

ESSENTIAL SNAPPERS

Dr. Anna Schwartz
Dr. Frantz-Daniel Lafortune
Dr. Pier-Maude Lanteigne

NOVEMBER 6, 2025
RBC CONVENTION CENTRE WINNIPEG, MB





Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations. The CFPC recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being.

The CFPC respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes. I invite all attendees to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

Presenter disclosure

Presenter: Dr. Pler-Maude Lanteigne

Relationships with financial sponsors: none

Any direct financial relationships, including receipt of honoraria: none

Membership on advisory boards or speakers' bureaus: none

Patents for drugs or devices: none

Other: no other conflicts of interest declared



Presenter disclosure

Presenter: Dr. Frantz-Daniel Lafortune

Relationships with financial sponsors: none

Any direct financial relationships, including receipt of honoraria: Quebec College of Family Physicians (QCFP), Director;
Black Physicians of Canada (BPC), Director

Membership on advisory boards or speakers' bureaus: none

Patents for drugs or devices: none

Other: Recipient of CMA's Health Care Unburdened Grant Program
with the QCFP

Presenter disclosure

Presenter: Dr. Anna Schwartz

*Hospitalist / Family Physician in 5th year of practice in MB
CFPC First Five Years in Family Practice Committee, Chair
Site Medical Lead, Extended Hours Primary Care Clinic
Mentorship and Clinical Enhancement Program Director,
IMG Program, University of Manitoba*

Relationships with financial sponsors: none

Any direct financial relationships, including receipt of honoraria: none

Membership on advisory boards or speakers' bureaus: FFYFP, CFPC

Patents for drugs or devices: none

Other: no other conflicts of interest declared



Disclosure of financial support

This program has received no financial support.

This program has received no in-kind support.

The speakers have no financial conflicts of interest related to this presentation.

Objectives

This workshop presented by First Five Years Committee will review:

1. Role of clinical practice guideline (CPG) in clinical decision making
 - Use a tool to assess whether a guideline meets a required standard (modified G-TRUST)
2. Initiating and handling difficult conversations with patients/family
 - Apply the actionable strategies and phrases in day-to-day practice
3. Choosing a family medicine practice that fits your professional and personal goals
 - Implement specific strategies and tools to address practice management issues frequently faced in early career

POLL

Q1: What is your level of training?

a. medical student

b. Resident

c. first 5 year physician

d. physician beyond 5 years of practice



CHOOSING SUITABLE CPG FOR YOUR PRACTICE

Dr. Frantz-Daniel LaFortune

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PLoS MEDICINE

Policy Forum

Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up?

Hilda Bastian^{1*}, Paul Glasziou², Iain Chalmers³

1 German Institute for Quality and Efficiency in Health Care (IQWiG), Cologne, Germany, **2** Centre for Research in Evidence-Based Practice, Faculty of Health Sciences, Bond University, Gold Coast, Australia, **3** James Lind Library, James Lind Initiative, Oxford, United Kingdom

A SERIES FROM THE CANADIAN TASK FORCE

PREVENTION IN PRACTICE

EXCLUSIVEMENT SUR LE WEB



PRÉVENTION EN PRATIQUE

UNE SÉRIE DU GROUPE D'ÉTUDE CANADIEN

Choosing guidelines to use in your practice

James A. Dickinson MBBS PhD CCFP FRACGP Neil R. Bell MD SM CCFP FCFP Roland Grad MDCM MSc CCFP FCFP
Harminder Singh MD MPH FRCPC Stéphane Groulx MD CCFP FCFP Olga Szafran MHSA

Choisir les guides de pratique clinique à utiliser

James A. Dickinson MBBS PhD CCFP FRACGP Neil R. Bell MD SM CCFP FCFP Roland Grad MDCM MSc CCFP FCFP
Harminder Singh MD MPH FRCPC Stéphane Groulx MD CCFP FCFP Olga Szafran MHSA



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- ▶ Family physicians must make decisions quickly, while still retaining a scientific approach and communicating with our patients to reach mutually agreeable solutions. Guidelines help clinicians to make good decisions, especially in uncertain situations.
- ▶ Guidelines are often most useful when they address controversial issues, where there is doubt about what to do and help us explain this to our patients. Increasingly, we can expect guideline producers to provide tools to help us communicate the evidence to our patients.
- ▶ Readers should focus on the critical issues when choosing guidelines: Does this guideline help us solve the problems that we face in our practice? Are the recommendations based on an open-minded and transparent process of assessing the evidence?
- ▶ The AGREE II (Appraisal of Guidelines for Research Evaluation) and G-TRUST (Guideline Trustworthiness, Relevance, and Utility Scoring Tool) approaches are useful in assessing the quality of guidelines.

**Tool to
evaluate
guidelines**

AGREE tool

- Six domains, 23 items
- For assessing guideline quality, not trustworthiness or relevance

Table 2. Summary of main components of AGREE II reporting checklist

DOMAIN	REPORTING CRITERIA	IMPORTANCE
Scope and purpose		
• Objectives	Intent	+
• Questions	Benefits or outcomes	++
• Population	People to whom this applies	+++
Stakeholder Involvement		
• Group membership	Name, discipline, Institution, role in guideline preparation	++
• Target population preferences and views	Strategy to obtain target population views and incorporate into recommendations	++
• Target users	Intended audience and how they might use the guideline	++
Rigour of development		
• Search methods	Details of how searches were done	++
• Criteria for selection of evidence	Target population, study design, Interventions, comparisons, outcomes	+++
• Strengths and limitations of the evidence	Study designs, methods, and limitations; relevance of outcomes; consistency of results; size of benefit vs harms	++++
• Formulation of recommendations	Development process, outcome of process (eg, voting)	+
• Consideration of benefits and harms	Supporting data on benefits and harms; reporting of trade-offs	+++
• Link between recommendations and evidence	How the group used evidence to inform recommendations	++++
• External review	Description of external reviewers and methods used to obtain their ideas; how reviewers' opinions informed the guideline	++
• Updating procedure	Criteria or time frame to do update	+
Clarity of presentation		
• Specific and unambiguous recommendations	Recommended action purpose, relevant populations; caveats about whom it does not apply to; degree of uncertainty about options	+++
• Management options	Description of options and in what situation each should be used	+++
• Key recommendations	Summary box, flow chart, or algorithm	++
Applicability		
• Facilitators and barriers to application	What was considered; methods to obtain; facilitators and barriers; how this affected recommendations	++
• Implementation advice and tools	Additional supporting materials (eg, summary documents, manuals)	+
• Resource implications	Types of cost information; methods of obtaining, costs, and description	+
• Monitoring and auditing criteria	How to assess effects and adherence to recommendations	0
Editorial Independence		
• Funding body	Source of funding and whether it influenced content	++++
• Competing interests	Types of interests considered and how they were sought; description of competing interests and how they influenced the guideline process	++++

AGREE: Appraisal of Guidelines for Research Evaluation.
Data from AGREE Enterprise.⁹

**Tool to
evaluate
guidelines**

G-TRUST tool: Guideline Trustworthiness, Relevance, and Utility Scoring

- **Three domains, 8 items**

Developing a Clinician Friendly Tool to Identify Useful Clinical Practice Guidelines: G-TRUST

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ABSTRACT

BACKGROUND Clinicians are faced with a plethora of guidelines. To rate guidelines, they can select from a number of evaluation tools, most of which are long and difficult to apply. The goal of this project was to develop a simple, easy-to-use checklist for clinicians to use to identify trustworthy, relevant, and useful practice guidelines, the Guideline Trustworthiness, Relevance, and Utility Scoring Tool (G-TRUST).

METHODS A modified Delphi process was used to obtain consensus of experts and guideline developers regarding a checklist of items and their relative impact on guideline quality. We conducted 4 rounds of sampling to refine wording, add and subtract items, and develop a scoring system. Multiple attribute utility analysis was used to develop a weighted utility score for each item to determine scoring.

RESULTS Twenty-two experts in evidence-based medicine, 17 developers of high-quality guidelines, and 1 consumer representative participated. In rounds 1 and 2, items were rewritten or dropped, and 2 items were added. In round 3, weighted scores were calculated from rankings and relative weights assigned by the expert panel. In the last round, more than 75% of experts indicated 3 of the 8 checklist items to be major indicators of guideline usefulness and, using the AGREE tool as a reference standard, a scoring system was developed to identify guidelines as useful, may not be useful, and not useful.

Box 2. G-TRUST approach to classifying the value of guidelines

Relevance threats

1. The patient populations and conditions are relevant to my clinical setting
2. The recommendations are clear and actionable
3. The recommendations focus on improving patient-oriented outcomes, explicitly comparing benefits versus harms to support clinical decision making

Evidence threats

4. The guidelines are based on a systematic review of the research data
5. The recommendation statements important to you are based on graded evidence and include a description of the quality (eg, strong, weak) of the evidence
6. The guideline development includes a research analyst, such as a statistician or epidemiologist

Interpretation threats

7. The chair of the guideline development committee and a majority of the rest of the committee are free of declared financial conflicts of interest, and the guideline development group did not receive industry funding for developing the guideline
8. The guideline development includes members from the most relevant specialties and includes other key stakeholders, such as patients, payer organizations, and public health entities, when applicable

G-TRUST—Guideline Trustworthiness, Relevance, and Utility Scoring Tool.

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Modified tool designed to ease guideline choices

Simplified version of Guideline Trustworthiness, Relevance, and Utility Scoring Tool (G-TRUST) for physicians in practice

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Commentaire

Un outil modifié, conçu pour faciliter le choix des lignes directrices

Une version simplifiée de G-Trust (un outil d'évaluation de la fiabilité, de la pertinence et de l'utilité des lignes directrices) à l'intention des médecins en pratique

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Modified G-TRUST tool

Box 1. Simplified G-TRUST: Elements to consider for identifying potential threats in clinical practice guidelines.

Relevance: Is this guideline useful and applicable in my practice?

- Are the patients, population, and context similar to mine?
- Do the guidelines address patient-oriented outcomes?
- Are the recommendations clear and actionable?
- Has time needed to treat been considered?

Interpretation: Do I trust the people who interpreted the evidence and made the recommendations?

- Are the guidelines free of competing interests (financial, intellectual)?
- Have conflicts of interest been managed?
- Are the panel members diverse?

Confidence: What is the factual basis of the recommendations, and is this transparent in the guideline?

- Is a systematic review available?
- Was GRADE methodology or another rigorous method used?

GRADE—Grading of Recommendations Assessment, Development and Evaluation; G-TRUST—Guideline Trustworthiness, Relevance, and Utility Scoring Tool.

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Comparison using modified G-TRUST tool

Case 1. A second-year resident returns from a cardiology rotation in a tertiary care centre. When evaluating a patient for their cardiovascular disease risk, the resident suggests measuring apolipoprotein B and lipoprotein a levels to help decide whether statins should be initiated. These recommendations differ from the 2023 PEER simplified lipid guideline, where measurement of lipoprotein a and apolipoprotein B levels is not recommended.²

Table 1. Comparison of recommendations on screening for and prevention of cardiovascular disease risk

CONSIDERATIONS	PEER SIMPLIFIED LIPID GUIDELINE (2023) ²	CANADIAN CARDIOVASCULAR SOCIETY GUIDELINES (2021) ³
Relevance	<ul style="list-style-type: none">• Provides a tool to illustrate individualized risk in absolute numbers• Takes time needed to treat into consideration	<ul style="list-style-type: none">• No illustration of benefits in absolute numbers• No shared decision-making tool provided
Interpretation	<ul style="list-style-type: none">• Authors reporting conflicts of interest: 1/28	<ul style="list-style-type: none">• Authors reporting conflicts of interest<ul style="list-style-type: none">-Primary panel: 18/26-Secondary panel: 6/10
Confidence	<ul style="list-style-type: none">• Based on an available systematic review from 2023	<ul style="list-style-type: none">• No systematic review available

Case 2. You have recently read about the 2023 Osteoporosis Canada guidelines³ and are considering requesting a bone mineral density scan for a 70-year-old male patient whose medical history is unremarkable aside from hypertension, and who has never sustained a fragility fracture in the past. These recommendations differ from the Canadian Task Force on Preventive Health Care 2023 guidelines on screening to prevent fragility fractures.⁴

Table 2. Comparison of recommendations on screening to prevent fragility fractures

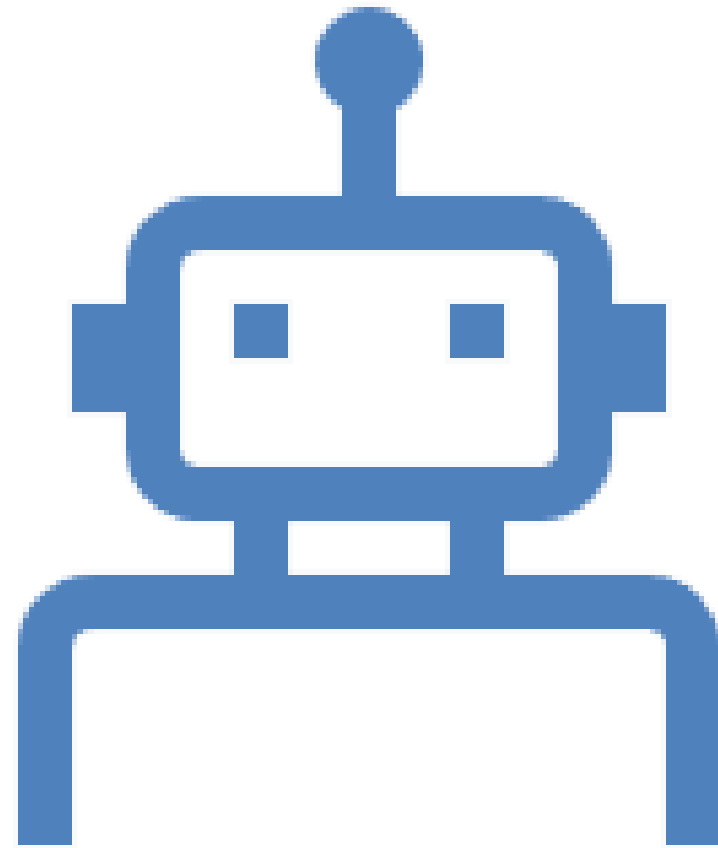
CONSIDERATIONS	OSTEOPOROSIS CANADA RECOMMENDATIONS ON SCREENING (2023) ^a	CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE GUIDELINE (2023) ^a
Relevance	<ul style="list-style-type: none"> • No absolute values and no tool provided to support shared decision making • No consideration of overdiagnosis (but mentions overtreatment) • No consideration of the time needed to treat 	<ul style="list-style-type: none"> • An interactive shared decision-making tool is provided to share benefits and harms in absolute numbers • Considers overdiagnosis and time needed to treat
Interpretation	<ul style="list-style-type: none"> • Financial conflicts of interest in the year before publication: 1/30 voting members and 8/40 authors 	<ul style="list-style-type: none"> • Financial conflicts of interest: 0/7 voting members and 0/9 authors • Panel representative of a variety of clinical practices
Confidence	<ul style="list-style-type: none"> • Systematic review unavailable, but tables from the evidence-to-decision framework are available 	<ul style="list-style-type: none"> • Systematic review available • GRADE used for all recommendations
<p>GRADE—Grading of Recommendations Assessment, Development and Evaluation.</p>		

Box 2. Key points

- The adaptation of Shaughnessy and colleagues' G-TRUST¹ into a simplified version offers a helpful resource for physicians seeking to compare clinical practice guidelines
- By combining essential evaluation criteria in a user-friendly format, this tool may enhance guideline selection, shared decision making, and patient-centred care
- Implementing the adapted tool in daily practice has the potential to empower physicians to make informed, evidence-based decisions that optimize patient outcomes

G-TRUST—Guideline Trustworthiness, Relevance, and Utility Scoring Tool.

NOW, WHAT
DOES AI SAY
ABOUT THIS?



Take away message



Be picky even ruthless with
guidelines



Use a tool

Difficult situations during the first 5 years

Pier-Maude Lanteigne

- First 5 years common topics...
- Felt like I was pushed into the lion's mouth unprepared
- Ive felt burned out, crying at first then it became easier with resources and colleagues

Patient's factors

- Somatizing patients
 - Naming the situation directly at the beginning (I've noticed that you've seen many health care providers, and you did extensive tests to try to find the cause of your symptoms.)
 - Regular schedule visit to address any new concerns and monitor evolution of current concerns
- Manipulative patients
 - Acknowledge and recognize your own emotions
 - Try to understand the patient's expectation
 - Identify when you need to say no
- "Frequent flyers"
 - Identify the main reason for their frequent visit (need to talk, reassurance, concerns about symptoms, pain) (FIFE)
 - Use support staff if needed
 - Schedule regular appointment

Patient's factor

- Defensive, angry, resistant patients
 - Validate emotions
- Grieving patient
 - Familiarize yourself with the normal stages of grief
 - Validate emotions
 - Look for signs of depression / maladaptive behaviors
 - Avoid medication to suppress emotions

Example #1

- Reason of consult: Patient admitted for medical reason. Also has Covid and they are spitting toward the staff. Takes amphetamines occasionally. Please assess and admit in your bed.
 - Notifying situations before its out of the line
 - Addressing patient's needs
 - Can I meet patient's expectation (in this case to continue to use) and how I can ensure safety of patient, staff and others

Physician's factors

- Angry or defensive physician
 - Recognizing our own triggers
- Fatigued physician
 - Delegate to others
 - Avoiding “over commitment”, adding task is easier than removing task (but feasible)
 - Set our personal safety limits
 - Choosing work environment which values our limits

Example #2

- Phone call to patient
- 1- Is this task appropriate for me to do or is it more appropriate that one of my staff member do it

Situational issues

- Language and literacy issues
 - Using a trained interpreter (they are excellent support in code white), remain culturally sensitive
 - Adapt the language to patient's understanding level
- Environmental issues
 - Is this the best environment to have this discussion? Hallway is not as convenient. Ensure you are in a safe environment (not alone in the end of hallway, support is around, etc...)

Example #3

- Community staff refused to serve patient's medication due to repetitive aggressive behavior

Non-violent communication

- Addressing conflicts in a non-confrontational way
- Express concerns without blaming or judging
- Helps facilitating mutual understanding
- Express observations in non-judgmental way

If "violent" means acting in ways that result in hurt or harm, then much of how we communicate could indeed be called "violent" communication.

Nonviolent **COMMUNICATION**

A Language of Life



3rd Edition

Words and the way we think matters.
Find common ground with anyone, anywhere,
at any time, both personally and professionally.

MARSHALL B. ROSENBERG, PhD

Foreword by **Deepak Chopra**

Endorsed by Satya Nadella, Arun Gandhi, Tony Robbins,
Marianne Williamson, John Gray, Jack Canfield, Dr. Thomas Gordon, and others

Documentation

- Difficult encounters should be documented in the medical record.
- Document verbatim
- Describe behaviors in an objective way

Safety matters

- We need to feel safe in order to co-regulate our patients
- If you feel unsafe and there is a serious threat you can contact the police or hospital security. Provide **only the information necessary for the police to address the threat.**
- If we do not feel safe or if our relationship repair technique failed, we can consider ending our patient-doctor relationship
 - Contact CMPA if you have any concerns or questions, (I personally find that they were helpful) and your respective college
 - Ask a colleague to take over the care, return the favor

Remember

- The majority of interactions are going well
- Identify behaviors before they are out of line
- Many ruptures and repairs in a doctor-patient relationship
- Be there for your colleagues and ask for tips/help/ debrief
- You are not alone, talk to colleagues, the first 5 years group is there

Website, resources, training

- UBC conflict theater
- CMPA: Challenging patient encounters: How to safely manage and de-escalate
- Programme Omega, gestion et prevention des situations de violence, CAMH has a similar program
- [How to Handle Angry Customers in a Call Centre](#)
- A colleague recommended this one for support staff: [Healthcare Staff Training Webinars - Practice Builders](#) or any other conflict management training
- CMPA, the office safety plan: [CMPA - The office safety plan](#)

Ressources

- [Non-violent communication as a technology in interpersonal relationships in health work: a scoping review – PubMed](#)
- [A Verbal De-escalation Standardized Patient Workshop for Third- and Fourth-Year Medical Students – PMC](#)
- [Non-violent communication as a technology in interpersonal relationships in health work: a scoping review – PMC](#)
- [CMPA - Challenging patient encounters: How to safely manage and de-escalate](#)
- [Conflict Engagement - Respectful Environments, Equity, Diversity & Inclusion](#)
- [p30.pdf](#)
- [How to Handle Angry Customers in a Call Centre](#)
- [Nonviolent Communication - Center for Nonviolent Communication](#)
- [About Workplace Violence | Violence | CDC](#)
- [Oméga formateurs – ASSTSAS](#)
- [CMPA - When physicians feel bullied or threatened](#)

Choosing a family medicine practice that's right for you

Dr. Anna Schwartz, Winnipeg, Manitoba

Why do we go into Family Medicine?

- Envision sitting in a clean, sun-lit office across from a smiling patient who is deeply appreciative of your care
- You have treated several generations of his family over the course of your 40-year career
- Exactly at 5 pm every weekday, you get up from your chair, say bye to your friendly office manager, and go home to your happy, loving family



<https://youtu.be/Y62EgHvwa8k>

Well, it doesn't always go that way...

Traditional family medicine practices have looked like this:

- Clinic
- Hospital
- (maybe) ER
- (maybe) PCH
- (maybe) teaching

But sometimes, you need to step out of a box!



My path to “less traditional” FM practice

- After completed FM training in 2021, worked in FFS clinic
- After first year, decided not to renew contract
 - Problematic clinic management, beginning to burnout
 - Difficult to take time off on short notice
- Decided might as well explore other FM areas
- It was a good opportunity to completely change gears!
- Did a locum in another province before starting new jobs:
 - fly-in Northern community
 - HMO in Ophthalmology
 - rural hospitalist locum

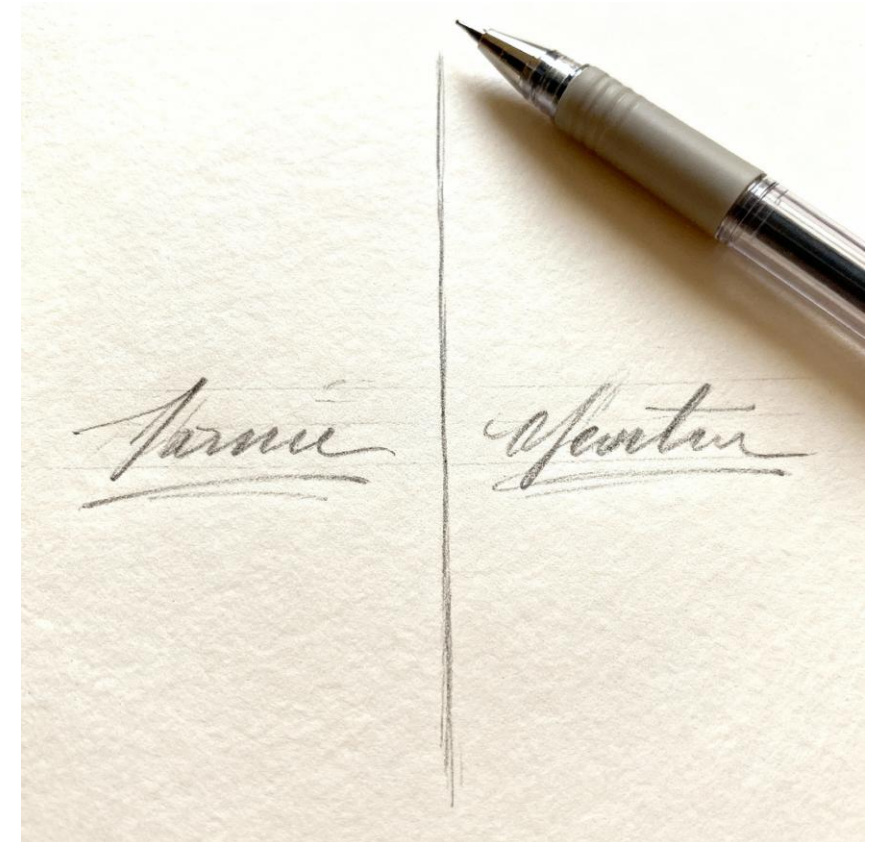
What settings can you work at as FMD?

- Turns out, the sky is the limit
- Hospitalist
- ER (might need to get more cert depending on requirements)
- HMO (ICU, Psychiatry, Neurology, Surgery, Ophtho, Obs, IM)
- Minor Illness and Injury Clinics
- Extended Hours Primary Care Clinics (like WIC but no f/u)
- Private clinics, patients pay out-of-pocket
- Virtual services (QDoc, VICS): FFS/salaried shifts
- Teach in medical school
- Administrative position: University, local college, CMPA
- Leadership clinical position (e.g., site medical lead)
- Consulting, writing

Make a list

What you want | What you don't want

- MRP?
- Clinical, non-clinical, mix?
- Teaching?
- Leadership / University/ Admin track?
- Take call / work nights?
- Being able to change your schedule on short notice?



What's your style?

Figure out your preferred work style:

- in-person vs virtual
- team environment vs solo
- salaried vs FFS
- rural vs urban
- Shift work vs “work until work is done”

Try it on until it fits!



What are your goals

- Personal:
 - start family
 - explore Canada
 - be there for elderly family member
- Professional
 - E.g., accumulate 4 years of ER work to challenge CCFP-EM exam
 - Acquire leadership experience
- Financial
 - Have mortgage / LOC to pay off?
 - Support extended family members / spouse during parental leave
 - Retire early???

Take away points

- Don't be afraid to explore outside of traditional family practice settings
 - You might need to work in rural/remote locations to get clinical / leadership expertise
 - Find your preferred work style
 - Volunteer on boards / committees, it counts as leadership!
 - Put your family first, work will always be there
 - Have a life outside of medicine.
- Medicine is an ever-hungry beast that will take as much as you give it



Questions?

THANK YOU!

PLEASE FILL OUT YOUR SESSION

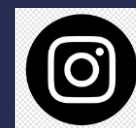
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