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McMASTER UNIVERSITY: FAMILY MEDICINE CLERKSHIP EXAM INSTRUCTIONS FOR EXAMINEES

In this exam, students will be presented with a series of clinical scenarios, each followed by a number of questions which address critical aspects in resolving the case. These questions are often referred to as “Key Features” questions; they can pertain to issues involving data-gathering (eg. history taking, physical examination, laboratory investigations), diagnosis or treatment. The Key Feature questions focus on the most important information or concept that allows for appropriate clinical decision making.

The Key Features questions will ask for answers in different ways: the student may be asked to either (i) select up to a specified number of answers from a menu of options, (ii) list up to a specified number of answers by printing each answer on a blank line or (iii) provide only one answer. The scoring procedures are described below.

Please note the following guidelines before proceeding:

1. After reading the description of the scenario, read the question carefully. Take note of the maximum number of answers. If the student exceeds the number, they will receive no credit for the question. Also note that the students should not feel obliged to select or list the maximum number of specified because this number is not necessarily equal to the number of correct answers.
2. If the students are asked to select answers from a menu, they must:
 1. Read the complete menu of options before recording their answers
 2. Make certain that the number of answers they record is not greater than the number they have been asked to select.
3. If they are asked to list their answers below the question, they must:
 1. Ensure that they print each answer legibly.
 2. Record each answer on a separate blank line.
 3. Do not record more than the maximum number they are asked to list.

The answers to Key Features questions are scored using a number of different methods. **Each question is worth a maximum of one mark, there are NO partial marks. If the student does not elicit an “essential” response, they will get zero for that question even if their other responses were correct. If they give more than the maximum responses they will be scored zero.**

This Key Feature Exam has been written and prepared by the Department of Family Medicine’s Undergraduate Program Exam Writing Committee at McMaster University. The Committee is comprised of six family physicians with 138 years of collective clinical experience. References have been provided in those instances where clear guidelines have been established as of August 18, 2009.

Family Medicine Clerkship Tutorials

Tutor's Guide

Goals for the Family Medicine Tutorials

1. To provide a forum for students to discuss and ponder puzzling, troubling or interesting issues or cases which have arisen in their clinical work

The fundamental purpose of any tutorial is to provide an environment for sorting out that which cannot easily be learned on one's own.

2. To help the student understand the role of the family doctor in the health care system

This includes the nature of first-contact care, and relationships with other health care providers, as well as big picture issues of how primary care fits into the health care system.

3. To teach student in some of the areas in which family physicians are particularly proficient, using the literature and academic underpinnings to augment clinical experiences

There are a multitude of such areas, but some to consider are: communication skills, minor office procedures, health promotion and disease prevention strategies.

4. To integrate concepts of professionalism into all aspects of the tutorial: role modeling, discussion, expectations and evaluations of students

This includes the demonstration of respect (for patients, peers, teachers, health care professionals), an understanding of bioethics, and a willingness to contribute to the learning of others, amongst other things.

Key Family Medicine Concepts - for tutorial

- In primary care, problems present in early and undifferentiated stages, so ambiguity and uncertainty needs to be not just tolerated, but actively managed
- Family physicians provide care to patients and families across the spectrum of care (health promotion, disease prevention, curative, rehabilitation, palliation), sometimes all in one visit
- Patient centred care is effective and efficient, as well as satisfying to both physician and patient
- It is crucial to understand the context of the patient in order to be effective as a physician (consider the impact of the determinants of health, culture etc)
- Family physicians provide continuity of care to their patients – over time as well as place, and this is highly valued by both parties
- Physicians function as a part of a large health care system, which includes diverse health care professionals and community agencies

Process of the Tutorial

First Tutorial

- Introductions
- Name, areas of interest in medicine, and each person's overall objectives for the tutorial in family medicine (tutors can include the goals noted above)
- Establish ground rules
- Name a time keeper
- Name a communicator
- Discuss how the family medicine tutorials are organized and what is expected of students (e.g. bring several cases to each tutorial)
- As the first tutorial takes place on the first day of the placement, the general tutorial process used for subsequent tutorials needs to be modified

The first tutorial should have a focus on motivational interviewing. Several useful papers and websites are available on the Department website at <http://fammedmcmaster.ca/undergrad>

Rationale:

Family physicians have expertise in working with patients who need to make changes in order to improve their health, and all future physicians can benefit from teaching in this area. This is no longer covered elsewhere in medical school. Medical students can find it frustrating and de-motivating when patients are not apparently making the requested changes. Physicians all need to make their own behavioural changes and students will benefit from recognizing what is needed to optimize their own health.

Objectives for this tutorial:

1. Understand the complexity and difficulty of behavioural change for patients (and self)
2. Be able to assess life style problems using the stages of change model
3. Begin to apply appropriate strategies which can aid patients in their efforts to change

Suggestions:

Discuss with students any patients they have seen, in any setting, who would benefit from making a behavioural change (e.g. smoking, alcohol intake, exercise, interpersonal interaction, diet etc). Ask students to consider any changes they might wish to make personally. Have a discussion about the stages of change model, and strategies for working at different levels (see Motivational Interviewing outline provided by Dr. Joyce Zazulak). Organize the students into 2-3 small groups to practice motivational interviewing on each other. The attached guide may be used for feedback for the students, either by a student observer, or by the tutor.

General Tutorial Process

Check-in

Each student in turn reviews what they have done clinically in the past week, highlighting any interesting, puzzling or disturbing moments (which may or may not be patient cases). This may lead to the identification of issues to be discussed by the group after all students have checked in, and will most likely help the students determine learning objectives for future tutorials. For the first tutorial, this check-in, or the objectives initially identified in the introductions, will likely determine the content of the remainder of that session.

Learning objectives (identified at a previous tutorial)

The focus for the tutorial is on cases and clinical encounters. All students are to bring to each tutorial several cases of patients that they themselves have seen, unless the focus of the tutorial makes this less relevant.

Students should review the literature, search out resources as appropriate; however didactic presentations of the material are to be actively discouraged. Rather, through discussing the cases, with the tutor's probing questions to facilitate the process, most of the material should be brought out.

Review of key learning points

Students summarize the important new learning points gained from the tutorial.

Setting new learning objectives

Students set new learning objectives for the subsequent tutorial(s).

Role of the tutor

There will be only one mandatory tutorial topic: communication skills. The rest of the tutorials should be used to meet the overall goals of the Family Medicine Clerkship tutorials, and to convey the concepts described above. The students will generate the content based on their clinical work in family medicine, and it will be the tutor who has the task ensuring the key concepts surface throughout the discussions, and that all students have a solid grasp of them by the end of the rotation. Since the potential content for tutorials is vast, there will be no attempt to "cover" specific clinical topics; it is sufficient to allow students to come up with objectives based on their clinical experiences.

Communication Skills Tutorial

One tutorial at minimum should be focused on communication skills. The students have used an *Interview Observation Checklist* in their Professional Competencies sessions, and this guide should be re-visited in this tutorial (please see Appendix 1 for more details). Role play scenarios are provided, however the best cases are may come from the students' own experiences. If desired, for those tutorial groups close to Hamilton, a standardized patient (SP) may be booked through the Department of Family Medicine

Undergraduate Program office. This should be done as soon as possible in the rotation to ensure availability of the desired SP. The tutor's role is to provide the students with an opportunity to practice skills in dealing with challenging patient situations, to coach them in enhancing their skills, and to encourage them to coach each other. Students are likely to have good ideas of how to structure this tutorial for maximum benefit, however please feel free to contact the Department of Family Medicine Undergraduate Program if you wish to discuss this further.

Objectives

Family Medicine Clerkship is based on the National undergraduate Family medicine Learning Goals and Objectives as outlined by the College of Family Physicians of Canada.

<http://www.cfpc.ca/English/cfpc/education/section%20of%20teachers/general%20information/default.asp?s=1>

A resource for tutoring: Although written for tutoring in problem based learning, not the clerkship, there are some useful tips in this guide:

<http://www.fhs.mcmaster.ca/facdev/tutorPBL.pdf>

WHAT TO DO WITH A STUDENT HAVING DIFFICULTIES

When a preceptor identifies a student doing poorly in the office (or a tutor has concerns in tutorial) the following is the protocol:

1. The tutor and/or preceptor collect objective information individually about the poor performance in the tutorial or clinical setting.
2. The tutor and/or preceptor contacts the Family Medicine Undergraduate Program Assistant to arrange a meeting with each other to discuss the concerns and document them in writing.
Note: If there have been concerns in the clinical setting, the preceptor should have discussed the concerns with the student prior to the meeting.
3. After the meeting, the tutor meets with the student to discuss the concerns.

If the difficulties are not rectified after the first meeting,

4. The tutor and/or preceptor contacts the Family Medicine Undergraduate Program Assistant to arrange a meeting between the tutor, preceptor, student and the Family Medicine Undergraduate Program Director to develop a remedial program for the remainder of the rotation, including the problems identified, the learning objectives and activities to be undertaken and the evaluation.
5. Once a student is deemed provisional or unsatisfactory for the rotation, the Family Medicine Undergraduate Program Director will contact the Program Administrator in the Undergraduate MD Program as outlined in the "Faculty Policy and Procedure for the Evaluation of Undergraduate MD Students".
6. This identification should be done **prior** to the Mid-Phase Report on Student Performance. Documentation at the mid-point of the rotation is vital.

MOTIVATIONAL INTERVIEWING

What is motivational interviewing (MI)?

MI defined

"Motivational interviewing is a directive, patient-centered counseling style for eliciting behavior change by helping patients explore and resolve ambivalence." ~**Rollnick & Miller**

As people dedicated to helping others, we may often be tempted to give patients "good advice." A few patients will take such advice and improve their health behaviors. Others, particularly those who have either both reasons to persist with the health-compromising behavior or reasons to change, will most likely not use basic advice to make the needed adjustments. **Motivational interviewing is a style of interacting with a patient that resolves his or her ambivalence to practicing health-promoting behaviors.**

Motivation to change is elicited from the patient themselves; it is not imposed. The therapeutic relationship is more like a partnership or companionship than like "expert and student" roles.

MI focuses on the patient's experience, yet quietly directs the interview process. The patients use their own experience to self-educate rather than having this information taught to them.

The 5 principles of MI

These concepts will be explained in greater detail throughout the MI modules:

1. Express empathy
2. Develop discrepancy
3. Avoid argument
4. Roll with patient resistance
5. Support self-efficacy

The purpose of MI

The goal of motivational interviewing is to meet the patient where they are and advance them toward changing behavior.

The healthcare professional's task is to **create a set of conditions that will enhance the participant's own motivation for and commitment to change.** Rather than relying on prescriptive advice, the health professional seeks to mobilize the participant's inner resources as well as fostering those inherent in the participant's naturally occurring supportive relationships. MI seeks to utilize intrinsic motivation for change. This can lead to the participant initiating, maintaining, and succeeding in this challenge.

Research in MI

Research into interventions designed to increase patient involvement in decision making and self-care has shown impressive results. Patients urged to take responsibility for care have:

- increased knowledge (Brown 1988),
- improved adherence to medical regimens (Fisher 1992),
- improved physical outcomes (Mumford et al. 1982),
- decreased rates of rehospitalization (Beckie 1989), and
- utilized health services more efficiently (Check 1982).

When MI is compared to other approaches, how does it fare?

Motivational interviewing was developed to help resistant or ambivalent drinkers to change behaviors. College students, pregnant women and unmotivated adults who were all identified as heavy drinkers showed superior responses to motivational interviewing over prescriptive approaches (Rollnick & Miller 1995). Since then, this approach has been applied to a wide variety of problems.

Researchers also tried this technique with other substance abusers including those using opiates (Saunders et al. 1995) or smoking. MI has been successfully used with obese diabetic people (Smith & Heckemeyer 1997), hypertensive people (Woollard et al. 1995), and anorexic individuals (Treasure & Ward 1997). Other behaviors successfully addressed include medication compliance (Hayward et al. 2000), encouraging mammography (Ludman et al. 1999) and decreasing parental arguments in front of children (Crous 1998).

Consider this: A motivational interviewing style is more often used by patients to produce change than prescriptive approaches.

Listed below are 5 helpful strategies used in motivational interviewing:

1. Use paraphrasing

Paraphrasing occurs when the **question** you have about a patient's health-compromising behavior is put **into a statement**. (That is, you turn your voice or inflection down, rather than up, at the end of the statement.)

Examples:

- "You're feeling..."
- "Sounds like you..."
- "It seems you..."
- "So you have been..."

- "If I have heard you correctly, you..."

2. Ask open-ended questions

Open-ended questions allow the individual to do more than simply answer the question.

Examples:

- "Your spouse has some concerns but you tell me how you see things."
- "What have you noticed about your [behavior] in the last few years?"
- "What do you like or enjoy about [behavior]?"

3. Ask where the health-compromising behavior fits in with lifestyle, health, or stress

Examples:

- "Where does [behavior] fit in with the traveling and trouble falling asleep?"
- "So [behavior] helps you unwind at the end of the day. What else does it help with?"
- "How does [behavior] relate to your weight?"
- "On a 1 to 10 scale with 10 being the most important thing in your life, how important is it to change this [behavior]? What are the things that are more important? Less important?"
- "On a scale of 1 to 10 with 10 being the most concerned you've ever been about anything, how concerned were you about your [behavior] when you called for this appointment? Where are you today? What has changed?"

4. Ask the patient to describe his or her typical day, from morning to evening

By asking for a morning to evening summary of the patient's day, you can examine the context for the health-compromising behavior.

The information you need is in the details.

5. Ask the patient why they stop participating in the health-compromising behavior when they do

Asking the individual to describe situations when they don't perform the health-compromising behavior may provide clues about when the patient can make positive change.

- "Why do you suppose you stop drinking after dinner when you're at home and there's more wine available?"

Increasing the experience of discrepancy

"Internal Discrepancy" seeks to provide a conflict for the individual-where do I want to be versus where am I currently and what's preventing me from achieving my goals.

Paraphrasing is a useful technique to develop this discrepancy. Using an individual's language to reflect apparent incongruity between what is said and what is performed creates conflict that needs to be resolved. Often, simply acknowledging this allows an individual to move beyond their barriers and consider engaging in a more health-promoting behavior.

Open ended questions about specific events or concerns

"In your daily activities how does your concern about [behavior] come up?"

"What things during the day don't you do because of your [behavior]?"

"When is it that you don't like how you feel because of [behavior]?"

Open ended questions about what the patient might be imagining

"How do you think this [behavior] is going to get worse?"

"What are you worried about the most with this [behavior]?"

"Why has this [behavior] not been a problem in the past?"

Facilitating the patient recalling how things were before the [behavior] was a problem

"What was it like before you increased your [behavior]?"

"What was your experience of college like when you didn't [behavior] at all?"

Facilitating the patient imagining the future, both with and without the [behavior]

"What do imagine will happen if you don't make a change now?"

"What things might go away or not happen if you continue to [behavior]?"

"How do you see yourself in 5 years?"

Connecting things the patient values with the [behavior]

"How does the [behavior] help or hurt your work?"

"What are the things that matter the most to you now? What do you do each day to make those things happen?"

"If 100 stands for how you would like to be or how you would like your life to be, where are you today? When have you been closest to 100?"

"On a scale of 1 to 10 with 10 being the most concerned you have been about anything, what would you rate your concern about your [behavior]? At what number would your spouse rate their concern?"

"What do you like about [behavior]."

"Describe the things you **do not** like about [behavior]."

Reminders & cues

1. Ask about...

... lifestyle or stresses & the health compromising behavior, or

... the patient's health & the health compromising behavior

- Talk about the patient's lifestyle, stresses or health concerns.
- Ask open-ended questions like, "Where does

[behavior] fit in?"

- Listen for the context in which the behaviors occur.
- Listen for why the patient thinks it is a good thing.

2. Ask the patient to describe a typical day and go through it from beginning to end. Listen for...

... context in which the health-related behavior occurs

... concerns the patients may have

... how ready the patient is to change

- Do not identify problems or concerns.
- If the patient identifies such, acknowledge & maybe return to it later.

3. Develop discrepancy between...

... where a patient currently is with a health habit, and

... where the patient could be.

- Ask, "What are some things you like about [behavior]?"
- Ask, "What are some things you don't like about [behavior]?"
- Don't ask for problems or concerns. Rather, elicit these one at a time by asking, "How does this affect you?"
- Summarize & wait for the patient's response.

Phase I: Quick Assessment

Rapport:

"What sort of smoker are you? Tell me a bit about your smoking."

"You may well be fed up with people lecturing you about your smoking. I'm not going to do that, but it would help me if I understood how you **really feel** about your smoking."

Motivation to quit:

"If on a scale of 1 to 10, 1 is not at all motivated to give up smoking and 10 is 100% motivated to give it up, what number would you give yourself at the moment?"

Confidence in ability to quit:

"If you were to decide to give up smoking now, how confident are you that you would succeed? On a scale of 1 to 10, 1 means that you are not at all confident and 10 means that you are 100% confident you could give it up and remain a non-smoker, what number would you give yourself now?"

Phase II: Patient Identifies Problems & Solutions

Motivation:

- **Find out what the patient believes are the pros and cons of the behavior**
- **Offer non-judgmental information about personal risk**

"Why are you at (chosen number) and not at 1?"

"What would need to happen for you to get from (chosen number) to (higher number)?"

"What do you like about smoking?"

"What do you dislike about smoking?"

"Where does that leave you now?"

"Would up-to-date information about the risks involved help you in your decision-making about smoking?"

Confidence:

- **If no ideas come from the patient, offer a range of possibilities.**
- **Brainstorm solutions.**
- **Help the patient select a general problem area first (e.g. withdrawal, weight, social situations, mood states, stress, etc.).**
- **Do not immediately offer a single, simple solution.**
- **Encourage the patient to say what could work (their past successes, experience of others, wild**

speculation).

- **Supplement the patient's ideas with your ideas.**
- **Let the patient choose the best option.**

"Why are you at [chosen number] and not at 1?"

"What would you need to happen for you to get from [chosen number] to [higher number]?"

"How can I help you get from [chosen number] to [higher number]?"

Phase III: Target & Follow Up

Target:

- Reinforce the value of small gains and openness.
Can the patient set a manageable goal?
- It may relate to numbers of cigarettes smoked (not to increase, cut down, or quit).
- It may relate to factors that influence smoking, such as relationships, weight or exercise.
- If the patient is not ready to set any sort of target, keep the communication open.

"Things do change... Can we agree to leave the door open on this one?"

Follow up:

- Find out how they believe you can help them attain their target. Ideas could include follow up visits, telephone calls, advice on nicotine replacement (for those with definite signs of nicotine addiction only).

1. Strategies for rolling with resistance

Look over these new strategies.

1. Simple reflection
2. Amplified reflection
3. Double-sided reflection
4. Shifting focus
5. Agreement with a twist
6. Emphasizing personal choice & control
7. Reframing

Simple reflection

Demonstrating that you understand the meaning of the patient's statements

patient: I don't really have a problem. I just have to manage all this anxiety when I am at work.

physician: The real reason you drink has to do with the anxiety you often feel.

patient: I had thought I might be drinking too much, but I haven't missed drinking in the last several days since being here.

physician: So from the viewpoint of missing alcohol you don't think you have been drinking too much.

patient: I drink because I drink. There is no particular mood or events that led to drinking for me.

physician: You don't see a pattern other than you choose to drink.

Amplified reflection

Reflecting back what the patient has said in a more intense or extreme form so as to facilitate the individual taking the other side of the argument

patient:	I don't have a problem unless my friends come by to party. They don't have to work so they can stay out all night.
physician:	You can make your own choices except when these friends make you party.
patient:	I doubt if there is a problem. I don't have difficulties doing my work.
physician:	As long as the work is getting done everything is OK.

Double-sided reflection

Reflecting back what the patient is saying now and some other things the individual has said previously that might highlight the other side of the argument

patient: I don't see how my liver enzymes can be that high. My doctor just 2 months ago said that I was fine.

physician: It doesn't seem possible that your liver could have changed so quickly even though you recognize your drinking has increased some in the last months.

patient: I'd hate to have to never drink again. You know, stop all together.

physician: You don't want to have to avoid drinking but you don't want to be causing yourself any undue risks either.

<i>Shifting focus</i>	
Moving away from an issue about which the patient has said a number of words that seem to indicate little possibility of changing now, and focusing on something about which you and the individual already agree or are more likely to agree	
patient:	I am bored. I am bored with my life. I can't see going on for another five years, so what does it matter whether I drink or not.
physician:	There is no incentive to do much of anything anymore. Tell me how your days go, you know what you actually do in the morning, afternoon, and evenings.
patient:	I don't see any possibility or reason to be abstinent.
physician:	Yeah that's not very attractive to you. And at the same time you still need a better way to get to sleep than the alcohol because you're finding that doesn't work until 2 or 3 am.

Agreement with a twist

Expressing your agreement with a part of what the patient has said, creating the appearance of being in the same place, however, you emphasize a different aspect of the meaning

patient: There is no way I am going to go back to doing what she wants. It is my life and I have to do what I decide.

physician: You're right about that. If you let anyone else decide you will likely resent it later. So, by making the decision yourself, it is likely to be more successful.

patient: I just need to cut down on my drinking. I don't want to have to be abstinent.

physician: Yeah, what you want is to have the enjoyment without the extra risks or calories.

<i>Emphasizing personal choice & control</i>	
Explicitly and implicitly stating that the patient is responsible, the one to make and carry out decisions, and that you are available to provide guidance or opinion but not "the truth" or "the answer"	
patient:	I don't know if I have a drinking problem or not. I don't want to go to AA.
physician:	You are not sure what you want to or need to do about your drinking. There are lots of things you could choose to do other than AA.
patient:	I'd hate to start a period of abstinence now with this event in Hollywood coming up next week. You know, all the parties and standing around with a drink in your hand.
physician:	Most people have a drink in their hand at those things and like ordering a meal at a restaurant you may want to specify what you prefer to drink.

<i>Reframing</i>	
Using the same observations the patient has described to provide a meaning you want the individual to use	
Example A:	
Observation the patient has made	The experience of drinking more and feeling the effects less than before or less than others (this is the common experience of drinking tolerance).
Meaning patient might give this observation	I can drink more with less problems than others.
Meaning you might want the patient to have	You can drink more without feeling the effects including the warning signs that most people use to stop drinking.
Example B:	
Observation the patient has made	Attendance at several AA meetings, promises to self and others to stop drinking, inpatient treatment several years ago, antidepressants, individual therapy has not produced abstinence.
Meaning patient might give this observation	Nothing works, I can't stop or be helped.
Meaning you might want the patient to have	You have been motivated enough to try a variety of possibilities. Some things produced some change.

Other useful websites:

1. American Family Physician - March 1, 2000: A 'Stages of Change' Approach to Helping Patients Change Behavior
<http://www.aafp.org/afp/20000301/1409.html>
2. Motivational Interviewing website;
<http://motivationalinterview.org/clinical/overview.html>

MOTIVATIONAL INTERVIEWING: SIMULATED PATIENT PRACTICE

Student: _____ Scenario: _____ Date: _____

Signatures: _____

General Comments on MI Interviewer Attributes:

Acceptance (low; high)

Egalitarianism (authoritarian; egalitarian)

Empathy/understanding (low; high)

Genuineness/congruence (low; high)

Warmth (cold; warm)

Spirit (low; high)

Simulated Patient Attributes:

Affect (low; high)

Cooperation (resisting; cooperative)

Disclosure (low; high)

Engagement (passive; active)

Student and Simulated Patient Interaction:

Collaboration (wrestling; dancing)

Student Question Style

Closed Questions:

Open Questions:

Student Reflection Style (has SM affect been recognized?)

Repeating

Student Reflection Style (con't) (has SM affect been recognized?)

Rephrasing

Paraphrasing

Summarizing

Other MI Consistent Responses that Student has Endorsed:

Reframing

Supporting

Providing structure

Raising concern (with permission)

Advising (with permission)

Informing (with permission)

Emphasizing personal control

Affirming

MI inconsistent Responses that Student has Endorsed:

Confronting

Directing

Warning

Raising concern (without permission)

Advising (without permission)

Informing (without permission)

Simulated Patient Counter Motivational Behaviours:

Arguing

Interrupting

Negating

Not following

Simulated Patient Pro Motivational Features

Problem recognition

Concern

Desire/intention to change

Optimism for change

COMMUNICATION

Appendix 1

Communication Skills Tutorial

At least one of the tutorials in the family medicine clerkship should have communication skills as its focus. The students have had a number of communication skills sessions during their pre-clerkship, which used standardized patients, as well as the interview observation checklist. This checklist will likely feel very familiar even to those who have never seen it before, and is entirely consistent with the approach used in the postgraduate family medicine programs. Two versions are included - one which includes a summary of the relevant literature supporting its use (Appendix 2), and another which can be used to provide a guide and commentary to students (Appendix 3).

The goal of the communication skills tutorial is to remind students of the important concepts previously learned and to give them an opportunity to practice them in a safe setting. Students will benefit from bringing challenging situations they have encountered and trying out different ways of communicating. Coaching and feedback should be provided, both by the tutor and by the other group members.

This is NOT an evaluation and should not be treated as such. It takes multiple observations of patient encounters to make a valid assessment of a student's performance, which is clearly not possible for a tutor to do here. It is important to ensure that this is explained to students. The students' performance in the interviews at this tutorial should NOT be a component of their final evaluation.

The format of the tutorial can be decided by the group, however it should incorporate an opportunity for each student to practice skills, and not simply consist of discussion. Students might wish to divide up into two groups with the tutor moving between them, in order to allow the maximum opportunity for practice, or they may prefer to stay in a large group with the entire group observing each student as they practiced an interview. Cases for practice can come from the students' own experiences (often it is helpful if the student role plays the patient), from the provided list of role play scenarios, or a standardized patient can be booked from the list, for those tutorial groups meeting in Hamilton.

It is also possible to include a communication component to each tutorial rather than to set aside one full tutorial for this purpose. At least one tutorial group chose to role play a challenging patient situation encountered by one member during the week. The student who had been involved role played the patient/family member/colleague while another group member, with coaching from the group, tried out various strategies for establishing effective communication.

It is important to be careful with time, however this was found to be engaging for students, a relatively non-threatening mode of practicing communication skills, and a good illustration of common family practice issues.

Suggested Scenarios for Communications Tutor

#48 Grief – Loss of Partner through divorce
#91 Impotence
#205 Hypertension
#1188 Depression Anxiety attacks
#1260 Eating disorder
#1263 Chronic Mental Illness
#32 Request for abortion

***Please note:** As standardized patients (SPs) must be booked several weeks ahead of time, and there is no guarantee of availability, **please discuss the plans for this tutorial as soon as possible with your group.** The bookings for the SPs will be done through Andrea Colbert-DeGeit in the Undergraduate Program Office once you have made a list of preferred choices.*

Your suggestions comments and questions are welcomed on this new component of the tutorial. Please contact Andrea Colbert-DeGeit in the Undergraduate Program Office at 905-525-9140 Ext. 21659 or colbert@mcmaster.ca.

Scenarios for Communication Skills Tutorial

A woman in her mid-forties books an appointment – the reason noted is “Needs to talk – personal”. When seen, she discloses that her husband told her 2 weeks ago that he was leaving the marriage, and had a new partner, a young woman he works with. She had no idea this was coming, although in retrospect she realizes that they have not been close for some time. They have both been very busy working (she is a teacher, he works in sales) and raising their two sons, age 15 and 17. She is angry with her husband, but also feels guilty that she has not been a “good-enough” wife. Her self esteem is very low. While her mood is very low, she is not suicidal. She is hoping for something to help her sleep and would also like the doctor to talk to her husband. She thinks the doctor might be able to help her husband come to his senses.
(adapted from Standardized Patient scenario #48)

A 71 year old man comes in complaining of an infection in his left eye. He has noticed that it is irritated – like sand is in there – and it was stuck together in the morning. The white of his eye was pink coloured for several days, although it looks better today. There has been a thick yellow discharge. No photophobia, and no systemic symptoms. He seems to have something else on his mind, however, and tries to bring it up, obviously uncomfortable with the topic. He has been having difficulty with erectile dysfunction for the last year. He has trouble sustaining erections, and they are of poor quality. He attributes this to his age. He has one partner, his wife of 42 years. They have a good relationship in general, although they have been having some disagreements over their 30 year old son who has lost his job. His wife keeps giving money to the son, and the patient doesn't think this is a good idea. The patient is a nonsmoker. He drinks about 4 beers a day, and more on the weekend, but does not volunteer this information readily – he has to be pushed to give exact numbers. CAGE questionnaire is negative. He would like some pills to help with his erections – he is not interested in cutting down on his drinking and doesn't think it influences his sexual functioning.
(adapted from Standardized Patient scenario #91)

A 55 year old man is here for a routine blood pressure check. This is the 3rd visit, his pressure has been elevated on two previous visits, so he was asked to come back in. His previous BPs were 175/105 and 160/100, LAS. He was asked to get some blood tests done at the last visit, but lost the requisition. His diet is rather high in saturated fats, and low in fruits and vegetables. He exercises on the weekends by playing golf and sometimes baseball, not much of anything in the winter. He quit smoking 2 years ago. He drinks about ½ bottle of scotch a week. He is on no medications now, and would like to keep it that way. He has not seen the doctor much in the past, and is not comfortable with the idea that he will need to come in regularly for visits about his blood pressure. His family history is unknown as he was adopted as an infant.
(adapted from Standardized Patient scenario #205)

A 17 year old woman has booked an appointment to talk about her positive pregnancy test. She is distraught and overwhelmed - she bought a test at the drug store last night, and has not talked to anybody about the positive results. She wants to make sure that no one knows, especially her parents who will be so upset and disappointed with her. Her

last period was 2 months ago, and she broke up with her boy friend at about the same time. They have had no contact since that time, and the relationship is definitely over. She is in grade 12, and planning on starting University next year. She thinks she would like an abortion, but she isn't sure. She is looking for someone to help her – she doesn't know what to do at all.

(adapted from Standardized Patient scenario #32)

**INTERVIEW OBSERVATION CHECKLIST
FACULTY OF HEALTH SCIENCES
MCMASTER UNIVERSITY**

Element/ Task **	Skills	Comments
Builds Relationship	<ul style="list-style-type: none"> • Greets and shows interest in patient as a person • Uses words that show care and concern throughout the interview • Uses tone, pace, eye contact, and posture that show care and concern 	
Opens Discussion	<ul style="list-style-type: none"> • Allows patient to complete opening statement without interruption • Asks “Is there anything else?” to elicit full set of concerns • Explains and/or negotiates an agenda for the visit 	
Gathers Information	<ul style="list-style-type: none"> • Begins with patient’s story using open-ended questions (e.g. “tell me about...”) • Clarifies details as necessary with more specific “yes/no” questions • Summarizes and gives patient opportunity to correct or add information • Transitions effectively to additional questions 	
Understands Patient’s	<ul style="list-style-type: none"> • Asks about life events, circumstances, other 	

Perspective	<p>people that might affect health</p> <ul style="list-style-type: none"> • Elicits patient's beliefs, concerns and expectations about illness and treatment • Responds explicitly to patient's statements about ideas and feelings 	
Shares Information	<ul style="list-style-type: none"> • Assesses patient's understanding of problem and desire for more information • Explains using words that patient can understand • Asks if patient has any questions 	
Reaches Agreement	<ul style="list-style-type: none"> • Includes patient in choices and decisions to the extent he/she desires • Checks for mutual understanding of diagnostic and/or treatment plans • Asks about patient's ability to follow diagnostic and/or treatment plans • Identifies additional resources as appropriate 	
Provides Closure	<ul style="list-style-type: none"> • Asks if patient has questions, concerns or other issues • Summarizes • Clarifies follow-up or contact information • Acknowledges patient and closes interview 	

Overall comments and specific suggestions

**** Adapted from: Participants in the Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education (2001). Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. *Academic Medicine* 76: 390-93.**

Recommended Text:

Silverman J, Kurtz S, Draper J (2005 Second Edition). Skills for Communicating with Patients. Radcliffe Publishing, UK.
(JAMCO Distribution - jamco@majors.com)

Recommended Website:

www.skillscascade.com
carl.delottinville@learnlink.mcmaster.ca
2006

**INTERVIEW OBSERVATION CHECKLIST
FACULTY OF HEALTH SCIENCES
MCMASTER UNIVERSITY**

Element/ Task **	Skills	References
Builds Relationship	<ul style="list-style-type: none"> • Greets and shows interest in patient as a person • Uses words that show care and concern throughout the interview • Uses tone, pace, eye contact, and posture that show care and concern 	<ul style="list-style-type: none"> • <i>Interviewers who concentrate on the psychosocial as well as biomedical factors obtain more accurate and thorough data over a shorter time period, while increasing patient satisfaction</i> <ul style="list-style-type: none"> - Platt FW, Grasper DL, Coulehan JL, Fox L, Adler AJ, Weston WW, Smith RC, and Stewart M (2001). Tell Me About Yourself: the patient-centred interview. <i>Ann Intern Med</i> 134, 1079-85. • <i>Displays of verbal empathy can guard against client alienation, misrepresentation and missing information and strengthen patient satisfaction and compliance</i> <ul style="list-style-type: none"> - Kim SS, Kaplowitz S and Johnson MV (2004). The effects of physician empathy on patient satisfaction and compliance. <i>Eval Health Prof</i> 27(3): 237-51. - Coulehan JL, Platt FW, Egner B, Frankel R, Lin CT, Lown B, Salazar WH (2001). 'Let me see if I have this right...': Words that help build empathy. <i>Ann Intern Med</i> 135: 221-7. • <i>Non-verbal displays of caring are linked to heightened perceived competence, credibility and persuasiveness of the interviewer and increased patient compliance.</i> <ul style="list-style-type: none"> - Manuel G, Manjon-Ace P, Puerto-Bamber J, Sanchez-Garcia E, Gomez-Beneyto M (1998). Clinical Interview skills and identification of emotional disorders in primary care. <i>Am Journ Psychiatry</i> 155(4): 530-5 • <i>The effective display of non-verbal skills such as eye contact and body posture are critical in demonstrating attentive listening and encouraging patients to disclose information</i> <ul style="list-style-type: none"> - Branch WT and Malik TK (1993). Using 'windows of opportunity' in brief interviews to understand patients' concerns. <i>JAMA</i> 269: 1667-8.

<p>Opens Discussion</p>	<ul style="list-style-type: none"> • Allows patient to complete opening statement without interruption • Asks “Is there anything else?” to elicit full set of concerns • Explains and/or negotiates an agenda for the visit 	<ul style="list-style-type: none"> • <i>Incomplete initial descriptions of presenting problems by patients frequently lead to late-arising concerns and missed opportunities to gather important data. Soliciting the patient’s agenda takes little time and can improve interview efficiency and yield increased data</i> <ul style="list-style-type: none"> - Marvel K, Epstein R, Flowers K, Beckman H (1999). Soliciting the Patient’s Agenda: Have we improved? <i>JAMA</i> 281(3): 283-87. • <i>Letting patients finish their opening statements usually allows them to tell you 90% of what they consider is wrong with them, which improves accuracy and efficiency.</i> <ul style="list-style-type: none"> - Maguire P and Pitceathly C (2002). Key communication skills and how to acquire them. <i>BMJ</i> 325: 697-700. • <i>There is a strong association between effectively negotiating an agenda and few if ever late arising concerns in an interview. Eliciting the patient’s agenda early on has the potential to reduce physician frustration and decrease the length of the visit.</i> <ul style="list-style-type: none"> - Haas LJ, Houchins L, Leiser JP (2003). Changing family physicians’ visit structuring behaviour: A pilot study. <i>Family Medicine</i> 35(10): 726-29. - Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, Jordon J (2000). The impact of patient-centred care on outcomes. <i>Journ Fam Pract</i> 49: 796-804 - Wissour LS, Roter DL and Wilson MEH (1994). Pediatrician interview style and mothers’ disclosure of psychosocial issues. <i>Pediatrics</i> 93: 289-95. - Manning P, Ray GB (2002). Setting the agenda: An analysis of negotiation strategies in clinical talk. <i>Health Commun</i> 14: 451-73.
<p>Gathers Information</p>	<ul style="list-style-type: none"> • Begins with patient’s story using open-ended questions (e.g. “tell me about...”) • Clarifies details as necessary with more 	<ul style="list-style-type: none"> • <i>The “Invite, Listen and Summarize” method of gathering data emphasizes techniques of open-ended inquiry that have been shown to elicit accurate data, improve compliance and combat high physician-controlled interviews</i> <ul style="list-style-type: none"> - Boyle D, Dwinnell B, Platt F (2005). Invite, Listen and Summarize: A

	<p>specific “yes/no” questions</p> <ul style="list-style-type: none"> • Summarizes and gives patient opportunity to correct or add information • Transitions effectively to additional questions 	<p>Patient-Centred Communication Technique. <i>Academic Medicine</i> 80: 29-32</p> <ul style="list-style-type: none"> • <i>Patients suffering from headaches and blood pressure problems who perceived that their conditions were fully discussed reported better symptoms relief.</i> <ul style="list-style-type: none"> - Stewart MA (1995). Effective physician-patient communication and health outcomes: a review. <i>Can Med Assoc Journ</i> 152: 1423-33 • <i>Premature closed-ended questions may decrease the amount of valuable information attained and potentially bias the information gained. Techniques such as active listening, paraphrasing and reflecting feelings are effective communication strategies to obtain more detailed and accurate information.</i> <ul style="list-style-type: none"> - Kravitz RL, Cope DW, Bhrany V, Leake B (1994). Internal medical patients’ expectations for care during office visits. <i>J Gen Intern Med</i> 9: 75-81. - Little P, Williamson I, Warner G, Gould C, Gantley M and Kinmonth AL (1997). Open randomized trial of prescribing strategies in managing sore throat. <i>BMJ</i> 314: 722-7 - Cox A, Rutter M, Holbrook D (1981). Psychiatric Interviewing Techniques V: Experimental study. <i>Br J Psychiatry</i> 139: 29-37 - Levinson W, Gorawara-Bhat R, Lamb J (2000). A study of patient clues and physician responses in primary care and surgical settings. <i>JAMA</i> 284: 1021-7.
<p>Understands Patient’s Perspective</p>	<ul style="list-style-type: none"> • Asks about life events, circumstances, other people that might affect health • Elicits patient’s beliefs, concerns and expectations about illness and treatment • Responds explicitly to patient’s statements about 	<ul style="list-style-type: none"> • <i>Patients’ beliefs about their illness, including treatment, aetiology, the role of health in their lives and the relationship between spirituality and health are factors that have a significant impact on how well they will cope with their condition</i> <ul style="list-style-type: none"> - Wright LM, Watson WL, Bell JM (1996). Beliefs: the heart of healing in families and illness. <i>Basic Books, New York.</i> - Lang F, Floyd MR, Beine KL, Buck P (2002). Sequenced questioning to elicit the patient’s perspective on illness:

	<p>ideas and feelings</p>	<p>Effects on information disclosure, patient satisfaction and time expenditure. <i>Fam Med</i> 34: 325-30.</p> <ul style="list-style-type: none"> - McLean M, Armstrong D (2004). Eliciting patients' concerns: A randomized controlled trial of different approaches by the doctor. <i>Br J Gen Pract</i> 54(500); 663-6. - Kinmouth AL, Woodcock A, Griffith S, Spiegel N, Campbell MJ (1998). Randomized controlled trial of patient-centred care of diabetes in general practice: impact on current well-being and future disease risk (the Diabetes Care from Diagnosis Research Team). <i>BMJ</i> 317: 1202-8.
<p>Shares Information</p>	<ul style="list-style-type: none"> • Assesses patient's understanding of problem and desire for more information • Explains using words that patient can understand • Asks if patient has any questions 	<ul style="list-style-type: none"> • <i>Doctors and patients engage in "communication conspiracy" in which both parties overlook the lack of understanding and use of technical language to ensure limited patient questions. This can often result in major issues of recall, limiting adherence to treatment and progress.</i> <ul style="list-style-type: none"> - Bertakis KD (1977). The communication of information from physician to patient: A method for increasing patient retention and satisfaction. <i>J Fam Pract</i> 5: 217-22 • <i>Simple everyday words put into a medical context can be ambiguous. Reducing the use of jargon, clarifying patient understanding, and using shorter words and sentences are all techniques that enhance understanding.</i> <ul style="list-style-type: none"> - Hadlow J, Pitts M (1991). The understanding of common terms by doctors, nurses and patients. <i>Social Science and Medicine</i> 32: 193-196 • <i>Information-giving by doctors in response to information seeking by patients has been associated with better patient health outcomes</i> <ul style="list-style-type: none"> - Kaplan SH, Greenfield S, Grandek B, Rogers WH, Ware JE (1990). Characteristics of physicians with participatory decision-making styles. <i>Ann Intern Med</i> 124: 497-504.

Reaches Agreement	<ul style="list-style-type: none"> • Includes patient in choices and decisions to the extent he/she desires • Checks for mutual understanding of diagnostic and/or treatment plans • Asks about patient's ability to follow diagnostic and/or treatment plans • Identifies additional resources as appropriate 	<ul style="list-style-type: none"> • <i>Taking time to discuss treatment plans is vital, since physicians underestimate the amount of information that patients desire in 65% of their encounters, while overestimating in only 6% of cases</i> <ul style="list-style-type: none"> - Waitzkin H (1984). Doctor-patient communication: clinical implications of social scientific research. <i>JAMA</i> 252: 2441-6 • <i>Doctors who listen to patient concerns, discuss patient suggestions, negotiate a plan and identify additional resources can increase patient satisfaction and compliance and decrease lawsuits and doctor-shopping</i> <ul style="list-style-type: none"> - Lelie A (2000). Decision-making in nephrology: shared decision-making? <i>Patient Education and Counselling</i> 39: 81-89 • <i>While all patients should be made to feel part of a decision-making team, for improved compliance, patients may have different levels of desired decision-making responsibility.</i> <ul style="list-style-type: none"> - Rhodes KV, Vieth T, HE T, Miller A, Howes DS (2004). Resuscitating the physician-patient relationship: Emergency department communication in an academic medical centre. <i>Ann Emerg Med</i> 44(3): 262-7
Provides Closure	<ul style="list-style-type: none"> • Asks if patient has questions, concerns or other issues • Summarizes • Clarifies follow-up or contact information • Acknowledges patient and closes interview 	<ul style="list-style-type: none"> • <i>Screening for incomplete business before closing the interview ("Is there anything else?") helps ensure that late-arising concerns are meaningfully addressed.</i> <ul style="list-style-type: none"> - White JC, Rosson C, Christensen J, Hart R, Levinson W (1997). Wrapping things up: A qualitative analysis of the closing moments of the medical visit. <i>Patient Education and Counselling</i> 30: 155-65 • <i>Clarification of follow-up arrangements including contracting with the patient helps the physician and the patient clarify their roles and responsibilities regarding next steps. Acknowledging the patient at the close of the interview is an important component of the interview process</i> <ul style="list-style-type: none"> - Teutsch C (2003). Patient-doctor communication. <i>Med Clin N Am</i> 87: 1115-1145

		<ul style="list-style-type: none">- Robinson J (2001). Closing medical encounters: two physician practices and their implications from the expression of patients' unstated concerns. <i>Soc Sci Med</i> 53(5): 639-656.
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**** Adapted from: Participants in the Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education (2001). Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. *Academic Medicine* 76: 390-93.**

Recommended Text:

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(JAMCO Distribution - jamco@majors.com)

Recommended Website:

www.skillscascade.com

carl.delottinville@learnlink.mcmaster.ca

2006

EVALUATIONS

Using the McMaster University Tutors Evaluation Website

The Tutorial Clerkship Evaluation website has been designed to enable tutors to easily enter information on the students that are studying with them for the current Clerkship Rotation. By simply opening the Tutor Evaluation website, logging in with a user ID and password, each tutor can enter the current information, then click on a "Save" button to send the information to a database on a special server at McMaster. Each tutor will also print a version of the evaluation, sign the form and mail it to McMaster.

This manual outlines how to use the website.

First, some caveats:

- a. The system works best using Microsoft Internet Explorer, version 4 or later.
- b. The system works less well using Netscape.
- c. Currently, the database is open for tutors to change information for a particular student as often as necessary.

How to use the website and change evaluation information:

It is recommended that you log in through Medportal, as Medportal has a mapping feature that requires you to enter your User ID and Password only once. After you have done this the first time, Medportal should automatically sign you into the One45 (evaluation) website seamlessly.

- 1 Connect your computer to the internet and enter the following web site address into the browser: <http://fhsundergrad.csu.mcmaster.ca:8080/servlet/Clerkship>.
- 2 Enter the user ID and password that have been sent to you. They are not case sensitive. It is important that the security of the system is always maintained. Most computers will ask you if you want to save the password. We recommend that you only answer "Yes" if you are the sole user of the computer, as this reduces the security of the system. Click on the "Login" button. (If you have any questions about your user ID or password, please see the contact information below).
- 3 The next screen allows you to select (using the arrow-button to the right of the student names) the student whose file you wish to work on. Click on the arrow-button, then click on the name of the student and rotation. The student's name and rotation will appear in the box. Click on the "Go" button to the right of the name and in a few seconds, the form for that student will appear.

- 4 The next screen is the data entry screen. This is where you enter the evaluation information. The small boxes are check boxes, i.e. just click on the appropriate box and a check mark will appear there and that will be recorded in the database.
- 5 Enter the dates (Period Ending; Date Tutor Signed; Start Date; and End Date). You can either click on the small square box to the right of each date box, in which case a calendar will appear, and you can select the right month and year, then click on the actual day or you can enter the date right into the date box using the format yyyy/mm/dd. For example the date February 28, 2004 would be entered as 2004/02/28.
- 6
 - a. There are ten groups of check boxes, each having ten choices. The default is blank. In each case, click on the appropriate check box.
 - b. There is also a group of check boxes with five choices which records the "Encounter Card Performance". This section is to be completed by the clinical supervisor.
 - c. There is also a set of five boxes to be completed at the "end-of-rotation" examination by either the tutor or clerkship coordinator. These boxes can contain numbers (including decimal places) or the words "Satisfactory" or "Unsatisfactory".
- 7 The "Summary of Student Performance" (text) box at the bottom of the page is completed just as with a word processor. There is a limit of 1500 characters per box. If you exceed this amount, the box will still accept the data, but when you click on the "Save" button, you will get a message on the screen informing you that you have exceeded the limits. At this point, you can return to the text box and reduce the amount of text until it fits within the limits. One method to make this process easier is to create the text using a word processor such as Microsoft Word or Corel WordPerfect. Once the text is complete, just highlight the block of information and copy and paste into the web page. (To do this, highlight the text, hold down the "Control" key and press the letter "C", then click onto the web page, hold down the "Control" key and press the letter "V"). If for any reason you lose the Internet connection before you "Save" the information, you can log back in and use the information in the word processor file and will not need to recreate the text for that student's evaluation. This "Summary of Student Performance" text box at the bottom of the page should be a narrative summary of all aspects of the student's performance. This summary will be printed on the student's transcript.
- 8 Once all of the data has been entered, it is important to remember to click on the "Save" button at the bottom of the form. Until you do this, the information is sitting on your computer and has not been sent via the Internet to the McMaster server database. As soon as you have clicked on the "Save" button, your text is automatically transferred to the McMaster server database. You will know when the transfer is complete when you see the top of the form again. Any changes

- made to the information will overwrite the McMaster database when the “Save” button is pressed.
- 9 If you need to do other things before completing the evaluation, we recommend that you “Save” the information, even if the evaluation is incomplete, as the system has a time-out feature when there has been no activity for approximately 30 minutes. You can always re-open the evaluation file and continue with the evaluation later.
 - 10 At this point, you have completed the task for that particular student. Until this particular record is locked, you can change the information as many times as you wish, and each time you press the “Save” button, the database will be updated to what you currently have on your screen.
 - 11 At this point you can either exit the system by closing the web page or you can click on another student and continue data entry. Just be sure to save the information for each student individually by clicking on the “Save” button before moving to another student.
 - 12 Once you have finished the final data entry for a particular student, or if you just wish to view a paper copy of the evaluation to date, click on the blue coloured “Printable version” link at the top of the screen. In a few seconds, another web page will open with the same data but in a form suitable for printing and signing. The data on this web page will be that currently in the McMaster server database. If you made changes to the data and clicked on the “Printable version” link before you saved the changes, the date on the printable web page will be that from the last time the data was saved. We therefore advise that you get into the habit of saving your work each time you make any changes that you wish to keep. The first page of the “Printable version” has signature and date boxes for the tutor, student and Unit Chair respectively.

Contact information: If you have any questions related to your user ID or password, please contact Chantelle Campbell, McMaster MD Program, 905-525-9140 extension 22234 or email her at campc@mcmaster.ca. It is important to recognize the need to maintain confidentiality of the information you are handling. Therefore, we request that you take special steps to ensure that your user ID and password are kept private. If you have any doubts at all, please contact Chantelle immediately and she will change your user ID and/or password.

Although the above description of the use of the web based system has a lot of detail, we think that you will find it very easy to use and hopefully, will enable you to simplify keeping up to date with the written evaluation part of the process. We believe that the overall efficiencies that will ensue due to the use of this method of collecting evaluation information will make the project worth doing.



McMASTER UNIVERSITY
 FACULTY OF HEALTH
 SCIENCES
 UNDERGRADUATE MD
 PROGRAM

SUMMARY OF STUDENT
 PERFORMANCE
 Unit 5 (CLERKSHIP)

Student Name:			
Student Advisor's Name:			
Dates of Rotation:		Rotation:	

Tutor to attach all evaluation documents

Progress Decision:

Satisfactory; overall satisfactory achievement of objectives

Provisional Satisfactory; remedial contract required in the area of:

- Knowledge
- Skills
- Professional Behaviour

Unsatisfactory; overall unsatisfactory achievement of objectives

Incomplete

Signature Tutor _____ Date: _____

Signature Student _____ Date: _____

(Signature without additional comment will be taken to mean acceptance of the content of this form as accurate and adequate.)

Reviewed by Clerkship Coordinator: Signature _____

Date: _____

Please return all copies to Undergraduate MD Program: Evaluations, MDCL-3116

SUMMARY OF CLERKSHIP PERFORMANCE

1) Fund of Knowledge

Below Expectations		Borderline Meeting of Expectations		Meets Expectations		Exceeds Expectations		Exceptional	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	8	9	10

2) Knowledge Integration

Below Expectations		Borderline Meeting of Expectations		Meets Expectations		Exceeds Expectations		Exceptional	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	8	9	10

3) History Taking

Below Expectations		Borderline Meeting of Expectations		Meets Expectations		Exceeds Expectations		Exceptional	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	8	9	10

4) Clinical Examination

Below Expectations		Borderline Meeting of Expectations		Meets Expectations		Exceeds Expectations		Exceptional	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	8	9	10

5) Clinical Management

Below Expectations		Borderline Meeting of Expectations		Meets Expectations		Exceeds Expectations		Exceptional	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7	8	9	10

6) Learning Skills

Below Expectations	Borderline Meeting of Expectations	Meets Expectations	Exceeds Expectations	Exceptional					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
1	2	3	4	5	6	7	8	9	10

7) Communication Skills

Below Expectations	Borderline Meeting of Expectations	Meets Expectations	Exceeds Expectations	Exceptional					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
1	2	3	4	5	6	7	8	9	10

8) Respect (Appropriate verbal and non-verbal behaviour. Acts in an ethical manner in relation to patients and colleagues)

Below Expectations	Borderline Meeting of Expectations	Meets Expectations	Exceeds Expectations	Exceptional					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
1	2	3	4	5	6	7	8	9	10

9) Responsibility (Follows through on commitments made to patients and colleagues. Attends regularly.)

Below Expectations	Borderline Meeting of Expectations	Meets Expectations	Exceeds Expectations	Exceptional					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
1	2	3	4	5	6	7	8	9	10

10) Self-Awareness (Shows a realistic understanding of own knowledge base, skills and behaviour. Able to give and accept constructive feedback)

Below Expectations	Borderline Meeting of Expectations	Meets Expectations	Exceeds Expectations	Exceptional					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
1	2	3	4	5	6	7	8	9	10

SUMMARY OF PERFORMANCE ON ROTATION EVALUATION TOOLS

(to be completed by the clinical tutor supervisor at the end of the rotation):

Passport Tracing of Family Medicine Experience

Unsatisfactory

Satisfactory

Performance on end-of-Rotation Examination (To be completed by clerkship coordinator).

Please note: The Student Score plus four Comparative Group fields below can include the text "Satisfactory" or "Unsatisfactory" as well as holding numerical values.

Student Score:

Comparative Group Average:

Comparative Group Standard Deviation:

Comparative Group Maximum:

Comparative Group Minimum:

SUMMARY OF STUDENT PERFORMANCE

Narrative summary of all aspects of the student's performance on this rotation as reflected in the preceding ratings / summary of performance on evaluation tools.

This narrative summary is to be entered on Student Transcript

Clinical Preceptor

Clerk

Date