INTERNAL MEDICINE

COLLEGE OF MEDICINE AND LIFE SCIENCES

THE UNIVERSITY OF TOLEDO

STUDENT HANDBOOK

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Education Administrator:
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Clerkship Office:
419-383-5022
UTMC Hospital, Room 0245A (basement)

COLLEGE OF MEDICINE AND LIFE SCIENCES
THE UNIVERSITY OF TOLEDO

TO: Class of 2025

FROM: Mani Askari, M.D.
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.

If you need anything or have any questions, the Clerkship Office is located in the basement of the main UTMC Hospital Building, Suite #0245A. You may also call Dawn Jagodzinski at 419-383-5022 or email her at dawn.jagodzinski@utoledo.edu. Office hours are 7:00 a.m. – 3:30 p.m.

UT DEPARTMENT OF MEDICINE FACULTY

CARDIOLOGY
Mohamad Alghothani, M.D., Assistant Professor
Mark Burket, M.D., Professor
Paul Chacko, M.D., Assistant Professor
Christopher Cooper, M.D., Professor
Ehab Eltahawy, M.D., Professor
Blair Grubb, M.D., Professor
Rajesh Gupta, M.D., Associate Professor
Samer Khouri, M.D., Professor & Chief
Samar Khoury, M.D., Assistant Professor
George Moukarbel, M.D., Professor

COMMUNITY BASED
Richard Paat, M.D., Professor

DERMATOLOGY
Lorie Gottwald, M.D., Professor & Chief
Nancy Parquet, M.D., Assistant Professor

ENDOCRINOLOGY
John Jun, M.D., Associate Professor
Yara Tovar, M.D., Assistant Professor

GENERAL INTERNAL MEDICINE
Basil Akpunonu, M.D., Professor & Chief
Mani Askari, M.D., Assistant Professor
Faiza Fakhar, M.D., Assistant Professor
Douglas Federman, M.D., Professor
Rashmi Goyal, M.D., Professor
Srini Hejeebu, D.O., Professor
Bryan Hinch, M.D., Associate Professor
Nicholas Horen, M.D., Assistant Professor
Sarah Jackson, D.O., Assistant Professor
Sadik Khuder, M.D., Professor
James Kleshinski, M.D., Professor
Chiamaka Mbaso-Ogbo, M.D., Associate Professor
Ruby Nucklos, M.D., Professor
Shuhao Qui, M.D., Assistant Professor
Hoda Shabpiray, M.D., Assistant Professor
Brian Tasma, M.D., Assistant Professor

GASTROENTEROLOGY
Yaseen Alastal, M.D., Assistant Professor
Benjamin Hart, M.D., Ph.D., Assistant Professor
Mona Hassan, M.D., Assistant Professor
Abdallah Kobeissy, M.D., Assistant Professor
Ali Nawras, M.D., FACP, FACG, FASGE Professor & Chief
Thomas C. Sodeman, M.D., FACP Professor

GERIATRICS
Anu Garg, M.D., Associate Professor
Cletus Iwuagwu, M.D., Professor
Ammar Kayyali, M.D., Assistant Professor

HEMATOLOGY/ONCOLOGY
Danae Hamouda, M.D., Assistant Professor
Roland Skeel, M.D., Professor
Divya Vijendra, M.D., Assistant Professor
Richard Phinney, M.D., Community Based Faculty
Rex Mowat, M.D., Community Based Faculty
Hammad Rashid, M.D., Community Based Faculty

HOSPITALISTS
Manesh Gangwani, M.D., Assistant Professor
Omar Horani, M.D., Assistant Professor & Interim Chief
Asif Mahmood, M.D., Assistant Professor
Sarmed Mansur, M.D., Assistant Professor
Nooraldin, Merza, M.D., Assistant Professor
Idrees Mohiuddin, M.D., Assistant Professor
Stephanie Schwarz, D.O., Assistant Professor
Hani Saad, M.D., Assistant Professor
Sara Shafqat, M.D., Assistant Professor

INFECTIOUS DISEASE
Joan Duggan, M.D., Professor
Michael Ellis, M.D., Professor, Chief
Hend Elsaghir, M.D., Assistant Professor
Claudiu Georgescu M.D., Associate Professor
Caitlyn Hollingshead, M.D., Assistant Professor
Joel Kammeyer, M.D., Assistant Professor & Chief
Basmah Khalil, M.D., Assistant Professor
Komal Masood, M.D., Assistant Professor
Haroon Shah, D.O., Assistant Professor

NEPHROLOGY
Zubia Alam, M.D., Assistant Professor
Samer Akrawi, M.D., Assistant Professor
Dinkar Kaw, M.D., Professor
Deepak Malhotra, M.D., Ph.D., Professor & Chief
Shobha Ratnam M.D., Ph.D., Professor
Muhammad Usman Ali, M.D., Assistant Professor

PALIATIVE CARE
Annette Collier, M.D., Assistant Professor
Marsha Paul, M.D., Assistant Professor

PULMONARY/CRITICAL CARE & SLEEP MEDICINE
Andre Aguillon, M.D., Assistant Professor
Ragheb Assaly, M.D., Professor
Mohamed Omballi, M.D., Assistant Professor
Fadi Safi, M.D., Associate Professor
Youngsook Yoon-Krawcyzk, M.D., Professor

RHEUMATOLOGY
Nezam Altorok, M.D., Associate Professor
Bashar Kahaleh, M.D., Professor & Chief
Aya Abugharbyeh, M.D., Assistant Professor
Sherlyana Surja, M.D., Assistant Professor (Allergy)

In addition, we utilize numerous Community-Based Volunteer Faculty in many subspecialties

PROMEDICA TOLEDO HOSPITAL FACULTY

Hospitalist:
Steven Zook, M.D., Director
Evan Abalos, M.D.
Abul Faiz Ahmed, M.D.
Ghattas Alkhoury, M.D.
Mamtha Balla, M.D.
Shubhita Bhatnagar, M.D.
Avijit Das, M.D.
Taylor Dimmerling, M.D.
Faiza Fakhar, M.D.
Rani Hanna, M.D.
Rahaf Ibrahim, M.D.
Tejaswini Jagadish, M.D.
David Jones, M.D.
Muhamad Kalifa, M.D.
Sandeep Kukreja, M.D.
Susie Namo, M.D.
Andre Noumi, M.D.
Mary Pellioni, M.D.
Albert Pham, M.D.
Divya Ramaswamy, M.D.
Ali Sahlieh, M.D.
Pooja Suri, M.D.

Cardiologist:
William Colyer, M.D.
Laura DeBenedetti, M.D.
Brent DeVries, M.D.
Brian Dolsey, M.D.
Mohamed Elamin, M.D.
Robert Grande, M.D.
Imad Hariri, M.D.
Sahar Ismail, M.D.
Raj Kattar, M.D.
Mohammed Maaieh, M.D.
Hazem Malas, D.O.
Todd Monroe, M.D.
Carson Oostra, M.D.
Ronak Patel, M.D.
Thomas Pappas, M.D.
Raji Ramanathan, M.D.
Mujeeb Sheikh, M.D.
Fred Stockton, M.D.

INTERNAL MEDICINE REQUIRED CLERKSHIP HANDBOOK INDEX

1. REQUIRED INTERNAL MEDICINE CLERKSHIP

The required Medicine rotation is 8 weeks in length. You will spend a total of 6 weeks on inpatient services at a Toledo area hospital (UTMC, ProMedica Toledo Hospital, Riverside Hospital (Columbus), Akron General, Trinity Health (Ypsilanti, MI), Naples Healthcare (Naples, FL) or AHEC inpatient site and 2 weeks on an outpatient/ambulatory service at UTMC, a local clinic or an Area Health Education Center (AHEC).

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 a written mid-clerkship formative feedback report halfway through the clerkship. This report will not be used to determine your final grade for the clerkship.

INTERNAL MEDICINE ORIENTATION

1. **Reporting information and study locations for the following locations:**

UTMC Hospitalist, UTMC GIM, UTMC Nephrology and UTMC Cardiology 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.

Campus Map(interactive): https://www.utoledo.edu/campus/tour/?hsc

Study areas can be located as follows for this location:

- Mulford Café / AEC: Mulford Library Basement, lounge and study space, computers, beverages, microwave, vending
- Mulford Library: 4th & 5th floor, conference rooms with tables, chairs
- Mulford Library Annex: first floor, front (Arlington side) of building
- Treehouse: Mulford Library Annex top floor, student ID required to access, 24/7
- HEB Computer Lab: Main level, back of building (towards courtyard), individual works stations with computers
- Alumni Room: Mulford Library basement, student ID required to access, 24/7, computer, refrigerator, ping-pong, pool table, tv, microwave, sink
- Classrooms: any classroom that is not booked can be accessed and used for quiet study space
- Library: Mulford Library, 4th floor
- Random nooks: can be located throughout campus, like space outside of anatomy lab, hallway to the SIM Center, outdoor tables, etc.

Riverside: Riverside Methodist Hospital is located at 3535 Olentangy River Road, Columbus, Ohio 43214. The Coordinator at Riverside is Wendy Steele, she can be reached at 614-566-3202. Wendy will send you reporting information, which will include a quick orientation with her, then she will place you with your team. If you don't receive reporting information at least 3 business days prior to the start of your rotation, please reach out to Wendy. If you requested housing, you will receive an email from the UT Department of Medical Education the week prior to the start of your rotation.

Study areas can be located as follows for this location:

- Cafeteria: Hospital, 1st floor, 6:00 a.m. – 2:00 a.m.
- Library: Basement Green Area, Badge access 24/7, private study rooms, individual computers
- Call Rooms: Hospital basement (IM and Surg share a call room), common/lounge space, computers, TV, video games, ping pong, refrigerator, water cooler, microwave, sink, showers
- Computer Labs: 1st floor, Yellow Area Medical Education & 2nd floor Green Area Gibbons Conference Center, computers, conference rooms

Trinity Health (formerly St. Joseph) students you will receive an email from Erin Madden at Trinity Health 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 Department of Medical Education the week prior to the start of your rotation.

Study areas can be located as follows for this location:

- Call room for medical students has computers and lockers available
- Library has computers available
- Physician Services Area Resident/Student Lounge has computers available

ProMedica Toledo Hospital (PTH) IMS-1, IMS-2 & IMS-3, IMS-4, IMS-GIM, CCU & PPH students park in **levels 3-5** of the P2 or P5 parking garages (P5 is closest to entrance F for PPH Team). The Academic Conference Center is located on the 2nd floor of the Legacy Building.

Campus map: https://www.promedica.org/toledo-hospital/pages/visitors/campus-maps.aspx

Study areas can be located as follows for this location:

- ProMedica Health Science Library; Legacy Building, 1st floor lobby. ProMedica ID badge needed to access, available 24/7, staffed during normal business hours Mon-Fri., computers available
- Resident Lounge: Legacy Building, Academic Conference Center, 2nd floor, computers available
- Academic Classrooms: Legacy Building, Academic Conference Center, 11 classrooms available when not booked by programs. Classroom 11 has extra computers available.
- Generations Tower: Academic Rooms on 2nd, 3rd, 5th, 6th & 8th floors, computers available

IMS Teams should proceed to the 2nd 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-4: (phone) 419-291-7662 or (pager) 419-444-0096

CCU – Cardiology Team should proceed to the Generations Tower 5th floor academic center at 8:15 a.m. to meet your team. Below is contact information in case you have trouble locating your team:

- CCU: (phone) 419-291-0271 or (pager) 419-442-3013

PPH – Hospitalist Team

- 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 righthand side of the hallway

- PPH Team A (pager) 419-321-0960
- PPH Team B (pager) 419-539-0307
- PPH Team C (pager) 419-444-1059
- PPH Team D (pager) 419-444-1340
- PPH Day Czar (pager) 419-321-0852
- PPH Day Czar 2 (pager) 419-321-0876

Akron General – watch for reporting information via email from Lisa Lawson

2. **Check your e-mail daily**. This rotation is HIGHLY dependent on e-mail communication.

3. To request an excused absence 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 F** 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, depending on availability in the Clinical Skills Center. 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 1 hour 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 scheduled Tuesday 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 one of the following by the end of the clerkship:
   18 **Elsevier Clinical Key Internal Medicine online cases**:
   https://www.clinicalkey.com/student/login
   OR
   600 **Internal Medicine questions from any preferred question bank.** Students must provide proof of number of completed questions at the START, MIDDLE and END of clerkship in order to receive credit.
   OR
   Combination of both of the above equaling 9 Elsevier Clinical Key cases and 300 questions.

7. Each student is expected to **review the High Value Care and Quality Improvement Powerpoint**, which is located on the MEDI703 Blackboard course.

8. Students will attend **Ethics sessions** during this clerkship. Students are expected to review an assigned case PRIOR to the Ethics session and be prepared to discuss. To prepare for the discussion the student will complete the Clinical Ethics worksheet developed by Campelia, et al and forward to Annette.collier@utoledo.edu the Wednesday prior to the Thursday session. The worksheet uses the "4-box method" for evaluating ethical questions. All of these items can be found in APPENDIX G of this handbook.
    - Ethics session 1 – review case Ms. Y and complete worksheet
    - Ethics session 2 – review case Ms. Panghorn and complete worksheet
    - Ethics session 3 – review case Vijay and complete worksheet

    The worksheet and the 4-box method are used in the ethics sessions to introduce students to a process for evaluating clinical situations that can be used in clinical practice. The goal is to encourage students to appreciate complexities in an ethical case and to consider all ethical principles and patient values before making a decision.

    *The Clinical Ethics worksheet and the Four Topics Chart will be reviewed during the IM Orientation. Students are encouraged to present an ethical question or dilemma they have faced in the clerkship. Fifteen minutes at the end of each session will be reserved to discuss student-generated topics or cases.

9. The **evaluations** that you need to complete at the end of your Internal Medicine Clerkship can be found by logging into http://rocketmed.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.**

10. The **Internal Medicine OSCE** (Objective Structured Clinical Examination) is usually during the last week of the IM Clerkship. 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.

11. The **NBME Internal Medicine Subject Exam** is typically scheduled during the last week of your Internal Medicine Clerkship, usually in the morning. Additional information will be e-mailed at a later date.

12. Any students that have filed for accommodations with **Student Disability Services** for this clerkship, must meet with the Clerkship Coordinator prior to starting clinical rotations.

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
    - There are no required call responsibilities at UTMC or ProMedica Toledo Hospital
    - Call will be discussed at each of these sites individually: Riverside Hospital, Trinity Health, Akron General

- Do not utilize or check your cell phones during rounds or teaching sessions unless instructed to do so.

3. **DUTIES:**
   - Attend all required educational conferences. Attendance will be confirmed during each required session or by 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. **CONFERENCES:**
   Students on rotations at UTMC and Toledo Hospital are to attend conferences. See Block-specific schedule for exact dates, locations and if participation is required. Also be sure to SIGN/LOG IN BEFORE each conference.

   - Noon/Research Conference
   - Clinical Case Conference
   - Resident-Directed Student Didactics
   - Chairman Rounds Students are assigned by team to present and all others are expected to participate.
   - Grand Rounds/M&M Conferences (students must sign in using CloudCME®, see below for additional information)
   - Ambulatory Rounds: Only required for students on Ambulatory rotation.

   NOTES:
   - If your team is rounding during one of the sessions that you are required 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 respective sites.
   - CloudCME® will be used for signing into Grand Rounds, M&M and any conferences having CME credits. Students must download the CloudCME® app or go to https://utoledo.cloud-cme.com/default.aspx and create an account in order to sign into these conferences. The organizational code you will need is: utoledo. You need to open the app to scan the QR code provided at each Grand Rounds for attendance to be recorded.

5. **ELECTRONIC MEDICAL RECORDS (EMR):**
    - Students on outpatient services at both UTMC and ProMedica sites/services will use EPIC; all students should have received training for this during the Bridge Course, if you did not receive this training, please let the Clerkship Coordinator know ASAP before your scheduled rotation!

ADMISSION ORDERS

Admit to [team, physician, floor]
Diagnose (primary and secondary)
Condition
Vitals
Allergies
Nursing
Diet
Activity
Labs
I V Fluids
Special tests
Medications

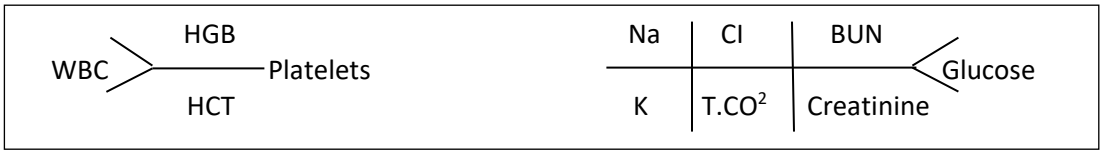
DISCHARGE ORDERS

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

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.
- Appropriate books: Washington Manual / Drug book.
- 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

ROS:	This is for complete History and Physical (H&P)
General:	Usual weight, weight changes, fever/chills, night sweats
Skin:	Rashes, lumps, itching, ulcers, color changes, changes in hair or nails
Head:	Headache, head injury
Eyes:	Vision, last eye exam, glasses/contacts, pain, redness, excessive tearing, double vision, spots, specks, flashing lights, glaucoma, cataracts
Ears:	Hearing, tinnitus, vertigo, earaches, infection, hearing aids
Nose & Sinus:	Frequent colds, nasal discharge or itching, nosebleeds, allergies, sinusitis
Mouth & Throat:	Dentures, last dental exam, sore tongue, sore throat, hoarseness, ulcers
Neck:	Lumps, goiter, pain or stiffness
Breasts:	Lumps, skin dimpling, pain, nipple discharge, self-exams
Respiratory:	Cough, sputum, hemoptysis, wheezing, asthma, bronchitis, emphysema, pneumonia, TB cancer, pulmonary embolus
Cardiac:	HTN, MI, heart murmurs, chest pain or pressure, palpitations, orthopnea, paroxysmal nocturnal dyspnea, edema, dyspnea, h/o EKG, stress test, cardiac cath
GI:	Trouble swallowing, heart burn, appetite, n/v hematemesis, h/o ulcers, h/o cancer, bowel habits, rectal bleeding or black tarry stools
Urinary:	Frequency of urination, polyuria, nocturia, burning with urination, hematuria, urgency, hesitancy, dribbling, incontinence, infections or stones
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: T Tm P R BP I/O WeightSat 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.

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.
6. Demonstrates independent and self-directed learning.

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.

Patient Safety Curriculum

As part of the longitudinal Patient Safety Curriculum, students need to complete a self-reflection evaluation (see **Appendix E** in the back of this handbook) which should be turned in to the Clerkship office. Almost all students will attend a Morbidity and Mortality (M & M) conference during their rotation which can form the basis for your self-reflection evaluation. In the unusual circumstance that you do not attend an M & M conference during your rotation, you can elect to complete this evaluation on any patient that you believe may have had a potential adverse outcome related to patient safety.

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

Utoledo.edu/med/md/report OR 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 the Office of Medical Education.

2. EDUCATIONAL COURSE OBJECTIVES

	Core Comp	Clerkship Objective *At the end of the IM Required Clerkship the student will be able to:*	Instructional Method	Outcome Measure
1	PC-1	Demonstrate an ability to obtain a complete medical history	Patient care in inpatient and outpatient settings Teaching rounds, inpatient	Clinical Competency Evaluation OSCE

			rounds Faculty observed history & physical	Case Report (written assignment) Formative feedback on faculty observed history & physical
2	PC-1	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-4, MK-6, MK-7; PC-1, PC-6, PC-7; IPC-1, IPC-2, IPC-3,	Synthesize information to develop an appropriate 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-4, MK-6, MK-7; PC-1, PC-6, PC-7	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-4, MK-6, MK-7; PC-1	Perform a complete H & P for new patient encounters and document the results in an organized and succinct manner.	Patient care in inpatient and outpatient settings	Clinical Competency Evaluations
6	MK-1, MK-4, MK-6, MK-7; PC-1, PC-6, PC-7	Regularly re-evaluate patients' status including appropriate interpretation of history and physical exam findings	Patient care in inpatient and outpatient settings	Clinical Competency Evaluations
7	MK-1, MK-4, MK-6, MK-7; PC-1, PC-6, 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 Ambulatory assignment (written assignment)
8	PC-6, PC-7	Demonstrate an ability to utilize and interpret laboratory and radiographic tests used in diagnosing common disease	Patient care in inpatient and outpatient settings Lab Medicine experience	Clinical Competency Evaluations NBME Subject Exam

9	MK-6; PBL-2, PC-6	Describe the different approaches to pain management.	Patient care in inpatient and outpatient settings Chairman Rounds & Student Morning Report	Clinical Competency Evaluations
10	MK-1, MK-4, MK-6, MK-7; PC-8	Recognize and manage common medical emergencies	Patient care in inpatient and outpatient settings	Clinical Competency Evaluations NBME Subject Exam
11	PC-2, MK-1, MK-2, MK-3; PB-1	Identify ethical problems which arise in patient treatment and care	Patient care in inpatient and outpatient settings Ethics Conference	Ethics Conference participation
12	PC-2, MK-1, MK-2, MK-3	Use ethical principles to reach a resolution in a presented case	Patient care in inpatient and outpatient settings Ethics Conference	Ethics Conference participation
13	PC-2, MK-1, MK-2, MK-3; PB-1	Recognize how race, culture and/or spirituality may influence choice of treatment and health care decision-making.	Ethics Conference	Ethics Conference participation
14	PC-6	Utilize self-directed learning in evaluation and management of patients.	Case Reports on Ambulatory rotation	Case Report evaluations
15	PB-1, PB-2	Demonstrate an ability to meet or exceed the institutional standards for professional behaviors.	Patient care in inpatient and outpatient settings	Clinical Competency Evaluations

3. Diagnostic Categories

Required Clinical Experiences:

To help learners achieve the 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 (Elsevier 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 required to evaluate **at least 16 inpatients** over the 6-week experience. The level of involvement for each patient must include:

1. Independently gathered history information
2. Independently performed physical exam
3. Presented patient case
4. Wrote patient note
5. Opportunity to discuss laboratory or test results
6. Opportunity to offer and discuss differential diagnosis
7. Opportunity to offer and discuss management options

In addition to participating in Medicine inpatient service, students spend 2 weeks in a variety of ambulatory/outpatient sites. Students are required to assess **at least 8 outpatients** during this experience. The level of involvement for each patient must include:

1. Observed or performed patient interview
2. Observed or performed physical exam
3. Opportunity to discuss laboratory or test results
4. Opportunity to offer and discuss differential diagnosis
5. Opportunity to offer and discuss management options

Students must log all patient encounters and logs will be monitored to ensure an adequate experience.

Diagnostic Category	Minimum Number of Patients	Comments/Explanation
Cardiovascular Disease	2 *(at least one patient with CAD and one patient with HTN)*	Includes CHF, ischemic heart disease, arrhythmia, hypertension, or peripheral vascular disease.
Endocrinology Disease	2 *(at least one patient with Diabetes Mellitus)*	Includes hyper/hypothyroidism, diabetes mellitus, or adrenal disease
Pulmonary Disease	2 *(at least one patient with obstructive lung disease)*	Includes COPD, asthma, interstitial lung disease
Hematologic/Oncologic Disease	2 *(at least one patient with anemia)*	Includes anemia, hematologic malignancy, or solid organ malignancy
Infectious Disease	2 *(at least one patient with pneumonia)*	Includes sepsis, endocarditis pneumonia, meningitis, urinary infection or HIV
Rheumatologic Disease	2 *(at least one patient with arthritis)*	Included rheumatoid arthritis, degenerative arthritis, or SLE
Gastroenterology Disease	2 *(at least one patient with gastrointestinal bleeding)*	Include peptic ulcer disease, esophagitis, cirrhosis or inflammatory bowel disease
Nephrology Disease	2 *(at least one patient with renal failure)*	Includes renal failure, electrolyte disturbance, acid-based disturbance, nephritic syndrome, or renal calculi

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 around the middle of the clerkship 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)

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.

4. 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	Describe normal and abnormal structure and function for all organ systems across the life span.
MK-2	Recognize how people of diverse cultures and belief systems perceive health/illness and respond to symptoms, diseases and related treatments.
MK-3	Describe the impact of gender and racial bias, as well as the cultural, economical, psychological, and social factors on health and disease.
MK-4	Apply the principles of basic sciences to the etiology, pathophysiology, diagnostic testing, prevention, and treatment of human diseases.
MK-5	Identify the core principles of health systems science and its impact on patients and populations.

MK-6 Describe the mechanism and action of pharmacological treatment across all clinical settings.
MK-7 Apply scientific principles required to practice evidence-based medicine.
MK-8 Identify end of life care issues from the patient and physician perspective.

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 Acquire and document a comprehensive history and perform a complete physical/mental status examination, and differential diagnosis.
PC-2 Apply ethical principles and practices to all aspects of patient care.
PC-3 Apply principles of epidemiology and social determinants of health to identify risk factors, disease prevention, and treatment strategies for patients and populations
PC-4 Discuss the fundamental principles of patient-centered and team-based care, patient safety as well as quality improvement in health care delivery.
PC-5 Obtain an informed consent for and perform common medical and surgical procedures in a safe, compassionate, and professional manner.
PC-6 Apply biomedical knowledge to understand clinical problems and to interpret laboratory data, imaging studies, and other diagnostic tests and procedures to deliver safe and effective clinical care.
PC-7 Make informed decisions about appropriate diagnostic and therapeutic interventions for patients with commonly encountered conditions.
PC-8 Recognize emergency medical conditions and initiate appropriate treatment.
PC-9 Collaborate as a member of an interprofessional team.

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 Demonstrate ethics and professionalism including compassion, cultural humility, and accountability when interfacing with patients, families, society, and healthcare team members.
PB-2 Exhibit professional and emotional maturity by managing conflicts, coping with personal and professional stress, and practice flexibility in ambiguous situations.
PB-3 Provide compassionate treatment for and respect the privacy and dignity of all patients and their families.

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 Communicate in a timely manner, both verbally and in writing, with patients, patients' families and caregivers, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities.

IPC-2 Communicate with colleagues across health professions in a respectful, professional, and timely manner to ensure interdisciplinary and interprofessional delivery of high-quality care.

IPC-3 Communicate in a culturally sensitive manner with patients, families/caregivers, and the community at large and apply principles of cultural humility 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 Identify personal limitations in knowledge and clinical skills, independently set learning and improvement goals, and participate in reflective practice to continuously improve as a lifelong learner.

PBL-2 Continually identify, analyze, and implement new knowledge, guidelines, standards, technologies, or products that have been demonstrated to improve patient outcomes.

PBL-3 Incorporate all forms of feedback to address gaps in knowledge, skills, and behaviors.

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 Assess the roles and responsibilities of physicians and other healthcare professionals in various models of healthcare organizations and determine the impact of finances/economics on delivery of health care.

SBP-2 Assess the impact of healthcare disparities in delivery of health care.

SBP-3 Determine the economic impact of diagnostic and therapeutic evaluations and the risk-benefit analysis in both patient and population-based care.

SBP-4 Respond to the larger context of systems of healthcare through effective use of systems resources, coordination of care, and practices that enhance quality and safety.

SBP-5 Participate effectively in and deliver care in an interprofessional team.

SBP-6 Assess the role of structural racism in health disparities and implement strategies to encourage and advocate for health equity.

5. 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 completing 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 completing 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 completing 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 completing 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 completing 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 completing 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)

Gastroenterology Diseases

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 completing reading materials and didactics related to diagnosis and management of gastroenterologic disease, the student will be able to:

a. recognize symptoms that may signify gastroenterologic disease including diarrhea, constipation, hematemesis, hematochezia and jaundice
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 gastroenterologic disease
e. develop a systematic approach to the management of common gastroenterologic diseases (including the recognition and management of situations that are potential emergencies)

Nephrology Diseases

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 completing assigned reading materials and didactics related to diagnosis and management of nephrologic disease, the student will be able to:

a. recognize symptoms that may signify nephrologic disease including hematuria, fatigue, nausea/vomiting and muscle cramps
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 nephrologic disease
e. develop a systematic approach to the management of common nephrologic diseases (including the recognition and management of situations that are potential emergencies)

6. READING

The recommended text for Internal Medicine will be Cecil Essentials of Medicine (10th 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. Cecil Essentials of Medicine is available via the ClinicalKey as well (https://go.openathens.net/redirector/utoledo.edu?url=https://www.clinicalkey.com/dura/browse/bookChapter/3-s2.0-C2017000616X).

In addition, key journals, books and websites pertaining to Internal Medicine can be located by following this link: https://libguides.utoledo.edu/md/internalmed

7. 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 interactions and procedures you performed during your medicine clerkship as well as your assigned educational hours.

After your clinical activity starts you will need to start logging cases and procedures into the website. The website for this is: http://rocketmed.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 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. You will not receive a final grade until you have entered at least 24 patients.

In additions to the cases, students are required to log their Assigned Educational Hours into the Case Log System (RocketMed) throughout the entire clerkship. Student assigned educational hours are defined as all clinical activities (both hospital and outpatient) and academic activities related to the clerkship. These hours include time spent in the hospital, time spent in the ambulatory setting and all scheduled academic activities such as lectures, conferences and orientation. Student

assigned educational hours do not include reading/studying and preparation time spent away from the hospital/clinical site(s). Under no circumstances should students have assigned educational hours that exceed 80 hours per week. If you feel that you are exceeding this amount of time, please contact the Clerkship Coordinator or Clerkship Director immediately. This Policy is described in detail in the UTCOM website (Policy3364-81-04-004-00).

8. STANDARD GRADING SYSTEM FOR INTERNAL MEDICINE CLERKSHIP

The Internal Medicine clerkship grade will consist of 3 components:

1. Clinical Competency Evaluation (CCE)
    a. Professionalism (PROF)
    b. Patient Care (PC)
    c. Practice Based Learning & Improvement (PBL)
    d. Interpersonal Communication Skills (IPC)
    e. Systems Based Practice (SBP)
2. National Board of Medical Examiners (NBME) Subject Exam
3. Departmental Education Program

Overall Grade	**1. CCE profile**	**2. NBME** (**PERCENTILE** based on National NBME average from the previous year)	**3. Departmental Education Program Points (20)**
Fail	Fail PC**	< 5%	< 11
Defer	Pass/High Pass/Honors	≥ 5th	< 11
	Pass/High Pass/Honors	< 5th	≥ 11
	Pass/High Pass/Honors	< 5th	< 11
	Fail (PB*) OR (PBL or IPC) ***	≥ 5th	≥ 11
Pass	Pass	≥ 5th	≥ 11
High Pass	Honors/High Pass/ Pass	≥ 55th	≥ 11
	Honors/ High Pass	≥ 5th but < 55th	≥ 11 but < 17
High Pass	Honors****	≥ 5th but < 55th	≥ 17
Honors	Honors	≥ 55th	≥ 17

PB = Professionalism; PC = Patient care; PBL = Practice-Based Learning and Improvement; IPC = Interpersonal and Communication Skills

***** Remediation through OSA/conduct and ethics committee

****** Repeat clerkship

******* Remediation determined by Clerkship Director

****** Clinical Excellence–** will be distinguished on the MSPE on the end of clerkship narrative

1. Clinical Competency Evaluation (CCE) performance

a. *Weighting of preceptor evaluations* – the weight of each preceptor evaluation will be determined by the amount time (direct contact hours) a student has with each preceptor:

Direct Contact Hours	Weight
Extensive (> 40 hours)	X16
Substantial (11 to 40 hours)	X8
Moderate (5 to 10 hours)	X4
Limited (1 to 4 hours)	X2
No Contact (< 1 hour)	0

b. Your CCE grade will be based on your performance in each of the 5 competencies. Final grade can be found in the highlighted boxes.

a) To qualify for CCE honors a student must have HONORS IN PROFESSIONALISM.

b) If the professionalism grade is HP or Pass, the highest CCE grade that can be assigned is HP.

c) Patient care and Interpersonal communication skills are vital components of the CCE grade.

d) Receiving Honors in Systems based practice and Practice based learning and improvement can improve your grade, but receiving High Pass or Pass cannot lower your grade.

	Competency Grades for Patient Care, Interpersonal and Communication Skills	Systems-Based Practice, and Practice-Based Learning and Improvement	PROFESSIONALISM		
			HONORS	HIGH PASS	PASS
1	2H	Either H or HP or P	H	HP	P
2	1H + 1HP	HONORS in both SBP and PBL required	H	HP	P
3	1H + 1HP	All others except HONORS in both SBP or PBL	HP	HP	P
4	2HP	Either H or HP or P	HP	HP	P
5	1H + 1P	HONORS in both SBP and PBL required	H	HP	P
6	1H + 1P	All others except HONORS in both SBP or PBL	HP	P	P
7	1HP + 1P	Either HP or H or P	HP	P	P
8	2P	Either HP or H or P	P	P	P

c.

High Pass with Clinical Excellence – If a student performs at an honors level for clinical performance and departmental points, a designation of "High pass with clinical excellence" will be noted in the MSPE narrative for the relevant clerkship.

d. Fail in one competency for assessment of clinical performance will result in the following

i. If a student fails Professionalism, Practice-Based Learning and Improvement, or Interpersonal and Communication Skills, a grade of DEFER will be assigned and REMEDIATION will be required. Once the remediation is successfully completed, the student's transcript grade will be changed to a PASS.

ii. If a student fails Patient Care, a grade of FAIL will be assigned, and the clerkship must be REPEATED in its entirety.

iii. The lowest grade possible for the Systems-Based Practice competency is a pass.

2. <u>NBME subject exam: Most recent national data from NBME will be used. For the 2024-2025 academic year, data from 2022-2023 will be used.</u>

a. Honors: ≥ 55 %tile

b. HP/P: 5-54 %tile

c. Fail: < 5%tile*

* Students must achieve the 5th percentile on the NBME subject examination to successfully complete the clerkship. Failure to achieve the 5th percentile will require the student to retake the subject examination and a grade of DEFER will be assigned. A second attempt on the NBME subject examination must be completed within one year from the first attempt. If the student achieves the 5th percentile or higher on the second attempt a grade of PASS will be assigned. PASS is the highest grade that can be achieved after a DEFER grade. If a student fails the NBME exam on a second attempt, then the final grade is FAIL and the clerkship must be repeated.

3. **Departmental Educational Program** (20 points total)
   a. Honors: ≥ 17
   b. HP/P: 11-16
   c. Fail < 11 points

Point distribution – 12 of the 20 points will be for OSCE performance.

1. There will **2 OSCE cases**
   a. Each case will be worth 6 points with points distributed as follows:
      i. Communication skills = 20%
      ii. History/Physical exam = 40%
      iii. Write up = 40%

A student must score at least 70% on each of the OSCE cases to pass the OSCE and the departmental education program category. A score of 4.2 on each case is required to pass. The highest clerkship grade a student can achieve after completing the required retake for the case(s) they failed is a PASS. A grade of Incomplete is submitted until the OSCE is successfully remediated and passed.

2. 8 points – discipline specific activities, such as:
   a. Conference/Lecture Attendance: 2 points
   b. Completion of required activities: 6 points
      i. Such as logging, OCS forms, Patient Safety, Q-bank/Clinical Key, etc.

3. A minimum of 11 total points must be achieved in the Departmental Education Program. If a student does not meet the minimum threshold a grade of DEFER will be assigned until remediation is completed. PASS is the highest grade that can be achieved after a DEFER grade is resolved.

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 expected to attend Medicines' Grand Rounds, if their schedule permits.

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

Students attending Grand Rounds and M&M Conferences at UTMC or Toledo Hospital, don't forget that you will need to sign in using the CloudCME® app!

X. THE INPATIENT/CONSULT HOSPITAL ROTATION

UTMC, ProMedica Toledo Hospital, Riverside Hospital (Columbus, OH), Trinity Health (Ypsilanti, MI), Akron General (Akron, OH) and Naples Healthcare (Naples, FL)

Students' Responsibilities and Criteria for Evaluation:

- Perform complete history and physical exam on new patients admitted to the service. H&P should be on the chart within 24 hours of admission.
- Be prepared to present a 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/M&Ms.
- 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.
- 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 descriptions for members of the medical team can be found in Section XV.
- Observation and Feedback

<u>Holidays</u>
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 including Riverside, Trinity Health, ProMedica Toledo Hospital, Akron General or Naples Healthcare.

<u>Change of Rotation</u>
Students will be expected to be at their assigned hospitals throughout the duration of the rotation at that hospital.

Students going to an AHEC site, Riverside Methodist Hospital, Columbus, Trinity Health,

Ypsilanti, Akron or Naples may leave at the end of business the day before starting the next Block after they have completed their assigned patient care duties.

Below is an example of the Observation of Clinical Skills (OCS) Form. There are four of these forms in **Appendix C** located in the back of this handbook. **Remove these pages and divide the forms**. During your rotation you should give a form to the attending physician that you are working with (or their designee) for formative feedback on your performance. A minimum of 3 of these signed forms must be returned to the Clerkship Office by the end of the clerkship. Failure to return these forms will result in an incomplete grade.

INTERNAL MEDICINE CLERKSHIP			
OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK			
Student Name (print):			
Week of (dates):			
Faculty Name (print):			
Please evaluate the following skills you observed during a student-patient clinical encounter:	Satisfactory	Needs to improve	Did not observe
Interviewed the patient and collected pertinent information	☐	☐	☐
Performed a complete and focused physical exam as appropriate	☐	☐	☐
Selected and interpreted common tests used in diagnosing common diseases	☐	☐	☐
Periodically re-evaluated the patient, interpreting the results of new tests and physical changes	☐	☐	☐
Synthesized information, determined a differential diagnoses	☐	☐	☐
Accurately presented a patient by preparing case reports based on patient encounters and research	☐	☐	☐
Demonstrated appropriate knowledge in the clinical setting	☐	☐	☐
Showed respect for the patient, protects their privacy and dignity	☐	☐	☐
This student is ethical, reliable and responsible	☐	☐	☐
This student is honest and displays integrity	☐	☐	☐
This student dressed professionally, was well groomed and communicated clearly	☐	☐	☐
This student shows respect for other health care professionals and staff	☐	☐	☐
Additional comments or notes for improvement:			
Faculty Signature:			

XI. THE AMBULATORY MEDICINE ROTATION

Students' Responsibilities and Criteria for Evaluators:

1. Each student not assigned to an outpatient AHEC will spend 2 weeks of their 8-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.

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. On scheduled Fridays 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. Case Reports will be returned to the faculty member with whom you saw the patient. You will need to prepare two Case Reports during the Ambulatory Medicine Rotation.

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

8. Evaluations will be based on the following:
   a) Case Reports will be evaluated by the faculty with whom you saw the patient 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.

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 below 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 turn it in to the IM Clerkship Office by the end of your rotation.

CASE REPORT EVALUATION

Student Name:

_____

Patient Initials: **Date:**

_____ _____

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

Attending Name:

_____

Overall, this report is:

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

Suggestions / Comments / Feedback:

_____

_____

_____

_____

_____

_____

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

Sample Case Report (used by permission of Stanley Chung CCIV)

Case Report July 20, 1989

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 1/min) treatment. Current mediation includes Proventil, Atrovent, and Vanceril inhalers, Theodur 300 mg bid, and Premarin 0.625 mg qd. The patient appears calm, and cheerful. She seems 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 ware 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 July 27, 1989

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 erythematosus 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 migraines. 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 migraines. 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

Stage	Findings
I	Lasts a median of 4 weeks: Erythema migrants, Influenza-like illness, Severe fatigue, musculoskeletal pains, headache, stiff neck
II	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
III	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.

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 of North America, Sept. 1987; 1(3):511-527.)

Table 2. CDC Diagnostic Criteria for Lyme Disease

Endemic Area:
1. Erythema migraines (EM) with exposure no more than 30 days prior to onset.
2. Involvement of >one organ system (musculoskeletal, neurologic, or cardiac) and positive antibody test.

Nonendemic Area:
1. EM with positive antibody test.
2. EM with involvement of > two organ systems.

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 a two-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 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 inpatients, patients receiving hospice care at home and in extended care facilities.
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.

XIV. PROCEDURAL COMPETENCE

All students on the Internal Medicine Clerkship will be encouraged to perform simple procedures outlined below:

- 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 or library. 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. There is no requirement to perform procedures during the Clerkship.

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 house-staff.
- 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 are 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 house-staff 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.

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 house-staff. 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 Clinical Competency Evaluation for STUDENT NAME

Clerkship:	MEDI703 001	Evaluator:		Start Date:	
End Date:		Rotation Number:		Site:	

Hours assigned to the student

- ○ Extensive (>40 Hours)
- ○ Substantial (11 to 40 Hours)
- ○ Moderate (5 to 10 Hours)
- ○ Limited (1 to 4 Hours)
- ○ No Contact (Less than 1 Hour)

- View the medical school educational program objectives.

Evaluations may be negatively influenced by implicit biases. These biases include our subconscious attitudes, perceptions, and stereotypes that influence our understanding, actions, and behavior while interacting with various identities. Implicit bias can influence perceptions of race, gender, sexual orientation, gender identity, ability, religion/spirituality, nationality, and socioeconomic status. Systematically, this may result in lower evaluations, even when there are no differences in performance. We ask that all evaluators recognize the potential impact of bias and resist stereotypes to ensure balanced evaluations.
- Adapted from Georgetown University School of Medicine

For each of the following statements, rate your observation of the student's performance during the clerkship. Please be as objective as possible and keep in mind that the **student is NOT expected to perform at the highest level** on each of these to receive a passing or even an honors score. The bolded frequency corresponds to the expected level of performance for a 3rd year student by the end of the clerkship. Our scoring algorithm reflects realistic expectations of performance and for some of the statements, this may even be a lower rating. Your objective reflections will also be very valuable to the student and help us identify areas of continuous improvement and ultimately secure better patient care.
Please remember: "Always" means 100% of the time. "Nearly always" means at least ¾ (75-99%) of the time. "Often" is between 50% and 74% of the time. "Rarely" is less than half (50%) of the time.

Competency: PROFESSIONALISM

Displays honesty, integrity, and ethical values in all team interactions

○ Always	○ Nearly Always	○ Often	○ Rarely	○ Not Observed

On time to duties (punctuality)

○ Always	○ Nearly Always	○ Often	○ Rarely	○ Not Observed

Prepared for assigned responsibilities

○ Always	○ Nearly Always	○ Often	○ Rarely	○ Not Observed

Receptive to feedback

○ Always	○ Nearly Always	○ Often	○ Rarely	○ Not Observed

Includes social/structural factors (e.g., access to food, local laws, zip code) that impact medical decision making and patient health

○ Always	○ Nearly Always	○ Often	○ Rarely	○ Not Observed

Uses proper language/terminology (e.g., identity, ethnicity, ability, level of education) when discussing patients and their care

Always	Nearly Always	Often	Rarely	Not Observed

Demonstrates compassion and empathy for patients (e.g., patient feels heard)

Always	Nearly Always	Often	Rarely	Not Observed

Competency: INTERPERSONAL AND COMMUNICATION SKILLS

Uses language that is appropriate for patient understanding

Always	Nearly Always	Often	Rarely	Not Observed

Demonstrates active listening skills with patients (e.g., asks clarifying questions, repeats back to patient what was heard, not distracted).

Always	Nearly Always	Often	Rarely	Not Observed

Interacts respectfully with the healthcare team

Always	Nearly Always	Often	Rarely	Not Observed

Is a proactive and engaged member of the healthcare team

Always	Nearly Always	Often	Rarely	Not Observed

Competency: PATIENT CARE

HPI is organized

Always	Nearly Always	Often	Rarely	Not Observed

HPI includes pertinent positives and negatives

Always	Nearly Always	Often	Rarely	Not Observed

Relevant other history is complete (e.g., includes medical, past surgical, family, social history, ROS)

Always	Nearly Always	Often	Rarely	Not Observed

Uses proper technique when performing a physical (or mental status) exam

Always	Nearly Always	Often	Rarely	Not Observed

Identifies pertinent positives and negatives from the exam

Always	Nearly Always	Often	Rarely	Not Observed

Accurately interprets tests (e.g., labs, imaging, surveys, screening studies)

Always	Nearly Always	Often	Rarely	Not Observed

Identifies the most important (e.g., most likely, critical, life-threatening) diagnoses

Always	Nearly Always	Often	Rarely	Not Observed

Identifies less likely but relevant diagnoses

Always	Nearly Always	Often	Rarely	Not Observed

Patient plan of care is appropriate for the diagnosis

Always	Nearly Always	Often	Rarely	Not Observed

Patient plan of care integrates evidence-based practice

Always	Nearly Always	Often	Rarely	Not Observed

Patient presentation is organized (e.g., utilizes SOAP)

Always	Nearly Always	Often	Rarely	Not Observed

Patient presentation is accurate, relevant, and complete

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

Documentation (e.g., progress note) is accurate, relevant, and complete

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

Demonstrates application of basic/foundational concepts in clinical care (e.g., pathophysiology, differential diagnosis, lab interpretation, plan of care)

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

Explains all steps of procedure(s)

Always	Nearly Always	Often	Rarely	Not Observed/Not Applicable
○	○	○	○	○

Competency: PRACTICE-BASED LEARNING AND IMPROVEMENT

Identifies areas for self improvement (e.g. knowledge, communication, presentation, and/or professionalism)

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

Identifies clinical questions and begins to take initiative to address the question in the context of patient care

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

Competency: SYSTEMS-BASED PRACTICE

Suggests ancillary resources to optimize patient care (e.g., community support groups, social work, home health, palliative care).

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

Identifies errors in patient care and/or articulates system failure (e.g., medication errors)

Always	Nearly Always	Often	Rarely	Not Observed
○	○	○	○	○

MSPE/NARRATIVE COMMENTS

- MSPE comments are required (130 character minimum). The comments in this text box will be used for the student's MSPE.

Enter text here

characters
Comment has a minimum length of 130 characters.

- ("Not for MSPE") Narrative comments. Please also include specific comments if you feel a student did exceptionally well or exceptionally poorly, including examples where such behavior was demonstrated.

Enter text here

By submitting this evaluation, I hereby attest that I do not have a conflict of interest with this student, including but not limited to a consensual relationship, familial relationship, physician-patient (health care) relationship, or financial relationship. If I feel there is a COI, it is my responsibility to contact the coordinator and have myself removed from evaluating the student.
View the policy.

I also certify that the information I have provided is correct to the best of my knowledge. I understand that this constitutes an electronic signature and take responsibility for the content herein. I am aware of the Family Education Rights and Privacy Act that states that this information may not be released to anyone other than the registrar's office. Therefore, I will have anyone who requests this information contact the registrar's office.

APPENDIX B: HISTORY AND PHYSICAL CHECKLIST

INTERNAL MEDICINE CLERKSHIP: FACULTY OBSERVED HISTORY TAKING & PHYSICAL EXAM CHECKLIST

GENERAL LAYOUT OF INTERVIEW		Yes	No
1.	Did the student knock on the door before entering?		
2.	Did the student introduce themselves to the SP?		
3.	Did the student ask how the SP wished to be addressed?		
4.	Did the student sit down?		
5.	Did the student establish eye contact with the SP?		
6.	Did the student inquire about the reason for the SP visit?		
7.	Did the student wash/sanitize their hands before entering the examining room?		
8.	Did the student avoid medical jargon when communicating with the SP?		
9.	Did the student summarize the information given by the SP to confirm understanding of the information?		
10.	Did the student explain to the SP what will happen next?		
11.	Did the student ask the SP if they had any questions/concerns prior to ending visit?		
12.	Did the student use at least one empathy statement during the visit?		
13.	Is the student's white coat professional in appearance?		
14.	Explained procedures and gave clear instructions		
15.	Considered patient comfort during the exam and kept areas not being examined covered by a gown or a drape.		

CHIEF COMPLAINT		
16.	Reason (s) for visit.	☐

PRESENT ILLNESS		
17.	Location. Where is it? Does it radiate?	☐
18.	Quality. What is it like? Describe it.	☐
19.	Quantity/Severity. How bad is it?	☐
20.	Timing. Onset, Duration, Frequency. When did it start? How long does it last? How often does it occur?	☐
21.	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.	☐
22.	Remitting/relieving factors. What makes it better?	☐
23.	Exacerbating/aggravating factors. What makes it worse?	☐
24.	Associated symptoms. Anything that accompanies it?	☐
25.	Patient's perspective. Patient's idea about what is causing the problem, how the problem affects everyday functioning, fears/concerns, thought about what would help.	☐

STUDENT NAME:

COMMENTS:

26.	Medications – name, dose, route and frequency of use (Medications include prescriptions, home remedies, over-the-counter drugs, vitamins, minerals, herbal supplements and oral contraceptives.	☐
27.	Allergies – must ask agent and reaction (e.g., medication, food, insect, environmental factor).	☐
28.	Tobacco – type and quantity and frequency and attempt(s) to quit.	☐
29.	Alcohol – type and quantity and frequency.	☐
30.	Illicit drug use – type and quantity and frequency (MUST ask all three).	☐
PAST HISTORY		
31.	Childhood Medical Illnesses.	☐
32.	Adult Medical Illnesses.	☐
33.	Surgical History.	☐
34.	Obstetric/gynecologic (e.g., pregnancies, menstrual periods).	☐
35.	Psychiatric (e.g., depression anxiety).	☐
36.	Health maintenance – (e.g., immunizations, screening tests).	☐
FAMILY HISTORY		
37.	Health/illnesses of immediate relatives (e.g., parents, grandparents, siblings, children, grandchildren).	☐
PERSONAL AND SOCIAL HISTORY		
38.	e.g., occupation, educational level, living arrangements, relationships, personal interests, spirituality, exercise, diet and safety measures.	☐
GENERAL INSPECTION AND VITAL SIGNS		
39.	Measure Blood Pressure in one arm (on bare skin and must check for pulse first)	☐
40.	Palpate Radial Pulse (for at least 15 sec. – may not use thumb)	☐
HEAD AND NECK		
41.	Inspect Scalp	☐
42.	Estimate Visual Acuity – bilaterally by covering one eye at a time	☐
43.	Inspect External Ocular Structures (lid, cornea, conjunctivae)	☐
44.	Check visual fields by confrontation	☐
45.	Observe bilateral pupillary response to light	☐
46.	Evaluate extra ocular muscle function in 4 quadrants	☐
47.	Uses ophthalmoscope or panoptic to examine each eye	☐
48.	Examine outer ears – bilaterally	☐

COMMENTS:

INTERNAL MEDICINE CLERKSHIP: FACULTY OBSERVED HISTORY TAKING & PHYSICAL EXAM CHECKLIST

49.	Test auditory acuity	☐
50.	Inspect ear canals bilaterally with otoscope	☐
51.	Inspect turbinates and septum with otoscope	☐
52.	Inspect lips, gums, teeth, buccal mucosa	☐
53.	Inspect palate, uvula, pharynx, tongue	☐
54.	Observe midline protrusion of tongue	☐
55.	Observe elevation of the palate by asking patient to say "ah"	☐
56.	Examine thyroid gland with and without swallowing	☐
57.	Palpate lymph nodes of neck and posterior occipital region	☐
CHEST, LUNGS AND THORAX		
58.	Inspect and palpate spine on bare skin	☐
59.	Perform fist percussion of CVA – bilaterally on bare skin	☐
60.	Check Thoracic (chest) expansion – must ask patient to take a deep breath	☐
61.	Percuss posterior lung fields bilaterally and symmetrically (side to side at least 6 areas) on bare skin	☐
62.	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	☐
63.	Auscultate anterior chest symmetrically (side to side at least 6 areas) on bare skin and must ask patient to take a deep breath	☐
64.	Auscultate lateral chest symmetrically (side to side at least 4 areas) on bare skin and must ask patient to take a deep breath	☐
65.	Auscultate aortic area with diaphragm of stethoscope on bare skin	☐
66.	Auscultate pulmonic area with diaphragm of stethoscope on bare skin	☐
67.	Auscultate tricuspid area with diaphragm of stethoscope on bare skin	☐
68.	Auscultate mitral (apical) area with diaphragm of stethoscope on bare skin	☐
69.	Observe neck veins with head of table elevated	☐
ABDOMEN		
70.	Auscultate before percussion or palpation on bare skin	☐
71.	Auscultate over each of four quadrants on bare skin	☐
72.	Palpate abdomen (light and deep in all four quadrants) on bare skin	☐
73.	Palpate liver edge on bare skin	☐
74.	Percuss for upper border of liver on bare skin	☐
VASCULAR SYSTEM		
75.	Carotids – Palpate pulses – bilaterally	☐
76.	Femoral – Palpate pulses – bilaterally	☐

COMMENTS:

77.	Dorsalis pedis and/or posterior tibial on bare skin – Palpate pulses – bilaterally	☐
MUSCULOSKELETAL SYSTEM – Upper Extremities		
78.	Inspected hands, nails, joints, palms – bilaterally	☐
79.	Inspected and palpated upper extremity joints – bilaterally	☐
80.	Tested range of motion of fingers and wrists – bilaterally	☐
81.	Tested range of motion of upper arm (shoulder, elbow) – bilaterally	☐
82.	Tested muscle strength of arms (shoulders, elbows, wrists) – bilaterally	☐
MUSCULOSKELETAL SYSTEM – Lower Extremities		
83.	Inspected and palpated lower extremity joints	☐
84.	Tested muscle strength of legs	☐
85.	Tested Muscle strength of thighs	☐
NEUROLOGICAL EXAM – Nerve I		
86.	Sense of smell – Ask about change or directly assess	☐
NEUROLOGICAL EXAM – Nerve V		
87.	Test sensory briefly in all 3 divisions (temple, jaw, chin) patient's eyes must be closed	☐
88.	Test contraction of masseter (jaw) muscles on opening of mouth	☐
NEUROLOGICAL EXAM – Nerve VII		
89.	Raise eyebrows or forced eyelid closure	☐
90.	Show teeth and or puff out cheeks	☐
NEUROLOGICAL EXAM – Nerve VIII		
91.	Weber Test	☐
92.	Rinne Test	☐
NEUROLOGICAL EXAM – Nerve XI		
93.	Test rotation of head against resistance	☐
94.	Test shoulder shrug against resistance	☐
Reflexes		
95.	Biceps (inside elbow) – bilaterally	☐
96.	Brachioradialis (near wrist) – bilaterally	☐
97.	Triceps (back of elbow) – bilaterally	☐
98.	Patellar (knee) – bilaterally	☐

COMMENTS:

INTERNAL MEDICINE CLERKSHIP: FACULTY OBSERVED HISTORY TAKING & PHYSICAL EXAM CHECKLIST

99.	Achilles (ankle) – bilaterally	☐
100.	Plantar – Babinski (sole of foot/without sock) – bilaterally	☐
Cerebellar		
101.	Test rapid alternating movement of hands	☐
102.	Test finger to nose – bilaterally	☐
103.	Test heel to shin – bilaterally	☐
Sensory		
104.	Test light touch or pin prick in upper extremities – bilaterally and patient's eyes must be closed	☐
105.	Test light touch or pin prick in lower extremities – bilaterally and patient's eyes must be closed	☐
106.	Test position sense in feet – bilaterally	☐
107.	Test vibratory sense in ankles – bilaterally	☐
108.	Perform Romberg test with eyes closed and feet together	☐

COMMENTS:

OVERALL COMMENTS:

FACULTY OBSERVER: Mani Askari, M.D.	**FACULTY SIGNATURE:**

Please do NOT give this form to the student, it needs to be returned to the Clerkship Office.

INTERNAL MEDICINE CLERKSHIP			
OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK			
Student Name (print):			
Week of (dates):			
Faculty Name (print):			
If the above name is a resident, enter the faculty who designated them:			
Please evaluate the following skills you observed during a student-patient clinical encounter:	Satis-factory	Needs to improve	Did not observe
Interviewed the patient and collected pertinent information	☐	☐	☐
Performed a complete and focused physical exam as appropriate	☐	☐	☐
Prepared a complete H&P for a new patient admitted to the service and charted the results	☐	☐	☐
Selected and interpreted common tests used in diagnosing common diseases	☐	☐	☐
Periodically re-evaluated the patient, interpreting the results of new tests and physical changes	☐	☐	☐
Synthesized information, determined a differential diagnoses	☐	☐	☐
Accurately presented a patient by preparing case reports based on patient encounters and research	☐	☐	☐
Demonstrated appropriate knowledge in the clinical setting	☐	☐	☐
Showed respect for the patient, protects their privacy and dignity	☐	☐	☐
This student is ethical, reliable and responsible	☐	☐	☐
This student is honest and displays integrity	☐	☐	☐
This student dressed professionally, was well groomed and communicated clearly	☐	☐	☐
This student shows respect for other health care professionals and staff	☐	☐	☐
Additional comments or notes for improvement:			
Faculty Signature:			

INTERNAL MEDICINE CLERKSHIP			
OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK			
Student Name (print):			
Week of (dates):			
Faculty Name (print):			
If the above name is a resident, enter the faculty who designated them:			
Please evaluate the following skills you observed during a student-patient clinical encounter:	Satis-factory	Needs to improve	Did not observe
Interviewed the patient and collected pertinent information	☐	☐	☐
Performed a complete and focused physical exam as appropriate	☐	☐	☐
Prepared a complete H&P for a new patient admitted to the service and charted the results	☐	☐	☐
Selected and interpreted common tests used in diagnosing common diseases	☐	☐	☐
Periodically re-evaluated the patient, interpreting the results of new tests and physical changes	☐	☐	☐
Synthesized information, determined a differential diagnoses	☐	☐	☐
Accurately presented a patient by preparing case reports based on patient encounters and research	☐	☐	☐
Demonstrated appropriate knowledge in the clinical setting	☐	☐	☐
Showed respect for the patient, protects their privacy and dignity	☐	☐	☐
This student is ethical, reliable and responsible	☐	☐	☐
This student is honest and displays integrity	☐	☐	☐
This student dressed professionally, was well groomed and communicated clearly	☐	☐	☐
This student shows respect for other health care professionals and staff	☐	☐	☐
Additional comments or notes for improvement:			
Faculty Signature:			

INTERNAL MEDICINE CLERKSHIP				
OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK				
Student Name (print):				
Week of (dates):				
Faculty Name (print):				
If the above name is a resident, enter the faculty who designated them:				
Please evaluate the following skills you observed during a student-patient clinical encounter:		Satis-factory	Needs to improve	Did not observe
Interviewed the patient and collected pertinent information		☐	☐	☐
Performed a complete and focused physical exam as appropriate		☐	☐	☐
Prepared a complete H&P for a new patient admitted to the service and charted the results		☐	☐	☐
Selected and interpreted common tests used in diagnosing common diseases		☐	☐	☐
Periodically re-evaluated the patient, interpreting the results of new tests and physical changes		☐	☐	☐
Synthesized information, determined a differential diagnoses		☐	☐	☐
Accurately presented a patient by preparing case reports based on patient encounters and research		☐	☐	☐
Demonstrated appropriate knowledge in the clinical setting		☐	☐	☐
Showed respect for the patient, protects their privacy and dignity		☐	☐	☐
This student is ethical, reliable and responsible		☐	☐	☐
This student is honest and displays integrity		☐	☐	☐
This student dressed professionally, was well groomed and communicated clearly		☐	☐	☐
This student shows respect for other health care professionals and staff		☐	☐	☐
Additional comments or notes for improvement:				
Faculty Signature:				

INTERNAL MEDICINE CLERKSHIP				
OBSERVATION OF CLINICAL SKILLS (OCS) – FORMATIVE FEEDBACK				
Student Name (print):				
Week of (dates):				
Faculty Name (print):				
If the above name is a resident, enter the faculty who designated them:				
Please evaluate the following skills you observed during a student-patient clinical encounter:		Satis-factory	Needs to improve	Did not observe
Interviewed the patient and collected pertinent information		☐	☐	☐
Performed a complete and focused physical exam as appropriate		☐	☐	☐
Prepared a complete H&P for a new patient admitted to the service and charted the results		☐	☐	☐
Selected and interpreted common tests used in diagnosing common diseases		☐	☐	☐
Periodically re-evaluated the patient, interpreting the results of new tests and physical changes		☐	☐	☐
Synthesized information, determined a differential diagnoses		☐	☐	☐
Accurately presented a patient by preparing case reports based on patient encounters and research		☐	☐	☐
Demonstrated appropriate knowledge in the clinical setting		☐	☐	☐
Showed respect for the patient, protects their privacy and dignity		☐	☐	☐
This student is ethical, reliable and responsible		☐	☐	☐
This student is honest and displays integrity		☐	☐	☐
This student dressed professionally, was well groomed and communicated clearly		☐	☐	☐
This student shows respect for other health care professionals and staff		☐	☐	☐
Additional comments or notes for improvement:				
Faculty Signature:				

APPENDIX D: CASE REPORT EVALUATION

CASE REPORT EVALUATION - #1

Student Name:

_____

Patient Initials: **Date:**

_____ _____

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

Attending Name:

_____

Overall, this report is:

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

Suggestions / Comments / Feedback:

_____

_____

_____

_____

_____

_____

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

Student Name:

_____

Patient Initials: **Date:**

_____ _____

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

Attending Name:

_____

Overall, this report is:

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

Suggestions / Comments / Feedback:

_____

_____

_____

_____

_____

_____

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

APPENDIX E: PATIENT SAFETY CURRICULUM SELF-REFLECTION EVALUATION

Patient Safety Curriculum Self-Reflection Evaluation

The purpose of this self-reflection evaluation is to give you an opportunity to consider the importance of patient safety in the provision of high-quality clinical care. You can use information from a Morbidity & Mortality Conference or you can identify a patient safety issue that you may have seen during your rotation. You will need to submit this form to the Clerkship office. Failure to complete this form will result in a grade of Incomplete until it is submitted. Feel free to use the back of this page if additional space is needed.

1) Brief description of patient scenario (Age, Demographics, Reason for admission (or clinic visit), Location (hospital, clinic, etc.)

2) Description of patient safety issue identified.

3) Role of health care professional(s) in the patient safety event.

4) If you were taking care of a similar patient, how could you play a role in preventing this from happening again?

☐ This is based off a Morbidity & Mortality Conference Date of conference: _____

Student Name (printed) _____

Signature: _____ Date: _____

APPENDIX F: ABSENCES

COLLEGE OF MEDICINE AND LIFE SCIENCES
THE UNIVERSITY OF TOLEDO

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: **Click here to enter text.**
Class Year: Choose an item.
Email Address: Click here to enter text.
Phone #: Click here to enter text.

REQUEST 1	**Request from:** Day: Choose an item. Date: Click here to enter a date. Time: Click here to enter text. ☐ ALL DAY **Returning on:** Day: Choose an item. Date: Click or tap to enter a date. Time: Click here to enter text. Reason for absence: Choose an item. *To be completed by the Clerkship Director:* ☐ Approve ☐ Disapprove
REQUEST 2	**Request from:** Day: Choose an item. Date: Click here to enter a date. Time: Click here to enter text. ☐ ALL DAY **Returning on:** Day: Choose an item. Date: Click here to enter a date. Time: Click here to enter text. Reason for absence: Choose an item. *To be completed by the Clerkship Director:* ☐ Approve ☐ Disapprove

TOTAL number of absences that you have utilized this academic year: Click here to enter text.

What other days have you requested off or plan to request off from this elective/clerkship? Click here to enter text.

Clinical Site *(list actual service where line permits)*:

☐ UTMC: Click here to enter text.
☐ProMedica: Click here to enter text.
☐AHEC: Click here to enter text.
☐Other Site: Click here to enter text.

Scheduled activities that will be / have been missed: Click here to enter text.

Have you provided additional documentation (doctor's note, interview invitation, etc.)? ☐Yes ☐ No

I will notify the following attendings and/or residents on the service I am assigned to of this absence: Click here to enter text.

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 Notes: _____
_____

_____ _____
Approval Signature: *Clerkship Director* Date

APPENDIX G: ETHICS SESSIONS

"THE CASE OF VIJAY – CONFLICTING GOALS"

case study

Conflicting Beliefs

Vijay is a forty-eight-year-old man with profound mental retardation and cerebral palsy. He uses a wheelchair, cannot speak or eat by mouth, and requires constant care. He lived in a group home for twenty-eight years.

During the last year, Vijay has required two visits to the emergency room on average per month and has been hospitalized for two hundred days in total. These hospitalizations are the result of a number of painful and dangerous complications related to the gastrostomy tube that provides his nutrition. The last time he was in the hospital, doctors had to give him a peripherally inserted central catheter, or PICC line, to provide nutrition because the gastrostomy tube was no longer effective and Vijay was losing weight. But the PICC line has had its own problems. Shortly after insertion, it became infected, requiring a prolonged course of antibiotics and Vijay's transfer to a nursing home for care, since the group home does not have the manpower to care for and maintain a PICC line. Vijay's stay at the nursing home lasted two months, and many attempts during this time to return to feeding him through the gastrostomy tube failed.

Vijay has just been rushed to the ER yet again because the PICC line is not flowing. The ER physician wants to change it, but his parents refuse to consent. They consider his care futile at this point and believe he will never resume enteral feeding through the gastrostomy tube. They also consider his care a burden, both to him and to themselves. They tell doctors that the constant surgeries and procedures—along with the pain and suffering they may be causing Vijay—violate his dignity. They also say that dealing with his chronic problems has made it impossible to pay attention to their own lives and the rest of their family. And finally, his parents are Hindus. They believe that Vijay's body is now trapping his spirit, keeping it from its onward journey. They say Hinduism prohibits unwholesome efforts to prolong life like the repeated surgeries that Vijay has undergone. They tell the ER physician that they will not allow another surgical procedure to adjust or replace Vijay's PICC line, even if doing so means he will starve to death.

Faced with this decision, the ER physician proposes returning Vijay to the nursing home, but the medical director there will not accept him back without a PICC line. He tells the physician that while Vijay's parents may believe his care is futile, he does not think that Vijay meets the usual criteria for withholding life-sustaining treatment—he is not terminal or permanently unconscious, and his recent failure to thrive is not conclusively irreversible. The medical director also believes that the PICC line will probably be a temporary measure, despite a lack of success so far in restoring enteral feeding. And he admits he is afraid that letting Vijay die will make both him and the nursing home vulnerable to accusations of euthanasia and possibly a lawsuit.

How can Vijay's situation be resolved in a way that all parties concerned can accept?

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"MRS. PANGHORN"

Mrs. Pangborn is a 68-year-old patient with recent recurrence of breast cancer, currently receiving chemotherapy. She was admitted to the hospital after three days of worsening crampy abdominal pain, nausea, vomiting, inability to tolerate oral intake, and constipation. Prior to this, she had good functional status and still worked as Chief Financial Officer of a large non-profit organization. She now has acute kidney injury (AKI) and a likely complete malignant small bowel obstruction. Her advance directive names her two daughters as her medical decision-makers, but it does not include written treatment preferences. The hospitalist, Dr. Farley, briefly discussed code status with Mrs. Pangborn on admission; Mrs. Pangborn responded, "do everything you can," so Dr. Farley entered a code status of full code.

Mrs. Pangborn experienced symptomatic improvement with placement of a nasogastric tube for decompression, appropriate antiemetics, and other medications, but she frequently refused opioid pain medications, saying "they make me too drowsy and not as alert as I like to be." A general surgeon evaluated her and recommended surgical intervention.

Unfortunately, surgery was complicated by more extensive metastatic involvement than was seen on imaging and brief hypotension, requiring vasopressors. Consequently, the planned resection was abandoned, and a venting G-tube was placed for relief of her nausea and vomiting. After surgery, Mrs. Pangborn recovered quickly and was lucid and stable to return to the hospital floor, where she was placed on a patient-controlled analgesic (PCA) pump to ensure comfort. She used the PCA frequently for pain control for a day but then became confused and unable to operate the PCA; she was transitioned to nurse-administered analgesics. Her daughters, Kelly and Linda Pangborn, frequently at her side, asked Dr. Farley to decrease her pain medications, fearing that these were contributing to her progressive delirium. Dr. Farley was hesitant to do so, explaining that she did not want their mother to suffer unnecessarily, but agreed to decrease the pain medications slightly.

That evening, Mrs. Pangborn became septic and declined further. Dr. Farley discussed the patient's broader goals of care with her daughters and recommended transitioning to comfort measures and/or hospice given her rapid decline and metastatic disease. Her distraught daughters asked if there was a possibility that she might regain decision-making capacity to help make such choices, noting that their mother, a widow, was fiercely independent, "a fighter," and preferred to make her own decisions. They were still worried that the pain medications were making her confused and again requested that they be discontinued to help their mother regain improved cognition.

QUESTION: Would it be appropriate for Dr. Farley to continue higher doses of pain medication despite daughter's request to lower the dose? Use the Clinical Ethics worksheet by Campelia, et al to formulate your answer.

What communication skills and shared-decision-making skills could have been used earlier in the hospitalization to avoid this dilemma? (Refer to the Annals of Internal Medicine article "When patients want everything")

MS. Y – PATIENT CARE AT THE END OF LIFE

Ms. Y (she/her) is 58 years old with widely metastatic recurrent endometrial endometrioid adenocarcinoma. She has significant tumor burden in her pelvis with invasion into bowel and bladder, with partial bowel obstruction. Ms. Y has been admitted for worsening leukocytosis and osteomyelitis. Ms. Y has two children. She currently lives with a son, his partner, and their newborn child. She has had 5 inpatient admissions over the last 6 months.

Ms. Y hopes for recovery and extra time with her children and current/future grandchildren. She says that she expects to live until she is 100 years old. She continues to request that "everything" be done. Consensus among Ms. Y's clinicians is that maximal treatment has failed. They do not expect further medical interventions, including cardiopulmonary resuscitation (CPR) and intubation, to restore adequate circulation or prolong her life in line with her goals of care. In a family meeting with Ms. Y and her son, clinicians informed Ms. Y that CPR and intubation would no longer offer medical benefit and that they recommended a transition to comfort-focused care, possibly discharging home with home hospice. However, Ms. Y became frustrated and insisted that there was more that could be done. She wants to be alive as long as possible to be with her family. She reiterates that she would rather "die trying than give up now." Her son recognizes that these interventions may not offer any benefit but emphasizes that his mom has always been a fighter and suffers more when she feels like she is not fighting for what's best.

Is it ethically permissible not to offer CPR and intubation over Ms. Y's objections when consensus among Ms. Y's clinicians is that these interventions are medically nonbeneficial? Use the Clinical ethics worksheet in the ethics handbook to formulate your answer.

PATIENTS WHO WANT EVERYTHING

Annals of Internal Medicine | PERSPECTIVE

Discussing Treatment Preferences With Patients Who Want "Everything"

Timothy E. Quill, MD; Robert Arnold, MD; and Anthony L. Back, MD

When asked about setting limits on medical treatment in the face of severe illness, patients and their families often respond that they want "everything." Clinicians should not take this request at face value, but should instead use it as the basis for a broader discussion about what "doing everything" means to the patient. The discussion might include questions about what balances of treatment burden and benefit the patient can tolerate and about emotional, cognitive, spiritual, and family factors that underlie the request. After this initial exploration, the clinician can propose a philosophy of treatment and make recommendations that capture the patient's values and preferences in light of the medical condition. Clinicians should respond to emotional reactions, directly negotiate disagreements, and use harm-reduction strategies for the relatively infrequent instances in which patients continue to request burdensome therapy that is unlikely to help. By using this approach, patients, families, and clinicians will be better able to understand each other and join together to develop a treatment approach that best respects patient and family values in light of what is medically achievable.

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A 75-year-old man with oxygen-dependent chronic obstructive pulmonary disease, dialysis-dependent chronic renal failure, and peripheral vascular disease has been hospitalized 3 times in the past 3 months for impending respiratory failure. His performance status is progressively decreasing, but he still enjoys some aspects of his life. He values his independence and has difficulty adjusting to his progressive disability. When an intern appropriately asks about setting limits on invasive treatment, such as cardiopulmonary resuscitation (CPR) and mechanical ventilation, the patient replies, "I want everything." (This case is a composite based on many patients we have seen under similar circumstances.)

Physicians whose patients ask for "everything" might reasonably conclude that the patient is asking for every imaginable treatment, no matter how harsh, invasive, or unlikely to be of benefit. One obvious course of action is to write a "full code—no limitations" order in direct response to the request. However, we believe that a more appropriate response, after physicians acknowledge the request, is to discuss the patient's underlying treatment values and nonmedical concerns and to provide accurate information about the patient's illness and prognosis (1–4). With that information, physicians can make more informed recommendations, and patients can make better decisions about what should (and should not) be done to help them achieve their goals (5–7). We review this approach to requests for "everything" and provide examples of how physicians can manage some aspects of the conversation.

Step 1: Understand What "Doing Everything" Means to the Patient

In our experience, the phrase "do everything" usually does not mean that the patient and family want every invasive and possibly life-prolonging treatment with a high burden and only a tiny chance of benefit (1–3). Rather, the request may reflect more nuanced wishes for how to balance the burdens and benefits of treatments and underlying affective, cognitive, spiritual, or family concerns.

For some patients, "everything" means only treatments whose probability of helping outweighs the probability of aggravating suffering. For other patients, "everything" means any treatment that has even a remote chance of prolonging biological life for a short time regardless of its adverse side effects. **Table 1** provides examples of differences in the ways patients may balance treatment burdens and benefits.

Table 2 outlines patient concerns that may underlie requests to "do everything" and gives examples of useful questions to ask. For some patients, wanting "everything" may be less about medical decisions that need to be made and more about fears associated with getting sicker, concerns that treating physicians will be less vigilant if the patient does not request all possible interventions (8), or worries about abandonment if the patient considers forgoing aggressive treatment and opting only for comfort (9). A question such as, "What are your biggest worries (fears)?" (10) might elicit some of these concerns.

Other patients may be unaware of their "true" prognosis or the limited ability of medical therapy to influence their illness, and may reconsider their wish for invasive or life-prolonging technologies once they are fully informed about the high burdens and minimal benefits of these treatments (11). In the latter instance, the only way to figure out what the patient knows about his illness and the potential role of medical treatment is to ask such questions as, "What have others told you about the status of your disease?", "How is the treatment working?", and "What

See also:

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Table 1. **Different Treatment Philosophies Underlying Requests for "Everything"**

- Everything that might provide maximum relief of suffering, even if it might unintentionally shorten life.
- Everything that has a reasonable chance of prolonging life, but not if it would increase the patient's suffering.
- Everything that has a reasonable chance of prolonging life, even if it may cause a modest increase in suffering.
- Everything that has a reasonable chance of prolonging life even a small amount, regardless of its effect on the patient's suffering.
- Everything that has any possible potential to prolong life even a small amount, regardless of its effect on the patient's suffering.

does the future look like?" The physician should offer information about treatment efficacy and burdens to ensure that the subsequent decision is as informed as possible (12) and follow up with a question, for example, "Given what you have now learned about your disease, what is most important to you?" (13).

This follow-up question is important, because patients rarely want "everything" for its own sake. Rather, most patients want a specific outcome, and conversations about what they mean by "everything" may allow exploration of their hopes and goals for those outcomes. For example, most patients want a life that allows them to accomplish certain goals, such as talking to their family or being physically active. Those goals may change over time, such as when a patient is willing to tolerate a considerable risk for suffering to be alive for a grandchild's birth and is less willing to tolerate the same risk for suffering after the birth. Understanding what a patient means by "everything" requires an understanding of what the patient would consider a treatment success and how much the patient would be willing to go through for a chance at success (5).

In contrast, some patients may find extension of biological life most important by far, regardless of the effect of treatment on quality of life. Often, this vitalist approach to treatment comes from a spiritual or religious context, and discussions about what the patient means by "everything" can lead to an exploration of the patient's beliefs about the relationship between the patient's religion and medical treatment (14). For example, some patients may believe that their religion requires that they try "everything" to stay alive. Others may think that only God should make the decision about when someone dies, and still others might request "everything" to give God time for a miracle. A deeper understanding of these beliefs may lead to very different answers about what "everything" means and point to resources other than biomedical expertise that might be pivotal in a patient's decision making.

Because the social context of illness may be involved in requests for "everything," exploring family dynamics is sometimes key to unlocking the underlying meaning and importance of these requests (15). As a general rule, begin with open-ended questions, such as "How is your family (children, parents, spouse) handling your illness?", and watch for both verbal and nonverbal responses. Sometimes, this leads directly to responses that uncover critical family

Table 2. **Potential Underlying Meanings of "Everything"**

Domain	Concept	What "Everything" Might Mean	Questions to Ask
Affective	Abandonment	"Don't give up on me."	"What worries you the most?"
	Fear	"Keep trying for me."	"What are you most afraid of?"
	Anxiety	"I don't want to leave my family."	"What does your doctor say about your prospects?"
	Depression	"I'm scared of dying."	"What is the hardest part for you?"
		"I would feel like I'm giving up."	"What are you hoping for?"
Cognitive	Incomplete understanding	"I do not really understand how sick I am."	"What are your most important goals?"
	Wanting reassurance that best medical care has been given	"Do everything you think as a doctor is worthwhile."	"What is your understanding of your condition/prognosis?"
	Wanting reassurance that all possible life-prolonging treatment is given	"Don't leave any stone unturned."	"What have others told you about what is going on with your illness?"
		"I really want every possible treatment that has a chance of helping me live longer."	"What have they said the impact of these treatments would be?
		"I will go through anything, regardless of how hard it is."	"Tell me more about what you mean by 'everything.'"
Spiritual	Vitalism	"I value every moment of life, regardless of the pain and suffering (which has important meaning for me)."	"Does your religion (faith) provide any guidance in these matters?"
	Faith in God's will	"I will leave my fate in God's hands; I am hoping for a miracle; only He can decide when it is time to stop."	"How might we know when God thinks it is your time?"
Family	Differing perceptions	"I cannot bear the thought of leaving my children (wife/husband)."	"How is your family handling this?"
	Family conflict	"My husband will never let me go."	"What do your children know?"
	Children or dependents	"My family is only after my money."	"Have you made plans for your children (other dependents)?"
		"I don't want to bother my children with all this."	"Have you discussed who will make decisions for you if you cannot?"
			"Have you completed a will?"

dynamics (for example, "My wife insists I'm going to beat this, but I can't envision getting better from here," or, "We haven't told the children anything yet"), which must be explored, understood, and possibly resolved before any major decision about shifting goals of treatment can be made. Sometimes a family meeting is needed to help all individuals come to a common understanding of the patient's illness, prognosis, and future treatment goals.

Finally, inquiring about potential concerns underlying requests for "everything" is a way to learn about the patient's and family's psychological and emotional status in response to the loss of health (16, 17). Kubler-Ross described stages of grief that have been empirically validated (18, 19), with patients and their families experiencing a mix of shock, denial, bargaining, depression, and acceptance. Asking for "everything" in response to an inquiry about setting medical limits may initially represent a reluctance to face painful emotions connected with the patient's loss of health and potential impending death, preferring instead to keep hope alive by avoiding any such discussion. Such requests may even touch on initially painful spiritual or religious issues (14), such as wondering how a caring God could allow such a tragedy to happen.

In summary, physicians must not assume that "everything" means any and all invasive treatments unless they have explored what the patient is trying to express with the request (6, 20, 21). Neglecting to explore the underlying meaning of a request for "everything" may reinforce patients' denial of how critically ill and close to death they may be, potentially depriving them of the opportunity to progress through the grieving process. In addition, it may subject patients to unnecessary suffering by committing them to harsh treatment with little likelihood of benefit that they would not want if they were reassured of the physicians' commitment to their care or if they were fully informed about their prognosis.

Step 2: Propose a Philosophy of Treatment

After an adequate exploration of what the patient means by "everything," the physician can then propose a philosophy of treatment consistent with the patient's values and priorities and the physician's own assessment of the patient's medical condition and prognosis: "Given what we know about your illness and what I have learned about your priorities, it sounds like you would prefer the following balance of burdens and benefits in your treatment . . ." (**Table 1** lists some potential risk–benefit balances that can be inserted). Such statements help the patient and family know that any subsequent recommendations are based on knowledge of their values and priorities. Patient and family should be invited to respond to this proposal by a follow-up question, for example, "Does that make sense to you?", and any misreading of the patient's philosophy can then be corrected in subsequent conversation.

Step 3: Recommend a Plan of Treatment

Once the physician and patient have agreed on a philosophy of treatment, the physician can make a more specific recommendation about what should (and should not) be done to support the patient's treatment philosophy, given the patient's medical condition and prognosis. This often means making recommendations about CPR, intubation, and other invasive treatments, ideally framed in the context of how the recommendation to pursue or forgo interventions supports patient goals and philosophies. All recommendations should include careful attention to the patient's treatment philosophy. To avoid the patient feeling abandoned by the physician, clinicians should emphasize what will be done to achieve the patient's goals before talking about what will not be done. For example, "Given your desire to have any treatment that might reasonably help you but to avoid harsh treatments that have little likelihood of helping, I would recommend that we continue everything we have started, continue to look for treatments that might help, and set limits on CPR and mechanical ventilation, because they would do more harm than good. Of course, we will continue to provide the best possible pain and symptom management along with all other treatments that might help."

Step 4: Support Emotional Responses

When physicians talk with patients and their families about their hopes and fears, the limitations of medicine, or the possibility of death, patients and families may respond with strong emotions. It is important to support and explore these emotional responses. Some simple yet powerful ways to respond to the emotions include taking time to acknowledge them ("These are difficult discussions") and legitimize them ("Anyone confronting these issues would feel somewhat frightened"), to explore the patient's response ("Tell me what is the hardest part for you"), and to empathize with the patient ("I can imagine that the future looks much less certain now that we have had this discussion") (22–24). It is also important that the clinician reiterate his or her commitment to continue to care for the patient no matter what the future holds (9).

Step 5: Negotiate Disagreements

Sometimes, patients request treatments with marginal efficacy that are outside the physician's usual treatment recommendations. If differences between what the patient requests and what the physician recommends are substantial, the physician should begin by reviewing his or her understanding of the patient's condition, values, and philosophy to ensure common understanding and reiterate his or her assessment of the patient's condition and prognosis with or without treatment. Look for common ground, and try to invent new solutions that accommodate all perspectives (25).

One such option is to consider a time-limited trial. A treatment's potential effectiveness may be too uncertain for a patient to make a nontreatment decision. Requests to try a particular treatment may be offered in a time-limited way. Then the treatment can be continued or stopped depending on its subsequent effects. For example, the patient we described in the introduction might not want CPR (too burdensome and ineffective), but he could benefit from going on a ventilator if he developed a potentially reversible respiratory problem (a mucus plug). He clearly did not want long-term ventilatory support, but the possibility of a "time-limited trial" might provide some middle ground between forgoing this possibly helpful but invasive treatment and accepting that treatment forever without limitations. The challenge is to adapt medical treatments to best serve patients' needs and values in light of their medical conditions.

Step 6: Use a Harm-Reduction Strategy for Continued Requests for Burdensome Treatments That Are Very Unlikely to Work

Some patients and families may value life extension much more highly than avoiding preventable suffering, others may not trust the medical system enough to forgo any treatment, and still others may be unwilling to confront the possibility of dying. Once the patient's philosophy is clearly articulated in favor of all possibly effective treatments no matter how harsh or invasive, continuing to negotiate around limit setting is unlikely to be productive and may feel abusive (26, 27). In this circumstance, as suggested in **Table 3**, the clinician should honor the patient's philosophy and order "full CPR—no limits" status, even if it has high burden and low likelihood of success.

In these cases, we suggest that clinicians still exercise clinical judgment. The negotiation with the patient and family (step 5 in this process) has ended in an agreement to try all possibly life-prolonging treatments no matter how high the burden. Rather than repeatedly badgering the patient and family to reconsider a do-not-resuscitate decision (6, 28), initiating CPR if the patient has a cardiopulmonary arrest is appropriate. Under these circumstances, stopping CPR after 1 cycle if the patient is unresponsive is an example of exercising good clinical judgment because success is so unlikely. This is very different from a "show code" or a "slow code" (29), in that CPR is genuinely, albeit briefly, attempted. This allows the patient and family to know that "everything possible" was done but avoids having staff go through the futile ordeal of prolonged CPR with no prospect of recovery.

Table 3. **Harm-Reduction Strategy When Patients Request Treatments That Do More Harm Than Good**

- Acknowledge and adhere to the patient's treatment philosophy so that patient and family feel heard and respected.
- Stop regularly discussing limitations on invasive treatments unless this issue is raised by the patient or family.
- Address the medical team's discomfort and disapproval by:
  - Communicating the reasoning behind the treatment decision.
  - Finding other patient-centered goals to work toward (symptom management, support, disease treatment).
- Use clinical judgment to limit treatment that does not advance patient-defined goals.

Applying This Shared Decision-Making Model to the Case

The physician set up a time to update the patient and family about the patient's condition and to discuss how to move forward. The physician began by asking, "What have you been told so far about your condition?" The patient said he knew he was getting sicker. The physician confirmed that his condition was worsening and asked the patient whether he wanted any information about time frame. The patient said "yes," so the physician explained that patients with his conditions live an average of 3 to 6 months, with possibilities of exceptions in both directions (12).

The physician asked, "What is most important to you now?" The patient spoke of his hopes of being physically comfortable, not burdening his family, and wanting to see the birth of another grandchild in a few months. The physician acknowledged the importance of the patient's goals by saying, "Those are very important goals. We can certainly keep you comfortable, and we will do our best to keep you alive until your grandchild is born, but living that long is beyond what we can guarantee."

Then the physician made a recommendation: "Given how your disease has progressed and what I know about what is important to you, it makes sense to work toward maximizing both the length and the quality of your life, to help you live as well as you can for as long as you can. I recommend that we continue all treatments that contribute to that goal. However, given your desire to avoid harsh treatment that is unlikely to help, I recommend that we not perform CPR or put you on a breathing machine if you get much sicker from here. We will continue to look at and discuss all other potentially effective treatments that would help you either live longer or feel better. Does that make sense to you?"

The patient agreed with the plan, with sadness and also relief. It was the first time his impending mortality had been explicitly addressed, and he appreciated the honesty and compassion even though he was not encouraged by what he had learned. His physician recommended that he make some contingency plans with his family to leave messages and gifts for his yet-unborn grandchild in case he did not make it that long, while at the same time continuing to try potentially effective treatments.

The patient and his family were able to spend meaningful time on these contingency plans, allowing them to be much more open with one another about their feelings, hopes, and fears. The patient did not require any more hospitalizations, but 4 months after this discussion (and 2 months before his

grandchild was born), he died quietly in his sleep. Cardiopulmonary resuscitation and intubation were not attempted.

Conclusion

Asking patients and families to explore the underlying emotions, concerns, and values that prompt their requests for "everything" is a powerful way to inform the health care team about a patient's treatment philosophy. This exploration provides information on the relative value that patients place on extending life versus avoiding suffering in light of their medical condition. Physicians can use this information to make recommendations about invasive treatments. Many times, limits can be set after this conversation, but CPR and other invasive treatments are sometimes desired no matter how small the benefits and how high the burdens. In these cases, patient preferences should generally be honored, but clinical judgment must still be exercised to maximize benefit and minimize harm.

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Link to article: https://www.acpjournals.org/doi/abs/10.7326/0003-4819-151-5-200909010-00010?journalCode=aim

ETHICS SESSIONS CONT'D

FOUR-TOPICS CHART

Paradigm (4 boxes)

A case-based approach to ethical decision-making
Adapted from AR Jonsen, M Siegler, W Winslade, Clinical Ethics, 7th edition. McGraw-Hill, 2010.

MEDICAL INDICATIONS The Principles of Beneficence and Nonmaleficence	PATIENT PREFERENCES The Principle of Respect for Autonomy
1. What is the patient's medical problem? Is the problem acute? Chronic? Critical? Reversible? Emergent? Terminal? 2. What are the goals of treatment? 3. In what circumstances are medical treatments not indicated? 4. What are the probabilities of success of various treatment options? 5. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?	1. Has the patient been informed of benefits and risks, understood this information, and given consent? 2. Is the patient mentally capable and legally competent, and is there evidence of incapacity? 1. If mentally capable, what preferences about treatment is the patient stating? 2. If incapacitated, has the patient expressed prior preferences? 3. Who is the appropriate surrogate to make decisions for the incapacitated patient? 4. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
QUALITY OF LIFE The Principles of Beneficence, Nonmaleficence, and Respect for Autonomy	**CONTEXTUAL FEATURES** The Principles of Justice and Fairness
1. What are the prospects, with or without treatment, for a return to normal life, and what physical, mental, and social deficits might the patient experience even if treatment succeeds? 2. On what grounds can anyone judge that some quality of life would be undesirable for a patient who cannot make or express such a judgment? 3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life? 4. What ethical issues arise concerning improving or enhancing a patient's quality of life? 5. Do quality-of-life assessments raise any questions regarding changes in treatment plans, such as forgoing life-sustaining treatment? 6. What are plans and rationale to forgo life-sustaining treatment? 7. What is the legal and ethical status of suicide?	1. Are there professional, interprofessional, or business interests that might create conflicts of interest in the clinical treatment of patients? 2. Are there parties other than clinicians and patients, such as family members, who have an interest in clinical decisions? 3. What are the limits imposed on patient confidentiality by the legitimate interests of third parties? 4. Are there financial factors that create conflicts of interest in clinical decisions? 5. Are there problems of allocation of scarce health resources that might affect clinical decisions? 6. Are there religious issues that might affect clinical decisions? 7. What are the legal issues that might affect clinical decisions? 8. Are there considerations of clinical research and education that might affect clinical decisions? 9. Are there issues of public health and safety that affect clinical decisions? 10. Are there conflicts of interest within institutions or organizations (e.g. hospitals) that may affect clinical decisions and patient welfare?

The Four-Topics Chart can also be found here: https://depts.washington.edu/bhdept/ethics-medicine-bioethics-tools/paradigm-4-boxes

STAKEHOLDERS & VALUES (list primary stakeholders in the case, and what they value)

GATHER RELEVANT INFORMATION

MEDICAL INDICATIONS	**PATIENT PREFERENCS**
QUALITY OF LIFE	**CONTEXTUAL FEATURES** *Organizational Ethics:* *Cite/Analyze hospital policies, laws, practices relevant to case*

**This is the 4-Box Method developed by A. Jonsen, M. Siegler, W. Winslade. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 7th Ed. New York: McGraw-Hill-Medical, 2010.

WHAT IS THE ETHICAL QUESTION? (write it here)

CONSEQUENCES

Which course of action is likely to produce the greatest benefit for the patient? For everyone involved?

Tip: Consider harm/benefit broadly, from clinical, moral, spiritual, cultural perspectives.

RULES/PRINCIPLES

What are the different rules (e.g., laws or policies) or moral principles/obligations (e.g., respect for autonomy, beneficence) that come into conflict in this case?

Tip: Consider which of the four principles of bioethics come into conflict in this case. Which should be given priority? Can you articulate why?

VIRTUES

Consider what it means to be excellent in your role as a healthcare professional? How do different virtues help guide and justify an ethical response?

Tip: Consider virtues like integrity, empathy, trustworthiness, respectfulness, curiosity, humility, etc.

SOCIAL RELATIONS

How do interpersonal relations (e.g. parent-child) and social norms (e.g., related to race, class, gender, etc.) impact analysis of this case and moral responsibilities?

Tip: Consider how power imbalances intersect with different interpersonal and societal relationships.

PARADIGM CASES

Casuistry: Are there settled paradigm cases that inform your analysis? How is your case similar & different?

Tip: Consider well-known cases as well as cases from your own hospital or region.

ANALYSIS

You may already know which position you want to defend. Here try to use the ethical frameworks to the left to build your justification. If you don't know which position you defend, you can use this space to build justifications for each "side".

RECOMMENDATIONS

Provide 2-3 recommendations for the clinical team.

APPENDIX H: FINAL CHECKLIST

INTERNAL MEDICINE
STUDENT CHECKLIST

By the end of the clerkship, make sure you have:

- ☐ Logged patients throughout the entire clerkship with a minimum of 24 patients logged
- ☐ Logged your hours throughout the entire clerkship (if you logged any more than 60 hours in a one-week period, please contact the Clerkship Coordinator)
- ☐ Completed evaluations of attendings, residents & fellows
- ☐ Completed evaluations of sites/rotations/clerkship
- ☐ Turned in 3 completed/signed Observation of Clinical Skills (OCS) Feedback Forms
- ☐ Turned in 2 Case Reports *(ambulatory rotations only)*
- ☐ Completed online Elsevier Clinical Key Cases and/or Q-bank questions (as outlined on page 8)
- ☐ Turned in completed Patient Safety Self-Reflection paper
- ☐ Turned in Ethics Conference Worksheets (if required by Dr. Collier)
- ☐ Viewed High Valued Care PowerPoint on Blackboard
- ☐ Turned in any scrubs that have been checked out
- ☐ If assigned a locker at PTH, make sure it is cleaned out
- ☐ Turn in any Absence Request forms for days missed