INTERNAL MEDICINE CLERKSHIP SYLLABUS 2007-2008

INTERNAL MEDICINE CLERKSHIP SYLLABUS
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WAYNE STATE UNIVERSITY

DEPARTMENT OF INTERNAL MEDICINE
MEDICAL EDUCATION
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WAYNE STATE UNIVERSITY PHYSICIAN GROUP

Welcome to the Internal Medicine Clerkship:

During this two-month rotation, you will learn to evaluate and manage sick hospitalized patients. Caring for acutely ill patients is challenging but immensely rewarding. Take time to reflect. As you go through the clerkship, keep an open mind. Perhaps Internal Medicine is the right specialty for you. If not, the basic principles taught during this clerkship will help you to become a better physician no matter which field of medicine you choose to practice.

Carefully review the materials contained in this syllabus. Review the goals and objectives for the clerkship. Know your role and responsibilities. Look over the appendices for helpful suggestions. Look at "Advice from the Front" a compilation of recommendations from students who recently completed their rotation.

As you go through the clerkship, make the most out of every clinical encounter, every rounding session, every conference and every lecture. Seize opportunities to learn from your patients and those around you. Never forget, you are caring for real people. **Do your best** no matter what time of day or what your state of mind. **Excellence is a habit!**

Finally, you need to read. You decided to be a doctor to help people. (You said so on your personal statement and during your interview.) To be able to provide outstanding care you need to be knowledgeable and up to date. The only way to do this is to **READ!**

Good luck on your Internal Medicine Clerkship. We hope you have an exceptional educational experience and make a positive difference to your patients.

Diane Levine M.D.
Clerkship Director
Associate Professor of Medicine
Department of Internal Medicine
Wayne State University School of Medicine

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE
2005-2006 YEAR III SCHEDULE/CALENDAR

Registration:	Wednesday - Friday, May 9-11, 2007
Academic Year Begins:	Thursday June 28, 2007
Orientation:	Thursday & Friday, June 28-29, 2007
Independence Day Recess:	Wednesday, July 4, 2007
Labor Day Recess:	Monday, September 3, 2007
Thanksgiving Recess:	Thursday & Friday, November 22-23, 2007
Christmas Recess:	Friday, December 21 – Tuesday, January 1, 2008
Clerkship/Elective Resume:	Wednesday, January 2, 2008
Martin L. King Day Recess:	Monday, January 14, 2008
Memorial Day Recess:	Monday, May 26, 2008
Year III OSCE Examination:	Saturday & Sunday, June 14-15, 2008
Academic Year Ends:	Sunday, June 15, 2008

INTERNAL MEDICINE CLERKSHIP ROTATION DATES

Block 1	**July 3** – August 24, 2007
Block 2	**August 27** – October 19, 2007
Block 3	**October 22** – December 20, 2007
Block 4	**January 2** – February 22, 2008
Block 5	**February 25**– April 18, 2008
Block 6	**April 21** - June 13, 2008
OSCE Exam	June 14-15, 2008

Please note, there is a mandatory **orientation at 9:30 AM** on the first day of the clerkship. You will be notified of the room location by email.

INTERNAL MEDICINE CLERKSHIP TESTING DATES

August 23, 2007	1:00 PM	Green Auditorium, Scott Hall
October 18, 2007	1:00 PM	Green Auditorium, Scott Hall
December 20, 2007	1:00 PM	Green Auditorium, Scott Hall
February 21, 2008	1:00 PM	Green Auditorium, Scott Hall
April 17, 2008	1:00 PM	Green Auditorium, Scott Hall
June 12, 2008	1:00 PM	Green Auditorium, Scott Hall

Key Personnel Year III Clerkship
Contact Information

Department of Internal Medicine
Wayne State University

Department Chairman	Dr. John Flack	(313) 745-8244
Clerkship Director	Dr. Diane Levine (11204)	(313) 745-4629

Detroit Receiving Hospital

WSU III/IV Site Director	Dr. Shiva Rau	(313) 577-5025
	Fax: (313) 745-4707	
	Ms. Aisha Hadi	(313) 745-3265
	ahadi@med.wayne.edu	
	Fax: (313) 993-2988	

Harper University Hospital

WSU III/IV Site Director	Dr. Renee Dwaihy	
Secretary	Dana Cooley.	(313) 745-8334
	dcooley@dmc.org	

Henry Ford Hospital

WSU III Site Director	Dr. Nicole C. Rocco	
	Nrocco1@hfhs.org	
Secretary	Monica Lacoursiere	(313) 916-3829
	Mlacour1@hfhs.org	

Oakwood Hospital

WSU III/IV Site Director	Dr. Walid Harb	
	harbw@oakwood.org	
Secretary	Marianne Soroka-Martin	(313) 593-7872
	Marianne.soroka@oakwood.org	
	Kathleen Summers	(313) 436-2071
	Summerk3@oakwood.org	

Providence Hospital

WSU III/IV Site Director	Dr. Valerie Overholt, DO (248) 849-4719 office (248) 367-1443 text pager valerie.overholt@stjohn.org	
Secretary	Sonja Michelle Brown Sonja.Brown@stjohn.org Fax: (248) 849-5324	(248) 849-5665

Sinai-Grace Hospital

WSU III Site Director	Dr. Michael Feldman mfeldman@dmc.org	pager: 1556
WSU IV Site Director	Dr. Joel Appel (3092)	
Secretary	Pam Nelson Pnelson@dmc.org Fax: (313) 966-1738	(313) 966-1728

St. John Hospital

WSU III/IV Site Director	Dr. Donald Rozzell donald.rozzell@stjohn.org	(313) 343-3878 (313) 343-3051
Secretary	Anne Dwyer Anne.dwyer@stjohn.org Fax: (313) 343-7840	(313) 343-3878

Veterans Administration Hospital

WSU III Site Director	Dr. S. Gappy Saib.gappy@med.va.gov	
WSU IV Site Director	Dr. D. Abu-Hamdan	
Secretary	Tracy Tessens Tracy.tessens@va.gov Fax: (313) 576-1122	(313) 576-1000 ext. 3450

William Beaumont Hospital

WSU III Site Director	Dr. Linda Misra lmisra@beaumont.edu	
Secretary	Melinda Maxwell Melinda.maxwell@beaumonthospitals.com Fax: (248) 551-8880	(248) 551-7107

INTERNAL MEDICINE CLERKSHIP
SITE ORIENTATION INFORMATION

Detroit Receiving Hospital—Report to Aisha Hadi at **1:30pm** in the **5P19** conference room of DRH. Park the same as if you are going to the medical school. For further questions please contact Aisha at 313-745-3265.

Harper University Hospital—Report to Dana Cooley at **12:00pm** in **2 Hudson** (the last door on the left) HUH in room 2917. For further questions please contact Dana Cooley at 313-745-8334.

Henry Ford Hospital—Report for Orientation at **3:30pm** in the **Clara Ford Pavilion Basement 38**. There is a parking lot in front of the building. It is a pay lot so students on your first day you will need to bring $2.50 this is only for the first day. For further question please contact Dianne Wieland at 313-916-1465

Oakwood—Report to Marianne Soroka-Martin or Kathleen Summers at **12:45pm** in the **Department of Medical Education.** Park in the visitor structure in the back of the hospital. Your parking ticket will be validated, this is for today only. For further questions Marianne can be reached at 313-593-7872

Providence—Report to Josette Crumble at **1:00 PM** at **16001 W. Nine Mile Rd, Fisher Building** (near the Professional Medical Building) at Providence Dr and North Park Drive. Park in the Northland Theatre parking lot and there is a shuttle service to the old Emergency Room entrance. Signs to direct you to the **Fisher Building. Proceed to the 4th Floor**, Medical Education. For further questions call 248-424-8441

Sinai-Grace—Report to Pam Jones at **1:00 pm** at **6071 W. Outer Drive**, in the **main hospital.** Park in the visitors' there a 3.00 fee. Proceed to **the 4th floor; follow sign to Dept of Medicine**. For further questions Pam Jones can be reached at 313-966-1728.

St. Joseph Ann Arbor – Report to Trisha Wellock, 5333 McAuley Drive, Ypsilanti, MI 48197, Reichert Building, Suite 2111, at 1:00 pm for orientation. Contact (734) 712-2442 if you have any questions.

St. John— Report at 1:15 to 19251 Mack Ave., Suite 340 Grosse Pointe Woods, MI 48236 Please park in the East Parking Structure, to avoid the $2.50 visitor lot fee. The Medical Education Building is located near the hospital on Mack Ave., across from the Pointe Plaza, adjacent to the Enterprise Car Rental, & across from the Barnes and Noble Bookstore. Medical Education is on the 3rd Floor, Suite 340. Doors do not open before 7:30 a.m. Your Student Coordinator is Anne Dwyer: (313) 343-3878.

William Beaumont Hospital—Report to the **Administration Services Building/West-Medical Administration Suite-3rd floor at 2:30 pm** for orientation. **Students should park in the South parking lot.** For further questions please contact Melinda Maxwell at 248-551-7107.

Veterans' Administration Medical Center- Report to **Tracy Tessen** at **1:00 pm** in **C3700**. For further questions please contact Tracy at 313-576-1000 ext 3450.

DESCRIPTION OF CLERKSHIP
Goals and Learning Objectives

Introduction

The Year III Internal Medicine clerkship consists of a two month block rotation. Each student is assigned to one clinical site. Students function as an integral member of the health care team and are actively involved in the care of sick patients. The learning experience is based on direct patient care supervised by resident and attending physicians, clinical teaching during a variety of rounding sessions, conferences and personal reading.

Overall Goal

The overall goal of the clerkship in Internal Medicine is to help students understand and obtain practical experience in the **recognition, evaluation, diagnosis and management of adult patients with acute non-surgical illnesses.**

During this rotation you will learn

1. To evaluate and manage sick hospitalized patients.

2. To develop familiarity with the common problems seen by internists in the hospital setting.

3. To understand the role of the general internist in providing care and coordinating care for hospitalized patients.

Student Learning Objectives for Internal Medicine Clerkship

1. Students will develop familiarity with the **CORE PROBLEMS** in Internal Medicine listed below. This objective may be satisfied by either caring for a patient with one of the identified core problems or by completing a simulated ("Medcase") for that problem. Students must document patient encounters and the corresponding problem on Campus Mobility weekly. In addition, **all Medcases must be completed one week prior to the conclusion of the rotation**. Medcase transcripts must be turned in to the clerkship director.

    1. **Arrhythmias**
    2. **Chest pain**
    3. **Cough and Dyspnea**
    4. **Diabetes**
    5. **Gastrointestinal complaints**
    6. **Geriatric syndromes**
    7. **Hematologic disorder**
    8. **Infectious Disease**
    9. **Kidney Disease**
    10. **Liver disease**

Simulated Cases (Medcases) which can satisfy core problem requirement.

- Arrhythmias 554
- Chest pain 451
- Cough and Dyspnea 416, 445, 472
- Diabetes 549
- Gastrointestinal Diseases 482, 607, 588
- Geriatric syndromes 464, 554
- Hematologic disorder 588, 460, 489, 496
- Infectious Disease 450
- Kidney Disease 402, 462, 495
- Liver Disease 494

2. There are a variety of specific disease entities that are commonly seen by internists. In addition, they are often encountered on shelf examinations. It is therefore recommended that students develop familiarity with the following "**non-essential" problems.**

    - Anemia (anemia of chronic disease, iron deficiency, and megaloblastic anemia)
    - Atrial fibrillation
    - Common cancers (breast, colon, and lung)
    - Coronary artery disease and acute coronary syndromes
    - Deep venous thrombosis and pulmonary embolism
    - Diabetes
    - Geriatric syndromes (confusion, dementia/delirium, syncope)
    - GI bleeding
    - Heart Failure
    - Hepatitis and cirrhosis
    - HIV/AIDS
    - Kidney Failure (acute renal failure—pre-renal azotemia, acute tubular necrosis and chronic renal failure)
    - Obstructive lung disease (asthma and COPD)
    - Pneumonia
    - Renal failure (acute-pre renal, renal and post renal and chronic)
    - Thrombocytopenia
    - Urinary tract infection

3. Students will be able to **obtain an accurate Medical** H**istory** and **perform** a **thorough Physical Examination** in an efficient and timely manner as evidenced by successful completion and logging of a minimum of **12 H&Ps**, as well as by a satisfactory clinical evaluations in the following competencies: "*taking a history" and "performing physical exam," and "record keeping.*"

    In addition, the Internal Medicine Clerkship is taking ownership of ensuring students develop basic skills in **rectal examination** and **male genital examination**. These examinations **must be chaperoned!**

4. Students will be able to compose an accurate and complete patient encounter note **documenting** the patient's **daily progress.** Students must **submit one history and physical and corresponding follow-up note** for evaluation to their attending physician. In addition, students must successfully complete the patient encounter note on the clerkship OSCE and receive a satisfactory clinical evaluation in the "*record keeping*" competency.

5. Students will begin to **develop diagnostic decision-making skills** that incorporate probability-based thinking as evidenced by successful completion of the assessment and plan portion of H&P and patient encounter notes documenting well ranked differential diagnoses and the clinical rationale for the proposed diagnostic work-up. This skill must be demonstrated on the end-of rotation OSCE. Students must also receive satisfactory clinical evaluations in the "*medical knowledge*" and "*application of knowledge in the clinical setting" competency.*

6. Students will learn to **interpret the results of basic tests** and properly determine how the results should influence patient management including analysis of

   - ☐ **Acid base and electrolyte disturbances including**
     - **Acidosis and alkalosis**
     - **Abnormalities of sodium,**
     - **Abnormalities of potassium,**
   - ☐ **Renal function including**
     - Prerenal azotemia
     - Acute tubular necrosis
   - ☐ **Gram Stains and acid fast stains**
     Students will be able to identify **diagnostic gram stains of sputum** and
     - recognize common pathogens such as
     - pneumococcus,
     - gram negative bacilli,
     - mixed flora
     - acid fast bacilli
     - gram stains of other fluids such as urine
   - ☐ **Peripheral smears and complete blood counts including**
     - **Microcytic anemia**
     - **Normochromic normocytic anemia**
     - **Macrocytic anemia**
   - ☐ **Liver function tests including**
     - **Interpretation of tests of synthetic function**
     - **Abnormalities of cholestasis and inflammation**
   - ☐ **Basic electrocardiograms**
     Students will be able to determine the **rate, rthythm axis**, and **intervals** on electrocardiograms. Students will also be able to recognize a variety of pathologic tracings including **non-sinus rhythms, AV blocks, ventricular hypertrophy, bundle branch blocks signs of ischemia and infarction** and electrocardiographic manifestations of **electrolyte disturbances.**
   - ☐ **Chest radiographs**

Students will be able to recognize **normal landmarks**, and be familiar with the radiographic findings in the following conditions:

- **Atelectasis**
- **Congestive heart failure**
- **Lung Cancer**
- **Pneumonia,**
- **Pneumothorax**
- **Pulmonary embolism**
- **Tuberculosis**

To assess this objective, students will complete the **EKG packet and the** "**Interpreting Diagnostic Tests" Exercise**.

7. Students will **develop therapeutic decision-making** skills that incorporate pathophysiologic reasoning and evidence-based knowledge as evidenced by successful completion of the plan portion of the H&P and patient encounter note and satisfactory clinical evaluations in the, "*application of knowledge in the clinical setting"* competency.

8. Students will develop facility with different types of **case presentations**: written and oral, new patient and follow-up as evidenced by satisfactory completion of the presentation component of the clerkship **OSCE** and satisfactory clinical evaluations in the "*written and oral case presentation*" competency.

9. Students will **develop proficiency in communication and interpersonal skills** with patients and colleagues with attention to how diversities of age, gender, race, culture, socioeconomic class, personality, and intellect require sensitivity and flexibility as evidenced by successfully completing the clerkship **OSCE** and satisfactory clinical evaluations in the "*communication and relationships with patients and families*" competency.

10. Students will **recognize the importance of ensuring smooth transition of care** from acceptance of patients from the Emergency Department, to transfer of patients to other services and finally to discharge. **Students will participate in discharge planning.** Students must select one discharge progress note for evaluation by their attending physician.

11. Students will begin to **recognize that negotiating systems is critical** to achieve high quality patient care. Students will make use of systems-based thinking and participate in the process of assessing current practice. To assess this objective, students will complete a 2-3 paragraph **reflective essay** outlining the role the health care system played in the outcome of one patient. This must be emailed to the Clerkship Director (Dr. Diane Levine dllevine@med.wayne.edu) prior to completion of the rotation.

12. Students will **develop and practice self-directed life-long learning**, including the ability to access and utilize information systems and resources efficiently. To demonstrate proficiency in this area, students will be required to identify a clinical question and research the answer to that question. This exercise demonstrates what good

physicians do when faced with a clinical dilemma. Students then will do a **formal presentation** to their team including literature review, identification of one review article and one recent article. The Student's presentation will be evaluated by the attending physician. The grading schema is as follows:

- ☐ Fails to meet expectations
- ☐ Meets expectations
- ☐ Exceeds expectations

Students must also submit a brief summary of their presentation and references used to the Clerkship Director.

EXPECTATIONS AND RESPONSIBILITIES

1. All Year III students regardless of hospital assignments are to report as per notification to the **Year III Internal Medicine Orientation** held at Scott Hall. During this meeting the goals and objectives for the clerkship will be outlined and the expectations and grading policies will be reviewed. Students will report to their **assigned sites** for a site specific orientation. (Please consult site orientation information on page 7 of Clerkship Syllabus).

2. **Students are expected to have their resident and attending physicians sign the Attestation** by the first week of <u>each</u> month of the Clerkship.

3. **Attendance is mandatory**. Students are excused for ACLS and for all WSUSOM recognized holidays. In addition, students are excused from their inpatient assignments to attend their weekly continuity clerkship session. Any other absences in excess of two days must have a written explanation from a physician and the approval from Student Affairs. Extended absences must be made up. Students are not to take extended call the evening prior to exams, ACLS or University recognized holidays.

4. Students are expected to attend assigned **Year III teaching activities** at each site. **Specific schedules** (including weekend schedules) will be provided by each hospital site.

5. **Students are expected to be in the hospital daily** with the following limitations:

   Students' duty hours follow resident duty hours as described under current **RRC guidelines**. Thus, students may not work more than 80 hours per week and must have an average of one day off in seven averaged over four weeks. Student may not spend more than 30 hours in the hospital at one time and must have a minimum of 10 hours between duty shifts.

6. Students are expected to **arrive at the hospital early enough to see and evaluate their patients prior to work rounds**. This usually means about 7:00- 7:30 A.M. but varies depending on the student's patient load and the student's efficiency as well as the requirements of the specific hospital site.

7. Students will **attend work rounds and teaching rounds** with their team.

8. Students are expected to **attend laboratory and x-ray rounds** with their team, participating in interpretation of studies performed on their assigned patients, e.g. x-rays, gram stain, etc.

9. **Students will take call** with their assigned team. **The nature of call depends on the assigned site but generally will end by 9-10PM.** To provide a unique educational experience, **students are required to take <u>one</u> overnight call <u>each</u> month**, preferably with their team. Overnight call is otherwise optional.

10. **Students will complete an H&P on all assigned new admissions** including patients redistributed from the night float. (See attached example.) Student will write daily SOAP notes on all their patients. The H&P and notes should be reviewed with the resident and or attending physician.

11. **Students are responsible for reading about their patients**.

12. **Students are responsible for soliciting feedback and evaluation and completing the Wayne State University Mid-rotation Self Evaluation form.**

13. **Students must log all clinical experience and procedures on the PDA** as required by the School of Medicine.

14. Students will evaluate their resident and attending physicians' performance at the end of the clerkship. This must be done on Black Board.

15. **Students must complete an "end-of-clerkship" evaluation on their PDAs**. The information gathered will be used to evaluate each site and the overall clerkship and will serve as a basis for improving the Internal Medicine rotations.

16. The clerkship is completed at all sites at 12:00 pm two days prior to the exam.

17. **Students must submit the signed attestation to sit for the National Subject (shelf) Examination in Internal Medicine!**

EVALUATION AND FEDBACK

Clinical Evaluation

Midway through the first month of the clerkship, **students should seek formal feedback** on their performance from their resident and attending physicians. This allows for identification of deficiencies and provides time for improvement in performance. The student should be proactive in arranging these meetings.

This year the School of Medicine is requiring students to complete a **self reflective midmonth formative evaluation form**. Each student must complete the form and then review with his or her attending physician who must the sign the form. This form must be submitted to the Clerkship Director at the end of the rotation in order to get credit for the rotation.

Students' clinical performance including participation on rounds, ability to answer questions, quality of H&Ps and SOAP Notes, all factor into the clinical grade. **At the end of each month**, resident and attending physicians will assess students' clinical performance utilizing the **generic year III evaluation form.** Note: intern evaluations, while helpful for personal growth, will NOT be for grading purposes.

OSCE

Students will have an opportunity to receive feedback and discuss their OSCE performance.

EXAMINATIONS

At the end of the first month students will complete an Interpretation of Laboratory Tests exercise. Completion of the exercise is required for successful completion of the clerkship.

At the end of the two-month clerkship, students will take the **National Board of Medicine Examination** (N.B.M.E.) subject examination commonly known as the "shelf exam." This exam consists of one hundred multiple-choice questions given over two hours and ten minutes. One make-up test will be allowed for each examination.

GRADING

The **final clerkship grade** is based on **completion of the student learning objectives**, **the OSCE**, final clinical evaluations and the shelf exam. Furthermore, students must fulfill all student responsibilities of the clerkship.

The **clinical grade** is assigned by the Clerkship Director in accordance with the SOM grading policies and the specific policies set forth by the Internal medicine Clerkship Medical Education Committee.

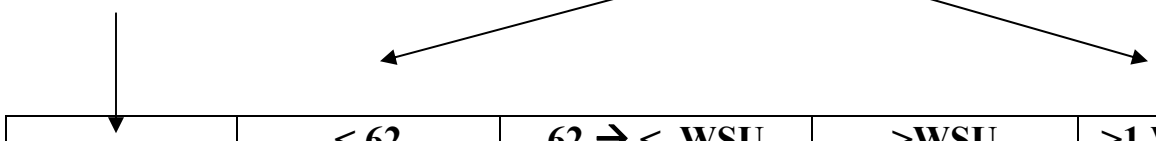
Students must achieve "exceeds expectations" on 7 out of 11 competencies (including 3 of the first five competencies) the on the composite clinical evaluation to achieve a *final clinical evaluation* of "outstanding'. Note: The IM MEC requires that students have **a minimum of half of evaluations in the outstanding category *for that competency*** to achieve an overall final evaluation of "outstanding" or "exceeds expectations" for that competency.

Students achieving "**Below expectations**" in **fifty percent of the clinical evaluations in one area of assessment** will receive **"Fails to meet course expectations" in that competency.** Receiving "Fails to Meet Course Expectations" in any competency will receive an "Unsatisfactory" for the final clinical evaluation.

Students receiving "**Below expectations**" **in any area** of assessment **from more than fifty percent of evaluators** will also receive a clinical grade of "Unsatisfactory."

Performance on *both* the clinical evaluation and multiple-choice examination must be satisfactory for a student to be given a passing grade. **Good or superior clinical performance does not compensate for a failing exam score, nor does a high exam score negate inadequate clinical performance.** A summary of the criteria for unsatisfactory, satisfactory (passing), commendation and honors are described below.

Clinical Performance **Exam Score**



	< 62	**62 → < WSU group mean**	**≥WSU group mean**	**≥1 WSU SD above mean** but no higher than 82
Outstanding	Repeat Exam	Pass	Commendation	Honors
Satisfactory	Repeat Exam	Pass	Pass	Commendation
Unsatisfactory	Repeat Clerkship	Repeat Clerkship	Repeat Clerkship	Repeat Clerkship

Criteria for satisfactory

Students must pass both clinical months and the shelf exam.

Criteria for commendation (two ways to secure commendation):

- To receive a commendation, students must receive **clinical "Outstanding**" on the composite evaluation **and** score **at or above the mean on the shelf exam.**
- Student may also receive a commendation if they achieve **clinical "Satisfactory**" on the clinical composite evaluation may also receive a commendation if they score **one standard deviations above on the shelf exam.**

Criteria for honors:

Students must receive **clinical honors** and score at **least one standard deviation above the mean** on the exam.

Criteria for failing:

Students who **fail to pass the exam by the second attempt** but pass both clinical rotations will be referred to the office of Student Affairs.

Students who pass the exam but **fail one clinical month** must repeat one clinical month.

Students who pass the exam but **fail two clinic months** of the rotation must repeat the entire clinical rotation.

Students whose evaluations indicated a clinical failure will be brought up to the IM MEC for discussion prior to assigning their final grade. However, the final course grade will be assigned by the Year III Clerkship Director.

Grade Appeals

1. Students wishing to appeal their grade must submit a formal appeal to the Clerkship Director who in turn will present the appeal to the Internal Medicine Medical Education Committee (IM MEC) which is composed of Year III site directors. At no time may students appeal their grade directly to the site director where they completed their clinical rotation as doing so will invalidate the student's right to appeal his or her grade. The Internal Medicine Education Committee will meet and make a determination regarding the student's appeal.

2. This decision may be appealed to the Year III Grading Committee. For further information regarding appeals Students are directed to their counselor.

Appendix A: **ATTESTATION**

I have reviewed the goals and objectives for the Junior Clerkship in Internal Medicine. I am familiar with the expectations and understand my role and responsibilities for this clerkship.

Circle rotation month:

July Aug Sept Oct Nov Dec Jan Feb Mar Apr May Jun

STUDENT NAME (printed)	**Signature**	**Date**
Attending Physician Name (printed)	Signature	Date
Attending Physician Name (printed)	Signature	Date
Resident Name (printed)	Signature	Date
Resident Name (printed)	Signature	Date

Circle rotation month:

July Aug Sept Oct Nov Dec Jan Feb Mar Apr May Jun

Attending Physician Name (printed)	Signature	Date
Attending Physician Name (printed)	Signature	Date
Resident Name (printed)	Signature	Date
Resident Name (printed)	Signature	Date

Appendix B: CHECKLIST FOR SUCCESSFUL COMPLETION OF CLERKSHIP

- ☐ Have each team sign **attestation**
- ☐ Complete **12 work-ups**
- ☐ Log clinical experience with **10 core problems** on PDA
- ☐ Submit **H&P, follow-up progress note, and discharge note** to attending physician
- ☐ Give **formal presentation** with lit search and articles to team; Submit summary and references to Clerkship Director
- ☐ Complete **reflective essay--**email to Clerkship Director
- ☐ Complete **mid month formative evaluation** form. Review with attending physician and obtain attending signature
- ☐ Complete **OSCE**
- ☐ Complete **EKG packet**
- ☐ Complete **lab interpretation exercise**
- ☐ Complete **clinical rotation**
- ☐ Complete **Medcases** if student has not documented all required problems
- ☐ Pass **shelf exam**
- ☐ Complete site **evaluation on Black Board**
- ☐ Clerkship **evaluation on PDA**

Appendix C: THE HISTORY AND PHYSICAL EXAMINATION

Learn to do **an efficient, meaningful and thorough H&P** on hospitalized sick patients. Remember you must workup a minimum of 12 patients during the rotation. Here are some tips for performing an outstanding H&P.

Chief Complaint:

Describe the chief complaint using the patient's own words. Note duration of complaint.

History of Present Illness:

Begin with the **patient identification** i.e. a Mr. Jones is a 25 year old man. **Avoid racial identification** as it introduces stereotypic bias.

Relate the **temporal sequence of events** starting from when the patient was in their usual state of health. Pay special attention to the chronology and development of complaints.

Describe the complaint in detail. i.e. give the PQRSTs of pain. Delineate the severity and of shortness of breath. Describe the character and amount of the bloody diarrhea.

D**escribe associated complaints**. What else has the patient noted? In addition, ask about complaints in the involved system. For example, if the patient comes in with a cough and progressive shortness of breath you would ask if he had any hemoptysis, wheezing, and orthopnea or chest pain.

Address potential risk factors or possible etiological factors if you know them. For example, consider the patient with complaints of epigastic pain. You already described the temporal sequence, the PQRSTs of his pain, the associated symptoms and any other symptoms in the GI ROS. Now ask if the he uses NSAIDS, aspirin, or alcohol.

Finally, ask about the patient's **attribution.** What does the patient think is wrong or what is he or she worried about?

Past Medical History:

The Past Medical History is more than a list of diagnoses. Get details. When was the diabetes diagnosed? How long has the patient had COPD? To learn the most from you patient ask how the diagnosis was made. For example, how was the breast CA diagnosed—by patient exam or mammogram? Be careful NOT to cast aspersions on previous physicians or healthcare systems. Do not leave the patient feeling guilty that had they or their physician done something different things would be much better. Remember, you may never diagnosis a pheochromocytoma but if you patient had one removed find out how they presented and how the diagnosis was made.

Medications:

List all meds. Remember to **ask about herbal preparations and vitamins**. If the patient does not remember the names or dosages of medications ask where prescriptions are filled. **You can call the pharmacy** to find out which medications the patient is taking. Also, remember to ask about compliance and adherence. And do not be judgmental!

Allergies:

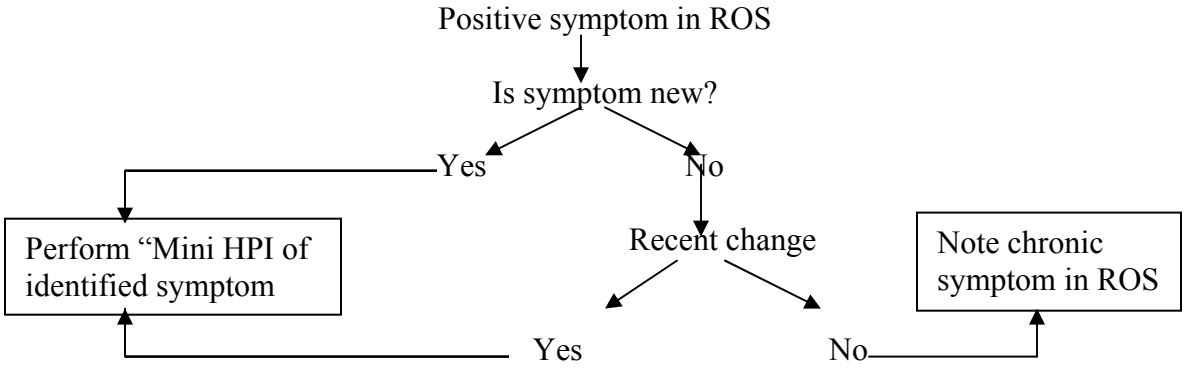
List all allergies. Describe adverse reactions.

Social History:

The social history is more than just a list of risky behaviors such as smoking, i.e. "the patient smokes a pack a day, drinks socially and uses crack cocaine' is not what social history is all about. What does the patient do? Who do they live with, what are their hobbies? For older patients, knowing if they drive is very helpful to understand how they get to their doctor.

The Review of Systems:

The Review of Systems is **a way to discover symptoms in a systematic manner going from system to system.** Diagnosed conditions do not belong in the review of systems. However, if a patient has a diagnosis of angina, it is appropriate to ask how often he has chest pain in the ROS section. **For long standing complaints, ask about recent change.** Remember the elderly woman who has been suffering from constipation for 40 years may still develop colon cancer. The key is to find out if there has been a recent change in her chronic symptoms. The **purpose of the ROS** is **to identify complaints related to the HPI (**complaints the patient may not realize were related**)** and to **identify other important health problems**. When discovering a positive complaint in the ROS one has to fully delineate the complaint—i.e. doing a HPI on that complaint.



The Physical Exam:

Learn to do a thorough PE. **Don't skip the difficult stuff.** Practice funduscopic exam. Try to find the thyroid. Learn to appreciate jugular venous distension. Do **chaperoned** breast, pelvic, testicular and rectal exams.

Impressions:

Note: The impression and Plan is last part of the History and Physical Examination but it is the most important part, it is what makes you a physician.

Take a step back. Think. Get organized. Group related complaints and findings.

Make a problem list. Include all problems identified, including problems discovered in the PMH and ROS. List them in rank order. You do not have to "work up" every problem but you do **need to develop a differential diagnosis for undiagnosed problems** and determine if any evaluation or treatment is indicated.

Develop a **well ranked differential diagnosis for each active problem. Discuss and defend the differential diagnosis. W**hat is the most likely diagnosis? What supports your diagnosis? For example, consider the patient presents with cough, SOB and fever. On physical examination the patient has dullness and bronchial breath sounds. The chest ex-ray is not available. Your impression might read, "Patient presents with cough, SOB, and fever. He has signs of consolidation on exam. Strongly suspect pneumonia. With history of seizure disorder suspect aspiration pneumonia, however, patient could have pneumococcal pneumonia." **Do not provide an "inferential differential" listing diagnostic tests without discussing the differential diagnosis.** Don't make your attending come up with ***your*** differential diagnosis based on the diagnostic tests ***you*** order.

Remember to address all problems including those identified in the PMH and ROS.

Plan:

The plan includes a strategy for both evaluation/diagnosis and management. It is actually the easiest part of the H&P because **it follows logically from the differential diagnosis.**
However, since you are new to clinical medicine you will need assistance to develop an appropriate plan. Resources such as *The Washington Manual, Ferri's, or Up-To-Date* can be very useful.

Sample H&P

Chief Complaint: "Gnawing feeling in my stomach" for 3 days

History of Present Illness: Ms. Jones is a 65 year old woman who was in her usual state of health until two months ago when she noticed her "arthritis acting up." She says that this has been happening for "years" with weather changes in the fall and spring, and that it has been particularly severe this spring. Her joint pain—that she describes as an "aching stiffness"—is located predominately in her knees, though she occasionally has less severe symptoms in her shoulders as well. She notes that the pain is worse with inactivity and improves somewhat with movement, and is associated with less than 15 minutes of morning stiffness. She has no limits in her range of motion of the joints, and no swelling, redness, or point tenderness, though she does notice "crackling" in her knees with movement. She attributes the worse symptoms this year to a high-impact aerobics class she has been taking at her gym to lose weight. At it's worst, the pain is a 5 out of 10, but with "pain medicine" it decreases to a 1 to 2 out of 10. She has been taking ibuprofen 200 mg pills "almost around the clock" for the last few weeks in order to continue doing the aerobics. She takes up to three pills every 6 hours and says that she goes through a 100 tablet bottle in a little over a week.

Three days prior to admission she started noticing epigastric pain. The pain is worse with eating, particularly spicy foods and coffee, and she describes it as a "gnawing ball" of pain, 6 out of 10 in severity. It does not radiate anywhere, and she denies any nausea, vomiting, sour taste in her mouth, loss of appetite, dysphagia, early satiety, or jaundice, though she has noticed black, tarry, hard to flush stools for the past two weeks. She has never had pain like this before and has never noticed any similar changes in her stool. She has no lightheadedness or dizziness. When the abdominal pain started she increased her ibuprofen intake even more, with little relief so she came to the Emergency Room.

Past Medical History:

1) "Arthritis" as above. She has never seen a physician for her arthritis pain, though she has had symptoms for more than 20 years.
2) Seasonal allergic rhinitis, for which she takes a nasal steroid during ragweed season with good control of her symptoms.
3) She denies any other past medical history, though she has not seen a physician "for years" so has had no routine screening.

Allergies: Her mother told her that she was allergic to penicillin as a child because she broke out in a rash.

Medications: Other than the ibuprofen, she takes a multivitamin and a calcium supplement. She takes echinacia when she feels a cold coming on.

Social History: She has recently retired from Ford, where she worked for most of her adult life as an engineer. She had no exposure history, since her job was entirely office-based. She lives with her husband and one of three grown children. She reports having "one glass of wine" on holidays, and does not smoke or use any illicit drugs.

Family History: Her mother died at 85 of natural causes. She had hypertension and heart disease diagnosed in her 80s. Her father died at age 50 in a motor vehicle accident. She has three healthy adult children. No other illnesses run in her family.

Review of Systems:
Constitutional: no fever/chills, (+) intentional 10 lb wt loss over the last 3 months but appetite is decreased
HEENT: no vision or hearing changes or sore throat
CV: no CP, palpitations, PND, or orthopnea
Resp: no dyspnea or cough
Breast: no masses or discharge
GI: per HPI; no diarrhea or constipation
GU: no dysuria, hematuria or discharge
Ext: per HPI; no edema or claudicaiton
Skin: no rashes or bruising
Neuro: occasional mild headaches with no associated symptoms, no weakness or numbness or paresthesia
Endo: No cold or heat intolerance, no polyuria or polydipsia
Psych: no depressive symptoms

Physical Exam:
General: WD/WN woman who appears her stated age, sitting at the side of bed in looking uncomfortable.
Vitals: T 36.5 HR 85 BP 155/85 (orthostatics were negative) RR 12 sat 99% BMI 32
HEENT: NCAT, PERRLA, EOMI, no scleral injection or icterus, TMs clear, nares clear, oropharynx clear, no papilledema/AV nicking or flame hemorrhages
Neck: supple, normal ROM, normal thyroid, no bruit
Lymph: no LAN
Breast: no masses palpated
CV: RRR, nl S1&S2, no M/R/G, non-displaced PMI, no JVD, 2+ pulses in radial/brachial/femoral/popliteal/DP/PT arteries, normal carotid upstroke
Resp: normal symmetric expansion, clear to auscultation and percussion, no egophany or whispered petrillioquy
Abd: soft, moderate tenderness to palpation epigastric region, otherwise non-tender, non-distended, NABS, no HSM
Rectal: normal tone, no masses appreciated, guaiac positive
Back: no point spinal tenderness, no CVAT, full ROM
Ext: full ROM in all extremities; knees with crepitus, boney enlargement with small bilateral effusions but no erythema or warmth, otherwise no joint abnormalities
Skin: no rashes or bruising
Neuro:
Mental status: AA&Ox3; normal affect and mood; memory 3 out of 3 at zero and 5 minutes; apropriate insight and judgment
Cranial nerves: CN II through XII intact
Motor: normal tone and bulk, strength 5/5 in bilateral shoulders, elbows, wrist, grip, hip, knees, and ankles to flexion and extension
Sensation: intact to light touch, pinprick, heat and cold

Reflexes: 2+ and symmetric at biceps, triceps, knees, and ankles; plantar response downgoing bilaterally
Cerebellar: normal rapid alternating movements and fine finger movements; no dysmetria; Romberg absent
Gait: nomal tandem, heel, and toe waling

Lab data:

Impression:
Ms. Jones is a 65 year old woman with a history of long-standing arthritis, worse recently, who presents with a two week history of melena and a three day history of epigastric pain.

1) **Epigastric pain**. Highest on my differential diagnosis for her pain are peptic ulcer disease, and gastritis given the location, recent NSAID use, and melena. Other possibilities include gastroesophageal reflux disease—though this will not usually cause melena; pancreatitis—less likely given the lack of radiation to her back, but the severity and association with food are consistent with this; gastric cancer—though she has no traditional risk factors or symptoms of early satiety and loss of appetite, she has lost weight recently; gall stones—though pain is usually in the right upper quadrant and associated with fatty meals, not spicy ones; and hepatitis—though this will usually cause right upper quadrant pain, nausea, vomiting, and jaundice.
   Plan:
   a. Stop ibuprofen and council on NSAID avoidance in the future
   b. Consult gastroenterology for possible endoscopy
   c. NPO after midnight incase GI wants to do Endoscopy tomorrow
   d. Check H. pylori serologies and treat if positive
   e. Start proton pump inhibitor IV

2) **Melena**. This is most likely secondary to an upper intestinal bleed secondary to her NSAID use as above. She has no history of iron supplementation use (which can also turn stool dark—though it will not cause a positive guaiac test), and has no history of bright red or maroon blood per rectum, which would suggest a lower intestinal source. She is not orthostatic nor does she have signs or symptoms of severe anemia, which makes me less concerned about massive blood loss. Also we would generally expect nausea and hemoptysis, though this is not always present.

   Plan:
   a. Place NG tube for lavage, but will remove if no active bleeding found
   b. Place two large bore peripheral IVs for access in case more severe bleeding occurs
   c. Start IV proton pump inhibitor
   d. Consult GI emergently if active bleeding found (less likely), or electively if no active bleeding found on lavage. She will likely need an endoscopy, so we will keep her NPO for now.

3) "**Arthritis**". Her bilaterally symmetric, large joint oligoarthritis and exam findings are most consistent with osteoarthritis. Though rheumatoid arthritis also affects joints symmetrically, it will affect the hands and wrists predominantly, will cause morning stiffness for longer than an hour, and will usually have active synovitis on exam. Lupus would be less likely given the lack of constitutional or systemic symptoms and signs. Though gouty arthritis can cause relapsing symptoms such as this patients in the knee (though podagra is more common), it rarely affects joints bilaterally and is often much more severe with more predominant inflammation on exam. Infectious arthritis is unlikely given the multiple sites and long time course of her symptoms.
   Plan:
   a. Start scheduled acetaminophen for her pain; recommend long acting acetaminophen (counseling her on the maximum dose per day and side effect profile)
   b. Council patient on low-impact aerobic exercises

4) **Single elevated blood pressure reading**. She has no prior known history of hypertension, though she has not seen a doctor recently. This is likely either essential hypertension, or secondary to her pain.
   Plan:
   a. We will monitor her blood pressure for now and see if this improves as her pain improves. Antihypertensives would be contraindicated at this time anyway given her GI bleed, but her goal blood pressure given her risk factors would be <140/90.

5) **Weight loss**. Though this is likely intentional given her recent exercise regimen initiation, given her age and lack of routine cancer screening in the past we will council her on pursuing age-apropriate cancer screening as an outpatient, including mammography and colonoscopy.

6) **DVT prophylaxis is not necessary as patient is not immobilized.**

Appendix D: The PATIENT ENCOUNTER OR PROGRESS NOTE

Although Wayne State students are instructed in writing SOAP notes during Clinical Medicine, many students are overwhelmed when asked to write progress notes on sick hospitalized patients. The following should help you to become excellent SOAP note writers.

To review, SOAP stands for **S**ubjective, **O**bjective, **A**ssessment, and **P**lan. The **SOAP note is a daily progress report**. It is different from the comprehensive history and physical examination you learned to write in Physical Diagnosis. The instructions below should give you a general idea of what information to include and where. As the name implies, **a progress note sums up the progress that has been made in the patient's care since the last note.**

The SOAP note in hospitalized patients **should reflect what is going on**. So often the note is nearly the same, day after day, and then one day the patient goes home. If your patient is sick enough to be in the hospital or needs care that can only be provided in the hospital your note should reflect just that. We call this meeting the **severity of illness** and/or **intensity of care** requirement for hospitalization. This may sound like stuff you are not interested in but, let's face it, if your patient isn't that sick and doesn't need the kind of care that can only be provided in the hospital he should go home. Hospitals can be very dangerous places.

The <u>subjective</u> section should **describe any changes in** the patient's **symptoms or complaints** and **reflect trends**. For example, "the patient continues to cough throughout the night and is unable to sleep," or the patient's cough has diminished but he still complains of exertional shortness of breath, "He continues to use a bedside commode because he is too short of breath to go to the bathroom." You might also have the situation where, "the patient's pain is improved but he continues to require iv pain meds to control his pain, when meds wear off his pain is 10/10 After he receives his meds the pain is tolerable at 5/10."

The objective portion should **describe the current physical exam, noting any changes from previous examinations**. **Important findings** should be described including **how the patient looks, vital signs,** and **findings in all pertinent systems.** On the Internal Medicine service we generally describe heart, lungs and abdomen**.** Why? Because we give IV fluids and patients are at risk for going into heart failure. We check for crackles. Our patients are also at increased risk for atelectasis. We listen for that too. We listen for an S3. We also examine for abdominal tenderness. I strongly encourage all of you to **examine and describe the IV sites** as well. Obviously you need to examine other important aspects of the exam that relate to the patients' primary reason for admission. You **do not have to examine aspects of the exam that are unlikely to change over 24 hours**, like the breast exam (unless the patient has mastitis) or the nose exam (except in a patient with sinusitis or other pertinent pathology.

New laboratory findings, results of imaging or other diagnostic tests should be noted after the physical examination.

The **assessment and plan** are what make you a physician. Here you will discuss the formulation and plan for your patient. I usually **do an A/P for each problem. In this section you will define the problem and working diagnosis** e.g., "Shortness of breath secondary to pneumococcal pneumonia." Sometimes you will not have a working diagnosis but only a differential diagnosis e.g.**, "**Shortness of breath secondary to either COPD or CHF.**" Describe the status of the patient working diagnosis**—i.e. "pneumonia responding to antibiotic therapy." Then describe the plan e.g., Continue IV penicillin until the patient is afebrile for 24 hours. Will repeat chest x-ray in 4 weeks."

Please remember, **the chart is a legal document**. Be bold in your presentations, but conservative in the chart. Also, because it is a legal document, you should start your note right after the last note in the chart so it will be in chronologic order. Strike out any blank space above your note. Always date and time your note.

While writing your note, do not leave blank lines in between text. This is to prevent someone else from writing in your note. Similarly, if you make a mistake, simply cross out the word with a single horizontal line, write "error", and initial it. Do not scribble out a mistake and never, ever use white-out. Legally one must be able to see your mistakes and know that you personally crossed out the word or sentence. Always sign your notes after your printed name and include your beeper number. You will develop your own style, and you should try to accommodate house staff preferences as this will allow you to experiment with subtle differences in technique.

Appendix E: SUGGESTIONS FOR PRESENTATION

Students should be prepared to present all assigned cases.

New Cases:

New cases will be presented the morning following the patient's work-up. Students should practice presenting to the intern or supervising resident. A new patient presentation should take **no more than five minutes to present**. Students should obtain thorough and complete histories and perform comprehensive physical examinations. However, this does not mean everything you did must be presented out loud! The **presentation is a means to an end**. It provides data used to evaluate and manage patients. The presentation **should be succinct and clear**. The format to be used is as follows:

The presentation should **begin with an introductory statement that identifies the patient**. For example Mr. Jones is a 25 year old man who comes in complaining of abdominal pain." Avoid racial identification as it introduces stereotypic bias. Some physicians prefer to add additional identifying information to show the patient is a person. The introductory statement might read, "Mr. Jones is a 25 year old *single school teacher* who presents with…" When presenting in front of the patient one is advised to eliminate the patient's gender as it is generally obvious. Thus, one would state, "Mr. Jones is 25 years old and comes in complaining of abdominal pain for five days."

The **history of present illness should be presented in a concise and organized fashion starting from when the patient was in his or her usual state of health**. The chief complaint should be fully characterized. Associated symptoms should be described. Pertinent positives and negatives relating to the chief complaint from the systems review should be mentioned in the HPI.

Past medical history, which is important to the chief complaint, should be presented in the HPI. For example, "Mr. Jones is a 25 year man *with long standing Crohn's Disease* and chronic abdominal pain who presents with a three day history of abdominal pain." He was doing well until three days prior to admission when he developed peri-umbilical pain. The pain was gradual and was campy in nature. Over the next 12 hours the pain intensified to 8-9/10. The patient could not identify and provocative factors but was afraid to eat. He could not find any relief from changing his position or from Tylenol #3 he had at home. The patient denies diarrhea but has …

Past history not related to the patient's chief complaint should be presented in the PMH section.

All medications and allergies should be presented.

Family history pertinent to the chief problem should be mentioned. Otherwise a statement noting, "noncontributory" suffices. Social history should provide information which will better help understand the patient. The presentation of the review of systems should consist only of

pertinent factors, and if none are present, the review of systems should be dismissed as "noncontributory". **A pertinent factor is identified as one that would be included in the problem list.**

In presenting the physical examination the student should initially make mention of the patient's appearance, i.e. "an acutely ill-appearing, thin 25 year-old man." Vital signs should always be reported. Ideally, the values presented are those by the student (not those from the nursing notes or the ER). The rest of the presentation of the physical exam should consist primarily of the positive findings. Negative findings should be mentioned only if they are valuable to the understanding of the patient's problems. It is preferable to list systems and then, if no findings are significant, describe WNL i.e. "Heart lungs and abdomen were within normal limits."

Next the student should give the results of the laboratories and imaging studies.

The presentation concludes with the impressions and diagnostic and therapeutic plan. Students should elaborate a complete problem list including all active and established problems. Problems should be ranked in order of importance.

Students should develop a well ranked differential diagnosis and be able to discuss and defend each diagnostic consideration. Some physicians prefer to list life threatening conditions at the beginning of the differential diagnosis as "rule outs." In our patient one might "rule out small bowel obstruction." I prefer to rank diagnoses in order of likelihood. For example, "patient appears to have exacerbation of Crohn's disease, however, he might have obstruction but it is less likely in that he had a bowel movement one day prior to admission and this episode is similar to other episodes of exacerbation per patient."

Next discuss all diagnostic tests you want to order. Be ready to discuss the rationale for each test. Be ready to outline what you will do with a positive or negative result from each of the studies. Discuss how you wish to manage the patient. Finally be ready to discuss an educational plan for the patient. This will add a little finesse to our presentation and help you patient a great deal. Your patient will want to know what is wrong, why, what you plan to do, and what might go wrong etc. Also you will need to educate your patient about his treatment and medications. Remember to use regular language not the medical language you are learning to use. The goal is to enlist your patient as a partner in his or her own care.

After you finish your presentation ask for feedback. That way presentation number two will be better than presentation number one and so on……..

Appendix F: SUGESSTIONS FOR EFFECTIVE READING

READ about your patients!!

Read about your patient's problem!!!

- What is the pathophysiology of the problem?
- What conditions are associated with the problem?
- What is the differential diagnosis of the problem?

Once a diagnosis is made, **read about that diagnosis**.

- Read about the classic presentation and common physical findings for that diagnosis.
- GO back to your patient and ask about classic symptoms.
- Repeat key portions of the physical exam to look for classic physical findings.
- How is the diagnosis made?
    - What is the best initial diagnostic test? What is the gold standard for diagnosis?

Read about potential complications.

- Watch for the development of complications. Use this information to formulate a well thought out sign out.

Read about treatment.

- What is the best initial treatment? What is the definitive treatment?

Read about prognosis.

- What influences prognosis? What improves mortality?

Think about what *you* would want to know if you were the patient—read about it.

Finally, ask your patient what they want to know…then read to answer his or her questions.

The bottom line is you have to read, READ, **READ**!

This is real clinical medicine. It is what you have been waiting for.
READ to become a great physician and provide the best care for your patients.
Isn't that why you are in medical school?

Appendix G: ADVICE FROM YOUR PEERS

(This is what last year's third year students told me to tell you)

What to Know Before Starting the Rotation

- Before starting floor months, I would have liked a review of how to present patients on rounds and also how to write orders. I have the memory card, but I was never taught how to write orders. i.e. What are the different options to write for nursing, special diets, IVF, or how to write for certain labs? I know we learn a lot throughout the month, but that learning process takes longer when we just write what our senior or resident tells us and we don't know why we write orders a certain way.

- To prepare for the rotation: Logistics type stuff on how to write a Soap note, (what the heck is a soap note), really how to write an H&P in the chart. I know we cover this in Physical Diagnosis done second year, but it's different when you actually have to put stuff as documentation in the chart.

- I think a little primer on lab values, what the heck are they, what are normal, and some initial steps to take if they are not--something more than trying to pull it out of Maxwell's little book.

What to learn as soon as possible

- I wish someone had given me an orientation to the forms used at the hospital I was at and how to fill them out properly. I think that the most important way to give students the chance to work up their own patients from start to finish is to get them writing admission orders, daily orders, discharge summaries, and transfer forms as soon as possible.

To know before going into the rotation:

"This ain't Kansas anymore Toto"...That their training is now clinical, they will definitely get great education, but the real guts of the training is hands on and while they are "caring" for their patients. Don't expect to be spoon-fed, read up on stuff, then ask questions. Also, know that the interns and residents to whom they report are "in training" too, don't have all the answers and maybe they'll all be learning some parts of medicine together.

How to be successful on rounds

- I would suggest reading in detail about each patient the student has as their own and at least skimming something about the other patients on the team. One of my interns was quite helpful in printing something off Up to Date for me on many of my patients. Harrison's was also helpful.

- Other advice would be to always ask questions. Students should also be firm that their role is to learn and that they should be assertive about this with their team. Call is not simply for the purpose of admitting patients, but to work-up and manage a variety of types of patients.

- I think thoroughness is the key to the IM clerkship--and asking questions. I think most people like the rotation b/c it feels like they are learning the things that they envisioned themselves learning when they started med school. I think some students are most bothered by the sometimes longer rounds but they fail to appreciate how IM is about treating multiple systems/multiple problems thoroughly, often b/c it is not really made clear to them and they have not had another rotation like it.

- My advice would be to review all patients with a resident before rounds to make sure they know everything that is going on with the patient. (It always seems like the residents know more information, maybe because they don't have to write all of the notes). Hope this helps.

- ASK QUESTIONS!!!!! Everyone on the team (even the attending) is learning something new everyday.

- Each patient is a learning opportunity. After performing a thorough history and physical and getting help in the diagnosis of the disease process, read about the disease. (I like to do a Google search including the term "E-medicine" to get access to the E-medicine website without having to subscribe). Questions I ask myself when I am reading:
    1. What aspects of this patient's history and physical are typical of this disease process? What aspects are atypical?
    2. What is the pathophysiology?
    3. What other disease processes should I be considering?
    4. What diagnostic tests should be obtained? What will the tests rule in/out?
    5. What interventions are necessary? How do these interventions halt/slow down the disease process? What interventions provide symptom relief?
    6. What does the patient require during admission? What needs to be followed up after discharge?
    7. What aspects of this admission went well? What aspects would you have changed?

- Be aggressive. Ask for a wide variety of patients. Make sure you see cases of:
    - CHF
    - Hypertension
    - Asthma
    - Diabetes- DKA
    - Infectious disease- pneumonia
    - GI- GI bleed, pancreatitis, abdominal pain
    - Heme- coagulopathy, anemia

- Learn how to thoroughly read x-rays and EKGs. Especially critical diagnoses that can be made with each.

- Even if you are not directly involved with the care of a patient who is an interesting case, follow along the course of that patient with whoever is directly involved.

- You are working as part of a team. Do what you can (within reason) to help the team out. Help out someone if they are asking for it-- they will probably turn around and help you out when you need it. And when the

team works well together, everyone has more time to learn and to relax at the end.

- The most important thing I think a 3rd year should know is that sometimes you get a great attending and/or residents that do a lot of helpful teaching, and sometimes you don't. Once you figure out that you're not learning anything by being at the hospital other than collecting lab data on your patients and standing around in rounds post-call about to faint from no time for breakfast, you should let your senior resident know. If they can't make time for teaching among the students and residents, they ought to be your advocate and let you get home at a decent hour so you can do some reading while you still have the energy.

How to Prepare for the Exam

- My advice to 3rd years in their rotation is to READ! That's really the only way to be successful on the Shelf exam.

- The hospital site also plays a big role in preparation.

- Attend morning report/lectures/conferences. Many teaching points come up on the shelf exam. And at the very least, you may get some food out of it.

- I wish someone had told me that all of the presentations you do will really help you on the shelf. I was stressed out b/c my attending the 1st month made me give a mini-talk every day and I would spend the night before looking stuff up for them instead of "studying" and it freaked me out, but they really ended up helping me at the end.

- The last thing I can think of that may be helpful is to focus on being an expert on a few patients rather than rushing to take on as many patients as you can. I sometimes see medical students trying to impress by taking on a ton of patients and then are confusing their patients, labs, shuffling papers, etc. during presentations and not having the time to really learn from their patients or have other students to learn from them because of this.

- My one piece of advice that you may want to edit out: don't start trying to do your systematic board studying your first week on the rotation. It

is difficult enough to get in the groove of seeing patients, rounding, and figuring out where radiology is. You won't remember it two months from now anyway.

-

How to study for the Shelf

- MKSAP

- As far as preparing for the shelf I found blueprints helpful, I also did the supplemental 100 bluebook question book and pretest (also read on your patients.

- The Ferri Guide is a waste of time as a pocket book, I was very sorry that I bought it and the whole time wished that I had a Wash Manual. The Dubin's is good for beginners EKG and most of them will already have it. I used pre-test questions, which were good, but thought the MKSAP were better.

- Kumar and Clark "Clinical Medicine" or Current Diagnosis and Treatment are good for the shelf. Also the student MKSAP questions were good. I also read Dubin for EKG's and Felson for chest X-rays, but that does not help with the shelf. Students should make sure that they get attendings and/or residents to go over EKGs and X-rays with them as these are practical skills that they will use, regardless of specialty. I would also advise students to read review articles from NEJM and elsewhere in order to be current with knowledge. There are recent articles on CHF, a fib, COPD, pneumonias, etc that might make a good web resource. This can be useful as even the most recent texts are badly out of date.

- I don't want to sound like a sales representative, but I recommend the Kaplan Internal Medicine Step 2 Lecture Note book. You normally have to sign up for a Kaplan course to get these books, but you can find them on e-bay. Also the Q-book that comes with the set has about eight Internal Medicine Shelf style exams of 50 questions each. They explain the correct answer and why all the others are incorrect (5-in-1 style questions). Some of the questions were identical to the shelf exam questions and also were invaluable for Step 2.

- I also did the Kaplan questions from KAPLAN QBOOK. These are the most similar and same level of difficulty as the shelf exam. The only way to get this book is to sign up for the course to receive the whole set of IM, Ob/Gyn, Peds, Surg, etc etc. I honestly believe these are the best questions out there. These are completely high yield concepts with a few "zebras" in there.... reminds me just like a shelf.

- I also read the Kaplan Internal Medicine book. Again, not that I am a Kaplan salesman or anything but they seem to know what concepts are on these exams. And their notes prepare you in this fashion. The notes are under 200 pages so they can be read easily before or during a rotation with lots of time to review or do questions as I did.

- I used Blueprints for my clerkship, and while I did well on the shelf, I have never once referred back to that book and likely never will. I like the Mosby guide: "The Care of the Medical Patient" by Fred Ferri as a pocket guide, and I think that the best advice I got was to keep my BRS physiology book close at hand (especially useful with Dr. Cardozo in the same hospital). A pharmacopoeia is indispensable, a Sanford is extremely useful, and for any budding internists: beg, borrow, or steal a Pocket EKG Survival Guide.

- I used Blue Prints for a general guide.

- I enjoyed NMS but realize that it's not for everyone. Other students I know read Blueprints and did Pre-Test questions. Dr. Alfonzo took the DRH students through some of the MKSAP questions, which were very helpful.

- Text: NMS for Internal medicine, Boards & Wards

- To answer your questions....read Boards and Wards (inc. ObGyn and Surg) and do many questions to succeed on the shelf. E-medicine website helped me out a lot to understand my patients' problems but didn't necessarily help with the shelf. I'd still recommend reading that topic the day after or night of getting a new patient. One day to become familiar with the history and lab results, next day to understand the diagnosis. Too much too soon just blurs it.

- Focus on the shelf exam near the end of the rotation-many clerkships have a some reviews before the final exam-it not only helps the students to do well on the shelf but on step 2 further down the line and in future clerkships going over sample questions would be great.

Some Final Thoughts:

- I also did pretest before the boards, but I think reading about my patients and paying attention on rounds and at the didactic sessions taught me what I needed to know. I didn't honor, but I did come close. The rotation will be what you make of it. There is someone there to go over whatever you want with you, you just have to find out who they are and seek them out. Dr. Afonso's EKG and CXR sessions as well as Dr. Levine's gram stain lectures were the most helpful. I didn't get to go to the peripheral smear lectures because of continuity clinic, but I did hang out with Dr. Tranchida whenever possible.

Appendix H: REFERENCES AND RECOMMENDED READING

Please use the most recent editions of the following

Major Textbooks (recommended for reading about specific assigned patients)

Harrison's Principles of Internal Medicine.

Wyngaarden and Smith, Eds. Cecil Textbook of Medicine. W.B. Saunders, Philadelphia.

Manuals/Short Textbooks (recommended for survey reading to prepare for shelf exam)

Stobo, JD. The Principles and Practice of Medicine, Appleton and Lange, Stamford, Connecticut.

Cecil's Essentials of Medicine. Third Edition, Sanders, Philadelphia.

Larson and Ramsey. Medical Therapeutics: A Pocket Companion, Saunders, Philadelphia.

Ferri, FF. Practical Guide to the Care of the Medical Patient, C.V. Mosby, St. Louis.

Friedman, HH. Problems-Oriented Medical Diagnosis,. Little, Brown, Boston.

Stein, JH. Internal Medicine, Diagnosis and Therapy, Appleton & Lange, Norwalk, Conn

EKG Interpretation

Dubin,

Thaler, MS. The Only EKG Book You'll Ever Need, J.B. Lippincott, Philadelphia.

http://ecg.bidmc.harvard.edu/maven/mavenmain.asp

Chest X-ray Interpretation

http://www.med-ed.virginia.edu/courses/rad/cxr/index.html

So you think you might want to go into Internal Medicine ☺

….Talk to an Internal Medicine Advisor

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*Best for students interested in a career that is primarily research oriented