FAMILY MEDICINE – 6L
(FMCH 532)
Curriculum Guide & Clerkship Handbook

2008-2009

Department of Family Medicine and Community Health
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INTRODUCTION TO THE FAMILY MEDICINE CLERKSHIP

INTRODUCTION

Welcome to your family medicine clerkship! We hope to make this experience both interesting and educational and to give you a good sense of what the specialty of Family Medicine has to offer. The goal of the family medicine clerkship is to introduce students to the care of patients and their families as a first access provider. Students will see patients from all age groups and with a wide spectrum of concerns and problems. These include health care maintenance issues (including screening and prevention), life habit counseling (i.e. smoking cessation, diets), acute illness management (i.e. sinusitis, tendonitis), and chronic illness management (i.e. asthma, diabetes, depression). Indigent health care, sexual and reproductive health, behavioral medicine, community medicine, sports medicine, cross-cultural sensitivity, evidence-based medicine and medical informatics are also important components of the curriculum. To supplement your primary preceptor experience, you may also rotate with preceptors who specialize in or have special interests in sports medicine, geriatrics and home care, as well as prison medicine. You will also staff the H.O.M.E. (Homeless Outreach & Provider Education) Project student-run free clinics or participate in caring for the homeless at other community sites during your clerkship.

Please make sure that you contact your preceptor before the start of the rotation. If you are having difficulty reaching your preceptor, please notify our office as soon as possible. Keep in mind that all of our community preceptors volunteer their time to work with our medical students and that they all have busy practices that they must keep up with in addition to teaching you. Although each clerkship site is different, your patient care experiences will be monitored and we will make sure that you obtain an adequate exposure to family medicine at whatever location you are placed.

Although we try to take into account your site preferences for placement, we are not always able to accommodate all students’ requests. If at any time during the rotation you feel strongly that your particular placement site is not working well for you, please notify the clerkship director as soon as possible.

All the content of this manual (except the Doctor-Patient Seminar readings) can be accessed via the clerkship website at http://www2.jabsom.hawaii.edu/FamilyMedicine/

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**Curricular Guidelines for the Third-Year Family Medicine Clerkship**

By the completion of a third-year family medicine clerkship, the medical student is expected to possess, at a level appropriate for a third-year student, the knowledge, attitudes, and skills needed to:

1) Provide personal care for individuals and families as the physician of first contact and continuing care in health as well as in illness.

2) Assess and manage acute and chronic medical problems frequently encountered in the community.

3) Provide anticipatory health care using education, risk reduction, and health enhancement strategies.

4) Provide continuous as well as episodic health care, not limited by a specific disease, patient characteristics, or setting of the patient encounter.

5) Provide and coordinate comprehensive care of complex and severe problems using biomedical, social, personal, economic, and community resources, including consultation and referral.

6) Establish effective physician-patient relationships by using appropriate interpersonal communication skills to provide quality health care.

**Curriculum Goals and Objectives**

The following goals and objectives represent minimum course requirements. Each site offers unique learning opportunities and therefore may place greater or lesser emphasis on some of these core elements. For a copy of the curricular goals and objects as they relate to the JABSOM Graduation objectives, please contact our office.

**Goal I:** The student will learn a primary care approach to the diagnosis and management of common medical problems in patients of all age groups presenting in a family medicine setting.

**Objective A:** The student will learn the diagnosis and management of a defined set of common problems cared for by family physicians.

**Strategy 1:** (Knowledge) The student will diagnose and manage 29 common problems (refer to required topics on page 11) through involvement in first clinical contact with an average of at least three patients per half-day clinic. The student should make the first clinical contact in at least 100 patient encounters during his/her clerkship. Midway through the clerkship, each student will receive a report based on their PDA logs as to their progress on meeting the minimum number of required patient encounters for each of the 29 common problems. Students should review this report with their preceptors so that their preceptors can assist them with finding patients with problems that they have not seen or met the minimum numbers for. If the student and their preceptor feel that they will not be able to meet the minimum required numbers for a particular problem at their current site, the student should contact the clerkship director as soon as possible so that arrangements
can be made for the student to see patients at another site in order to meet the minimum required patient encounters for the problem(s) in question.

**Strategy 2:** (Knowledge) The student should read the recommended reading materials on the provided Clerkship CD-Rom addressing common ambulatory problems as well as utilize other recommended resources.

**Strategy 3:** (Knowledge/Skills) The student will complete the PBL patient web-cases and required web-modules by the end of the clerkship.

**Strategy 4:** (Knowledge/Professionalism) The student will attend the required didactic sessions that address common ambulatory care issues.

**Strategy 5:** (Skills/Professionalism) The student will be observed at least once during a patient counseling encounter (i.e. lifestyle modifications, family planning, smoking cessation, etc.)

**Evaluation:** Student evaluation of objective A will be via preceptor evaluation/observation and feedback (appendix A and I), review of student PDA logs, and by the end clerkship OSCE and departmental examinations.

**Objective B:** The student will understand and apply the principles of evidence-based medicine as it applies to common ambulatory problems and health care maintenance. Students will show familiarity with medical informatics resources and will be able to access resources at the point of care.

**Strategy 1:** (Knowledge/Skills) The student will research at least one ambulatory care topic using web-based medical informatics resources, applying the principles of evidence-based medicine, for discussion with his/her preceptor. The critically appraised topic form (Appendix J) will be turned in to the department by the end of the rotation.

**Strategy 2:** (Knowledge/Skills) The required didactic sessions will utilize the principles of evidence-based medicine.

**Strategy 3:** (Skills) The student will make appropriate and efficient use of mobile information devices such as personal digital assistants to answer clinical questions during the course of patient encounters.

**Strategy 4:** (Skills) The student will utilize web-based resources provided to them in the course of completing their PBL web-cases and web-modules.

**Evaluation:** Student evaluation of objective B will be via preceptor/faculty evaluation (appendix A) of the student’s performance during the clerkship, faculty observation and evaluation during didactic sessions, as well as review of the student’s critically appraised topic form (Appendix J) which is to be turned in at the completion of the clerkship.

**Objective C:** The student will understand the concept of continuity of care.
Strategy 1: (Skills) The student will be given the opportunity to participate in managing continuity of care for selected patients from setting to setting (i.e. office, home, nursing home, hospital).

Strategy 2: (Skills/Professionalism) The student will provide continuing care for clinic patients. This may include management of chronic disease, follow-up of acute illnesses or visits for health maintenance and disease prevention.

Evaluation: Student evaluation of objective C will be via faculty/preceptor evaluation of the student’s clinical performance (appendix A) with their preceptors.

Objective D: The student will learn to view the patient within the context of relevant biological, social, familial, environmental, psychological, cultural, and genetic factors in health or illness.

Strategy 1: (Skills/Professionalism) The student will, when presenting patients to the preceptor, demonstrate an awareness of the patient’s health or illness within the context of relevant biological, social, familial, environmental, psychological, cultural, and genetic factors.

Strategy 2: (Skills) The student will participate in at least one home visit with a core family medicine department faculty member or with their preceptor.

Strategy 3: (Knowledge/Professionalism) The student will read and view the required materials for the cross-cultural issues in medicine series and participate in group discussions with their peers and course leaders.

Strategy 4: (Professionalism) The student will complete an essay describing how consideration of cultural factors affected their decisions, actions, or attitudes in a particular patient encounter during their clerkship.

Strategy 5: (Knowledge/Professionalism) The student will read and view the required materials for the doctor-patient seminars and participate in group discussions with their peers and course leaders.

Strategy 6: (Skills/Professionalism) The student will see patients as primary care providers in the H.O.M.E. Project student-run free homeless clinics or participate in the health care of the homeless at other community or H.O.M.E. Project sites on average of one-two half-days per week. In caring for the homeless, the student will see the firsthand impact and challenges one’s social situation has on acute and chronic disease management.

Strategy 7: (Skills/Professionalism) The student will interview at least one homeless individual/family to discover their “story of homelessness”. In addition, the student will be required to experience some of the same challenges, including applying for housing, welfare and medQuest, these patients must face in accessing resources. The student will complete an essay by the end of the clerkship describing their individual/family’s story of homelessness and the student’s experience with accessing resources.

Strategy 8: (Skills/Professionalism) The student will attend one-two half-days of clinic during their rotation within the Hawaii State Department of Corrections. This experience is meant to expose the student to the unique aspects and challenges of prison medicine and to
help him/her understand the impact that being incarcerated has on the patients’ overall
health and health care management.

**Evaluation:** The student will be evaluated by their participation in the above experiences
(home visit, prison experience, H.O.M.E. Project clinics, didactics/discussion/seminar
sessions). Students will also be graded on the completeness of their essays on culture and
medicine, the homeless experience, and on the doctor-patient seminar series essays. The
impact of the biological, social, familial, environmental, psychological, cultural, and genetic
factors in health or illness will also be covered on the OSCE and end/mid clerkship
examinations.

**Objective E:** The student will learn the principles and practice of disease prevention and health
maintenance.

**Strategy 1:** (Knowledge/Skills) The student will discuss disease prevention and health
maintenance assessments and plans with patients. Students will reflect on guidelines and
controversies as they pertain to particular patients.

**Strategy 2:** (Knowledge/Skills) The student will use recognized health maintenance
protocols in caring for pediatric, adolescent, adult, and geriatric patients.

**Strategy 3:** (Knowledge/Skills) The student will develop and initiate a smoking cessation
plan for at least two patients.

**Strategy 4:** (Knowledge/Professionalism) The student will attend the required didactic
session on health care maintenance.

**Evaluation:** Evaluation of student performance of objective E will be via preceptor
observation and evaluation (appendix A) as well by participation and attendance at the
didactic session on health care maintenance. The OSCE and departmental examinations
will also cover principles of health care maintenance and prevention.

**GOAL II:** The student will increase his/her understanding of the role of the primary care
physician.

**Objective A:** The student will learn how a family physician works with other professionals in
facilitating and coordinating patient care.

**Strategy 1:** (Skills) The student will work primarily with one preceptor/group for the entire
clerkship.

**Strategy 2:** (Skills) The student will demonstrate competence in the coordinated
management of selected patients with other professionals. It will include a consultation with
a physician about the management of at least one patient.

**Strategy 3:** (Skills) The student will refer at least one patient to a community resource (i.e.
support group, organization, home health, etc.). The student may choose to utilize the
medical school’s McGuire Fund (see appendix H for more information on the fund) for a
patient to satisfy this requirement. If the McGuire fund is utilized, this will also count towards one of the student’s community service requirements.

**Evaluation:** Student evaluation of objective A will be primarily via their preceptor (appendix A). Students may also have opportunities to practice and to have the above skills observed at the H.O.M.E. and other supplemental clinics.

**Objective B:** The student will learn the family physician’s role in facilitating cost effective medical care.

**Strategy 1:** (Skills/Knowledge) The student will consider cost-effective and cost-beneficial diagnostic and therapeutic approaches to the problems of patients presenting in the primary care setting regardless of socio-economic or health insurance status.

**Strategy 2:** (Skills/Knowledge) The student will consider the requirements and limitations of patients’ health insurances when prescribing medications and ordering laboratory or diagnostic tests.

**Evaluation:** Student evaluation of objective B will be primarily via their preceptor (appendix A). Students may also have opportunities to practice and to have the above skills observed at the H.O.M.E. and other supplemental clinics.

**Objective C:** The student will learn about the lifestyles and community roles of the family physician.

**Strategy 1:** (Professionalism) Preceptors and students will discuss relevant lifestyle and community role issues as they arise in their daily contact.

**Strategy 2:** (Professionalism) The student will participate in two community service activities during their clerkship, preferably in the community that they are working in. If the McGuire fund was utilized as your community resource referral, this counts as one community service activity.

**Strategy 3:** (Knowledge/Professionalism) The student will read the recommended readings and attend the didactic sessions addressing the role of the family physician.

**Strategy 4:** (Skills) In recognition of the variety of practices and patient-types that family physicians may choose to serve, the student will also have opportunities to supplement their primary preceptor experiences by rotating with family physicians that have special interests in sports medicine, prison medicine, geriatrics and home care.

**Evaluation:** Evaluation/completion of objective C will be evaluated by the student’s preceptor (appendix A) as well as by completion of the student’s community service log (http://www2.jabsom.hawaii.edu/FamilyMedicine/NewPredoc.html) at the end of the clerkship.

For a summary of the required clerkship components as they pertain to the clerkship goals and objectives, please refer to the Family Medicine Clerkship Objective Checklist in appendix D. The following sections describe the clerkship components and the grading and evaluation process for...
the clerkship in more detail.
# REQUIRED TOPICS FOR THE FAMILY MEDICINE CLERKSHIP

The following is a list of common ambulatory care topics that you should be encountering during your family medicine clerkship. The number represents the required number of patients presenting for that type of visit that you should have significant contact with during the clerkship. We have provided examples of what types of specific diagnoses would qualify for each of these problems (other diagnoses may apply as well).

## Health Maintenance
- Well Child Check/School Physicals/Sports Physicals - 3
- General PE/Well Woman Check (work physicals, pre-op physicals, disability physicals) - 3
- Family Planning (contraception, und fertility, IUD, implanon, abortion counseling) - 2
- Smoking Cessation Counseling - 2

## Acute Problems
- Dizziness (labarynthitis, vertigo, benign positional vertigo, syncope) - 1
- Ear Problems (otitis media, cerumen impaction, otitis externa) - 1
- Gastrointestinal Problems (abdominal pain, AGE, constipation, GI bleed) - 2
- GYN Problems (amenorrhea, DUB, menopause, abnormal vaginal bleeding) - 1
- Musculoskeletal Problems (sprain, strain, fracture, acute joint pain, acute back pain) - 2
- Pharyngitis (strep, viral, mono) - 1
- Pulmonary Problems (bronchitis, pneumonia, chronic cough) - 1
- Rhinosinusitis - 1
- Skin Problems – Infectious (tinea, scabies, cellulitis, abscess, candidiasis, folliculitis, warts) - 1
- Skin Problems – Non-Infectious (contact dermatitis, urticaria, corns, calluses, allergic dermatitis) - 1
- Upper Respiratory Infection (URI, influenza) - 2
- Urinary Tract Infection (UTI, cystitis, prostatitis, pyelonephritis) - 1

## Chronic Problems
- Allergic Rhinitis - 1
- Arthritis (gout, OA, rheumatoid, psoriatic, pseudogout) - 1
- Cardiac Problems (CHF, CAD, Angina, MI, chest pain, arrhythmia) - 2
- Chronic Pain (chronic back pain, fibromyalgia, polymyalgia rheumatica) - 2
- Diabetes Mellitus, Type II - 3
- GI Problems (irritable bowel syndrome, Crohn's, UC, PUD, GERD) - 1
- Headache (migraine, tension, cluster) - 2
- Hypertension - 3
- Lipid Disorder (hypercholesterolemia, hypertriglyceridemia, hyperlipidemia) - 2
- Psychiatric Problems (depression, anxiety, bipolar, dementia, delirium, ADHD, adjustment d/o) - 2
- Pulmonary Problems (asthma, COPD, bronchiectasis) - 2
- Skin Problems (acne, eczema, psoriasis, rosacea, seborrheic keratosis) - 1
- Thyroid Problems (hypothyroidism, hyperthyroidism, thyroid nodule, thyroiditis) - 1
Other Common Ambulatory Care Topics

In addition to the items listed above, the following are other common ambulatory care topics encountered by family physicians. You will probably see some of these in your clinics and you will cover others in your required/recommended readings, and/or as part of the web-based patient cases.

**NEWBORN CARE**
- Newborn physical exam
- Common congenital abnormalities
- Physiologic jaundice of the newborn

Feeding/nutrition, weight gain, bowel habits
Identifying the sick neonate; when to refer
Common outpatient problems (e.g. rashes)

**CARE FOR THE INFANT, TODDLER, PRE-SCHOOLER**
- Immunizations
- Accident Prevention
- Screening for child abuse

Developmental Delays
Recognition of life-threatening disease
Failure to Thrive

**THE SCHOOL YEARS**
- Immunizations
- Accident Prevention
- Mental Health
- Sports Physicals

Growth and Development
Sexuality & Reproductive Health
Family Health (i.e. abuse/violence)
Life-style Habit Counseling:

Smoking, drugs, alcohol, safe sex

**ADULT HEALTH**
- Adult Immunizations
- Stress Management
- Work Place Injury/Disability
- Life-Style Choices and Health:
  - Nutrition, exercise, CAD prevention/detection, ASCVD prevention/detection, CA prevention/detection, accident prevention
- Sexual and Reproductive Health:
  - Sexual abuse, vaginitis/STDs, STD counseling, infertility, impotence, prenatal care
- Acute/Chronic Disease Management:
  - Constipation, fractures/dislocations, obesity, chronic pain, chronic fatigue, fibrositis/myalgias, incontinence, BPH
- Front-line evaluation of life-threatening conditions:
  - Acute abdominal pain, acute chest pain, acute severe headache, shortness of breath, acute muscle weakness, altered mental status

**GERIATRICS**
- Geriatric Assessment
- Dementia/Delirium/Depression
- Physiologic Changes with aging

Home Visits/Nursing Home Care
Osteoporosis

**ORAL HEALTH**
- Oral Health Assessment
- Common oral conditions in children, adults, geriatrics
- Dental emergencies

Relationship between oral and systemic disease
Fluoride and prevention
CLERKSHIP COMPONENTS

1) Preceptor Experience

a. Each 6L student is expected to spend two half days per week with a family medicine preceptor for the duration of their ambulatory 6L experience. In addition, you will be expected to participate in 8 additional half-days of department specified supplemental experiences (i.e. extra H.O.M.E. or PCM clinics).

b. Your preceptor should be observing your history taking and physical exam skills when possible. Your preceptor(s) needs to sign you off on the history and physical exam checklist by the end of your rotation.

c. Although clinic notes that you write on a day to day basis will vary greatly depending on what site you are at, you should try to write a complete formal SOAP note on at least 1-2 patients per week. You should ask your preceptor to review these notes for you. If you do not receive feedback on your formal notes from your preceptor, please inform Dr. Lee or Dr. Omori before the end of the rotation so that you can obtain adequate feedback prior to your end-clerkship OSCE.

d. If your preceptor goes on vacation or is unavailable for a period of time, please let the clerkship coordinator know ASAP. In this case, you can either work with a FM colleague of the preceptor in a site that has been approved for teaching by the clerkship coordinator or you will be assigned temporarily to another preceptor.

e. All students will spend at least two half days during their clerkship at the Physician Center at Mililani to broaden their experience.

f. Some preceptors will require their students to do in-patient rounds and call at their affiliated hospitals.

2) H.O.M.E. Project and Other Supplemental Experiences

a. Oahu based 6L students will staff the H.O.M.E. project student-run free clinic either at the Waianae homeless shelter or at the Kalaeloa Shelter one half-day per week. Clinic hours for Waianae are Tuesday afternoons from 2-6PM. Kalaeloa hours are either Saturday mornings from 830-12 or Saturday afternoons from 1-4. Students based on the neighbor islands may participate in local homeless health care activities in their assigned communities. In addition, students will participate at the Homeless Clinic at the Next Step shelter in Kaka’ako on at least four occasions during the year. Next Step clinic hours are 6-10 PM. You should bring your JABSOM nametag, stethoscope, oto/ophthalmoscope, and blood pressure cuffs to each clinic experience. Please make sure that your equipment is properly labeled. White coats are optional, but please wear your identification/name tags. For the mobile H.O.M.E. Waianae and Kalaeloa clinics carpool sites may be arranges with clinic staff. (Van leaves from Kakaako).

b. As part of the H.O.M.E. Project experience, you will be interviewing a homeless individual or family to discover how and why they became homeless. You will also be required to apply for certain resources, including welfare, housing and medQuest that these patients access to experience the same challenges that they must face. You will complete a 1-2 page essay by the end of the clerkship describing your homeless individual/family’s story and your experience with accessing resources.
c. Throughout the clerkship, students will also be required to attend supplemental experiences with family physicians that specialize in sports medicine, geriatrics and home care, and prison medicine. Please refer to your individual schedules for the dates/times of these experiences.

d. For each supplemental experience you participate in, please have your preceptors complete the supplemental experience evaluation form (appendix K) and return it to the clerkship coordinator by the end of the clerkship. Although you may not spend a large amount of time with these preceptors, their evaluation of you will be used to supplement your evaluations from your primary preceptor(s).

3) Interactive Web-Cases

During your family medicine clerkship, you will be required to complete a set of patient cases. The cases are based on a hypothetical family and should be completed in the order specified. These cases take the place of PBL sessions in this clerkship and are organized very similarly to PBL cases that you have had in the past. Your answers will not be graded, however, to get full credit you must answer each question thoughtfully and with good effort. If you do not know the answer to a question, you are expected to research that item at the time that you are completing the web-case. Do not answer “I don’t know” to any of the questions. Allow yourself 45 minutes to 1 hour to complete each of the web-cases. Each page of the web-cases gets submitted individually once you hit the buttons at the bottom of the page. If you need to stop in the middle of a case, please remember where you left off and when you return to the case, leave the pages that you already completed blank and go forward until you reach the page where you left off. If you wish to receive extra feedback on your progress with the cases, please let Dr. Lee or Dr. Omori know and someone will get back to you as soon as possible. There is a list of resources that goes along with each of the cases and it can be and should be accessed from each page of the case by clicking on the “resources” button in the upper right hand corner of the page. The cases are meant to supplement your learning in family medicine and will assist you in preparing for the end-clerkship examinations. You can access the web-cases from the clerkship website: http://www2.jabsom.hawaii.edu/FamilyMedicine/NewPredoc.html by clicking on the appropriate link. You will be given a username and password to gain access to these cases. Grading is pass/fail.
Doctor-Patient Seminars

There are four doctor-patient seminars which meet for about two hours each. The purpose is to introduce students to issues that affect the ways that doctors and patients relate to each other and to help develop skills that make that relationship therapeutic and satisfying. There are required readings/videos, which should be done before each session, and two required essays (write-ups). Grading is pass/fail. To pass, you must attend the sessions, participate in group discussions, and turn in the two required write-ups. Please refer to Appendix L for the topics and required readings for each of the seminars. The following are summaries of the required write-ups.

Write-up #1: Narrative of Family Illness (Needs to be turned in at seminar #2)

This paper should describe a time when there was an illness in your family and how this affected you and your family. You will be sharing your story at the second seminar. It should include:

- Portrayal of family dynamics - nature of interaction between members
- Awareness of family beliefs or assumptions about illness
- Impact of those beliefs or assumptions on the course of illness or treatment
- Awareness of impact of family values on your view of the practice of medicine

Write-up #2: Finding Common Ground (Needs to be turned in at seminar #3)

This paper should discuss a scenario where you or one of your preceptors found common ground with a patient, or perhaps a time when it would have been useful. This does not have to come from your FM clerkship. You will discuss your paper at the third seminar. It should include:

- Clarity of understanding in what areas common ground was needed - etiology, treatment and/or role of the patient and physician
- Description of the patient viewpoint and the physician viewpoint
- Description of the negotiations between the two viewpoints
- Description of the outcome of the negotiations - common ground achieved or not achieved.

Participation in the group discussions is evaluated by:

- Ability to understand, explore, challenge and articulate the perspective of the allopathic physician
- Ability to understand, explore, challenge and articulate the perspective of the patient (and family)
- Ability to explore, discuss and negotiate the terrain that lies between the physician and patient ("common ground") and to see what meaning that may have in patient care.

4) Didactic Sessions

There is a series of didactic sessions designed to supplement your clinical learning. These sessions are mandatory and some may require advance preparation. There are other recommended readings that you should also complete during your FM clerkship that will help to supplement your learning. The recommended readings can be found on the CD-ROM that you will receive from the department. You are welcome to copy the CD, however, you will need to return the original to the department at the end of your clerkship.
5) **Web-Based Modules**

You will be required to complete two web-based modules during the course of your clerkship. One module is on smoking cessation and the other reviews common ENT problems. Your username and password for the modules are the same as that for the web-cases. The link for the web modules can also be found at http://www2.jabsom.hawaii.edu/FamilyMedicine/NewPredoc.html.

6) **Cultural Competency in Medicine**

As part of the FM cultural competency curriculum, we will be having a general orientation session on cultural competency at the start of the clerkship. There are also several readings on the CD-ROM in the health and culture folder. In addition, you will be watching several videos (*Wit* and *Ikiru*), after which all students will participate in a discussion regarding culture in medicine. You will also be required to turn in a 1-2 page essay by the end of the clerkship describing how consideration of "culture" affected your decisions, actions, or attitudes in a particular patient encounter or in a variety of encounters. Grading is pass/fail. To pass, you must participate in the discussions and turn in the final essay.

7) **MSIII Colloquium**

This is a seminar series conducted for all 3rd year students. It will be held once a month on a Friday (entire day) at the Kaka’ako campus (normally from 10:30-3:30 pm). The schedule is available through the Office of Medical Education or Office of Student Affairs.

8) **Community Service Activities**

You are required to participate in two different types of community service activities during your family medicine clerkship, preferably in the community where you are working during your rotation. These activities can include, but are not limited to, support groups, sporting events, primary/secondary school talks & activities, patient education projects, and health fairs. You will be asked to submit a community service log on-line to document each activity that you participated in. Please refer to the website at http://www2.jabsom.hawaii.edu/FamilyMedicine/NewPredoc.html for ideas on a variety of community service projects.

9) **10) Patient Logs**

Patient log encounter data is required to be kept on a personal digital assistant utilizing the T-Res software. Your FM template will be loaded onto your PDA prior to the start of the rotation. Whenever you synch your PDA, your database will automatically be uploaded to the T-Res website so that our department can track your progress in the clerkship. The data is used to document the range of patient care encounters that you experience. You will receive a summary print out of your patient log half way through your rotation to help guide your patient care experiences. The patient logs will be used to determine whether any supplemental clinic experiences will be needed before the end of the clerkship. Please refer to appendix F for more information on the PDA logs.

10) **Optional**

The Family Medicine Residency afternoon teaching conferences are held from 1-5 pm every Wednesday in the second floor conference room at the Physician Center at Mililani. Lunch is often provided by a pharmaceutical representative. Check the department website for the current resident conference schedule. (http://www2.jabsom.hawaii.edu/FamilyMedicine/NewResidency.html)
EVALUATIONS AND GRADES

1. **OSCE (Observed Structured Clinical Exam)**

   You will be observed (and videotaped) interviewing two standardized patients at the Center for Clinical Skills at the Kaka’ako Medical Education Building (2nd floor Diamond Head wing). You will be given a patient scenario and then you should proceed to take a history as you would in a real situation. In addition to taking a complete history from these patients, you will be expected to perform an appropriate physical exam for each patient. You will also be expected to provide patient education as appropriate. Do not forget to address health care maintenance and prevention issues with these patients. You have a **total of 20 minutes** to complete your history, physical, and patient education with each patient.

   For one of these patients, you will be presenting your findings along with your assessment and plan to a faculty preceptor. You have **10 minutes to gather your thoughts and finalize your assessment and plan** after meeting with the patient. You will then present the patient along with your assessment and plan to a faculty preceptor. You have another **10 minutes** for this portion of the OSCE.

   For the second patient, you will be graded on your SOAP note for the visit. You **will have 20 minutes to write your SOAP note**. The note should not be documented like an H&P but rather a progress note that encompasses all pertinent positives and negatives and gives the reader an adequate insight into the patient you interacted with. It should be documented in the formal SOAP note format that you learned during your Unit 6 orientation session. You do not need to include a subjective and objective section for each problem, but you do need to include a detailed assessment and plan for each separate problem. DO NOT merely document a problem list. Your assessments should include discussion as well as differential diagnoses for all appropriate problems. You should also be able to commit to the diagnosis that you feel is most likely for problems where the exact diagnosis is not known and be able to justify your decision based on the information you gathered in your history and physical. Your plan should include all aspects of management, including diagnostic, therapeutic, and educational components.

   You are allowed to carry any resource materials with you that fit in your coat pockets, so it would be advisable for you to wear your white coats for the OSCE.

   In addition to the two standardized patient stations, there will be a third, **writing station**. For this station, you will be presented with two patient scenarios. Each scenario will be followed by a series of short-answer questions for you to complete. The scenarios and question-types are very similar to those found in the web-cases. The total writing station is worth 30 points (15 points possible per scenario). **You will have 30 minutes to complete this portion of the OSCE.** Whereas the standardized patients stations are open-book, you **may not** use your resources to answer the questions in this part of the OSCE.

You will be graded on:

a. The completeness of your history taking and physical exam.

b. Your assessment, plan, and presentation skills: Organization, focus and clarity, ease of following, all-important data included, appropriately prioritized assessment, and plan consistent with patient needs and risk of illness.

c. Your ability to write concise yet complete progress notes. (This will include the legibility and organization of your note).
d. Your physical exam technique.

e. The standardized patients will also be evaluating your skills in the following:

- **Personal Manner and Rapport**: introduction and greeting, treating patient on the same level (not patronizing), showing interest in patient as a person, acknowledging patient concerns.

- **Communication/Counseling**: explained medical terms in simple language, listening carefully and not interrupting, asking thoughtful questions, asked for patient opinions and encouraged questions, checked for understanding, being encouraging and empowering.

- **Whether they would return to you as a patient.**

- **Physical examinations skills**: washing hands, appropriately draping patient, describing the physical exam and explaining findings, considering patient comfort during the exam, examining underneath clothing.

f. The accuracy and thoroughness of your answers to the writing station questions.

Any questions regarding the grading of the OSCE must be presented to the clerkship director within one week of receiving your OSCE grade.

2) Department Exam

The department exam is a multiple choice exam (approximately 100 questions) based on the didactics, web-cases/modules, recommended reading topics, and common ambulatory care problems. It is a two hour computer based exam that is taken at the Kaka‘ako computer lab (1st floor). Instructions for log-in to the exam will be provided prior to the test. Any questions regarding the grading of this exam must be presented to the clerkship director within one week of the examination date.

3) Student Performance Evaluations

Every faculty member, community preceptor, and resident who has a significant role in supervising you during your clerkship completes an evaluation form for you at the end of your clerkship (see Appendix A). These ratings are the major, but not sole determining factor of your overall grade. Forms are returned to the clerkship director who summarizes them. Written comments are separated into two sections: formative and summative. The formative comments are considered diagnostic feedback for your use only. The summative comments should reflect your overall performance. These comments are used in your Medical Student Performance Evaluation. If you have any questions or concerns about comments you receive, we encourage you to talk with your preceptor or the clerkship director.
GRADING

Our evaluation of students during the FM clerkship is based on an analysis of knowledge, attitudes, and skills. The grading is assessed as follows:

Minimum requirements to pass:
1. Passing grade from preceptor and average ratings of 2.5 or above (scale of 1-5).
2. Passing grade from didactic sessions and interactive web-cases/modules (Pass/Fail only).
3. Passing grade from doctor-patient and cultural competency sessions (Pass/Fail only).
4. Score of 65% or above on the OSCE.
5. Score of 65% on department exam.
6. The student is also required to turn in:
   - Community service log, observed H&P checklist, clerkship objective checklist, FM clerkship CAT form, final patient log, homeless experience essay, and cultural competency essay
   - Student evaluation by preceptor (you are responsible for making sure this is turned in)
   - Evaluations of FP preceptor/rotation, didactics, and doctor-patient seminars

Minimum requirements for honors (need all to honor):
1. Recommendation for honors by your preceptor.
2. Passing grade from didactic and cultural competency sessions, interactive web-cases/modules, and doctor-patient seminars.
3. Composite score of: (The composite score is your weighted score: Preceptor 40%, OSCE 25%, Department exam 35%)
   6L Fall: 88  6L Spring: 90
4. The student must receive an honors level score (85%) for at least one of the end-clerkship examinations.
5. The student is also required to turn in all documents described above.
6. The Family Medicine predoctoral education committee has the right to review all student cases of honors and near-honors scores to determine the student’s final grade.
Remediation in case of failure:

1. If a student fails the preceptor portion, he/she must repeat the clerkship as a 6B student.

2. If a student fails the interactive web-cases/web-modules or cultural competency series, he/she must repeat the clerkship as a 6B student.

3. If a student fails the doctor-patient course, he/she must spend four hours of one-on-one discussion with the course leaders, and re-do the required write-ups. It is then the decision of the course leaders whether to pass the student or not. If they fail the student, then the student must repeat the clerkship as a 6B student.

4. If a student fails the OSCE, he/she will receive an incomplete and have to make-up the exam at any of the block end exam dates, or at the mid-year 6L exam date in April. If the student fails the OSCE on the second try, he/she may have to repeat the clerkship as a 6B student.

5. If a student fails the department exam, he/she will receive an incomplete and have to make-up the exam(s) at a time approved by the clerkship coordinator. If the student fails the exam on the second try, he/she may have to repeat the clerkship as a 6B student or complete a remediation program of at least four weeks as designed by the clerkship director under guidance of the predoctoral education curriculum committee.

6. The predoctoral education committee reviews all students with two failures on department exams and/or OSCEs. Final determination of student remediation will be determined by the curriculum committee with input by the Office of Student Affairs.

7. All remediation must be completed before beginning Unit 7.

8. In the event of a failure, the Department of Family Medicine predoctoral education curriculum committee will review the student’s performance on the examination, OSCE, or clerkship component in question and a determination as to the student’s final grade will be made. All student requests for consideration of grade changes will be reviewed by the FM predoctoral education committee, who will make the final grade determination. Formal requests for review should be done within one week of notification of your clerkship grade.

9. A copy of the JABSOM academic appeals policy and processes may be accessed at:
   http://jabsom.hawaii.edu/JABSOM/admissions/Academic_Appeals_Policy_10-24-01.pdf

STUDENT CONDUCT AND RESPONSIBILITY

As a reminder, students at JABSOM are expected to behave ethically and responsibly at all times. Please refer back your General Guide to the M.D. Program for specifics regarding student conduct and responsibility. You can also refer to the University of Hawai‘i Student Conduct Code located on the web at www.hawaii.edu/student/conduct/. We would like to stress that any discussion with other students regarding content or details of the web-cases and modules, OSCE, or the department exam would constitute a violation of the student honor code. All violations will be handled according to the University’s student conduct policy and could result in expulsion from the medical school.

All procedures that you perform should be supervised by medical school faculty, your preceptor/attending physician, or a second or third year resident. Breast, pelvic, rectal, or genital exams need to be performed with a chaperone (i.e. clinic staff member, resident, your preceptor/attending physician, or medical school faculty member) present.
POLICY ON STUDENT WORKLOAD

The Department of Family Medicine and Community Health recognizes the importance of balancing medical education, patient care and student well-being. To accomplish this goal, we have adopted the provisions set forth by the Accreditation Council for Graduate Medical Education (ACGME) for residency programs nationwide:

- Duty hours are generally limited to a maximum of 80 hours per week (Students may exceed this at their own discretion and with approval of the clerkship coordinator)
- Duty periods cannot last for more than 24 hours, although students may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities (i.e. didactics, colloquia, seminars, etc.).
- Students are expected to have one day out of seven free from all clinical and educational responsibilities.
- Students should be given at least 10 hours for rest and personal activities between daily duty periods and after any in-house call.

POLICY ON STUDENT MISTREATMENT AND HARASSMENT

The Department of Family Medicine and Community Health will not tolerate any mistreatment or harassment of any individual. Examples of mistreatment or harassment include, but are not limited to:

- Physical punishments or threats
- Sexual harassment
- Discrimination based on race, religion, gender, age, sexual orientation, or physical disability
- Repeated episodes of psychological punishment such as public humiliation or intimidation
- Requiring the performance of personal services
- Taking credit for another individual’s work

If you feel that you are being mistreated or harassed at any point in your clerkship, please notify someone as soon as possible. Please refer to the Unit 6 Handbook’s section on medical student mistreatment for a list of appropriate individuals that you should contact in these cases. Please be assured that all student reports of mistreatment and harassment are protected from retaliation and will be investigated fully. These reports will have no bearing on your clerkship evaluations.

CAREERS IN FAMILY MEDICINE

As part of your clerkship experience in Family Medicine, we would like you to get a good idea of what it is like to be a Family Physician and to explore the possibility of choosing this specialty for your career choice. If you are interested in pursuing a career in Family Medicine, please talk with the Residents and Faculty members who can give you good insight into residency requirements, work opportunities, and lifestyle issues. A wonderful resource to utilize if you are contemplating a career in Family Medicine is the American Academy of Family Physician’s Family Medicine Interest Group website (http://fmignet.aafp.org/). It is filled with numerous student resources that will come in very handy for both your third and fourth year in medical school. The intro to family medicine folder on your CD-ROM also contains articles and information on FM as a specialty. You should also contact either Dr. Jill Omori or Dr. Damon Lee who are career advisors for the department.
The Learning Contract

Introduction and General Instructions

Students bring to clerkships different histories, interests, and skill levels. Likewise, preceptors bring an assortment of talents, philosophies, and clinical skills which, when combined with the unique characteristics of their patients, practices, and communities, offer students a rich learning environment.

To capitalize on this learning opportunity and to accommodate individual student needs and interests, each student and preceptor will negotiate a “learning contract.” This contract outlines expectations for the rotation and will constitute guidelines for the preceptor’s evaluation of the student. The contract is accomplished by determining the student’s learning objectives and interests, in concert with the preceptor’s assessment of the student skill, potential, and educational priorities.

During the first week, the student and preceptor should each identify learning objectives and strategies and describe them in the spaces provided. The student is responsible for arranging a conference with the preceptor to review the information below and develop the contract as outlined on the following page.

The Learning Contract
(For your use - not to be turned in)

I. Setting Goals

A. Student Goals: To be completed after first full day in preceptor’s office.

List the three most important goals you have for the clerkship.

1. ____________________________________________.

2. ____________________________________________.

3. ____________________________________________.

List specific strategies for accomplishing these goals.

B. Preceptor Goals: To be completed by the end of the first week.

List the three most important areas on which the student should focus.

1. ____________________________________________.

2. ____________________________________________.

3. ____________________________________________.

List strategies for addressing these areas.
II. Negotiation and Clarification of Expectations for the Clerkship.
By the end of the first week in the practice, the student should schedule a conference with the preceptor to discuss learning goals and strategies as outlined above.

III. Agreement on Goals for the Clerkship.
The student is to write a summary of the discussion above, including both preceptor and student goals. After this is reviewed with the preceptor, both parties sign the learning contract.

Student Signature__________________________________________________________.

Preceptor Signature________________________________________________________.

Date____________________________.
MID-CLERKSHIP FORMATIVE REVIEW

Instructions
The student should arrange a mid-clerkship meeting with the preceptor to discuss the issues listed below, progress on your objective check list, and the clerkship goals established in the Learning Contract. This discussion should be brief and provide a clear understanding of standards and expectations, as well as a basis for adjusting performance for the rest of the clerkship. This review should take place at the end of the third week of the rotation.

Issues to Include
How is the clerkship going so far? Is the preceptor meeting the objectives in the learning contract? Is the student? Are there additional learning experiences the student would like to initiate in the remaining three weeks? What are the student’s strengths? What are the student’s weaknesses? What specifically should the student do during the last three weeks to improve performance? Are there any changes or additions to the goals described in the learning contract?

Midclerkship Examination
Students will be required to complete a midclerkship examination during week four. The examination will be on the same web-based system as the final departmental exam, however it will be taken individually. Although it will not be proctored, students should treat it like the final examination (not open book; timed) to gain the most from the experience. The examination should take 30-45 minutes to complete. The examination will be an abbreviated version of the department examination (see page 18), comprise 25-30 multiple choice questions, and will be based on the didactics, web cases, web modules, recommended readings and common ambulatory problems. Although the examination does not count towards your final grade, students receiving a grade of less than 65% will be required to meet with the clerkship director and a plan of study for the reminder of the clerkship will be developed.

Students should complete the on-line mid-clerkship survey during week 4 at http://www2.jabsom.hawaii.edu/FamilyMedicine/NewPredoc.html (see also appendix C) so that any interventions that need to take place can be done in a timely manner. If you are experiencing any major problems with your preceptor, please let the clerkship director know as soon as possible (i.e. do not wait until the midclerkship survey). Preceptors are also asked to complete the preceptor mid-clerkship evaluation form to document that the review has been covered with the student.

The clerkship coordinator may do a site visit during the 4th or 5th week of the rotation to observe the student interview a patient, perform a physical exam, & present the patient to his/her preceptor. Preceptors should let the clerkship director know if a student is at risk of failing the rotation based on clinical performance as soon as possible.

Communication with Family Medicine Office
Please feel free to call the Department of FM predoctoral office, 627-3235, with any questions or problems.

FORMAL EVALUATION BASICS

Definition
Evaluation is the process of making judgments based on factual information and observations in order to rate, rank, or assess an individual’s status at a given point.
Purposes of Evaluation

1. Summarize performance at a given point in time.
2. Provide information for planning future educational experiences.
3. Communicate summary information to other parties.

Guidelines for Evaluation

1. Evaluation should be based on a systematic observation recorded over a period of time.
2. Evaluation should emphasize both changes in behavior (improvement) and progress toward a goal.
   - Example: Julie’s suturing skills are comparable to other third-year medical students. She has mastered proper wound preparation. Her suture spacing and tension are improving.
3. Evaluation should be both verbal and written whenever possible. If only verbal evaluations are given, those being evaluated should be asked to review their understanding of the evaluation.
4. Evaluation should be conducted in an unhurried atmosphere. The evaluator should undertake an evaluation only of what can be adequately covered in the available time.
5. The individual being evaluated should have the opportunity to provide input.
6. Evaluation should fulfill due process procedures.

Sources of Information for Evaluation
Collecting evaluation information during the day-to-day activities of the clerkship will facilitate the final evaluation session. These sources of information may include:

- Observation
- Questioning
- Demonstration
- Review of patient notes and records
- Self-assessment
- Testing
- Presentations
- Input from staff and/or patients

Summative comments are extremely important as they demonstrate insight into an individual’s strengths and weaknesses and they are the basis for the descriptive portion of the Medical Student Performance Evaluation.
Appendix A: Family Medicine Final Evaluation of Student by Preceptor

Student ______________________________     Rotation Dates ________________
Preceptor ______________________________
If compiled from multiple evaluators, please list names here: _______________________________________________

I recommend this student for: ________     Honors _________     Credit ________     No Credit

(**Honors should correlate to a score of 4.7 or higher)

Note:  1-2 = performance below expected level of training  3 = at expected level of training  4-5 = exceeds expected level of training
Any 1 or 2 ratings need to be clarified in the comments section.

I.  LIFE-LONG LEARNING SKILLS
Searches for, critically appraises, and applies biomedical information appropriately to patient care:

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<tr>
<td></td>
<td></td>
<td>Fails to show evidence of independent learning. Poor understanding and application of principles of evidence-based medicine.</td>
<td>Learns independently from available resources. Understands principles of evidence-based medicine.</td>
<td>Enthusiastically seeks information from a variety of sources. Understands, articulates and regularly seeks to apply principles of evidence-based medicine in clinical care.</td>
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Evaluates the knowledge base supporting good patient care and recognizes gaps between prevailing and best practices:

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<tr>
<td></td>
<td></td>
<td>Uninterested in improving clinical knowledge and addressing deficiencies.</td>
<td>Interested in expanding knowledge base. Asks appropriate questions and shows evidence of independent learning.</td>
<td>Demonstrates consistent enthusiasm for improving knowledge. Eagerly learns independently from a wide variety of relevant resources.</td>
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II.  BIOLOGICAL SCIENCES
Knows the various causes of illness and ways in which they operate on the body (pathogenesis):

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<tr>
<td></td>
<td></td>
<td>Major knowledge deficits in pathogenesis of illness.</td>
<td>Expected level of knowledge for level of training</td>
<td>Exceptional basic science knowledge/understanding of disease pathogenesis</td>
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Knows the altered structure and function (pathology and pathophysiology) of the body and its major organ systems:

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<tbody>
<tr>
<td></td>
<td></td>
<td>Major deficits in pathology/pathophysiology knowledge</td>
<td>Expected level of knowledge for level of training</td>
<td>Exceptional understanding of pathophysiology and pathologic principles</td>
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Applies the biological sciences to diagnosis and therapy:

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<td></td>
<td></td>
<td>Not able to apply basic science knowledge to clinical settings</td>
<td>Applies knowledge appropriately to clinical settings</td>
<td>Exceptional ability to apply knowledge clinically</td>
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### III. PATIENT CARE

**Approaches each patient with an awareness and sensitivity to the non-biological determinants of health:**

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<tr>
<td>Fails to consider the psychosocial, cultural, familial determinants of health and illness in the patient encounter.</td>
<td>Appropriately considers the psychosocial, familial, cultural determinants of health and illness in the patient encounter.</td>
<td>Always recognizes the psychosocial, cultural, familial and cultural determinants of health and illness in patient interactions.</td>
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**Demonstrates clinical reasoning, critical thinking, and problem solving skills:**

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**Elicits an appropriate and relevant history:**

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<tr>
<td>Disorganized and/or deficient history taking. Frequently misses important facts and does not gather breadth or depth of information required.</td>
<td>Generally organized, obtaining key points of history with relevant qualifying factors.</td>
<td>Very-well organized and comprehensive history taking. Good balance between active listening and being appropriately directive.</td>
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**Performs a thorough and accurate physical examination:**

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<tr>
<td>Inadequate physical examination. Not comprehensive. Poor ability to elicit clinically significant findings. Fails to consider patient comfort, modesty and privacy.</td>
<td>Adequate scope of physical examination. Shows frequent ability to recognize and elicit pertinent positive and negative findings. Makes effort to ensure patient comfort, privacy, and modesty.</td>
<td>Consistent and comprehensive in recognizing and eliciting pertinent positive and negative findings. Able to determine subtle findings. Consistently sensitive to patient comfort, privacy and modesty.</td>
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**Formulates a problem list and differential diagnosis:**

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<tr>
<td>Unable to formulate an acceptable problem list and differential diagnosis when given adequate information.</td>
<td>Consistently formulates an appropriate problem list and differential diagnosis including the most likely/significant diagnoses.</td>
<td>Problem lists and differential diagnoses are consistently comprehensive, appropriate, and relevant.</td>
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**Plans appropriate diagnostic tests:**

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<tr>
<td>Unable to order diagnostic tests in a rational or cost-effective manner. Poor understanding of the benefits, risks and costs of ancillary studies. Does not justify tests based on the ddx.</td>
<td>Able to recommend an appropriate range of diagnostic tests based on the differential diagnosis or clinical practice guidelines. Understands the benefits and risks of ancillary studies.</td>
<td>Consistently recommends diagnostic tests that are helpful in refining the differential diagnosis or are based on clinical practice guidelines. Appropriately considers effectiveness, costs and risks.</td>
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**Accurately interprets patient responses, physical findings, and diagnostic test results:**

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<td>Seldom to never. Requires frequent prompting.</td>
<td>Frequently able to formulate appropriate assessment and plan based on gathered information.</td>
<td>Always formulates appropriate assessment and plans based on gathered information.</td>
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Department of Family Medicine-Clerkship Handbook

Page 28
Develops an appropriate therapeutic plan:

1. Focuses only on acute problem without considering continuing care, including health care maintenance. Fails to recognize or address significant psychosocial issues. Is unaware of cost-effective, evidence-based treatments.

2. Considers full scope of acute and chronic health issues. Explores and addresses psychosocial issues. Chooses medications/treatments appropriate to the presenting problems.

3. Excellent understanding and coordination of care for acute and chronic problems. Very comfortable with exploring and addressing psychosocial issues. Chooses treatments from an evidence-based, cost-effective approach.

Educates patients, families, and other health care providers about health, illness, and the prevention of disease:

1. Fails to convey information to patients on health issues and interventions in an age, education, or culturally appropriate manner.

2. Conveys information to patients in an age, education, and culturally appropriate manner. Confirms patient understanding and answers questions.


Performs technical skills safely under appropriate supervision and at a level commensurate with training:

1. Poor understanding of appropriate sterile technique and universal precautions. Unable to perform basic skills.

2. Recognizes and demonstrates appropriate sterile technique and universal precautions. Performs basic skills adequately.

3. Consistently applies appropriate sterile technique and universal precautions. Performs basic skills well.

IV. ORAL AND WRITTEN COMMUNICATION SKILLS

Greets patients warmly using rapport-building techniques:

1. Poor communication skills. Does not introduce self and role. Does not listen actively, interrupts patient frequently or has many long, uncomfortable pauses during patient interaction.


3. Demonstrates empathy and concern for the patient. Consistently listens actively, uses mirroring and summary statements.

Presents cases clearly and concisely:

1. Disorganized, incomplete, inaccurate presentations. Fails to present pertinent information. Unable to tailor length and complexity to the clinical setting.

2. Organized, accurate presentations with appropriate presentation of pertinent information.

3. Highly-organized, accurate presentations that are appropriately concise for the clinical setting yet address significant positive and negative information.

Writes legible, comprehensive progress notes and H&P’s:

1. Disorganized, poor quality, illegible, inaccurate, and/or deficient documentation.

2. Satisfactory level of organization, quality, legibility and completeness. Record facilitates patient care.

3. Exceptional level of organization, quality, length, legibility and completeness.
**V. POPULATIONAL AND COMMUNITY HEALTH**

Knows the epidemiology of common illnesses within diverse populations and approaches useful in reducing such illnesses:

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<thead>
<tr>
<th>1</th>
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<tbody>
<tr>
<td>Below level expected for level of training</td>
<td>Appropriate to level of training.</td>
<td>Exceeds that expected for level of training.</td>
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Knows how the health of certain subgroups of the population and ethnic groups differs from the population at large:

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<thead>
<tr>
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<tbody>
<tr>
<td>Fails to recognize the importance of culture and community in disease presentation and management.</td>
<td>Appropriately considers cultural and community influences on health and illness.</td>
<td>Consistently recognizes cultural and community influences on patient management.</td>
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**VI. PROFESSIONALISM**

Presents in a professional appearance and demeanor:

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<th>5</th>
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</thead>
<tbody>
<tr>
<td>Unprofessional attire, grooming, or hygiene. Demeanor inappropriate to the clinical setting. Fails to recognize and acknowledge own limitations. Reluctant to ask for help when appropriate.</td>
<td>Courteous, professional to patients. Aware of own limitations and asks for help appropriately.</td>
<td>Consistently professional and appropriate appearance. Demeanor is consistent with the clinical setting. Aware of own limitations and asks for help appropriately. Anticipates situations that may require additional assistance in advance.</td>
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Treats patients with compassion, respecting patient confidentiality and preserving patient dignity:

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<tr>
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<th>5</th>
<th>U/E</th>
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</thead>
<tbody>
<tr>
<td>Fails to establish a therapeutic relationship with patients and families. Lacks empathy, concern, or sensitivity. Fails to consistently maintain patient privacy.</td>
<td>Establishes rapport with patients and families. Shows compassion and sensitivity. Sensitive to patient privacy.</td>
<td>Outstanding bedside manner. Shows exceptional compassion and sensitivity. Sensitive to patient privacy.</td>
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</table>

Completes assignments and fulfills responsibilities promptly and with a positive attitude:

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<th>U/E</th>
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<tbody>
<tr>
<td>Frequently arrives late or misses sessions without appropriate reason. Fails to perform assigned tasks. Poor time management skills. Requires an inordinate amount of time to perform history taking and physical exam and/or document encounters.</td>
<td>Arrives on time. Any absences discussed and appropriate. Performs assigned tasks in a reasonable amount of time. Performs appropriate history and physical in a satisfactory amount of time. Completes documentation appropriately and efficiently.</td>
<td>Always on time. No inappropriate absences. Performs assigned tasks rapidly and efficiently. Dependable and punctual. Performs appropriate history and physical in a very efficient manner. Completes documentation appropriately and efficiently.</td>
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Works effectively with peers:

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<th>U/E</th>
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<tbody>
<tr>
<td>Discourteous, uncooperative and disrespectful.</td>
<td>Courteous, cooperative, and respectful towards peers.</td>
<td>Cooperative and comfortable learning from and sharing with peers. Recognizes peers as equal partners.</td>
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</table>
### Works effectively with nurses and ancillary staff:

1. Discourteous, uncooperative. Unreasonably demanding

2. Courteous and cooperative with staff. Recognizes staff importance as members of health care delivery team.

3. Cooperative and comfortable learning from nurses and ancillary staff.

### Works effectively with attending staff and/or residents:

1. Discourteous, uncooperative. Reluctant to speak with attendings or residents, or does so inappropriately.


3. Cooperative and comfortable in learning from attendings and/or residents.

### Works effectively as a member of a team:

1. Does not contribute well to team dynamic. Causes conflict and impairs team ability to provide patient care.

2. Cooperates well with team. Helps team fulfill patient care responsibilities.

3. Highly-valued team member for contribution to patient care. Promotes cooperation.

### Open to feedback:

1. Does not accept feedback well. Fails to appreciate deficiencies. Resistant to change in response to criticism. Becomes defensive or exclusive when feedback attempted.

2. Acknowledges deficiencies when discussed. Recognizes areas for improvement and shows change in response to feedback.

3. Actively and sincerely seeks feedback on performance to identify areas for improvement. Demonstrates significant positive change in response to criticism.

### Proactive, has initiative and motivation; is adaptable:

1. Lacks initiative and motivation for patient care and learning. Requires constant supervision. Functions poorly in new settings. Lacks flexibility to deal with unanticipated events or schedule changes.

2. Shows initiative and motivation for patient care and learning. Self-directed and able to function independently when appropriate. Able to adapt to new settings. Accommodates for unanticipated events or schedule changes.

3. Outstanding initiative and motivation for patient care and learning. Adapts to new settings well. Responds well to unanticipated events. Seeks to take advantage of new learning opportunities that may arise.
**Summative Comments:** (These comments are required & are used in the MSPE (Dean’s Letter); Please address each of the main categories of evaluation as they pertain to the JABSOM graduation objectives.)

___________________________________________________________________________________________

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**Formative Comments:** (For Student’s use only)

___________________________________________________________________________________________

___________________________________________________________________________________________

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___________________________________________________________________________________________

Preceptor’s Signature ___________________________________________ Date _____________________

I confirm that I have reviewed this evaluation with my preceptor

___________________________________________________________________________________________

Student’s Signature

___________________________________________________________________________________________
APPENDIX B: STUDENT EVAL OF FAMILY MEDICINE PRECEPTOR, SITE & ROTATION

Student Name ___________________________________________ Date __________________

Preceptor(s) __________________________________________ Site __________________

Directions: Please evaluate the experience of your FM clerkship by rating each of the items below. Your honesty and constructive criticism will be used to improve the clerkship for students in the future. Thank you.

5 = Always  4 = Frequently  3 = Sometimes  2 = Rarely  1 = Not at all  N/A = Not able to evaluate

<table>
<thead>
<tr>
<th>My Preceptor as a Practitioner:</th>
<th>5</th>
<th>4</th>
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<th>1</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. Was acutely aware of the concerns of patients and their families.</td>
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<td>2. Demonstrated an ease of communication with both patients and their families.</td>
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<td>3. Was involved in community-oriented activities.</td>
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<td>4. Respected different opinions.</td>
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<td>5. Was up-to-date in general approach and treatment of medical problems.</td>
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<th>My Preceptor as an Instructor:</th>
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<td>6. Was enthusiastic about teaching and having me as a student.</td>
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<td>7. Was available to me.</td>
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<td>8. Encouraged me to accept ever-greater responsibilities in working with patients.</td>
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<td>9. Allowed me ample opportunity for practicing my newly learned technical skills (e.g. EKGs, physicals, and X-rays)</td>
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<td>10. Stimulated my problem-solving capabilities by asking probing questions.</td>
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<td>11. Explained to me the approach to problems that was used and the reasons decisions were made.</td>
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<td>12. Encouraged me to ask questions.</td>
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<td>13. Provided me with useful and timely feedback.</td>
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<td>14. Encouraged independent learning by suggesting articles, books, and other resources.</td>
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<td>15. Gave me the opportunity to offer opinions on patient problems and treatment.</td>
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<td>16. Provided a model of the type of physician I would like to be</td>
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<td>17. Observed my history taking and physical exam skills.</td>
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<td>18. Provided me with feedback on my documentation skills.</td>
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<tr>
<th>My Site:</th>
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<tr>
<td>19. Provided a wide variety of patients.</td>
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<td>20. Included staff who were helpful and pleasant to work with</td>
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<td>21. Provided opportunities for additional exposure to health care (e.g. new-born care, in-patient care, community resources, etc.).</td>
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<tr>
<td>General:</td>
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<tr>
<td>22. The staff in the predoctoral office were helpful and easily accessible during my FM clerkship.</td>
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<tr>
<td>23. The clerkship director was helpful and easily accessible during my FM clerkship.</td>
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<tr>
<td>24. The clerkship director provided adequate guidance throughout my FM clerkship.</td>
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<tr>
<td>25. PDA patient logs were easy to keep.</td>
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</table>

After my FM clerkship, I feel: (*in terms of specialty choice)  
___ More interested in FM  ___ Less interested in FM  ___ The same about FM  

PDA Patient Log Questionnaire:

1. When did you log most of your entries?  
   _____ Right after seeing the patient  _____ Later that same day  _____ At the end of the week  

2. What percentage of your total patient encounters do you think you were able to log?  
   _____ 100%  _____ 90-99%  _____ 75-89%  _____ 50-75%  _____ 25-50%  _____ 0-25%  

3. How long do you think it took to log each patient encounter?  
   _____ Less than 30 sec.  _____ Around a minute  _____ Few minutes  

4. Did you ever refer back to your database?  _____ yes  _____ no  
   If yes, for what purpose ____________________________________________________________________________  

5. Did you use your PDA for other clinical uses during your clerkship?  _____ yes  _____ no  
   If yes, what programs did you use ____________________________________________________________________  

6. Did you use your PDA during the OSCE?  _____ yes  _____ no  
   If yes, what programs did you use ____________________________________________________________________  

General comments/Suggestions regarding your FM Clerkship:  
____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________  
____________________________________________________________________________________
**APPENDIX C: Student Family Medicine Mid-Clerkship Survey**

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Block:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor:</td>
<td>Location:</td>
</tr>
</tbody>
</table>

**What are your general impressions about your preceptor? Are you satisfied with your placement?**

**What are your general impressions about your site?**

**What are some of the particular strengths of your preceptor and the site you are at?**

**Do you have any concerns regarding your preceptor or your site?**

<table>
<thead>
<tr>
<th>Do you feel that you have enough autonomy?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel that you see an adequate range of problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you feel that you see an adequate range of ages?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has your preceptor directly observed you taking a history and performing a physical exam?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has your preceptor given you feedback on your SOAP notes?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you received mid-unit feedback from your preceptor?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you feel that your work load/hours is in line with the departmental policy as stated in the handbook?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>What is the average number of patients that you have significant contact with in each half-day?</td>
<td>Avg</td>
<td>Pts</td>
</tr>
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</table>

**Please feel free to attach any comments or concerns to this survey.**
APPENDIX D: FAMILY MEDICINE CLERKSHIP OBJECTIVE CHECKLIST

The following checklist is to be used throughout the clerkship and is intended to help the student understand the course goals and objectives and to have a clear sense of whether they are meeting those stated objectives. The checklist should be completed by the student and reviewed by their preceptor.

Student: _____________________________ Preceptor: ________________________________

GOAL I: THE STUDENT WILL LEARN A PRIMARY CARE APPROACH TO THE DIAGNOSIS AND MANAGEMENT OF COMMON MEDICAL PROBLEMS IN PATIENTS OF ALL AGE GROUPS PRESENTING IN A FAMILY MEDICINE SETTING.

☐ Saw the recommended number of patient care visits for the 30 common ambulatory care problems.
☐ Made first clinical contact in at least 100 patient encounters during the clerkship.
☐ Read the recommended material from the clerkship CD-ROM.
☐ Completed all of the PBL patient web-cases/web-modules and utilized the web-based resources associated with them.
☐ Attended required didactic sessions and seminars.
☐ Researched at least one ambulatory care topic using web-based, medical informatics resources, applying the principles of evidence-based medicine, discussed with preceptor, and completed the EBM form.
☐ Made use of a PDA to answer clinical questions during the course of daily patient encounters.
☐ Participated in managing continuity of care of patients from setting to setting (i.e. home, office, nursing facility, hospital).
☐ Provided continuity of care for clinic patients, either for management of chronic disease, follow-up of acute illnesses, or health maintenance and disease prevention.
☐ Demonstrated an awareness of patients’ health or illness within the context of relevant biological, social, familial, environmental, psychological, cultural, and genetic factors.
☐ Participated in at least one of home visit
☐ Participated in the Cross-Cultural Issues in Medicine series and completed the required essay.
☐ Participated in the Doctor-Patient Seminars and completed the required essays.
☐ Participated in the H.O.M.E. Project clinic, completed required experiences, and completed required essay.
☐ Discussed disease prevention and health maintenance assessments and plans with patients and the preceptor as part of regular patient care.
☐ Utilized national health maintenance guidelines and protocols in caring for pediatric, adolescent, adult, and geriatric patients.
☐ Developed a smoking cessation plan for at least two patients.
☐ Was observed at least once by the preceptor during a counseling activity
☐ Was observed by the preceptor(s) during each main portion of a history and physical (see check list)
☐ Provided appropriate life habit counseling to patients on a routine basis.

GOAL II: THE STUDENT WILL INCREASE HIS/HER UNDERSTANDING OF THE ROLE OF THE PRIMARY CARE PHYSICIAN.

☐ Worked with a family physician for at least 95% of all clinical experiences.
☐ Referred at least one patient to a community resource
☐ Consulted with another physician specialist regarding one or more patients.
☐ Considered cost-effective & cost-beneficial diagnostic and therapeutic approaches to patients’ problems.
☐ Considered the requirements and limitations of patients’ health insurance policies
☐ Discussed relevant lifestyle and community role issues with preceptors.
☐ Participated in at least two community service activities
APPENDIX E: RECOMMENDED READINGS/RESOURCES

Textbooks:
Dershewitz, *Ambulatory Pediatric Care*, 3rd Edition
Goroll, A.H., et al. (Eds.) *Primary Care Medicine*, 5th Edition
Rudy, D.R. *NMS Family Medicine*
Swanson, R.W. *Family Practice Review: A Problem Oriented Approach*, 3rd Edition

Websites:
American Academy of Family Physicians: [www.aafp.org](http://www.aafp.org)
Cochrane Database: [www.cochrane.org](http://www.cochrane.org)
MD Consult: [www.mdconsult.com](http://www.mdconsult.com)
The Provider’s Guide to Quality and Culture: [http://erc.msh.org/](http://erc.msh.org/) (Click on link off of main page)
University of Hawaii Department of Family Medicine: [http://www2.jabsom.hawaii.edu/FamilyMedicine/](http://www2.jabsom.hawaii.edu/FamilyMedicine/)

*These are recommended in addition to the readings/resources on the CD-ROM & Web-cases/modules
APPENDIX F: GENERAL INSTRUCTIONS FOR FAMILY MEDICINE PDA LOG

1. You are responsible for collecting data for every patient that you see. Try to log your items right after seeing the patients so that your information will be accurate.
2. You will be responsible for hot syncing and uploading your patient log data at least once every week so that the clerkship director can track your progress.
3. Choose “Family Medicine” for the “Type” choice. Your screen will look like this:

   ![Example Screen]

   **New Activity**

   Type: Family Medicine

   Date: Jun 22, 2008

   Problem: None

   Setting: None

   Diagnoses: None

   Continuity: None

   Procedures: None

   Age Group: None

   Sex: None

4. If you are entering data on the same date that you saw the patient, the date will be automatically entered correctly for you. If you need to enter data for a patient that you saw on a previous date, you will need to change the date.
5. The “Problem” option corresponds to your 29 required problems that you are responsible for during your clerkship. Please become familiar with this list which is located in your handbook and on the Family Medicine website. If you see one of the 29 required problems, please choose the correct option…if you are seeing a patient with diagnoses that do not correspond to any of the required problems, choose the option “none”. The problems are broken up into three groups – Acute Problems, Chronic Problems, and Health Care Maintenance (HCM). At times you may see a patient with multiple diagnoses which may meet the requirements for more than one required problem area – you can enter up to five different problems. Click on the “+” sign and another line will appear to allow you to enter another problem.
6. The “Setting” option corresponds to the setting in which you saw your patient. The choices for “setting” include ER, Home Visit, Homeless Clinic, Inpatient, Nursing Home, Outpatient, and Prison.
7. You should log in ALL of the diagnoses that you address with each of the patients that you see. You are allowed to enter up to 5 diagnoses per patient. Please use the diagnoses listed in the pull down menu when possible as this makes it much easier to compile data. If the diagnosis that you want is not listed, you can choose “other” and write in your own diagnosis.
8. The “Continuity” option refers to whether the visit was the first time that you saw that particular patient or if you had seen the patient before. The two options are: “first visit” and “return visit”.
9. The “Procedures” field also has a drop-down list for you to choose from. Please review the pre-set procedure list to familiarize yourself with the procedures that are already there and use those when possible. You may write in a procedure if it is not on that list by choosing “other”.
10. Please note that “smoking cessation counseling” is considered a procedure.
11. For “Age Group” and “Sex”, choose the appropriate options from the pull down lists.

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12. For the procedures that you enter, please indicate under “Proc Role” whether you witnessed it, assisted with it, or were the primary one doing it. If you aren’t sure if something would be considered a procedure, include it anyway. You can enter diagnoses and procedures during the same entry. Only log those procedures that you actually witness, assist on, or actually do yourself. Do not list procedures that you order for a patient but have nothing to do with.

13. For “PtCare Role”, you should list your role in the visit. Choose “shadowed” if you just followed your preceptor into the room and mainly watched the visit. Choose “Precepted” if you did your initial history and physical alone with the patient first and then presented the patient to your preceptor and went in together to wrap-up the visit. Choose “Observed” if your preceptor observed you doing any part of the visit (i.e. watched you taking part of the history, watched your shoulder exam, watched you doing counseling, etc.).

14. For the last three items “Learning”, “Confidence”, and “Competence”, please rate your assessment of each of these items for that particular patient visit on a scale from 1-5….with 1 being the lowest and 5 being the highest level.

General Reminders/Common Errors:

1. Any adult physical exam is considered under the “problem” – “HCM: General PE/Well Woman”. This includes disability physicals, work physicals, and pre-op physicals. This includes both females and males. Remember that the physical goes in the diagnosis field and not in the procedure field.

2. Only log those diagnoses that you actually address. A patient may have DM, HTN, CHF, COPD, Osteoarthritis, and A.fib…but if you only talked about the DM and HTN then those are the only diagnoses you should log.

3. You don’t have to qualify your diagnosis (i.e. right vs. left, mild/severe) and for sprains/strains/fractures you don’t have to specify location (i.e. ankle sprain).

4. Don’t qualify with “recheck” or “follow-up” for the diagnosis.

5. The page numbers for each log are on the top right corner of the screen…or you can use the direction arrows on the bottom right to navigate to the next screen.

Here is an example of a completed patient visit:
APPENDIX G: Family Medicine PDA Diagnosis List

Allergic Reaction
Breast
Breast Cancer
Breast Lump
Cardiovascular (CV)
Angina
Arrhythmia
Atrial Fibrillation
CAD
Chest Pain
CHF
Hypertension
MI
Peripheral Edema
PVD
Dermatology (Derm)
Acne
Actinic Keratoses
Contact Dermatitis
Dermatitis, Other
Eczema
Epidermal Inclusion Cyst
Folliculitis
Head Lice
Impetigo
Lipoma
Psoriasis
Rosacea
Scabies
Seborrheic Keratoses
Shingles
Skin Tags
Tinea
Urticaria
Viral Exanthem
Warts
Endocrine/Metabolic Disorders (Endo/Metab)
Diabetes Mellitus, Type 1
Diabetes Mellitus, Type II
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Obesity
Ear-Nose-Throat (ENT)
Allergic Rhinitis
Cerumen Impaction
Epistaxis
Eustachian Tube Dysfunction
Mononucleosis
Otitis Externa
Otitis Media
Pharyngitis; Strep
Pharyngitis; Viral
Rhinosinusitis
URI (Upper Resp. Infxn)
Fluid/Electrolytes
Dehydration
Electrolyte Disorder
Gastrointestinal (GI)
Abdominal Pain
Constipation
Diarrhea
Food Poisoning
Gastroenteritis
GERD
GI Bleed
Hemorrhoids
Hepatitis
Pancreatitis
PUD/Gastritis
Growth & Development (growth&develop)
Failure to Thrive
Learning Disability
Gynecology Problems (GYN)
Abnormal Pap
Amenorrhea
Dysfunctional Uterine Bleeding
Endometriosis
Family Planning
Infertility
Menopause
Menorrhagia
Pelvic Pain
Vaginitis
Health Care Maintenance (HCM/PE)
Annual Exam
General PE
Pre-op Physical
School PE
Sports Physical
Well Child Check
Well Woman Exam
Work Physical

Hematology/Oncology (Heme/Onc)
Anemia
Leukemia
Lymphoma
Thrombocytopenia

Infectious Disease
Abscess
Cellulitis
HIV
Influenza
STD
Viral Syndrome

Miscellaneous (Misc)
Chronic Fatigue Syndrome
Chronic Pain
Domestic Violence

Neurology
BPV (Benign Positional Vertigo)
Dizziness
Headache, Migraine
Headache, Other
Headache, Tension
Neuropathy
Parkinson’s Disease
Seizure Disorder
Stroke
Syncope
TIA
Vertigo

Obstetrics (OB)
Prental Exam
Post-partum Exam
Premature Labor
Bleeding in Pregnancy

Ophthalmology (Ophthal)
Chalazion
Conjunctivitis
Hordeolum
Cataracts
Glaucoma

Psychiatric Disorders (Psych)
ADHD
Anxiety
Delerium
Dementia
Depression
Eating Disorder
Neuroses/Psychoses

Pulmonology (Pulm)
Asthma
Bronchitis
COPD
Pneumonia
Sleep Apnea

Renal & Urology Problems (Renal/Uro)
BPH
Prostatitis
Pyelonephritis
Renal Failure
Urinary Incontinence
Urinary Tract Infection (UTI)

Rheumatology/Musculoskeletal (Rheum/MS)
Bursitis
Carpal Tunnel Syndrome
Dislocation
Fibrositis/Myositis/Fibromyalgia
Fracture
Gout
Low Back Pain
Osteoarthritis
Osteoporosis
Patello-Femoral Syndrome
Plantar Fasciitis
Radiculopathy
Rheumatoid Arthritis
Rotator Cuff Tendonitis/Tear
SLE (Systemic Lupus Erythematosus)
Sprain
Strain
Tendonitis
TMJ Syndrome
Sexual Dysfunction
Substance Abuse
   Alcohol Abuse
   Drug Overdose
   Nicotine Addiction
Trauma
   Abrasion
   Bite; Animal
   Bite; Human
   Bite; Insect
   Burn
   Contusion
   Laceration
   Stings

PDA Procedure List

Anoscopy
Bimanual Exam
Blood Draw
Casting/Splinting
Central Line Placement
Colposcopy
Cryotherapy
Debridement
DRE
EKG
Ear Irrigation
Endometrial Biopsy
Excision
Flex. Sig
IV Start
Incision and Drainage
Injection
Joint Aspiration
Joint Injection
Lumbar Puncture
Nail Removal
Norplant Insertion/Removal
Pap Smear
PPD Placement
Punch Biopsy
Shave Biopsy
Smoking Cessation Counseling
Suture Repair
Suture/Staple Removal
Urine Dipstick/Micro
Vaginal Culture
Appendix H:  
Howard & Dorothy McGuire Memorial Fund  
For the Health of Hawaii’s Communities  
(Taken from HMA newsletter 2002)  

Authored by Christy Han and Lanelle Dulloog  
McGuire Fund Co-Chairs 2003  

Physicians take the Hippocratic Oath to dedicate their lives for the health of others. Unfortunately, there are still patients who fall through the cracks due to financial difficulties. The Howard & Dorothy McGuire Memorial Fund was established in response to this need. 

Endowed by Mrs. Dorothy McGuire, the McGuire Fund was established in 1988 after the death of her husband, who was a patient of Christian L. Gullbrandsen, the former Dean of John A. Burns School of Medicine. Mrs. McGuire established the fund after noticing that other patients, who were not as fortunate as she and her husband, were unable to afford some basic necessities related to their health care. A committee was established, consisting of both JABSOM students and faculty, to fulfill the mission created to satisfy Mrs. McGuire’s wishes.

Our Mission Statement

The McGuire Fund has several purposes: 1) to increase the availability of care to patients who are in need of financial resources; 2) to augment the educational experiences of the students; and 3) to enhance the service functions of the school.

A. Primary requirement: The grant must provide patient care in the State of Hawaii to medically underserved individuals and/or communities. The student/patient should have exhausted all attempts to find patient care funds before utilizing the McGuire Fund.

B. Primary requirement: The grant must engage and enhance the education of medical students within the John A. Burns School of Medicine (JABSOM).

C. Secondary/discretionary option: Recognize and fund community medical research and/or community medical programs that further both of the aforementioned guidelines.

Impact on the Community

Since the establishment of the McGuire Fund, medical students are privileged to serve their patients by fulfilling needs important to their health care. The students are reaching out to several populations of people, such as the homeless, the elderly, the terminally ill, and those in between jobs, that are unable to tap into resources available to others. Among these needs are laboratory tests, medications, and surgical procedures not covered by insurance or community resources. The fund has also provided financially for dentures, eyeglasses, hearing aids and even shoes to improve the quality of life for many patients.
The McGuire Fund is not restricted to the needs of any one individual. Several programs and special events have been supported by the committee. Education, counseling, and community services were provided to those with special needs and chronic illnesses. Organizations and events that have received funding includes JABSOM Pediatrics Club Halloween party for Diabetic children, Shriners Hospital Christmas party, and Sunny Buddies.

**Behind the Scenes**

Not only do patients benefit, the fund enhances the educational experience for medical students. The students are responsible for research, planning, and executing all patient requests and community programs/events. One example is the Sunny Buddies Program founded by several medical students who saw a need in mentorship programs for special needs children. The program was planned and executed solely by students and the McGuire Fund provided the start up money.

The committee requires medical students to first explore whether other sources are available before requesting support from the fund. In doing so, the students take responsibility for identifying patients’ needs and assessing their financial resources. Thereby, they gain a deeper awareness and understanding of patient care, as well as a familiarity with community resources.

**Looking to the Future**

In recent years, the McGuire committee recognized research as an important aspect of medicine significant to the health of the community. The McGuire Fund strongly encourages students to engage in research project aimed at health issues important to the community. One such project studied obesity in Native Hawaiians. The results were significant in showing the efficacy of a wellness program, incorporating a traditional Hawaiian diet and exercise regimen, on weight reduction and improvement of health risk factors. This wellness program is now available for the improvement of Native Hawaiian health. In addition to obesity, osteoporosis is also a health issue prevalent in Hawaii. Another project was funded to investigate the knowledge base of both young adult and elderly population regarding osteoporosis. This research will aid in future educational programs in the prevention of this disease. The McGuire Fund is honored to continue helping those in need and enabling others to significantly impact the health of Hawaii’s communities.

For more information, please visit our website at [www.McGuireFund.org](http://www.McGuireFund.org). We welcome your comments and questions.
Appendix I:
University of Hawai‘i Department of Family Medicine & Community Health
Observed History and Physical Checklist

<table>
<thead>
<tr>
<th>Student ________________________________</th>
<th>Date ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

Evaluators (Include anyone who may have signed off on any of the skills listed):

To preceptor/faculty/resident: Please directly observe the student performing the following components of a history and physical exam. All of the components do not necessarily have to be observed during the same patient encounter, but each of the components need to be observed by the end of the student’s rotation.

Indicate either “C” for credit, “I” for needs improvement, or “N” for not done.

### Professionalism/Communication Skills

| _____ | Introduces self appropriately |
| _____ | Demonstrates respect for patients and their family members |
| _____ | Respects comfort and privacy of the patient at all times |
| _____ | Uses appropriate and understandable language with patients; avoids jargon |
| _____ | Encourages patient to ask questions |
| _____ | Gathers information in an organized and logical sequence |
| _____ | Uses open-ended questions in history taking |
| _____ | Counseling/Patient education |

### History

| _____ | Addresses all pertinent elements of the HPI |
| _____ | Reviews pertinent past medical/surgical history and family history |
| _____ | Reviews medications with patient |
| _____ | Discusses all important aspects of the patient profile: occupation and current family status, social support structure, habits, diet, and exercise with patient |
| _____ | Reviews appropriate health maintenance issues including immunizations |
| _____ | Reviews pertinent review of systems |

### Physical Exam

| _____ | Washes hands before examining patient |
| _____ | Repeats blood pressure measurement for elevated readings |
| _____ | Assesses general appearance |
| _____ | Eyes (pupils, EOMs, correct use of fundoscope with dimmed lights) |
| _____ | Ears (proper stabilization of otoscope and use of insufflation bulb when assessing for infection) |
| _____ | Nose (turbinates and sinuses) |
| _____ | Mouth/Throat |
Neck (Thyroid palpation, Lymph nodes, JVD-with correct positioning of patient, carotid bruits)
Breasts and Axillae
Lungs (Auscultating on bare skin in appropriate locations throughout lung fields, percussing when indicated)
Heart (Palpating PMI, Auscultating on bare skin in all appropriate locations)
Abdomen (Inspection, bowel sounds, palpating masses/spleen/liver/tenderness – with patient supine with knees bent)
Pelvic/Pap (Ensure patient comfort)
Joint exam (Inspection, palpation, appropriate range of motion, special maneuvers)
Please list which joint exam(s) observed:
Neurologic (cranial nerves, strength, sensation, DTRs, cerebellar)
Skin

Overall Evaluation:

H=Outstanding performance, above level expected of a 3rd year student
C=Competent performance, level expected of a 3rd year student
U=Unsatisfactory performance, below level expected of a 3rd year student

Professionalism and Communication
History taking skills
Physical Exam skills
Counseling/patient education skills

Comments:

______________________________         ____________________
Primary Preceptor Signature                                                    Date

______________________________  ____________________
Student Signature         Date
Appendix J:

Critically Appraised Topic (CAT) Form

Answer the following and discuss with your preceptor:

1. What is the clinical question you investigated? Why is it important to the clinical care of your patients?

2. How did you find articles to answer your clinical question? If you used MEDLINE/PUBMED, what search terms did you use? If you were able to find the full text of the article, please indicate where you found it.

3. List at least two articles which you found that were relevant to your clinical question. For each article, summarize the key points, addressing the following: Are the results/findings valid? What are the results? Will the results help me in caring for my patients?

4. What is the “bottom line” effect of your review with regards to your clinical question and the care of your patients?
Appendix K:
Family Medicine Clerkship
Supplemental Experience Preceptor Evaluation Form

Student Name: Block:
Preceptor(s): Date:
Site:
__H.O.M.E. Project Clinics __Prison Medicine __Home Visit
__Sports Medicine __Physician's Center Mililani __Continuity OB Clinic
__Other: (specify)

Please circle the appropriate rating and comment:

General Knowledge and Clinical Judgment (Consider, where appropriate, the student's basic science knowledge, clinical science knowledge, application of basic science to clinical science, ability to establish a differential diagnosis, interest in expanding their clinical knowledge, problem solving skills and clinical judgment)

Below Expectations Appropriate to their level of training Exceptional
1 2 3 4 5

Patient Evaluation and Management (Consider, where appropriate, the student’s history-taking and physical examination skills, procedural technical skills, ability to order appropriate studies to work through a differential diagnosis, quality of their write-up and medical records documentation, oral presentations, communication skills)

1 2 3 4 5

Professionalism (Consider, where appropriate, the student’s interaction with patients, staff, faculty; bedside mannerisms; punctuality; professional appearance, responsiveness to feedback, adaptability, recognition of limitations/asking for assistance; interest/self-motivation and initiative)

1 2 3 4 5

Comments:

Student’s Overall Experience Performance: __Satisfactory __Unsatisfactory

Preceptor Signature/Date
Department of Family Medicine-Clerkship Handbook
page 49
Appendix L:

Doctor-Patient Seminar Handouts

Session I: Hope, Physicians and Their Families

- Hope and the cancer patient
- A visit from my daughter

Session II: Coping

- No Handout (Video – *Life as a House*)

Session III: Communication & Miscommunication

- Chapter 5 in Stewart, et.al., *Patient-Centered Medicine: The Third Component, Finding Common Ground*

Session IV: Humanity & Physician Mistakes

- Mistakes by David Hilfiker, *On Doctoring, Stories, Poems, Essays*
  - Physician Suicide
  - Off to see the wizard