Research design
   (b) Sample size and characteristics of the proposed sample
   (c) Data collection and data analysis procedures

5. Determine the research design.
   a) The next step in good academic writing is to outline the research design of the research proposal. For each part of the design, it is highly advised that you describe two or three possible alternatives and then tell why you propose the particular design you chose. For instance, you might describe the differences between experimental, quasi-experimental, and non-experimental designs before you elaborate on why you propose a non-experimental design.

   b) Determine the Sample Size and the Characteristics of the Sample. There are several free online sample size calculators, though you will need a basic understanding of statistics to know how to use and interpret them. Some sites include:
   http://www.stat.ubc.ca/~rollin/stats/ssize/ http://www.raosoft.com/samplesize.html
   http://homepage.stat.uiowa.edu/~rlenth/Power/

   c) In this section of your research proposal, you will describe the sample size and the characteristics of the participants in the sample size. Describe how you determined how many people to include in the study and what attributed they have which make them uniquely suitable for the study.

6. Determine the data collection and the data analysis procedures.
   a) In this section you will describe how you propose to collect your data (e.g. through a questionnaire survey if you are performing a quantitative analysis or through one-on-one interviews if you are performing a qualitative or mixed methods study).

   b) After you collect the data, you also need to follow a scheme as to how to analyze the data and report the results. In a quantitative study you might run the data through Mintab, Excel, or better yet, SPSS, and if you are proposing a qualitative study you might use a certain computer program like ATLAS to perform your analysis using a specific qualitative approach such as the narrative study, grounded theory study, or framework analysis, that exposed the main themes from the proposed interviews (see Tips and Tricks on Statistics).

7. Software and analysis. There are several options for creating a database, cleaning your data and conducting your analysis.

   Free analysis software is available through Dalhousie. Minitab and SPSS for quantitative analyses and NVivo is used for qualitative analyses. They are found here: https://software.library.dal.ca/index.php. User guides and tutorials can be found here: http://www.minitab.com/en-CA/training/. Additionally, students familiar with conducting statistics in Excel can download the free add-on package to a windows suite. However, reviews demonstrate that Excel has many issues handling data correctly for analysis and is not as user-friendly as Minitab.
   Ethics. You will need to address any ethical considerations and how they will be dealt with, including confidentiality, data storage, etc. If Research Ethics Board (REB) approval is required for your study, you should check the website for relevant REB review. Each site has its own REB process.

Step 5: Ask the experts

Review your proposal with your Project Supervisor and site Project/Research Coordinator. Depending on your research needs, you may also consult with the Research Methods Unit (RU) at Dalhousie University. An initial consultation is free, although there may be a fee if further assistance is required. Early consultation can help you avoid costly mistakes.

Consider using the ARECCI tool when determining whether REB approval is required.
http://www.aihealthsolutions.ca/arecci/screening/454024/c70dc91203975709879104256 8d e7c6e

Tips and Tricks When Applying to a Research Ethics Board (REB) for a Family Medicine Resident Project

When collecting data for a resident (research) project involving human beings, an ethics review from a recognized Research Ethics Board (REB) is required.

This application requires a proposal with a brief background, methods and data analysis section. In addition, the REB is particularly interested in the consent process regarding research participants. It is paramount that research participants are volunteers, who are fully aware to what they are consenting.

The Tri-Council - Canadian Institutes for Health Research (CIHR), Social Science and Humanities (SSHRC) and National Science and Engineering Research Council (NSERC) – has developed a joint research ethics policy. See this link for the entire policy:

http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_W_eb.pdf

The Tri-Council states:

> REBs shall consider whether information is identifiable or non- identifiable. Information is identifiable if it, alone or when combined with other available information, may reasonably be expected to identify an individual. The term "personal information" generally denotes identifiable information about an individual.

However, there are some exceptions. The Tri-Council states:

> Research that relies exclusively on publicly available information does not require an REB review when: (a) the information is legally accessible to the public and appropriately protected by law; or (b) the information is publicly accessible and there is no reasonable expectation of privacy.

Chart reviews, or chart audits, usually require REB approval when the resident is planning to discuss the results publicly (Resident Project Day).

Many resident projects are considered "minimally invasive" and they may qualify for an "expedited review". An expedited review usually takes between 3 to 4 weeks, while a full review may take up to 2 months.

After REB approval has been obtained, no changes to the research instruments or recruitment strategy can be made. If that is required, the REB needs to be informed.

Each family medicine resident who requires REB approval needs to obtain it in the province or hospital of their residency.

Please consult with your site Project/Research Coordinator regarding the need for an REB application and how to go about it.

Typically, residents and Project Supervisors will be required to provide a statement around data management and storage requirements

Here are some links for REB websites in various provinces that residents can access for a specific REB application information and forms (each institute has a different process).

New Brunswick
https://en.horizonnb.ca/home/research/research-ethics-board.aspx
http://www.mta.ca/reb/Vitalite%20Guide%20Feb%202011%20English.pdf

Prince Edward Island
http://www.healthpei.ca/reb

Nova Scotia
www.cdha.nshealth.ca/discovery-innovation-29 https://www.cdha.nshealth.ca/discovery-innovation/ethics
https://www.dal.ca/dept/research-services/responsible-conduct-/research-ethics-.

Tips and Tricks When Doing Statistics Family Medicine Resident Project

If you want to do a resident project that involves collecting data and requires statistical analysis, here are some tips of how you can go about that. Keep in mind that you are responsible for doing the work, and should be prepared to know how to collect data, enter data, run your own analysis and interpret your findings, though some resources are available to assist you.

Assistance Resources
BEFORE you start collecting data, find somebody you can discuss your plan and statistical needs with. It could be your project supervisor, your resident project site coordinator and/or somebody else who can help you who is experienced with statistics. Resident project site coordinators can help you find someone to assist you. Also, the Dalhousie University Research Methods Unit (see below) can be consulted. There will likely be a cost associated with receiving assistance, and these should be appropriately budgeted. Each resident has access to $50 towards their resident project. Additional funds would require an application with proposal and budget to your resident project site coordinator. Funding is at the discretion of the Department.

Dalhousie Research Methods Unit
If you need more sophisticated help you can consult with the Dalhousie Research Methods Unit http://www.cdha.nshealth.ca/discovery-innovation/research-methods-unit. The initial consultation with them is free.

Software resources
Several software packages are available to assist with statistical analysis and they often have helpful tutorials. Here are some examples:

MINITAB
data in Minitab or import from excel. This program is free of charge from the Dalhousie website; http://its.dal.ca/helpdesk/licences.html (not for MAC users). Minitab is useful for basic statistics, regression, ANOVA, reliability and survival analysis.

Here is a YouTube getting started video: http://www.youtube.com/watch?v=Ql88ytNBNgw Or tutorials from Minitab: http://www.minitab.com/en-GB/training/tutorials/default.aspx

SPSS
Statistical Package for Social Sciences (SPSS) is a popular statistical analysis program that is fairly easy to learn with several resources available. All Dalhousie University faculty and learners can download SPSS programs. Resident project site coordinators can sometimes assist in finding access to a computer with SPSS.

Microsoft Excel
Microsoft Excel is included in most MS office suites and can be used to conduct some basic statistics and creates attractive charts and graphs. However, a quick Google search will provide concerns as the reliability of its statistical analysis accuracy, so use with caution. You can use Microsoft Excel sheets to enter data.

These Excel sheets can be easily imported to the statistical package Minitab. In theory you can also import the Excel data sheet in SPSS but it has caused some problems in the past.

There are several videos and other supports found online.

Statistical Analysis Software (SAS)
If you require more advanced statistical techniques than the above options provide, you may want to use SAS or STATA, and unless you have advanced training and experience, you will likely need to hire assistance. It is recommended you consult with your supervisor, resident project site coordinator and/or the Research Methods Unit.

R
R is free software for statistical computing and graphics. It compiles and runs on a wide variety of platforms such as Windows and MacOS. You can download it from http://www.r-project.org/

Tips and Tricks When Creating a Clinical or Medical Education Tool Family Medicine Resident Project

Clinical education tools concisely summarize evidence-based information on a specific topic for health care providers, patients or both. While clinical education tools "educate", they are intended to be practical guides to help people in clinical settings.

Medical education tools, on the other hand, are a resource for undergraduate or postgraduate medical education, aimed at practicing family physicians, family medicine learners and educators. Examples include but are not limited to Problem Based Learning Cases, OSCE development, online curriculum modules, self-learning question writing.

Examples of education tool products include but are not limited to infographics (handouts), apps, articles, Self-Learning questions or webpages.

Once you have determined that you want to create your own clinical or medical education tool, do the following (see Thompson et al. 2024 for more guidance about these points):

- Identify a topic that interests you.
- Consult the literature to find out whether a tool already exists, whether you could revise an existing tool, or whether you could you adopt an existing tool to local conditions.
- Identify your audience and their needs. You might want to consult representatives of your intended audience early and throughout the process.
- Clarify the message you want to provide.
- Identify the medium you want to use for the education tool. A tool could be passive or interactive. A tool could be disseminated on paper, electronically or in person (presentation). A tool could use text, imagery or video. Do you have easy access to the medium?
- Consider how you could distribute the tool. Examples include but are not limited to paper handouts, email, websites, letters, presentations, and video.
- Identify evidence-based content. Remember, an education tool's information has to be grounded in the scientific literature. In describing how you developed the tool, you must cite relevant literature. The assessor needs to see that your tool's content is scientifically sound.
- Design the tool. Design principles for infographics (handouts) are described in the above reference, but some tools might require other design considerations. Think about the story you want to tell the audience, and how best to combine text and imagery.
- Consider consulting experts in content and design as well as the intended audience.
- Describe how to evaluate the final tool. Even a small pilot test may inform you about the readability and validity of the education tool.

In most cases, the tool will be attached to the required 2,500-to-4,000-word paper as an appendix. The paper describes why and how the tool was developed.

Self-learning Question Writing

Self-learning question writing is a new medical education tool type in 2025/2026. The Self-Learning Program is a continuing education program under the umbrella of the College of Family Physicians of Canada's CPD offerings for its members. Questions are created by family physicians who select recent (within 6-12 months) articles relevant to the practice of family medicine, and using evidenced-based approaches to adult education, create questions that prompt learning and reflection. Residents choosing to make self-learning questions for their project are referred to the guide by Lespérance mentioned below (2025).

References:

Thompson JM, Macartney G, Welton S. Designing infographics – A manual for health care provider learners and practitioners. Charlottetown (PE): Robertson Library, University of Prince Edward Island. 2024. Available from: https://pressbooks.library.upei.ca/infographicsmanual. https://doi.org/10.32393/DesigningInfographics. A PDF version is also available for free at LINK (to Brightside or Dal FM website projects resources page). Although this manual is primarily about creation of infographics (handouts), the concepts can apply to other types of tools.

Lespérance S. 2025 Self-Learning Question Writing Guide (see next page)

Self-Learning Question Writing Guide (2025)

(Self-Learning Question Writing as a Resident Scholarly Project)
Sarah Lespérance, Chair CFPC Self-Learning Program, 2024

The Self-Learning program is a continuing education program that falls under the umbrella of the College of Family Physicians of Canada's CPD offerings for its members. Questions are created by family physicians who select recent (within 6-12 months) articles relevant to the practice of family medicine, and using evidence-based approaches to adult education, create questions that prompt learning and reflection. These articles are then reviewed at a national level for publication in quarterly volumes. Question writers are expected to critically review articles for study quality, relevance to family medicine in Canada, and likelihood that the article offers findings that may either change practice, or answer a clinical question not yet answered. Authors must then create a question and educational point to summarize article findings and convey information effectively to the reader.

Learner support and guidance

Members of the Self-Learning program (several of whom are Dalhousie Family Medicine Faculty in Nova Scotia), are willing to act as Resident Project Supervisors for residents. They can provide feedback and guidance to residents on the question creation process. Dr. Sarah Lespérance can be a resource for interested residents (drsarahlesperance@gmail.com).

Publication Opportunity as Self-Learning Questions with the CFPC

Questions written for articles within 6-12 months of the article's publication will be submitted to the CFPC National Self-Learning Committee for review and possible acceptance for publication in a future edition of CFPC Self-Learning™. There are over 10 000 subscribers to Self-Learning, so accepted questions will directly impact the practice of many primary care providers across the country.

Requirements for a Self-Learning Question Writing Medical Education Tool project
Residents choosing to create Self-Learning questions for their resident project should:

- Collaborate with a member of the Self-Learning Question Writing Team with the CFPC (see contact below)
- Prepare a minimum of 6 questions, including at least one Short-Answer Management Problem (SAMP)
- The remaining questions can be either Multiple Choice or True/False questions, or additional SAMPs
- The questions should all be related to one theme of relevance in family medicine
- The project must follow the Resident Project Guide format for a Medical Education Tool with the Results section discussing the questions. The questions are to be attached as an appendix to the project
- Sample questions and the Guidelines from Self-Learning for Question Writers are found below

Self-Learning Question Writing Guidelines

Guidelines for Selecting Articles

1. Relevant to family practice.
2. Offers new knowledge or meets a deficiency in the knowledge of the reader
3. Based on original research or a review article
4. If the article is based on original research, the methodology is sound
5. If the article is a review article the article is focused on the topic area of interest
6. Contains a good description of the literature search done to prepare the article
7. Taken a peer-reviewed journal, preferably in common circulation
8. Published within the last 12 months

Guidelines for Writing Good Questions

Certain articles will lend themselves better to a multiple choice or short-answer management problem, while others may have one key finding and be better suited as a true/false question. Review articles often will be useful to create short-answer management

problems. A multiple-choice question should consist of the question followed by 4 possible responses. The 4 responses should include one answer, and 3 distractor statements.

In drafting a question, ask the following to ensure the question will be clear to readers.

1. Is the key outcome/finding (objective) of the question clear?
2. Do the important elements of the problem appear early in the statement of the question?
3. Is there an unnecessary repetition of words?
4. Does the question contain any double negatives in either the stem or the response?
5. Are all responses grammatically consistent with the stem?
6. In multiple-choice question, do the answer and 3 distractors highlight independent outcomes or findings?
7. Are all responses parallel in form? (e.g., single words, phrases, complete sentences, etc.)
8. Are any inclusive or exclusive expressions such as “never”, “always”, etc. used in such a way as to not cue the person answering the question?
9. Is the punctuation correct?
10. Are all items written in clear and simple language with vocabulary kept as simple as possible?
11. Are all responses plausible and attractive to our subscribers who might lack the information or ability tested by the item?

Guidelines for Writing Good Educational Points

Educational Points are an important part of a well-structured question. Due to copyright legislation, the text of the Educational Point must be taken word for word from the article and not paraphrased.

When writing an Educational Point ask these questions:

1. Is there an introduction to the topic at the beginning of the Educational Point?
2. Is there enough material presented to give a good overview of the topic?
3. Are each of the distractors discussed adequately in the Educational Point, and have the supporting statements for each distractor been bolded (see sample questions)?
4. Does the Educational Point flow logically from beginning to end?
5. Are important points regarding the topic which couldn’t be included in the question itself included in the Educational Point?
6. Is the Educational Point too wordy? Ideally, approximately 20% of the article content should be the aim.

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Sample questions for 3 styles used in Self-Learning

1. True/False Question

Plantar fasciitis
Categories: Sports Medicine, Physical Medicine & Rehab

Treatment of plantar fasciitis with botulinum toxin A therapy leads to clinically significant improvement in pain at 12 months.
1. True
2. False

Answer: 1

Reference: Acosta-Olivo C, Simental-Mendía LE, Vilchez-Cavazos F, Peña-Martínez VM, Elizondo-Rodíguez J, Simental-Mendía M. Clinical Efficacy of Botulinum Toxin in the Treatment of Plantar Fasciitis: A Systematic Review and Meta-analysis of Randomized Controlled Trials. Arch Phys Med Rehabil. 2022 Feb;103(2):364-371.

PMID: 34688605

Educational point: Plantar fasciitis is a common injury that occurs in the plantar apo-neurosis as a result of constant microtrauma and excessive strain. This affection is the most frequent cause of plantar heel pain, which is estimated to occur in approximately 10% of the general population, where active working adults between the ages of 25 and 65 years account for 83% of these patients. Obesity, prolonged standing, excessive foot pronation, running, and decreased ankle dorsiflexion are the main predisposing factors for plantar fasciitis. This condition is essentially a chronic degenerative process owing to the repetitive stress and weight-bearing−associated microtears.

Because plantar fasciitis is characterized by a multifactorial etiology, multiple therapeutic options have been tested. The different treatment modalities may be classified into noninvasive and invasive therapies, including plantar fascia stretching exercises, taping, shoe inserts, night splints, nonsteroidal anti-inflammatory drugs, extracorporeal shock wave therapy, corticosteroid injections, platelet-rich plasma injections, botulinum toxin injections, and surgical approaches. Noninvasive interventions have usually been the first treatment option (used in 85%-90% of cases) for treating plantar fasciitis, with an effectiveness of up to 90%. A recent meta-analysis reported inconclusive results for clinical practice of both conservative and nonpharmacologic treatments regarding pain relief in patients with plantar heel pain. Thus, injected therapies are frequently used in patients who did not respond to noninvasive treatments.

The authors' meta-analysis only included RCTs (parallel, crossover, or pre- post treatment) assessing the effect of BTX-A injections on either pain (visual analog scale [VAS]), functional improvement (Maryland Foot Score, Foot Health Status Questionnaire [FHSQ], Foot and Ankle Disability Index, Foot and Ankle Ability Measures, American Orthopedic Foot and Ankle Society score), or plantar fascia thickness in patients with plantar fasciitis. The multiple database searches identified 535 articles; an additional reference was identified by manual searching in previously published reviews. After duplicated records were removed, 413 studies were screened and 372 of them were excluded because they did not meet the inclusion criteria. Subsequently, 41 full-text articles were reviewed for possible eligibility and 31 were excluded for the following reasons: not being an RCT (4), not using BTX-A therapy (2), not having complete results (10), and duplicates (15). Finally, 10 studies fulfilled the eligibility criteria and were included in the systematic review and meta-analysis.

A total of 485 individuals were recruited from 10 RCTs, including 236 in the BTX-A group and 249 in the control group. Almost all studies had a parallel double-blind design, except 1 single-blind study and another with an open-label fashion. The follow-up period within the studies varied from 31 days to 12 months. The doses and volume of the injected BTX-A ranged from 50 U14 to 250 U30 and from 0.7 mL to 2.5 mL, respectively. The anatomic region where the BTX-A was applied was also different among studies; most of them reported the application was directly or near the plantar, while 2 indicated that the injection was administered in the calf muscles (gastrocnemius and soleus).

Meta-analysis of 10 treatment arms showed a significant improvement in pain after BTX-A therapy (MD, 2.07 [95% CI, 3.21 to 0.93]; P=.0004; I2 =97%), and this effect size was robust in the sensitivity analysis. Furthermore, the calculated change obtained for pain relief after BTX-A intervention (D=2.07) was higher than the established MCID on the VAS for average pain (0.8 and 0.9cm) and the MCID for pain of first step (1.9cm).

Six studies reported functional outcomes in a total of 273 patients (130 in the BTX-A intervention and 143 in the control group). A significant functional improvement was revealed after meta-analysis in favor of BTX-A injections (MD, 15.15 [95% CI, 3.11-27.19]; P=.01; I2=96%) (fig 4). The effect size was robust in the sensitivity analysis. Additionally, the calculated change for functional improvement (D=15.15) was higher than the MCID reported in the FHSQ function subscale (7 points). A subanalysis according to the treatment duration was performed. **A significant pain relief was detected at 0-6 months and 12 months after BTX-A treatment;** on the other hand, this subanalysis indicated a significant functional improvement at 0-6 months.

The current meta-analysis of RCTs indicated that BTX-A leads to a statistically and clinically significant improvement of pain and function in patients with plantar fasciitis.

2. Multiple Choice Question

Local anesthetic systemic toxicity
Categories: Emergency medicine, Pharmacology

Which *one* of the following statements regarding local anesthetic systemic toxicity is false?

1. Bupivacaine is most commonly implicated in events
2. Symptoms of toxicity include a metallic taste
3. Severe manifestations may appear up to 6 hours after initial symptom onset
4. Pregnancy may increase the risk of an event

Answer: 1

Reference:
Antel R, Ingelmo P. Local anesthetic systemic toxicity. CMAJ. 2022 Sep 26;194(37):E1288. doi: 10.1503/cmaj.220835.

PMID: 36162843

Educational point:

Local anesthetic systemic toxicity (LAST) is estimated to occur in 1 of 1000 local anesthetic administrations. It results from supratherapeutic levels of local anesthetic in the bloodstream.

Most cases occur in hospitals (61%), while fewer occur in outpatient settings (14%), primarily following upper or lower extremity nerve blocks (19%), naso-oropharyngeal infiltration (17%) or spinal and epidural blocks (11%). **Lidocaine is most commonly implicated in LAST events (44%); however, bupivacaine has a lower safety margin and greater cardiac toxicity.** Ropivacaine has a decreased potential for toxicity.

Signs and symptoms of LAST typically appear within 1–5 minutes of local anesthetic administration and include oral numbness, metallic taste, dizziness, drowsiness and disorientation. Severe manifestations may appear up to 6 hours after initial symptom onset, and include seizures, arrhythmias, cardiac arrest and death.

Extremes of age, pregnancy, renal disease, cardiac disease and hepatic dysfunction may increase risk of LAST. The minimum effective dose of local anesthetic should be used in these populations (generally 10%–20% dose reduction) and patients should be warned to report any signs or symptoms of LAST immediately.

Accidental intravascular injection of large doses of local anesthetic is the most important trigger of LAST. A slow injection technique (< 1 mL/s) with frequent aspirations and ultrasonography guidance for peripheral nerve blocks can decrease the likelihood of this. The addition of epinephrine to local anesthetic infiltrations decreases systemic absorption. After securing the airway and suppressing seizures, a bolus of 1.5 mL/kg of 20% lipid emulsion followed by infusion at 0.25 mL/kg/min for 30–60 minutes is recommended for patients at first signs of severe LAST. Lipid emulsion absorbs local anesthetic from tissues to attenuate the progression of toxicity.

Short Answer Management Problem (SAMP)

Food allergy
Categories : Allergy & Immunology
You are seeing a 21yo patient with known peanut and shellfish allergy. Up until this age, they have strictly avoided food triggers, though unfortunately they have required the use of epinephrine via autoinjector a couple of times. They are seeing you today as they have heard there may be other treatment options available for their food allergies.

1. In addition to oral immunotherapy (OIT), several other treatments targeting the immune response to a food allergen have emerged in recent years. Name two.

Your patient is interested in oral immunotherapy, but is worried about the potential of an allergic reaction by being exposed to increasingly larger daily doses of the food allergen.

2. At what point in therapy do allergic reactions mostly occur?
3. What "safe dosing" rules exist for OIT? Name two recommendations.
4. In what other situations may dose adjustments be required? Name three.

Your patient returns after having tried OIT, but finds the daily regimen very difficult to adhere to. They have also unfortunately had an allergic reaction during OIT.

5. What treatment may be the preferred option at this time?
6. Immunotherapy demonstrates equal efficacy in younger and older individuals. True or False?

Answers

1. Sublingual immunotherapy
   Epicutaneous immunotherapy
   Biologics (such as omalizumab)
2. During the build-up phase
3. Taking doses on a full stomach
   Avoiding or altering doses when reaction-augmentation factors may be present (times of exercise or passive warming (eg, hot showers)).
4. Times of illness (eg, viral infection)
   Sleep deprivation
   Menstruation
   If the patient is also taking nonsteroidal anti-inflammatory medications
5. Omalizumab
6. False

Educational Point:

The traditional management approach for food allergy involves strict avoidance of the food trigger, education on how to recognize signs and symptoms of allergic reactions and how to treat them, and training on the use of epinephrine autoinjectors in case of anaphylaxis. **In addition to this approach, multiple treatments specifically targeting the immune response to a food allergen have emerged in recent years in both clinical and research settings, including various forms of food allergen immunotherapy (oral immunotherapy [OIT], sublingual immunotherapy [SLIT], and epicutaneous immunotherapy [EPIT]) and biologics, such as omalizumab.** Rates of accidental exposures vary across different studies, and strict allergen avoidance may be challenging for some patients.

OIT involves the oral administration of increasingly larger daily doses of the food allergen. The dose is increased usually every 2 to 4 weeks during the build up phase, with the aim to reach a target daily maintenance dose that will protect individuals with food allergy from accidental exposures and reduce severity of allergic reactions. The efficacy of OIT is high (roughly 60% to 80% may achieve desensitization, with some studies suggesting higher or lower rates in specific populations), but the therapy is associated with potentially burdensome adverse effects and limitations. **Allergic reactions mostly occur during the build up phase and are often mild or moderate in severity (often involving oral/pharyngeal or gastrointestinal symptoms) though anaphylaxis across all stages does occur.**

To help limit dose-related adverse effects, "safe-dosing" rules have evolved. These include taking doses on a full stomach and avoiding or altering doses when reaction-augmentation factors may be present, such as avoiding dosing around the times of exercise or passive warming (eg, hot showers). In addition, dosing adjustments may need to be made at times of illness (eg, viral infection), sleep deprivation, menstruation or whether the patient is also taking nonsteroidal anti-inflammatory medications. Across studies, a small percentage of individuals may be able to achieve remission; however, protection tends to wane with dose interruption or discontinuation, and long-term regular exposure is necessary to maintain dose tolerance for most individuals. Multiple studies generally reveal that OIT results in a level of challenge-proven desensitization that should offer protection from accidental exposures after 6 to 12 months of therapy.

SLIT refers to tablets or liquid drops, typically containing a few milligrams of the allergen which are placed under the tongue and held. The dose is 100 to 1000 times smaller compared with OIT and targets submucosal Langerhans cells. Common SLIT adverse effects may include oropharyngeal symptoms (mostly pruritus and lip swelling). Anaphylaxis is rarely reported in SLIT studies. A recent study suggests that remission may be possible with SLIT (at least in younger children), with rates similar to OIT, but more studies are needed to confirm this finding.

EPIT is a therapy in which the allergen is continuously applied to intact skin, which is currently in phase III development using a proprietary technology. The dose is administered in the form of a patch that is placed on the skin and changed every 24 hours.

In general, research regarding "early life" immunotherapy (preschool OIT, SLIT, or EPIT) has revealed a better efficacy and safety profile for all forms compared with similar studies in older individuals, suggesting that intervention during periods of increased immune plasticity may offer a valuable opportunity for potential disease modification, though comparative efficacy studies definitively supporting an optimal age for intervention are lacking.

Omalizumab is FDA approved for "IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (type I), including anaphylaxis, that may occur with accidental exposure to 1 or more foods. To be used in conjunction with food allergen avoidance." **Patients for whom omalizumab may be the preferred option include those who desire any or all of the following: a non-daily or non-oral treatment, did not tolerate previous immunotherapy, have multiple food allergies and/or multiple allergic disorders (eg, allergic asthma, chronic rhinosinusitis with nasal polyps, and chronic spontaneous urticaria).**

Omalizumab treatment is intended to be of long term, as treatment effects are expected to wane if omalizumab is discontinued, although longer-term treatment outcomes are lacking, but being studied. Importantly, the FDA approval for omalizumab in food allergy indicates that it is to be used in conjunction with food allergen avoidance. Omalizumab is intended to increase allergen threshold of a moderate-to-severe reaction, but it does not eliminate risk of an allergic reaction. Data have revealed omalizumab can be used to reduce OIT-related dosing adverse events and speed the build up phase (both single and multiple foods), can increase thresholds of tolerance for single or multiple different foods and enable reintroduction of varying doses of these foods into the diet regularly (while remaining on continuous omalizumab therapy), and is associated with improvements in QoL.

Tips and Tricks When Doing a Medical/Health Humanities Family Medicine Resident Project

This stream involves two main components:

1. A paper: including a Cover Page, Abstract, Introduction, Methods, Results and Discussion, Strength and Limitations, and Conclusion.
2. The artistic piece: included as an Appendix and summarized in the results section.

The medical/health humanities are a burgeoning stream of scholarship that involves areas connected to, but not limited to, the field of medicine. Your project may explore themes such as compassion, ethics, or lived experience. It will involve the creation of an original piece of work, which may take the form of writing, audio, film, visual art, or music, for example. In the Introduction, you may choose to describe your inspiration for the project. This is optional

Examples:

- Exploring the social determinants of health using photography
- Podcast about understanding patient values in diagnosis and recommending therapy
- The use of the visual arts to affect public health policy
- A multimedia project (e.g. video or blog) about women's health
- Create a musical composition based on prior published evidence for using therapy in the treatment of children with autism spectrum disorder
- The use of visual art in understanding the patient experience with mental illness, then creating a visual art piece reflecting their understanding

These are just a few examples to launch your creativity.

For the methodology section, be sure to include the steps taken in creation of your final piece. If, for example, you are making a podcast, describe the steps involved in the production process (e.g. arranging interviews, construction of interview questions, recording technique, use of editing software). For music, the process of song writing and what influenced your choice of musical style and lyrics could be explained. For a piece of visual art, you could explain the art-making process, your choice of media and colour, and what they hope to portray by making these choices.

Sharing humanities projects publicly would be encouraged, whether as an art installation, publication in the Humanities section of a medical journal, or live reading of a short story.

Your Methodology section also needs to explain the rationale for your choice of medium of expression.

Ethics and Confidentiality. Humanities projects are not exempt from ethics review. If your scholarship involves human subjects, you must propose your project to the appropriate Research Ethics Board for your site.

As within clinical practice, protecting confidentiality is paramount. It is key when considering a humanities- related project. If writing a story based on an actual patient experience, for example, you would change the name, gender and clinical scenario so that the patient cannot be identified. If pursuing a photography-based project, capturing identifying images without an individual's consent is not permitted.

The following websites may help you learn more about the medical/health humanities:
Art for the Sake of Medicine (an article by Dr. Sarah Fraser about why the health humanities are important)
https://www.cfp.ca/content/64/10/760

Canadian Association of Health Humanities: https://www.cahh.ca/

Tips and Tricks When Doing a Literature Review Family Medicine Resident Project

Literature reviews are used to systematically and critically evaluate available evidence as a basis for practice or further research. Examples include reviewing evidence for the effectiveness of a drug, the causes of a physical or mental health problem, or barriers and facilitators that patients experience in accessing health care. When doing a literature review project, you need to adhere to some conventions. Before you start you may find it helpful to consult with a university/hospital librarian or a subject matter expert on how best to access resources for the literature review.

1) Research question must be relevant to family medicine.
2) Search for original primary papers (not reviews) published in peer-reviewed journals. If you include other types of evidence, provide a rationale. Obtain and review whole papers, not just abstracts.
3) Assess the strength of evidence of the studies you are reviewing, using an approach appropriate to the type of research question (see Basic Evidence Levels for Treatments).
4) Create a table to summarize your findings with respect to the research question and objectives (see Sample Table).
5) Do not repeat word for word in the text what you have in the tables: they should be complementary
6) Use the same outline as a regular scientific study.
    a) Introduction/Background): why did you want to do this project?
    b) Set up the research question by reviewing what has been published on the topic and explain the rationale for your review.
        i) Finish the section with a clear research question and 1-3 objectives designed to answer the question.
    c) Methods need to include the following:
        i) Search terms
        ii) Inclusion and exclusion criteria.
        iii) Citation databases searched - e.g. PubMed. List other sources if used.
        iv) Number of articles pulled and ultimately reviewed.
        v) Method of analyzing the literature collected. Examples include narrative review pointing out findings, level of evidence and basic strengths and limitations for each study; or systematic review using formal procedures to categorize strength of evidence and certainty of conclusions (e.g. GRADE); or statistical meta-analyses of data obtained from published studies combined with formal assessment of strength of evidence and certainty of conclusions.
    d) In the discussion, describe the strengths and limitations of each article and synthesize the data in the context of published literature. Use subtitles to help the reader. Answer the objectives to answer the research question.
    e) In the conclusion pull it all together. No new information should be added. Draw conclusions and point out implications for practice and further research. Make an overall statement regarding strength of evidence and certainty of conclusions.
    f) Acknowledgments: supervisor and others that may have helped you.
    g) Use a standard bibliography format and do not mix bibliography styles.

Levels Of Evidence

Level of Evidence	Study Design	Definition	How does sleeping with a bottle of juice versus a bottle of water affect children's dental hygiene?
1	Randomized Control Trials (RCTs)	RCTs are considered the most reliable form of scientific evidence. They involve the random assignment of participants to interventions and controls.	A group of children are randomly selected from the general population (each child has the same likelihood of being selected as all the others). This group is then randomly divided into two groups (A and B). Again, each child has an equal chance of being placed in either group. Group A is given a bottle of juice to sleep with at night. Group B is given a bottle of water to sleep with at night. The effect on the children's teeth is monitored for a set amount of time.
2	Cohort Studies	A Cohort Study is a study in which participants who presently have a certain condition and/or receive a particular treatment are followed over time. They are then compared with another group who are not affected by the condition.	A group of children who have poor dental health are followed across time. The habit of sleeping with a bottle of juice or water of the poor dental health group is compared to the sleep habits of a control group.
	Ecological/ Epidemiological Studies	Ecological studies look for associations between the occurrence of disease and exposure to known or suspected causes. The unit of observation is the population or community and may be defined in various ways.	Children with poor dental health are identified. Then correlations are made between (a) sleeping with a bottle of juice and dental health and (b) sleeping with a bottle of water and dental health.
3	Case-Controlled Studies	Case-control studies are frequently used in epidemiological studies. Case-control studies compare participants who have a specific condition with participants who do not have the condition. Otherwise, similar in order to identify factors that may contribute to the condition of interest.	Comparing children with poor dental health, with those who have good dental health who are the same age, ethnicity, socio-economic background, number of dental check-ups, etc.
	Non-Randomized Control Trials	The participants and interventions are not randomly assigned.	The first 50 to volunteer are instructed to have their child sleep with a bottle of juice, with the last 50 volunteers are instructed to have their child sleep with a bottle of water.
4	Case-Series	A number of individual cases of a particular condition are identified and followed individually over time.	Ten cases of poor dental hygiene in children are identified and intensely followed for a set amount of time.
5	Expert Opinion	The opinion of a professional who is considered an expert in their field.	The advice/opinion of a dentist who specializes in children's oral health and who has worked in the field for a long period of time.

Sample Table for a Literature Review

Author	Design	n	Variables	Results	Limitations
Bjelland et al.	RCT	1465	Sugared beverage intake, sedentary behaviour	Preventive initiatives more effective in girls, need to study gender subgroups	Crude estimates of sedentary behaviours, sampling bias, social desirability in data
Brown T, Summerbell C.	Literature Review	38	Weight outcome	School based interventions may have benefit but inconsistent, may be short-term, girls/younger children have more benefit, physical activity must be combined with diet interventions	Heterogeneity of studies evaluated, therefore difficult to generalize any findings.
Bryn Austin S et al.	Qualitative	9	Effectiveness of *School Health Index*, Role of external facilitator	Presence of external facilitator influenced effectiveness of *SHI* and ability of schools to implement health promotion initiatives	Most schools in one geographical location (New England), reliance on self-reported data, did not include an objective data source
Card A, Doyle E.	Qualitative	40	Effectiveness of School Health Coordinator in implementing health promotion strategies in Nfld.	School health coordinator can change the approach of health promotion in schools to involve social, environmental as well as physiological health determinants	Vague descriptors regarding effectiveness of school health coordinators, results very preliminary in nature
Crawford PB et al.	Position paper	n/a	n/a	Using a bioethics framework further justifies the promotion of nutritional health through schools	n/a

Tips and Tricks When Doing an Advocacy Family Medicine Resident Project

In this project type, the resident takes a position on an issue of importance to family medicine and appraises evidence for and against the position. The resident either ***describes*** or ***undertakes*** an advocacy action related to the position. In either case, the report is to include a self-reflection component as described below.

Actions could include but aren't limited to sharing the position paper or another written product (e.g. a letter, editorial, or government submission) or various forms of direct actions (e.g. public rally, protest, or petition drive). The report should include a description of the action, the goal of action, the real or potential outcomes and impact of the action, and the real or potential consequences/complications resulting from the action along with a self-reflection component.

Advocacy for access to culturally safe, affordable, high-quality, and comprehensive health care, along with the social conditions that promote health is one of four primary responsibilities articulated by the College of Family Physicians of Canada (https://www.cfpc.ca/CFPC/media/Resources/Education/FM-Professional-Profile.pdf). This requires outreach and engagement, such as working with community partners and including patients experiencing hardship and/or barriers to care. Respecting patients and community partners as holders of expertise is paramount to effective advocacy. Advocacy projects can include a range of strategies, including but not limited to letters and editorials, press releases and media advisories, government submissions, and direct action (e.g. public rally or march, creative actions, or public petitions drives). Examples of these strategies are described in this Tool Kit (https://fmf.cfpc.ca/wp-content/uploads/2017/10/F175_Introduction-to-System-Level-Advocacy-for-Family-Physicians.pdf).

Responsibility and accountability:
Physician advocacy requires respect for professionalism, evidence, and appreciation of the risk/liability beyond what might be expected of the general public. Some resources that might help to navigate these concepts include:

- https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/advocacy-for-change-an-important-role-to-undertake-with-care
- https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/participating-in-health-advocacy
- https://cpsns.ns.ca/resource/advocacy-and-public-communications-by-physicians/
- https://www.cma.ca/get-involved/cma-ambassador-program

Mentorship:
Mentorship in advocacy can be particularly beneficial given the sometimes messy or controversial aspects of advocacy. Mentorship can help to provide guidance around strategy and can also help to centre ourselves when we are feeling discouraged or are questioning our position. Along with your supervisor for this project, there are options for mentorship in advocacy within the Department of Family Medicine. Examples include:
Dr. Tiffany O'Donnell – tiffany.odonnell@dal.ca , Dr. Tim Holland - timothy.holland@dal.ca

Self-Reflection:
Self-reflection is paramount to effective advocacy as it helps us to remain centred on our "why", to understand our own role/position in the advocacy effort, to know when it's time to change course, and to maintain perspective when our efforts fail to achieve our desired outcome. The following are some prompts to consider as you engage in self-reflection throughout the course of this project. Some of your reflections should be shared in the discussion section of your report.

1. What is the story of my journey to this piece of advocacy? Why does this matter to me? Who is most affected by this issue, and if not me, why am I motivated to be involved?

2. What are my personal values, and how do my personal values align with this cause? https://personalvalu.es/personal-values-test

3. Who are the experts in this area? What is my relationship to those with lived experience, and what have I learned/am I learning from these experts?

4. What are my blind spots? What sources of power and privilege do I carry, and how might this bias my thinking in this work? https://implicit.harvard.edu/implicit/takeatest.html

5. What sources of bias might exist in the literature that is available to me? If I was reading this literature from the position of someone with lived experience, how might it land differently?

6. Do I hold privilege that allows me to decide whether to take action on this issue or is this an issue that I don't have the luxury to ignore? How might my involvement in this advocacy work impact my professional identity? How might it impact my professional relationships? What personal risks might I be taking by engaging with this issue?

7. What feedback have I received from stakeholders along the way, how did I receive it, and what do I intend to do about it?

8. If this effort does not generate my intended outcome, how will I feel, and how will I handle it? Will I continue to pursue this issue and change my approach? What can I do differently? What have I learned here?

DALHOUSIE UNIVERSITY | DEPARTMENT OF FAMILY MEDICINE

END OF RESIDENCY

for academic year 2025-2026

Department of Family Medicine
1465 Brenton Street, Suite 402
Halifax, NS B3J 3T4

family.medicine.dal.ca

Your residency training will go by fast and before you know it you will be preparing to start your career in Family Medicine. Below you will find a list of requirements for completing your residency.

Program Requirements for Completion of Training:

- All One 45 items must be completed
  - Evaluations of Service
  - Evaluations of Preceptors
  - Evaluations of Curriculum Sessions
- All ITARs completed (with the exception of the last ITAR)
- Resident Project completed, marked as acceptable and presented
- QI Project completed
- Residents as Professional Peer Educators completed
- All periodic reviews completed
- Promotion by the Competence Committee

In order to receive your CCFP designation you will have had to successfully complete all of the requirements of the program in addition to successfully passing both the SAMP and SOO section of the CFPC exam.

Licensing

You will require a license to practice medicine once you have completed your training. The requirements for licensing vary by province and can be found on the provincial College of Physicians and Surgeons websites.

CMPA

You will be required to update your CMPA coverage as you transition from residency to practice. Details regarding this can be found on the CMPA website: https://www.cmpa-acpm.ca/en/membership/transitioning-to-practice

Hospital Privileges

You will need to apply for hospital privileges in the community you intend to work in. Privileges are hospital specific. For further details contact the hospital in your desired community.

CFPC

All graduating residents are encouraged to join and maintain their membership with the CFPC after program completion. There are many helpful resources both nationally and through local provincial chapters including the First Five Years of Practice which has many valuable resources for early career physicians.

Faculty Appointment

After completing the program consider becoming a faculty member of Dalhousie Family Medicine. Teaching is a fun way to incorporate variety into your career. There are many opportunities at both the undergraduate and postgraduate levels and lots of faculty development resources to help you along the way. For more information check out the Dalhousie Family Medicine website.

Timelines for Documentation

If you require any documentation from our program office (i.e. a form or reference) please submit your request to fmeducation@dal.ca no later than the 28th of the month prior to the end of the month you will require the document. For example requests for June 30th will need to be submitted no later than May 28th. Reference letters and forms for anyone planning to practice in the Maritimes can be completed by your Site Director.

Resident Completion Pre-Checklist

Site Administrator to complete and forward to Medical Education Assistant

Resident Name:	
Residency Period:	Start Date: _____ End Date: _____
Site:	

Item	Yes	No	Comment
All ITARS submitted			
One45 "To-Do's" completed (except for ITAR and EoS/EoT from last rotation)			
Resident QI Project Completed			
Resident Project -Completed and presented) add date in the comment section)			
Resident approved for promotion by Competence Committee			

*References and certificates will not be sent out until all residency requirements are met—this includes the resident project and ITARS/ToDos and any IELP/FELPs completed successfully.

**Residents requesting letters for banks or financial institutions must be requested from the PGME office, NOT the Program (MedEd or Site office).

Resident's Forwarding Address/E-mail/Phone Number: (Certificates will be sent to address below unless otherwise indicated by the Site)

Street/Number: _____

Town/City: _____ Postal Code: _____

Email: _____ Phone Number: _____

This Resident will be working in: **New Brunswick:** _____ **Nova Scotia:** _____ **PEI:** _____

Other: _____ **Unknown:** _____

Site Administrator Signature: _____ **Date:** _____

Site Director Signature: _____ **Date:** _____

THIS PORTION TO BE COMPLETED BY DFM MEDICAL EDUCATION ASSISTANT

Program Level Checklist
Project marked as a pass: Yes: _____ No:_____
Certificate received from PGME: Yes: _____ No: _____
Licensing letter requested: Date:_____ Date Sent: _____

This Resident has completed the requirements of the Dalhousie Family Medicine Program, and a completion of certification letter may
be sent to a licensing body.

Initials: _____(DFM Medical Education Assistant)