TO:       Class of 2020

FROM:    Christopher Lynn, M.D.
         Clinical Clerkship Director

RE:       Required Internal Medicine Clerkship
           Course Requirements and Handbook

On behalf of our Chairman, the faculty and staff in the Department of Medicine, I would like to welcome you to the Internal Medicine Clerkship.

The attached materials are indexed to allow easy reference. I encourage you to read all of this material at the beginning of your clerkship and review it frequently if questions develop.

As you move from the classroom-oriented education of the first two years, it is important to recognize that you will now be called on to use this information and acquire additional knowledge in order to care for your patients. This knowledge will not be "given" to you. You must acquire the personal motivation and self-study habits necessary for a lifetime of learning.

The faculty looks forward to working with you during your clerkship. We are here to help you reach your goal of becoming a physician.

The Clerkship Office is located in the basement of Main Hospital Building, Suite #0245A. If you have any questions, call Dawn Jagodzinski at 383-5022 between 7:30 a.m. – 4:00 p.m.
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Svitlana Zhukivska, M.D., Assistant Professor

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UT Dept of Medicine Faculty cont’d

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Lance Dworkin, M.D., Professor, IM Chairman
Alexei Fedorov, M.D., Ph.D., Associate Professor
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Svetlana Kriegel, Asst Professor (Allergy/Immunology)
Navya Parsa, M.D., Assistant Professor
Rujuta Trivedi, M.D., Assistant Professor
Yongqing Wang, M.D., Assistant Professor

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Nishit Srivastava, M.D.
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John Wehrmeister, M.D.
## INTERNAL MEDICINE REQUIRED CLERKSHIP HANDBOOK INDEX

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I. **REQUIRED INTERNAL MEDICINE CLERKSHIP**

The required Medicine rotation is 9 weeks in length. You will spend a total of 6 weeks at a Toledo area hospital (UTMC, ProMedica Toledo Hospital, St. Vincent Mercy Medical Center,) or at Riverside Hospital (Columbus), Akron General, or St. Joseph Hospital (Ypsilanti, MI) and 3 weeks either at an Area Health Education Center (AHEC), UTMC or local ambulatory site/service.

**Goals:**

The Department of Internal Medicine will provide all third-year medical students with a broad-based educational experience in outpatient and inpatient medicine so that they will:

- Develop skills in the evaluation and basic management of patients.
- Acquire the knowledge necessary for the competent practice of medicine in a supervised setting as measured by acquiring a minimum score on the Internal Medicine subject exam.
- Acquire excellent interpersonal and professional communication skills.

The Department of Medicine has established a set of Educational Course Objectives. These are in alignment with The University of Toledo College of Medicine & Life Sciences Core Competencies Required for Graduation. We would encourage you to review these frequently throughout the clerkship.

Students will receive written Mid-Clerkship feedback at the end of the fifth week of the rotation. This will not be used to determine your final grade for the clerkship.
INTERNAL MEDICINE ORIENTATION

1. Reporting information for the following locations:

**UTMC Med A-B-C-D & Med V Inpatient/Consult** students please report to the IM Resident Conference Area/ Library (Hospital basement, room 0245 – door code is 1-2-3-4-5-6) at 7:50 a.m. Following a quick orientation session with Dawn, a Resident will meet you to provide further instruction for the rotation.

**Mercy St. Vincent Medical Center (MSVMC)** students report at 7:30 a.m. to Kathleen Burkett. Her office is located the ACC Building (Please park in the Main Parking Garage off Cherry Street). Her office is located on the 1st floor on the inside of the hallway look for her name on the door. She will give you an ID badge and a brief orientation / tour before having you report with your team to didactics or morning report.

**Riverside** students are to report to the ID Badge Center prior to Orientation (Green Area/South Medical Office Bldg, Ste 3070A, 3555 Olentangy River Rd, Columbus, OH 43214). You must have your Driver’s License and OPID (can be found in the email from Wendy Steele). Orientation will begin at 8:45 a.m. in the Medical Education Department across the hall from the Lost and Found on the first floor Yellow Area of the Main Building (unless otherwise instructed by Riverside). Your contact at Riverside is Wendy Steele, she can be reached at 614.566.3202. If you requested housing, you will receive an email from the UT Office of Medical Education the week prior to the start of your rotation.

**St. Joseph** students you will receive an email from Sarah Schmanske at St. Joe’s regarding reporting information. If you need to contact her, she can be reached at 734.712.5583. If you requested housing, you will receive an email from the UT Office of Medical Education the week prior to the start of your rotation.

**ProMedica Toledo Hospital (PTH) IMS-1, IMS-2 & IMS-3, PPH & PPC** students park in levels 3-5 of the P5 parking lot (North Cove side of campus) and enter the hospital through entrance F.

**IMSs Teams** should proceed to the second floor classroom area at 8:15 a.m. to meet your team. Below is contact information in case you have trouble locating your team:

- IMS-1: Phone 419-291-1773 or Pager 419-534-0054
- IMS-2: Phone 419-291-0260 or Pager 419-292-3111
- IMS-3: Phone 419-291-0261 or Pager 419-292-3112
- IMS-GIM: Phone 419-291-0262 or Pager 419-292-3099

**PPH & Cardiology Teams** report as noted below:

- PPH (Hospitalist): Contact person Katie Miller, Phone 419-291-1111
  - Report at 7:30 a.m. to the PTH PPH Hospitalist Office. From Entrance F follow the hallway towards the ER and down the stairs. Office will be on the right hand side of the hallway
  - PPH Team A Pager 419-321-0960
  - PPH Team B Pager 419-539-0307
2. **Check your e-mail daily.** This rotation is HIGHLY dependent on e-mail communication.

3. If you need to be excused from your assigned rotation for any reason, either a scheduled or emergent issue, you need to submit an **Excused Absence Request** form to the Clerkship Office (dawn.jagodzinski@utoledo.edu) for approval. In addition, you need to notify both your attending or senior resident and the Clerkship Coordinator of your absence ASAP or by the start of your shift. A copy of the Absence Request Form is located in Appendix E of this handbook or can be obtained through the IM Clerkship Office. Absence request forms must be submitted as far in advance as possible or for emergent absences within 48 hours of your return.

4. All students will have the opportunity to be observed by a faculty member performing a complete **History & Physical** on a standardized patient. Formative feedback will be provided after completion of the exercise. Please be sure to note the date and time for your scheduled session. You will be excused for your clinical duties for this session. A copy of the History & Physical Checklist can be found at Appendix B in the back of this handbook.

5. A required **Lab Medicine** experience will be offered for all students. These sessions will be held on two consecutive Wednesday afternoons and will be organized by the Department of Pathology. The purpose of these sessions is to familiarize the student with the appropriate use of the laboratory. Topics to be reviewed will include the interpretation, costs, frequency of ordering and sensitivity/specificity of common laboratory tests. You will be excused from your clinical duties for these sessions.

6. Students are also required to complete 18 of the **Aquifer Internal Medicine cases** (SIMPLE cases) prior to the end of the Clerkship. Students are encouraged to complete all of the cases available to them. Using your UT email address, create an account to access the cases here: https://utoledo-md.medapp.com/users/sign_in

7. The **evaluations** that you need to complete at the end of your Internal Medicine Clerkship can be found by logging into http://meded.utoledo.edu. You can complete the evaluations at the end of each block, but all evaluations will need to be completed no later than seven (7) days after the end of the Clerkship.

8. The **Internal Medicine OSCE** (Objective Structured Clinical Examination) will be given during the last week of the IM Clerkship, usually on Wednesday. This exam will assess your skills in taking a history, performing a physical exam and interpreting clinical studies. The schedule and additional information will be e-mailed to each student at a later date.

9. The **NBME Internal Medicine Subject Exam** is typically scheduled on the last Friday of your Internal Medicine Clerkship, usually in the morning. Additional information will be e-mailed to each student at a later date. Students will be released from their clinical duties at noon the day before the exam to study.

**Hospital Rotations:**

1. **DRESS CODE:** Professional attire, clean and pressed white coat unless otherwise instructed

2. **WORK HOURS:**
   - Minimum of 7:30 a.m. – 4:30 p.m., Monday through Friday and round on patients either Saturday or Sunday
   - There are no required call responsibilities at UTMC or Toledo Hospital
   - Call will be discussed at each of these sites individually: Riverside Hospital, St. Vincent Hospital, and St. Joseph Hospital

3. **DUTIES:**
   - Attend all educational conferences. Attendance will be confirmed by sign in sheets and completion of any exercises presented during the sessions.
   - History and physical write-ups are to be completed within 24 hours; ask your senior resident to proof and provide feedback.
   - Assigned patients must be seen prior to pre-determined round time
   - Have notes prepared before rounds; review labs and medication lists
   - Be prepared to present your patients on rounds.
   - Participate in rounds by asking questions to clarify issues that are not clear to you.
   - Follow-up on all laboratory studies, radiology orders and results of special procedures or tests.
   - Prepare for check-out rounds
   - Update patient census list
   - Check with senior or intern prior to leaving

4. Students on rotations at UTMC and Toledo Hospital are required to attend the following sessions: (see Block-specific schedule for exact dates, locations and participation schedule. Also be sure to SIGN IN BEFORE each conference.)
   - **Ethics Conference;** students assigned to Toledo Hospital will need to come to the UT campus to attend this session
   - **Noon/Research Conference;** shown at both the UTMC and Toledo Hospital campuses
   - **Clinical Case Conference;** shown at both the UTMC and Toledo Hospital campuses
• **Didactics;** shown at both the UTMC and Toledo Hospital campuses

• **Time with the Chief;** once per week for students assigned on Inpatient/Consult rotations at UTMC and Toledo Hospital campuses

• **Resident-Directed Student Didactics;** once per week for students assigned on Inpatient/Consult rotations at UTMC and Toledo Hospital campuses

• **Chairman Rounds;** once per 3-week rotation for students at UTMC and once per 3 weeks for students at Toledo Hospital. Students are assigned by team to present and all others are expected to participate.

• **Afternoon Report;** students on the UTMC campus attend only

• **Grand Rounds/M&M Conferences;** shown at both the UTMC and Toledo Hospital campuses. Students on Ambulatory are encouraged to attend also, if their schedule permits.

• **Ambulatory Rounds: ** Only required for students on Ambulatory rotation

**NOTES:**

• The sessions listed above are mandatory for those mentioned. If your team is rounding during one of the sessions that you are supposed to attend, you need to excuse yourself from rounds to attend the session.

• Students on rotations outside of UTMC or Toledo Hospital will receive a separate schedule from their perspective sites.

**ADMISSION ORDERS**

Admit to [team, physician, floor]

Diagnose (primary and secondary)

Condition

Vitals

Allergies

Nursing

Diet

Activity

Labs

I V Fluids

Special tests

Medications

**DISCHARGE ORDERS**

Discharge to [home, facility, expired]

Diagnosis (primary and secondary)

Condition

Diet

Activity

Medications

Follow-up
STANDARD S.O.A.P. NOTE

S: Subjective
- Summary of patient and condition
- What happened since last seen
- How is the patient doing? Symptoms/review of pertinent systems

O: Objective
- Vitals: heart rate, respiratory rate, temperature and blood pressure
- Physical exam: HEENT, CV, RESP, GI/abdomen, extremities, NEURO
- Labs: date / time
- Test results: EGD, CT, CXR, MRI, stress test, CATH, etc.

A: Assessment
- Primary and active problem first (problem list in order of importance)

P: Plan
- Correlate your plans with each assessment

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<tr>
<th>WBC</th>
<th>HGB</th>
<th>Platelets</th>
<th>Na</th>
<th>Cl</th>
<th>BUN</th>
<th>Glucose</th>
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<td></td>
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<td></td>
<td>T.CO₂</td>
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<td>Creatinine</td>
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TOPICS TO COVER:
- What is expected of you on rounds
  - Present in clear voice. Speak directly to the team.
- History and Physical (H&P): Be as complete as possible. This will be one major part of how you are evaluated. Be sure to include a differential diagnosis discussion under the assessment.
- Notes: Show organization, this will be another major part of how you will be evaluated.
- Problems:
  - **Student to student**: attempt to work it out amongst yourself. Squabbling and bickering will reflect poorly on everyone regarding professional behavior.
  - **Student to intern**: speak to your senior resident
  - **Student to senior resident**: speak to your attending or the chief resident
  - **Student to attending**: speak to the Clerkship Director
  - Patient confidentiality must be foremost!
**S.O.A.P. Note – for floor patients**

**Subjective: How the patient is feeling and review of systems**

<table>
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<th>ROS:</th>
<th>This is for complete History and Physical (H&amp;P)</th>
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<tr>
<td>General:</td>
<td>Usual weight, weight changes, fever/chills, night sweats</td>
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<td>Skin:</td>
<td>Rashes, lumps, itching, ulcers, color changes, changes in hair or nails</td>
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<tr>
<td>Head:</td>
<td>Headache, head injury</td>
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<td>Eyes:</td>
<td>Vision, last eye exam, glasses/contacts, pain, redness, excessive tearing, double vision, spots, specks, flashing lights, glaucoma, cataracts</td>
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<td>Ears:</td>
<td>Hearing, tinnitus, vertigo, earaches, infection, hearing aids</td>
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<tr>
<td>Nose &amp; Sinus:</td>
<td>Frequent colds, nasal discharge or itching, nosebleeds, allergies, sinusitis</td>
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<tr>
<td>Mouth &amp; Throat:</td>
<td>Dentures, last dental exam, sore tongue, sore throat, hoarseness, ulcers</td>
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<tr>
<td>Neck:</td>
<td>Lumps, goiter, pain or stiffness</td>
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<td>Breasts:</td>
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<td>Respiratory:</td>
<td>Cough, sputum, hemoptysis, wheezing, asthma, bronchitis, emphysema, pneumonia, TB cancer, pulmonary embolus</td>
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<td>HTN, MI, heart murmurs, chest pain or pressure, palpitations, orthopnea, paroxysmal nocturnal dyspnea, edema, dyspnea, h/o EKG, stress test, cardiac cath</td>
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<td>GI:</td>
<td>Trouble swallowing, heart burn, appetite, n/v hematemesis, h/o ulcers, h/o cancer, bowel habits, rectal bleeding or black tarry stools</td>
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<td>Urinary:</td>
<td>Frequency of urination, polyuria, nocturia, burning with urination, hematuria, urgency, hesitancy, dribbling, incontinence, infections or stones</td>
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| Genital: | Males: hernias, discharge or sores on penis, testicular pain or masses, h/o STD’s  
Females: age at menarche, regularity, frequency and duration of periods, LMP, age of menopause, postmenopausal bleeding, discharge, sores, lumps, STD’s, pregnancies and abortions |
| Peripheral Vascular: | Intermittent claudication, leg cramps, varicose veins, DVT’s |
| Musculoskeletal: | Muscle or joint pain or stiffness, DJD, gout, cellulitis |
| Neurologic: | H/o stroke, LOC, seizures, weakness, paralysis, numbness or tingling, tremors |
| Hematologic: | Anemia, easy bruising or bleeding, past transfusions and reactions to them |
| Endocrine: | Thyroid disease, heat or cold intolerance, excessive sweating, diabetes, excessive thirst or hunger, polyuria |
| Psychiatric: | Anxiety, depression, memory |
OBJECTIVE: Tm P R BP I/O Weight Sat O2
Gen: How do they appear?
HEENT:
Neck:
Heart:
Lungs:
Abd:
Back:
Ext:
Lines:
Current medications:
Labs:
Tests:
- resulted
- pending

ASSESSMENT: Problem list and status of problems

PLAN: How we are addressing these problems and what we will do today and why

STUDENT RESPONSIBILITIES:
1. Keep list updated – must be updated every night before you leave
2. Complete SOAP note on each patient every day, before rounds
3. Inform intern of abnormal test/lab results or unusual delays
4. Do not talk with patients/families about plan of care or test results unless clearly instructed to do otherwise. This is generally a senior resident or attending responsibility
5. Participate in teaching rounds
6. Participate in check-out rounds
7. Always let the interns know where you will be during the day.
8. Be in the hospital early enough to complete your work and no later than 7:30 a.m.
9. Try not to surprise your senior or intern on rounds with your information – discuss your patients with your senior or intern before rounds.
10. If you have questions about your patient, try to address these with your intern or senior before rounds
ACLS Training

NOTE: You will need to take Appendix F in the back of this book to the classroom portion of the ACLS course!

The College of Medicine and Life Support Training Program have made the following arrangements for ACLS (Advanced Cardiac Life Support) training for those who are in their 3rd year of medical school at the University of Toledo. Training will consist of a Lecture/Video session as well as a Skill Session. Both sessions must be attended in order to receive certification. Both training sessions will be in conjunction with the Internal Medicine rotation. The Lecture/Video session will take place during orientation. Students will be required to register for the Skills Session on a date the class is offered.

PRECOURSE PREPARATION:
Students will be provided with the most current ACLS textbook (unless otherwise specified). Students are fully responsible for the care of these books and will be held financially responsible for their replacement in the case of loss or damage. The books are required to be turned in when he/she attends the skill session.

As a part of your pre-course preparation, you must go to the AHA student website and type in the code found in your book. The website and code is found on page ii in the front of your provider manual. At this website, you must complete the following BEFORE attending the Skill session:

1) Watch the following videos:
   - Acute Coronary Syndromes
   - Acute Ischemic Stroke
   - Science of Resuscitation

2) Complete the pre-course assessment with a minimum score of 70%. The assessment can be repeated as needed to obtain the required score. The printed results of the pre-course assessment must be submitted when you arrive to check-in at the beginning of the hands-on session.

**Students who do not have the printed pre-course assessment with a 70% minimum will not be allowed to attend the skill session for that day.

Lastly, because your exposure to EKG interpretation and cardiac-specific medications has been limited to this point, it is strongly recommended that you review the supplementary materials found on the student website.

SKILL AND HANDS-ON SESSIONS:
You must register to attend one Skill session. To register, go to the UT Life Support website at: http://utoledo.edu/lifesupport Search for the courses specifically entitled: ACLS – MS3 Students Courses are listed alphabetically, or you can search by date. If you sign up for any course other than the “ACLS – MS3 Students”, you may obtain a refund, but it will be minus a 10% administrative fee for the refund. Therefore, be certain you are registering for the correct course as listed above!

The skill sessions are held in the basement of Collier (take the Collier Building elevator to the basement, turn left and go thru the glass doors. You will check in at the desk and turn in your pre-course assessment at that time, and then be directed to the classroom. Unless otherwise stated, all sessions begin promptly at 8:00 a.m., so students are expected to arrive at the Life Support Training Center area at least 10 minutes prior to the scheduled start time. Students arriving after the class has started will not be allowed to attend!
Standards for Professional Behavior for Students in the COM

The following standards for professional behavior are in alignment with the Educational Program Objectives for the College of Medicine and are meant to supplement the Standards of Conduct, listed in policy #01-027, which apply to all staff and students of the University of Toledo.

Self
1. Adheres to dress code consistent with institutional standards.
2. Is punctual for all educational experiences (I.E., exams, clinics, rounds, small group sessions, appointments at the clinical skills center).
3. Fulfills all educational assignments and responsibilities on time.
4. Accepts constructive feedback and makes changes accordingly.
5. Recognizes personal limitations and seeks appropriate help.

Relationships with students, faculty, staff, patients and community
1. Establishes effective rapport.
2. Establishes and maintains appropriate boundaries in all learning situations.
3. Respectful at all times of all parties involved.
4. Demonstrates humanism in all interactions.
5. Respects the diversity of race, gender, religion, sexual orientation, age, disability, and socioeconomic status.
6. Resolves conflict in a manner that respects the dignity of every person involved.
7. Uses professional language being mindful of the environment.
8. Maintains awareness and adapts to differences in individual patients including those related to culture and medical literacy.

Support of ethical principles of the Medical Profession
1. Maintains honesty.
2. Contributes to an atmosphere conducive to learning and is committed to advance scientific knowledge.
3. Protects patient confidentiality.
Learning Environment Survey

Dear Students:

The Learning Environment is created by the interactions among faculty, staff, and students.

As part of our ongoing efforts to maintain a positive learning environment that supports optimal educational programs, we have developed a short (one page) online survey tool to gather data regarding your perceptions and experiences. We are interested in receiving information about experiences, and possibly individuals that had a positive impact on your learning as well as any that may have created barriers. All responses are anonymous. Data will be anonymously forwarded to the college and/or hospital personnel who are in positions to acknowledge positive behaviors in addition to providing intervention if ever warranted.

Your feedback in a real-time way is key to this success. If there is a resident, nurse or faculty member who has demonstrated outstanding professionalism and contributed to your learning environment or has detracted we want to know, and know quickly. If there should ever be an event that reaches a degree of urgency, you may indicate this and/or request follow-up using this data collection tool.

Instructions:
The Learning Environment Assessment and Event Report can be accessed from an icon in your current courses in BlackBoard. The link has been included on the Blackboard home page for all preclinical blocks and required clerkships. Additionally, you can go directly to the site at

http://utmc.utoledo.edu/learningenvironment

You will need to sign on and will be prompted for your UTAD User ID and password and then the assessment page will display. Use the pull-down menus to select a location such as University of Toledo Medical Center (UTMC), Health Science Campus (HSC), and to select the primary person(s) involved. Use the radio buttons to answer the questions and click on submit when completed. If appropriate, please provide specific comments regarding the event as well.

If you indicate that an event is of a serious nature and warrants immediate follow up, you will be prompted to enter a contact name and phone number.

We strongly encourage you to provide feedback on the learning environment experienced in each of your required and elective clerkship rotations as well as regarding your encounters with the various offices and departments across our campus. If you have any questions, please don’t hesitate to contact me.

IA
Imran Ali, MD
Professor of Neurology
Chair, Department of Medical Education
Vice Dean for Undergraduate Medical Education
University of Toledo
### II. EDUCATIONAL COURSE OBJECTIVES

<table>
<thead>
<tr>
<th></th>
<th>Core Competencies</th>
<th>Clerkship Objectives</th>
<th>Instructional Method</th>
<th>Evaluation Method / Outcome Measure</th>
</tr>
</thead>
</table>
| 1 | PC-2, PC-3, PC-5  | Demonstrate an ability to obtain a complete medical history | Patient care in inpatient and outpatient settings  
Teaching rounds, inpatient rounds  
Faculty observed history & physical | Clinical Competency Evaluation  
OSCE  
Case Report (written assignment)  
Formative feedback on faculty observed history & physical |
| 2 | PC-2, PC-4        | Demonstrate an ability to perform a complete or focused physical examination as appropriate and distinguish normal from abnormal findings | Patient care in inpatient and outpatient settings  
Faculty observed history & physical session  
Teaching rounds, inpatient rounds  
Harvey simulator session | Clinical Competency Evaluation  
OSCE  
Formative feedback on faculty observed history & physical |
| 3 | MK-1, MK-2, MK-4, MK-6, MK-7; PC-4, PC-7, PC-8 | Synthesize information to develop a reasonable differential diagnosis and present information in a succinct and organized manner | Patient care in inpatient and outpatient settings  
Faculty observed history & physical  
Presentation at Chairman Rounds  
Presentation at Morning Report | Clinical Competency Evaluation  
NBME Subject Exam  
OSCE  
Formative feedback on faculty observed history & physical |
| 4 | MK-1, MK-2, MK-4, MK-6, MK-7; PC-4, PC-7, PC-8 | Demonstrate an ability to assess the patient’s chief complaint and develop an appropriate management plan | Patient care in inpatient and outpatient settings  
Presentation at Chairman Rounds  
Presentation at Morning Report | Clinical Competency Evaluations |
| 5 | MK-1, MK-2, MK-4, MK-6, MK-7; PC-1, PC-2, PC-4 | Perform a complete H & P for new patient encounters and document the results | Patient care in inpatient and outpatient settings | Clinical Competency Evaluations |
| 6 | MK-1, MK-2, MK-4, MK-6, MK-7; PC-1, PC-2, PC-4; PC-7, PC-8 | Regularly re-evaluate patients’ status including interpretation of new history and physical exam findings | Patient care in inpatient and outpatient settings | Clinical Competency Evaluations |
| 7 | MK-1, MK-2, MK-4, MK-6, MK-7; PC-1, PC-2, PC-4; PC-7, | Accurately prepare case reports based on patient encounters and research into the primary diagnoses | Patient care in outpatient settings | Clinical Competency Evaluations  
Case Reports on |
<table>
<thead>
<tr>
<th></th>
<th>PC-8, PC-10</th>
<th>Demonstrate an ability to utilize and interpret laboratory and radiographic tests used in diagnosing common disease</th>
<th>Patient care in inpatient and outpatient settings Lab Medicine experience</th>
<th>Ambulatory assignment (written assignment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>PC-7, PC-8</td>
<td>Patient care in inpatient and outpatient settings Clinical Competency Evaluations</td>
<td>Clinical Competency Evaluations NBME Subject Exam</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>MK-8</td>
<td>Demonstrate an understanding of the skills necessary to identify appropriate pain management strategies</td>
<td>Patient care in inpatient and outpatient settings Chairman Rounds &amp; Student Morning Report</td>
<td>Clinical Competency Evaluations</td>
</tr>
<tr>
<td>10</td>
<td>MK-1, MK-2, MK-4, MK-6, MK-7, PC-9</td>
<td>Recognize and manage common medical emergencies</td>
<td>Patient care in inpatient and outpatient settings</td>
<td>Clinical Competency Evaluations NBME Subject Exam</td>
</tr>
<tr>
<td>11</td>
<td>MK-9, MK-10, MK-11, MK-12, MK-13; PB-1, PB-6</td>
<td>Identify ethical problems which arise in patient treatment and care</td>
<td>Patient care in inpatient and outpatient settings Ethics Conference</td>
<td>Ethics Conference participation</td>
</tr>
<tr>
<td>12</td>
<td>MK-9, MK-10, MK-11, MK-12, MK-13</td>
<td>Use ethical principles to reach a resolution in a presented case</td>
<td>Patient care in inpatient and outpatient settings Ethics Conference</td>
<td>Ethics Conference participation</td>
</tr>
<tr>
<td>13</td>
<td>MK-9 to MK-13; PB-1, PB-7</td>
<td>Recognize how race, culture and/or spirituality may influence choice of treatment and health care decision-making.</td>
<td>Ethics Conference</td>
<td>Ethics Conference participation</td>
</tr>
<tr>
<td>14</td>
<td>PC-10</td>
<td>Utilize self-directed learning in evaluation and management of patients.</td>
<td>Case Reports on Ambulatory rotation</td>
<td>Case Report evaluations</td>
</tr>
</tbody>
</table>
| 15| PC-2 to PC-7 | Demonstrate an ability to meet or exceed the institutional standards for professional behaviors as evidenced by:  
- adhering to the dress code consistent with clerkship standards.  
- being punctual for all educational experiences (i.e. exams, clinics, rounds, small group sessions, appointments at the clinical skills center).  
- fulfilling all educational assignments and responsibilities on time.  
- displaying honesty in all interactions and situations.  
- contributing to an | Patient care in inpatient and outpatient settings Clinical Competency Evaluations |
atmosphere conducive to learning and is committed to advance scientific knowledge.

• establishing and maintaining appropriate boundaries in all learning situations.
• using professional language being mindful of the environment.
• establishing effective rapport.
• being respectful at all times of all parties involved.
• resolving conflict in a manner that respects the dignity of every person involved.
• respecting the diversity of race, gender, religion, sexual orientation, age, disability and socioeconomic status.
• exhibiting humanism in all interactions.
• protecting patient confidentiality.
• being aware of and adapting to differences in individual patients including those related to culture and medical literacy.
• recognizing personal limitations and seeking appropriate help.
• accepting constructive feedback and making changes accordingly.
• exhibiting independent and self-directed learning.
Required Clinical Experiences:

To help learners achieve these educational course objectives, requirements for both patient type (diagnostic category) and students’ level of involvement have been established. These clinical experiences will be complimented by faculty-directed small group sessions, resident-directed clinical discussions and web-based interactive self-study (Aquifer Internal Medicine Cases).

Patient type:

During this clerkship, students are required to recognize symptoms that may signify disease in eight categories. They need to distinguish normal from abnormal findings on physical exam, formulate a differential diagnosis based on signs and symptoms, use and interpret common tests used in diagnosing disease and develop a systematic approach to management of these common diseases. This provides the core of the internal medicine experience. All categories are required and considered essential as part of an introduction to internal medicine. The minimum number of patients in each category is defined.

Patients are seen in both inpatient and outpatient settings. All students complete 6 weeks of Medicine inpatient service. Students are involved with patients admitted to acute care inpatient services with a wide variety of medical diagnoses. Students are required to evaluate at least 16 patients over the 6 week experience. In addition to participating in Medicine Service, students spend 3 weeks in a variety of ambulatory sites. During this experience, students work with preceptors who care for a wide spectrum of patients with medical diagnoses including both new patients and patients returning for follow up care. Students are required to assess at least 8 patients during this experience. Students must log all patient encounters and logs will be monitored to ensure adequate experience.
### III. Diagnostic Categories

<table>
<thead>
<tr>
<th>Diagnostic category</th>
<th>Minimum Number of Patients to be seen</th>
<th>Comments/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>2</td>
<td>Includes CHF, ischemic heart disease, arrhythmia, hypertension, or peripheral vascular disease</td>
</tr>
<tr>
<td>Endocrinologic Disease</td>
<td>2</td>
<td>Includes hyper/hypothyroidism, diabetes mellitus, or adrenal disease</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>2</td>
<td>Includes COPD, asthma, interstitial lung disease</td>
</tr>
<tr>
<td>Hematologic/Oncologic Disease</td>
<td>2</td>
<td>Includes anemia, hematologic malignancy, or solid organ malignancy</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>2</td>
<td>Includes sepsis, endocarditis pneumonia, meningitis, urinary infection or HIV</td>
</tr>
<tr>
<td>Rheumatologic Disease</td>
<td>2</td>
<td>Included rheumatoid arthritis, degenerative arthritis, or SLE</td>
</tr>
<tr>
<td>Gastroenterologic Disease</td>
<td>2</td>
<td>Include peptic ulcer disease, esophagitis, cirrhosis or inflammatory bowel disease</td>
</tr>
<tr>
<td>Nephrologic Disease</td>
<td>2</td>
<td>Includes renal failure, electrolyte disturbance, acid-based disturbance, nephritic syndrome, or renal calculi</td>
</tr>
</tbody>
</table>

**Level of involvement:**
In addition to seeing patients in the diagnostic categories listed above, how the students are engaged in the encounter is also an important factor in helping students achieve the objectives for this clerkship. Level of involvement is likely to include various types of interaction with patients and the health care team and should be monitored to ensure a complete experience. Levels of involvement will be indicated for logged patient encounters so **log accurately!** The logs will be reviewed mid-block to ensure that students have a range of experiences in both inpatient and/or outpatient settings.
Level of involvement during patient encounters will be logged using the following categories:

- Independently gathered history information*
- Observed patient interview
- Independently performed physical exam*
- Observed physical exam
- Presented patient case*
- Wrote patient note*
- Opportunity to discuss laboratory or test results*
- Opportunity to offer and discuss differential diagnosis*
- Opportunity to offer and discuss management options*
- Observed procedure
- Performed procedure (not required for this clerkship)

For the levels of involvement marked with an *, the following numbers are considered to be the minimum expected for this clerkship and should be reflected in the logs:

<table>
<thead>
<tr>
<th>Activity:</th>
<th>Elicit History information</th>
<th>Perform Physical Exam</th>
<th>Present patient</th>
<th>Recommend or discuss dx, tx, management</th>
<th>Interpret tests</th>
<th>Write notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency:</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>16</td>
</tr>
</tbody>
</table>

**Other Clerkship Experiences:**

In addition to required clinical experiences (patient type and level of involvement), successful completion of the clerkship requires student participation in a variety of additional experiences. These experiences are coordinated through the Department of Internal Medicine and include lecture/discussions and presentations.
IV. **CORE COMPETENCIES REQUIRED FOR GRADUATION**

**Medical Knowledge**
Students must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences across the lifespan, as well as the application of this knowledge to patient care.

Graduating medical students will be competent and have demonstrated

MK-1 Knowledge of the normal structure and function of all organ systems

MK-2 Knowledge of the molecular, biochemical and cellular mechanisms related to normal and abnormal function

MK-3 Knowledge of underlying causes of common disorders and their pathogenesis

MK-4 Knowledge of altered structure and function (pathology and pathophysiology) associated with various diseases

MK-5 Knowledge of clinical manifestations of common diseases

MK-6 Knowledge of pharmacological basis of therapeutics

MK-7 Knowledge of scientific principles required to practice evidence-based medicine

MK-8 Knowledge about pain relief and palliative care

MK-9 Knowledge of ethical principles that govern decision making in medicine

MK-10 Knowledge of normal and abnormal human behavior

MK-11 Knowledge of the manner in which people of diverse cultures and belief systems perceive health/illness and respond to symptoms, diseases and related treatments

MK-12 Knowledge of the non-biological determinants of health and the economic, psychological, social and cultural factors that contribute to health and disease

MK-13 Knowledge of gender, cultural and other biases that impact delivery of health care

MK-14 Knowledge of fundamentals of medical professionalism

MK-15 Knowledge of fundamental principles of preventive medicine and population/public health

MK-16 Knowledge of fundamental principles of patient centered and team based care, patient safety as well as quality improvement in health care delivery
Patient Care

Students must be able to provide patient care that compassionate, appropriate, and effective for the treatment of health problems and the promotion of health across the life span. Students must be able to utilize all medical, diagnostic, and procedural skills considered essential for the area of practice.

Graduating medical students will be competent and have demonstrated

PC-1 The ability to obtain an accurate, relevant and complete medical history that covers all essential aspects of the history

PC-2 The ability to perform a physical examination that is both complete and accurate

PC-3 The ability to conduct an accurate, relevant focused history and physical in appropriate clinical situations

PC-4 The ability to document a patient encounter that is legible (if applicable), organized, concise, timely and accurate

PC-5 The ability to obtain informed consent for common medical and surgical procedures in a compassionate, professional and efficient manner

PC-6 The ability to perform common procedures utilizing safe and effective techniques and with universal precautions

PC-7 The ability to use knowledge of the most frequent clinical, laboratory, radiographic and pathological manifestations to interpret the results of commonly used diagnostic procedures

PC-8 The ability to construct appropriate common diagnostic and therapeutic strategies for patients with common conditions, both acute and chronic

PC-9 The ability to recognize emergency medical conditions and institute appropriate initial therapy

PC-10 The ability to retrieve (from electronic databases and other resources), manage, and utilize biomedical information to deliver safe and effective clinical care

PC-11 The ability to deliver care in interprofessional teams

Professionalism

Students must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Graduating medical students will be competent and have demonstrated
PB-1 Ethical, responsible, reliable and dependable behavior in all aspects of their professional lives and a commitment to patients, society and the profession

PB-2 Honesty and integrity in all interactions with patients, families, staff, colleagues and others with whom students interact in their professional life

PB-3 Professionalism in dress, grooming, manner of speech and personal interactions with patients, families, staff, colleagues and others with whom students interact in their professional life

PB-4 Respect for the privacy and dignity of patients and their families

PB-5 Compassionate treatment of patients

PB-6 Knowledge of, and respect for other health care professionals, and of the need to collaborate with others in caring for patients as well as promoting population health

PB-7 Knowledge of key principles required for delivery of culturally competent care

PB-8 Professional maturity by appropriately managing conflicts, coping with personal and professional stress and showing flexibility in potentially ambiguous situations

**Interpersonal and Communication Skills**

Students must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients across the life span, their families, other health professionals, and the community at large.

Graduating medical students will be competent and have demonstrated

IPC-1 The ability to communicate effectively in a timely manner, both verbally and in writing, with patients, patients’ families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities

IPC-2 The ability to communicate effectively with colleagues within one’s discipline as well as other health professionals in a respectful, professional and timely manner to ensure interdisciplinary and interprofessional delivery of high quality care

IPC-3 The ability to communicate in a culturally competent manner with patients, families and community at large

IPC-4 The ability to apply principles of cultural competence to all aspects of health care delivery
Practice Based Learning and Improvement

Students must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Graduating medical students will be competent and have demonstrated

PBL-1 The capacity to recognize and accept limitations in one’s own knowledge and clinical skills, and a commitment to continuously improve one’s knowledge and ability through lifelong learning

PBL-2 The ability to independently set learning and improvement goals

PBL-3 The ability to incorporate all forms of feedback in identifying gaps in knowledge, skills and professionalism and implement remediation plans

PBL-4 The ability to utilize information technology in improving medical knowledge and delivering care to patients and populations

PBL-5 The ability to identify, analyze and assimilate evidence from scientific research and apply to patients’ health problems

PBL-6 The ability to participate effectively in education of patients, their families and caregivers, other trainees, and other health professionals

PBL-7 The ability to apply fundamentals of basic sciences to clinical problems

Systems Based Practice

Students must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Graduating medical students will be competent and have demonstrated

SBP-1 Knowledge of the role and responsibilities of physician and other health care professionals in various models of health care organizations, and the impact of finances/economics on delivery of health care

SBP-2 Knowledge of impact of health care disparities in delivery of health care

SBP-3 Knowledge of economic impact of diagnostic and therapeutic evaluation and risk-benefit analysis in both patient and population-based care

SBP-4 The ability to identify and report systems error as well as identify potential solutions.

SBP-5 The ability to participate effectively in and deliver care in an interprofessional team
V. LEARNING OBJECTIVES FOR PATIENT ENCOUNTERS

Cardiovascular Disease

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with cardiovascular disease (CHF, Ischemic heart disease, Arrhythmia, Hypertension, Peripheral Vascular Disease, etc.)

2. To have exposure to assigned reading materials and didactics related to diagnosis and management of cardiovascular disease.

Learning Objectives

After having primary responsibility for evaluating at least two patients with cardiovascular disease (CHF, Ischemic heart disease, Arrhythmia, Hypertension, Peripheral Vascular Disease, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of cardiovascular disease, the student will be able to:

a) recognize symptoms that may signify cardiovascular disease including chest pain, shortness of breath, orthopnea and edema

b) distinguish normal from abnormal findings on cardiovascular exam

c) formulate a differential diagnosis based on signs and symptoms

d) use and interpret common tests used in diagnosing cardiovascular disease

e) develop a systematic approach to the management of common cardiovascular diseases (including the recognition and management of situations that are potential emergencies)

Endocrinologic Disease

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with endocrinologic disease (Hyper/Hypothyroidism, Diabetes Mellitus, Adrenal Disease, etc.)

2. To have exposure to assigned reading materials and didactics related to diagnosis and management of endocrinologic disease.

Learning Objectives

After having primary responsibility for evaluating at least two patients with endocrinologic disease (Hyper/Hypothyroidism, Diabetes Mellitus, Adrenal Disease, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of endocrinologic disease, the student will be able to:

a) recognize symptoms that may signify endocrinologic disease including weakness, polyuria/polydipsia and hypo/hypertension

b) distinguish normal from abnormal findings on endocrinologic exam

c) formulate a differential diagnosis based on signs and symptoms

d) use and interpret common tests used in diagnosing endocrinologic disease

e) develop a systematic approach to the management of common endocrinologic diseases (including the recognition and management of situations that are potential emergencies)
**Pulmonary Disease**

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with pulmonary disease (COPD, Asthma, Interstitial Lung Disease, etc.)
2. To have exposure to assigned reading materials and didactics related to diagnosis and management of pulmonary disease.

Learning Objectives

After having primary responsibility for evaluating at least two patients with pulmonary disease (COPD, Asthma, Interstitial Lung Disease, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of pulmonary disease, the student will be able to:

a) recognize symptoms that may signify pulmonary disease including shortness of breath, cough, hemoptysis and chest pain
b) distinguish normal from abnormal findings on pulmonary exam
c) formulate a differential diagnosis based on signs and symptoms
d) use and interpret common tests used in diagnosing pulmonary disease
e) develop a systematic approach to the management of common pulmonary diseases (including the recognition and management of situations that are potential emergencies)

**Hematologic/Oncologic Disease**

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with hematologic/oncologic disease (Anemia, Hematologic Malignancy, Solid Organ Malignancy, etc.)
2. To have exposure to assigned reading materials and didactics related to diagnosis and management of hematologic/oncologic disease.

Learning Objectives

After having primary responsibility for evaluating at least two patients with hematologic/oncologic disease (Anemia, Hematologic Malignancy, Solid Organ Malignancy, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of hematologic/oncologic disease, the student will be able to:

a) recognize symptoms that may signify hematologic/oncologic disease including weight loss, lymph node enlargement, easy bruising, hematochezia, hemoptysis and hematuria
b) distinguish normal from abnormal findings on hematologic/oncologic exam
c) formulate a differential diagnosis based on signs and symptoms
d) use and interpret common tests used in diagnosing hematologic/oncologic disease
e) develop a systematic approach to the management of common hematologic/oncologic diseases (including the recognition and management of situations that are potential emergencies)
Infectious Disease

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with infectious disease (Sepsis, Endocarditis, Pneumonia, Meningitis, Urinary Infection, HIV, etc.)
2. To have exposure to assigned reading materials and didactics related to diagnosis and management of infectious disease.

Learning Objectives

After having primary responsibility for evaluating at least two patients with infectious disease (Sepsis, Endocarditis, Pneumonia, Meningitis, Urinary Infection, HIV, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of infectious disease, the student will be able to:

   a) recognize symptoms that may signify infectious disease including fever/chills, altered mental status, dysuria, diarrhea and cough
   b) distinguish normal from abnormal findings on exam
   c) formulate a differential diagnosis based on signs and symptoms
   d) use and interpret common tests used in diagnosing infectious disease
   e) develop a systematic approach to the management of common infectious diseases (including the recognition and management of situations that are potential emergencies)

Rheumatologic Disease

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with rheumatologic disease (Rheumatoid Arthritis, Degenerative Arthritis, SLE, etc.)
2. To have exposure to assigned reading materials and didactics related to diagnosis and management of rheumatologic disease.

Learning Objectives

After having primary responsibility for evaluating at least two patients with rheumatologic disease (Rheumatoid Arthritis, Degenerative Arthritis, SLE, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of rheumatologic disease, the student will be able to:

   a) recognize symptoms that may signify rheumatologic disease including joint pain/swelling, fatigue, low grade fever and skin lesions
   b) distinguish normal from abnormal findings on exam
   c) formulate a differential diagnosis based on signs and symptoms
   d) use and interpret common tests used in diagnosing rheumatologic disease
   e) develop a systematic approach to the management of common rheumatologic diseases (including the recognition and management of situations that are potential emergencies)
**Gastroenterologic Disease**

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with gastroenterologic disease (Peptic Ulcer Disease, Esophagitis, Cirrhosis, Inflammatory Bowel Disease, etc.)
2. To have exposure to assigned reading materials and didactics related to diagnosis and management of gastroenterologic disease.

**Learning Objectives**

After having primary responsibility for evaluating at least two patients with gastroenterologic disease (Peptic Ulcer Disease, Esophagitis, Cirrhosis, Inflammatory Bowel Disease, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of gastroenterologic disease, the student will be able to:

- recognize symptoms that may signify gastroenterologic disease including diarrhea, constipation, hematemesis, hematochezia and jaundice
- distinguish normal from abnormal findings on exam
- formulate a differential diagnosis based on signs and symptoms
- use and interpret common tests used in diagnosing gastroenterologic disease
- develop a systematic approach to the management of common gastroenterologic diseases (including the recognition and management of situations that are potential emergencies)

**Nephrologic Disease**

1. Evaluate at least two patients on the inpatient or outpatient service, as a primary student, with nephrologic disease (Renal Failure, Electrolyte Disturbance, Acid-Based Disturbance, Nephrotic Syndrome, Renal Calculi, etc.)
2. To have exposure to assigned reading materials and didactics related to diagnosis and management of nephrologic disease.

**Learning Objectives**

After having primary responsibility for evaluating at least two patients with nephrologic disease (Renal Failure, Electrolyte Disturbance, Acid-Based Disturbance, Nephrotic Syndrome, Renal Calculi, etc.) and being exposed to assigned reading materials and didactics related to diagnosis and management of nephrologic disease, the student will be able to:

- recognize symptoms that may signify nephrologic disease including hematuria, fatigue, nausea/vomiting and muscle cramps
- distinguish normal from abnormal findings on exam
- formulate a differential diagnosis based on signs and symptoms
- use and interpret common tests used in diagnosing nephrologic disease
- develop a systematic approach to the management of common nephrologic diseases (including the recognition and management of situations that are potential emergencies)
VI. **READING**

The recommended text for Internal Medicine will be Andreoli and Carpenter’s Cecil Essentials of Medicine (9th Edition). This is an excellent, easily readable text, which covers the major topics in Internal Medicine. You will need to be acquainted with the material in this text in order to pass the Subject Exam at the end of this rotation and the Internal Medicine portion of the National Boards. You will not see enough disease variety in your patient population during this rotation to adequately cover all of the important topics in Internal Medicine. You must keep up with your reading during the rotation or you will not pass the Subject Exam. The students will be expected to read in depth on their own patients from one of the major medical textbooks.

VII. **CASE & HOUR LOGS**

The medicine clerkship will be using a web-based system for monitoring students’ clinical activity during their medicine clerkship. You are responsible for logging all patient interaction and procedures you performed during your medicine clerkship.

After your clinical activity starts you will need to start logging cases and procedures into the website. The website for this is: [http://MedEd.utoledo.edu](http://MedEd.utoledo.edu) Once inside the website, enter your user name and password as described on that web page and then click the link: Log Clinical Cases and Procedures. You are expected to log cases and procedures in a timely fashion.

It is imperative that you honestly log cases and procedures. Students from each rotation will randomly be selected for a review of their entered data. All of their data will be double checked with proctors and/or medical records for accuracy.

**NOTE:** In order for the patient information to be permanently recorded, it is necessary to enter the six digit Medical Record Number. AHEC sites may not use patient Medical Record Numbers. In that situation, the patient’s birth date should be entered into the Case Log. If the Medical Record Number or birth date is not available, enter numbers such as 000001 for the first patient, 000002 for the second patient, 000003 for the third patient, etc. If a six digit entry is not made, cases entered will not appear the next time your Case Log is opened.

You must log throughout your entire clerkship and enter a minimum of 24 patients. At least eight of these should be from your Ambulatory Medicine/AHEC experience. Failure to enter a minimum of 24 patients will result in an incomplete grade. No final grade will be submitted until you have entered at least 24 patients.

Students are responsible for recording their Educational Assigned Hours into the Case Log System. Clinical Cases and Educational Assigned Hours need to be updated weekly throughout the entire clerkship.
VIII. STANDARD GRADING SYSTEM FOR INTERNAL MEDICINE CLERKSHIP

Students are asked to refer to the “Grading Policy for Required Clinical Clerkships” (Policy 3364-81-04-013-06) for details of the evaluation system. This system was presented during your Orientation to Clinical Clerkships.

For the Internal Medicine Rotation, the three major Components include the following:

A) Clinical Competency Grade (50% of final grade) 50 points:

Clinical Competency Evaluations will be completed by the faculty, residents and interns on each service that you are assigned. The only exception will be the Ambulatory rotation, in which only the Faculty Coordinator listed on your schedule will evaluate you. The final grade for clinical competence will be determined by compiling all of the evaluations for the entire clerkship. The evaluations for each three-week block will constitute one-third (1/3) of the total grade. Within each three-week block, each evaluation will contribute an equal weight, adjusted only for the amount of time spent with the evaluator. A copy of the evaluation can be found in Appendix A in the back of this handbook.

B) Departmental Educational Program (20% of final grade) 20 points:

1. Five of the 20 points will come from attendance and participation in/on required activities. Students must keep up with their Case Log entries to qualify for these points.

2. Fifteen of the 20 points will come from the OSCE (Objective Structured Clinical Exam) mentioned in Section III.

3. Students must obtain at least ten (10) points for the Departmental Educational Program. Failure to do so will result in a grade of Defer until the deficiency is remediated.

C) National Board of Medical Examiners (NBME) Subject Examination (30% of the final grade) 30 points:

The NBME Subject Examination is offered at the end of the Internal Medicine Clerkship. Students who fail to attain a score equal to the 5th percentile (or the next closest score above the 5th percentile) on the first attempt will receive a grade of Defer for the Clerkship and be required to retake the examination within one year of the first attempt. If the student attains a score greater than the 5th percentile in the second attempt, he/she will receive a Pass for the Clerkship. The student who fails to attain a score equal to or above the 10th percentile on this second attempt will receive a grade of Fail for the clerkship. The student will be required to perform a five-week supplemental clerkship experience followed by a third administration of the subject examination.

The final grade awarded will be Honors, High Pass, Pass or Fail. See the “Grading Policy for Required Clinical Clerkships” for details.
IX. REQUIRED ATTENDANCE AT CONFERENCES

All students assigned to inpatient/consult services are required to attend Medical Grand Rounds at their respective hospital sites. In addition, students on ambulatory rotations are encouraged to attend Medical Grand Rounds, if their schedule permits.

Each of the hospitals will have daily noon or morning conferences, in which you are required to attend. You are also required to attend morning report if offered at your institution. These schedules may be obtained at the respective hospitals.

X. THE INPATIENT/CONSULT HOSPITAL ROTATION

(UTMC, ProMedica Toledo Hospital, St. Vincent Mercy Medical Center, Akron General, Riverside Hospital (Columbus, OH) & St. Joseph Mercy Hospital (Ypsilanti, MI)

Students' Responsibilities and Criteria for Evaluation:

- Perform complete history and physical exam on new patients admitted to service. H&P should be on the chart within 24 hours of admission.
- Be prepared to present complete H&P on any admitted patient for attending rounds the next day.
- See all patients for whom you have primary responsibility prior to rounds and be prepared to present a sketch of the chief problems and plans for treatment.
- Keep up to date on your patients' problems and notify your intern if changes in condition or abnormal tests are seen.
- Attend required conferences/seminars/didactics and Grand Rounds.
- Take advantage of any and all opportunities to perform procedures even if they seem fairly minor or routine (starting IV's, placing NG tube, urinary bladder cath., etc.). You should make sure that you receive permission from your team before performing any procedure.
- History and physicals for staff admissions will be reviewed by the attending. They must be complete and most importantly have a differential diagnosis for each major presenting problem. There must also be evidence that you have read from one of the major Internal Medicine textbooks (Cecil's, Harrisons) on each of your patients' problems.
- You will not be expected to follow more than five patients at a time on average. If you are carrying greater than that number, some will be "pulled" from your service so that you can continue to see and evaluate new patients. You must prepare progress notes on each of your assigned patients every day.
- The attending and residents may have additional expectations. If you have questions regarding stated or implied expectations, you must ask the attending or resident early during your rotation.
• General job description for members of the medical team can be found in Section XV.

• Observation and Feedback

Below is an example of the Observation of Clinical Skills Form. There are six of these forms in Appendix C located in the back of this handbook. Remove these pages and divide the forms. Once a week give a form to the attending physician that you are working with (or their designee) for formative feedback on your performance. All 6 of these signed forms must be returned to the Clerkship Office by the end of your rotation. Failure to return these forms will result in an incomplete grade.
**Weekends**
Students will have one weekend day off per week (usually either Saturday or Sunday) which will be determined by the senior resident.

**Holidays**
Students will not be expected to come into the hospital on days designated as UTCOM holidays. This includes students assigned to services outside of the UTMC campus like Riverside, St. Joseph, St. Vincent Hospital or ProMedica Toledo Hospital.

**Change of Rotation**
Students will be expected to be at their assigned hospitals throughout the duration of the rotation at that hospital, which usually begins on a Monday and ends on a Sunday (unless it is the final rotation, which ends at Noon on Thursday). Changing hospitals within the Toledo area does not warrant an entire weekend off.

Students going to an AHEC site, Riverside Methodist Hospital, Columbus, Akron General, or St. Joseph Mercy, Ypsilanti may leave at the end of business on Friday before starting the next Block after they have completed their assigned patient care duties and attending the seminar session. If students are on call Friday, they will be expected to complete this responsibility before leaving for the next rotation.
XI. THE AMBULATORY MEDICINE ROTATION

Students' Responsibilities and Criteria for Evaluators:

1. Each student not assigned to an AHEC will spend 3 weeks of their 9-week clerkship in an Ambulatory rotation where they will be assigned to work in an outpatient clinic or clinics.

2. Your weekly schedule should be about the same from week to week. If specific clinics are canceled, you will generally be assigned to another clinic scheduled that same day (contact the Clerkship Office ASAP if you are scheduled for a clinic that has been scheduled).

3. Students will perform different functions in different clinics at the discretion of the faculty preceptor. Some students will act primarily as observers and some will see and examine patients under supervision. This will depend on the clinic experience available.

4. During each week of clinic, students will identify one patient presenting with an interesting problem about which they would like to spend time reading and researching. They will prepare a brief written case presentation based on their evaluation of the patient and a review of their chart. One of these Case Reports will be prepared each week. Please see the “Directions for Case Report Preparation” and “Sample Case Report” sections in this handbook for more information.

5. Each Friday the students on the Ambulatory block will meet for rounds as a group with a faculty member. Each student will present at least one patient for review and discussion. Discussions may include a review of pathophysiology as well as discussion and plans for treatment.

6. Each student on this rotation will have one faculty member assigned to them as a Faculty Coordinator. This person will meet with the student individually on a weekly basis to review the students' Case Report and provide feedback on their performance.

7. Students on the Ambulatory block are encouraged to attend all noon conferences when possible.

8. Evaluations will be based on the following:
   a) Case Reports will be evaluated by the Faculty Coordinator on the basis of their clarity and comprehensiveness. Evidence of research into a specific topic will be given prime consideration in the evaluation.
   b) Presentation and discussion during the Friday rounds will be evaluated on the basis of your preparation for this exercise and your ability to present pertinent information in a clear and concise manner.
   c) Patient evaluation and management skills will be assessed by the faculty working with you in the outpatient clinics.

9. Students will be given ongoing verbal feedback during the rotation. If a student
feels that they are not getting adequate feedback about their rotation, they are encouraged to ask the attending physician for an evaluation of their performance.

10. During the week at Hospice, students will not be expected to prepare Case Reports.

Case Report Preparation (A sample Case Report follows this description)

1. Case Reports should include a brief description of the reason for the clinic visit, pertinent past medical history and a summary of treatment plans. Pertinent findings on physical exam should also be mentioned whether or not you actually performed this exam yourself.

   This is to be a directed history and physical summary only. It should not be a comprehensive history and physical as you would perform on a hospitalized patient.

2. The Case Report should include an assessment of the presenting problem. This should include a differential diagnosis for the presenting problem.

3. The Case Report should include a discussion of some aspect of the presenting problem. This might be a summary of the pathophysiology or etiology of a specific disease. It might be a discussion of therapeutic options or prognosis. It is important that you read in detail on the disease process reviewed because you may be asked about it during Ambulatory Rounds.

   The Case Report should generally be used to answer some specific questions related to a patient's presenting complaint or illness. Your faculty preceptor should act as a guide in the selection of an appropriate topic. The Case Report should not be a simple reiteration of textbook material. It should demonstrate understanding of a specific area of Internal Medicine.

4. Excessive length is not required. Case Reports longer than 3-4 pages are inappropriate.

5. Each submitted Case Report should have an evaluation form like the example on the next page attached to it. Two Case Report Evaluations are located in the back of this book in Appendix D; remove that page, divide it into two separate forms. Attach an evaluation to each of your reports prior to submitting them to the attending physician supervising your patient encounter. They will review, provide feedback and assign a "grade" (Outstanding, Above Average, Average, Below Average, Poor) based on the clarity and comprehensiveness of your Case Report.

6. After the attending physician has reviewed and graded your report show it to the faculty preceptor for any additional feedback before turning it in to the Clerkship Office by the end of your rotation.
CASE REPORT EVALUATION - 71

Student Name: 

Patient Initials: Date: 

This section to be completed by the attending whose clinic you saw the above patient.

Attending Name: 

Feedback: Comments:

☐ Outstanding
☐ Above Average
☐ Average
☐ Below Average
☐ Poor

This section is for the Faculty Coordinator that is listed at the top left corner of your schedule.

Faculty Coordinator Name: 

☐ If this is the same person that is listed in the section above, check this box and submit the report to the Clerkship Office.
☐ I have reviewed the attached report and feedback provided above.
☐ I would like to add the following comments/feedback:

NOTE: The Faculty Coordinator is the only person to evaluate this student for their Ambulatory rotation. Please remember to complete this student’s evaluation as soon as possible.

Please return this evaluation and case report to the Clerkship Office (UTMC Hospital basement 024SA/ MS1159) for the student file in a timely manner.
AA is a 52 year old white female seen in South Toledo Internists clinic for evaluation of chronic obstructive pulmonary disease. She is a referred patient because her previous internist left the area. AA has 11 years history of lung disease. She was diagnosed of having bronchiolitis obliterans by a pulmonary specialist at Ohio State University in Columbus. For this problem, she was treated with steroid for 6 months. The outcome of the treatment was not successful. AA was a cigarette smoker in the past. She has a history of arthritis, back pain, elbow and hip joint problem. Her past medical record will be obtained from her previous physician. AA’s blood pressure was 120/76, weight 168 lbs. At present, she requires continuous oxygen (1.5 l/min) treatment. Current medication includes Proventil, Atrovent, and Vanceril inhalers, Theodur 300 mg bid, and Premarin 0.625 mg qd. The patient appears calm, and cheerful. She seems to well adjusted with her illness.

Assessment: Bronchiolitis obliterans
Chronic emphysema

Discussion:
Bronchiolitis obliterans is a pathologic disorder which characterized by partial or complete obstruction of the small airways (bronchioles and alveolar ducts) by granulation tissue or peri-bronchiolar fibrosis. Histologically, there are two distinct patterns: (1) Intraluminal granulation tissue extends from small airways into alveoli and is often referred to as organizing pneumonia. A study by Epler, G. R. et al indicates that majority of patients (57 out 67 patients) have this histologic pattern. (2) For the other patients, the lesions was limited to small airways without parenchymal involvement. (Epler, G.R. et al, Bronchiolitis Obliterans Organizing Pneumonia, N. Engl. J. Med. 1985; 312:152-8.)

It is believed that bronchiolitis obliterans results when injury to small airways is repaired by proliferation of granulation tissue. The degree of functional impairment is directly related to the number of bronchioles involved. Patients generally presented with cough and dyspnea due to obstruction. Many causes and disease conditions have been fume inhalation, patients develop irreversible airflow obstruction one to three weeks after toxic fume exposure; 2) postinfectious, usually seen in children, after viral or mycoplasma infection; 3) associated with connective tissue disorders, development of bronchiolitis obliterans in patients with rheumatoid arthritis has been associated with penicillamine therapy; however, it is also seen in patients who have never received penicillamine; 4) localized lesions, incidental radiographic findings in asymptomatic patients where biopsy was performed to rule out neoplasia; and 5) idiopathic with patchy or diffuse organizing pneumonia, most frequent pattern. Patient with idiopathic bronchiolitis obliterans organizing pneumonia usually presented with cough and flu-like symptoms which last weeks to months. Crackles were heard in 68% of patients. Radiographically, 81% of patients showed an unusual pattern of patchy density with ‘ground glass’ appearance. Physiologically, 72% of patients have reduced lung volume, and 86% have gas exchange impairment.

Treatment for the localized lesion is by resection. As for the other four groups of patients, if they are in the acute stage of disease, they can be successfully treated with high dose of prednisone, 1 mg/kg for one to three months, then followed by lower maintenance dose for six to 12 months. As shown by Epler et al, 65% of patients was completely recovered after such treatment. On the other hand, patients with late stage of bronchiolitis obliterans have not been shown to respond to steroid therapy. For these chronic stage patients, they are usually treated symptomatically with bronchodilator agents. AA appears to belong to this group of patients. These results suggest that early diagnosis and treatment are important in determining the clinical course of the disease. (Epler, G.R. et al, The Spectrum on Bronchiolitis Obliterans, Chest, Feb. 1983, 83(2):161-2.)

Stanley Chung
Case Report

JR is a 26 year old white female seen in South Toledo Internists clinic for routine pelvic examination and evaluation of Lyme disease. Patient indicated that about a month ago, she had noticed a small erythematous rash on her right leg which was followed by flu-like symptoms two days later. She was distressed that she might have contracted the disease. At present, she does not have any sign of this disorder. Despite reassurance, she insisted to have a blood test for Lyme disease. Consequently, a test was ordered. During the pelvic examination, purulent discharge was found at the cervical os; this was cultured. Otherwise, the pelvic examination was unremarkable. Pap smear and quaiac test were also obtained. The quaiac test was negative. In general, patient appears to be in good health. Her blood pressure was 122/70, weight 126 lbs. Her latest lab results did not indicate any abnormality.

Assessment: Pelvic examination (purulent discharge?) Lyme disease?

Discussion:
Lyme disease is a multi-system disease caused by a tick-transmitted spirochete, *Borrelia burgdorferi*. It was named for Lyme, Connecticut, where was first recognized. The disease was thought to be originated in Europe and is now found world-wide. In U.S., three endemic areas have been identified: the northeastern states from Massachusetts to Maryland, the upper Midwestern states of Minnesota and Wisconsin, and portion of four western states, California, Oregon, Nevada, and Utah. However, cases have been reported from other part of country, suggest that the disease is spreading. Study by Piesman et al indicates that May and June are the main months of transmission risk of Lyme disease. (Piesman J. et al, Seasonal variation of transmission risk of Lyme disease and human babesiosis. Am J. Epidemiol 1987; 126:1187-9.)

Lyme disease occurs in three stages (see Table 1) which roughly parallel their chronologic appearance. Overlap of stages is common; however, not all patients will have these signs and symptoms and the problem seems to come and go. In stage I, approximately 86% of patients developed erythema migrans. In stage II, about 15% of patients developed problems in the central and peripheral nervous systems four weeks to several months after the onset of erythema migrans. Arthritis is the dominant manifestation in stage III, about 60% of patients developed recurrent dominant manifestations in stage III, about 60% of patients developed recurrent monarticular or symmetric pauciarticular arthritis of large joints.

Table 1. Characteristic findings in various clinical stages of Lyme disease

<table>
<thead>
<tr>
<th>Stage</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Lasts a median of 4 weeks: Erythema migrans, Influenza-like illness, Severe fatigue, musculoskeletal pains, headache, stiff neck</td>
</tr>
<tr>
<td>II</td>
<td>Lasts days to months: Central nervous system disease with meningitis, encephalitis, Bell’s palsy, peripheral nervous system involvement with radiculopathy or neuropathy (or both); Cardiac involvement with variable heart block, myopericarditis, congestive heart failure; Ophthalmitis</td>
</tr>
<tr>
<td>III</td>
<td>Lasts months to years: Asymmetric, pauciarticular arthritis (often intermittent but chronic in 10% of cases; severe, chronic, late central nervous system disease with encephalitis, demyelinating syndromes, and psychiatric disorders.</td>
</tr>
</tbody>
</table>
Recovery of a microorganism from a patient is the most reliable method of establishing proof of infection. However, it is not practical for Lyme disease today. Currently, serologic test to detect a specific antibody to *B. burgdorferi* is the best alternative to confirm *B. burgdorferi* infection. The serologic test most commonly used is the enzyme-linked immunosorbent assay (ELISA) to detect both IgM and IgG antibodies. Because of low levels of specific anti-*B. burgdorferi* antibody during the first two weeks of infection, the ELISA is not very sensitive. On the other hand, for stages II and III diseases, the test is very sensitive. False-positive test results are not common. They occur primarily in patients with other spirochetal infections (such as syphilis), infectious mononucleosis and in those with autoimmune disease. Although the specificity of the ELISA is quite high (97.6%), the low prevalence of confirmed Lyme disease (2.2%) making it less useful for routine screening of Lyme disease. In other word, false-positive will occur in approximately 50% of patients with positive test result. (Duffy, J. et al, Diagnosing Lyme Disease: The Contribution of Serologic Testing, Mayo Clin. Proc., Nov. 1988; 63:1116-21.) Consequently, the test should only be used for confirmation of a clinical diagnosis. It should not be sued as a basis for the institution of therapy to prevent possible illness in persons who are otherwise healthy such as in the case of JR. The diagnostic criteria for definite Lyme disease according to the Center for Disease Control (CDC) are listed in Table 2. (Duffy, J., Lyme Disease, Infectious Disease Clinics Clinics of North America, Sept. 1987; 1(3):511-527.)

### Table 2. CDC Diagnostic Criteria for Lyme Disease

<table>
<thead>
<tr>
<th>Endemic Area:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Erythema migrans (EM) with exposure no more than 30 days prior to onset.</td>
</tr>
<tr>
<td>2. Involvement of &gt;one organ system (musculoskeletal, neurologic, or cardiac) and positive antibody test.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nonendemic Area:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EM with positive antibody test.</td>
</tr>
<tr>
<td>2. EM with involvement of &gt; two organ systems.</td>
</tr>
</tbody>
</table>

Stanley Chung
XII. **THE AHEC ROTATION**

**Student’s Responsibilities and Criteria for Evaluations:**

1. Each student assigned to an AHEC site will work with a physician or group of physicians for the entire three week period.

2. Students will perform different functions in different inpatient and outpatient sites at the discretion of the faculty preceptor. Students will act both as observers and participants in the care of selected inpatients and outpatients.

3. Depending on the teaching site, student responsibilities may include evaluating and documenting patient care in the physicians office or in the hospital. AHEC preceptors are encouraged to ask students to read about various topics and prepare short presentation based on their research.

4. Other activities that may occur at AHEC sites include a Hospice experience, attendance at medical staff functions or participating in CME activities at local hospitals. If students are unsure about whether to attend a specific activity, they should ask their physician preceptor or the staff at the local AHEC Office.

5. Students will be given ongoing verbal feedback during the rotation. If a student feels that they are not getting adequate feedback about their rotation, they are encouraged to ask the attending physician for an evaluation of their performance.

6. Students on AHEC services are not required to complete any case reports, but it is recommended that you complete at least one of them and have the faculty give you feedback, if time permits.

XIII. **THE HOSPICE ROTATION**

**Student’s Responsibilities and Criteria for Evaluations:**

1. Each student assigned to the Hospice site will see both inpatients and patients receiving hospice care at home.

2. Students will attend a variety of didactic sessions relating to the care and management of patients receiving Hospice care.

3. Students will observe Interdisciplinary Team Conferences with physicians and staff providing care to patients receiving Hospice care.

4. During the week at Hospice, students will not be expected to prepare Case Reports.
XIV. **PROCEDURAL COMPETENCE**

All students on the Internal Medicine Clerkship will be encouraged to demonstrate competence for a number of simple procedures.

Procedures that may be performed include:
- Phlebotomy/IV Line Placement
- Arterial Blood Gas
- NG Tube Placement
- Urinary Bladder Catheterization
- Pelvic Examination

Students are encouraged to avail themselves of opportunities to perform these procedures. Residents and nursing personnel can assist you with these procedures. A number of manuals describing the indications, complications and details of performing procedures may be found in the bookstore. You are encouraged to obtain one of these manuals.

All procedures should be logged as part of the Case Log Website. This information will be tracked throughout your medical school career.
XV. JOB DESCRIPTIONS FOR THE MEDICAL TEAM

Those new to a teaching hospital service, often have difficulty sorting out the roles of the numerous physicians and students involved in patient care. The following guidelines roughly describe the responsibilities of each member of the team.

THE ATTENDING GENERAL MEDICINE SERVICE
The attending on service has a dual role (i.e., teaching and patient care). Teaching responsibility includes making rounds with the entire team 3 or 4 times per week at a prearranged time and place, for approximately 2 hours. These rounds consist of:

- Presentation by the students or interns of cases recently admitted to the team. This should include both staff and non-staff patients. Patient presentations should be followed by bedside evaluation of the patient and bedside teaching.

- Other patients, both staff and non-staff, should also be discussed and evaluated as time permits. Any extra time could be spent with x-ray review, smear evaluation, didactic teaching or topic presentations by the students or house staff. One of the goals of service rounds is for the attending to assess the competence and attitude of each member of his team, both students and housestaff.

- The service attending also is the attending of record for staff patients on his service. He is responsible for overseeing the care of these patients by the house staff. The supervising resident should contact the attending for any admissions or changes in patient status. If the attending feels a change in plans or therapy is needed, he/she should contact the supervising resident or, if the problem is not urgent, place a note in the chart. If possible, the attending should leave the specifics of patient care to the house staff and concentrate advice on general goals and strategies.

- If there is a particular problem with a student or house officer, the attending should meet with him/her part way through the rotation to discuss the deficiency and plan how to correct it.

THE NON-SERVICE ATTENDING
The attendings not on the Medicine Service have mostly patient care responsibilities.

When the attending is aware of an admission, he should communicate with the supervising resident on the appropriate admitting team. This could be done in writing, in person or by phone. Again, general principles and plans as opposed to details should be discussed. It is the responsibility of the resident to contact the attending after admission and initial evaluation to discuss impressions and plans.

If there is a significant change in patient status or the resident feels a major change in diagnostic or therapeutic plans is necessary he/she should personally contact the attending to discuss it. When the attending has urgent suggestions to make to the primary care team, (i.e., verbal communication is required) it is recommended that the attending personally contact the supervising resident involved. When feasible he/she should supply literature to the primary care resident and student.
Consulting attendings also have teaching responsibilities. Rounds with the attending should be made on a prearranged schedule with students and housestaff on that particular elective. New consults and patients should be presented and discussed with attention to both teaching and patient care. The same is true of follow-up on old patients. It is recommended that subspecialty students not write notes on patients who are on the medical service.

Generally, communication pertaining to patient care should be between the attending and the supervising resident.

**THE SUPERVISING RESIDENT**
The job of the supervising resident is to “run the service”. This would include the following:

- Doing a thorough, directed History and Physical on all patients admitted, writing a summary of that in the form of a resident admit note, and formulating and recording a diagnostic and therapeutic plan for the patient.

- Evaluating emergency room consultations. It is the responsibility of the resident to determine if the Emergency Room patient requires admission to the hospital. If the resident and the emergency room attending physician agree that the patient can be treated and followed up as an outpatient, then the resident should arrange for this. However, if there is disagreement (i.e., the emergency room attending feels admission is necessary but the resident thinks outpatient treatment is adequate), then the internal medicine attending should be contacted for the final decision.

- Communicating with the attending regarding plans for the patient. The resident should have a plan formulated at the time of calling the attending. This plan may, of course, be subject to alteration dependent upon further information which the attending is able to provide. In cases of conflict with the attending, while it is advisable to proceed with the plans of the attending, the resident should consider it part of his/her function to review the appropriate data and literature so as to resolve the conflict. If review of data does not provide resolution, then with the agreement of the resident and the attending, other specialty consultation, or consultation with the Resident/Faculty Grievance Committee may prove helpful.

- Delegating responsibility for carrying out the plans for the patient. The supervising resident will be held responsible for the care of patients on his service. This is obtained via daily work rounds early in the morning and daily “check out” rounds in the afternoon, as well as communication throughout the day with the other members of his/her team. The supervising resident is not expected to perform the “nuts and bolts” of patient care, but should see to it that plans are executed efficiently by his/her interns and medical students.

- Medical student teaching. This involves critical review of the medical students’ H&P’s and presentations, as well as providing teaching regarding pathophysiology, therapy, etc. on patients on the service. This may be done on a formal or informal basis, but it should be done.

- It is the responsibility of the supervising resident to coordinate the care of the patient, especially when there are multiple consultants offering opinions. This may involve a good deal of communication with consultants. If a consultant’s advice is not taken, it
should be stated in the chart why this is the case, and the reasons should be defensible.

- The supervising resident must be available to provide backup for the intern in managing complicated and critically ill patients, and to help out if the number of patients on the service becomes unmanageable.

- It is the function of the supervising resident on call at night and on weekends to provide emergency medical or medical subspecialty consultation for patients on non-medical services. After seeing the patient, he/she should communicate with the appropriate attending or GIM resident. It is not his function to see non-urgent consults or to provide non-urgent opinions on patients followed by medical or medical specialty consultants.

- Responding to CODE Blue. It is the responsibility of the supervising residents on their call days to head the CODE Blue. The resident will respond immediately when the CODE is announced, and upon arrival is expected to take over the management of the CODE. If the attending physician is present, the resident has the option of asking whether the attending wishes to run the CODE.

- Outpatient clinic responsibilities. The supervising resident is expected to attend his/her outpatient clinics as scheduled. The clinic hours take precedence over ward service responsibilities; if the resident is admitting that day, the admissions for that day and responding to CODE Blue are to be handled by one of the other ward supervisors for that hospital. Any other duties of the supervising resident that conflict with clinic are to be addressed outside of the clinic hours. Similarly, it is the responsibility of the ward supervising residents to help cover for each other when one or more of them have clinic obligations conflicting with their admitting/CODE Blue duties.

**THE RESIDENT ON ELECTIVE**

The job of the resident on the subspecialty service is to learn. This is usually accomplished by seeing ambulatory and hospitalized patients with problems related to that subspecialty and reading and discussing with the attending about those problems. The consulting resident should also complete the consults and discuss the findings and plans with the attending in a timely manner, and then review any pertinent literature pertaining to that particular problem. It is recommended that the resident supplement this experience with reading as recommended by the attending and the core curriculum.

When interacting with the medical services, it should be remembered that the function of a consultant is to offer an opinion and/or suggestion, unless further action is requested by the primary service. The consulting resident should avoid daily progress notes unless the course of the patient is such that daily new suggestions are required. It is also recommended that medical students on the consult services not write progress notes on medical patients. On non-medical patients, the consulting resident may take a more direct role in patient care as needed.

It should be noted that it is not the function of the consulting resident to be the intermediary between the consulting attending and the primary medical service.

The other major function of the consulting resident is to act as the supervising admitting resident as indicated on the call schedule.
Residents on “primary care” elective at St. Vincent Mercy Medical Center (SVMMC) take a more “hands on” role in patient care. In addition to consults, the primary care resident should complete a history and physical on patients admitted to their attending physician with problems pertinent to the subspecialty being studied. The resident should also follow these patients daily and perform any procedures, write progress notes and orders, and obtain consultations as needed under the supervision of the attending physician. The resident should follow the consults closely as well.

Despite all these duties, the primary care consulting resident’s main job, as with other consulting resident’s is to learn. He should not be expected to be a “mini-attending” and duties such as taking calls from outpatients, functioning as a general medical physician on consults, or spending large portions of time on private patients of the attending who do not have problems pertinent to his subspecialty, should be avoided.

**THE INTERN**

The intern’s major obligation is the providing of patient care. This involves, among other things, the performance and recording of a complete history and physical, writing or supervising daily progress notes, writing or supervising all orders on the patient, and procuring and/or noting results of laboratory test and diagnostic procedures in a timely fashion.

It should go without saying that the intern should see all patients at least daily and perform directed physical examination to assess the patients’ progress. Also, it is the responsibility of the intern to notify the supervising resident of significant or unexpected changes in the patient’s status or when major therapeutic or diagnostic changes are contemplated. It is also his/her responsibility to seek help from the supervising resident when in doubt as to appropriate actions in patient care. When time permits, the intern should help in the teaching of medical students.

A number of the intern’s duties parallel those of the supervising resident, beyond what is described above:

- **CODE Blue.** On admitting days, the intern is a member of the CODE Blue team, and is expected to respond immediately when a CODE is announced. The intern is to administer therapies during a CODE effort as directed by the physician in charge of the CODE (usually the supervising resident); if there is no senior person (attending or resident) present, the intern should run the CODE until relieved by a senior physician.

- **Hours.** As per supervising resident description.

- **Overnight call duties.** As per supervising resident description.

- **Outpatient clinic responsibilities.** The intern is expected to attend his/her outpatient clinics as scheduled. The clinic hours take precedence over ward service responsibilities; if the intern is admitting on a clinic day, the admissions are to be worked up outside of clinic hours, or be assigned to another intern on the admitting team. The intern is not expected to respond to CODE Blue while in clinic; ideally, the CODE pager should be given to another intern during clinic hours. Any other duties of the intern that conflict with clinic hours should be addressed outside of clinic.
STUDENT ON ELECTIVE
The job of the fourth year medical student on an elective medicine rotation is to learn by observing inpatients, outpatients, and consults, and discussing these patients and their problems with the attending and house-staff.

Teaching should be centered on rounds with the team. Rounds may consist of student case presentations, topic discussions and bedside patient evaluation and should take place at a predetermined time. The student should not fill out consults or write progress notes on Internal Medicine in-patients (to avoid “chart clutter”), however, this should not prevent him/her from following these patients closely and learning from them. Consults and progress notes may be completed by the student on non-medicine patients under the direction of the attending or housestaff. The student should also attend one or more out-patient clinics with the attending each week. The student may be asked to do some of the “busy work” involved in patient care such as making flow sheets, obtaining specimens, and searching through old charts, however, he/she should have enough free time to read and study. The student is not expected to act as a “go between” for his attending and other services.

STUDENT ON REQUIRED MEDICINE
The job of the 3rd year medical student on the required medicine clerkship is to learn by experiencing “hands on” medicine. The clerk’s duties include the following:

Completing an extensive history and physical on assigned patients admitted to their medical service. This is recorded in a history and physical, which should include an impression, differential diagnosis and plan. The student should also complete the problem list and participate in writing orders with the intern. He/she needs to be prepared to present this patient during the next scheduled attending rounds.

Close follow-up of patients. The student is responsible for daily clinical evaluation of the patient, progress notes, and updating of the problem list. The student should be up to date on all lab work, x-ray results, etc. He/she needs to be available during the day and when on call for any change in patient status or procedures for which he should be present. The student should participate in work, attending and checkout rounds with his assigned team.

Periodically, the student will be asked to help with some of the “footwork” involved in patient care (e.g. carrying specimens to the lab) however, this should not constitute a large portion of time.
# APPENDIX A: CLINICAL COMPETENCY EVALUATION FORM

## Required Clerkship Clinical Competency Evaluation

### Clerkship: REQ 201730

**Evaluator:**

**Start Date:** 6/3/2017  
**End Date:** 8/22/2017  
**Rotation Number:** 15  
**Site:** UTMC

**Time Spent with Student:**

- **Extensive (More than 10 Hours)**  
- **Moderate (4 to 10 Hours)**  
- **Minimal (1 to 4 Hours)**  
- **No Contact (Less than 1 Hour)**

For each item in each category, please select a value from 1 to 5, or N/A. A selection of N/A will not impact a student’s final evaluation score.

### Competency: Medical Knowledge

<table>
<thead>
<tr>
<th>Significantly below expected competency</th>
<th>Below expected competency</th>
<th>At expected competency</th>
<th>Above expected competency</th>
<th>Significantly above expected competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation of knowledge and understanding of disease mechanisms is inadequate. Unable to clinically apply knowledge base.</td>
<td>Adequate overall foundation of knowledge with some gaps. Limited ability to clinically apply knowledge.</td>
<td>Expected foundation of knowledge and understanding of disease mechanisms. Frequent summertime ability to apply knowledge in clinical situations.</td>
<td>Broad foundation of knowledge and understanding of disease mechanisms. Consistently has ability to apply knowledge in clinical situations.</td>
<td>Comprehensive foundation of knowledge and understanding of disease mechanisms. Consistently applies knowledge in clinical situations. Effectively educates patients and peers.</td>
</tr>
</tbody>
</table>

### Competency: Patient Care (Patient History)

<table>
<thead>
<tr>
<th>Significantly below expected competency</th>
<th>Below expected competency</th>
<th>At expected competency</th>
<th>Above expected competency</th>
<th>Significantly above expected competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccurate or disorganized history. Poor interviewing technique. Unable to develop assessment and plan. Does not ask pertinent history to suspected patient problems.</td>
<td>History is often incomplete. Interviewing technique weak. Acquisition of information from history is inconsistent and often incomplete. Assessment and plan not well-developed.</td>
<td>Accurate history and good interviewing techniques. Able to develop a reasonable assessment and plan based on history obtained.</td>
<td>Thorough and accurate history. Strong interviewing techniques. Identifies key facts in patient history, which assist in formulating a comprehensive assessment and plan.</td>
<td>Comprehensive, accurate history includes vital signs from patient interview. Excellent interviewing techniques. Formulates insightful assessment and plan.</td>
</tr>
</tbody>
</table>

### Competency: Patient Care (Physical Exam)

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<thead>
<tr>
<th>Significantly below expected competency</th>
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<th>At expected competency</th>
<th>Above expected competency</th>
<th>Significantly above expected competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccurate and disorganized physical exam. Does not recognize normal or abnormal findings in patient exam.</td>
<td>Incomplete and somewhat disorganized physical exam. Recognizes some normal physical exam features.</td>
<td>Accurate, complete physical exam. Recognizes normal features and common abnormalities in patient exam.</td>
<td>Thorough, accurate and organized physical exam. Recognizes significant and important abnormalities in patient exam.</td>
<td>Comprehensive, accurate and organized physical exam. Recognizes both significant and important abnormalities in patient exam.</td>
</tr>
</tbody>
</table>

### Competency: Patient Care (Clinical Reasoning)

<table>
<thead>
<tr>
<th>Significantly below expected competency</th>
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<th>Above expected competency</th>
<th>Significantly above expected competency</th>
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</thead>
<tbody>
<tr>
<td>Strategy to integrate relevant findings and lab study data into clinical assessments. Unable to develop an assessment and plan.</td>
<td>Limited ability to integrate findings and lab study data into clinical assessments. Assessments are accurate and reflect all relevant information.</td>
<td>Integrates findings and lab study data into clinical assessments. Assessments are comprehensive, accurate, and include a well-developed differential diagnosis.</td>
<td>Integrates relevant findings and lab study data into clinical assessments. Assessments are comprehensive, accurate, and include a well-developed differential diagnosis.</td>
<td>Integrates and prioritizes findings and lab study data into clinical assessments. Assessments are accurate and comprehensive. Able to develop and defend an extensive differential diagnosis.</td>
</tr>
</tbody>
</table>

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*Page 49*
### Competency: Practice Based Learning and Improvement

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<thead>
<tr>
<th>Significantly below expected competency</th>
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<th>At expected competency</th>
<th>Above expected competency</th>
<th>Significantly above expected competency</th>
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</thead>
<tbody>
<tr>
<td>Completely unaware of own gaps in knowledge and skills. Poor acceptance of feedback and does not make an effort to change.</td>
<td>Inconsistently recognizes gaps in knowledge and skills. Does not demonstrate improvement after specific feedback.</td>
<td>Recognizes most gaps in own knowledge and skills. Accepts criticism when offered and makes an effort to change based on specific feedback.</td>
<td>Recognizes gaps in own knowledge and skills. Encourages feedback weekly and accepts constructive criticism well. Aims to affect change. Self-motivated.</td>
<td>Recognizes gaps in own knowledge and skills. Regularly solicits feedback and receives feedback with insights and affects change. Self-motivated.</td>
</tr>
</tbody>
</table>

### Competency: Interpersonal and Communication Skills

<table>
<thead>
<tr>
<th>Significantly below expected competency</th>
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<th>Above expected competency</th>
<th>Significantly above expected competency</th>
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</thead>
<tbody>
<tr>
<td>Does not maintain rapport with patients; lacks empathy and does not communicate effectively. Does not communicate well with other health care professionals.</td>
<td>Sometimes has difficulty establishing rapport with patients. Ineffective communication with patients and other health care providers. Participation in a team-based case is inconsistent.</td>
<td>Rises well to meet patients and family members. Proficient verbal and written communications with other health care professionals. Actively participates in team-based case.</td>
<td>Rises well to meet patients and family members. Demonstrates empathy; uses easy to understand language in patient communications. Proficient verbal and written communications with other health care professionals. Actively participates in team-based care.</td>
<td>Rises well to meet patients and health care team work with complex clinical scenarios. Shows empathy, compassion and respect; engages patients in shared decision making. Excellent communication with healthcare professionals. Role models active, respectful participation in team-based care.</td>
</tr>
</tbody>
</table>

### Competency: Professionalism

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<thead>
<tr>
<th>Significantly below expected competency</th>
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<th>At expected competency</th>
<th>Above expected competency</th>
<th>Significantly above expected competency</th>
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</thead>
<tbody>
<tr>
<td>Attendance and punctuality are erratic. Cannot be relied upon to carry out tasks and needs frequent reminders of responsibilities. Does not actively participate in most educational activities. Intervention needed regarding student's commitment.</td>
<td>Regular attendance, but inconsistent punctuality for duties. Needs reminders at times to complete responsibilities. Does not actively participate in all educational activities. Needs reminders to complete responsibilities.</td>
<td>Timely, regular attendance. Can be relied upon in fulfilling responsibilities as a member of the health care team and in the delivery of patient care. Completes assigned responsibilities without need for reminders.</td>
<td>Student is always on time or early for duties. Outstanding in dependability, punctuality and participation in team activities and patient care responsibilities. Makes extra effort to be an integral team member.</td>
<td>Exceptionally conscious. Excellence in attendance, dependability, punctuality, and participation in team activities and patient care responsibilities. Makes extra effort to be an integral team member; assumes leadership role.</td>
</tr>
</tbody>
</table>

### Competency: Systems Based Practice

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<thead>
<tr>
<th>Significantly below expected competency</th>
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<th>Above expected competency</th>
<th>Significantly above expected competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No awareness of hospital or clinic resources. Unable to recommend any additional resources for patient care delivery.</td>
<td>Rarely suggests and normative medical resources in patient care. Rarely displays awareness and discussion of cost-effectiveness of care.</td>
<td>Regularly suggests and norms medical resources to optimize patient care. Demonstrates basic understanding of the roles of multidisciplinary care providers, and regularly includes in patient care discussions. Demonstrates awareness of cost-effectiveness of patient care.</td>
<td>Shows in-depth understanding of the roles of multidisciplinary care providers in achieving optimal patient outcomes and frequently includes in patient care discussions. Demonstrates in-depth understanding of cost-effectiveness of care and includes frequency in patient care discussions.</td>
<td>Has advanced knowledge of all hospital and clinic resources available and utilizes appropriately. Demonstrates advanced understanding and ability to employ cost-effectiveness of care strategies. Recognizes sources of potential system failures.</td>
</tr>
</tbody>
</table>

### Summary Comments: Narrative comments are required. Please also include specific comments if you feel a student did exceptionally well or exceptionally poorly (ex. If student was a <3 or >3), including examples where such behavior was demonstrated.
# Internal Medicine Clerkship: Faculty Observed History Taking & Physical Exam Checklist

## Appendix B: History and Physical Checklist

### Chief Complaint
1. Reason(s) for visit.

### Present Illness
2. Location. Where is it? Does it radiate?
4. Quantity/Severity. How bad is it?
5. Timing. Onset, Duration, Frequency. When did it start? How long does it last? How often does it occur?
6. Setting in which it occurs. What are you doing when it occurs? Environmental factors, personal activities, emotional reactions, or other circumstances that may have contributed to the illness.
7. Remitting/relieving factors. What makes it better?
8. Exacerbating/aggravating factors. What makes it worse?
9. Associated symptoms. Anything that accompanies it?
10. Patient’s perspective. Patient’s idea about what is causing the problem, how the problem affects everyday functioning, fears/concerns, thoughts about what would help.
11. Medications – name, dose, route and frequency of use. (Medications include prescriptions, home remedies, over-the-counter drugs, vitamins, minerals, herbal supplements, and oral contraceptives).
12. Allergies – must ask agent and reaction (e.g., medication, food, insect, environmental factor).
13. Tobacco – type and quantity and frequency and attempt(s) to quit.
15. Illicit drug use – type and quantity and frequency (MUST ask all three).

### Past History
16. Childhood/Medical Illnesses.
17. Adult Medical Illnesses.
18. Surgical History.
19. Obstetric/gynecologic (e.g., pregnancies, menstrual periods).
20. Psychiatric (e.g., depression anxiety).
21. Health maintenance – (e.g., immunizations, screening tests).

### Family History
22. Health/illnesses of immediate relatives (e.g., parents, grandparents, siblings, children, grandchildren).

### Personal and Social History
23. E.g., occupation, educational level, living arrangements, relationships, personal interests, spirituality, exercise, diet and safety measures.

### Student Name:

### Comments:
<table>
<thead>
<tr>
<th>INTERPERSONAL/COMMUNICATION SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Introduced self in respectful manner and used proper name of patient.</td>
</tr>
<tr>
<td>25. Summarized pertinent information to clarify for patient and interviewer.</td>
</tr>
<tr>
<td>26. Asked if patient had questions or anything to add at the end of the interview.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERAL INSPECTION AND VITAL SIGNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Wash/Clean hands before starting exam</td>
</tr>
<tr>
<td>28. Measure Blood Pressure in one arm (on bare skin and must check for pulse first)</td>
</tr>
<tr>
<td>29. Palpate Radial Pulse (for at least 15 sec. – may not use thumb)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>HEAD AND NECK</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Inspect Scalp</td>
</tr>
<tr>
<td>31. Estimate Visual Acuity – bilaterally by covering one eye at a time</td>
</tr>
<tr>
<td>32. Inspect External Ocular Structures (lid, cornea, conjunctivae)</td>
</tr>
<tr>
<td>33. Check visual fields by confrontation</td>
</tr>
<tr>
<td>34. Observe bilateral pupillary response to light</td>
</tr>
<tr>
<td>35. Evaluate extra ocular muscle function in 4 quadrants</td>
</tr>
<tr>
<td>36. Uses ophthalmoscope or panoptoc to examine each eye</td>
</tr>
<tr>
<td>37. Examine outer ears – bilaterally</td>
</tr>
<tr>
<td>38. Test auditory acuity</td>
</tr>
<tr>
<td>39. Inspect ear canals bilaterally with otoscope</td>
</tr>
<tr>
<td>40. Inspect turbinates and septum with otoscope</td>
</tr>
<tr>
<td>41. Inspect lips, gums, teeth, buccal mucosa</td>
</tr>
<tr>
<td>42. Inspect palate, uvula, pharynx, tongue</td>
</tr>
<tr>
<td>43. Observe midline protrusion of tongue</td>
</tr>
<tr>
<td>44. Observe elevation of the palate by asking patient to say “ah”</td>
</tr>
<tr>
<td>45. Examine thyroid gland with and without swallowing</td>
</tr>
<tr>
<td>46. Palpate lymph nodes of neck and posterior occipital region</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHEST, LUNGS AND THORAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>47. Inspect and palpate spine on bare skin</td>
</tr>
<tr>
<td>48. Perform fist percussion of CVA – bilaterally on bare skin</td>
</tr>
<tr>
<td>49. Check Thoracic (chest) expansion – must ask patient to take a deep breath</td>
</tr>
<tr>
<td>50. Percuss posterior lung fields bilaterally and symmetrically (side to side – at least 6 areas) on bare skin</td>
</tr>
<tr>
<td>51. Auscultate posterior lung fields bilaterally and symmetrically (side to side – at least 6 areas) on bare skin and must ask patient to take a deep breath</td>
</tr>
<tr>
<td>52. Auscultate anterior chest symmetrically (side to side – at least 6 areas) on bare skin and must ask patient to take a deep breath</td>
</tr>
<tr>
<td>53. Auscultate lateral chest symmetrically (side to side – at least 4 areas) on bare skin and must ask patient to take a deep breath</td>
</tr>
</tbody>
</table>

**COMMENTS:**
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>54.</td>
<td>Auscultate aortic area with diaphragm of stethoscope on bare skin</td>
</tr>
<tr>
<td>55.</td>
<td>Auscultate pulmonic area with diaphragm of stethoscope on bare skin</td>
</tr>
<tr>
<td>56.</td>
<td>Auscultate tricuspid area with diaphragm of stethoscope on bare skin</td>
</tr>
<tr>
<td>57.</td>
<td>Auscultate mitral (apical) area with diaphragm of stethoscope on bare skin</td>
</tr>
<tr>
<td>58.</td>
<td>Observe neck veins with head of table elevated</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>59.</td>
<td>Auscultate before percussion or palpation on bare skin</td>
</tr>
<tr>
<td>60.</td>
<td>Auscultate over each of four quadrants on bare skin</td>
</tr>
<tr>
<td>61.</td>
<td>Palpate abdomen (light and deep in all four quadrants) on bare skin</td>
</tr>
<tr>
<td>62.</td>
<td>Palpate liver edge on bare skin</td>
</tr>
<tr>
<td>63.</td>
<td>Percuss for upper border of liver on bare skin</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>64.</td>
<td>Carotids – Palpate pulses – bilaterally</td>
</tr>
<tr>
<td>65.</td>
<td>Femoral – Palpate pulses – bilaterally</td>
</tr>
<tr>
<td>66.</td>
<td>Dorsalis pedis and/or posterior tibial on bare skin – Palpate pulses – bilaterally</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>67.</td>
<td>Inspected hands, nails, joints, palms – bilaterally</td>
</tr>
<tr>
<td>68.</td>
<td>Inspected and palpated upper extremity joints – bilaterally</td>
</tr>
<tr>
<td>69.</td>
<td>Tested range of motion of fingers and wrists – bilaterally</td>
</tr>
<tr>
<td>70.</td>
<td>Tested range of motion of upper arm (shoulder, elbow) – bilaterally</td>
</tr>
<tr>
<td>71.</td>
<td>Tested muscle strength of arms (shoulders, elbows, wrists) – bilaterally</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>72.</td>
<td>Inspected and palpated lower extremity joints</td>
</tr>
<tr>
<td>73.</td>
<td>Tested muscle strength of legs</td>
</tr>
<tr>
<td>74.</td>
<td>Tested Muscle strength of thighs</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>75.</td>
<td>Sense of smell – Ask about change or directly assess</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>76.</td>
<td>Test sensory briefly in all 3 divisions (temple, jaw, chin) patient’s eyes must be closed</td>
</tr>
<tr>
<td>77.</td>
<td>Test contraction of masseter (jaw) muscles on opening of mouth</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>78.</td>
<td>Raise eyebrows or forced eyelid closure</td>
</tr>
<tr>
<td>79.</td>
<td>Show teeth and or puff out cheeks</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>80.</td>
<td>Weber Test</td>
</tr>
<tr>
<td>81.</td>
<td>Rinne Test</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>82.</td>
<td>Test rotation of head against resistance</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COMMENTS:</td>
</tr>
<tr>
<td></td>
<td>Test shoulder shrug against resistance</td>
</tr>
<tr>
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<td>--------------------------------------</td>
</tr>
<tr>
<td><strong>Reflexes</strong></td>
<td></td>
</tr>
<tr>
<td>84.</td>
<td>Biceps (inside elbow) – bilaterally</td>
</tr>
<tr>
<td>85.</td>
<td>Brachioradialis (near wrist) – bilaterally</td>
</tr>
<tr>
<td>86.</td>
<td>Triceps (back of elbow) – bilaterally</td>
</tr>
<tr>
<td>87.</td>
<td>Patellar (knee) – bilaterally</td>
</tr>
<tr>
<td>88.</td>
<td>Achilles (ankle) – bilaterally</td>
</tr>
<tr>
<td>89.</td>
<td>Plantar – Babinski (sole of foot/without sock) – bilaterally</td>
</tr>
<tr>
<td><strong>Cerebellar</strong></td>
<td></td>
</tr>
<tr>
<td>90.</td>
<td>Test rapid alternating movement of hands</td>
</tr>
<tr>
<td>91.</td>
<td>Test finger to nose – bilaterally</td>
</tr>
<tr>
<td>92.</td>
<td>Test heel to shin – bilaterally</td>
</tr>
<tr>
<td><strong>Sensory</strong></td>
<td></td>
</tr>
<tr>
<td>93.</td>
<td>Test light touch or pin prick in upper extremities – bilaterally and patient’s eyes must be closed</td>
</tr>
<tr>
<td>94.</td>
<td>Test light touch or pin prick in lower extremities – bilaterally and patient’s eyes must be closed</td>
</tr>
<tr>
<td>95.</td>
<td>Test position sense in feet – bilaterally</td>
</tr>
<tr>
<td>96.</td>
<td>Test vibratory sense in ankles – bilaterally</td>
</tr>
<tr>
<td>97.</td>
<td>Perform Romberg test with eyes closed and feet together</td>
</tr>
<tr>
<td><strong>Interpersonal/Communication Skills</strong></td>
<td></td>
</tr>
<tr>
<td>98.</td>
<td>Explained procedures and gave clear instructions</td>
</tr>
<tr>
<td>99.</td>
<td>Considered patient comfort during the exam and kept areas not being examined covered by a gown or a drape.</td>
</tr>
<tr>
<td>100.</td>
<td>Informed patient that encounter was concluded, and what would happen next</td>
</tr>
</tbody>
</table>

**OVERALL COMMENTS:**

---

**FACULTY OBSERVER:** Christopher Lynn, M.D.  
**FACULTY SIGNATURE:**

*Please do not give this form to the student, leave it with the Clinical Skills Center Staff. This form will then be returned to the clerkship office.*
## APPENDIX C: OBSERVATION OF CLINICAL SKILLS

### INTERNAL MEDICINE CLERKSHIP

#### OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK

<table>
<thead>
<tr>
<th>Student Name (print):</th>
<th>Week of (dates):</th>
<th>Faculty Name (print):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please evaluate the following skills you observed during a student-patient clinical encounter:**

<table>
<thead>
<tr>
<th>Skill Description</th>
<th>Satisfactory</th>
<th>Needs to improve</th>
<th>Did not observe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewed the patient and collected pertinent information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed a complete and focused physical exam as appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepared a complete H&amp;P for a new patient admitted to the service and charted the results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selected and interpreted common tests used in diagnosing common diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodically re-evaluated the patient, interpreting the results of new tests and physical changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Synthesized information, determined a differential diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accurately presented a patient by preparing case reports based on patient encounters and research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrated appropriate knowledge in the clinical setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Showed respect for the patient, protects their privacy and dignity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This student is ethical, reliable and responsible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This student is honest and displays integrity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This student dressed professionally, was well groomed and communicated clearly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This student shows respect for other health care professionals and staff</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional comments or notes for improvement:**

---

<table>
<thead>
<tr>
<th>Faculty Signature:</th>
<th></th>
</tr>
</thead>
</table>
### INTERNAL MEDICINE CLERKSHIP

### OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK

<table>
<thead>
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- Periodically re-evaluated the patient, interpreting the results of new tests and physical changes
- Synthesized information, determined a differential diagnoses
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Additional comments or notes for improvement:

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- This student shows respect for other health care professionals and staff

Additional comments or notes for improvement:

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Faculty Signature: | Faculty Signature:
## Internal Medicine Clerkship

### Observation of Clinical Skills (OCS) – Formative Feedback

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</tr>
</thead>
<tbody>
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<td>Week of (dates):</td>
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<td></td>
</tr>
</tbody>
</table>

Additional comments or notes for improvement:

Faculty Signature:  

Faculty Signature:
### APPENDIX D: CASE REPORT EVALUATION

#### CASE REPORT EVALUATION - #1

<table>
<thead>
<tr>
<th>Student Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Initials:</td>
<td>Date:</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

This section to be completed by the attending whose clinic you saw the above patient.

<table>
<thead>
<tr>
<th>Attending Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feedback:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Outstanding</td>
<td></td>
</tr>
<tr>
<td>□ Above Average</td>
<td></td>
</tr>
<tr>
<td>□ Average</td>
<td></td>
</tr>
<tr>
<td>□ Below Average</td>
<td></td>
</tr>
<tr>
<td>□ Poor</td>
<td></td>
</tr>
</tbody>
</table>

This section is for the Faculty Coordinator that is listed at the top left corner of your schedule.

<table>
<thead>
<tr>
<th>Faculty Coordinator Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________________________</td>
</tr>
</tbody>
</table>

□ If this is the same person that is listed in the section above, check this box and submit the report to the Clerkship Office
□ I have reviewed the attached report and feedback provided above
□ I would like to add the following comments/feedback:

---

**NOTE:** The Faculty Coordinator is the only person to evaluate this student for their Ambulatory rotation. Please remember to complete this students’ evaluation as soon as possible.

Please return this evaluation and case report to the Clerkship Office (UTMC Hospital basement 0245A / MS1150) for the students file in a timely manner.

#### CASE REPORT EVALUATION - #2

<table>
<thead>
<tr>
<th>Student Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Initials:</td>
<td>Date:</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

This section to be completed by the attending whose clinic you saw the above patient.

<table>
<thead>
<tr>
<th>Attending Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feedback:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Outstanding</td>
<td></td>
</tr>
<tr>
<td>□ Above Average</td>
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<tr>
<td>□ Average</td>
<td></td>
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<td></td>
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<tr>
<td>□ Poor</td>
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</thead>
<tbody>
<tr>
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</tr>
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</table>

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**NOTE:** The Faculty Coordinator is the only person to evaluate this student for their Ambulatory rotation. Please remember to complete this students’ evaluation as soon as possible.

Please return this evaluation and case report to the Clerkship Office (UTMC Hospital basement 0245A / MS1150) for the students file in a timely manner.
ABSENCE REQUEST FORM

Please print, complete all sections and return this form to the appropriate clerkship office for approval. If you have multiple absence requests, complete separate forms for each different rotation/site.

Name: _______________________________________________________          Class Year: _________________________
Email Address: _________________________________________________            Phone #: (     ) ______________________

REQUEST 1

<table>
<thead>
<tr>
<th>Day</th>
<th>Date: _____________________</th>
<th>Time: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
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<td>Saturday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALL DAY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Returning on:

<table>
<thead>
<tr>
<th>Day</th>
<th>Date: _____________________</th>
<th>Time: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
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<td>Saturday</td>
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<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled start of day</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical Service / Site Assignment: ________________________________________________________________

*Heart Station cannot request final 3 days off

Activities that will be missed: ___________________________________________________________________

Reason for absence: ___________________________________________________________________________

To be completed by the Clerkship Director: ☐ Approve  ☐ Disapprove

REQUEST 2

<table>
<thead>
<tr>
<th>Day</th>
<th>Date: _____________________</th>
<th>Time: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
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<tr>
<td>Tuesday</td>
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<td>Wednesday</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALL DAY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Returning on:

<table>
<thead>
<tr>
<th>Day</th>
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<th>Time: ____________________</th>
</tr>
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<tbody>
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Clinical Service / Site Assignment: ________________________________________________________________

*Heart Station cannot request final 3 days off

Activities that will be missed: ___________________________________________________________________

Reason for absence: ___________________________________________________________________________

To be completed by the Clerkship Director: ☐ Approve  ☐ Disapprove

What other days have you requested off or plan to request off from this elective/clerkship?

List date(s):_______________________________________ OR I have not/do not plan on requesting any other days off: ☐

Verification attached (doctor’s note, boarding pass, interview invitation, etc.): ☐ Yes  ☐ No

I have/had notified the following attendings / residents, on the service that I am assigned, of this absence:

List attendings/residents:________________________________________________________________________________________

I understand that I am responsible for all clerkship/curriculum content during my absence. It is MY responsibility to contact the clerkship coordinator no later than the first day of my return to find out what the requirements are to make-up my time missed.

________________________________________________________________  ___________________________________
Student Signature        Date

☐ Make-up time required: ____________________________________________

________________________________________________________________  ___________________________________
Approval Signature:   Clerkship Director        Date
APPENDIX F: ACLS CLASSROOM HANDOUT – must take to class!

**Sinus Rhythms**
- Normal Sinus (60 – 100)
- Sinus Brady (less than 60)
- Sinus Tach (&gt;100)

➤ Must have a “P” wave preceding each QRS in order for it to be called “Sinus”.
➤ Sinus Tach is most commonly less than 150 in adults and always has an underlying problem causing the symptoms.
➤ Don’t use the “Tachycardia” Algorithm for Sinus Tach. Instead, provide supportive care of airway, breathing, oxygenation, BP while looking for & managing underlying causes.
SVT vs Atrial Fib with RVR
- Both are sudden onset arrhythmias
- Both are treated using the Tachycardia algorithm

- SVT starts at 150, is regular, has a distinct “T” wave in between each QRS, no “P” waves
- AFib is irregular, no distinct and regular pattern of P or T waves (wavy baseline)
**Ventricular Rhythms**

- VFib vs VTach vs Asystole
- Monomorphic VTach is shown below and is what your instructors will expect you to know.
- Polymorphic VTach & Torsades dePointes: Don’t worry about these at this point in your education!!

- VTach is a sudden onset arrhythmia.
- The more common VTach is monomorphic, which means it is originating from one spot in the ventricles. It is an organized pattern of wide QRS complexes with a rate ≥100. The complexes will look very similar, if not exactly the same.
- When VTach is present, you need to confirm whether or not there is a pulse!
- VTach with a pulse will be treated using the “Tachycardia” algorithm, while VTach without a pulse will be treated the same as VFib.

- VFib is chaotic and very disorganized. There might be some waves that look like a pattern, but when you look at the overall picture, it is disorganized and chaotic-looking.
- VFib never produces a pulse.
- Shown are examples of varied degrees of VFib (such as coarse, fine, and very fine).

- Asystole is where there is no electrical activity. Basically a flatline.
- If the baseline has squiggly waveforms, then it is most likely a very fine VFib.
**PEA (Pulseless Electrical Activity)**
- Any organized rhythm (a series of QRS complexes), other than VTach, that is pulseless
- Below are a small sampling of examples of what PEA could look like. The patient in each of the following rhythms does NOT have a pulse.
AV Blocks

PR Interval

Constant

1\textsuperscript{st} Degree

2\textsuperscript{nd} Degree II

Number of P's per QRS's?

1 P per QRS

More P's than QRS's

2\textsuperscript{nd} Degree I

Irregular rhythm

3\textsuperscript{rd} Degree

Regular rhythm

Not Constant

A "Constant" PR interval is one in which the length of the PRI is the same every time. A "Non-constant" PRI is one in which the PRI is not the same length each time.

In A Nutshell:

If the PR Interval is regular (constant), and you have more P's than QRS complexes, it is a 2\textsuperscript{nd} II block.

If the PR Interval is irregular (non-constant), then it is either a 2\textsuperscript{nd}-I or a 3\textsuperscript{rd} degree. The 2\textsuperscript{nd}-I always has an irregular ventricular rhythm, and the 3\textsuperscript{rd} degree would have a regular ventricular rhythm.
NSR / 1st Degree

2nd Degree - Type I

2nd Degree - Type II

3rd Degree
Sample 1

PR Interval: Constant or Non-constant?
Which 2 rhythms? __________ or __________

Sample 2

PR Interval: Constant or Non-constant?
Which 2 rhythms? __________ or __________

Sample 3

PR Interval: Constant or Non-constant?
Which 2 rhythms? __________ or __________

Sample 4

PR Interval: Constant or Non-constant?
Which 2 rhythms? __________ or __________
Key

Sample:  
1 – 3°  
2 – 2° I  
3 – 2° II  
4 – 1°  
5 – 2° I  
6 – 3°  
7 – 2° II  

Sample 5

PR Interval:  
Which 2 rhythms?  
Constant or Non-constant?  
_________________________ or ________________

Sample 6

PR Interval:  
Which 2 rhythms?  
Constant or Non-constant?  
_________________________ or ________________

Sample 7

PR Interval:  
Which 2 rhythms?  
Constant or Non-constant?  
_________________________ or ________________