

MICHIGAN STATE UNIVERSITY

**Department of Family Medicine
College of Human Medicine**

**FAMILY MEDICINE
CLERKSHIP SYLLABUS
2009-2010**

DEPARTMENT OF FAMILY MEDICINE

Student Syllabus and Administrative Handbook

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Developed by the Department of Family Medicine – 2009

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FAMILY MEDICINE CLERKSHIP
REQUIRED READINGS 2009-2010

Educational Activity	REQUIRED READING (in Essentials of Family Medicine , 5 th edition, unless otherwise noted; note that different activities may require the same readings)
Common Problems 1 (see detail page in syllabus)	<ul style="list-style-type: none"> • Chapters 8, 21, 28, 29, 30, 31, 39, 47, 48
Common Problems 2	<ul style="list-style-type: none"> • Chapters 2, 14, 19, 27, 37, 42, 45, 50 • Adelman A, Daly M. Initial Evaluation of the Patient with Suspected Dementia. <i>Amer Fam Phys</i> 2005;71:1745-1750. http://www.aafp.org/afp/20050501/1745.html Accessed 6.21.2009
Common Problems 3	<ul style="list-style-type: none"> • Chapters 5, 14, 15, 18, 29, 43 • Brigham and Women's Hospital <i>Contraception and Family Planning</i> (Available as PDF on ANGEL. See "Additional Materials")
Common Problems 4	<ul style="list-style-type: none"> • Chapters 11, 26, 35, 36, 44, 49
Common Problems 5	<ul style="list-style-type: none"> • Chapters 9, 10, 18, 22, 33, 34, 35, 36, 51
Dermatology Lecture	<ul style="list-style-type: none"> • Chapters 40, 41
Musculoskeletal Lecture, Workshop	<ul style="list-style-type: none"> • LON-CAPA program (see ANGEL) • Chapters 12, 35, 37, 38, 39 (note that some chapters required for Common Problems are also relevant here)
Suturing, Casting, and Splinting Workshop	<ul style="list-style-type: none"> • Chapter 41
Informed Decision Making Module	<ul style="list-style-type: none"> • Braddock CH, Edwards KA, Hasenberg NM, Laidley TL, and Levinson W. informed decision making in outpatient practice. <i>JAMA</i> 1999;282:2313-2320. (Available as PDF on ANGEL in "Additional Materials") • Screening for Colorectal Cancer in Adults, http://www.ahrq.gov/clinic/uspstf/uspsscolo.htm Accessed 6.21.2009 • Screening for Breast Cancer, http://www.ahrq.gov/clinic/uspstf/uspssbrca.htm Accessed 6.23.2008 • Screening for Prostate Cancer, http://www.ahrq.gov/clinic/uspstf/uspssprca.htm Accessed 6.23.2008 • "PSA screening does not reduce mortality from prostate CA (PLCO study)—summarized in Essential Evidence Plus, Daily Poems, May 2009)—first entry. Available in InfoPOEMS-May-2009 under "Additional Materials" on ANGEL • PSA screening has marginal effect on mortality in European study (ERSPC study)—summarized in Essential Evidence Plus, Daily Poems, May 2009)—second entry. Available in InfoPOEMS-May-2009 under "Additional Materials" on ANGEL
Maternity Care Module	<ul style="list-style-type: none"> • Chapter 4
Smoking Cessation Module	<ul style="list-style-type: none"> • Chapter 46 • A clinical practice guideline for treating tobacco use and dependence. A US Public Health Service Report. <i>JAMA</i>, June 28, 2000; 283(24):3244-3254. (Available as PDF on ANGEL. See "Additional Materials")
Hospice/Palliative Care	<p>"End of Life Care" (Available as PDF on ANGEL. See "Additional Materials")</p> <ul style="list-style-type: none"> • "Management of Cancer Pain" http://www.ahrq.gov/clinic/epcsums/canpainsum.htm Accessed 6.21.2009
Health Disparities/Cultural Competence	<ul style="list-style-type: none"> • PowerPoint through ANGEL

CLERKSHIP OVERVIEW

The specialty of Family Medicine is a discipline focused on the healthcare needs of all people without regard to gender, age, disease, or life-stage. With the unique perspective of this focus we are concerned with contextualizing care and integrating the complex biologic, social, psychological, economic, and cultural needs of people and families. While this approach may take many different forms, our focus has traditionally been on offering comprehensive health care for all.

The Family Medicine Clerkship is a required eight-week clinical clerkship, taken in the third year of the Michigan State University CHM curriculum. It introduces students to the profession of Family Medicine.

This clerkship consists of clinical and didactic sessions. The clinical training is predominantly outpatient, where the vast majority of care in the United States and around the world is generally delivered, and is the only clerkship to offer this perspective. The didactic sessions make extensive use of adult learning techniques and include web-based materials, independent reading, and group discussion. Students must take responsibility for their own training including understanding the clerkship requirements noted in this syllabus. This syllabus supersedes information given by the clerkship director, preceptors, and administrative staff.

OVERALL EDUCATIONAL GOALS

The overall goals of the Family Medicine Clerkship are:

1. To introduce students to the concepts of primary care in the Family Medicine setting, including:
 - a. Access
 - b. Comprehensive longitudinal care
 - c. Coordination of care
 - d. Community oriented practice
 - e. Management of undifferentiated medical problems
2. To enable the student to grasp the interplay between family dynamics, disease, and behavior.
3. To demonstrate the clinical reasoning and knowledge base needed to implement comprehensive care of patients, incorporating evidence-based sources, and reasoning in clinical decision making.
4. To demonstrate through preceptor role modeling that mastery of the field of Family Medicine requires skills in communication, professionalism, time management, and cultural competence.
5. To enable students to develop skills as adult learners and to recognize the need for personal responsibility in maintaining, increasing, and sharing knowledge of current medical practice.

OVERALL EDUCATIONAL OBJECTIVES

Upon completion of the clerkship, students should be able to:

1. Diagnose and understand management principles for the most common problems in Family Medicine, while outlining possible roles of family relationships, stages in the family life cycle, and the community setting.
2. Conduct appropriately focused histories and physical exams on patients in the inpatient and outpatient settings, refining skills learned in the basic Clinical Skills Course of Block II.
3. Develop, prioritize, and justify differential diagnoses for the patients seen.
4. Develop treatment plans that include clinical evaluation, treatment, patient education, and follow-up.
5. Compose appropriate clinical progress notes in the SOAP format for the chart and more complete ambulatory write-ups to demonstrate understanding of the clinical encounter.
6. Implement current evidence-based principles about different aspects of patient care in notes, discussions, and presentations to classmates.
7. Incorporate knowledge of genetics and family dynamics in patient care.

8. Recognize issues that may result in disparities in the delivery of health care, including access, cultural differences in health beliefs, and characteristics of health and disease in different populations.
9. Demonstrate and recognize appropriate professional behavior.
10. Demonstrate mastery of the assigned textbook chapters and other assigned materials such as internet-based cases.
11. Demonstrate competence in the following aspects of Family Medicine:
 - a. Advising patients on contraception alternatives
 - b. Performing musculoskeletal examinations
 - c. Recognizing common dermatologic problems
 - d. Performing common office procedures
 - e. Accessing community agencies and resources in patient care
 - f. Performing prenatal and postnatal assessments, including newborn care, and consideration of the impact of a new child on the family
 - g. Advising patients to quit smoking
 - h. Understanding palliative care and hospice
 - i. Counseling patients on health maintenance and prevention
 - j. Advising patients using the informed decision making model
12. Begin to recognize the value for a physician to know his or her limitations in a given field of knowledge.

OVERVIEW OF INSTRUCTIONAL ACTIVITIES

Clinical Experience

During the course of the clerkship, students should have an opportunity to participate in ambulatory and hospital clinical experiences, a home visit focused on end-of-life care, and underserved population clinics. The time spent on inpatient activities, community activities, end-of-life care, and other clinics differs from community to community, but these differences are not significant in terms of enabling students to meet the clerkship objectives.

Didactic Sessions

Didactic sessions are devoted to clinical topics chosen to exemplify the breadth and depth of Family Medicine knowledge and skills. The types of sessions include:

1. Common Problems in Family Medicine
 - Sore throat
 - Headache
 - Fever
 - Abdominal pain
 - Chest pain
 - Dizziness
 - Respiratory infections
 - Women's health issues (menopause, osteoporosis, breast lump, contraception, first trimester bleeding)
 - Depression
 - Musculoskeletal complaints
 - Genetourinary complaints
 - Dementia
 - Diabetes mellitus
 - Hypertension
 - Dyspnea
 - Asthma
 - Fatigue
 - Geriatric health issues
2. Dermatology
3. Musculoskeletal Exams and Procedures
 - a. Upper and Lower Body Exam Skills
 - b. Suturing, Casting, and Splinting
4. Oral Presentation Sessions
 - a. Student Choice Topics
 - b. Screening and Prevention

5. Special Topic Modules
 - a. Community Resources
 - b. Health Disparities
 - c. Informed Decision Making
 - d. Maternity Care in Family Medicine
 - e. Smoking Cessation Screening and Intervention
 - f. Hospice/Palliative Care
 - g. Patient Safety

DETAILS OF INSTRUCTIONAL ACTIVITIES

A. Clinical Experience

Learning Objectives

During the clinical experience in Family Medicine, students will learn to:

- Refine their skills in conducting appropriate focused histories and physical examinations on patients in the inpatient and outpatient settings.
- Develop prioritized differential diagnosis.
- Develop treatment plans that include clinical evaluation, treatment and patient education, preventive medicine, health maintenance, and follow-up.
- Compose appropriate clinical progress notes in the SOAP format.
- Recognize issues that may result in disparities in the delivery of health care.
- Demonstrate and recognize appropriate professional behavior.
- Begin to recognize the value for a physician to know his or her limitations.
- Utilize the medical team and multi-disciplinary (nursing, social work, other ancillary services) approach to care.

1. Ambulatory Experience

The ambulatory care experience in Family Medicine offers exposure to patients of all ages and medical problems. Students will have the opportunity to observe and participate in the care of patients from birth to end of life, presenting for health problems, as well as health maintenance.

Students are scheduled in the office practices of family physicians and will be **required to**:

- Attend **all** assigned clinical sessions.
- **Document** all patient encounters in E-Value until the minimums in the diagnostic categories have been met. (See “Diagnoses List and Minimum Requirements” on page 26). Note that one patient will often have multiple problems, and you can log them as such. For example, one patient might have dyslipidemia, hypertension, and diabetes. If all three of those problems are addressed in that visit, you can log three different diagnoses.
- While you should strive to see any and all patients you can, you should especially seek out opportunities to work with patients who have problems listed on the minimums list referenced above.
- Seek out opportunities to observe or assist in 15 different procedures and/or musculoskeletal exam skills over the course of the clerkship. A list of these “Procedures and Minimum Requirements” is on page 27. All procedures and examinations are to be done **ONLY** under supervision. Students should not perform any procedure or physical exam on a patient without the direct supervision by a physician responsible for the patient.
- Find patients for the following Special Topic Module experiences:
 - Smoking cessation counseling
 - Informed decision making related to screening
 - Prenatal visit
 - Patient Safety—document **four** total experiences with prescription writing in the ambulatory and/or inpatient settings

2. Inpatient Experiences

Students are generally scheduled for one to two weeks of inpatient experience during the 8-week clerkship and will be required to seek out opportunities for the following experiences:

- Observing a labor and delivery in Family Medicine
- Following up on baby and/or mother
- Attending morning report
- Participating in writing admission orders
- Performing initial history and physical examinations
- Writing daily progress notes
- Observing the interactions of the family physician with consulting specialist for inpatient care and the multidisciplinary process of discharge planning
- Students will be scheduled for **call** one to two evenings during their inpatient experience to experience after hours care of patients including observation of phone management, after-hours admissions, and floor coverage.

3. Chart Notes – Inpatient and Outpatient

IMPORTANT NOTE

Medical student's documentation of the review of systems (ROS) and past medical history, family history, and social history (PFSH) may be used by teaching physicians, however, the teaching physician must review and comment on the information. The teaching physician may not use the chief complaint (CC) or history of the present illness (HPI).

Only the student's notes on ROS and PFSH do not need to be re-documented.

The teaching physician may not use any portion of the medical student's physical examination unless it was performed in the physical presence of a teaching physician. The physician must personally perform the key elements.

Patient Confidentiality: Students will have access to medical records that contain health information pertaining to patients. Health information includes, but is not limited to, the patient's name, address, phone number, diagnosis, treatment, medications, and billing codes. This health information is required by law to be protected. Students must make themselves aware of the responsibilities and abide by the policies and procedures protecting the confidentiality of this information at each assigned clinical site.

All chart notes in the hospital and preceptor(s) office should be legible, including the signature. Students should sign all chart notes. All student notes must be counter-signed by the teaching physician. Clerkship write-ups are not representative of actual write-ups in patient charts. Both the inpatient and ambulatory write-ups will be longer than chart notes because part of their purpose is for the student to demonstrate knowledge of the pertinent parts of the history, physical examination, assessment, and plan. Write-ups should be concisely worded and complete, and may use approved abbreviations as noted in the appendix (available on ANGEL under Lessons-Clerkship Syllabus). Age, gender, and date of the office visit should be included on the front of the write-up. Write-ups should include a problem list that includes chronic, temporary or acute problems, and health maintenance issues, as well as a medication list. The Assessment portion of the write-up should demonstrate critical thinking and integration of elements found on the history, physical examination, and diagnostic tests that support the differential diagnosis. Both the Assessment and Plan portions of the write-up must incorporate age and gender appropriate health maintenance issues.

Learning Objectives

Through completion of these written exercises, students will learn:

- To identify critical elements in the history and physical examination of patients that aid in clinical problem solving and decision making
- To present thorough problem lists for patients with multiple medical concerns
- To identify biopsychosocial issues that are important to the patient visit

- To formulate reasonable management plans, including patient health education, preventive medicine and health maintenance, and follow-up

Required Readings

- Assigned chapters in Essentials of Family Medicine, 5th Edition 2008 plus other assigned readings.

Educational Activities

A. Outpatient Write-Ups

- Students are required to complete two or three ambulatory write-ups (discretion of community clerkship director) on patients seen in the office setting using the SOAP note format (see example in appendices available on ANGEL under Lessons – Clerkship Syllabus). These write-ups should include:
 - Age, Gender
 - Master Problem List
 - Active Problems-Stable
 - Active Problems-Current
 - Health Maintenance
 - Medications
 - Subjective
 - Chief Complaint (reason for this visit now, in the patient's own words)
 - Review of Systems (ROS)
 - PPQRST-any changes in the chronic problem and any new problems
 - Past Medical History (PMH) – habits, behaviors, past medical history or family history which may affect problems
 - Age and Gender-specific health maintenance
 - Psychosocial
 - Objective
 - General Appearance
 - Relevant Vital Signs
 - Focused Physical Exam Related to Problem(s)
 - Assessment
 - Health Maintenance
 - Discussion of Differential of all New Problems and Evidence in Support of Differential
 - Discussion of Reasons for Changes in Problems
 - Discussion of Status of Chronic Problems on Problem List
 - Discussion of How These Different Problems May Interrelate
 - Plans For:
 - Diagnosis
 - Monitoring
 - Therapy
 - Contingency Plans
 - Health Maintenance
 - Patient Education – separated for each problem addressed
 - Discussion of Diagnosis
 - Discussion of Treatment
 - Discussion of Prognosis and Possible Outcomes
 - Discussion of Contingencies if the Diagnosis Changes or if Treatment Doesn't Work
 - Follow-Up

B. Inpatient Write-Ups

- Students are required to complete one inpatient write-up on a patient seen in the hospital (see example in appendices available on ANGEL under Lessons-Clerkship Syllabus). This write-up should include:

- Master Problem List (MPL)
- History
 - Chief Complaint (CC)
 - History of the Present Illness (HPI)
 - Past Medical History (PMH)
 - Health Maintenance (HM)
 - Social History (SH)
 - Family History (FH)
 - Review of Systems (ROS)
- Physical Examination (PE)
- Diagnostic Tests
- Assessment (includes health maintenance)
- Plans
 - Diagnostic Plan
 - Treatment Plan
 - Health Maintenance Plan
 - Patient Education Plan
 - Follow-Up Plan

Evaluation

- Evaluation of one inpatient and two or three outpatient write-ups will be completed by the clerkship director or designee in E-Value (see example of evaluation forms in appendix; available on ANGEL under Lessons – Clerkship Syllabus).
- Write-ups can be emailed to the evaluator or handed in to the community clerkship assistant.
- Performance in the ambulatory setting will be evaluated on the Clinical Performance Evaluation (CPE) form in E-Value (see example available on ANGEL under Lessons – Additional Materials).
- The student is required to maintain an E-Value electronic logbook of patients and problems seen in ambulatory and inpatient settings. The logbook is used to verify that the student has:
 - Met the minimum clinical attendance criteria. Students are required to attend all scheduled clinical sessions throughout the clerkship, even after the minimum is met
 - Observed or assisted in the minimum of 15 different clinical procedures appropriate to Family Medicine
 - Participated in the care of patients with the diagnoses listed under Ambulatory Experiences (minimums met)

B. Didactic Sessions

1. Common Problems

Learning Objectives

During these small group sessions, the student will learn:

- To formulate prioritized differential diagnoses
- To interpret medical and historical data accurately
- To critically assess the likelihood of diagnoses based on available data
- To evaluate the appropriateness and economic feasibility of diagnostic tests (e.g. medical imaging) and treatments
- To formulate assessments and plans integrating biopsychosocial, cultural, and family and genetic information
- To develop an approach to the undifferentiated medical problem
- To recognize the role of an individual office visit in the continuum of care
- To obtain appropriate history, physical findings, and diagnostic tests for many common problems in Family Medicine

Educational Activities and Required Readings

- Students are expected to attend and prepare for these sessions by reading the clerkship text chapters listed below

Common Problem Session # 1	
Problem	Essentials Text and Other Required Readings
Sore throat	Chapters 8, 21
Menopause/osteoporosis	Chapters 29, 30
Depression	Chapters 47, 48
Hematuria	Chapters 28, 31
Shoulder pain	Chapter 39
Common Problem Session # 2	
Headache	Chapter 45
Ear pain	Chapters 2, 14, 19
Low back pain	Chapter 37
Dementia/delirium	Chapter 42, Adelman A, Daly M. Initial Evaluation of the Patient with Suspected Dementia. <i>Amer Fam Phys</i> 2005; 71: 1745-1750. http://www.aafp.org/afp/20050501/1745.html Accessed 6.21.2009
Preconception/respiratory infection	Chapters 27, 50
Common Problem Session # 3	
Fever in children	Chapters 5, 14
Vaginal bleeding	Chapter 29, Contraception and Family Planning (Brigham) Available on ANGEL
Dizziness	Chapter 43
Diabetes (2)	Chapters 15, 18
Common Problem Session # 4	
Hypertension	Chapter 11
Breast lump	Chapter 26
Asthma	Chapter 49
Fatigue	Chapter 44
Ankle/foot pain	Chapters 35, 36
Common Problem Session # 5	
Chest Pain	Chapter 9
Dyspnea	Chapters 10, 51
Knee pain	Chapters 18, 35, 36
Vaginitis	Chapters 33, 34
STI	Chapters 22, 33

Evaluation

- Student attendance and participation in these small group sessions is required. Material covered during these sessions will be evaluated during the oral examination and final clerkship multiple-choice examination.

2. Dermatology Problems

Learning Objectives

During this session, the student will learn:

- To describe skin lesions accurately and appropriately, using basic dermatological terminology
- To identify common dermatological conditions, based on history, physical examination, and diagnostic test findings
- To describe basic treatment for common skin conditions such as eczema, psoriasis, and tinea
- To describe the evaluation and treatment, including patient education, of adolescent acne

Required Readings

- Chapter 40 and 41 in Essentials of Family Medicine, 5th Edition 2008

Additional Reading

- Web sites:
 - <http://www.pediatrics.wisc.edu/education/derm/tutorials.html>
Accessed 6.21.2009
 - <http://www.logicalimages.com/morphology/morphology3content.html>
Accessed 6.21.2009

Dermatology Educational Activities

A clerkship faculty member reviews basic dermatology terminology, using the collection of slides on dermatological conditions that may be seen in Family Medicine and as listed below:

- Papulosquamous Dermatoses
- Tinea Varieties
- Warts
- Skin Infections
- Bioterrorism
- Conditions involving blood vessels
- Wheals
- Scars
- Neoplasms
- Acne

Evaluation

- Competence in the objectives will be evaluated on the oral examination and on the final clerkship multiple-choice examination.

3. Musculoskeletal Examination Skills and Procedures

Learning Objectives

During lecture sessions, workshops, web exercises and clinical experiences, the student will learn:

- Common injuries related to sports and exercise
- Important parts of the patient history related to joint pain and injury
- Specific components of the physical examination of the foot and ankle, knee, hip, spine, wrist, elbow, and shoulder
- Office-based approaches to the diagnosis of common musculoskeletal problems
- Appropriate medical imaging techniques to assess injury, including evidence-based decision rules on medical imaging
- Clinical interventions used in the management of common musculoskeletal problems, including systems-based care principles
- An approach to suturing, splinting, and castings in acute injuries

Required Readings

- Musculoskeletal lecture and workshop: Chapters 12, 35, 37, 38, 39 & the LON-CAPA Musculoskeletal Program on ANGEL
- Suturing, Casting, and Splinting Workshop: Chapter 41

Additional Readings

Essentials of Musculoskeletal Care, 2nd edition, Ed. Walter B. Green, M.D.

Educational Activities

A. Musculoskeletal Lecture

A Family Medicine faculty member will lead a lecture/interactive discussion covering the objectives for this part of the clerkship. The lecture will cover common injuries and mechanisms of injury, appropriate elements in the patient history, and the physical examination of the spine and joints. Lecturers may also discuss medical imaging findings. The lectures will cover initial management and prevention of sports-related injuries. In some communities, an on-line lecture may be substituted.

B. Musculoskeletal Workshops

Examination technique will be reinforced through workshops on both the upper body and lower body musculoskeletal examinations.

C. Suturing, Casting, and Splinting Workshop

A faculty member instructs the students in the relevant procedures and techniques. Students are provided an opportunity to practice on models or on each other. Upon completion of the Family Medicine Clerkship, students will have experience in:

1. Repairing a laceration
2. Applying a cast
3. Splinting an injured extremity

Evaluation

- Students must seek out opportunities for procedural and musculoskeletal examinations during the clerkship, document them in E-Value, and have them verified by a supervising physician. By the end of the clerkship, students are expected to have observed or assisted in at least 15 **different** procedures and/or musculoskeletal exam skills.
- Competence in the objectives for the musculoskeletal portion of this unit will be evaluated by the oral examination and the final clerkship multiple-choice examination.

4. Student Choice Oral Presentation

Learning Objectives

Through performance of this exercise the student will:

- Learn and practice presentation skills
- Incorporate current literature into summarizing assessments and plans for patients encountered during the Family Medicine Clerkship
- Consider how cultural differences and health disparities may impact the delivery of preventive and treatment of health care services

Educational Activities

- Students will be required to complete an oral presentation on a topic of their choice with an evidence-based focus. This presentation will consist of two parts – a long version and a short version (see presentation format below). The student may choose any common problem in Family Medicine and should avoid “zebras”. The topics selected should be ones that are of interest to the student presenter and should be based on a case seen during the Family Medicine Clerkship. Common problems with an interesting twist or problems which the student’s preceptor does not have a clear answer make ideal cases. Examples would include a family with multiple cases of strep pharyngitis or a patient not responding to treatment for hypertension, diabetes, or dyspepsia.

Presentation Format

Each student is allotted 30 minutes for the case presentation(s) and discussion. The student presents a case for the first 5 minutes, presents information from the literature for 10 to 15 minutes, and returns to discussion of the case and a question and answer period for 5 to 10 minutes. Following this there will be a 2 minute mini presentation of the case.

The long case presentation should be presented in classical format for physicians' group discussion of patients who present challenging diagnostic and therapeutic problems. The usual format includes a brief presentation of findings related to the patient, a discussion of problematic aspects of the particular case with reference to the medical literature (**use at least 3 current, evidence-based sources***), and finally an explanation of what actually happened to the patient in question.

The presenter should be prepared to answer questions about the topic from the group. Presentation software should be utilized by the student presenter and handouts should be provided to all participants. Particulars for the long presentation include:

The Case: Give patient description (age, gender, and race – if relevant), chief complaint, and history of the present illness, followed by relevant past medical history, health maintenance, social history, family history, review of systems, physical examination findings, and diagnostic test results. Other than the history of the present illness, which should be presented in detail, the other categories may range from very brief to non-existent, but should be covered if pertinent.

The Discussion: The discussion should be either a general overview of the problem the patient presents, or a focused discussion of a particular aspect of the case. Examples of general overviews are discussions of the diagnosis of abdominal pain or of the diagnosis and treatment of asthma. Examples of focused discussions are drug treatment of asthma, use of imaging studies in the diagnosis of abdominal pain, and antibiotic treatment of acute bronchitis. Controversies related to the problem in the medical literature should be described.

Patient Disposition: The presenter should describe what happened to the patient – what diagnoses were entertained, nature of the treatment, what other tests were ordered and the plans for follow-up. The results of the literature search should be related to this particular patient.

The best student case presentations avoid simple reading of slides to the audience. Please try to avoid creating slides that have too much information, or information that is too small to read.

The short case presentation should be presented in a concise fashion consistent with how physicians might communicate to each other during a patient consultation.

*Evidence-based resources: Please check these resources for EBM material relevant to your topic and cite as needed:

1. Cochrane Database of Systematic Reviews: <http://www.cochrane.org/> Accessed 6.21.2009
2. US Preventative Services Task Force: <http://www.ahrq.gov/clinic/USpstfix.htm> Accessed 6.21.2009
3. Turning Research into Practice (TRIP): <http://www.tripdatabase.com/index.html> Accessed 6.21.2009
4. PubMed Clinical Queries: <http://www.ncbi.nlm.nih.gov/corehtml/query/static/clinical.shtml> Accessed 6.21.2009

Evaluation

- Evaluations of the oral presentation will be completed by the clerkship director or designee in E-Value.

5. Screening and Prevention Oral Presentation

Learning Objectives

Through performance of this exercise, the student will learn:

- The nature of current controversies in screening and prevention

- How to construct an appropriate strategy for screening and prevention of a common problem in primary care
- To discuss potential barriers to the intervention that may occur in different subsets of the population (e.g. does a lack of insurance require that the patient receive care at the health department and not the primary physician's office?)
- The essential elements to be considered in determining an effective screening test

Educational Activities

Prior to this session, the Community Clerkship Director will assign each student one of the topics noted below:

- | | |
|---|--|
| <ul style="list-style-type: none"> ▪ Breast Cancer ▪ Cervical Cancer ▪ Lung Cancer ▪ Alcohol Abuse ▪ Ovarian Cancer ▪ Colorectal Cancer ▪ Depression | <ul style="list-style-type: none"> ▪ Postmenopausal Osteoporosis ▪ Family Violence ▪ High Blood Cholesterol and Other Lipid Abnormalities ▪ Other, as approved by Community Clerkship Director |
|---|--|
- Students are required to complete one screening and prevention presentation.
 - In preparation for this presentation, the student should:
 1. Consider the essentials elements for effective screening tests.
 - Disease must be of a certain level of prevalence in the population.
 - Finding the disease early must result in prevention of morbidity and/or mortality.
 - Screening test must be relatively sensitive, specific (accurate), and reliable.
 - Reasonable cost.
 - Low morbidity/risk to screening.
 - Absence of lead-time and length bias.
 2. Review at least three sources of current recommendations for screening and prevention related to their topic from the National Guidelines Clearing House web site at <http://www.guideline.gov/>. Accessed 6.21.2009
 3. Critically analyze the research evidence, upon which these recommendations were made, and assess whether or not the recommendations have a logical basis.
 4. Discuss characteristics of any disparities that occur with this screening and prevention intervention, such as percentages of minorities who receive the intervention, differences in prevalence of disease in various minority groups, and potential barriers to the intervention that may disproportionately affect minorities or patients of lower socioeconomic classes.
 5. Collect and analyze patient education materials pertinent to the problem, such as lay press articles or brochures handed out to patients.
 6. Develop a recommended protocol for screening and prevention for the problem.
 7. Assess the practicality, accessibility to patients, ease of implementation and cost-effectiveness of the recommended protocol.
 8. Assess the effect that the recommended protocol might have on routine patient care.

Evaluation

- Evaluation of this presentation will be completed by the clerkship director or designee in E-Value.

6. Special Topic Modules

A. Community Resources

Learning Objectives

In completing this module, the student will:

- Gain an understanding of how community based resources can be used to facilitate health care of patients and their families.

Educational Activities

This experience will be arranged in cooperation with the Community Clerkship Director and may include visits to community agencies or clinics, such as senior neighbors, family planning, etc. Students may be asked to present on their community agency visit.

Evaluation

- Student completion of the expectations outlined by the Community Clerkship Director is satisfactory evidence of completion of this module.

B. Health Disparities Exercise

Learning Objectives

In completing this module, the student will:

- Be able to recognize issues that may result in disparities in the delivery of health care, including access, cultural differences in health beliefs and characteristics of health and disease in different populations.

Educational Activities

- During the clerkship, students are expected to review a web-based presentation on Health Disparities and Cultural Competence. This may be found on ANGEL.

Evaluation

- The exercise listed above is to be performed independently, and some questions on the final multiple-choice exam will relate to the material.

C. Informed Decision Making

Learning Objectives

In completing this module, the student will learn:

- The basic tenets of informed decision making, including:
 - Role of patient
 - Issue to be discussed
 - Preference of the patient
 - Uncertainties of the proposed intervention
 - Understanding by the patient

Required Readings

- Braddock, CH, Edwards, KA, Hasenberg, NM, Laidley, TL, and Levinson, W. "Informed Decision Making in Outpatient Practice", JAMA. 1999; 282:2313-2320. (Available as a PDF on ANGEL.
- "Screening for Colorectal Cancer in Adults," <http://www.ahrq.gov/CLINIC/uspstf/uspscolo.htm> Accessed 6.21.2009
- "Screening for Breast Cancer," <http://www.ahrq.gov/CLINIC/uspstf/uspsbrca.htm> Accessed on 6-21-09
- "Screening for Prostate Cancer," <http://www.ahrq.gov/CLINIC/uspstf/uspsprca.htm> Accessed 6.21.2009
- "PSA screening does not reduce mortality from prostate CA (PLCO study)—summarized in Essential Evidence Plus, Daily Poems, May 2009)—first entry. See ANGEL Additional Materials, InfoPOEMS.
- PSA screening has marginal effect on mortality in European study (ERSPC study)—summarized in Essential Evidence Plus, Daily Poems, May 2009)—second entry. See ANGEL Additional Materials, InfoPOEMS.

Educational Activities

Introductory Lecture

A faculty member will introduce the material covered in this module using a powerpoint presentation and an online group activity that includes video clips from a health care communication website. The following mnemonic will be introduced in the presentation as a way to focus the “Elements of Informed Decision Making.” **RIP-UU**

- **Role**—Emphasize to the patient his or her **Role** in the decision
- **Issue**—What is the **Issue** (e.g. screening for colon cancer has been shown to decrease mortality from colon cancer)?
 - √ **Alternatives** – It is important to understand the tests to be done in order to explain them to the patient. One should also discuss alternatives to the proposed intervention. Is this intervention controversial (i.e. is it heavily supported by the evidence, or is it purely consensus, or is this something that the physician feels strongly about?). This should be made clear.
 - √ **Pros and Cons** – What are the pros and cons of screening and not screening? Does this screening test fulfill the essential criteria of a good screening test (see Screening and Prevention Case Presentation)?
- **Preference**—What is the patient’s **Preference** regarding the intervention?
- **Uncertainties**—**Uncertainties** should be discussed openly.
- **Understanding**—Make sure the patient **Understands** the issue and his or her role in the decision.

Web based on-line shared decision making exercise regarding prostate cancer screening

- You will need to complete a web-based prostate cancer screening case. The case can be found on ANGEL under “Prostate Cancer Case and Quiz”. You will need to have completed the Shared Decision making didactic session with required readings for that session plus the additional readings in the “Prostate Cancer Case and Quiz” prior to performing this on-line exercise. Most students report that this exercise takes approximately two hours to complete. **Please make sure to complete this case using a high speed internet connection, no later than the 4th week of the clerkship.**

Office Practice

- Each student will **need to find a patient** to practice share decision-making techniques on one of the following topics:
 - Contraceptive Counseling
 - Screening for Osteoporosis
 - Use of Antibiotics
 - New Medications to Treat Chronic Illnesses
 - Screening for Colorectal Cancer

You will need to log this activity onto E-value upon completion and will need to complete this prior to the PBA listed below.

PBA – Performance Based Assessment

- Each student will be required to complete a performance based assessment (PBA) with a simulated patient to evaluate skills learned in this module. For most communities this will be done at the time of the oral exam but for others it may be independent from this. You will need to complete the above web-based case and office practice patient informed decision making exercise before the PBA.

Evaluation

- The student will record his/her in-office practice with the informed decision making model in E-Value as noted previously

- The preceptor's verification in E-Value is satisfactory evidence of completion of this component of the informed decision making module.
- The student is required to complete the online prostate screening case. Feedback will be given to you regarding this.
- A performance based assessment (PBA) with a simulated patient is a part of the clerkship oral exam experience done generally week 6 or 7 of the clerkship. It will evaluate the student's ability to rationalize and use an informed decision making model in a patient encounter.
- Questions on the final multiple-choice examination may also address elements of informed decision making.

D. Maternity Care Module

Learning Objectives

During this module, the student will learn:

- To identify potential risks that may need to be managed in a patient contemplating pregnancy, or a patient presenting for prenatal care
- To counsel patients on optimizing the chances of becoming pregnant
- To perform the initial history and physical examination on a patient presenting for prenatal care
- To list and explain the laboratory tests obtained on an initial prenatal visit.
- To describe and perform the interval history and physical examinations appropriate for interval prenatal visits according to trimester
- To state the timing for other prenatal interventions such as ultrasound to predict dates, AFP/Quad testing (or other), prenatal classes, glucose screening, rH testing, and group B strep screening.
- List common problems that occur during pregnancy and the essential elements of management
 - Morning sickness
 - GERD
 - First trimester bleeding
- Identify ways in which the family can be included in the maternity experience
- Discuss delivery expectations, common procedures during delivery, and cultural aspects of delivery

Required Reading

- Chapter 4 in Essentials of Family Medicine, 5th ed., 2008

Education Activities

A Family Medicine faculty member will provide a powerpoint presentation covering four major points in maternity care:

- Initial risk assessment
- Routing prenatal care
- Delivery and postnatal care
- Family considerations

The presentation contains information relevant to the objectives of the module. There are video clips involving the prenatal history and specific parts of the physical examination such as measuring the fundal height, Leopold's maneuvers, and Doppler identification of fetal heart tones.

Additionally, this session provides three practice exercises:

- Using an OB wheel to determine estimated gestational age (EGA) and estimated date of delivery
- Role-playing the history taking at a first prenatal visit, with use of the American College of Obstetrics and Gynecology (ACOG) prenatal form
- Role-playing a prenatal visit, including history and describing essential parts of the physical examination, again using the ACOG checklist

- Students should attempt to identify, with the preceptor or Community Clerkship Director, a pregnant patient for a prenatal visit. The student does a prenatal interview to collect appropriate history, review of systems, and patient profile.
- Students should also attempt to observe a delivery, preferably by a faculty, community, or resident family physician. The student should make a postpartum visit to the mother and baby, again taking appropriate history. Ideally, the patient who delivers is from the practice of one of the student's preceptors, and there will be opportunities for discussion of the delivery and post-partum course.

Evaluation

- The medical knowledge and patient care components of the module may be evaluated by the oral examination and/or the clerkship final multiple-choice examination.
- The prenatal visit, labor and delivery observation, and postpartum visit should be recorded in E-Value, along with verification by the supervision physician.

E. Smoking Cessation Module

Learning Objectives

In completing this module, the student will learn how to:

- Use the Fagerstrom Test for nicotine dependence (see appendices available on ANGEL – under lessons – Clerkship Syllabus)
- Use an evidence-based model from the U.S. Public Health Service Clinical Practice Guidelines for Tobacco Use and Dependence to help patients to be tobacco-free (see appendices available on ANGEL – under Lessons – Clerkship Syllabus)
- Adjust interventions in response to indications of patient motivation
- Adjust pharmacotherapy intervention to patient circumstances
- Translate diagnostic and therapeutic approaches that are appropriate for nicotine addiction to other addictions

Required Reading

- Chapter 46 in Essentials of Family Medicine, 5th ed, 2008
- A clinical practice guideline for treating tobacco use and dependence. A US Public Health Service Report. JAMA, June 28, 2000; 283(24):3244-3254. (Available as a PDF on ANGEL. See "Additional Materials")

Additional Reading

1. Block II Review Articles
2. See "Smoking Cessation – Additional Materials" in ANGEL

Educational Activities

Introductory Lecture

A faculty member will introduce the material covered in this module with a brief lecture describing the following:

- Physiological basis for addiction
- Epidemiology of nicotine addiction
- Key points of nicotine dependence
- Clinical Practice Guideline for Tobacco Use and Dependence
- How to adjust advice to patient's willingness to quit (chapter 46 in Essentials of Family Medicine, 5th ed. 2008)

Cases are presented on patients who have relapsed to smoking. Instructor role-plays responses to the cases, showing how the appropriate response can be adjusted for different smokers (i.e. heavy addiction,

pre-contemplators, contemplators, and action takers). The instructor's responses will be grounded in the Treating Tobacco Use and Dependence guideline.

Case #1

A 20 year-old male MSU student smokes two-three packs per day. He tried to quit smoking four months ago with your advice and prescription for 15 mg nicotine patch. He has a history of depression requiring Prozac. When he tried to quit he was smoking only ten cigarettes per day. He is now smoking 30-40 cigarettes per day. You are seeing him for acute bronchitis. What other smoking-related history is important that was not detected during your previous visits? How do you initiate another attempt to quit smoking?

Case #2

A 30 year-old female patient quit smoking for five days, six months ago, when you advised her to do so and to use nicotine gum 2 mg. at ten sticks per day. She now smokes at least one pack per day. She remains interested in quitting but can't give up several key cigarettes in the day when she attempts to cut down. She is here for symptoms of acute bronchitis, with a past history of asthma requiring inhalers. How do you advise her now?

Clinical Experience

- Students will counsel a patient in the ambulatory setting using the Clinical Practice Guideline for Tobacco Use and Dependence.
- The student records his/her counseling experience with a patient from the ambulatory setting in E-Value.

Evaluation

- The preceptor's verification in E-Value of the above activity is satisfactory evidence that the patient interaction for smoking cessation occurred.
- The Performance-Based Assessment (PBA) component of the final examination will also include counseling a patient regarding smoking cessation skills gained in this module.

F. Hospice/Palliative Care Module

Learning Objectives

- Students will be able to describe the role of Hospice in the care of patients.
- Students will learn about the various venues where Hospice care is provided.
- Students should be able to state the Medicare Hospice benefit.
- Students should understand the role of the physician in the Hospice team.
- Students will understand how cultural and ethnic background may influence patient and family attitudes about pain management and end-of-life care.
- Students will discuss how poor access to care or lack of insurance may impact end-of-life care.
- Students will list appropriate agencies available in their clerkship communities for providing Hospice care and other services for the terminally ill.

Required Readings

- "End-of-Life Care" available on ANGEL under "Additional Materials"
- Management of Cancer Pain at <http://www.ahrq.gov/clinic/epcsums/canpainsum.htm>
Accessed 6.21.2009

Educational Activities

- During this clerkship, students are expected to review a web-based PowerPoint presentation on Hospice and Palliative Care. This may be found on ANGEL.
- The students will do one of the following:

- Attend an interdisciplinary team meeting in a Medicare-certified hospice program in the community
- Round with a hospice/palliative care expert
- Accompany a palliative care nurse on a home visit
- Accompany a palliative care nurse to a hospice facility to see a new or established hospice patient
- E-Value documentation of the student experience with the hospice/palliative care specialist, team, or nurse is required.

Evaluation

- Material covered in this module will be tested on the final multiple-choice examination.

G. Patient Safety Module

In this module students will learn a systematic approach to writing prescriptions and understand appropriate responses when medication (and other) errors are identified in medical practice.

Learning Objectives

- Students will be able to describe all the elements of a quality medication order or prescription
- Students will be able to write a prescription that contains all the required prescription elements following a checklist for prescription writing
- Students will become familiar with look-alike, sound-alike (LASA) medications used in inpatient and outpatient practice
- Students will become familiar with the official “Do Not Use” list of medical abbreviations
- Students will learn how errors occur, how they can be identified and how they can be prevented
- Students will learn how error is identified, natural responses to error and disclosure
- Students will learn elements of apology in medical practice
- Students will learn about root cause analysis and failure modes analysis as systematic approaches to evaluating error and preventing error

Required Readings

- For this module there are no required readings
- Students are required to load their hand-held devices with Epocrates Rx prior to the start of this clerkship. The “Rx” version of Epocrates is free to download. When prompted, students should also load formularies appropriate to their communities but at the least should load:
 - BCBS of MI/Blue Care Network
 - Michigan Medicaid Drug List

Educational Activities

- During this clerkship students will participate in an introductory interactive session which will introduce them to the concepts of patient safety, safe prescription writing and how to avoid and address medical errors.
- Students will use job aides (laminated cards) given them during the introduction session, find at least four patients for whom a new prescription is written or a change in medication has occurred and using their aides should either write or review the prescription. They should then log a total of four of these experiences into E-value.

Evaluation

- There will be a pretest given at the beginning of the clerkship and a post test at the end of the clerkship. These will be graded and feedback on prescription writing will be given but these grades are formative only and not part of the clerkship grade.
- Students will need to complete and log four patient prescription writing events as indicated in educational activities above.

Examinations

Clerkship examinations are based on all of the clerkship materials presented in small group sessions and on required readings. They reflect the clerkship objectives. All of the clerkship exams are to be taken “closed book”.

With the exception of the Upper Peninsula students, the oral and PBA exams are done during the clerkship oral exam day, generally week six or seven of the clerkship, and the multiple choice exam is done at the end of the clerkship.

Oral Examination Information

The clerkship oral exam will be given in East Lansing (except for UP students). It is 25 minutes in length and consists of two cases, each worth up to 50 points with a total score of 100 points possible. The exam is designed to test a student’s ability to obtain a pertinent history and physical, create an appropriate differential diagnosis, and develop an initial plan based on this information. (details below)

Performance Based Assessment (PBA) Information

The PBA is a 20 minute exam with a standardized patient that is given during the sixth or seventh week of the clerkship (most campuses) and administered in East Lansing (most campuses). It is designed to test a student’s ability to engage a patient in informed decision making regarding screening/prevention and smoking cessation. Scoring is done via review of the video and the prioritized problem list created by the student.

DETAILED ORAL AND PBA EXAM INSTRUCTIONS FOR STUDENTS

Prior to the exams you will have 20 minutes total to review materials for the PBA (standardized patient) and oral exams. As you prepare for these exams you will want to take notes on the cases as well as write out problem lists for the PBA (see PBA instructions). You are not allowed to use any books, notes, electronic resources, or other reference materials.

Oral Exam Instructions

You will need to complete two cases in 25 minutes. At the designated time, you should enter the room and proceed to solicit the history, physical exam information you feel you need and follow this by giving a differential diagnosis and initial management strategies. Be sure to keep a few minutes for a remaining question. You will have 12 minutes for the first case. At the end of these 12 minutes you will hear overhead instructions to switch rooms where you will complete the second case. There will be a clock in each room. When the 25 minutes is up, the exam is concluded. It is your responsibility to keep track of the time.

You can assume that the PMH, FH, SH, Habits, and Health Maintenance information for each case is as printed on your review materials except that the patient may have added medication related to the chief complaint. See oral exam PowerPoint & mock oral exam for further details.

PBA Exam Instructions

Review both sides of the PBA sheet. You will need to complete a prioritized problem list on the back of the PBA case information sheet prior to meeting the standardized patient. All materials will be handed in to the standardized patient at the end of the exam. At the designated time, you may enter the room and introduce yourself to the patient. You will have 20 minutes with a five minute warning. You are responsible for watching the clock in the room.

With the standardized patient you may briefly discuss your findings so far. You will then need to address two issues with the patient, using the appropriate informed decision making model. There will be two scenarios used for the PBA. Some students will have one scenario, and some will have the other. One scenario involves a screening intervention where the decision of when and how to screen is very clear,

based on medical consensus (RIP Model), followed by the smoking cessation intervention using the 5A's. The other scenario will be a Smoking Cessation Intervention using the 5R's, followed by a screening intervention that involves the RIPUU model. These concepts will have been covered in the clerkship readings and presentations. In the interview with the patient, if you perceive that the patient is not interested in the proposed intervention (e.g. smoking cessation) you should respond appropriately and then move down your priority list.

Once the overhead speaker signals the end of 20 minutes, you may finish your sentence and the interview is complete. If you finish the interview early, you are free to excuse yourself from the patient, but may not return to the room to finish any part of the interview. You must turn in your notes and the case sheet to the simulated patient.

The standardized patient will complete a checklist and their comments may or may not be reflected in your final grade on this exercise, depending on faculty review of the video.

**Please refer to the appendices on ANGEL for detailed grading criteria of the PBA.

REMINDER: YOU MAY NOT DISCUSS THE ORAL EXAM OR PBA EXAM WITH ANY OTHER STUDENT. Furthermore, the Block III Handbook states: “systematically memorizing questions from secured exams and collating them for future study” and “removing or acquiring an examination during preparation, typing, duplication, storage, or after administration...” constitutes academic dishonesty. The College of Human Medicine considers any breach of professional behavior or academic honesty a serious issue and a potential cause for failure of this clerkship or dismissal from the college. Please help us to maintain the integrity of these exams.

Multiple-Choice Examination

The multiple-choice examination consists of 100 multiple choice questions (worth one point each), is administered at the end of the clerkship, and is two hours in length. It is administered in the clerkship community campus.

- It is **strongly recommended** that students review the student study questions provided with the Essentials of Family Medicine 5th Edition, 2008 text (available online after entering code inside front cover of textbook) prior to the multiple choice exam. These questions are also available on ANGEL in the Additional Materials folder. **THESE QUESTIONS AND THEIR ACCOMPANYING ANSWERS ARE FOR PERSONAL USE ONLY. DO NOT COPY, DISTRIBUTE OR DISSEMINATE THESE QUESTIONS IN ANY WAY.**

Additional Student Responsibilities & Information

Required Text

Students are expected to obtain the following required textbook for this clerkship as listed below:

- Phillip D. Sloane, Lisa M. Slatt, Louis B. Jacques and Mindy A. Smith, eds: Essentials of Family Medicine, 5th Edition, Lippincott Williams and Wilkins, Baltimore 2008.

Other additional recommended readings are cited throughout the syllabus for each educational activity and in the interactive web-based materials.

Professional Behavior

- Students are expected to demonstrate appropriate professional behavior in all clinical and academic settings. This includes appropriate dress, punctuality, respect, courtesy, and helpfulness toward all patients, preceptors, teaching staff, and classmates; responsibility for knowledge of the content of the clerkship syllabus, schedules, verbal instructions, clerkship memorandum, and timely completion of all components of the clerkship. Students are also expected to adhere to the Student Oath taken at matriculation into the College of Human Medicine and to the Principles of Professional Behavior in the Block III Handbook.

Attendance

- Students should be available by pager during the clerkship. Attendance at all scheduled activities during the clerkship is mandatory, including orientation. Should any other activity(s) be added during the clerkship, students will be notified by the Community Clerkship Director. Additional details specified in the Block III Handbook.

Absences

- If a student is unable to attend any activity of the clerkship due to extenuating circumstances, the student is responsible for obtaining the "Excused Absence Form" from the Community Clerkship Director's office. This form must be signed by all parties noted on the form before the planned absence occurs in order for the absence to be considered "excused." If permission is granted, the student is responsible for notifying his/her preceptor(s). It is expected that all absences, excused and unexcused, during the clerkship will be made up. Absences of more than five days may result in the student repeating the clerkship. This includes excused and unexcused absences. In all cases, except for emergencies and sudden illness, requests for scheduled absences are to be submitted at least 30 days prior to the date(s) of absence whenever possible. Additional details specified in the Block III Handbook.

Unexcused Absences

- Any unexcused absences will be considered unprofessional behavior and will be noted as such by the clerkship director on the student's CPE form and in the clerkship final performance letter.

Step 2 Policy

- Students will not be excused from required clerkships to take either of the Step 2 exams. Any student who takes time off a required clerkship to sit for either part of the Step 2 exam will receive an N grade for the clerkship and need to repeat the clerkship.

CHM Clinical Student Work Hours Policy

- Clinical student work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Students must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour period provided after in-house call lasting 24 or more hours.

Clerkship Challenges & Grievances

Challenging a PBA grade

- If a student wishes to challenge a grade on the PBA, the challenge must be submitted via email or in writing to the MSU Family Medicine Department, within two weeks of release of the grade to the student through E-Value. As part of the challenge, the student must state the specific part(s) of the PBA where he/she believes the scoring is inaccurate. In the case of a second review of a PBA video, which is part of the review process of any challenge, the grade assigned by the second examiner will stand as the final PBA grade.

Challenging an oral exam grade

- Students have the right to challenge their oral exam grade. If you wish to have your oral exam regarded, this challenge must be submitted via email or in writing to the MSU Family Medicine Lead Clerkship Director within two weeks of the release of the grade thru E-Value. Your final grade on the oral exam will be that determined by the regrading.

Grievances

- Students have the right to grieve elements of their clerkship final grade if they feel that there are significant errors or misstatements that need rectification. The process for doing so is detailed in the Block III Handbook under "Procedure for Grieving a Clerkship Grade". There is absolutely no guarantee that any element of your clerkship grade will be changed unless there is a significant compelling reason to do so. While the above should be your primary source for information, additional information can be obtained from the "Medical Student Rights and Responsibilities" and "Academic Review, Grievances & Complaints" sections at the MSU link: http://humanmedicine.msu.edu/current_students/ Accessed 5.07.2009.

Required Activities and Evaluations

At the end of each clerkship, student performance is reviewed by the CHM overall Clerkship Director of the Family Medicine Clerkship and the Clerkship Director in your assigned community campus. Students receiving a passing grade and/or a designation of honors must satisfactorily complete all of the clerkship requirements, (previously reviewed and summarized below) and complete the assigned clerkship evaluation which are also discussed below.

EVALUATIONS (see Appendices available on ANGEL under Lessons – Clerkship Syllabus)

- Clinical Performance Evaluation (CPE) by preceptors
 - Data Collection and Assessment
 - Professional Behavior
- Screening and Prevention Oral Case Presentation
- Student Choice Oral Case Presentation
- Inpatient Write-Up 1
- Ambulatory Write-Ups 2-3
- Final Oral Examination
- Final Multiple Choice Examination
- Final Performance Based Assessment
- Community Clerkship Director's Mid-Clerkship Evaluation
- Community Clerkship Director's Professional Behavior and Final Recommendation
- Student Assessment of Clerkship Preceptor
- Student Assessment of Clerkship Program

ACTIVITIES

- Clinical Experiences
- Didactic Sessions
- Special Topic Modules
- E-Value Logbook Documentation

WEB-BASED EVALUATION SYSTEM (E-VALUE)

During your clerkship you will be using a web-based evaluation system call E-Value. You will use this web-based system to:

- Check evaluations of your performance
- Complete end-of-clerkship evaluations
- Complete evaluation of your preceptor and lecturers
- Track patient encounters in the PxDx log system via a PDA or web-based interface
- Check your progress in meeting log requirements

E-Value Patient Encounter Log (PxDx Log System)

The patient log is part of the E-Value web-based evaluation system and will be used during your Family Medicine, OB/GYN, Pediatrics, Psychiatry, Junior Surgery, and Senior Surgery Clerkships. Patient encounters can be logged using either a PDA or a computer with a web interface.

All minimum requirements for diagnoses and procedures must be logged via your PDA or a computer with a web interface and **verified** by a supervising physician by the end of the clerkship. There are two ways in which verification can be obtained when using the PDA: (1) you can either save the patient encounter and an email will be sent to the supervisor, or (2) you can ask the supervising physician to verify by using the signature feature on the PDA. **WE STRONGLY ADVISE YOU TO HAVE YOUR PRECEPTOR VERIFY BY SIGNING YOUR PDA.** If you enter the patient encounters via the web, an email notification will be generated once the encounter is saved. It is to your advantage to enter patient encounters as soon as possible. This way the supervisor will remember your involvement and there will be less likelihood of a challenge occurring. You will only get credit for what is documented in E-Value.

In all clerkships you should synchronize your PDA-logged patient encounters at the end of each day. If for any reason you are unable to enter your patient encounters via your PDA and synchronize them regularly, you MUST enter the patient encounters via the E*Value web interface. Patient encounters entered via the web interface must be entered at the end of each week. Students will have until midnight on Friday of each week to make entries for patients seen during that week. Instructions are provided in the E*Value Information for Block III Students handbook.

Be sure to keep your PDA charged.

Mid-Clerkship Progress Check

During the fourth or fifth week of your clerkship, the clerkship director will meet with you individually to review your progress in meeting the minimum requirements for diagnoses and procedures and will complete a mid-clerkship formative evaluation in E-Value.

Viewing Your Log Progress

You can check your own progress in meeting the minimum log requirements on either your PDA or via the web interface. A complete list of minimum log requirements, as well as any other specific logging requirements is provided on pages 28 & 29.

Viewing Your Performance

You can check your performance on the clerkship via the E-Value website. You will receive an email notification informing you any time an evaluation is completed on your performance. A link will be provided in the email message which will take you directly into E-Value without having to log in manually. Instructions are provided in the E-Value Information for Block III Students handbook.

Completing Evaluations

At some point during the clerkship you will receive email notifications that you have been scheduled to evaluate a preceptor or the clerkship program. You can complete these evaluations by opening the email message and clicking on the link in it. The link will take you directly into E-Value without having to log in manually.

The End-of-Clerkship and Preceptor evaluations are anonymous. Preceptor evaluations are retained until there are at least three evaluation for a particular preceptor, at which time they will be sent to that preceptor.

SPECIFIC LOGGING REQUIREMENTS

All patient encounters must be logged until the minimums in the required categories have been met. These must be verified by a supervising physician. The preferred method is to enter patient encounter information into your PDA as you work and have the supervising physician sign this as you work with him/her. If you log this later then an email will be generated to the supervising physician asking them to verify your work.

Diagnoses

Diagnoses are listed alphabetically and/or in groups such as Acute Care, Chronic Care, etc. Log all patient encounters until you have reached the minimums for each diagnosis.

Procedures

The procedures are grouped by either Common Procedures or Musculoskeletal Exams. Log all patient procedures you were involved in until you have logged 15 different procedures (the minimum).

Special Topic Module Requirements

In addition to recording diagnoses and procedures, students will also track their completion of the Special Topic Modules. These include:

- **Outpatient smoking cessation counseling with a patient**
- **Informed (Shared decision making) with a patient related to “screening” with any of these:**
 - Contraceptive Counseling
 - Screening for Osteoporosis
 - Use of Antibiotics
 - New Medications to Treat Chronic Illnesses
 - Screening for Colorectal Cancer
- **Completion of on-line prostate shared decision making case**
- **PSA screening with a patient in the outpatient setting**
- **Four prescription writing activities (Patient Safety) (under procedures in E-value)**
- **Completion of health disparities module**
- **Hospice**

DIAGNOSES LIST AND MINIMUM REQUIREMENTS

Groupings:	Group Type:
ALPHABETICAL LISTING	Diagnosis
ACUTE CARE	Diagnosis
CHRONIC CARE	Diagnosis
HEALTH MAINTENANCE	Diagnosis
PSYCHOSOCIAL	Diagnosis
SPECIAL TOPIC MODULES	Diagnosis

<u>Diagnosis Name</u>	<u>Required</u>
01. Abdominal Pain(2)	2
02. ADD/ADHD	No Minimum Required
03. Adult Physical Exam – Female (2)	2
04. Adult Physical Exam – Male (2)	2
05. Anemia, acute	No Minimum Required
06. Anxiety	No Minimum Required
07. Asthma/Allergies(2)	2
08. Chest Pain(1)	1
09. Colorectal Screening(1)	1
10. Congestive Heart Failure(1)	1
11. COPD(1)	1
12. Coronary Heart Disease	No Minimum Required
13. Depression(2)	2
14. Diabetes Mellitus(3)	3
15. Dyslipidemia(2)	2
16. Eye problem(1)	1
17. Fatigue(1)	1
18. Headache(2)	2
19. Hypertension(4)	4
20. Injuries/poisonings(1)	1
21. Joint Pain, chronic(2)	2
22. Joint pain, acute; Sprain/Strain(1)	1
23. Laceration	No Minimum Required
24. Low back pain, acute(1)	1
25. Low Back Pain, chronic(1)	1
26. Menstrual Disorder(1)	1
27. Mental Health (other)	No Minimum Required
28. Mouth/dental problem	No Minimum Required
29. Neoplasms	No Minimum Required

30. Neuropathy	No Minimum Required
31. Obesity(2)	2
32. Otitis Media/Externa(1)	1
33. Pharyngitis	No Minimum Required
34. Pneumonia/Bronchitis(1)	1
35. PSA Screening(1)	1
36. Rash (2)	2
37. Respiratory System	No Minimum Required
38. Screening Interventions	No Minimum Required
39. Sinusitis	No Minimum Required
40. Skin Lesions (nevi, warts)(1)	1
41. Substance Abuse	No Minimum Required
42. Thyroid Disorders(1)	1
43. Upper Respiratory Infections(2)	2
44. UTI(1)	1
45. Vaginitis (1)	1
46. Well Child Check (3)	3
47. Other	No Minimum Required
48. Following up on baby &/or mother (1)	1
49. Hospice Visit(1)	1
50. Observing a delivery in family medicine	No Minimum Required
51. Observing labor in Family Medicine	No Minimum Required
52. Prenatal visit(1)	1
53. Informed decision making related to screening(1)	1
54. Smoking cessation counseling(1)	1
55. Review of Prescription	4
56. Prostate on-line case	1
57. Health Disparities Module – reviewed web-based presentation	1

PROCEDURES AND MINIMUM REQUIREMENTS

Groupings:	Group Type:
COMMON PROCEDURES	Procedure
MUSCULOSKELETAL	Procedure

<u>Procedure Name</u>	<u>Required</u>
01. Anoscopy	No Minimum Required
02. Audiometry	No Minimum Required
03. Carpal tunnel	No Minimum Required
04. Casting Application	No Minimum Required
05. Circumcision	No Minimum Required
06. Colposcopy	No Minimum Required
07. Cryo/Cautery	No Minimum Required
08. Endometrial Biopsy	No Minimum Required
09. Episiotomy Repair	No Minimum Required
10. Excision of Skin Lesion	No Minimum Required
11. Incision and Drainage	No Minimum Required
12. Indirect Laryngoscopy	No Minimum Required
13. Injections	No Minimum Required
14. IUD Insertion	No Minimum Required
15. Joint Aspiration	No Minimum Required
16. Laceration Repair	No Minimum Required
17. Local Anesthesia	No Minimum Required
18. Nasal Packing/Epistaxis	No Minimum Required
19. Norplant Insertion/Removal	No Minimum Required
20. Pap & Pelvic	No Minimum Required
21. Pneumatic Otoscopy	No Minimum Required

22. Removal of Cerumen	No Minimum Required
23. Removal of Foreign Body	No Minimum Required
24. Sigmoidoscopy/Protoscopy	No Minimum Required
25. Skin Biopsy	No Minimum Required
26. Spirometry	No Minimum Required
27. Splinting	No Minimum Required
28. Suturing	No Minimum Required
29. Tympanometry	No Minimum Required
30. Vasectomy	No Minimum Required
31. Ankle Exam	No Minimum Required
32. Back Exam	No Minimum Required
33. Elbow Exam	No Minimum Required
34. Foot exam	No Minimum Required
35. Hand Exam	No Minimum Required
36. Hip Exam	No Minimum Required
37. Knee Exam	No Minimum Required
38. Neck Exam	No Minimum Required
39. Shoulder Exam	No Minimum Required
40. Wrist Exam	No Minimum Required
41. Other:	No Minimum Required

Grading Criteria

Passing Grade

- a) Receive a “satisfactory” rating on the data collection and assessment component of the Clinical Performance Evaluation (CPE) forms (85% or greater in the “usually” and/or “consistently” columns) from all preceptors combined
- b) Receive a “satisfactory” rating (2 or fewer notations) on the professional behavior component of the Clinical Performance Evaluation (CPE) forms from all preceptor(s) and the Community Clerkship Director combined
- c) Receive a “meets expectations” rating (4 or better on a 9 point scale) on the student choice oral presentation
- d) Receive a “meets expectations” rating (4 or better on a 9 point scale) on the screening and prevention presentation
- e) Receive a “pass” rating on the two or three ambulatory write-ups
- f) Receive a “pass” rating on the one inpatient write-up
- g) Submit a completed log report in E-Value documenting:
 - Attendance in all clinical half days in the assigned ambulatory settings
 - Attendance in assigned inpatient experience
 - Satisfactory completion of at least 15 different procedures and skills, as outlined in the syllabus or e-Value, and as verified by an attending physician or resident
 - Satisfactory completion of a least the minimum number of patients within each diagnostic area
- h) Receive a score of 70 out of 100 (70%) on the Oral Examination*
- i) Receive a score of 21 out of 30 (70%) on the Performance Based Assessment (PBA)
- j) Receive a score of 62 out of 100 (62%) on the Multiple-Choice Exam
- k) Attend and participate in all scheduled didactic sessions and special topic modules
- l) Satisfactorily complete all web-based exercises

A Pass “P” grade will be given to students who fulfill criteria “a - l” by the end of the eight-week period for which the Family Medicine Clerkship is scheduled. Exceptions to this policy must be approved, in advance, by the Family Medicine Clerkship Overall Director in consultation with the Clerkship Committee.

* Special Oral Exam Grading Circumstances:

If the total score on the exam after the initial effort is <70%, but the student’s score on one case of the exam is 35 or greater (>70%), the student will be allowed one “second chance” to pass another case without receiving a “CP” grade. The “second chance” will consist of one case scenario worth 50 points. The student must score at least 35 points on that case to achieve a pass for the test. If, on “second chance,” the student scores <35 points (70%), the student will receive a “CP” on the exam, and must remediate the entire exam. If the student scores 70% or better on the remediation exam, the student will receive a “CP/P.” If the student scores less than 70% on the remediation exam, the student will receive a “No Pass” grade for the oral exam. If a student has to retake a case on the exam or remediate the exam, that student is ineligible for honors in the clerkship. All exams will be administered in East Lansing (except for the U.P. campus).

Honors Designation

To be eligible for nomination for honors, a student must meet the following standards:

- a) Satisfactorily complete all of the passing criteria, a – l
- b) **Earn a total of 197 points or more as a sum of the final exam components AND achieve minimum scores of at least:**
 - **80 or greater on Multiple Choice Exam**
 - **80 or greater on Oral Exam**
 - **25 or greater on Performance Based Assessment (PBA)**
- c) No notations of unprofessional behavior on all Clinical Performance Evaluation and the Student Professional Behavior forms combined
- d) Recommendation of Honors from the Community Clerkship Director. This will be based on their assessment of:
 - Consistent high effort
 - Consistent timeliness

- Improvements in areas needing attention at the mid-clerkship evaluation
 - No problematic behaviors not otherwise identified on the CPE evaluation
- e) Meet at least one of the two following criteria:
- No “Seldom” ratings and 75% or greater in the “Consistently” ratings on the Clinical Performance Evaluation data collection and assessment section from all preceptors combined
 - an average of 7 on the oral presentation and screening and prevention presentation combined

Conditional Pass

A conditional pass “CP” is given when a student has met all of the criteria for passing, but is deficient in a specific definable course segment or has failed to meet the overall pass level by a narrow margin.

Specific course segments which would result in a “CP” grade include, but are not limited to, the following:

Examinations

- a) Less than 62% on the Multiple-Choice Examination
- b) Less than 70% on the Oral Examination
- c) Less than 70% on the Performance Based Assessment (PBA)
- d) Arriving late to the Multiple-Choice Examination (see Block III Handbook)

Students will be provided an opportunity to retake these examinations. A passing score must be achieved on the second attempt in order to receive a “CP/P” grade. In the event that a student’s second attempt at passing is unsuccessful, an “N” grade will be given.

Clinical Performance Evaluations

- a) Greater than 15% in the “Seldom” columns on the CPE forms completed by all preceptors combined
- b) Three or more unprofessional behavior notations

Students receiving a “CP” grade in the data collection and assessment portion of the CPE will be required to repeat an additional four weeks, doing patient care and other specific remediation exercises as outlined by the Overall Clerkship Director and the Community Clerkship Director in conjunction with the Community Assistant Dean.

A passing score in the data collection and assessment portion of the CPE of 85% or greater in the “Usually” and/or “Consistently” columns from all preceptors combined, in the additional four-week experience, will be required for the student to receive a “CP/P”.

Failure to satisfactorily complete any remediation plan by the due date for any of the above “CP” situations will result in a grade of “CP/N”. In all cases, the “CP” marker will remain on the record.

No Pass Grade

Students who fail to successfully complete all of the requirements of the clerkship will receive a “No-Pass” grade and will have an opportunity to retake the clerkship, barring actions by the college’s Student Performance Committee, which would supersede this policy.

Students who fail two or more clerkship components will be given an “N” grade and will be required to repeat the clerkship.

2009-2010 Grading Criteria Table

ACTIVITY	HONORS CRITERIA	PASSING CRITERIA	CP REMEDIATION TO CP/P
Clinical Performance Evaluation completed by preceptors/residents	No marks in the "seldom" column & 75% or greater in "consistently" column	≥85% of all marks in the "usually" or "consistently" columns	Four weeks clinical experience with particular experience related to identified area(s) of weakness
Professional Behavior from CPE form	No notations	2 or fewer marks on the professional behavior portion of CPE	As noted above
Clerkship Director's Recommendation	Must recommend student for Honors	2 or fewer marks in professional behavior	As noted above
Logbook Data	Same as pass criteria	Log at least 15 different procedures observed or performed in E-Value, Log all required diagnosis in E-Value, Attendance in all clinical ½ days in the ambulatory & in-patient setting	Per clerkship director
Oral Case Presentations	Average of 7 on oral case presentation & screening & prevention presentation	A score of 4 or better (out of 9) on three OCP's	Repeat until satisfactory
Ambulatory Write-Ups	Same as pass criteria	Pass rating on 2 or 3 write-ups	Rewrites are assigned until a passing grade is achieved
Inpatient Write-Ups	Same as pass criteria	Pass rating on 1 write-ups	Rewrites are assigned until a passing grade is achieved
Special Topic Modules	Same as pass criteria	Satisfactory completion of requirements	Repeat until satisfactory
PBA smoking cessation/informed decision-max 30 pts.	At least 25 out of 30 points	21 out of 30 points	Retake and pass with 21
Oral Exam max 100 pts. 2 cases – 50 pts. max per case	At least 80 out of 100 points	70 out of 100 points Oral Exam consists of 2 cases: <ul style="list-style-type: none"> If student scores <70 but 1 case is >35, student repeats 1 case; If repeat case is >35 student receives "P," if repeat case is <35, student receives "CP" & repeats entire oral exam If student scores <70 with both cases <35 student receive "CP" and repeats entire oral exam (2 cases); If student receives >70 on repeat exam, student receives "CP/P;" If student scores <70 on repeat exam, student receives "N" 	Retake and pass with 70
Multiple Choice Exam (Departmental) max 100 pts.	At least 80 out of 100 points	62 out of 100 points	Retake and pass with 62
Combined Total Exam Points	197 Points with at least the minimum Honors level points in all 3 exams		