1. FAMILY MEDICINE

Family medicine placement	
Student's data. These fields are completed by the student	
Period of performing the placement	
First and last name	No of study book
E-mail address	Phone number
Performing the placement. The doctor supervising the student completes these fields at the end of the placement. We ask that you confirm the completion of different parts of the practice logbook with a mark in the **yes** box	
The student has presented 8 case studies, including: ▪ 6 case studies on mandatory topics ▪ 2 case studies on optional topics	☐ **yes**
The student has presented the self-analysis	☐ **yes**
I have also assessed the student's work during the placement in free form	☐ **yes**
	☐
Supervisor's data. The doctors supervising the student complete these fields at the end of the placement.	
First and last name	Doctor's registration code
Family doctor's practice	Stamp and/or signature
First and last name	Doctor's registration code
Family doctor's practice	Stamp and/or signature

1.1. Work with patients

During the family medicine placement, you have to write **8 case studies** on given forms, including: (a) **6 case studies** on mandatory topics; and (b) **2 case studies** on the optional topics. In the next list, you can keep account of already written case studies by making marks in box **C** (case study).

Try to distribute your activities evenly with your supervisor. If you will leave all of the case studies to the end of the placement, you may not have time to focus properly and your supervisor may not have the possibility to read them and give feedback. For example, agree to present one case study a week.

We would like to remind you that the family medicine placement is a good opportunity to practise some of the nursing skills brought out under the practical skills section. We recommend that you talk with your supervisor and ask if you could assist the nurse(s) for a couple of weeks. That would be a superb chance to practise doing ECGs, draw blood and all the rest our great nurses have to do. Give it a go!

Topics of case studies in family medicine	
Mandatory case studies	
Unclear diagnosis	☐ **C**
Prevention	☐ **C**
Management of a chronic illness	☐ **C**
Monitoring a child’s development	☐ **C**
Driver's and driver's licence applicant's health check	☐ **C**
Management of an acute illness	☐ **C**
Optional case studies	
Management a patient requesting referral to a specialist	☐ **C**
Management of an acute illness	☐ **C**
Management of a chronic illness	☐ **C**
Phone consultation	☐ **C**
Management of an acute illness	☐ **C**
	☐

Unclear diagnosis
Presenting problem
History
Objective findings. Include results from relevant analyses and investigations
Differential diagnosis
Taking into account the presenting problem, what would be the „red flags” and what could they indicate?
Primary diagnosis
Primary management. Substantiate briefly!
Further management. Do you plan the next contact, and if yes, when?

Supervisor's stamp and/or signature

Prevention
Presenting problem
More important chronic diseases and their duration
Unhealthy habits, social, occupational and inherited risk factors. Association with the presenting problem
Objective findings, results of relevant analyses and investigations. Do the chronic diseases have complications?
What prevention activities did you plan together with the patient? What priorities were set? Where would the patient need additional motivation and how can you help him/her?
Management of the presenting problem as well as concurrent diseases. Pharmacological and non-pharmacological treatment. When are you planning the next visit to take place?

Supervisor's stamp and/or signature

Management of a patient requesting referral to a specialist
The requirements of the referral are presented in the Minister of Social Affairs regulation **The conditions and procedure for maintaining records of the provision of health services and preservation of the documents thereof**. Look for this regulation in the electronic Riigi Teataja at www.riigiteataja.ee. The Estonian Health Insurance Fund has compiled a summary of requirements of e-consultation referral — you will find this at www.haigekassa.ee/sites/default/files/perearstid/e-kons_kodukale_2015.pdf.
Objective of the refererral ☐ **e-consultation** ☐ **regular consultation** ☐ **CITO!**
Presenting problem
Objective findings, results of relevant analyses and investigations
Clear and specific question to the specialist
What resources of the family doctor's practice have been used to solve the patient's problem? Are there other unused resources? What would be needed to use them?
A referral must include: (a) symptom, syndrome or diagnosis hypothesis; (b) history; (c) important results of objective examination; (d) performed analyses and investigations; (e) medications used by the patient; and (f) specific question to the specialist. Were they there? If not, why?
If the patient was referred to a specialist's consultation as CITO, then why?
If the patient was referred to an e-consultation, see if the reason for referral was consistent with conditions agreed with the speciality! The conditions you will find in the abovementioned Health Insurance Fund summary.

Supervisor's stamp and/or signature

Management of a chronic illness
Presenting problem
More important chronic illnesses and their duration. If possible, note the risk level of complications or mortality
Objective findings, results of relevant analyses and investigations. Do the chronic illnesses have complications?
Review the treatment guidelines for the patient's illnesses (www.ravijuhend.ee). Does the patient's recent monitoring and treatment comply with the valid guidelines? If not, why?
What aspects of living with the chronic illness does the patient manage well? Where would the patient need additional motivation and how can you help him/her?
Present the patient's brief treatment and monitoring plan for the next year

Supervisor's stamp and/or signature

Management of a chronic disease
Presenting problem
More important chronic illnesses and their duration. If possible, note the risk level of complications or mortality
Objective findings, results of relevant analyses and investigations. Do the chronic illnesses have complications?
Review the treatment guidelines for the patient's illnesses (www.ravijuhend.ee). Does the patient's recent monitoring and treatment comply with the valid guidelines? If not, why?
What aspects of living with the chronic illness does the patient manage well? Where would the patient need additional motivation and how can you help him/her?
Present the patient's brief treatment and monitoring plan for the next year

Supervisor 's stamp and/or signature

Monitoring a child's development
Monitoring of the development of an infant and child is regulated by **Health check guidelines for children under 18 years old,** which is available at www.ravijuhend.ee. Familiarise yourself with the guidelines and find out who performs the regular health check and vaccinations in your family doctor's practice!
Presenting problem
What activity or activities named in the guidelines did you perform?
Did the child's psychomotor skills correspond to age? How did you assess it? What is the further management?
Did the child's speech correspond to age? How did you assess it? What is the further management?
National immunization schedule is one of the most important facts you take with you into life. Write it down! Have all vaccinations been performed according to the child's age? If not, why?

12 hours	1 year
1 - 5 days	2 years
1 month	6 - 7 years
2 months	12 years
3 months	13 years
4,5 months	15 - 16 years
6 months	Every 10 years

Was the child vaccinated? Against which diseases? If the child was not vaccinated, then why?

Supervisor's stamp and/or signature

Driver's and driver's licence applicant's health check
Health requirements applying to a driver are presented in the Goverment's regulation **Driver's and driver's licence applicant's and a streetcar driver's and a streetcar driver's licence applicant's health check terms and conditions**. Look for this regulation in the electronic Riigi Teataja at www.riigiteataja.ee.
Presenting problem
Applicant's chronic diseases, their monitoring and treatment
Outcome of the treatment
Objective findings, results of relevant analyses and investigations
Based on the regulation, the applicant falls into ☐ **group 1** or ☐ **group 2**
Does the patient's health status allow him/her to drive a vehicle? Substantiate your decision!
If the health certificate was not issued, can the applicant apply again and when?

Supervisor's stamp and/or signature

Phone consultation
The consultation can also take place via Skype or e-mail.
Presenting problem
History
Differential diagnosis
Primary diagnosis
Primary management. Substantiate briefly!
What advice did you give to the patient over the phone?
If you decided to invite the patient to the family doctor’s practice, then when? Substantiate your decision!
What was the further course of the disease? Were chosen tactics right? Would you now do anything differently?

Supervisor's stamp and/or signature

Management of an acute illness
Presenting problem
History
Objective findings. Include results from relevant analyses and investigations
Differential diagnosis
Taking into account the presenting problem, what would be the „red flags” and what could they indicate?
Primary diagnosis
Primary management. Substantiate briefly!
Further management. Do you plan the next contact, and if yes, when?

Supervisor's stamp and/or signature

Management of an acute illness
Presenting problem
History
Objective findings. Include results from relevant analyses and investigations
Differential diagnosis
Taking into account the presenting problem, what would be the „red flags” and what could they indicate?
Primary diagnosis
Primary management. Substantiate briefly!
Further management. Do you plan the next contact, and if yes, when?

Supervisor's stamp and/or signature

Management of an acute illness
Presenting problem
History
Objective findings. Include results from relevant analyses and investigations
Differential diagnosis
Taking into account the presenting problem, what would be the „red flags” and what could they indicate?
Primary diagnosis
Primary management. Substantiate briefly!
Further management. Do you plan the next contact, and if yes, when?

Supervisor's stamp and/or signature

On these pages ease write down at east **three cases** that taught something extra valuable to you. For example, you could write here if during management of some patients: (a) you learned to use an unfamiliar medici-ne or treatment method; or (b) you learned something valuable about communication with patients or colleagues.

Presenting problem, short history	Interesting or informative aspect

Presenting problem, short history	Interesting or informative aspect

1.2. Self-analysis

Here you can: (a) write about what you saw and did during the practice; (b) analyse your strengths and weaknesses observed during everyday clinical work; or (c) think what you would like to and are able to improve in yourself, family medicine practice or the healthcare system in general. As a second task, record a consultation with your patient and evaluate it according to the worksheet consultation. The recording will help you to fill in the worksheets. Consultation worksheet is mandatory to submit aswell.

Self-analysis

Worksheet CONSULTATION

Name:

PREPARATION FOR THE CONSULTATION

1. INITIATING THE SESSION

Name, role, timeframe. Nature of the interview. Consent. Identify the the reason(s) for the consultation. Screen. Negotiate consultation agenda.

2. GATHERING INFORMATION

Patient perspective: ICE

PHYSICAL EXAMINATION

3. EXCHANGING INFORMATION

Elicit – Provide – Elicit.
Shared decision making.

DECISION

4. PLANNING

Mutually acceptlable plan.

5. STRUCTURE

Signposting. Summaries. Timing.

6. BUILDING RELATIONSHIP

Accept.. Partnership. Autonomy support. Use empathy. Support. Notice clues.

CLOSING THE SESSION

ASK LISTEN SUMMARISE EXCHANGE INFORMATION

PREPARATION FOR THIS CONSULTATION
Put aside last task, attend to self-comfort, focus attention and prepare to this consultation.

INITIATING THE SESSION
Greet patient, obtain patient's name, introduce yourself, your role and nature of interview.

PREPARATION FOR THE CONSULTATION

1. INITIATING THE SESSION

Name, role, timeframe. Nature of the interview. Consent. Identify the the reason(s) for the consultation. Screen. Negotiate consultation agenda.

Obtain consent if necessary. Demonstrate respect and interest, attend to patient's comfort.

Identify the the reason(s) for the consultation
Identify the patient's problems or issues that the patient wishes to address with appropriate opening question.

• **NB!** Be aware that there is no one universal opening question which always suits.

Screen
Screening is the process of deliberately checking with the patient that you have discovered all that they wish to discuss by asking further open-ended enquiries. Rather than assuming that the patient has mentioned all of their difficulties, double-check.

• **NB!** Studies have shown that patients have often several issues to discuss but the presented sequence does not correlate with clinical importance.

Negotiate consultation agenda
Screening naturally leads to negotiating and setting an agenda for consultation, taking both the patient's and the doctor's needs into account. Agenda setting helps structuring the consultation and set the priorities.

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

Objective of this part is

- to explore the patient's problems to discover the biomedical perspective, the patient perspective and background information;
- ensuring that the information is accurate, complete and mutually understood;
- ensuring that patients feel listened to, that their information and views are welcomed and valued.

PREPARATION FOR THE CONSULTATION

2. GATHERING INFORMATION

Patient perspective: ICE

ICE

- patient's **ideas** (i.e. beliefs regarding cause)
- patient's **concerns** (i.e. worries) regarding each problem
- patient's **expectations** (i.e.) goals, what patient had expected for each problem)

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

PHYSICAL EXAMINATION

3. EXCHANGING INFORMATION

Elicit – Provide – Elicit.
Shared decision making.

Objective is to assess each individual patient's information needs, to give comprehensive and appropriate information to neither restrict nor overload.

Elicit – Provide – Elicit
Exchange of information is most effective when starts from assessing patient's prior knowledge (**elicit**), providing information that is new for patient (**provide**) and inquires the value of new information to particular patient (**elicit**).

Shared decision making involves patients in decision making to the level they wish while exploring treatment options, offering suggestions and choices rather than directions.

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

DECISION

Process allows the patient to understand the need and meaning of treatment, engage them to assess their own recourses and negotiate further steps to increase patient's commitment to plans made.

4. PLANNING

Mutually acceptlable plan.

EXAMPLES

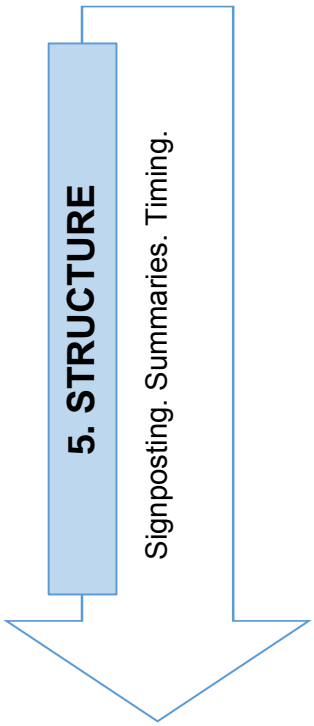
What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

STRUCTURE

• enables flexible yet ordered interview
• helps the patient to be involved and understand where and why the interview is going;
• encourages the patient to be part of the structuring process;
• enabling accurate information gathering and giving;
• allows efficient use of time.



Signposting

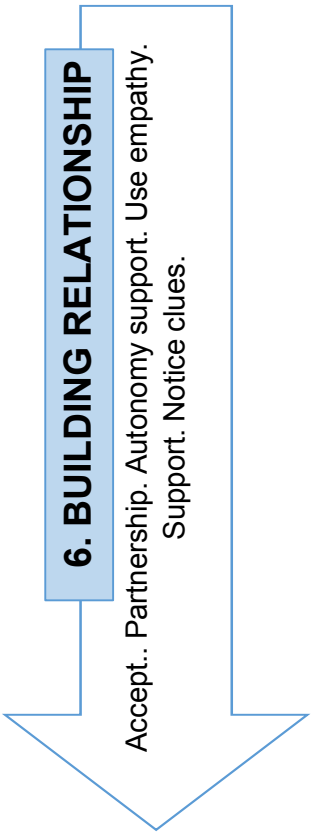
Statement introduces and draws attention to what we are about to say or do and allows you to share your thoughts and needs with the patient.

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience



Accepting the patients as they are, eliminating bias and stereotypes and acknowledging the patient's views and the right to hold them.

Partnership is clinician's active encouragement of power sharing in a way that the patient can contribute their ideas, wishes, opportunities to whole consultation.

Autonomy is honouring and respecting each person right and capacity of self-direction, i.e. patients' right to decide and choose.

Empathy is practitioner active effort to understand the patient's internal perspective.

Support is seeking and acknowledging the patient's strengths and efforts.

Noticing the clues which are patient's verbal and nonverbal signs of hidden thoughts and emotions.

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

ASK	LISTEN	SUMMARISE	EXCHANGE INFORMATION

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

CHIME

Connectedness

Hope and Optimism

Identity

Meaning and Purpose

Empowerment

How the worker does supports you in these areas?

- how does the worker supports you in feeling supported by other people? (Connectedness (C));
- how does the worker supports you in feeling hopeful about the future? (Hope (H));
- how does the worker supports you in dealing with stigma? (Identity (I));
- how does the worker supports you in understanding your own mental health? (Meaning (M));
- how does the worker supports you in feeling in control? (Empowerment (E)).

EXAMPLES

What I noticed about myself and / or others while doing the exercise:

My observer (if there was one in the exercise) pointed out:

My learning experience

1.4. Supervisor's assessment

We ask you to evaluate the student in free form. Questions to proceed from: (a) his/her relevant theoretical knowledge and how well he/she was able to implement them; (b) what was his/her attitude towards her everyday tasks; and (c) is there any reason why you would like to bring him/her into spotlight.

Supervisor's assessment

Supervisor's stamp and/or signature