Introduction

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

This syllabus describes the educational activities, requirements, and grading for the Family Medicine Clerkship. Students must take responsibility for their own training including understanding the clerkship requirements noted in this syllabus. This syllabus supersedes information given by the community clerkship director, preceptors, and administrative staff. Please refer to the Block III Handbook for additional important information on issues such as:

- work hours
- accommodations for persons with disabilities
- excused absences
- inclement weather
- student documentation in patient charts
- clerkship evaluations
Clerkship Overview

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 specialty 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.

Clerkship Educational Goals:

1. Demonstrate the unequivocal value of primary care as an integral part of any health care system.
2. Teach an approach to conducting a wellness visit for a patient of any age or gender.
3. Teach an approach to the evaluation and initial management of acute presentations commonly seen in the office setting.
4. Teach an approach to the management of chronic illnesses that are commonly seen in the office setting.
5. Model the principles of Family Medicine care.
6. Provide instruction in historical assessment, communication, physical examination, and clinical reasoning skills.

Clerkship Educational Objectives:

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

1. Discuss the principles of Family Medicine care.
2. Develop evidence-based health promotion/disease prevention plans for patients of any age or gender.
3. Gather information, formulate differential diagnoses, and propose plans for the initial evaluation and management of patients with common presentations.
4. Manage follow-up visits with patients having one or more common chronic diseases.
5. Demonstrate competency in advanced elicitation of history, communication, physical examination, and critical thinking skills.
6. Discuss the critical role of family physicians within any health care system.
7. Demonstrate and recognize appropriate professional behavior.
Overview of Instructional Activities

Clinical Experience

During the course of the clerkship, students will have an opportunity to participate in clinical experiences in various settings. The exact nature of the experience and the apportionment of time to various clinical experiences will vary from community to community, but these differences are not significant in terms of enabling students to meet the clerkship objectives. Various activities in the clinical setting will be logged in E-Value (see below). Students will need to practice certain skills and receive feedback to prepare for examinations. Students should read about the patients they see to increase general medical knowledge and prepare for examinations.

Small Group Didactic Sessions

Students will participate in small group instructional sessions that are devoted to clinical topics in Family Medicine. The types of sessions include:
1. Common Problems in Family Medicine – case based discussions covering common problems seen in the family physician’s office
2. Skin Problems
3. Mental Health
4. Geriatrics
5. Skills Workshops
   a. Musculoskeletal Examination
   b. Suturing, Casting, and Splinting

Screening and Prevention Oral Presentation

Write-up Assignments

Special Topic Modules
These learning modules may include small group sessions, online activities, practice with real patients, other assignments, and/or examinations.

A. Informed Decision Making
B. Maternity Care in Family Medicine
C. Smoking Cessation Screening and Intervention
D. Hospice/Palliative Care
E. Prescription Writing
F. Community Resources

Required Readings

Required readings for each activity are posted on ANGEL (even those referenced in the syllabus). All readings are available free to students either on the internet or through the MSU e-library. Students are expected to complete required readings before small group didactic sessions.
Recommended Texts:

Students should choose at least one of the following text books for supplemental reading and to prepare for the written examination. We do not require a single text because each student’s learning style is different. As adult learners, students should review the available resources and choose the one that suits them best. The NBME exam is not based on any specific text. Reading any of these should prepare a student well for the exam.

Blueprints Family Medicine Third Edition. Martin S. Lipsky & Mitchell S. King. Lippincott Williams and Wilkins 2011. 329 pp. (Shorter chapters, two to four pages long, on common problems in family medicine. Includes access to 150 practice questions.)

Case Files Family Medicine, Third Edition. Eugene C.Toy, Donald Briscoe, Bruce Britton. McGraw-Hill Medical, 2012. 625 pp. (60 Case based chapters on common problems in family medicine, each about eight to twelve pages long with three or four practice questions per case.)


fmCASES: 40 online interactive cases that teach principles of Family Medicine. No practice questions included. 90 day individual subscription costs $30. For more information and registration go to www.med-u.org.

Attendance

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

Absences

If a student is unable to attend any activity of the clerkship the student must submit an “Excused Absence Form” at least 30 days prior to the date(s) of absence. Absences are not “excused” until this form is signed by the Community Clerkship Director. Students must also notify their preceptors of any absences. The Community Clerkship Director will arrange make up experiences for all absences, excused or unexcused. Absences of more than five days, whether excused or unexcused, may result in the student receiving a CP grade for unprofessional behavior. For additional details see the Block III Handbook.

Unexcused Absences

Any unexcused absences will be considered unprofessional behavior. Each unexcused absence will count as one instance of unprofessional behavior, and will be noted as such by the clerkship director on the student’s CPE form and in the final clerkship evaluation. Instances of unprofessional behavior may be incorporated into the Medical Student Performance Evaluation. For further details see the Block III Handbook.
Required Activities and Evaluations

In order to receive a passing grade the student must satisfactorily complete all of the clerkship requirements summarized below.

Evaluations (available on ANGEL)
- Clinical Performance Evaluation (CPE) by preceptors
- Screening and Prevention Oral Case Presentation
- Inpatient Write-Up (1-2)
- Ambulatory Write-Ups (2-3)
- NBME Subject Examination
- Performance Based Assessment
- Oral Examination
- Prescription Writing Examination
- Community Clerkship Director’s Mid-Clerkship Evaluation
- Student Assessment of Clerkship Preceptor
- Student Assessment of Clerkship Program

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

Grading Criteria

Passing Grade

In order to receive a Pass in the Family Medicine Clerkship, students must:

1. Pass the CPE portion, i.e. 80% or greater in the “Met Expectations” and “Exceeded Expectations” categories, with no more than 2 unprofessional behavior notations from all evaluators combined (For further details, see the Block III Handbook).
2. Receive a “meets expectations” rating (4 or better on a 9 point scale) on the screening and prevention presentation.
3. Receive a “pass” rating on all ambulatory write-ups.
4. Receive a “pass” rating on the inpatient write-up.
5. Submit a completed log report in E-Value documenting:
   a. Satisfactory completion of at least 15 different procedures and skills, as outlined in the syllabus or E-Value, and as verified by a preceptor
   b. Satisfactory completion of at least the minimum number of patients within each diagnostic area
   c. Satisfactory completion of all special topic module activities
6. Receive a score of at least 70 out of 100 on the Oral Examination.
7. Receive a score of at least 70% on the Performance Based Assessment (PBA).
8. Receive a score of at least 5 out of 10 on the prescription writing exam.
9. Receive a score of at least 61 on the NBME Subject Examination.
10. Satisfactorily complete all other clerkship requirements.

Students who fulfill the criteria above within the eight week period for which the Family Medicine Clerkship is scheduled will receive a Pass grade. Exceptions to this policy must be approved, in advance, by the Lead Clerkship Director.
**Honors Designation**

To receive a designation of Honors, students must:

1. Satisfactorily complete all of the passing criteria above.
2. Achieve Honors on the CPE portion, i.e. 100% in the “Met Expectations” and “Exceeded Expectations” categories, with no unprofessional behavior notations.
3. Achieve minimum scores of at least:
   a. 76 on NBME Subject Exam
   b. 85 on Oral Exam
   c. 7 on the prescription writing exam
   d. 7 on the screening and prevention presentation

**Conditional Pass**

Students will receive a conditional pass “CP” when they have failed to pass only one component of the clerkship. Specific course segments which would result in a “CP” grade include, but are not limited to, the following:

1. CPE: Greater than 20% but no more than 40% in the “Below Expectations” category OR 3-4 unprofessional behavior notations from all evaluators combined.
2. Less than 61 on the NBME Subject Examination.
3. Less than 70 on the Oral Examination.
4. Less than 70% on the Performance Based Assessment (PBA).
5. Arriving late to the NBME Subject Examination (see Block III Handbook).

**Remediation of a Conditional Pass:**

If a student fails to pass only one examination (the NBME Subject Exam, the Oral Exam, the PBA, or the prescription writing exam) the student will be given the opportunity to remediate that examination. Students must submit a remediation plan by e-mail to the lead course director within 30 days of receiving their grade through E-Value. The plan should also include the date for a repeated attempt at passing the examination. 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 assigned. 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.

A CP grade on the CPE will require that the student repeat four weeks of the clerkship, in addition to remediating any other clerkship deficiencies. The student must pass the CPE component of the repeated four weeks in order to receive a “CP/P”.

**No Pass Grade**

Students will be assigned a No Pass (N) grade for any of the following:
- Receive an N for the CPE by any of the following:
  - Greater than 20% but no more than 40% in the “Below Expectations” category AND 3-4 unprofessional behavior notations from all evaluators combined.
  - Greater than 40% in “Below Expectations”.
  - 5 or more unprofessional behavior notations from all evaluators combined.
- Fail two or more clerkship components.
- Fail to successfully complete all requirements of the clerkship.
- Fail an attempt to remediate a CP.

Students who are assigned a No Pass grade will be required to retake the clerkship, barring actions by the college’s Student Performance Committee.
Appealing a Clerkship Grade

Students have the right to appeal elements of their clerkship final grade if they feel that it does not reflect their actual performance. The process for doing so is detailed in the Block III Handbook under "Procedure for Appealing a Clerkship Grade". There is no guarantee that any element of a student's clerkship grade will be changed. In addition to the Block III Handbook, additional information can be obtained in the Academic Review, Grievances & Complaints sections of the "Medical Student Rights and Responsibilities" document.

Evaluation of 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. Professional Behavior is formally evaluated through the CPE and also the Professional Behavior portion of the Final Clerkship Evaluation (FCE). For further details see the Block III Handbook.

Use of Electronic Devices in Block III (Copied from the Block III Handbook)

Block III students are expected to be fully engaged in the clinical education experience. Using electronic devices while on clerkships, during the Core Competencies course, or during other required Block III activities can be distracting and disrespectful to patients, preceptors, lecturers, and your fellow students. Electronic devices are not to be used during rounds, meetings, small groups or lectures including Core Comps sessions, or when in the room with patients; the only exception would be if instructed to do so by an attending or resident faculty member. Students wishing to retrieve information that may be relevant to the patient or small group discussion should get permission to do so from the faculty member. It is never appropriate for students to use electronic devices for reading e-mail, texting, surfing the web or other personal activities while on any Block III required activity. Students may receive unprofessional behavior notation(s) for failure to use electronic devices appropriately.
Examinations

Clerkship examinations are based on all of the clerkship materials, including those presented in small group sessions, special topic modules, and 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, PBA, and prescription writing examinations are scheduled during the clerkship oral exam day, usually week six or seven of the clerkship. The NBME subject examination is scheduled at the end of the clerkship.

Students will be assigned a time to arrive at the Learning and Assessment Center in East Lansing for their oral examination day. Students should dress professionally including their white coats and ID. Students will not need physical examination equipment.

At the start of the examination time students will be given introductory materials describing their assigned cases for the oral exam and PBA. They will have 20 minutes to review these materials and should use this time to take notes and prepare. Students are not permitted to use any books, notes, electronic resources, or other reference materials. Following the 20 minute preparation time a proctor will direct students to the rooms where they will begin with either the oral examination or the PBA. Following completion of each examination proctors will direct students to the next examination.
Oral Examination

The oral examination 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 examination, create an appropriate differential diagnosis, and develop an initial plan based on this information.

Oral examiners are faculty from various community campuses. They are not simulated patients and will not be playing a role. Rather, the student will ask questions such as "What is the patient here for?", "When did it start?", or "What is the cardiac examination?" The examiner has set answers to these questions and a standardized score sheet.

At the designated time, the student should enter the room and proceed to solicit the history and physical exam information needed to determine a diagnosis for the patient. Following this the student should offer a differential diagnosis and initial management strategies. The examiners will provide only minimal prompting. Be sure to address any health maintenance issues for the patient in question.

Students will have 12 minutes for the first case. Students will receive a warning after 10 minutes that two minutes remain. At the end of the first 12 minutes students will receive instructions to change rooms and begin the second case in similar fashion. Each room has a clock and it is the student's responsibility to keep track of the time. When the 25 minutes is up, the exam is concluded.

You can assume that the PMH, Medications, FH, SH, Habits, and Health Maintenance information for each case is as printed on your review materials. You do not need to ask further questions about these areas.

The oral examination is graded using a detailed checklist with the 50 points divided more or less evenly between the following categories.
1. History of Present Illness
2. Physical Examination
3. Differential Diagnosis
4. Plan (including diagnostic testing and treatment)
5. Health Maintenance
6. Organization, employing a systematic approach, and being prudent with questions (avoiding unlikely diagnoses, choosing the best tests rather than everything you can think of, etc.)

The scoring system works in a way that ordering expensive tests that aren’t indicated could negatively impact your grade. However, asking about history or performing examination that is irrelevant, or discussing unlikely diagnostic possibilities, will only result in wasting time, not losing points.

A score of 70 is required to pass the oral examination. A score of 85 is required for Honors designation.

All oral examinations are video recorded.
Objectives for the oral examination:

Students should be able to:

- Elicit a focused history from a faculty examiner.
- Describe how they would use patient-centered interviewing techniques.
- Describe a focused physical examination, including musculoskeletal exam.
- Describe the initial management of common diagnoses that present with a particular symptom.
- Employ a cost-effective approach to diagnostic workup.
- Apply the current guidelines for immunizations for patients of any age.
- Develop a health maintenance plan for a patient of any age or gender that addresses the core health promotion conditions listed below.

Core Health Promotion Conditions for Adults

- Breast cancer
- Cervical cancer
- Colon cancer
- Coronary artery disease
- Depression
- Fall risk in elderly patients
- Intimate partner and family violence
- Obesity
- Osteoporosis
- Prostate cancer
- Sexually transmitted infection
- Substance use/abuse
- Type 2 diabetes mellitus

Core health promotion conditions for children/adolescents

- Diet/exercise
- Family/social support
- Growth and development
- Hearing
- Lead exposure
- Nutritional deficiency
- Potential for injury
- Sexual activity
- Substance use
- Tuberculosis
- Vision

The Student’s Task

1. Elicit the history (remember to use patient-centered techniques, “What brings the patient in today? Is there anything else?” However, the examiner is not a patient or simulated patient.
2. Ask about symptom dimensions (PPQRST) (“Is the patient’s pain radiating anywhere?”).
3. Ask about relevant review of systems.
4. Ask for examination results and describe or demonstrate examination techniques.
5. Give a broad differential diagnosis (aim for at least 5 diagnoses).
6. Give initial steps for management of the problem.
7. Delineate a health maintenance plan for the patient.

You do not need to justify your choice of questions, exam, differential diagnoses or diagnostic plan. It will not benefit your grade and will only use up time.
Preparing for the oral examination

This examination is looking at your ability to use your content knowledge and synthesize it as you approach real life clinical scenarios. It is somewhat difficult to study for in the conventional sense. You do need to be organized and thoughtful in your approach to a case, so any time spent talking through cases, as in Common Problems sessions, will help. In addition, be sure to:

- Read the required readings.
- Review your Common Problems session notes.

Challenging an oral exam grade

A student who wishes to challenge his or her oral exam grade must submit the challenge in writing, including specific reasons the student believes the grade is inaccurate, via e-mail to the Lead Clerkship Director within two weeks of the release of the overall clerkship grade thru E-Value. The Lead Clerkship Director or designee will review the video and re-grade it. The result of the re-grade will stand as the final grade for the oral examination.
PBA Examination

The PBA is a 20 minute exam with a standardized patient. It is designed to test a student’s ability to engage a patient in shared decision making regarding screening and to counsel a patient on smoking cessation.

At the designated time, students will enter the room and introduce themselves to the patient. Students will have 20 minutes with a five minute warning and are responsible for watching the clock in the room and finishing on time.

The scenario is this: the patient has completed his or her physical examination already and your preceptor has asked you to talk to the patient about smoking cessation and colon cancer screening before the patient leaves. Each student will see one of two possible simulated patient scenarios.

For both patients, students should use the RIPUU model and information from the USPSTF Colorectal Cancer Screening Recommendation Statement to engage the patient in shared decision making about colorectal cancer screening.

Students should also counsel the patient about smoking cessation using the method outlined in the US Public Health Service Clinical Practice Guideline. One patient is ready to quit and, once the student ascertains the patient’s willingness, the student should use the five A’s to assist the patient in quitting. The other patient is not ready to quit and the student will need to use the five R’s to motivate the patient to quit.

Once the overhead speaker signals the end of 20 minutes, you may finish your sentence and the interview is complete. The simulated patient will give the student a prescription to complete (the prescription writing examination, described below). 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 before you leave the room.

The PBA exam is scored by the simulated patient using a detailed checklist with oversight from the Clerkship Director. All PBA examinations are video recorded.

A score of 70% is required to pass the PBA. There is no honors criteria for the PBA.
Preparing for the PBA

Review your handouts and notes from the “Smoking Cessation” and “Shared Decision Making” didactic sessions, as well as relevant required readings and information on ANGEL. You should have the 5 A’s, the 5 R’s, and the RIPUU method all memorized and you should have practiced them enough that you can do them quickly and comfortably.

Below are the various items that contribute to the PBA grade. The student will not know until part way through the interview which of the two potential scenarios he or she is facing.

One Scenario:

1. ASK about smoking. Elicit a smoking history, including duration, dose, previous quit attempts.
2. ADVISE the patient to quit smoking with a strong, personal, clear message.
3. ASSESS the patient’s willingness to quit.
4. Ask the patient how quitting smoking is RELEVANT to him or her particularly.
5. Ask the patient what RISKS he or she is taking by continuing to smoke.
6. Ask the patient what REWARDS he or she might receive by quitting.
7. Ask the patient what ROADBLOCKS are keeping him or her from quitting.
8. Explain the patient’s ROLE in making a decision about screening for colon cancer.
9. Discuss the ISSUE of colon cancer screening, including the risk factors for colon cancer and the value of screening.
10. Discuss the ALTERNATIVES, including doing nothing, fecal occult blood cards, sigmoidoscopy, and colonoscopy, as well as the PROS & CONS of each.
11. Explain the UNCERTAINTIES of the various screening methods.
12. Check the patient’s UNDERSTANDING of the information provided.
13. Ask the patient’s PREFERENCE for a type of screening.
14. Explain how the patient will receive his or her test results.
15. Be knowledgeable and organized.
16. Be patient-centered.

Second Scenario:

1. ASK about smoking. Elicit a smoking history, including duration, dose, and previous quit attempts.
2. ADVISE the patient to quit smoking with a strong, personal, clear message.
3. ASSESS the patient’s willingness to quit.
4. Congratulate the patient on his or her decision to quit.
5. ASSIST the patient to make a quit plan by setting a quit date, telling others, anticipating challenges, and removing tobacco products from the environment.
6. ASSIST the patient by offering medications that can help with quitting, including both nicotine replacement and urge suppressant medications.
7. ASSIST the patient by practical counseling such as advising about the importance of complete abstinence, dealing with other smokers in the household, anticipating triggers, and avoiding alcohol.
8. ARRANGE follow up within the first week after quitting.
9. Explain the patient’s ROLE in making a decision about screening for colon cancer.
10. Discuss the ISSUE of colon cancer screening, including the risk factors for colon cancer and the value of screening.
11. Discuss the ALTERNATIVES, including doing nothing, fecal occult blood cards, sigmoidoscopy, and colonoscopy, as well as the PROS & CONS of each.
12. Explain the UNCERTAINTIES of the various screening methods.
13. Check the patient’s UNDERSTANDING of the information provided.
15. Be knowledgeable and organized.
16. Be patient-centered.
Challenging a PBA grade

If a student wishes to challenge the PBA grade, the challenge must be submitted via email or in writing to the Lead Clerkship Director within two weeks of release of the final clerkship grade to the student through E-Value. The student may request access to the video recording to assist in formulating a challenge. As part of the challenge, the student must state the specific points on the PBA checklist where he/she believes the scoring is inaccurate. After receiving the request the Lead Clerkship Director or designee will review the PBA video. The grade assigned after this review will stand as the final PBA grade.

Prescription Writing Examination

At the time of the PBA exam (oral exam for UP students) students will be asked to write a prescription. No job aides will be permitted for this exam. Students will not need to reference any materials (e.g. Epocrates) to complete the examination. One point is given for each of the ten elements that should always be included on a prescription according to the patient safety lecture.

A score of 5 out of 10 is required to pass the prescription writing examination. A score of 7 out of 10 is required for Honors designation.

NBME Subject Examination

The NBME Family Medicine Subject Examination consists of 100 multiple choice questions. It is administered at the end of the clerkship in the student’s community campus. Students have two hours and thirty minutes to complete the examination.

A content outline and sample questions are available on the web at www.nbme.org. Specific links to helpful materials from the NBME website are posted on ANGEL. Of note, the exam you will be taking is “Family Medicine”, not “Family Medicine Modular”. The exam you will take is computerized. Students should use any of the recommended texts, required readings, and practice questions to prepare.

A score of 61 is required to pass the NBME Subject Examination. A score of 76 is required for Honors designation.

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.
Details of Instructional Activities

Clinical Experience

Learning Objectives

Through the clinical experience in Family Medicine the student will learn to:

- Conduct appropriate histories and physical examinations on patients in the inpatient and outpatient settings.
- Develop prioritized differential diagnoses.
- Develop plans for patients that include diagnostic evaluation, treatment, patient education, 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.
- Understand the importance of knowing one’s limitations.
- Use the medical team and multi-disciplinary approach to care (including nursing, social work, and other ancillary services).
- Write prescriptions safely and appropriately.

Outpatient Experience

The ambulatory care experience (care provided in the office setting, in other words, "outpatient" as opposed to the hospital or "inpatient") forms the core of the Family Medicine Clerkship. 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 offices of family physicians and will be required to:

- Attend all assigned clinical sessions.
- Try to be involved in as many patient encounters as possible and spend time reading about the problems they have.
- Document patient encounters in E-Value until the minimums in the diagnostic categories have been met. Especially seek out opportunities to work with patients who have problems listed on the minimums list.
- Document 15 different procedures or musculoskeletal examination skills and log these in E-Value. Students should seek out opportunities to perform or assist in these procedures or examinations. Procedures are to be done ONLY under the supervision of the physician responsible for that patient. In general, students should attempt to be observed by a preceptor when performing physical examination skills as well. Students may perform some physical examination independently with the permission of the preceptor.
- Document in E-Value the experiences described in the special topic modules.

Inpatient Experience

Students will spend one to two weeks in the inpatient (hospital) setting during the 8-week clerkship. Students should seek out opportunities for the following experiences.

- Observing a labor and delivery in Family Medicine (document in E-Value).
- Following up on baby and/or mother in the hospital following delivery (document in E-Value).
- Attend morning report.
- Participate in writing admission orders.
- Performing initial history and physical examinations.
- Writing daily progress notes.
- Observing the interactions of the family physician with consultants and the multidisciplinary process of discharge planning.
- Participate in after hours “call” with the goal of experiencing after hours care of patients including telephone management, after-hours admissions, and floor coverage.
**Patient Notes**

Students should document in the medical record for some of the patients they see in both the ambulatory and inpatient setting. Students should sign every note. Any student documentation must include school and level of training (e.g. MSU-CHM3). All notes should be legible, including the signature. Preceptors should read and countersign the notes and give feedback to the student. It is the student’s responsibility to be sure that a physician countersigns all student notes.

**Important note on E/M Service Documentation Provided by Students**  
*(From the Centers for Medicare & Medicaid Services Manual)*

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

**Important note on confidentiality**

Students will have access to medical records that contain patients’ protected health information. 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 protected by law. 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 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.

**Evaluation**

- Preceptors will evaluate the student’s performance in the clinical setting via the Clinical Performance Evaluation (CPE) form in E-Value (available on ANGEL).
- The student is required to document diagnoses and procedures in E-Value and meet the minimum requirements as described below.
Logging activities in E-Value

Students receive instruction and a manual on the use of the E-Value Patient Encounter Log (PxDx Log System) during Block III Orientation. All minimum requirements for diagnoses and procedures must be logged on e-value by the end of the clerkship. It is to your advantage to enter patient encounters as soon as possible. If your preceptor receives a confirmation e-mail and cannot recall the procedure they may challenge whether you actually did it.

Diagnoses

Diagnoses are listed in groups such as Acute Diagnoses, Chronic Diagnoses, or Health Promotion/Disease Prevention. If you see a patient with any of the diagnoses, or if a health promotion/disease prevention topic is addressed during the patient visit, log that diagnosis or health promotion topic. Log all patient encounters until you have reached the minimums for each diagnosis. Note that one patient will often have multiple problems and you may log each of the problems. For example, one patient might have dyslipidemia, hypertension, and need to be screened for diabetes. If all three of those problems are addressed in that visit, you can log three different diagnoses.

Procedures and Examinations

Log all patient procedures or examinations you were involved in until you have logged 15 different procedures and examinations combined, not including prescription writing and the hospice visit.

Special Topic Module Requirements

Included in these diagnoses, procedure, and examination lists are requirements for some of the special topic modules. These include:

- Smoking cessation counseling (under Health Promotion/Disease Prevention Visits)
- Shared decision making related to screening (under Health Promotion/Disease Prevention Visits)
- Hospice Visit (under Health Promotion/Disease Prevention Visits)
- Four prescription writing activities (under procedures)
## Diagnosis List and Minimum Requirements

<table>
<thead>
<tr>
<th>Acute Diagnoses</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Respiratory Symptoms</td>
<td>1</td>
</tr>
<tr>
<td>Joint pain and Injury</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy, Initial Presentation</td>
<td>no minimum</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>1</td>
</tr>
<tr>
<td>Common Skin Lesions</td>
<td>1</td>
</tr>
<tr>
<td>Common Skin Rashes</td>
<td>1</td>
</tr>
<tr>
<td>Abnormal Vaginal Bleeding</td>
<td>1</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>1</td>
</tr>
<tr>
<td>Cough</td>
<td>1</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>1</td>
</tr>
<tr>
<td>Headache</td>
<td>1</td>
</tr>
<tr>
<td>Vaginal Discharge</td>
<td>1</td>
</tr>
<tr>
<td>Dysuria</td>
<td>1</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1</td>
</tr>
<tr>
<td>Shortness of Breath/Wheezing</td>
<td>1</td>
</tr>
<tr>
<td>Fever</td>
<td>1</td>
</tr>
<tr>
<td>Male Urinary Symptoms/Prostate</td>
<td>1</td>
</tr>
<tr>
<td>Dementia/Delirium/Altered mental status</td>
<td>1</td>
</tr>
<tr>
<td>Leg Swelling</td>
<td>no minimum</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chronic Diagnoses</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple chronic illnesses</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>Type 2 Diabetes Mellitus</td>
<td>1</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>1</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Back Pain</td>
<td>1</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>1</td>
</tr>
<tr>
<td>Obesity</td>
<td>1</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis/osteopenia</td>
<td>1</td>
</tr>
<tr>
<td>Substance use, dependence, or abuse</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
### Health Promotion/Disease Prevention Screening for . . .

<table>
<thead>
<tr>
<th>Condition</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>1</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>1</td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>1</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Fall Risk in elderly</td>
<td>1</td>
</tr>
<tr>
<td>Intimate partner/family violence</td>
<td>1</td>
</tr>
<tr>
<td>Obesity</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>1</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>1</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td>1</td>
</tr>
<tr>
<td>Substance use/abuse</td>
<td>1</td>
</tr>
<tr>
<td>Type 2 Diabetes</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

### Health Promotion/Disease Prevention Visits

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Female physical/health maintenance exam</td>
<td>1</td>
</tr>
<tr>
<td>Adult PE Male</td>
<td>1</td>
</tr>
<tr>
<td>Well Child Check</td>
<td>1</td>
</tr>
<tr>
<td>Prenatal Visit</td>
<td>no minimum</td>
</tr>
<tr>
<td>Follow up office visit mother/baby</td>
<td>no minimum</td>
</tr>
<tr>
<td>Shared Decision Making related to Screening</td>
<td>1</td>
</tr>
<tr>
<td>Smoking cessation counseling</td>
<td>1</td>
</tr>
<tr>
<td>Hospice Visit</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>
## Procedure and Examination List and Minimum Requirements

Students must log at least 15 different procedures and examinations (combined total)

<table>
<thead>
<tr>
<th>Procedures (observe or perform)</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Writing (not counted toward 15)</td>
<td>4</td>
</tr>
<tr>
<td>Anoscopy</td>
<td>No minimum for the rest</td>
</tr>
<tr>
<td>Audiometry</td>
<td></td>
</tr>
<tr>
<td>Cardiac Stress Test</td>
<td></td>
</tr>
<tr>
<td>Cast Application</td>
<td></td>
</tr>
<tr>
<td>Cerumen removal</td>
<td></td>
</tr>
<tr>
<td>Circumcision</td>
<td></td>
</tr>
<tr>
<td>Colposcopy</td>
<td></td>
</tr>
<tr>
<td>Endometrial Biopsy</td>
<td></td>
</tr>
<tr>
<td>Excision of skin lesion</td>
<td></td>
</tr>
<tr>
<td>Foreign body removal</td>
<td></td>
</tr>
<tr>
<td>Immunization/medication injection</td>
<td></td>
</tr>
<tr>
<td>Implantable contraceptive placement/removal</td>
<td></td>
</tr>
<tr>
<td>Incision and Drainage</td>
<td></td>
</tr>
<tr>
<td>Indirect Laryngoscopy</td>
<td></td>
</tr>
<tr>
<td>IUD insertion</td>
<td></td>
</tr>
<tr>
<td>IUD Removal</td>
<td></td>
</tr>
<tr>
<td>Joint Aspiration or Injection</td>
<td></td>
</tr>
<tr>
<td>Labor Management</td>
<td></td>
</tr>
<tr>
<td>Laceration Repair</td>
<td></td>
</tr>
<tr>
<td>Local Anesthesia</td>
<td></td>
</tr>
<tr>
<td>Nasal Packing for Epistaxis</td>
<td></td>
</tr>
<tr>
<td>Non-stress test</td>
<td></td>
</tr>
<tr>
<td>Perineal laceration repair</td>
<td></td>
</tr>
<tr>
<td>Pneumatic Otoscopy</td>
<td></td>
</tr>
<tr>
<td>Sigmoidoscopy/proctoscopy</td>
<td></td>
</tr>
<tr>
<td>Skin Biopsy</td>
<td></td>
</tr>
<tr>
<td>Spirometry</td>
<td></td>
</tr>
<tr>
<td>Splinting</td>
<td></td>
</tr>
<tr>
<td>Suturing</td>
<td></td>
</tr>
<tr>
<td>Tympanometry</td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
</tr>
<tr>
<td>Urine microscopy</td>
<td></td>
</tr>
<tr>
<td>Vaginal Delivery</td>
<td></td>
</tr>
<tr>
<td>Vaginal saline prep</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
</tr>
<tr>
<td>Wart Treatment</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Examinations (perform, not observe)</td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Ankle Exam</td>
<td></td>
</tr>
<tr>
<td>Back Exam</td>
<td></td>
</tr>
<tr>
<td>Breast Exam</td>
<td></td>
</tr>
<tr>
<td>Elbow Exam</td>
<td></td>
</tr>
<tr>
<td>Foot Exam</td>
<td></td>
</tr>
<tr>
<td>Hand Exam</td>
<td></td>
</tr>
<tr>
<td>Hip Exam</td>
<td></td>
</tr>
<tr>
<td>Knee Exam</td>
<td></td>
</tr>
<tr>
<td>Neck Exam</td>
<td></td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td></td>
</tr>
<tr>
<td>Prostate Exam</td>
<td></td>
</tr>
<tr>
<td>Rectal Exam</td>
<td></td>
</tr>
<tr>
<td>Shoulder Exam</td>
<td></td>
</tr>
<tr>
<td>Wrist Exam</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
Small Group Didactic Sessions

1. Common Problems

Learning Objectives

During these small group sessions, the student will learn to:

- Obtain appropriate history, physical findings, and diagnostic tests for many common problems in Family Medicine.
- Interpret medical and historical data accurately.
- Formulate prioritized differential diagnoses.
- Critically assess the likelihood of diagnoses based on available data.
- Formulate assessments and plans integrating biopsychosocial, cultural, and family and genetic information.
- Evaluate the appropriateness and economic feasibility of diagnostic tests (e.g. medical imaging) and treatments.
- Write a prescription using job aides and Epocrates.
- Recognize the role of an individual office visit in the continuum of care.

Session Topics and Required Readings

<table>
<thead>
<tr>
<th>Common Problem Session # 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
</tr>
<tr>
<td>1-1 Otitis</td>
</tr>
<tr>
<td>1-2 Back Pain</td>
</tr>
<tr>
<td>1-3 Hematuria</td>
</tr>
<tr>
<td>1-4 Chest pain</td>
</tr>
<tr>
<td>1-5 Diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common Problem Session # 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
</tr>
<tr>
<td>2-1 Shoulder pain</td>
</tr>
<tr>
<td>2-2 Menopause &amp; Osteoporosis</td>
</tr>
<tr>
<td>2-3 Vaginitis</td>
</tr>
<tr>
<td>2-4 Hypertension</td>
</tr>
<tr>
<td>2-5 Confusion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common Problem Session # 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
</tr>
<tr>
<td>3-1 Sinusitis, allergic rhinitis, upper respiratory infection (URI)</td>
</tr>
<tr>
<td>3-2 Knee pain</td>
</tr>
<tr>
<td>3-3 Fever in children/URI/Immunizations</td>
</tr>
<tr>
<td>3-4 Headache</td>
</tr>
<tr>
<td>3-5 Follow up Diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common Problem Session #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
</tr>
<tr>
<td>4-1 Asthma</td>
</tr>
<tr>
<td>4-2 Foot &amp; ankle pain (gout)</td>
</tr>
<tr>
<td>4-3 Fatigue</td>
</tr>
<tr>
<td>4-4 Heart Failure</td>
</tr>
<tr>
<td>4-5 Sore Throat</td>
</tr>
</tbody>
</table>

Students are expected to prepare prior to each session by reading the required readings listed on ANGEL. Handouts for each session are also available on ANGEL.

Evaluation

- Attendance and participation in these small group sessions is required.
- Material covered during these sessions will be evaluated on the oral and written examinations.
2. **Skin Problems, Geriatrics, and Mental Health Lecture/Discussions**

A preceptor will present a lecture and discussion on each of the above topics seen in Family Medicine. Learning Objectives and Content for this didactic session can be found in the lecture handouts available on ANGEL.

**Required Prerequisite Readings** are listed on ANGEL

**Evaluation:** Competence in the objectives will be evaluated on the NBME subject examination.

3. **Skills Workshops**

   A. **Musculoskeletal Examination Workshop**

   Learning Objectives and Content for this workshop can be found in the lecture handout available on ANGEL. A preceptor will present an introduction to musculoskeletal examination and students will then practice on each other. Students should also be sure to seek out opportunities to practice these examinations in the clinical setting and receive feedback from their preceptors.

   **Required Readings:** Posted on ANGEL

   **Optional Readings:**
   - *Essentials of Musculoskeletal Care, 2nd edition*, Ed. Walter B. Green, M.D.
   - LON-CAPA Musculoskeletal Program (link on ANGEL)

   **Evaluation:**
   - Students are expected to attend and participate in the workshop.
   - Objectives will be evaluated on the oral and NBME examinations.

   B. **Suturing, Casting, and Splinting Workshop**

   A faculty member will instruct students in the relevant procedures and techniques. Students will then practice on models or on each other. Students are expected to gain exposure and confidence with suturing and casting but not to achieve independent competence.

   **Required Reading:** Posted on ANGEL

   **Evaluation:** Students are expected to attend and participate in the workshop.
Oral Presentation Session

Students will be required to give an oral presentation on a screening and prevention topic. Details of the presentation format are described below. The student should use presentation software and provide handouts. The best presentations avoid simply reading slides to the audience. Please try to avoid creating slides that have too much information, or information that is too small to read. The presenter should be prepared to answer questions about the topic from the group.

For additional help with creating and delivering excellent presentations, see the links on ANGEL.

Goals: 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:

- Breast Cancer
- Cervical Cancer
- Lung Cancer
- Alcohol Abuse
- Ovarian Cancer
- Colorectal Cancer
- Depression
- Postmenopausal Osteoporosis
- Family Violence
- High Cholesterol and Other Lipid Abnormalities
- Other, as approved by Community Clerkship Director

Presentation Format

Each student is allotted 20-25 minutes for the case presentation and an additional 5 minutes for questions/discussion. In preparation for this presentation, the student should:

- Consider the essential elements for effective screening tests.
  1. Disease must be of a certain level of prevalence in the population.
  2. Finding the disease early must result in prevention of morbidity and/or mortality.
  3. Screening test must be relatively sensitive, specific (accurate), and reliable.
  4. Reasonable cost.
  5. Low morbidity/risk to screening.
  6. Absence of lead-time and length bias.
- Review at least three sources of current recommendations for screening and prevention related to the topic from the National Guidelines Clearing House web site at www.guideline.gov.
- Critically analyze the research evidence upon which these recommendations were made and assess whether or not the recommendations have a logical basis.
- Discuss characteristics of any disparities that occur with this screening and prevention intervention, such as:
  o Percentages of minorities who receive the intervention.
  o Differences in prevalence of disease in various minority groups.
  o Potential barriers to the intervention that may disproportionately affect minorities or patients of lower socioeconomic classes.
- Collect and analyze patient education materials pertinent to the problem, such as lay press articles or brochures handed out to patients.
- Develop a recommended protocol for screening and prevention for the problem.
- Assess the practicality, accessibility to patients, ease of implementation, and cost-effectiveness of the recommended protocol.
Assess the effect that the recommended protocol might have on routine patient care.

Evaluation

The Community Clerkship Director or designee will evaluate the oral presentations according to the criteria listed below. Please reference the evaluation form on ANGEL. Students who fail to achieve “meets expectations” (4 on a scale of 1-9) will be required to repeat their oral presentation until they do.

- **Topic/Controversies**
  - Clearly delineated the topic and current controversies.
  - Identified population specific issues which may affect rates of intervention.
  - Included the essential elements for an effective screening test (1-6 listed above).
  - Reviewed the basis for current recommendations and analyzed patient education materials.

- **Protocol**
  - Developed and described a protocol for screening and prevention.
  - Defended the protocol in terms of its ease of implementation, accessibility to patients, and cost effectiveness.

- **Organization/Clarity**
  - Focused and orderly.
  - Good synthesis.
  - Effective use of handouts and visual cues.
  - Professional in presentation style and terminology.

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

- Cochrane Database of Systematic Reviews: [www.cochrane.org/](http://www.cochrane.org/)
Write-up Assignments

Students will be required to submit several write-ups on patients they have seen to their Community Clerkship Director. Write-ups can be emailed to the evaluator or handed in to the community clerkship assistant.

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 diagnostic testing, treatment, patient education, health maintenance, and follow-up.

Overview:

Clerkship write-up assignments should be concisely worded and complete, and may use approved abbreviations as per the list posted on ANGEL. Age, gender, and date of the office visit should be included on the front of the write-up. Write-ups should include a master problem list that includes chronic and acute problems as well as health maintenance issues. The assessment 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 must incorporate age and gender appropriate health maintenance issues. Clerkship write-ups will be longer and more detailed than a typical patient note.

A. Outpatient Write-Ups

Students are required to complete two or three ambulatory write-ups at the discretion of the Community Clerkship Director. These should describe patients seen in the office setting using the SOAP note format (see example on ANGEL).

These write-ups should include:

- Age, Gender
- Master Problem List
- Medication List

S-Subjective

- Chief Complaint
- Symptom Dimensions (PPQRST) if a new problem
- ROS appropriate for chief complaint
- Relevant past medical history
- Relevant family history
- Relevant risk factors
- Relevant psychosocial information

O-Objective

- General Appearance
- Relevant vital signs
- Focused physical exam as determined by the history

A-Assessment

- Differential diagnosis if an acute problem that is thorough and realistic
- Assessment of status of chronic disease or health maintenance issues

P-Plan

- Diagnostic
- Therapeutic
- Patient Education
B. Inpatient Write-Up

Students are required to complete one or two inpatient write-ups on a patient seen in the hospital (see example on ANGEL). For this write-up the student should make every effort to choose a patient with a new undiagnosed problem at the time of presentation to the office or emergency room.

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)
- Medications
- Allergies
- Social History (SH)
- Family History (FH)
- Review of Systems (ROS)
- Physical Examination (PE)
- Diagnostic Tests
- Assessment
  - Thorough and realistic differential diagnosis
  - Include health maintenance
- Plans
  - Diagnostic Plan
  - Treatment Plan
  - Health Maintenance Plan
  - Patient Education Plan
  - Follow-Up Plan

Evaluation:

The Community Clerkship Director or designee will evaluate one inpatient and two or three outpatient write-ups in E-Value according to the criteria listed above. Please see the evaluation form on ANGEL. Students who submit unsatisfactory write-ups will be required to rewrite them until they are satisfactory.
Special Topic Modules

Special Topic Modules are curricular elements that may include small group lecture/discussions, readings, online activities, practice with real patients, other assignments, and/or examinations.

A. Shared Decision Making Module (alternatively “Informed Decision Making”)

Learning Objectives

In completing this module, the student will be able to explain and demonstrate 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

- “Screening for Colorectal Cancer in Adults, Recommendation Statement” www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm
- “Screening for Breast Cancer, Recommendations and Rationale” www.uspreventiveservicestaskforce.org/uspstf/uspsbica.htm
- “Screening for Prostate Cancer, Recommendation Statement” www.uspreventiveservicestaskforce.org/uspstf/uspsprca.htm
- “PSA screening does not reduce mortality from prostate CA” (PLCO study)
- “PSA screening has marginal effect on mortality in European study” (ERSPC study)

Optional Readings & Video:
See ANGEL

Educational Activities

1. Introductory Lecture/discussion

A faculty member will introduce the material covered in this module using a PowerPoint presentation and an online group activity that includes video clips of health care communication. Please see the handout available on ANGEL.

2. Office Practice

Each student will need to find at least one patient to practice shared decision making on one of the following topics:

- Screening for Osteoporosis
- Screening for Colorectal Cancer
- Screening for Breast cancer
- Screening for Cervical Cancer
- Screening for Prostate Cancer

Students must log these activities on E-Value upon completion. The more a student practices, the better he or she will perform on the PBA.
Additional optional topics for practicing shared decision making include:

- Contraceptive choices
- Antibiotic choice
- Medication for chronic disease such as Hypertension or Diabetes

**Evaluation**

- Students are expected to attend and participate in the lecture/discussion.
- Students are required to log their office practice in E-Value. Preceptor verification is satisfactory evidence of completion.
- Shared Decision Making is a major component of the performance based assessment (PBA) examination, described separately. This is usually scheduled in week 6 or 7 of the clerkship.
- Questions on the written examination may address this content.

**B. Smoking Cessation Module**

**Learning Objectives**

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

- 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.
- Adjust interventions in response to patient’s willingness to quit and to other indications of readiness and motivation.
- Adjust pharmacotherapy intervention to patient circumstances.
- Translate diagnostic and therapeutic approaches that are appropriate for nicotine addiction to other addictions.

**Required Reading**

- *Smoking Cessation: U.S. Public Health Service Clinical Practice Guideline for Tobacco Use and Dependence.*

**Optional Reading**

- See ANGEL

**Educational Activities**

1. **Introductory Lecture/discussion**

A faculty member will introduce the material covered in this module with a brief lecture describing the physiology and epidemiology of addiction as well as the clinical practice guideline for tobacco use and dependence. The instructor will present cases and role play responses to the patient’s willingness to quit. Please refer to the handout available on ANGEL.

2. **Office Practice**

- Each student will need to find at least one patient to practice smoking cessation counseling using the Practice Guideline’s recommended strategies. Try to do this early in the clerkship, definitely before the PBA. The more patients with which a student practices, the better that student will perform on the PBA.
- Students will log their practice with a real patient in E-Value.

**Evaluation**
C. 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

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

Educational Activities

1. Introductory Lecture/discussion

   During Block III Orientation, students will participate in an introductory interactive session which will review concepts of patient safety, safe prescription writing and how to avoid and address medical errors.

2. Office Practice

   - Students will practice prescribing during their common problem sessions.
   - Then students must find at least four patients requiring a new prescription or a change in medication. Using their job-aides (laminated cards) they should write the prescription. In the case that students are unable to write prescriptions (for example, using an EHR), they may review those written by their preceptor. Students should focus on the six point cognitive checklist, rather than merely on the 10 point “elements of a medication order or prescription”.
   - Students should log a total of four of these experiences into E-Value.

Evaluation

- Preceptor verification in E-Value will be sufficient proof that the student has practiced.
- Prescription writing will be evaluated on the prescription writing examination.
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: See articles on ANGEL

Education Activities

1. Introductory Lecture/Discussion

A Family Medicine faculty member will provide a presentation covering the major aspects of maternity care. Content and Objectives for this session are available in the handout on ANGEL. The session includes several practice exercises.

2. Office Practice

Students should 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 document this visit in E-Value.

3. Hospital Practice

Students should also observe a delivery by a family physician (can be faculty, community, or resident). The student should make a postpartum visit to the mother and baby in the hospital, again taking appropriate history. Student should document these activities in E-Value.

Evaluation

- All students should attend and participate in the lecture discussion.
- The prenatal visit, labor and delivery observation, and postpartum visit should be recorded in E-Value, along with verification by the supervising physician.
- The medical knowledge and patient care components of the module will be evaluated by the oral examination and the written examination.
E. 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 Reading: “Michigan Physicians Guide to End-of-Life Care”

Educational Activities

- Students will read the required reading and then view a web based online presentation: “Hospice/Palliative Care Module”, available on ANGEL.
- The students will then participate in one of the following hospice/palliative care experiences:
  - 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.
- Students should document the Hospice/Palliative Care visit in E-Value.

Evaluation

- Students are expected to complete the prerequisites and participate in the hospice/palliative care experience.
- Material covered in this module will be tested on the written examination.

F. Community Resources Module

Learning Objectives

In completing this module, the student will gain an understanding of how community 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.