


THE COLLEGE OF  
FAMILY PHYSICIANS  
OF CANADA



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MÉDECINS DE FAMILLE  
DU CANADA

**Rural Competencies for the Purposes of  
Family Medicine Resident Assessment**

**FOCUS: CLINICAL COURAGE**

SRPC 2019 – Halifax, NS

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**Who are we?**

Elaine Blau



Nancy Fowler



Ivy Oandasan



Brent Kvern



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## Conflict of Interest Declaration

Dr. Nancy Fowler  
Dr. Ivy Oandasan  
Dr. Brent Kvern

} Are paid employees of the  
CFPC

Dr. Elaine Blau – no conflict to declare

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## Learning Objectives:

By the end of the session participants will:

- Become familiar with the broad content of the R&R Priority Topics document.
- Reflect on the concept of clinical courage.
- Explore ways of recognizing, nurturing, and assessing clinical courage in clinical settings.


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# CFPC Document

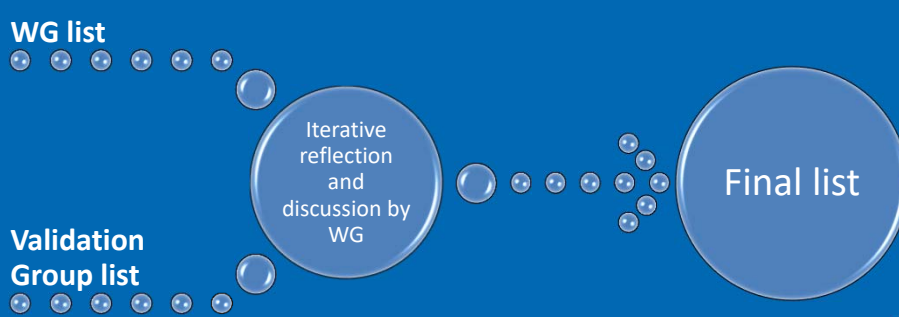
## Priority Topics for the Assessment of Competence in Rural and Remote Family Medicine

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# Development of Priority Topics



**WG list**


**Validation Group list**

Iterative reflection and discussion by WG

**Final list**

Sent to 975 participants

- Random selection from CFPC Membership database according to postal codes
- SRPC database
- ARFM members, contacts suggested by the WG

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## Development of Key Features


- What is the difference between a good family physician and a good rural family physician?
- What are the most important elements of decision-making and judgment in most important/common clinical/social situations that distinguish a competent physician at the beginning of their independent practice?

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## Rural Priority Topic List

1. Trauma	10. Fracture and dislocation management
2. Patient transfer	11. Intrapartum care
3. Septicemia	12. Altered level of consciousness
4. Pediatric emergencies	13. Procedural sedation
5. Acute cardiac presentations	14. Chronic pain
6. Psychiatric emergencies	15. Indigenous health
7. Diabetic emergencies	<b>16. Clinical courage</b>
8. Active airway management	17. Adapting to rural life
9. Urgent respiratory presentation	18. Cultural safety and sensitivity

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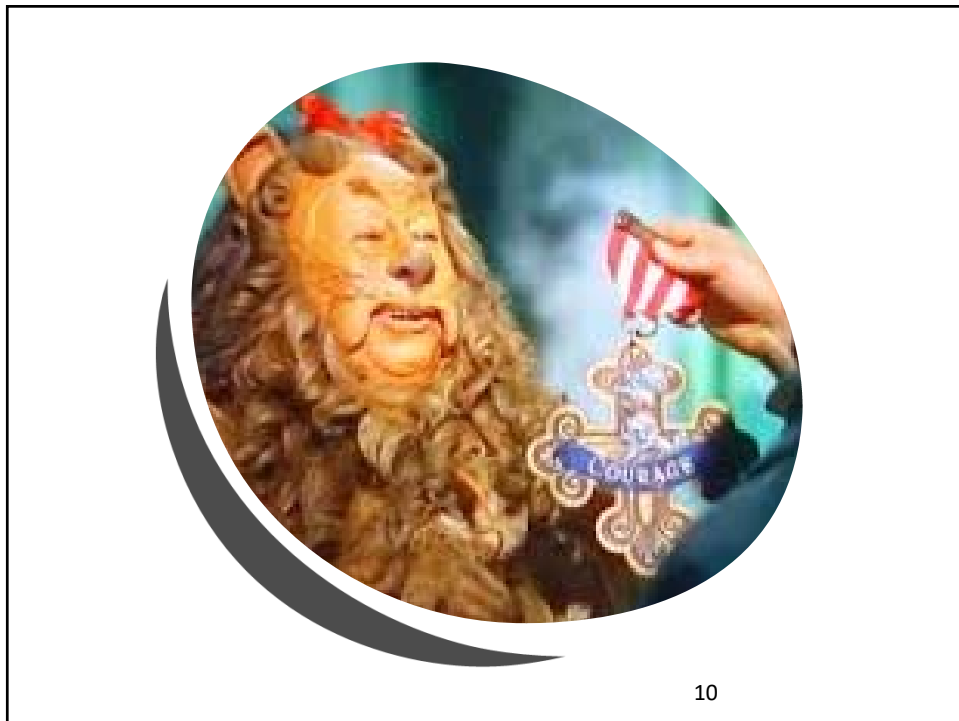
## Intended Uses

Not intended as a comprehensive curriculum description.

Is intended to inform priorities for educational experiences and assessment of all residents.

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Task #1 – Clinical Courage Narrative	
TIME	TASK
PART 1 5 min	<p>On your own, write about an experience(s) where you had to employ 'clinical courage' and you experienced discomfort:</p> <ul style="list-style-type: none"> <li>-- think beyond procedural skills if possible</li> <li>-- the outcome could be positive or negative</li> </ul> <p><i>Briefly describe the situation, how you handled it, and what happened?</i></p>
PART 2A 8 min	<p>Pair up with a neighbour (dyads)</p> <ul style="list-style-type: none"> <li>-- The teller relates their story (max 3 minutes). The listener does not interrupt but can take notes</li> <li>-- Once teller is finished, the listener can ask probing questions to understand why this scenario was chosen as an example of clinical courage</li> <li>-- Summarize key points about what they learned about clinical courage from the story. (max 5 minutes)</li> </ul>
PART 2B 8 min	Teller and Listener switch

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## Clinical Courage - the listener's task

- **Use Patient-Centred Approach (not just presence of clinical courage but your experience of clinical courage)**
  - How do we find something a learner is uncomfortable with so we can guide them to get better at it?
  - How can help learners get better at employing clinical courage?
- **What was happening cognitively/emotionally/in communication?**
  - If you were the preceptor talking to a resident who felt really uncomfortable in this situation, what would you like to assess and how would you know if he/she showed the skills you are assessing?

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## Task #2 – Creating a Clinical Courage field note

Large group discussion:

- What is important to notice in this conversation?
- Consider the Clinical Courage key features
- How might you initiate a conversation with the resident?

(10 min max)

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Thank you for participation!

For further conversation, don't hesitate to contact us

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