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</tbody>
</table>
June 28, 2011

Dear Year III Students:

Welcome to the Year III portion of your medical school program. We believe that the courses you have completed in the first two years here at Wayne State have prepared you well to learn and succeed in your clinical rotations. During this year you will be applying your knowledge of basic medical sciences, history taking skills, physical examination skills, and doctor-patient communication skills in a wide variety of clinical settings. During this time you will learn a great deal about how to work with patients, how to gather and interpret medical information including diagnostic studies, how to identify problems faced by patients, how to develop an appropriate differential diagnosis, how to devise an effective treatment program and plan for follow-up, how to skillfully perform many medical procedures, and how to help patients maintain health and wellness. This year also provides you with the opportunity to interact with many skilled and dedicated physicians and other health care professionals in world-class medical facilities. Finally, many students use this year to explore their interests and talents and to help them determine the area of medicine in which they wish to pursue their residency training and future careers.

This Guide describes the general policies of the Medical School relative to Year III. I highly recommend that you read this guide thoroughly, and review pertinent sections at the start of each clerkship. Note that every required clerkship in Year III has its own policies—as well as learning goals, objectives, educational philosophy and grading policies—that are described in detail. Use these objectives to organize structure and focus your studies. These course level goals and objectives are designed to achieve the overall School of Medicine Medical Student Competencies and Institutional Learning Objectives. These can be found in this Guide and you should review them as a means of judging your progress through the Year III program.

During Year III you will be evaluated by written examinations (NBME shelf and/or clerkship exams), clinical evaluations from your attendings and residents, and, in some clerkships, other methods. These are clearly outlined in the clerkship descriptions. Among the things you can do to have a successful year are to read constantly about the patients and conditions you see. You need to go beyond review books and question banks, which while useful, cannot replace the required or recommended texts and readings in every clerkship. Another key is to arrive promptly for all clerkship activities prepared to fully and actively participate in the learning and patient care activities. Professionalism is a key element to success in the clinical years and we hope that you will continue to display professional characteristics which we expect of a student of Wayne State School of Medicine.

As you rotate through the various departments work to develop relationships with faculty and other physicians. Seek out mentors who can help guide your future career choices. Looking to the future, you will be required to discuss your Year IV schedule with a faculty advisor. This is a time when you should think about the fields you may be interested in and consider talking to the designated advisors in the various departments. Throughout this year, you should try to identify physicians from whom you might request letters of recommendation to include with your residency applications.

Although graduation seems far off, the following requirements should be kept in mind as you go through Year III and plan for the senior year:
• Complete and achieve a Satisfactory grade in all required YR III clerkships before the start of any senior work
• From the start of YR III through graduation, complete and receive credit for six (6) electives
• During YR IV, complete three required clerkships
• Take and pass USMLE Step 2 CK Exam (Clinical Knowledge, the written exam)
• Take USMLE Step 2 CS Exam (Clinical Skills, the clinical exam)

The timeline for completion of the School of Medicine requirements related to the USMLE exams is contained in this Guide.

Please thoroughly review the information in this guide. Changes may be made to these guidelines for the junior and senior clinical curriculum at any time. The administration will notify you by e-mail when a change has been made. It is important for you to keep up with the policies as they may change during the course of the academic year. Check your email daily for messages or announcements from your clerkship director or the School of Medicine administration. Remember that email is the official method of communication between the School and you for all issues regarding the clinical curriculum and clinical courses. We will only send email to your official School of Medicine address, so if you regularly use other email accounts you should make arrangements to have your Medical School email forwarded.

Finally, while you should never hesitate to speak directly to the clerkship director if you have any questions or problems while on a clerkship or elective, if you need further assistance please do not hesitate to contact your counselor or me directly.

I hope that you find your clerkships this year enriching and enjoyable and that you have a successful year of studies.

Sincerely,

Renee T. Page, M.D.
Assistant Dean for Clinical Education
Wayne State University School of Medicine
WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE
RECORDS & REGISTRATION OFFICE

2011-12 YEAR III SCHEDULE/CALENDAR

Registration: Thursday-Friday, May 12-13, 2011
Academic Year Begins: Thursday, June 30, 2011
Orientation: Thursday-Friday June 30 – July 1, 2011
Independence Day Recess: Monday, July 4, 2011
Clerkship/Clinical Campus Orientation: Tuesday, July 5, 2011
Labor Day Recess: Monday, September 5, 2011
Thanksgiving Recess: Thursday & Friday, November 24-25, 2011
Clerkships/Elective Resume: Tuesday, January 3, 2012
Martin L. King Day Recess: Monday, January 16, 2012
Memorial Day Recess: Monday, May 28, 2012
OSCE Examination: TBD
Academic Year Ends: Sunday, June 17, 2012

Two (2) month Clerkships
- July 5 – August 26, 2011
  August 29 – October 21, 2011
  October 24 – December 21, 2011
  January 3 – February 24, 2012
  February 27, – April 20, 2012
  April 23 – June 15, 2012
OSCE Exam - TBD
  January 30 – February 24, 2012
  February 27 – March 23, 2012
  March 26 – April 20, 2012
  April 23 – May 18, 2012
  May 21 – June 15, 2012
  OSCE Exam – June 14-17, 2012

One (1) month Clerkships
- July 5 – July 29, 2011
  August 1 – August 26, 2011
  September 26 – October 21, 2011
  October 24 – November 18, 2011
  November 21 – December 21, 2011
IMPORTANT POLICIES PERTAINING TO YEAR III AND YEAR IV

MANDATORY ATTENDANCE POLICY FOR CLERKSHIP ORIENTATIONS

Students are required to attend the entire Clerkship Orientation Session for each of their assigned Year III and Year IV clerkships. Any student who does not attend a clerkship’s Orientation Session may be prohibited by the Clerkship Director from participating in that clerkship for the scheduled period and may have their entire schedule of clerkships revised by the Assistant Dean for Clinical Education as that official deems necessary to meet School of Medicine academic requirements.

SCHEDULE AND SITE CHANGES FOR ADMINISTRATIVE OR EDUCATIONAL REASONS

The School of Medicine Administration or individual Clerkship Directors maintain the right to alter the sequence and/or sites of students’ assigned clerkships for administrative or educational reasons.

ENTRY POINTS FOR BEGINNING YEAR III COURSE WORK

Only three entry points are permitted for students to begin Year III course work. These are:

1. At the beginning of Period 1 (the beginning of July)
2. At the beginning of Period 3 (late August/beginning of September)
3. At the beginning of Period 7 (the beginning of January)

These three allowed entry points for students to begin Year III clerkships apply to all students regardless of the reason(s) for their delayed start of Year III.

CLINICAL READINESS COURSE POLICY FOR 2011-2012

The Clinical Readiness Course (CRC) was created to help students be successful in clinical clerkships after being out of school for an extended period of time. The purpose of the CRC is to assess and provide enhancement, if necessary, for clinical skills prior to the resumption of clinical training. This course is a mandatory experience for any student who is returning to school a year or more since completion of the physical diagnosis portion of Clinical Medicine II.

Mandatory Participation
Participation in the CRC is mandatory prior to beginning a clerkship if more than a year has elapsed since the completion of Year 2 coursework. No student who has been out for a year or more will be allowed to begin a Year 3 clerkship without CRC
Any student who expects to return at some point during the academic year should plan to participate in a CRC session prior to returning. CRC is considered re-certification of clinical skills, and CRC certification is good for a year. This means that a student who completes the course in June could return to Year 3 in July, September, or January of a given academic year. Students can participate in CRC while on a leave of absence but must pass Step 1 prior to beginning the CRC.

Structure of Course
Each student is scheduled for a 2-hour baseline assessment of clinical skills. Enhancement sessions and a re-assessment of areas of deficiency are scheduled as needed. The CRC course is scheduled three times a year, corresponding to the three Year 3 entry points in July, September, and January.

Content of Course
**Session 1 - Baseline Assessment:** 2-hour head-to-toe exam (H&P) with a Standardized Patient followed by a SOAP note station and presentation of the case to a faculty member. This assessment is scored and reviewed by a faculty member. If the student satisfactorily performs in all areas of the baseline assessment, they require no additional (enhancement) sessions.

**Sessions 2 – 4 - Enhancement:** Up to 6 hours of “Enhancement Sessions” are scheduled in 2-hour blocks. The content of the sessions depends entirely on the results of the baseline assessment; if a student scores unsatisfactorily in areas involving communication, they will be required to work with a Standardized Patient Communications Associate if the student scores unsatisfactorily in any physical exam skills, they will be required to work with a Standardized Patient Teaching Associate. Students requiring enhancement in either the written SOAP note or presentation components of the baseline assessment will be provided with didactic materials and/or one-on-one sessions with faculty.

**Session 5: Reassessment:** Upon completion of any required Enhancement Sessions, students will be re-assessed in any areas of deficiency. If further enhancement is required, students will be referred to a member of the faculty for follow-up.

Scheduled Sessions for 2011-2012
CRC sessions are scheduled for three times during the year, approximately one month before the allowable return dates for Year 3 clerkships, which are July, September, and January. You will be contacted regarding scheduling your CRC sessions.
Limited Space Per CRC Session
The space per session is limited; therefore students cannot be guaranteed a spot in a particular session. Although we will do our best, some students may have to be re-scheduled for a later session if the number of students exceeds the available slots. Priority will be given to certain students, for example, those who have already passed USMLE Step 1.

Deadlines for Posting USMLE Step 1 Scores In Order to Begin a Clerkship
Students do not need to have passed Step 1 to participate in the CRC, but a passing score is required prior to beginning a clerkship for any student who has taken and failed the exam previously. The deadline to report a passing score is the Wednesday before your expected return, as scores are only released on Wednesdays.

• For a July return, the deadline is mid-June 2011
• For a September return, the deadline is mid-August 2011
• For a January return, the deadline is mid-December 2011 (scores are not posted again until January, and the University is closed for the Winter Recess).

The NBME says to allow six weeks for scores to be reported. Please keep the deadlines, and the time lag in reporting scores, in mind when scheduling exam dates. For a July return, you should take the exam by the middle of May. **No exceptions to the deadlines will be made in the case of unreported scores for exams later than six weeks before the reporting deadline.**

Keeping Us Apprised of Your Plans
Please keep in touch with your counselor in Student Affairs (577-1463) in order to ensure that you receive information about, and are scheduled for, an upcoming CRC session.
WSU-School of Medicine Criminal Background Check Guidelines  
Academic Year 2011-2012

PURPOSE:
In an effort to enhance the safety and well-being of patients and to ensure that students can become licensed physicians, the American Medical Colleges (AAMC) has recommended to medical schools the need to conduct criminal background checks on all enrolled medical students. Based on the recommendation of the AAMC and the expectations of our clinical partners, the immediate implementation of a criminal background check policy is necessary.

POLICY:
1. All currently enrolled medical students who have not obtained a WSU Public Safety criminal background check during the 2011-2012 academic year, must have one conducted prior to the start of any clinical activity in the undergraduate medical education program at WSU-SOM.

2. In August 2011, all matriculating students should have had a criminal background check.

3. Any student whose background check contains a felony conviction will be referred to the Criminal History Review Committee (CHRC). This committee will review the felony conviction report and allow the student an opportunity to correct any erroneous information and clarify the report.

4. If the CHRC upholds the findings in the report, the student will be referred to the School of Medicine’s Promotions Committee for review, with a recommendation for dismissal.

PROCESS:
1. At the beginning of the academic year every student will be required to complete a request and authorization form to conduct a criminal background check. Additionally, students will need to present a current drivers license or other identification that will be copied and attached to the form. The information will be obtained from the School of Medicine Records and Registration Office and Conjoint Teaching Services. All information will be secured by the records office following the strict student confidentiality procedures of that office. The request and authorization form must be completed at the time assigned to your class.

2. If upon completion of the background check a felony conviction is found, the felony report will be sent to the school of medicine and reviewed by the Criminal History Review Committee (CHRC). The review will include the severity of the felony conviction, age the felony occurred and the time that has elapsed since the conviction.1

3. Students will be immediately notified if their background check contains a felony conviction.  
1 Guidelines obtained from the Michigan Department of Community Health website: http://www.michigan.gov/mdch/0,1607,7-132-27417_27529_27541-136661--,00.html

4. The chair of the promotions committee will chair the CHRC. The CHRC will consist of the following members: the dean of student affairs, dean of evaluation, student information and education research, an appointed member of the promotions committee, and staffed by the chief administrative officer in the department of medical education.
5. Students with felony convictions listed on their report will be asked to meet with the CHRC. The student will have an opportunity to provide written documentation to refute or respond to the report. Students may request a copy of their criminal history report from Records and Registration. Students will have 5 business days following notification from the medical school of the felony to provide any information about the circumstances surrounding the felony conviction.

6. If the CHRC finds the felony conviction to meet an unacceptable level of severity, the student will be referred to the School of Medicine Promotions Committee with a recommendation for dismissal.
### 2011-2012 YEAR III GROUP SCHEDULE

#### GROUP I
- **July – Aug**: Medicine
- **Sept – Oct**: Fam Med/Elective or Free
- **Nov – Dec**: Pediatrics
- **Jan – Feb**: Surgery
- **Mar – Apr**: OB/GYN
- **May – June**: Neurology/Psychiatry

#### GROUP IV
- **July – Aug**: Surgery
- **Sept – Oct**: OB/GYN
- **Nov – Dec**: Neurology/Psychiatry
- **Jan – Feb**: Medicine
- **Mar – Apr**: Fam Med/Elective or Free
- **May – June**: Pediatrics

#### GROUP II
- **July – Aug**: Pediatrics
- **Sept – Oct**: Medicine
- **Nov – Dec**: Fam Med/Elective or Free
- **Jan – Feb**: Neurology/Psychiatry
- **Mar – Apr**: Surgery
- **May – June**: OB/GYN

#### GROUP V
- **July – Aug**: Neurology/Psychiatry
- **Sept – Oct**: Surgery
- **Nov – Dec**: OB/GYN
- **Jan – Feb**: Pediatrics
- **Mar – Apr**: Medicine
- **May – June**: Fam Med/Elective or Free

#### GROUP III
- **July – Aug**: Fam Med/Elective or Free
- **Sept – Oct**: Pediatrics
- **Nov – Dec**: Medicine
- **Jan – Feb**: OB/GYN
- **Mar – Apr**: Neurology/Psychiatry
- **May – June**: Surgery

#### GROUP VI
- **July – Aug**: OB/GYN
- **Sept – Oct**: Neurology/Psychiatry
- **Nov – Dec**: Surgery
- **Jan – Feb**: Fam Med/Elective or Free
- **Mar – Apr**: Pediatrics
- **May – June**: Medicine
### Testing Dates by Clerkship

#### 2011-2012

<table>
<thead>
<tr>
<th><strong>Family Medicine</strong></th>
<th><em>Neurology</em></th>
<th><strong>Pediatrics</strong></th>
<th><strong>Psychiatry</strong></th>
<th><strong>Surgery</strong></th>
<th><strong>Internal Med.</strong></th>
<th><strong>Ob/Gyn</strong></th>
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<tr>
<td>8:00 AM</td>
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<td>8:00 AM</td>
<td>8:00 AM</td>
<td>1:00 PM</td>
<td>8:00 AM</td>
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<tr>
<td>February 24, 2012</td>
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<td>February 24, 2012</td>
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<td>April 20, 2012</td>
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<td>April 20, 2012</td>
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<tr>
<td>May 18, 2012</td>
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<td>May 18, 2012</td>
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**Special Re-exam Dates**

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<th>8:00 AM</th>
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<tr>
<td>Thursday, July 7, 2011</td>
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<tr>
<td>Thursday, January 5, 2012</td>
</tr>
<tr>
<td>July, 2012 (TBA)</td>
</tr>
</tbody>
</table>

* = Location in Department, Check Orientation Materials
** = Location: NBME Shelf Exam Green Auditorium-Scott Hall
I. INTRODUCTION

This Curriculum Guide details general policies and procedures which apply to you as a medical student during Year III regardless of which clerkship or elective you are on. Included are policies regarding how you are graded and promoted from each clerkship, the appeals process, your elective time in Year III, the Objective Structured Clinical Exam (OSCE) at the end of Year III, needle-stick and other exposure policies, special requests for time off due to religious holidays, and absences. Also included is information about duty hours and the work environment on the clerkships and student dress and grooming standards in the clinical setting.

A. Overview of the Clinical Curriculum

Following satisfactory completion of your basic science courses and passage of USMLE Step 1, you are officially promoted to Year III status by the Promotions Review Committee of the School of Medicine. Students who begin Year III with presumptive evidence of passing USMLE Step 1 but are subsequently found to have failed the examination are not yet considered regular Year III students; policies regarding promotion of these “special matriculation” students to Year III are found in the Year II Curriculum Guide.

Students who are scheduled to return to regular academic status after an absence for any reason of 1 year or more at any time following completion of second year coursework are required to attend a one month clinical refresher program before starting or continuing third year clerkship rotations.

The Junior Year of medical school begins with Orientation scheduled for June 30 and July 1, followed by clerkships which begin thereafter. Students who delay entry into YR III because of academic or personal reasons beyond July 1 of the academic year will begin clerkships in January of that academic year. Deviations from these July and January start dates for YR III can only be approved after written petition to start at a different time is approved by the School of Medicine. The request for an alternate starting time for YR III must state the nature the delay and the reasons to begin clerkships in the middle of a 6 month clerkship block.

The Junior Year (YR III) of medical school includes 11 or 12 months of study, encompassing 8 required clerkships:

<table>
<thead>
<tr>
<th>Block</th>
<th>Clerkship</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Internal Medicine</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Pediatrics</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Family Medicine</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Continuity Clinic Clerkship</td>
<td>6 (1/2 day each week, concurrent with other clerkships)</td>
</tr>
<tr>
<td>Elective or Vacation</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Non-primary Care</td>
<td>General Surgery</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Obstetrics/Gynecology</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Neurology</td>
<td>1</td>
</tr>
</tbody>
</table>
Note that the Continuity Clinic Clerkship is a longitudinal, six-month experience with a consistent ½-day assignment to a primary care office. The Continuity Clinic Clerkship can only be done during the Primary Care block of clerkships unless special permission is given by the School of Medicine to allow any portions of that clerkship to be completed at a different time.

Please be aware, the School of Medicine Administration or individual clerkship directors have the right for educational or administrative reasons to alter the sequence of a student’s clerkships and/or the site to which they are assigned for a clerkship at any time including after the beginning of a rotation.

As discussed in detail below, the YRIII elective month can be deferred into the senior year, allowing a month of vacation during the junior year. Upon satisfactory completion of all YR III requirements, students are promoted to YR IV. In the Senior Year of the medical school curriculum, students are required to complete at least eight (8) months of study, assuming that an elective was done in your junior year. There are three (3) required clerkships of one month duration each: Ambulatory Medicine, Inpatient Medicine (your Sub-Internship, in Internal Medicine, Pediatrics, Family Medicine, or Surgery), and Emergency Medicine. The other five (5) months include elective courses, with the requirement that you plan a balanced program of study to complete your medical school education. If you deferred your junior elective into the senior year to take a month of vacation in YR III, you must complete six (6) elective months (9 months total) in YR IV.

B. Student Disabilities
If you have a disability and believe that you should receive accommodations for testing or learning, you must provide appropriate documentation for the diagnosis of:

1. Physical or medical disabilities
2. Deafness or hard of hearing
3. Blindness or low vision
4. Traumatic brain injury
5. Learning disabilities
6. Attention deficit/hyperactivity disorder
7. Psychological or psychiatric disabilities

This documentation must be sent to the Assistant Dean, Office of Student Affairs, Suite 315 Richard J. Mazurek MD Medical Education Commons, Wayne State University School of Medicine, 320 Canfield, Detroit, Michigan 48201 and must have been updated within the past 3 years. The documentation must be received in the Office of Student Affairs at least 1 full week before the examination for which the student hopes to have the accommodations provided. If documentation is received less than 1 full week before the examination, the student will have the option of rescheduling the examination or taking the examination without accommodations.

For ADHD, if documentation is more than six (6) months old, the treating professional must provide a letter updating all pertinent information.
All diagnostic evaluation reports must:

1. Be in the form of signed and dated report on official letterhead, prepared by a qualified professional. For learning disabilities and ADHD, that professional must be a neuropsychologist. For psychological disabilities, that professional must be a psychotherapist.
2. Include a clinical diagnosis or a clear diagnosis of the specific learning disorder and, for learning and psychiatric/psychological disabilities, should use the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (DSM IV-TR) or ICD-10 diagnostic codes and date of the last contact with the individual.
3. Establish a clear link between the requested accommodations and the substantiated functional limitations that are pertinent to the academic/function demands of the academic setting in the medical school. For learning disabilities, the report must include a history of the learning disability and previous accommodations, if any.
4. Detail treatments, medications (including side effects), assistive devices/services currently prescribed or in use. This would include hearing aids, corrective lenses, and service animals.
5. For all disabilities, the type of accommodation(s) required must be specified.

C. Longitudinal Curricular Themes
The art and practice of medicine is not static but rather continually evolves as new information presents itself and our understanding of health, illness and disease changes. Medical education requires constant updating and inclusion of new content areas while curricular hours remain fixed. We incorporate new important content areas by integrating them into existing required courses and clerkships. These vertically integrated portions of the curriculum, termed Longitudinal Curricular Themes (LCT), have defined educational goals, objectives, educational activities and expectations and are implemented across the four years of the undergraduate curriculum. The LCTs at the School of Medicine currently include:

- Alcohol, Tobacco and Other drugs
- Clinical Prevention and Population Health
- Complementary and Alternative Medicine
- Cultural Competence
- End-of-Life Care
- Evidence Based Medicine
- Geriatrics
- Interpersonal Violence Across the Lifespan
- Managing Care
- Medical Ethics
- Occupational and Environmental Medicine
- Professionalism

Assessment of knowledge in LCT topics is measured by various methods including OSCE performance, course examinations and completion of web-based assignments. Theme topics may appear explicitly—in lectures, directed readings, or course objectives—or their appearance may be subtle and indirect, woven into your day-to-day educational and patient care activities. However they appear, the topics covered by these LCTs are vital to the professional growth and development of a student physician. Their organization into themes, which cut across required courses and clerkships, should not be taken to imply that they are viewed as less important than other content by the School of Medicine, but rather that they represent the inclusion of relevant cutting edge topics into the traditional curriculum.
D. Clinical Competencies and the School of Medicine Educational Objectives

The Wayne State University School of Medicine has established a comprehensive set of competencies and institutional objectives to prepare students for practicing medicine in the 21st century. The following table summarizes the general competencies and institutional learning objectives. The first row defines the general competency. The second row refers to the specific learning objective associated with each competency and the cognitive domain (knowledge, skill, attitude/behavior) being evaluated for each objective.

The six general clinical competencies for medical students (identical to the general competences of residency training) include

- Integration of the Basic Sciences in Medicine
- Integration of Clinical Knowledge and Skills to Patient Care
- Interpersonal and Communication Skills
- Professionalism
- Organization and Systems-Based Approach to Medicine
- Life Long Learning and Self-Improvement

As you progress through the clinical curriculum of medical school, periodically review these competencies and educational objectives. They provide valuable guides to the organization of the knowledge, skills and attitudes you will learn during this phase of your professional growth.
<table>
<thead>
<tr>
<th>Cognitive Domain: K=Knowledge S=Skill AB=Attitude/Behavior</th>
<th>Institutional Learning Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1 Knowledge of the normal structure of the human body (cell tissues and organs).</td>
<td></td>
</tr>
<tr>
<td>K2 Knowledge of the normal function of the human body (cell tissues and organs).</td>
<td></td>
</tr>
<tr>
<td>K3 Knowledge of the nature of agents and mechanisms that produce alterations in structure and function of the body.</td>
<td></td>
</tr>
<tr>
<td>K4 Knowledge of the nature and course of alterations in function produced by etiological agents and mechanisms (Pathophysiology) of the body.</td>
<td></td>
</tr>
<tr>
<td>K5 Knowledge of the nature and course of alterations in structure produced by etiological agents and mechanisms (Pathological Anatomy) of the body.</td>
<td></td>
</tr>
<tr>
<td>K6 Knowledge of the appropriate use of laboratory techniques in identifying diseases or health problems.</td>
<td></td>
</tr>
<tr>
<td>K7 Knowledge of the action, metabolism, and toxic effects of drugs.</td>
<td></td>
</tr>
<tr>
<td>K8 Knowledge of the therapeutic use of drugs.</td>
<td></td>
</tr>
<tr>
<td>K9 Knowledge of normal growth and development.</td>
<td></td>
</tr>
<tr>
<td>K10 Knowledge of the principles and concepts underlying normal behavior and mental illness.</td>
<td></td>
</tr>
<tr>
<td>K11 Knowledge of the aging process.</td>
<td></td>
</tr>
</tbody>
</table>
### Competency:
Integration of Clinical Knowledge and Skills to Patient Care

<table>
<thead>
<tr>
<th>Cognitive Domain:</th>
<th>Institutional Learning Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>K=Knowledge S=Skill AB=Attitude/Behavior</strong></td>
<td><strong>Integration of Clinical Knowledge and Skills to Patient Care</strong></td>
</tr>
<tr>
<td>S1</td>
<td>The ability to perform a satisfactory physical exam.</td>
</tr>
<tr>
<td>S2</td>
<td>The ability to take a satisfactory medical history including psychosocial, nutritional, occupational and sexual dimensions.</td>
</tr>
<tr>
<td>S3</td>
<td>The ability to utilize data from the history, physical exam and laboratory evaluations to identify the health problem.</td>
</tr>
<tr>
<td>S4</td>
<td>The ability to formulate an appropriate differential diagnosis.</td>
</tr>
<tr>
<td>S5</td>
<td>The ability to formulate effective management plans (diagnostic, treatment, and prevention strategies) for diseases and other health problems.</td>
</tr>
<tr>
<td>S6</td>
<td>The ability to monitor the course of illnesses and to appropriately revise the management plan.</td>
</tr>
<tr>
<td>S7</td>
<td>The ability to perform routine technical procedures specific to the medical specialty.</td>
</tr>
<tr>
<td>S8</td>
<td>The ability to document the clinical encounter.</td>
</tr>
<tr>
<td>S9</td>
<td>The ability to apply the principles and concepts underlying normal behavior and mental illness.</td>
</tr>
<tr>
<td>S10</td>
<td>The ability to diagnose and participate in the management of mental illnesses.</td>
</tr>
<tr>
<td>S11</td>
<td>The ability to apply the therapeutic use of drugs in patient care.</td>
</tr>
<tr>
<td>S12</td>
<td>The ability to recognize normal growth and development.</td>
</tr>
<tr>
<td>S13</td>
<td>The ability to recognize the relationship between health and illness, the patient and the patient's environment.</td>
</tr>
<tr>
<td>S14</td>
<td>The ability to apply psychosocial principles and concepts in the delivery of health care.</td>
</tr>
<tr>
<td>S15</td>
<td>The ability to apply preventive and health maintenance principles and techniques in the delivery of health care.</td>
</tr>
<tr>
<td>S16</td>
<td>The ability to apply the appropriate use of laboratory methods in identifying diseases or health problems.</td>
</tr>
<tr>
<td>S17</td>
<td>The ability to recognize patients with immediately life threatening conditions.</td>
</tr>
<tr>
<td>K12</td>
<td>Knowledge about relieving pain and ameliorating the suffering of patients.</td>
</tr>
<tr>
<td>S18</td>
<td>The ability to apply Evidence Based Medicine principles to clinical decision making.</td>
</tr>
</tbody>
</table>
| Competency:  
Interpersonal and Communication Skills |
|--------------------------------------------------------------------------------------------------|
| **Cognitive Domain:**  
K=Knowledge S=Skill  
AB=Attitude/Behavior |
| **Institutional Learning Objectives:**  |
| S19 | The ability to demonstrate effective physician-patient interaction skills. |
| S20 | The ability to utilize appropriate communication skills to obtain a history, diagnosis, and deliver an effective treatment plan to patients. |
| S21 | The ability to effectively communicate with peers and members of the healthcare team in the care of patients and their families. |

| Competency:  
Professionalism |
|--------------------------------------------------------------------------------------------------|
| **Cognitive Domain:**  
K=Knowledge S=Skill  
AB=Attitude/Behavior |
| **Institutional Learning Objectives:**  |
| AB1 | The ability to apply humanistic values in the delivery of health care. |
| AB2 | The ability to work cooperatively with other health care workers in the delivery of health care. |
| AB3 | The ability to respect the patients’ dignity, privacy, and confidentiality in the delivery of health care. |
| AB4 | The ability to effectively interact with patients, peers and other healthcare workers from diverse cultural backgrounds. |
The integration of these School of Medicine competencies and revisions of the educational objectives were approved by the School of Medicine Curriculum Committee in February, 2005.

### Competency: Organization and Systems-Based Approach to Medicine

<table>
<thead>
<tr>
<th>Cognitive Domain: K=Knowledge S=Skill AB=Attitude/Behavior</th>
<th>Institutional Learning Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>S22</td>
<td>The ability to apply the concepts and principles of primary care and Family Medicine in the delivery of health care.</td>
</tr>
<tr>
<td>S23</td>
<td>The ability to apply cost containment principles and techniques in the delivery of health care.</td>
</tr>
<tr>
<td>K13</td>
<td>Knowledge of the health care delivery systems including social, economic and political dimensions.</td>
</tr>
<tr>
<td>K14</td>
<td>An understanding of the need and value of consultations and referrals in the delivery of health care.</td>
</tr>
</tbody>
</table>

### Competency: Life Long Learning and Self-Improvement

<table>
<thead>
<tr>
<th>Cognitive Domain: K=Knowledge S=Skill AB=Attitude/Behavior</th>
<th>Institutional Learning Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB5</td>
<td>Recognize the need to engage in lifelong learning to stay abreast of relevant scientific advances.</td>
</tr>
<tr>
<td>AB6</td>
<td>The ability to recognize personal educational needs and to select and utilize appropriate learning resources.</td>
</tr>
<tr>
<td>S24</td>
<td>The ability to critically appraise the medical literature.</td>
</tr>
</tbody>
</table>
1. EVALUATION, GRADING & PROMOTION POLICIES FOR CLERKSHIPS & ELECTIVES

The evaluation of Year III students is the responsibility of the School of Medicine Clerkship Committee, which delegates that authority to the individual Year III Clerkship Directors. In turn, Clerkship Directors and Departmental Medical Student Education committees determine the clerkship grade for each student and recommend this grade to the Clerkship Committee. The Clerkship Committee reviews and approves grades on a monthly basis. Grade Report Forms and Clinical Performance Evaluation Forms are then disseminated to students through the office of the Assistant Dean for Student Affairs and recorded by the Records and Registration Office.

Guidelines for evaluation of cognitive skills and clinical abilities are established for each clerkship by the clerkship director and departmental education committee. These guidelines are detailed elsewhere in department-specific clerkship policies and procedures. At each clerkship’s orientation or by some other means at the beginning of each clerkship, you will be informed about the specifics of the evaluation and grading policy. Your course grades will be determined at a minimum by written examinations and completion of clinical performance evaluations (on the Clinical Performance Evaluation form, shown below) by supervising attending physicians and/or supervising residents. Oral examinations, objective structured clinical exams, defined clinical exercises, reflective essays and/or research papers will also be a component of your grade in some clerkships.

Students should direct questions regarding the evaluation and grading system of a specific clerkship to that clerkship director. If further clarification is needed, please do not hesitate to contact the office of the Assistant Dean for Clinical Education, at 313 577-1450.

A. Mid-Clerkship Evaluations

Clinical Supervisors (Faculty, Attending Physicians, or Senior Residents) are required to provide students with a mid-clerkship evaluation. However, it is your responsibility to solicit this mid-clerkship evaluation from those physicians who work with you. The evaluation should detail your strengths, weaknesses and any recommendations for improvement during the remainder of the clerkship. A form for accomplishing this evaluation will be given to you during each clerkship with instructions on when they are due to be returned to the clerkship director. A generic example of that form is included in this Curriculum Guide. The specific format of the Mid-Clerkship evaluation may vary depending upon the needs of each clerkship.

In particular, the clerkship director should be notified by the student’s supervising physician if any student is (1) not performing as expected at the time of the mid-clerkship evaluation and if (2) that supervising physician is concerned at that time that the student will not satisfactorily complete the clerkship. If such a mid-clerkship evaluation is received, the clerkship director or his or her designee will offer to meet with the student to discuss his or her progress and plan for remediation to help the student improve his or her performance. A student who fails a clerkship clinically is expected to have had a documented mid-clerkship evaluation by that clerkship.

Administration recommends that copies of these written evaluations be kept by the student for future reference and reflection.
# SAMPLE MID-CLERKSHIP EVALUATION

(Actual format varies by clerkship)

## MID-CLERKSHIP EVALUATION

Rate yourself in each of these areas:

**Student Name __________________________ Signature __________________________ Date ______________**

<table>
<thead>
<tr>
<th>PROFESSIONAL RESPONSIBILITY</th>
<th>Performance Needs Improvement at Mid-Clerkship</th>
<th>Performance Satisfactory at Mid-Clerkship</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can be relied upon to complete tasks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have unexcused absences from clinical duties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am persistently tardy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can fulfill responsibilities independently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take independent responsibility for patient care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SELF-IMPROVEMENT, ADAPTABILITY, LEARNING</th>
<th>Performance Needs Improvement at Mid-Clerkship</th>
<th>Performance Satisfactory at Mid-Clerkship</th>
</tr>
</thead>
<tbody>
<tr>
<td>I accept criticism without becoming resistant or defensive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I engage in self-directed learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am respectful of others in lectures/educational environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am consistently prepared for rounds/other educational duties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take advantage of educational opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I respond to critique of my performance by making changes in behaviors/attitudes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPECT FOR OTHERS</th>
<th>Performance Needs Improvement at Mid-Clerkship</th>
<th>Performance Satisfactory at Mid-Clerkship</th>
</tr>
</thead>
<tbody>
<tr>
<td>I establish good rapport with patients and families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I demonstrate empathy for patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I function well within a health care team by: Demonstrating respect for supervisors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I function well within a health care team by: Demonstrating respect for nursing staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I function well within a health care team by: Demonstrating respect for other professionals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HONESTY</th>
<th>Performance Needs Improvement at Mid-Clerkship</th>
<th>Performance Satisfactory at Mid-Clerkship</th>
</tr>
</thead>
<tbody>
<tr>
<td>I provide honest answers to patients regarding their illness and treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honesty in data collection (accurate medical records, attendance sheets)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPLICATION OF KNOWLEDGE IN THE CLINICAL SETTING

<table>
<thead>
<tr>
<th>Performance Needs</th>
<th>Performance Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement at Mid-Clerkship</td>
<td>Satisfactory at Mid-Clerkship</td>
</tr>
</tbody>
</table>

- I have gained an appropriate level of medical knowledge in the discipline in which I am currently studying
- I integrate basic science knowledge with my clinical findings
- I apply my knowledge base to the patients I see
- Development of an appropriate Differential Diagnosis
- Development of an appropriate Treatment Plan

### HISTORY AND PHYSICAL EXAM

<table>
<thead>
<tr>
<th>Performance Needs</th>
<th>Performance Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement at Mid-Clerkship</td>
<td>Satisfactory at Mid-Clerkship</td>
</tr>
</tbody>
</table>

- I can do an appropriate history and physical exam
- I prioritize and focus on the most important parts of the patient history and physical exam
- I have effective interviewing skills
- I put the patient at ease when I ask about difficult topics
- I can recognize abnormal and normal findings on the physical exam
- I gather data independently, from multiple sources

### RECORD KEEPING

<table>
<thead>
<tr>
<th>Performance Needs</th>
<th>Performance Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement at Mid-Clerkship</td>
<td>Satisfactory at Mid-Clerkship</td>
</tr>
</tbody>
</table>

- My notes are timely and legible
- My notes convey relevant clinical information
- My notes are concise and organized
- My notes are accurate and complete

### ORAL PRESENTATIONS

<table>
<thead>
<tr>
<th>Performance Needs</th>
<th>Performance Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement at Mid-Clerkship</td>
<td>Satisfactory at Mid-Clerkship</td>
</tr>
</tbody>
</table>

- My oral presentations are well organized
- My oral presentations include all relevant data
- My oral presentations are concise and focused
- I prioritize information well in presentations
- I adapt format and style of presentation as needed

**NEEDS IMPROVEMENT: Action Plan (continue on reverse)**
B. Year III Examinations

There are three types of examinations, which the student may encounter while on clerkships in the third and fourth year curriculum:

1. Oral, practical or objective structured clinical examinations (OSCEs) developed and administered by the individual department.
2. Those that are written by School of Medicine faculty and are not returned because the faculty designates them as "protected" examinations.
3. Those that are "copyrighted" examinations developed by an external body and purchased for administration to medical students during the clerkship (i.e. NBME Subject/"Shelf" Examinations).

Unless specifically designated as an examination that will be returned to the student, written examinations during the clinical curriculum are either protected or copyrighted examinations. As such, the student has no right to retain these examinations, and possession of current copies of these examinations outside the testing room could violate School of Medicine Professionalism guidelines and University policy.

All YR III Clerkships use the Subject Examinations available from the National Board of Medical Examiners (NBME) as the written examination at the end of the clerkship. These examinations are the property of the NBME; they are scored by the NBME with results then reported to the School of Medicine. Because they are "copyrighted" examinations governed by NBME policies, students do not have the right to either retain or review them.

C. Written Examination Policies

The following policies pertain to the administration of written examinations administered at any time during a clerkship, whether administered at Scott Hall or at a departmental site. Policies stated by the NBME for administration of their copyrighted "shelf" examinations apply as if stated herein as well.

The role of proctors is to assure student honesty, and they must move about the room periodically and irregularly.

Students are not permitted to have books or papers at their seats or tables, or in their possession if they leave the testing room for any reason. Books and papers brought into examination rooms must be stored in a central place in the examination room designated by the proctor.

A faculty member or his/her designee will be present throughout the exam.

The student’s name will be written on each exam booklet and pages numbered.

All examination material must be turned in after the exams; removal of any pages from the examination could be grounds for disciplinary action.

D. Grading Written Examinations

Exams written by School of Medicine faculty are graded based on established departmental criteria specified in the pertinent section of this guide.
The NBME provides each clerkship director with individual examination scores and the mean and the standard deviation for the NBME Subject Examination for the WSU School of Medicine group administered that examination. Each Department through its clerkship director and departmental medical education committee decides how passing scores and honors scores for the written examinations are determined using this information. Again, this information is published in materials specific to each clerkship.

E. Clinical Performance Evaluation and Grade Report Forms

At the completion of each clerkship, the student’s clinical performance is evaluated using the Clinical Performance Evaluation form (see the following two pages) by those faculty and/or residents who have worked with him or her. Students are evaluated as ‘Below Expectations, ‘Satisfactory’ or ‘Outstanding’ on eleven different competencies (see example below). There is also space on the rear of the form for comments by the evaluator, along with suggestions for additional development. Note that no grade is assigned on this Evaluation form; faculty or residents are allowed to comment on what grade they believe the student earned in their comments section, but this constitutes only a recommendation from that evaluator. Your clinical grade, along with other aspects of your grade, are determined only by the department medical education committee and clerkship director. Again, it must be emphasized that a particular faculty member or resident who works with you does not assign grades. This is an important point that surfaces periodically: a student says “Dr. Samples said I was doing honors work, yet I was only given satisfactory. Why?” The answer is that Dr. Samples can only recommend that grade in the comments section; if, in the competencies, a sufficient number of competencies are not ranked as ‘Outstanding’, the clerkship director (who assigns the grade) will only assign a satisfactory grade.

Evaluation forms are completed by one or more faculty members, senior residents, or faculty-resident teams which have directly observed the student during the course of his/her training on the clerkship. Exactly who evaluates each student is determined by departmental policy, as is the number of evaluations expected for each student at the completion of the clerkship. This will vary from clerkship to clerkship based on the educational structure and curriculum of each clerkship.

Each of the completed Clinical Performance Evaluation forms is submitted to the School of Medicine as a part of the student’s grade report from that clerkship. While these documents are available to the student for his or her review, students may not possess a copy of the Clinical Performance Evaluations. However, these Clinical Performance Evaluations are also summarized on the Clerkship Grade Report Form (see example on following pages), a copy of which is given to the student from the Student Affairs office. Each department has discretion as to how to reduce the individual Performance Evaluations to the Grade Report, e.g. assigning more weight to certain evaluations, simply averaging the evaluations, etc.

The Grade Report Form is a summary of your performance in a clerkship. Detailed on your Grade Report Form is the number of Clinical Performance Evaluations used and summarized on the Grade Report Form, an averaged summary of how they were completed, and your written exam and other assessment scores. Also given at the bottom of the Grade Report is your exam and clinical assessment (Honors, Satisfactory, Unsatisfactory), along with your final course grade. These Grade Report Forms essentially are a “report card” of your performance during a clerkship. You may obtain a copy of your Grade Report Form from each clerkship from the Office of Student Affairs; School of Medicine administration recommends that you keep them in a portfolio for periodic reflection and review.
<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>DESCRIPTOR(S)</th>
<th>BELOW EXPECTATIONS</th>
<th>SATISFACTORY</th>
<th>OUTSTANDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1**. Application of knowledge in the clinical setting</td>
<td>Application of knowledge to clinical problem solving, integration of clinical data, development of differential diagnoses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2**. Taking a History</td>
<td>Skills in interview techniques, completeness of history, appropriately focused, thorough, organized, accurate, comprehensive</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3**. Performing a Physical Exam or Mental Status Exam</td>
<td>Technical competency and quality, completeness, follow up, recognition of abnormal and normal findings, focus and level of detail</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4.** Communication and relationships with patients and family</td>
<td>Sensitivity to patient's feelings and/or needs, empathy, compassion, rapport, respect, comfort w/ interactions, putting patients at ease</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5.** Professional attributes and responsibilities</td>
<td>Attendance, punctuality, commitment, reliability, motivation, conscientiousness, dependability</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Overall Knowledge Base</td>
<td>Breadth and depth of knowledge base at student's level of training</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Written and oral case presentations</td>
<td>Organization, clarity, use of appropriate terminology, focus of presentation, appropriateness of information</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Record Keeping (Write-ups, Progress Notes, etc.)</td>
<td>Timeliness of notes, clarity, organization, appropriate inclusion and exclusion of information, accuracy and completeness of information</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Facility with Technical Skills and Procedures, if applicable</td>
<td>Manual dexterity and competence in performing procedures and/or tests</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. Communication and relationships with health care team</td>
<td>Integration into the team, sensitivity to needs, feelings wishes and/or rights of others, interaction with team members, function within team structure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. Self-improvement and adaptability</td>
<td>Introspection, aware of own limitations, adaptability, receptivity to and acceptance of criticism, motivation, degree of effort, intellectual curiosity</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Composite Clinical Evaluation Summary (N = __________)

<table>
<thead>
<tr>
<th>CLINICAL COMPETENCY</th>
<th>DESCRIPTOR(S)</th>
<th>FAILS TO MEET COURSE EXPECTATIONS</th>
<th>MEETS COURSE EXPECTATIONS</th>
<th>EXCEEDS COURSE EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ** Application of knowledge in the clinical setting</td>
<td>Application of knowledge to clinical problem solving, integration of clinical data, development of differential diagnoses</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. ** Taking a History</td>
<td>Skills in interview techniques, completeness of history, appropriately focused, thorough, organized, accurate, comprehensive</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3. ** Performing a Physical Exam or Mental Status Exam</td>
<td>Technical competency and quality, completeness, follow up, recognition of abnormal and normal findings, focus and level of detail</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4. ** Communication and relationships with patients and family</td>
<td>Sensitivity to patient’s feelings and/or needs, empathy, compassion, rapport, respect, comfort w/ interactions, putting patients at ease</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5. ** Professional attributes and responsibilities</td>
<td>Attendance, punctuality, commitment, reliability, motivation, conscientiousness, dependability</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>6. Overall Knowledge Base</td>
<td>Breadth and depth of knowledge base at student’s level of training</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>7. Written and oral case presentations</td>
<td>Organization, clarity, use of appropriate terminology, focus of presentation, appropriateness of information</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>8. Record Keeping (Write-ups, Progress Notes, etc.)</td>
<td>Timeliness of notes, clarity, organization, appropriate inclusion and exclusion of information, accuracy and completeness of information</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>9. Facility with Technical Skills and Procedures</td>
<td>Manual dexterity and competence in performing procedures and/or tests</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>10. Communication and relationships with health care team</td>
<td>Integration into the team, sensitivity to needs, feelings wishes and/or rights of others, interaction with team members, function within team structure</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>11. Self-improvement and adaptability</td>
<td>Introspection, awareness of own limitations, adaptability, receptivity to and acceptance of criticism, motivation, degree of effort, intellectual curiosity</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### Summary of Clerkship Grade Components

**Final Clinical Evaluation**

- “Exceeds” evaluations for at least 3 (3) of first 5 competencies (identified with ** above) and “Exceeds” evaluations on at least seven (7) of the total available competencies are minimal criteria for an Outstanding Final Clinical Evaluation.

**Written Exam Score**

- **YOUR GROUP MEAN** _______________  **SD** _______________
- **MINIMUM WRITTEN EXAM PASSING SCORE**__________
- **MINIMUM WRITTEN EXAM OUTSTANDING SCORE**__________

**Other Assessment (Specify)**

**Final Course Grade**

- **INCOMPLETE**□ **PENDING**□ **EXPLANATION/MISSING WORK**

**STUDENT AFFAIRS REVIEW / DATE_____________________**

**MEDICAL STUDENT REVIEW / DATE____________________**
F. GRADING POLICIES

General criteria for assigning clerkship grades have been established by the School of Medicine as detailed below. When the process for determining the students’ final grades for clerkships, electives or years is completed, one of the below grades will be placed on the student's transcript. While students are informed of Unsatisfactory or Incomplete grades by the Assistant Dean’s office, it is still the students’ responsibility to determine their grade at the end of a clerkship to allow plans to be made to remediate or complete missing work in a timely fashion. These plans to remediate an Unsatisfactory grade or complete missing work must be made in writing by the student and his or her counselor.

I   Incomplete will be entered if verified circumstances have prevented completion of assigned work by the student before the end of the Clerkship. Incomplete work resulting in an Incomplete grade MUST be completed within 30 days of the end of the clerkship. Failure to complete the assigned work within that time could be cause for either cessation of the student’s academic progress until the work is completed, and/or reversion to an Unsatisfactory grade.

U   Unsatisfactory will be entered if the student failed to complete all the requirements for a satisfactory grade and is not eligible for a grade of I or Incomplete

S   Satisfactory will be entered if the student completed the requirements. (Successful remediation of failed clerkships will show a transcript comment like, Satisfactory after Remediation). This will be designated on the transcript as S*. The asterisk designates remediation.

S+  Satisfactory with commendations.

H   Honors will be entered if the student's performance was meritorious. In addition, because the School of Medicine values professionalism which entails responsibility and timely completion of tasks, students are not eligible for an Honors grade in a clerkship if all course requirements are not met on time, i.e., the student did not meet all deadlines during the clerkship. Please note that this could mean that a student who otherwise might have earned ‘Honors’, for example, might not receive that grade if requirements such as experience logging/tracking or course evaluations are not completed on time.

1. Determination of Clerkship Final Clinical Evaluations

Although each clerkship is responsible for determining criteria for written examination grades, as well as final course grades, the mechanism of how clinical grades are assigned is the same for all clerkships. This process is as follows:

The evaluations of all faculty, residents and teams that have worked with the student are summarized on the Clerkship Grade Report form. The process of summarizing these evaluations, e.g., weighting certain evaluations, etc., is determined by and at the discretion of each clerkship.
The Final Clinical Evaluation for the clerkship is reported on the Clerkship Grade Report form. Generally an ‘Outstanding’ Clinical Evaluation is needed for Course Honors, although this is at the discretion of each clerkship.

Five competencies are identified as Critical Competencies (Application of Knowledge, History Taking, Physical Examination, Communication with Patients, and Professional Attributes). The Final Clinical Evaluation of Outstanding will be given when the student is rated as ‘Exceeding Course Expectations’ in at least 3 of the 5 Critical Competencies AND when at least 70% of all competencies are rated as ‘Exceeding Course Expectations’.

The Final Clinical Evaluation of Unsatisfactory will be given when the student is rated as ‘Failed to Meet Course Expectations’ in any of the five Critical Competencies, OR the student is rated as “Failed to Meet Course Expectations’ on any three of the non-critical competencies.

The Clerkship Grade Report form also has space for reporting the student’s written examination grade, the results of other assessments, and the final course grade.

### 2. Determination of Final Clerkship Grades

Criteria for Clerkship Honors and Unsatisfactory grades are as follows:

a. Performance in both components of the student’s grade (clinical evaluation and examination) must be satisfactory for a student to be given a passing grade. Honors clinical performance does not compensate for a failing exam score, nor does an Honors exam score compensate for unsatisfactory clinical performance. Failure in one or the other category results in an unsatisfactory grade.

b. Performance in both components of the student’s grade must be Honors for a student to be given an Honors grade. In addition, the student must meet all clerkship deadlines to be eligible for an Honors grade, as stated above.

c. At the discretion of the department, certain failing students may be offered the opportunity to repeat examinations (written or oral). Please note that if clinical performance was notably poor, an Unsatisfactory grade may be given without offering a re-examination, and the student will then be required to repeat the rotation. **There is no presumption that each student will automatically be given the opportunity to repeat an unsatisfactory examination.**

   i. If the student performs adequately on the re-examination, the grade will be recorded as "S", with the comment, “Grade changed to Satisfactory by Re-Exam.”

   ii. If after re-examination, the person is still unsatisfactory, the grade remains "U", and the student will then be required to repeat the clerkship (including both clinical time and all examinations).

NOTE: STUDENTS WILL BE SCHEDULED & ASSESSED FEES FOR ANY REPEATED COURSEWORK.
3. Reporting Clerkship Grades

Clerkship grades are determined by each department’s medical student education committee. Grades are reported to the School of Medicine Clerkship Committee via the Grade Report Form, after which they are recorded by the Records Office and made available to the Office of Student Affairs. Clerkship grades are only reported to students through the Office of Student Affairs. Students must come to that office in person to receive their clerkship grade or to review Clinical Performance Evaluation or Grade Report forms. No grade will be reported over the telephone to the student by the staff of the Office of Student Affairs. A copy of the Clerkship Grade Report may be given by the Student Affairs Office to the student as a “report card” of his or her performance during a clerkship. These should be kept by the student for periodic review and reflection.

The directors and staff of the clerkships are not permitted to report the results of examinations, clinical evaluations, or overall clerkship grades directly to individual students outside of the process described in the preceding paragraph.

4. Criteria for Awarding Year III Honors

A minimum of 6 months of Honors in Year III clerkships is required in order for the student to be designated to have YR III Honors. This Honors designation is recorded on the student’s transcript. The Elective and Continuity Clerkships do NOT count toward YR III honors.

A reported Unsatisfactory grade or documented unprofessional behavior will automatically disqualify anyone from receiving Year III Honors.

5. Remediation of Failed Examinations

Remediation (retake) of failed examinations will generally be limited to one of two time periods, i.e., either at the time of a regularly scheduled examination or at a special examination session. Generally, special examination sessions are scheduled in early January (to take advantage of the study time available during the winter break) and in early July (to take advantage of the study time available between completion of clerkships at the end of an academic year and the July testing date).

Each department allows both special testing dates for remediation of failed or missed clerkship examinations in addition to regularly scheduled examinations. The exact dates for scheduled repeat examinations will be established by the Assistant Dean for Clinical Education along with the Records and Registration office. Once a student fails a written clerkship examination, the student, his or her counselor in the office of the Assistant Dean for Student Affairs, and the Assistant Dean for Clinical Education will develop a written plan for examination remediation. Remediation Forms should be completed no later than 30 days prior to the proposed re-examination date. It is recommended that students attempt to remediate failed clerkship examinations as early in the academic year as possible. In general, students with written examination failures during the months of July through November should consider remediation of their examination at the early January special test date, while students with examination failures between December and June should
Clerkship directors have been instructed to release students for the purpose of only these re-examination dates. No student will be released from a clerkship to take another clerkship examination other than as stated herein, since no student is allowed to take a make-up or repeat examination while enrolled in another clerkship. If a student intends to take a make-up exam at a time other than the special examination session (after consultation and approval from his/her counselor and Assistant Dean for Clinical Education), he or she may do so only if not currently on a clerkship. This rule applies also for rising senior students with outstanding deficiencies at the end of June of their third year; students will not receive senior elective credit until they complete all outstanding YR III work, and students may not repeat a clerkship examination while enrolled in an elective unless given special permission by the Assistant Dean for Clinical Education.

6. Remediation of Failed Clinical Work or Failed Courses

Clerkship grading committees may require students to repeat clerkship clinical time either for an initial course failure or after a second failure of the clerkship examination. Students will be assessed fees for any repeated coursework. When appropriate, the department clerkship committee will determine the length of time to be repeated upon recommendation of the Clerkship Director. Clerkship time will be repeated en bloc as soon as possible after the end of Year III. It is emphasized again that students must satisfactorily complete all Year III requirements and pass all Year III Clerkships before starting Year IV work.

7. Determination of Standard Scores at the End of Year III

Standard scores are computed at the end of each year of medical school to allow comparison of student performance, ranking, etc. For the purpose of the Medical School Performance Evaluation (MSPE, formerly the ‘Dean’s Letter’), a cumulative standard score is computed at the end of YR III that reflects each of the three years of medical school. This overall standard score computed at the end of YR III that includes all three years of medical school, is part of the Overall Comparative Performance ranking system used in the MSPE.

The YR III Standard Score is calculated as follows:

A. Points will be assigned for each of the 11 months of Year III clerkships using the following point system:

0 = Unsatisfactory (initial grade)

2 = Satisfactory

3 = Satisfactory with commendations

4 = Honors

B. These points are weighted based on the number of months of the clerkship, e.g., Honoring a 2-month clerkship would give you 8 points, honoring a 1-month clerkship would give you 4 points
C. The maximum possible score is 44 (11 months of honors). Grades in YR III electives are not counted in this computation.

D. The raw scores are then converted to a standard score by computation of the mean and standard deviation of all of the scores, based on the distribution of scores for the entire class. Each student’s raw score will then be converted to a standard score with the mean = 500 and one standard deviation = 100.

E. Mean = 28.54; Standard deviation = 7.72

44 points = 700.23 (approximately 2 standard deviations above the mean)
36 points = 596.63 (approximately 1 standard deviation above the mean)
29 points = 505.98 (approximately at the mean)
21 points = 402.38 (approximately 1 standard deviation below the mean)

F. Note that not all clerkships give commendations (Surgery does not), and that commendations are determined differently by clerkship (refer to the Clerkship Syllabi for specific information).

G. The standard score is not used to determine Year 3 honors (which is based on honoring 6 or more months, see above).

8. Overall Comparative Performance in Medical School (Years 1-3)

The Medical School Performance Evaluation (MSPE) contains information about an individual student’s overall performance over the first three years of medical school. A new system was developed to present our students in a more positive light during an increasingly competitive residency application process. The new system uses two dimensions—Academic Performance and Clinical Skills—plus end of year Comprehensive Honors, to arrive at an overall descriptive term (Exceptional, Outstanding, Excellent, Very Good, Good, and Satisfactory)

<table>
<thead>
<tr>
<th>Performance Descriptor</th>
<th>Approximate Percentage</th>
<th>Level of Academic Performance and Clinical Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceptional</td>
<td>5%</td>
<td>Outstanding academic performance and Superb clinical skills PLUS Comprehensive Honors for all Three Years</td>
</tr>
<tr>
<td>Outstanding</td>
<td>20%</td>
<td>Outstanding academic performance and Superb clinical skills</td>
</tr>
<tr>
<td>Excellent</td>
<td>35%</td>
<td>Outstanding academic performance and Proficient clinical skills</td>
</tr>
<tr>
<td>Very Good</td>
<td>20%</td>
<td>Very Good academic performance and Proficient clinical skills</td>
</tr>
<tr>
<td>Good</td>
<td>18%</td>
<td>Good academic performance and Proficient clinical skills</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>2%</td>
<td>Good academic performance and Competent clinical skills</td>
</tr>
</tbody>
</table>

ACADEMIC PERFORMANCE (Average Standard Score over Years 1-3)
[(Year 1 Standard Score plus Year 2 Standard Score plus Year 3 Standard Score) divided by 3]
Outstanding Academic Performance $\geq 485$ (approximately 60%)
Very Good Academic Performance = 431 to 484 (approximately 20%)
Good Academic Performance $\leq 430$ (approximately 20%)

CLINICAL SKILLS (Year 3 Grades Converted to Scores)

Clerkship grades are converted to scores, where Honors = 4 points, Satisfactory with Commendations = 3 points, Satisfactory = 2 points, and Unsatisfactory = 0 points. Each clerkship (grade) score is then multiplied by the appropriate number of months (e.g., honoring Surgery would be $4 \times 2 = 8$ points versus honoring Psychiatry would be $4 \times 1 = 4$ points). Clerkship scores are summed across all clerkships. The maximum possible score is 44 (which would result if a student honored all 11 months of Year 3 clerkships). Getting Satisfactory for all clerkships would result in a score of 22. Students who have failed a clerkship will get a score of zero for the clerkship even after the clerkship has been remediated.

Year 3 Standard Score is calculated from total Year 3 points, with the mean set to 500 and one standard deviation set to 100.

Superb Clinical Skills $\geq 35$ points (approximately 25%)
Proficient Clinical Skills = 14 to 34 points (approximately 73%)
Competent Clinical Skills $\leq 13$ points (approximately 2%)

G. Grade Appeals

When a student is dissatisfied with his or her grade in a clerkship, he or she has the right to appeal that grade. The steps in the appeal process are discussed below.

1. **Departmental Grade Appeals**

   The initial process by which students appeal evaluations, examination results, or final clerkship grades is as follows:

   a. The student must appeal in writing to the clerkship director within 4 weeks after the grade is available to the student through the Student Affairs Office. Note that appeals will be returned without action if they are submitted outside this four (4) week eligibility period.

   b. **IMPORTANT:** Students are strictly prohibited from contacting anyone (including site directors, attending physicians, “rounders”, residents, preceptors, or other faculty) other than the clerkship director with questions, concerns or grade appeals related to the evaluation of their performance in the clerkship. A student who contacts any of the individuals listed above other than the clerkship director regarding their evaluation/grade automatically voids their appeal.
c. The clerkship director will review the appeal request and if necessary, communicate with those who have evaluated the student’s performance on the clerkship. The clerkship director will communicate to the student in writing within six weeks of the appeal regarding the decision of the departmental medical education (clerkship) committee.

d. If still dissatisfied with the decision related to an appeal at the clerkship level, the student may request a review of his/her appeal by the School of Medicine Clerkship Committee.

e. Please note, students have a duty to report sickness that arises during an examination in a timely manner. If a student experiences an illness or other extenuating circumstance during a clerkship examination, the student must report that to the examination proctor and his or her counselor immediately. Each year, several students appeal an examination grade, claiming that he or she became ill during the examination. However, the students did not inform School of Medicine Administration that there was a problem either during or immediately after the examination. Failing to report the illness immediately will almost always be grounds for denial of a student’s appeal in this type of situation.

2. Appeals to the School of Medicine Clerkship Committee

a. An appeal to the School of Medicine Clerkship Committee is accomplished by written request to the Assistant Dean for Clinical Education with a copy sent to the Assistant Dean of Student Affairs. This request must state the specific nature of the appeal. It should be noted that appeal to the School of Medicine Clerkship Committee can be made on issues of fact and/or due process, and students must clearly state in their letter to the committee the facts or issues they are raising in their appeal. At its discretion, the School of Medicine Clerkship Committee could request a hearing with the student. The committee members will vote on the request and the student will receive notification of the committee’s decision by letter.

b. If still dissatisfied, the student may request a review of his/her appeal by the Promotions Committee of the School of Medicine as explained below.

3. The Promotions Committee Appeal Process

a. In order to appeal a Clerkship Committee decision, students must present a written statement to the Chairman of the Promotions Committee, clearly stating the specific nature of the appeal, within 10 business days of receipt of the action of the Clerkship Committee.

b. Appeals to the Promotions Committee will be heard at either a regularly scheduled or special meeting of the Committee at the discretion of the Chairman.

c. A quorum will be required to hear and act on the appeal, per Promotions Committee rules and policies.
d. The Office of Records and Registration will provide a complete updated academic summary of the student's entire tenure at the School of Medicine for each appealing student.

e. At the appeal session the Promotions Committee will review the student's record, and then may or may not call in the student for a hearing. The procedures for a hearing at the Promotions Committee are detailed elsewhere, and are incorporated into this Curriculum Guide in this abbreviated form for informational purpose.

f. Following the presentation of the appeal, the Promotions Committee will discuss the merits of the appeal, question staff for pertinent information, review extenuating circumstances presented, etc. If sufficient pertinent information is available to make a judgment, the Promotions Committee will arrive at a decision. If the Promotions Committee feels that insufficient pertinent information is available, it can table action to request further information, call new witnesses, etc., and consider the case at a future session of the Promotions Committee.

g. The Chairperson of the Promotions Committee will transmit actions of the Promotions Committee to the student in writing.

h. If an appeal is denied, the student will be informed of the right to re-appeal only if and when new information or evidence becomes available to him or her. Such a request for re-appeal, in written form, must be presented to the Chairperson of the Promotions Committee who will transmit the information to the other members of the Promotions Committee. The Promotions Committee will consider the request and will decide whether to hear the re-appeal. If such re-appeal is granted, the process for re-appeal will in all respects be identical to the primary appeal process. The student may appeal the actions of the Promotions Committee to the Provost of the University, as detailed below.

4. **Appeal To The University Provost**

   a. In matters where the student’s review and appeal process available to him or her within the School of Medicine have been exhausted, the student may ask the Provost of the University to review that decision. A written Request for Provostial Review must be made by the student, with a copy sent to the Dean of the School, Associate Dean for Academic and Student Programs, and Assistant Deans for Clinical Education and Student Affairs, postmarked within thirty calendar days of the postmark of the School's final decision which was sent to the address provided by the student in the School's appeal and review procedures.

   b. Provostial review of the School's decision will proceed as soon as possible after notification by the student of his or her wish to seek review.

   c. The student may also file with the Provost a Request for a Postponement of the effect of the School's final decision. Such a Request must be postmarked within seven calendar days of the postmark of the School's final decision, and a copy must be sent to the Dean of the School and others as noted above. Upon receiving a Request for Postponement, the Provost will immediately contact the Dean of the School of Medicine. Unless the School demonstrates clearly and convincingly that
an injury to the School or to third persons that would result from such a postponement would outweigh the injury to the student from denying the postponement, the effect of the decision rendered by the School will be postponed until the date that the Provost issues a decision regarding the underlying Request for Provostial Review. The Provost will inform the student and the Dean of his or her decision regarding the Request for Postponement within three school days after receiving the request.

d. Exceptions to this procedure may be granted by the Provost upon a showing of good and sufficient cause.

H. Probation During YR III

Students are evaluated following each clerkship in Year III, and when sufficient academic difficulty warrants referral for possible action, the information is forwarded to the Promotions Committee through the Assistant Dean for Clinical Education. At this point, the student is considered to be on academic probation, the conditions of which are detailed below.

The Promotions Committee and Review of Student Performance

At any time the Promotions Committee can be convened to review students whose academic performance has been brought to its attention by the Clerkship Committee via the Assistant Dean for Clinical Education. This review could include, but is not limited to, academic performance or professional behavior. The Committee has the right to place students on probation, suspension, or leave of absence if it is deemed that the student's performance and reasons thereof justifies this action. The committee can also dismiss students from the School of Medicine with cause.

Enrolled students are designated to be in good academic standing unless they are officially placed on probation or are suspended by the Promotions Committee.

a. Probation is defined as the subjection of a student to a period of trial, critical examination and evaluation while the student is attending classes in order to ascertain his/her fitness to continue as a student in the School of Medicine. The consequences of Academic Probation are specifically detailed below. The Promotions Committee will determine the conditions of probation, which may or may not be specified in Sections below. Generally, probation during Year III results from academic deficiencies, although probation can be recommended because of Professionalism issues.

b. Suspension is defined as prohibiting a student from attending classes pending a determination of his/her fitness to continue as a student in the School of Medicine

1. Consequences of Academic Probation

This policy refers to all courses taken during the clinical portion of the medical school curriculum, i.e., during YR III and YR IV, including elective courses.
When a student receives an unsatisfactory grade in two clinical courses (whether a result of poor clinical performance, examination failure, or both), the student will immediately be placed on Academic Probation, with the following consequences:

a. The student’s probationary status will be monitored by the Assistant Dean for Clinical Education and the Clerkship Committee through a Subcommittee of the Promotions Committee as defined below.

b. The student will be required to begin regular meetings with his or her counselor in the office of the Dean for Student Affairs.

c. At the beginning of Academic Probation, the student’s past and pending future clinical program will be reviewed by a Subcommittee of the Promotions Committee, which will recommend action. Such action could include, but is not limited to:

   i. continued monitoring with no alteration of the student’s clinical program, allowing re-examination and/or repetition of deficient courses, as applicable
   
   ii. alteration of the student’s clinical program for the remainder of that academic year and/or the next academic year(s), including restriction of site, travel, course content, or order of courses

   iii. requiring additional course completion beyond the usual curriculum to remediate apparent clinical inadequacy

   iv. referral for learning skills assessment and enhancement

   v. referral to the full promotions committee for possible action (see below)

d. The subcommittee of the Promotions Committee will consist of the Associate Dean for Academic and Student Programs (Chair, Promotions Committee) or his or her designee, Assistant Deans of Student Affairs and Clinical Education, the student’s counselor and/or other members of the Office of Student Affairs. This subcommittee will specify in writing to the student the required remediation needed to remove the probationary status. The Assistant Dean for Clinical Education is delegated the authority to alter the student’s schedule if recommended by the subcommittee.

e. Following satisfactory completion of the specified probationary status, the student will return to regular status with removal of imposed restrictions from that point through the remainder of his or her tenure. However, if the student does not comply with the stated conditions of probation, he or she may be referred to the full promotions committee which could recommend repetition of an entire year, suspension or leave of absence if it is deemed that the student’s performance and reasons thereof justifies this action. The committee can also dismiss students from the School of Medicine at this point with cause.

DISMISSAL

The Promotions Committee of the WSU SOM reserves the right to recommend the dismissal of any student whose conduct or academic performance would be judged to
render the student unfit for the practice of medicine. Recommendation for dismissal may be for academic reasons or reasons pertaining to disruptive or unprofessional behavior.

Once dismissed, a student has the right to appeal the Committee’s decision within 48 hours of receipt of the dismissal letter. The student should write a letter to the Chair of the Committee, indicating a desire to appear before it to show cause why s/he should not be dismissed from school. If this appeal is rejected, the student has the right to further appeal in writing to the Provost of Wayne State University for review of the Promotions Committee’s decision. This request for re-consideration must be received in the Provost’s office within 48 hours after the Promotions Committee has upheld its dismissal decision. The Provost will then postpone implementation of the dismissal until he/she has ruled on the appropriateness of the Committee’s decision.

I. Promotion of YR III Students to Senior (YR IV) Status

At the end of the year, students are promoted to YR IV upon the recommendation of the Clerkship Committee to the Promotions Review Committee. It is important to note that students are not promoted to Senior (Year IV) status until all requirements of Year III are met, as emphasized above; this includes remediation of any and all Year III courses and examinations, including Incomplete grades. This is an extremely important issue, since senior electives taken without clearing all Year III deficiencies means that those electives will not be credited toward graduation. It is the student’s responsibility to make sure that this rule is followed and that all deficiencies and requirements are met. **All Year III Incomplete grades must be cleared before any Year IV work is begun.**

The Promotions Committee meets to review the recommendations of the Clerkship Committee. The prime function of this review is to ascertain that the rules of the school and the rights of the individuals involved have been fairly met and that students have either satisfactorily passed the YR III requirements or that a remediation plan to complete these requirements is in place before the student can be promoted.

If a student is denied promotion to YR IV status, that student has the right to appeal such decisions by direct petition to the Promotions Committee, as specified elsewhere. In the event of such an appeal, the committee shall gather evidence and hear witnesses. The student involved has the right to be heard by the Promotions Committee if such an action is taken and appeal initiated.

III. ELECTIVES

A. YR III Elective/YR III Vacation

The YR III curriculum includes 8 required clerkships (Continuity Clerkship, Medicine, Surgery, Pediatrics, Family Medicine, Psychiatry, Neurology and Obstetrics and Gynecology), which comprise 11 months of study. The twelfth month of your YR III curriculum is a month of elective clinical time. During YR IV, you are required to complete 5 electives. Additional comments regarding the balance of your elective program, which includes both your Year III and Year IV electives, are detailed below.

As a junior medical student, you may select any elective from the elective course offerings of the School of Medicine for which you meet, or will meet by the time the elective is taken, the Department’s course prerequisites. Note, however, that your elective could be changed
if a course is failed that is a required prerequisite of the elective. This is at the discretion of the Department offering the elective and the School of Medicine Administration.

In addition, you have the choice of taking a month of vacation in your third year and deferring this required YR III elective into YR IV. Note, however, that there are significant ramifications to this choice. On the one hand, you do not get as much vacation, interview or travel time in your senior year and you now have 9 months of study to complete in YR IV (the three required courses, 5 YR IV electives, and now the YR III elective); this is balanced against the vacation time that you will have during YR III if you elect to take this time off. Since the electives have prerequisites that you must take into consideration, this may have an impact on when you take your YR III elective as well.

One of the critical components of the YR III curriculum is the organization of the primary care clerkships (Internal Medicine, Family Medicine, and Pediatrics) which allows completion of the Continuity Clinic Clerkship (CCC). The CCC requires that you be present for a certain number of sessions at your assigned site during the six (6) months that you are taking the Internal Medicine, Family Medicine and Pediatric clerkships and your elective.

Since you are allowed to miss only a small number of CCC sessions before satisfactory completion of that clerkship is jeopardized, it is NOT possible for you to be away from the Detroit Metropolitan Area both for your Family Medicine Clerkship and your YR III elective. However, if you complete your Family Medicine Clerkship in the Detroit Metropolitan Area, you are permitted to take an established YR III elective at another medical school (as distinct from an independent study elective defined below) outside the Detroit Metropolitan Area. Note that this YR III elective taken outside of the Detroit area counts as one of your AWAY electives during your clinical years, and you may then take only 2 AWAY electives in your senior year. The AWAY elective within YR III cannot be an international elective. To emphasize, YR III AWAY Independent Study electives are also not allowed.

All electives taken are to be evaluated by each student in the School of Medicine. Completion of this required evaluation of the elective by the student is a requirement to receive credit for the clerkship.

Students are not permitted to schedule electives with physician family members.

B. AWAY and HOME Electives – Policies for both YR III and YR IV

Home Electives are defined as those electives within the Elective Catalog of the School of Medicine and Independent Study Electives at our affiliated institutions within the Detroit Metropolitan area. An AWAY Elective is an elective at another medical school, clinical institution, other institution or office outside the network of our affiliated institutions.

The School of Medicine Administration has designated several affiliated institutions other than the Detroit Medical Center within the Detroit Area as offering HOME ELECTIVES. These courses are not treated as AWAY electives, and additional School of Medicine approval to take these clerkships is therefore not required. The distinction between HOME and AWAY electives is important because only three (3) AWAY electives may be done for credit toward graduation, counting the elective taken in the student’s junior year (YR III). If you elect to do more than the minimum number of electives required for graduation, you may take more than three (3) AWAY electives. All International Electives are obviously AWAY electives, and they count toward that number of allowed AWAY electives as well.
Applying for Away Electives

1. Requests to do more than three AWAY electives (e.g., when the student wishes to relocate for a significant portion of the senior year because a spouse is located outside the Detroit Metropolitan area) must be directed in writing to School of Medicine Administration. At no time will a student be allowed to complete his or her three required senior clerkships (Subinternship, Emergency Medicine, Ambulatory Medicine) outside the usual course offerings. Consideration will be given to students doing more than three (3) AWAY electives when documented circumstances (e.g., marriage) can be verified before the 4th AWAY elective would be started.

2. AWAY electives are available from many medical schools and a variety of clinical facilities. The Office of Student Affairs has information regarding various available electives which prior students have taken. Counselors also have information regarding AWAY electives which students have found beneficial, as do various faculty members in the departments who act as advisors to junior and senior students.

3. For the 2011-2012 academic year many host medical schools will use the AAMC’s Visiting Student Application Service (VSAS) to receive applications from students wishing to do 4th year clinical AWAY electives at their institutions. This service includes a searchable database of electives, a short application, the ability to pay application fees online, and tracking of offers and schedules. Detailed helpful information for students about VSAS and a list of participating host schools is available at:

   http://www.aamc.org/programs/vsas/students/start.htm

The WSU School of Medicine Records and Registration office will issue you authorizations to log into VSAS. This office as well as the Office of Student Affairs will assist you in the VSAS application process.

4. The application process for AWAY electives at host schools not yet participating in the VSAS process includes first making contact with the medical school or institution in question. In conjunction with your counselor in the Office of Student Affairs, the School of Medicine’s AWAY Elective form is then completed. This includes obtaining approval of the WSU SOM Chair or his/her designee of the department in which you plan to do your away elective along with the Assistant Dean for Clinical Education (both approvals are required). The Office of Student Affairs will also help you complete other application materials required by host institutions such as proof of vaccination or other health matters, verification of ‘good standing’ status, malpractice insurance, etc. It is the student’s responsibility to complete all required forms and requests (health forms, transcript requests, proof of health insurance, HIPAA training, respirator fit testing, USMLE scores, photo ID) and submit the completed packet to the Office of Student Affairs. Be certain to read host school requirements carefully and comply with the policies in addition to all WSU School of Medicine policies. The Office of Student Affairs will review and mail all of this information to the host institution to complete your application for an away elective. Please note that no applications will be processed or mailed by the Office of Student Affairs without submission of all of the required application materials.
5. Only one AWAY clerkship request form will be processed for a given month. Students may not try to get several different AWAY electives for a particular month as “backup electives”. Applying to and being accepted at two different institutions for the same month necessitates that the student will have to cancel one of the electives he or she requested after the request was approved by the institution; this is never interpreted favorably by the institution, and could have an impact on future student learning there. You are advised to list alternate courses in the same department when making your requests. By doing so you will avoid having to secure multiple chairs’ signatures for a given month and maximize your choices at a given institution.

6. The Office of Student Affairs will maintain a file of all completed requests and provide the student with a copy of the application materials.

7. The AAMC Extramural Electives Compendium (usually released in March or April of each academic year) contains information of electives offered to visiting students from a variety of institutions. It can be found on the web at:

http://www.aamc.org/students/medstudents/electives/start.htm

The compendium contains detailed information regarding the application, approval processes, deadline dates, etc. for taking guest electives at all accredited US and Canadian schools. Copies will be available in the Office of Records & Registration, the Office of Student Affairs, Student Organizations Office and the Shiffman Library. Most medical schools also post their senior year curriculum guide and elective offerings on their institutional web-site.

8. WSU AWAY elective forms are available in the Office of Records & Registration and the Office of Student Affairs.

9. The Office of Records & Registration must receive written confirmation of your acceptance as a guest student from the institution at least four weeks prior to the scheduled starting date for the clerkship. Please be sure to monitor this requirement carefully. If you do not obtain written confirmation by one month before the start of the elective, contact the Office of Student Affairs or the Office of the Assistant Dean of Clinical Education for assistance.

10. As with all other clerkships and electives, failure to attend an approved clerkship will result in an unsatisfactory grade. That unsatisfactory grade will be made up in a HOME clerkship.

11. Students will be given credit only for those AWAY courses for which they have registered and which appear on their approved Senior program. If changes are made by the student or imposed by the host institution, the Office of Records & Registration must be notified immediately.

C. Independent Study Electives

An Independent Study Elective is defined as any elective taken during the clinical curriculum of medical school (whether during YR III or YR IV) that does not have a previously defined and published syllabus which describes the objectives, work hours and
environment, resources, and evaluation methods of the course. In essence, the course is established by and for the particular student. This definition applies to proposed electives at Wayne State University School of Medicine or one of its affiliated HOME clinical institutions (HOME Independent Study Electives) as well as courses at other institutions (AWAY Independent Study Electives).

Except in unusual circumstances approved in writing after written petition by the student, students will not be allowed to complete more than three independent study electives during Years III and IV of medical school. This includes research electives. As discussed elsewhere, YR III Independent Study Electives can only be done here at the School of Medicine or its affiliated hospitals. YR IV Independent Study Electives can be done here, elsewhere in the USA, or at international sites (see below).

**Home Independent Study Electives**

Requests to establish a HOME Independent Study course for your elective will be considered by the Assistant Dean for Clinical Education in conjunction with the relevant Department of the School of Medicine. The request to establish an Independent Study Course is initiated at the Office of the Assistant Dean for Clinical Education or the Office of Student Affairs with the student’s counselor. The School of Medicine Independent Study Elective form must be completed in order to process the request. Several criteria are used in considering approval of the Independent Study request, including but not limited to, the student’s academic record, departmental resources, the student’s planned career, the presence of a compelling reason to establish such a course (for example the absence of an identical elective course at the School of Medicine), etc. The student contacts the department and/or individual with whom he or she intends to work. Together the plan of study is developed and written on the Independent Study form. When completed and signed, this is then submitted to the Assistant Dean for Clinical Education for formal approval. Please note that a request to establish a Home Independent Study Elective during YR III is looked at more closely, since at that phase of a student’s training it is less likely to be educationally beneficial. Thus, while Home Independent Study electives may be allowed during junior year, established electives are preferred. After approval by the Assistant Dean, the proposed Independent Study Course is then submitted for approval by the relevant Department Chair or his/her designee in the School of Medicine.

**AWAY Independent Study Electives**

AWAY Independent Study Electives are developed and approved in a very similar fashion, except that the approval from the Assistant Dean and Department Chair of the relevant department of the School of Medicine should be sought before attempting to establish the elective. The process is altered in this way to make sure that everyone at the School of Medicine will approve the elective before the student contacts the other institution. During YR IV, AWAY Independent Study Electives can be arranged when proper documentation of the educational value of the elective can be obtained.

AWAY International Electives are Independent Study Electives because the experience is unique, are discussed below.

Additional important points to consider regarding Away electives include the following:
1. If you plan to do an AWAY Independent Study Elective, it is your responsibility to make all arrangements regarding the elective, including approval by WSU School of Medicine. No credit will be given retroactively for courses taken but not approved before the start of the course.

2. Monitor the situation with regard to your AWAY Independent Study Elective requests carefully. If you determine that you will not get a requested AWAY Independent Study Elective, you must propose a substitute for that course which is then added to your program using the mechanism for courses changes specified in this program guide.

D. Elective Grades

You will be eligible for the usual clinical grades of Honors, Satisfactory, or Unsatisfactory in electives. The elective taken during Year III is not counted towards the number of Honors course evaluations needed to achieve YR III Honors.

E. Changing Your YR III Elective

The following policy refers only to changes involving electives. Changes in the order of clerkships (i.e., your clerkship group), the sites of your clerkship, or changes to your required senior courses are not governed by the following policy.

1. ALL requests to change electives must be initiated through the Office of the Assistant Dean for Student Affairs. The current program, requested change (the new course and alternatives, if indicated), and reason for the change will be listed on the Add/Drop Change form available in Student Affairs, Records and Registration, and Academic Affairs offices.

2. This documentation is to be submitted to the Assistant Dean for Student Affairs for approval of the curricular modification.

3. No changes will be made without the required signed Add/Drop form; if you have previously communicated with administration regarding the change by email, please submit a copy of the relevant discussion along with the change request so that all documentation is together that needs to be reviewed. To reiterate, any explanations, descriptions of extenuating circumstances, etc. including copies of email correspondence must be submitted with the Add/Drop form, as a decision will be made on the program change only with materials available at that time; no attempt will be made by School of Medicine Administration to correlate an Add/Drop form with past submitted information or verbal discussions.

4. **All requests to change electives must be submitted at least 45 days before the start of the elective.** Note that all paperwork to effect a change must be submitted at least 45 days before the start of the elective in question. This will allow completion of the change request within the Office of Records and Registration at least 30 days before the start of the elective. Affiliated hospitals and other clinical facilities have agreed to reserve their spots for WSU SOM students in exchange for the School’s adherence to the policy that last minute changes (i.e., those elective changes within 30 days of the
start of the elective) will be significantly limited. Since those individuals in the Offices of Student Affairs and/or Clinical Education who can approve your request could be busy, out of the office, etc., you should plan to initiate your request early. There will generally be no exceptions to the 45 day limit for changing electives, and in the case where the 45 day limit is waived it is only for extenuating circumstances beyond the control of the student.

5. If requested by administration, or at the student’s request, the student will meet with the Assistant Dean for discussion of his or her modified program. Once approved, the documents will be forwarded to the Office of Records and Registration for modification of the student’s official record. Course directors impacted by the change will be notified by the Office of Records and Registration.

6. It is to your advantage to submit the request as soon as you know you want to change your program, since the elective you wish to change into may not be available at a later time.

7. To request consideration for a program change with less than 45 days before the start of the course because of extenuating circumstances, you must personally meet with the Assistant Dean for Student Affairs or their designee.

8. While you are free to contact an elective coordinator, department, hospital, etc. to discuss your desire to change your senior program and take their elective, the availability of space in their elective does not necessarily mean that your elective change will be approved by the School of Medicine. Similarly, a program change suggested by your advisor or another faculty member is not automatically approved without review by School of Medicine administration via the procedures detailed above.

9. Decisions regarding the approval or disapproval of a senior elective change are final, irrespective of the availability of space to accommodate the student’s request.

10. All program changes must follow the policies in force at the School of Medicine, and be approved by School of Medicine administration. There are several reasons for possibly denying approval even though it appears to you that the course is available, including possible obligations by the School of Medicine to fill spots once students have indicated their desire to take them; other changes that have been recorded but not communicated to the coordinator or department or hospital that takes up the free spot; academic concerns after review of a students prior performance; program balance, etc. Any program change made by a student that does not have prior School of Medicine approval may not be recognized by the School of Medicine, resulting in denial of credit towards graduation for that elective.
IV. THE YEAR III OBJECTIVE STRUCTURED CLINICAL EXAM (OSCE)

Each Year III student will participate in the Objective Structured Clinical Examination (OSCE) given at the end of Year III to assess his or her clinical skills. The OSCE is a series of simulated clinical encounters during which students perform clinical tasks under the direct observation of faculty, proctors, and standardized patients. Examples of OSCE clinical stations include focused organ-system or regional examination; obtaining a history from a patient with a particular chief complaint; interpretation of x-rays, or other clinical data; construction of a management plan, etc.

The OSCE will be graded to provide timely feedback about a student’s clinical skills. Results of the OSCE could be used prescriptively by students, their advisors and School of Medicine administration in the preparation or modification of Year IV elective schedules, so that students and their advisors may address areas of relative weakness prior to graduation. The School of Medicine reserves the right to alter some or a student’s entire program based upon OSCE deficiencies. Participation in the OSCE and completion of prescribed remediation in the OSCE are both mandatory. Failure to complete prescribed OSCE remediation could be grounds for denial of degree completion.

V. Step 2 United States Medical Licensing Examination (USMLE) Policies

1. YR III (Junior) students are not allowed to take time off to take the USMLE Step 2 examination.

2. For your information, the School of Medicine deadlines for the USMLE Examinations to be taken in the senior year are presented in the following table.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline to post a first attempt score for the USMLE Step 2 CK examination</td>
<td>January 31 of senior year</td>
</tr>
<tr>
<td>Deadline to post a passing score for the USMLE Step 2 CK examination</td>
<td>May 1 of senior year – approximately 1 month before graduation</td>
</tr>
<tr>
<td>Deadline to pass the USMLE Step 2 CS examination</td>
<td>May 1 of senior year – approximately 1 month before graduation</td>
</tr>
</tbody>
</table>

3. The Administration of the School of Medicine strongly recommends that you attempt to post a score for Step 2 CK of the USMLE relatively early in your senior year, since many program directors are now using these results in the residency selection process. Since programs are reviewing applications and starting to consider who to invite for interviews, it is important to try to have a score as early as possible. Furthermore, if a student doesn’t pass the examination on his or her first attempt, he or she will have sufficient time to repeat the exam and still have a passing score at
the residencies of choice before the ERAS match closes. More often, students who have not passed Step 2 CK before match certification are having difficulty securing their top choices.

4. **USMLE Step 2CK (Clinical Knowledge)**

   All senior students must post the first attempt score for Step 2CK by January 31 in the year they expect to graduate, and post a passing score by May 1. Students without a passing score by May 1 will be removed from the list of students receiving a diploma at graduation, although they may be allowed to participate in commencement activities. If a student has obtained a residency position, the residency program will be alerted to the fact that the student may be unable to begin the residency on July 1.

   Students who do not post a passing score by July 1 of their senior year will be placed on administrative leave.

   Students have until May 1 of the academic year following their nominal senior year to post a passing score on Step 2 CK of the USMLE or they will face dismissal from the School of Medicine.

5. **USMLE Step 2CS (Clinical Skills)**

   Beginning with the Class of 2013, students will be required to pass USMLE Step 2CS by May 1st to graduate on time. Students who have not posted a passing score for USMLE Step 2CS by the following May 1st (one-year after their initial graduation year) will be dismissed. The one year time period is not altered for any Leave of Absence (LOA) once the one-year period has started.

6. The USMLE Step 2 CS and CK exams can be taken in either order.

7. Additional information regarding the USMLE examination process, including registration for the Step 2 examinations, can be obtained from their website [http://www.usmle.org](http://www.usmle.org)

VI. **GRADUATION REQUIREMENTS**

   In order to graduate from WSUSOM, each Year 4 student must:
   - Achieve a satisfactory or honors grade for all prescribed clerkships and electives.
   - Complete all required assignments.
   - Complete any OSCE remediation.
   - Resolve all holds (paid tuition and fees, returned books and beepers, etc.).
   - Act professionally toward patients, fellow students, faculty, and staff.
   - Pass USMLE Step 2CK
   - Pass USMLE Step 2CS
May 1\textsuperscript{st} of each year is the deadline for completion of all Year 4 requirements. Explicit permission must be given for any exceptions to the graduation requirement deadline. It is the student’s responsibility to know the requirements for completion of the senior program and the requirements for the awarding of the medical degree/graduation. Failure to complete all requirements by the May 1\textsuperscript{st} deadline may delay a student’s application for a temporary license, which may mean that the student is unable to begin a residency on July 1.

VII. STUDENT RESPONSIBILITY AND REQUIRED EXPERIENCE TRACKING AND CLERKSHIP/ELECTIVE EVALUATIONS

A. It is the student’s responsibility to know the requirements for completion of the senior program, the requirements for awarding the medical degree, the requirements for graduation, and the rules regarding away electives. Do not procrastinate and put off completion of these requirements until the end of your senior year when you have insufficient time to complete them before graduation.

B. In addition, you are required to complete an evaluation of each clerkship and elective course you complete during your clinical years. This requirement applies to both junior and senior elective courses as well as all required junior and senior clerkships. The School of Medicine Administration monitors the educational process with the hope of continually improving it. To that end, The School of Medicine requires the use of online systems to assist the Administration in gathering information regarding case exposure, procedures and assessment of educational programs by students. The policies and procedures for evaluating elective courses will be modified as new or modified online evaluation systems become available.

C. No grade will be recorded by the Office of Records and Registration until the student has completed the evaluation for each clerkship or elective.

D. The School of Medicine may at times require students to complete surveys for ongoing educational research, online educational activities for regulatory compliance (e.g., HIPAA, Universal Precautions, etc.) or other activities not listed or announced previously. Once these are announced via email or other means, students will do everything possible to complete the requirement in a timely fashion.

VIII. NEEDLESTICKS AND OTHER EXPOSURE TO BODY FLUIDS

During the course of a medical student’s education, he or she will come into contact with occupational hazards as a natural consequence to caring for sick patients. Medical students are at particular risk for needlestick injuries and other sharp injuries, since because they are in training they may not be skilled in specific procedures being performed. At all times, if a student is uncomfortable performing an assigned procedure because of the perception that his or her skills are inadequate or that supervision will not be adequate, then that student MUST refrain from doing the procedure. Never do a procedure you are uncomfortable performing.

It is the obligation of the School of Medicine to formally educate its students regarding the prevention of occupational injuries. In addition, the school has developed programs by which students who are injured or exposed in the course of their training have the knowledge to properly
seek care. Such programs have been formally presented to students in the first, second and third years of the medical school curriculum, most recently at your Year III Orientation. In the event that a student is stuck with a needle or other sharp instrument, or sustains exposure to a body fluid on mucus membranes or non-intact skin, the student must report this to the senior resident or attending physician immediately. A written report must be completed detailing the circumstances of the exposure. The student should also notify his or her counselor of the reported incident.

The medical school has an established relationship with all DMC and all other facilities (hospitals and ambulatory sites) through affiliation agreements, and specific policies must be followed when an exposure or potential exposure has occurred.

A. A student who sustains an exposure to blood and/or body fluids in the course of a clinical assignment at the DMC should go to the Occupational Health Services Section at UHC-4K if the injury occurs between 8:00 am and 4:00 pm. If the injury occurs after hours, the student should go to the DRH emergency room. The student will be promptly evaluated and treated.

B. The DMC Bloodborne Pathogen (BBP) protocol will be followed including source patient testing. The protocol is available for your review with your counselor in the Office of Student Affairs.

C. If antiviral prophylaxis is recommended, the students’ medical insurance co-payments or deductibles will be waived for the first dose and a supply of antiviral prophylaxis medications will be made available until the time of the first follow-up appointment with his or her private physician.

D. If the student is potentially exposed at a non-DMC site, the student must report the incident as above and be medically evaluated as directed by the hospital.

E. All Junior students have been provided at Orientation contact names and phone numbers for each of the hospitals at which medical students could complete their required YR III clerkships. You should keep this list for your potential use during Year IV as well.

Once a student receives care at one of our partner institutions, the student’s health insurance plan will be billed for the full amount of the hospital or clinic charges. The institution agrees to accept as payment in full the amount paid by the student’s insurance for that service. This policy applies only to care of the initial event, and does not implicate any hospital or clinic for ongoing or long-term care regarding an injury, accident or exposure which might occur on any institution’s premises.

IX. PARKING AT ASSIGNED HOSPITALS

Parking is at a premium at many of the hospitals to which you will be assigned or electively rotate. However, some of the hospitals provide contiguous parking in employee lots or structures; check the information at the end of this document and contact the departments to which you are assigned for more information.

Because of a supply-demand mismatch at the Detroit Medical Center Central Campus, contiguous parking in well-lit, safe lots or structures is not always provided by the hospital or department to which you are assigned. Students should understand that WSU does not control the lots and structures owned by the DMC and its member Hospitals. This year the DMC has indicated that they will only be able to provide afternoon and overnight parking for students assigned to the DMC for clerkships and electives. No parking will be available for students in DMC lots or structures.
during the day. Student vehicles that are found to be in DMC lots or structures during the day may be subjected to ticketing/towing. In light of this situation, the School of Medicine Administration has arranged to provide parking cards and hang-tags only for Year III and IV students rotating through DMC Central Campus facilities allowing them to park only while on these rotations in the SOM parking lot on Canfield across the street from Scott Hall (the “Flat Lot”). Students may park in this WSU lot for as long as necessary while on these rotations with the ability to enter and leave the lot an unlimited basis. While not optimal, this is a much safer alternative than parking on the street. The School of Medicine STRONGLY advises all students to avoid parking on public streets at any time.

The WSU parking cards and tags will be distributed either by the WSU department to which students are assigned or through the WSU Records and Registration Department. Failure to return parking cards and tags immediately upon completion of a rotation or elective may lead to the imposition of late fees and/or administrative sanctions being applied to the student. Please see above requirements for graduation.

X. REQUESTS FOR EXCUSED ABSENCES FOR RELIGIOUS HOLIDAYS AND OTHER ABSENCES

The School of Medicine recognizes and appreciates the diverse cultural and religious backgrounds of its students. Approved religious holidays are listed on the Year III schedule found elsewhere in this document. Everyone is off on those days, and you are not required to be at your YR III clerkships on those days. However, there are no official days off during your junior and senior electives. For students on electives, all days off are determined by the clinical service to which you are assigned for each month.

Requests for time away from clerkships and electives for other religious holidays must be submitted in writing to the clerkship or elective director on the first day of the clerkship, with a copy of the request also forwarded by the student to his or her counselor in the Office of Student Affairs. Leavess may not be granted by the Clerkship Director or Elective Coordinator if this policy is not followed.

Your attendance is expected and required at all other times by the faculty and the Clerkship Director or Elective Coordinator for satisfactory completion of each clinical clerkship or elective. Not appearing for clinical responsibilities and assignments is unprofessional as well. Indeed, unexcused absences could severely effect your grade; as detailed elsewhere in the policies and procedures for each clerkship, a clerkship or elective may fail you if you do not show up for an assigned activity, miss call, etc.

If for any reason you miss clinical time for illness, family emergency, weather delays, etc., you should immediately notify your supervising resident/faculty member or site coordinator and the Clerkship Director or his/her designee. Having notified these individuals, it is still the student’s responsibility to obtain an approved/excused absence from the Office of Student Affairs. To do so you must contact the Assistant Dean of Student Affairs or your counselor. When you return even from an excused absence, it is always a good idea to discuss making up the missed clinical time with the Clerkship.
SNOW DAYS:

Year III students observe all snow day closures posted by the University. If the University is closed, Year III students do not come to work.

XI. CHANGES TO THESE CURRICULUM GUIDELINES

Changes may be made to these guidelines for the junior and senior clinical curriculum at any time. The administration will notify you by e-mail when a change has been made. You should periodically check your e-mail and the web page for possible changes to these policies and procedures. It is your responsibility to keep up with the policies as they may change through the academic year.

XII. OTHER IMPORTANT INFORMATION

The following pages detail the School of Medicine policy on Duty Hours and Working Environment and the Clinical Student Dress and Grooming Standards. Please review these documents carefully. Also included are documents with contact information for the various Clerkship Directors and other important information regarding Hospitals where you will spend your clinical time.
Duty Hours and Working Environment Policy
Wayne State University School of Medicine

Adapted from the WSU/DMC Graduate Medical Education Graduate Trainee Duty Hours and Working Environment Policy

DUTY HOURS

1. Duty hours are defined as all educational activities in clerkships and electives during the third and fourth years of the medical school curriculum, including inpatient and outpatient care, administrative activities related to patient care (charting, discharge planning, transfer planning, etc.), and scheduled educational activities such as conferences, rounds, etc. Duty hours do not include reading and preparation time spent away from the duty site.

2. Both students and their supervising attending faculty and residents are reminded that medical students are here in an educational capacity. They are not on the floors, clinics, etc. to provide indispensable patient care. Consequently, there may be times when the educational requirements of the program dictate that patient care time be curtailed, in order to allow students to attend scheduled conferences, lectures and other required educational activities. An example of this would be to provide students the opportunity to sleep at night to allow them to attend scheduled required lectures the next day. It is also emphasized that the 16 hour continuous duty rule (see below ‘On-Call Activities’) allows for up to 20 continuous hours of duty as long as 16 are limited to patient care, with the other 4 hours only for educational activities and 10 hours between shifts.

3. Duty hours must be limited to 80 hours per week, averaged over a four week (one month) clerkship or elective. These 80 hours include in-house call activities.
   a. For example, a student may work 90 hours in one week, 60 hours in the next week, and two 75 hour work weeks during a 4 week (one month) clerkship. The average of 75 hours per week satisfies the above rule.
   b. Two 90 hour work weeks and two 70 hour work weeks also satisfy the above rule.

4. Students must be provided with 1 day off in 7, free from all educational and clinical responsibilities, averaged over a four week (one month) clerkship or elective, inclusive of call.
   a. For the purposes of this Policy, four week periods of a clerkship are treated the same as a one month elective.
   b. For two month clerkships, the rules stated herein apply to each of the four-week (one month) portions of the clerkship.
   c. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.
   d. For example, a student is required to work from Monday through the following Friday 12 days and then gets the entire following weekend is off. The two days off that weekend satisfies the requirement that the student has one day off in 7.

5. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.
ON-CALL ACTIVITIES

The objective of on-call activities is to provide medical students with continuity of care experiences and additional patient care experience that would not be available during a regular work day. On-Call activities that do not meaningfully provide for this objective should be critically evaluated.

1. In-house call is defined as those duty hours beyond the normal work day when students are required to be immediately available in their assigned institution.

2. In-house call must occur not more than every third night, averaged over a four-week (one month) clerkship or elective.

3. Continuous on site duty, including in-house call, must not exceed 16 consecutive hours. Students may remain on duty for up to six (4) additional hours after this 16 hour period to participate in didactic or other educational activities.
   a. No new patients may be assigned after 16 hours of continuous duty.

4. If students’ educational programs demand that they be available later in the day (e.g., lectures that begin in the afternoon), they must have at least four hours of uninterrupted sleep during their call shift. The four hour sleep ‘resets’ the 16 hour clock and allows students to stay through the conclusion of these late afternoon didactic or other educational sessions.

RESPONSIBILITY

The primary responsibility for monitoring and enforcing these regulations rests with the Clerkship Directors and Elective Coordinators/Preceptors. These physicians, in turn, are expected to promulgate these Duty Hours to all faculty and resident physicians who supervise and interact with medical students. At each clinical site, the site coordinators in the clerkship have this responsibility on a day-to-day basis. The Assistant Dean for Clinical Curriculum has ultimate responsibility for all aspects of these regulations.

REQUESTS FOR EXCEPTION

A clerkship or educational program wishing to request an exception to this Policy must submit a written proposal describing the educational rationale for the request to the Assistant Dean for Clinical Education, Wayne State University School of Medicine.

Final Version, October 2011
Clinical Student Dress and Grooming Standards
Wayne State University School of Medicine

OBJECTIVE

To promote a neat, clean, professional, and business like appearance consistent with preserving and enhancing the image of the Wayne State University School of Medicine, while assuring that attire is not hazardous or offensive to patients and employees.

SCOPE

All Wayne State University School of Medicine students assigned to inpatient or outpatient (including ambulatory sites, private offices, etc.) patient care areas.

POLICY

All students shall maintain personal appearance standards that are consistent with the image of a health care professional, and comply with all infection control, legal, and safety requirements.

UNIVERSAL PERSONAL APPEARANCE STANDARDS

1. Clothing should be of appropriate size and fit permitting freedom of movement. All personal clothing should be clean, neat, and of appropriate length with finished hems. Thighs, breasts and cleavage must be covered. Tucking pant legs into socks is not permitted.

2. Undergarments must be worn at all times, and color and/or design must not be visible through clothing. Socks or hosiery must be worn. Bare legs and feet are not acceptable.

3. A short white coat with appropriate School of Medicine identification (embroidery) is to be worn at all times during patient care activities, unless the student’s duties require wearing other items such as scrub clothing in the operating or delivery room.

4. Hair is to be neat and clean. Long hair must be so styled and/or restrained so as not to interfere with work performance, safety and infection control. Hair may not obscure vision or come in contact with patient or other surfaces. Head coverings mandated by religious beliefs are acceptable. Mustaches and beards must be clean and neatly trimmed.

5. Fingernails must be kept short (i.e., not to exceed 1/4 inch past the fingertip) and clean. Chipped nail polish or enhancements such as jewels may not be worn. Nail enhancements of any kind (e.g., wraps, acrylics, gels and stones) may not be worn in the Operating Rooms, Same Day Surgery, Intensive Care Units (for example, ICU, BMT, Burn unit, NICU, PICU, pheresis), step-down ICU units, or other areas where invasive procedures are routinely performed or when procedures require a surgical scrub. (CDC Guideline for Hand Hygiene in Health-Care Settings. MMWR 51(RR16); 1-44: 2002).
6. Jewelry must not create a hazard to self or others, and should be kept to a minimum. Visible adornment with tattoos or body paint is not acceptable. No visible ornamental piercing except for ears. **No bracelets are to be worn by students while engaged in patient care activities.**

7. **School of Medicine and/or appropriate Hospital Identification (Badges) must be worn at all times, on the upper chest or shoulder area, while on duty.** Full name and photo must be visible. Badge holders/lanyards must not interfere with patient care activities and be worn above waist level.

8. Shoe covers, where required, must be removed when leaving the patient care area.

9. Makeup should be appropriate for office daytime wear. Perfume and scented after-shave lotion must not be worn due to the health risk to others.

10. Personal headphones or personal cell phones are not to be used or worn while on duty in direct care of patients. Personal beepers may be worn, but must be on vibrating (non-audible) mode and must not be visible.

11. **Non-Direct Care Activities:** Unless otherwise directed, casual business wear may be worn while in orientation, or at other educational offerings. This includes appropriate shoes/hose. However, if a portion of the day is spent in the clinical area, the above guidelines regarding dress and grooming then apply.

12. **Off-Site Functions:** Wayne State University School of Medicine Clinical Student Dress and Grooming Standards must be adhered to when employees or contract employees represent the DMC at any outside conferences, community outreach functions, and other professional/educational events.

13. The following types of clothing are not permitted:
- Jeans or clothing of denim-like material
- T-shirts (without hospital approved design or logos)
- Sweatshirts, sweatpants, or jogging suits
  
  *Exception: Staff may wear sweatshirts with hospital approved logo-site specific. Personal Trainers at RIM wear RIM Logowear warm-up suits.*
- Shorts or Capris
- Tank or tube tops
- Military fatigues
- Stretch pants, spandex, stir-up pants
- See-through or revealing clothing
- Exercise apparel
- Mini-skirts or mini-dresses (mid-thigh) or slit above mid-thigh
- Leather
- Excessive or inappropriate jewelry
- Sunglasses
- Open toe shoes or sandals

**SPECIALTY AREAS**

1. Approved hospital-provided and laundered scrubs are to be worn in designated areas only. These include, but are not limited to, the Burn Center (DRH), Labor and Delivery, LDRP, Dialysis and Perioperative areas.
2. Refer to site or department policy for students assigned to the Rehabilitation Institute of Michigan, and Psychiatric or Chemical Dependency areas.

**RESPONSIBILITY**

1. Each student is responsible for maintaining an appearance consistent with this policy. It is the responsibility of School of Medicine Administration, in conjunction with resident and attending faculty along with administration of all assigned health care institutions, to assure compliance with these guidelines.

2. Resident and Faculty, or the student’s counselor from the Office of Student Affairs, are expected to counsel students who wear inappropriate or unsafe clothing.

3. Students repeatedly arriving at work in apparel deemed unacceptable or unprofessional will be sent home for more appropriate attire. Students may then be required to make up time missed from clinical activities.

4. If the student does not respond to counseling, he or she will be referred to the Professionalism Committee for further action.

5. Faculty and resident physicians to whom students are assigned may make exceptions to the above policy for specific purposes and events.
Student Mistreatment Policy

Wayne State University School of Medicine

The school adheres to the professional standards of behavior established by the Association of American Medical College. These standards of behavior prohibit behavior by faculty, staff and students which results in perceived or real incidents of inappropriate behavior or mistreatment. Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender, sexual orientation, physical handicap or age; humiliation, psychological or physical punishment and the use of grading and other forms of assessment in a punitive manner. When such perceived or real incidents occur, students are to report such incidents to the Office of Student Affairs. The University’s Office of Equal Opportunity investigates and responds to all reported incidents.

Sexual Harassment Statute and Policy

Wayne State University

It is the policy of Wayne State University that no member of the University community may sexually harass another. Any employee or student will be subject to disciplinary action for violation of this policy.

The law of the State of Michigan prohibits discrimination in employment and in education and provides that discrimination because of sex includes sexual harassment, which means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communication of a sexual nature when:

(a) Submission to such conduct or communication is made a term or condition either explicitly or implicitly to obtain employment, public accommodations or public services, education, or housing.

(b) Submission to or rejection of such conduct or communication by an individual is used as a factor in decisions affecting such individual's employment, public accommodations or public services, education, or housing.

(c) Such conduct or communication has the purpose or effect of substantially interfering with an individual's employment, public accommodations or public services, educational, or housing environment. (MCLA 37.2103 (h))

In the area of speech, what the law and this policy prohibit is speech as action: that is, sexual communication which is either directly coercive as demanding favors, or indirectly coercive, as rising to that level of offensiveness which interferes substantially with the victim's education or employment. The determination of what level of offensiveness is actually coercive, and therefore unlawful and prohibited by this policy, will in some cases be difficult. A significant element in the determination is provided by the fact that an unequal power relationship underlies sexual harassment. The more unequal the relationship, the greater the risk is of substantial interference with the victim's education or employment.

In the area of physical contact, physical contact which is unwelcome is so gravely offensive that it always has the effect of substantially interfering with the victim's employment or educational environment. Employees and students should not take for granted that they are welcome to touch
other employees or students, since if their contact is in fact unwelcome, they will be in violation of the law and of this policy. (WSUCA 2.28.06.010-2.28.06.080)
<table>
<thead>
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<th>CLERKSHIP DIRECTOR</th>
<th>CLERKSHIP</th>
<th>CONTACT PERSON</th>
<th>PHONE #</th>
<th>1st DAY LOCATION &amp; TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARGIT CHADWELL</td>
<td>FAMILY MEDICINE</td>
<td>LISA BLACKWELL</td>
<td>577-0878</td>
<td>Instructions will be forthcoming from department.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:lblackwe@med.wayne.edu">lblackwe@med.wayne.edu</a></td>
<td>577-2710 Fax</td>
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</tr>
<tr>
<td>DR. DIANE LEVINE</td>
<td>INTERNAL MEDICINE</td>
<td>CARMAN MCINTOSH</td>
<td>745-4984</td>
<td>Instructions will be forthcoming from department.</td>
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<td></td>
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<td>cm <a href="mailto:McIntosh@med.wayne.edu">McIntosh@med.wayne.edu</a></td>
<td>745-4052 Fax</td>
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<tr>
<td>DR. RENEE DWAIHY</td>
<td>CONTINUITY CLINIC CLERKSHIP</td>
<td>KAREN JANAS</td>
<td>577-1450</td>
<td>Instructions will be forthcoming from department.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:kjanas@med.wayne.edu">kjanas@med.wayne.edu</a></td>
<td>577-1457 Fax</td>
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<tr>
<td>DR. CHRISTOPHER STEFFES</td>
<td>SURGERY</td>
<td>NANCY LINENGER</td>
<td>916-2879</td>
<td>Instructions will be forthcoming from department.</td>
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<td></td>
<td></td>
<td><a href="mailto:nlinenge@med.wayne.edu">nlinenge@med.wayne.edu</a></td>
<td>916-8312 Fax</td>
<td></td>
</tr>
<tr>
<td>DR. YVONNE FRIDAY</td>
<td>PEDIATRICS</td>
<td>LYNN SCOTT</td>
<td>745-5751</td>
<td>Instructions will be forthcoming from department.</td>
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<td></td>
<td></td>
<td><a href="mailto:lscott@med.wayne.edu">lscott@med.wayne.edu</a></td>
<td>993-7118 Fax</td>
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</tr>
<tr>
<td>DR. MARY MORREALE</td>
<td>PSYCHIATRY</td>
<td>YOLANDA PITTS</td>
<td>577-3130</td>
<td>Instructions will be forthcoming from department.</td>
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<td></td>
<td></td>
<td><a href="mailto:ypitts@med.wayne.edu">ypitts@med.wayne.edu</a></td>
<td>577-2233 Fax</td>
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</tr>
<tr>
<td>DR. SATINDER KAUR</td>
<td>OB/GYN</td>
<td>CATHY RUTKOWSKI</td>
<td>993-4032</td>
<td>Hutzel Women’s Hospital -4th Fl Hudson Building, Morse Aud., 8:00 am</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:crutkows@med.wayne.edu">crutkows@med.wayne.edu</a></td>
<td>993-4116 Fax</td>
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<tr>
<td>DR. M. MAHER FAKHOURI</td>
<td>NEUROLOGY</td>
<td>LASHARA MONTGOMERY</td>
<td>577-1244</td>
<td>University Health Center, Crockett Classroom C or D 8:00 am</td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:lmontgom@med.wayne.edu">lmontgom@med.wayne.edu</a></td>
<td>745-4216 Fax</td>
<td></td>
</tr>
<tr>
<td>DR. SARKIS KOYOUUMJIAN</td>
<td>EMERGENCY MEDICINE</td>
<td>WILLIE JOHNSON</td>
<td>993-2527</td>
<td>Instructions will be forthcoming from department.</td>
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<td></td>
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<td><a href="mailto:wjohnson@med.wayne.edu">wjohnson@med.wayne.edu</a></td>
<td></td>
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<tr>
<td>DR. JOEL APPEL</td>
<td>AMBULATORY &amp; SUB-INTERNSHIP</td>
<td>SHIRLEY KMETZ</td>
<td>745-4901</td>
<td>Instructions will be forthcoming from department.</td>
</tr>
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<td></td>
<td></td>
<td><a href="mailto:skmetz@med.wayne.edu">skmetz@med.wayne.edu</a></td>
<td>745-4052 Fax</td>
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</tbody>
</table>
CONTINUITY CLINIC CLERKSHIP

YEAR III CURRICULUM GUIDE

2011 -2012

I. KEY PERSONNEL
Course Director
Renee L. Dwaihy, M.D.
Department of Internal Medicine
rdwaihy@med.wayne.edu

Coordinator
Karen Janas
Academic & Student Programs
(313) 577-1450

II. INTRODUCTION
Major changes are taking place in how health care will be practiced in the 21st century. There is an increasing emphasis on disease prevention and patient care in the community-based practice. Managing the care of patients is an evolving process that includes the use of outcome measures and clinical care guidelines to ensure “best practices” with emphasis on prevention, patient education, and continuity of care. It also includes strategies to prevent under- or over-utilization of health services to provide appropriate care while containing costs.

We distinguish managing the care of patients from managed care. Managed care is a market force that has added several features to the principles of managing care including the assumption of financial risks by physicians, the use of physicians as “gatekeepers,” the marketing of plans to selected low-risk patients, reducing utilization of services (especially of specialists), and the use of external vendors for pre-approval and utilization review.¹

The increase in the influence of managed care on the delivery of health care has had several positive effects including the development of databases to measure outcomes and identify unwarranted variations in surgical and other procedures. However, managed care has also created conditions that can inhibit the practice of quality clinical medicine. For example, one recent study found that the only cost advantage associated with managed care came from the denial of services.²

### III. OVERVIEW

The goal of the clerkship is to provide a continuity experience that will introduce the student to the basic skills, knowledge and attitudes necessary to manage the care of patients in an out-patient primary care setting.

The CCC occurs one half day each week during the six month block of the Family Medicine, Internal Medicine, Pediatrics and elective rotations. You will be assigned to a community-based primary care clinic. You must contact your preceptor to arrange your half day per week clinic. It is important to attend clinic on the same day each week in order to be able to see the same patient on return visits. If you cannot reach your preceptor, or experience any other difficulties, please contact Ms. Karen Janas immediately.

Please keep in mind that preceptors are voluntary faculty – they teach because they enjoy working with students. It is mandatory that you attend the orientation session of your first rotation during this block. At orientation you will be provided with the clerkship syllabus, which includes several clinical learning exercises, and the name and contact information for your preceptor.

You will begin your rotation by learning basic terminology, learning about the office environment and about managing patient care issues. Toward the end of this clerkship you will have the knowledge and experience necessary to talk with your preceptor about more in-depth issues such as patient confidentiality, patient expectations, conflict between managing patient care and managed care reimbursement, advanced care planning issues, using electronic evidence-based resources to solve clinical problems and physician/industry interactions, as directed by the appropriate CLEs. These discussions will introduce you to your responsibility as the patient’s primary advocate.

### IV. CLERKSHP REQUIREMENTS

---

¹ Kuttner R, Must Good HMO’s Go Bad? NEJM 338(21) 1558-63 May 1998
A. One half day each week must be spent in the preceptor’s office. It should be the same half day each week so that patients may be scheduled for return visits when you are in the office.

B. Students must attend a minimum of 18 of the possible 23 sessions. This allows some flexibility for you to complete out-of-town clerkships, take exams, study days, etc.

C. Students must complete and turn in at the end of the clerkship:
   - Attendance Log, with attendance documented for 18 visits
   - Patient Log
   - Completed Clinical Learning Exercises
   - The student evaluation of the preceptor and site

D. Students must take the written final exam.

V. GRADING

A. This is a PASS/FAIL course with a final grade of SATISFACTORY or UNSATISFACTORY. There is no ‘HONORS’ grade.

B. The SATISFACTORY grade is based on:

1. Preceptor’s satisfactory evaluation: the preceptor will complete a preliminary evaluation at the midpoint of the clerkship and a final evaluation at the completion of the clerkship.
2. Final Exam: the final exam will be given at the end of the CCC block (December or June).
3. Completion of the above clerkship requirements. Failure to meet the clerkship requirements, including timely submission of completed assignments and the attendance log may result in additional assignments, a deferred grade, or a grade of UNSATISFACTORY.
DEPARTMENT OF FAMILY MEDICINE
&
PUBLIC HEALTH SCIENCES

YEAR III FAMILY MEDICINE CLERKSHIP
CURRICULUM GUIDE

WAYNE STATE UNIVERSITY
SCHOOL OF MEDICINE

2011-2012
KEY PERSONNEL

Margit Chadwell, MD, FAAFP
Clerkship Director
(313) 577-8867
mchadwel@med.wayne.edu

Ms. Lisa Blackwell
Program Project Assistant
(313) 577- 0878
lblackwe@med.wayne.edu

INTRODUCTION
The Family Medicine Clerkship provides a four-week experience in community-based ambulatory primary care. The unique nature of this Clerkship arises from the variability of presenting conditions seen in Family Medicine. A patient of any age may present with any condition, from newborns with acute diseases to adolescents with behavioral issues to adults with acute and chronic diseases to the elderly who may present without any health problems! You will experience not only variety in patient experiences, but will also experience how diagnostic and preventive medicine procedures are utilized in ambulatory patient care. You will also have an opportunity to practice primary prevention in the outpatient clinical setting.

This will be a rich and rewarding month. During this clerkship you will be expected to complete several exercises with patients including behavioral risk factor interventions. In addition you will visit a hospice facility, interview a hospice patient, and discuss these experiences in a “debriefing” session. Finally you will be provided with a series of didactic presentations and discussions of related patient cases that are relevant to common problems seen in the ambulatory Family Medicine setting.

CLERKSHIP REQUIREMENTS

- You are expected to conform to professional standards during this four-week clerkship in a community practitioner’s office. These standards include timely attendance, appropriate attire and professional behavior.

- Any absences during the Clerkship must be reported immediately by the student to his/her preceptor, the Clerkship Director/Coordinator, and their counselor in the Office of Student Affairs. Failure to provide timely notification of an absence from the Clerkship may result in a grade of Incomplete or Unsatisfactory for the Clerkship and may result in the student being required to complete additional days at the clinical site.
In addition to attendance at your practitioner’s office, you are required to attend:

- Clerkship Orientation – 8:30 AM – 12:00 PM on the first day of the clerkship (3939 Woodward, second floor conference room). All Clerkship students, including those who will be working at locations outside of the Detroit Metropolitan Area MUST attend Orientation on the first day of the Clerkship!
- Assigned Wednesday afternoon case discussions (unless your scheduled Continuity Clinic Clerkship or hospice day occurs on Wednesday afternoon).
- Assigned Hospice visit
- Hospice debriefing
- NBME Shelf Examination

- You must satisfactorily complete and turn in all Clerkship written assignments as described in your Clerkship syllabus.
- You must comply with the requirements for campus mobility documentation of your patient encounters during the Clerkship as described in the syllabus.
- You must obtain a grade of Satisfactory on the Examination
- You must obtain a Satisfactory Final Clinical Evaluation

Failure to meet these Clerkship requirements may result in additional assignments, a deferred grade, or a grade of unsatisfactory.

PROCEDURAL ISSUES

- If you are assigned to the VA or DMC, you should submit an online application https://apps.med.wayne.edu/ssonew/ for your Clerkship site no later than four weeks prior to the scheduled start of your Family Medicine Clerkship. We will do our best to assign a preceptor of your choice, but please realize that it is not always possible to do so.
- Clerkship written assignments are due by 4:00 PM on the day of the Shelf Examination at 3939 Woodward. Assignments may be given to the Family Medicine proctor at the Exam.
- Any questions regarding the Clerkship should be directed to Dr. Margit Chadwell or Ms. Lisa Blackwell.

RURAL TRACK and OUT-STATE STUDENTS ONLY

- You must submit an online application https://apps.med.wayne.edu/ssonew/ for your site placement at least eight weeks in advance of the beginning of the clerkship.
- Orientation is mandatory.
- Day two (the day after orientation) may be used as a travel day, however, arrival at your site by the next day is expected.
- The last Thursday of the clerkship (the day before the exam) may also be a travel day.
- Students are encouraged to arrange a hospice experience through their preceptor.
- Students do not attend CCC during the clerkship
- Students don’t attend Wednesday Didactics/Case Discussions (instead review core cases in the syllabus on family medicine cases).

CLERKSHIP EVALUATION

Student evaluation of the Clerkship must be turned in at the end of the course with other written assignments.

STUDENT EVALUATION AND FEEDBACK

Evaluation of student performance in the Clerkship will be based on the following criteria:

1. **Clinical Assessment**
   
   School of Medicine Clinical Performance Evaluation forms will be completed and signed by the physician(s) to whom the student was assigned and by whom the student was observed. The Clerkship Director will assign a Final Clinical Evaluation score based on the Clinical Performance Evaluation form(s) submitted.

2. **The Final Examination**
   
   The final examination is a standardized National Board of Medical Examiners Subject (“Shelf”) Examination. The examination includes questions on all aspects of Family Medicine, including obstetric, gynecology, and pediatric problems. It will be scheduled through the Office of Academic and Student Programs in a Scott Hall Auditorium.

GRADING CRITERIA

**CLINICAL ASSESSMENT**

Clinical Honors: all of the following criteria must be met:

A. At least 3 of the 5 critical competencies (Application of Knowledge in the Clinical Setting, Taking a History, Performing a physical Exam or Mental Status Exam, Communication and Relationships with Patients and Family, and Professional Attributes and Responsibilities) must be rated as “Outstanding.”

B. Including the critical competencies, at least 70% of all competencies are graded as “Outstanding” (i.e. depending on whether or not the preceptor feels Competency 9 (Facility with Technical Skills and Procedures) is applicable or not, 7 of 11 or 7 of 10 competencies).

C. There can be no competencies rated as “Below Expectations.”

**Clinical Unsatisfactory:** ANY of the following are criteria for “Unsatisfactory”
A. “Below Expectations” in any of the 5 critical competencies listed above.

B. Three or more of any competencies evaluated as “Below Expectations.”

THE FINAL EXAMINATION

Honors:
To achieve “Honors” on the clerkship examination, you must achieve a score of 81 or above.

Satisfactory:
A score of 60-80 on the clerkship examination will result in an examination grade of “Satisfactory.”

Unsatisfactory:
A score of 59 or below will result in an examination grade of “Unsatisfactory.”

COURSE GRADE

Honors:
Honors on the examination and Honors on the Final Clinical Evaluation, as well as meeting all Clerkship requirements.

Satisfactory with a Letter of Commendation:
Honors on the examination and Satisfactory on the Final Clinical Evaluation, as well as meeting all Clerkship requirements, OR Satisfactory on the examination and Honors on the Final Clinical Evaluation, as well as meeting all Clerkship requirements.

Satisfactory:
A Satisfactory grade on the examination, a Satisfactory evaluation on the Final Clinical Evaluation, and completion of all Clerkship requirements.

Unsatisfactory:
Fails to meet requirements for Satisfactory.

APPEAL PROCESS

Refer to Year 3 Curriculum Guide to the appeal process.

Under no circumstances is a student to approach a clinical preceptor to discuss a change in a clinical evaluation. If a student approaches his or her preceptor regarding a change in evaluation, the appeal process will be null and void. All appeal requests should be directed to Ms. Lisa Blackwell within 30 days of receiving official notification of the Clerkship grade.
INTERNAL MEDICINE
CLERKSHIP
CURRICULUM GUIDE
2011-2012
# INTERNAL MEDICINE CLERKSHIP SYLLABUS

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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 and Vice Chair for Education  
Associate Professor of Medicine  
Department of Internal Medicine  
Wayne State University School of Medicine
## 2010-2011 Year III Schedule/Calendar

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<tr>
<th>Event</th>
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<tr>
<td>Registration</td>
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<td>Academic Year Begins:</td>
<td>Thursday, June 30, 2011</td>
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<td>Orientation:</td>
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<td>Independence Day Recess:</td>
<td>Monday, July 4, 2011</td>
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<td>Clerkship/Clinical Campus Orientation:</td>
<td>Tuesday, July 5, 2011</td>
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<td>Labor Day Recess:</td>
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<td>Thanksgiving Recess:</td>
<td>Thursday &amp; Friday, November 24-25, 2011</td>
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<td>Clerkships/Elective Resume:</td>
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<td>Martin L. King Day Recess:</td>
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<td>Memorial Day Recess:</td>
<td>Monday, May 28, 2012</td>
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<td>OSCE Examination:</td>
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<tr>
<td>Academic Year Ends:</td>
<td>Sunday, June 17, 2012</td>
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### Two (2) month Clerkships
- **July 5 – August 26, 2011**
- **August 29 – October 21, 2011**
- **October 24 – December 21, 2011**
- **January 3 – February 24, 2012**
- **February 27 – April 20, 2012**
- **April 23 - June 15, 2012**

### ACLS
- **August 11 & 12, 2011**
- **September 22 & 23, 2011**
- **November 10 & 11, 2011**
- **January 26 & 27, 2012**
- **March 22 & 23, 2012**
- **May 17 & 18, 2012**

### OSCE
- **Wednesday, August 3, 2011**
- **Wednesday, September 14, 2011**
- **Wednesday, November 2, 2011**
- **Wednesday, January 18, 2012**
- **Wednesday, March 14, 2012**
- **Wednesday, May 9, 2011**

### Exam Dates
(Exams are given at 1:00 PM)
- **Thursday, August 25, 2011**
- **Thursday, October 20, 2011**
- **Wednesday, December 21, 2011**
- **Thursday, February 23, 2012**
- **Thursday, April 19, 2012**
- **Thursday, June 14, 2012**
### Key Personnel Year III Clerkship Contact Information

#### Department of Internal Medicine - Wayne State University

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Department Chairman</td>
<td>Dr. John Flack</td>
<td>(313) 745-8244</td>
</tr>
<tr>
<td>Clerkship Director</td>
<td>Dr. Diane Levine (11204)</td>
<td>(313) 745-4832</td>
</tr>
<tr>
<td>Clerkship Coordinator</td>
<td>Carmen McIntosh</td>
<td>(313) 966-7680</td>
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#### Detroit Receiving Hospital

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
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<tbody>
<tr>
<td>WSU III/IV Site Director</td>
<td>Diane Levine MD</td>
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</tr>
<tr>
<td></td>
<td><a href="mailto:dllevine@med.wayne.edu">dllevine@med.wayne.edu</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aisha Hadi</td>
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</tr>
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<td></td>
<td><a href="mailto:ahadi@med.wayne.edu">ahadi@med.wayne.edu</a></td>
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<td>Fax: (313) 993-2988</td>
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#### Harper University Hospital

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<tbody>
<tr>
<td>WSU III/IV Site Director</td>
<td>Diane Levine MD</td>
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</tr>
<tr>
<td></td>
<td><a href="mailto:dllevine@med.wayne.edu">dllevine@med.wayne.edu</a></td>
<td></td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>Teresa Maxwell</td>
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</tr>
<tr>
<td>Clerkship Coordinator</td>
<td><a href="mailto:tmaxwell@dmc.org">tmaxwell@dmc.org</a></td>
<td></td>
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<tr>
<td></td>
<td>Dianne Weiland</td>
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</tr>
<tr>
<td></td>
<td><a href="mailto:Dweilan1@hfhs.org">Dweilan1@hfhs.org</a></td>
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#### Henry Ford Hospital

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<th>Position</th>
<th>Name</th>
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<tbody>
<tr>
<td>WSU III Site Director</td>
<td>Dr. Kelly Caverzagie, Interim</td>
<td>(313) 593-7872</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:kcaverz1@hfhs.org">kcaverz1@hfhs.org</a></td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td>Monica Lacoursiere</td>
<td>(313) 593-7872</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Mlacour1@hfhs.org">Mlacour1@hfhs.org</a></td>
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<td></td>
<td>Dianne Weiland</td>
<td>(313) 593-7119</td>
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<td><a href="mailto:Dweilan1@hfhs.org">Dweilan1@hfhs.org</a></td>
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#### Oakwood Hospital

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<tr>
<th>Position</th>
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<tbody>
<tr>
<td>WSU III/IV Site Director</td>
<td>Dr. Falgun Patel</td>
<td>(248) 849-4719 office</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:patelf@oakwood.org">patelf@oakwood.org</a></td>
<td>(248) 367-1443 text pager</td>
</tr>
<tr>
<td>Medical Student Coordinator</td>
<td>Kathleen Summers</td>
<td>(313) 593-7872</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Summerk3@oakwood.org">Summerk3@oakwood.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marianne Soroka</td>
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<tr>
<td></td>
<td><a href="mailto:Marianne.soroka@oakwood.org">Marianne.soroka@oakwood.org</a></td>
<td></td>
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<tr>
<td></td>
<td>Dawn Beutner</td>
<td>(313) 593-7119</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:beutnerdi@oakwood.org">beutnerdi@oakwood.org</a></td>
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#### Providence Hospital

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<tbody>
<tr>
<td>WSU III/IV Site Director</td>
<td>Dr. Valerie Overholt, DO</td>
<td>(248) 849-5665</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:valerie.overholt@stjohn.org">valerie.overholt@stjohn.org</a></td>
<td>(248) 367-1443 text pager</td>
</tr>
<tr>
<td>Medical Student Coordinator</td>
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</tr>
<tr>
<td></td>
<td><a href="mailto:Sonja.Brown@stjohn.org">Sonja.Brown@stjohn.org</a></td>
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<td>Fax: (248) 849-3931</td>
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**Sinai-Grace Hospital**

WSU III Site Director  
Dr. Marc Feldman  
[mfeldman@dmc.org](mailto:mfeldman@dmc.org)  
Pager: 1556

WSU IV Site Director  
Dr. Joel Appel (3092)

Secretary  
Pam Nelson-Jones  
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**St. John Hospital**

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**St. Joseph Ann Arbor**

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Medical Student Coordinator  
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**Veterans Administration Hospital**

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Pager (313)250-1816

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House Staff Coordinator  
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Fax (313) 576-3624

**William Beaumont Hospital**

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Secretary  
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Coordinators  
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Monica Demres  
[monica.demres@beaumont.edu](mailto:monica.demres@beaumont.edu)
INTERNAL MEDICINE CLERKSHIP - SITE ORIENTATION INFORMATION

Detroit Receiving Hospital—Report at 12:00 PM to KEI Auditorium at the Kresge Eye Institute for DMC Campus Longitudinal Educational Series. After conference report to Aisha Hadi in the 5S 10 Department of Internal Medicine offices for team assignments. For further questions please contact Aisha at (313) 745-3265.

Harper University Hospital - Report at 12:00 PM to KEI Auditorium at the Kresge Eye Institute for DMC Campus Longitudinal Educational Series. After conference report to Teresa Maxwell at 1:00pm on 2 Hudson room 2911. For further questions please contact Teresa Maxwell at (313)745-8334.

Henry Ford Hospital—Report for Orientation at 12:15. Please park in Lot 8 on Amsterdam and take the shuttle to the hospital. For further question please contact Dianne Weiland at (313) 916-1465.

Oakwood—Student report at 1:00 PM to Kalman Auditorium. Students will be notified via email by Kathleen Summers/Marianne Soroka-Martin as to where and what time to report. Please park in the Old Ford Lot (Located across from the hospital behind St. Martha’s Church). For further questions, Kathleen or Marianne can be reached at (313) 593-7872.

Providence—Report to Michelle Brown at 1:00 PM at 16001 W. Nine Mile Rd Room 415, 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 Professional Medical Bldg. entrance. Signs to direct you to the Fisher Building, Elevator C. Proceed to the 4th Floor, Medical Education. For further questions call (248) 849-5665.

Sinai-Grace—Report to Pam Nelson-Jones at 1:00 pm at 6071 W. Outer Drive, in the main hospital. The student parking lot is located on Schafer Avenue right across the street from the visitor's parking lot. Proceed to the 4th floor; follow sign to Dept. of Medicine. Prior to the start day a welcome letter with further information will be forwarded to your WSU email. Any questions Pam Nelson-Jones can be reached at 313.966.1728 or 313.966.3250.

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 - Students will be notified via email by Valbona Kociaj Cook, WSU Student Coordinator, as to where and what time to report. Please park in the West parking structure on the 2nd level or higher. For further questions, please contact Val at (313) 343-3576.

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 Beverly Greene at 1:00 pm in B3243. For further questions please contact Beverly at (313) 576-3334.
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.

OVERAL GOAL

The overall goal of the clerkship in Internal Medicine is to understand and obtain practical experience in the recognition, evaluation, diagnosis and management of adult patients with acute medical illnesses.

During this rotation you will learn

1. To develop familiarity with the common problems seen by internists in the hospital setting.
2. To evaluate and manage sick hospitalized patients.
3. To understand the role of the general internist in providing care within a health system and coordinating care and transitions of care for hospitalized patients.

At the end of the Internal Medicine Clerkship third year medical students should have a well-developed foundation in the in-patient setting.

LEARNING OBJECTIVES

Medical knowledge: To develop in depth knowledge of diseases and presentation of adult patients.

- Students will develop familiarity with the **CORE PROBLEMS** in Internal Medicine listed below. (MK)

Abdominal pain  
Altered mental status  
Anemia  
Chest pain syndromes  
Cough  
COPD/obstructive airways disease  
Diabetes Mellitus  
Dyspnea  
Fever  
Fluid, electrolyte, and acid-base  
Gastrointestinal bleeding  
Heart Failure
Patient Care: To develop and refine basic clinical skills required to provide effective, efficient, and safe in-patient care.

- Students will be able to obtain an accurate Medical History and perform a thorough Physical Examination **in an efficient and timely manner.** (PC)

- Students will be able to compose an accurate, complete and well-organized patient note (H&P, progress note) **documenting the patient’s status and daily progress.** (PC)

- Students will able to interpret the results of basic clinical information **including diagnostic tests and imaging studies** and determine how the results should influence patient evaluation and management (MK, PC).

- Renal function and Acid base and electrolyte disturbances

- Students will be able to identify **diagnostic gram stains** and recognize common pathogens.

- **Peripheral smears and CBCs** with an emphasis on approach to **anemias**

- **Liver function tests** including
  - Interpretation of tests of synthetic function
  - Abnormalities of cholestasis and inflammation

- **Basic electrocardiograms (EKGs) interpretation including**
  - Determination of rate, rhythm, axis, and intervals
  - Recognition of **arrhythmias**, **AV blocks**, **ventricular hypertrophy**; **bundle branch blocks**, ischemia/infarction, and **electrolyte disturbances**.

- Students will be able to recognize **normal landmarks on chest radiographs**, and be familiar with the radiographic findings in the following conditions:
  - Atelectasis
  - CHF
  - Masses/Lung Cancer
  - Pneumonia
  - Pneumothorax
  - Pneumonia
  - Pneumothorax
  - Tuberculosis

- Students will begin to **develop diagnostic decision-making skills that incorporate probability-based thinking and evidence based medicine.** (MK, PC, PBL)

- Students will **develop therapeutic decision-making** skills that incorporate pathophysiologic reasoning and evidence-based knowledge. (MK, PC, PBL) Students will be able to demonstrate accurate and organized written and oral presentations **of new admissions and follow up patients.** (PC, C)
Practice Based Learning: To develop and practice a commitment to self-directed learning.

- Students will **demonstrate curiosity, take initiative for their own learning and read about their patients in real-time.** (PBL, P)

- Students will **demonstrate the ability to access and efficiently utilize information systems and resources to learn about and from their patients.** (PBL)

**Communication Skills:** To develop effective communication skills to allow for the safe care of patients by the health care team.

- Students will **demonstrate proficiency in communication** with patients, families, physician colleagues and members of the extended healthcare team. (CS, P)

- Students will **demonstrate listening skills** to allow them to **gather information, process and address patients, families and health care team members concerns.** (PC, CS, P)

- Students will **recognize how patients, family members, physicians, and healthcare team members’ preferences and actions are affected by ethnic, cultural, and psychosocial factors.** (PC, CS)

Professionalism: To develop professional behavior demonstrating honesty and integrity in all professional activities.

- Students will demonstrate **professional behaviors** as they learn to deliver professional care. (P)

- It is unethical to copy and paste another person’s documentation. Students **will complete their own notes** accurately and objectively record all patient data. (P)

- Students will demonstrate respect for patients’ privacy when dealing with protected information. (P)

- Students will demonstrate respect for all members of the healthcare team. (P)

- Students will seek feedback and respond appropriately and productively to improve performance. (P, CS)

- Students will complete all learning assignments on time. (P)

**Systems Based Practice:**

- **Students will work with members of the health care team** including nurses, social worker/case managers/discharge planners etc. **to provide patient care** (CS, P, SBP)

- **Students will participate in coordination of care** working with healthcare providers and physicians from other services and health care setting including outpatient physicians. (CS, SBP)

- Students will **recognize the importance of ensuring smooth transitions of care** including acceptance of patients from the Emergency Department, signing out patient care and responsibility to the call team, transfer of patients to other services, and disposition and discharge of patients. **Students will participate in discharge planning and in the process of patient discharge.** (PC, SBP)
- Students will develop familiarity with the principles of **patient safety and health care quality** and learn to **recognize opportunities to prevent adverse events and medical errors.** See **patient safety curriculum pages 26-32.**

- Students will recognize that **negotiating health systems** is critical to achieving high quality patient care.  

  

### REQUIRED LEARNING ASSIGNMENTS

1. **Complete of assigned SIMPLE cases** (See Appendix E, page 25)

2. **Work up and document new-to-student patient case write-ups with integration of reading and documentation of one reference per case.**  
   (Requirement: **Log minimum of 2 cases/week, 14 cases/clerkship**)  

3. Document **post discharge phone call** for all discharged patients using discharge check-list. (see Appendix D, page 23)

4. Complete **formal didactic presentation** with **minimum of two different sources** answering a clinical question about related to one of your assigned patients (see Appendix for detailed description of presentation).

5. **Completion of assigned Agency for Healthcare Research and Quality (AHRQ) cases.** (See Appendix F, cases can be found on pages 29-32)

6. Participation in **OSCE**

7. Complete of 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 prior to completion of the rotation.

### REQUIRED LOGGING

Students will log cases documenting the experiences defined below. Student will also complete the reflection box commenting on the learning experience

1. Patient presenting with a new complaint
2. Patient presenting with worsening of a chronic medical condition
3. Patient with multiple medical illnesses/issues
4. Patient who is admitted as a consequence of a inability to access primary care
5. Patient with a quality/safety issue
6. Patient you cared for from a different cultural/ethnic background
7. Patient whom you educated about their primary illnesses
8. Patient whom you met with discharge planner/social worker or case manager to discuss discharge planning
9. Patient for whom you coordinated care and contacted the patient’s primary care physician
10. Patient whom you counseled about substance abuse
11. Patient whom you counseled about lifestyle
12. Patient whose life you positively impacted
13. Patient who had a impact on your professional growth
14. Free case ☺
ASSESSMENTS

- Bedside rounds
- Write-ups
- Assigned talk/formal presentation
- Clinical Evaluations by experienced faculty and residents
- Small group discussions
- OSCE
- National Medical Subject Examination (shelf exam)

EXPECTATIONS AND RESPONSIBILITIES

1. All Year III students must report for the **Internal Medicine Clerkship Orientation**.

2. Students will report to their **assigned sites** for a site-specific orientation.

3. **Attendance is mandatory.** Students are excused from ward duties to attend ACLS, the OSCE and for all WSUSOM recognized holidays. Students are excused to attend continuity clinic. Students must notify Student Affairs for all other absences. Extended absences must be made up.

4. **Students are assigned to an inpatient team.** Students are an integral part of the team and must learn to work as a team member.

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

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

7. 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.

8. Students are expected to attend assigned **Year III teaching activities** at each site.

9. **Students are expected to be in the hospital daily and take call as assigned by their site director and team. The nature of call varies depending on the assigned site.**

10. **Students’ duty hours follow** resident duty hours as described under current RRC guidelines. Students may not work more than 80 hours per week and must have an average of one day off in seven. Students may not spend more than 30 hours in the hospital at one time and must have a minimum of 8-10 hours between duty shifts.

12. **Students will complete an H&P on all assigned admissions/newly assigned patients** including patients redistributed from the night float. Students will **write daily progress** notes on all their patients. The H&P and notes should be reviewed with the resident and/or attending physician.

13. **Students are responsible for soliciting feedback and completing the WSUSOM Mid-rotation Self Evaluation form.**

14. **Students must log cases on Campus Mobility** as required by the School of Medicine.

15. Students must attend the Medicine **OSCE**
16. Students must successfully complete ACLS

17. Students must submit all learning assignments by the end of the clerkship.

18. Students will evaluate their resident and attending physicians’ performance and evaluate their site of rotation at the end of the clerkship. This must be done on Black Board.

19. Students must complete an “end-of-clerkship” evaluation on Campus Mobility.

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

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**EVALUATION AND FEEDBACK**

**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 School of Medicine requires students to complete a self-reflective mid-month formative evaluation form. Each student must complete the form and then review with his or her attending physician who must 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.

**OSCE**

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

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.

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**GRADING**

**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.
Assignment of Clinical Grade

The *Clerkship Director* in accordance with the SOM grading policies assigns the clinical grade. Determination of the composite clinical grade is based on the clinical evaluations received and any additional input from the Site Directors.

- **Clinical “Outstanding”**
  
  Students must achieve “Exceeds course expectations” in seven out of eleven competencies on the composite clinical evaluation including three of the first five critical competencies (with no ratings of “fails to meet expectations”) to achieve a final clinical evaluation of “Outstanding.”

- **Clinical “Unsatisfactory”**
  
  Students achieving “Fails to meet course expectations” in any of the five critical competencies, or is rated as “Failed to Meet Course Expectations” in any three of the non-critical competencies will receive a final clinical evaluation of “Unsatisfactory.”

- **Clinical “Satisfactory”**
  
  Students who do not meet the criteria for a clinical grade of “Outstanding” or “Unsatisfactory” will receive a clinical grade of “Satisfactory.”

Assignment of Final Grade

The *final clerkship grade* is based on clinical evaluations, participation in the OSCE and successful completion of ACLS, submission of all required assignments, as well as the results of the shelf exam.

- **Criteria for satisfactory**
  
  To receive a “Satisfactory” students must successfully complete all learning assignments and requirements and receive a “Satisfactory” on the final clinical evaluation and pass the shelf exam.

- **Criteria for commendation (two ways to secure commendation):**
  
  To receive a commendation, students must receive an “Outstanding” on the final clinical composite evaluation and achieve a score of 72 on the shelf exam.

  Students may also receive a commendation if they achieve clinical “Satisfactory” on the final clinical composite evaluation may also receive a commendation if they score one standard deviation above the mean or 82 (whichever is lower) on the shelf exam.

- **Criteria for honors:**
  
  Students must receive a final clinical evaluation “Outstanding” and score at least one standard deviation above the mean or 82 (whichever is lower) on the exam.
Criteria for failing:

Failure to pass either the shelf exam or the clinical rotation will result in an “Unsatisfactory” grade for the clerkship. **Good or superior clinical performance does not compensate for a failing exam score, nor does a high exam score negate unsatisfactory clinical performance.**

Students with clinical failures will be discussed in the Internal Medicine Education Committee. The Clerkship Director will assign the final clerkship grade.

The criteria for unsatisfactory, satisfactory, commendation and honors are summarized below.

<table>
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<th>Clinical Performance</th>
<th>Exam Score</th>
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<tr>
<td>&lt; 62</td>
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<tr>
<td></td>
<td>≥WSU group mean but no higher than 72</td>
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<td></td>
<td>≥1 WSU SD above mean but no higher than 82</td>
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<table>
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<tr>
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<th>Commendation</th>
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<td>Repeat Clerkship</td>
<td>Repeat Clerkship</td>
<td>Repeat Clerkship</td>
</tr>
</tbody>
</table>

Students who fail the shelf exam will receive and unsatisfactory grade for the clerkship.

Students who **fail to pass the exam by the second attempt** will be required to do additional clinical time as determined by the Clerkship Director.

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**GRADE APPEALS**

Students wishing to appeal their grade must submit a **formal appeal** to the Clerkship Director who in turn will present the appeal to the Medical Education Committee. Students may not appeal directly to the site director where they completed their clinical rotation; doing so will invalidate the student’s right to appeal. The Internal Medicine Education Committee (IMEC) will meet and make a determination regarding the student’s appeal. This decision by the IMEC may be appealed to the Year III Grading Committee.

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**CHECKLIST FOR SUCCESSFUL COMPLETION OF CLERKSHIP**

- Complete and log **14 write ups**
- Complete post discharge phone call for all patients discharged from student service
- Give **formal presentation** to team and upload to BlackBoard
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.

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.

**Describe 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.

```
Positive symptom in ROS
  └─ Is symptom new?  ── Recent change  ── Note chronic symptom in ROS
     └─ Yes  ── No  ──
         Perform “Mini HPI of identified symptom
```
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. What 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 Mass General Manuel (the Red Book), *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.
2) 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 echinacea 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 claudication
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; looks 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, TMrs clear, nares clear, oropharynx clear, no papilledema/AV nicking or flame hemorrhages
Neck: supple, normal ROM, normal thyroid, no bruit
Lymph: no lymphadenopathy
Breast: no masses palpated
CV: RRR, nl S1&S2, no M/R/G, non-displaced PMI, no JVD, normal carotid upstroke, 2+ pulses (radial, brachial, femoral, dorsalis pedis, posterior tibialis
Resp: normal symmetric expansion, resonant to percussion, no egophany or whispered pectoriloquy
Abd: Bowel sounds present. S, moderate tenderness to palpation epigastric region, otherwise non-tender, non-distended, no hepatosplenomegaly. Rectal: normal tone, no masses, 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; appropriate 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; no dysmetria; Romberg absent
Gait: normal tandem, heel, and toe walking

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 counsel 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. Will likely need an endoscopy, so 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-appropriate cancer screening as an outpatient, including mammography and colonoscopy.

6) **DVT prophylaxis is not necessary as patient is not immobilized.**
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 Subjective, Objective, Assessment, and Plan. 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 **subjective** 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 C: 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…………..
## Healthcare Provider Checklist

<table>
<thead>
<tr>
<th>Discharge Medications</th>
<th>Discharge Summaries</th>
<th>Communication with Patient/Family</th>
<th>Communication with the Primary Physician</th>
<th>Follow-Up Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review with the patient</td>
<td>Highlight changes from discharge</td>
<td>Include discharge medications (highlight changes from admission)</td>
<td>Provide patient with medication instructions, follow-up details, and clear instructions on warning signs and what to do if things are not going well</td>
<td>Discharge Clinic</td>
</tr>
<tr>
<td>Specifically inform patient about side effects</td>
<td>List outstanding tests and reports that need follow-up</td>
<td>List outstanding tests and reports that need follow-up</td>
<td>Confirm that patient comprehends your instructions</td>
<td>Follow-Up Phone Calls</td>
</tr>
<tr>
<td>Dictate in a timely fashion</td>
<td>Give copies to all providers involved in the patient's care</td>
<td>Include a family member in these discussions if possible</td>
<td>Include a family member in these discussions if possible</td>
<td>Appointments/Access to Primary Providers</td>
</tr>
</tbody>
</table>

PATIENT/CAREGIVER TOOLS AND CHECKLISTS

Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

☐ I have been involved in decisions about what will take place after I leave the facility.

☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.

☐ I have the name and phone number of a person I should contact if a problem arise during my transfer.

☐ I understand what my medications are, how to obtain them and how to take them.

☐ I understand what symptoms I need to watch out for and whom to call should I notice them.

☐ I understand how to keep my health problems from becoming worse.

☐ My doctor or nurse has answered my most important questions prior to leaving the facility.

☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.

☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCFPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation
AHRQ Patient Discharge Tool (to be used for post discharge phone call).

You are about to be discharged from the hospital. Please be sure you and/or your family members know the answer to these questions BEFORE you leave:

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you understand why you were hospitalized, what your diagnosis is, and what treatments you received?</td>
</tr>
<tr>
<td>Are there any test results you are still waiting for? Who should you contact for those results?</td>
</tr>
<tr>
<td>Has a provider reviewed your medications with you? Do you know which of your home medications to continue, what the current doses are, and which you should stop taking?</td>
</tr>
<tr>
<td>Where and when are your follow-up appointments?</td>
</tr>
<tr>
<td>What are the warning signs of relapse or medication side effects you should look for?</td>
</tr>
<tr>
<td>Who should you contact if you are having difficulties?</td>
</tr>
<tr>
<td>Does your primary care physician know you were here and that you are leaving?</td>
</tr>
</tbody>
</table>

MedU http://www.med-u.org/communities/students/
Click "simple" > Login > Click "simple" again > (tab) Case selections

1. 49-year-old man with chest pain - Mr. Monson
2. 54-year-old woman with syncope - Mrs. Koda
3. 67-year-old woman with shortness of breath and lower-leg swelling - Mrs. Rivers
4. 55-year-old man with fatigue - Mr. Kish
5. 28-year-old woman with lightheadedness - Ms. Williams
6. 55-year-old woman with upper abdominal pain and vomiting - Mrs. Turner
7. 48-year-old woman with diarrhea and dizziness - Ms. Blake
8. 45-year-old man with abnormal LFTs - Mr. Chapman
9. 55-year-old man with lower abdominal pain - Mr. Wilson
10. 28-year-old woman with anemia - Ms. Winters
11. 42-year-old woman with fever, lethargy, and anorexia - Mr. Ramirez
12. 71-year-old with cough and fatigue - Mr. Groszek
13. 54-year-old woman with fatigue - Ms. Torres
14. 52-year-old female with headache, vomiting, and fever - Mrs. Cole
15. 75-year-old woman with altered mental status - Mrs. Kohn
16. 58-year-old homeless man with altered mental status - Mr. Johnson
17. 70-year-old man with shortness of breath and leg swelling - Mr. Honig
18. 55-year-old woman with fever and chills - Mrs. Kapoor
19. 55-year-old with leg pain - Ms. Bond
20. 55-year-old with ascites Mr. Berlusconi
The patient safety and quality curriculum is a part of the Internal medicine clerkship curriculum.

**Goal**: To develop the knowledge, skills, and attitudes to ensure patients receive high quality and safe care.

**Objectives**: To be aware of safety and quality issues in
- History taking and physical examination
- Diagnostic decision making
- Medication use
- Care of special populations including the elderly, drug users, patients with health literacy issues, etc.
- Transitions of care including hand-offs and at discharge
- Working with other healthcare professionals

**Knowledge** will be obtained by completing specific cases from the Agency for Healthcare Quality and Research’s Web Mortality and Morbidity web site (see case list). Specific learning objectives are articulated for each case.

Students will have the opportunity to develop **skills** associated with the delivery of safe and high quality care during their clinical rotation.

Students will develop the **attitudes** related to the provision of safe and high quality care including personal commitment to delivering high quality safe care and recognition that respect, communication, and shared perceptions of the importance of safety and the acknowledgement of unsafe practices and errors contribute to a culture of safety.

**Resources**
- AHRQ (safety primer and web cases)
- National Patient Safety Goals Website  
  http://www.jointcommission.org/standards_information/npsgs.aspx
- CMS Quality Measures (Core measures) PowerPoint

**Assessment**:
- Pre and post test
- AHRQ cases
- OSCE
- Discharge phone call check list
- Clinical Evaluations

**Assignments**

The list of never events has expanded over time to include adverse events that are unambiguous, serious, and usually preventable. While most are rare, when never events occur, they are devastating to patients and indicate serious underlying organizational safety problems.

For a list of updated “never events” go to the National Quality Forum on Never Events:

Now click on Quality CME/CEU quiz tab at the top
Register as a New User for trainee certification
Please read all the cases listed below. “Spotlight cases” can be viewed as text of PowerPoint presentations.

- You must read all 15 cases.
- You must complete the 6 highlighted trainee CME/CEU quizzes and submit your trainee certificate to pass the clerkship.

You can find the cases by clicking on the hypertext below.

1. **All in the History** [SPOTLIGHT CASE](http://webmm.ahrq.gov/case.aspx?caseID=194)
   - Describe the Emergency Medical Treatment and Active Labor Act (EMTALA) and understand that it does not apply to transfers to emergency departments from non-acute care facilities (e.g., nursing homes).
   - Identify interventions to improve communication between referring facilities (such as nursing homes or clinics) and emergency departments.
   - Describe what critical information should be conveyed during transitions in patient care in the emergency department.
   - Appreciate how emergency physicians and inpatient physicians differ in their approach to patient diagnoses.

   - Appreciate the decline in proficiency and reliance on physical examination skills among health care
• List barriers to performance of comprehensive physical examinations.
• List interventions that may increase competence in physical examination skills.

3. **Diagnosing Diagnostic Mistakes**
   - Understand the biases that may contribute to overcalling medical errors
   - Describe the impact of considering the clinical spectrum of disease presentations or alternative diagnoses on assessment of error
   - Appreciate the challenges inherent in assigning the label of “missed diagnosis” to a clinical scenario

4. **The Forgotten Turn**
   - Describe the six stages of pressure ulceration per the National Pressure Ulcer Advisory Panel.
   - List risk factors for the development of pressure ulcers in hospitalized patients.
   - Appreciate the importance of early skin assessment and the challenges of pressure ulcer identification.
   - Describe measures that can be implemented early in the hospitalization to prevent pressure ulcer development.

5. **Delirium or Dementia?**
   - State the key diagnostic differences between delirium and dementia.
   - Describe the Confusion Assessment Method for workup of suspected delirium.
   - Explain the risks associated with using physical restraints in geriatric inpatients.
   - Describe the initial workup of delirium in a hospitalized patient.

6. **Another Fall**
   - List risk factors for falls in hospitalized patients
   - Understand appropriate use of restraints
   - Identify system issues contributing to falls in hospitalized patients

7. **Dependence vs. Pain**
   - Define opioid dependence and opioid withdrawal syndrome.
   - Describe the treatment of opioid withdrawal syndrome including the use of the Clinical Opioid...
Withdrawal Scale (COWS) and pharmacologic treatments.

- Appreciate the stigma associated with opioid dependence and the potential impact on the quality of care provided.

### 8. Standard Deviations


- Understand the safety risks associated with patients being discharged against medical advice (AMA).
- Recognize safety risks associated with being part of a stigmatized group.
- Explain how the concept of "cultural competence" should extend to include the homeless intravenous drug user population.
- Appreciate the role of ethics and psychiatric consultations in patients whose refusal to cooperate with treatment is perplexing.

### 9. Fumbled Handoff


- Discontinuity in the hospital is inevitable.
- Discontinuity may be increasing in teaching hospitals due to new duty hours mandates.
- The sign-out process should be standardized to include the following:
  - Change of culture to more obviously value the thorough signout.
  - Verbal signout training and use of read-backs.
  - Structured written information that must be included during signout.
  - A central repository [the patient's chart] where all patient contacts are documented.
  - Use of information technology to assist in the information transfer.

### 10. Triple Handoff


- Appreciate the prevalence of handoffs and sign out related errors.
- Understand the key elements of a safe and effective written and verbal sign out.
- List Kotter’s 8 steps to leading change.

### 11. Medication Reconciliation Victory after an Avoidable Error


- All health care providers should be aware of medications that are best avoided in general or in specific populations such as the elderly. The Beers list is a useful resource.
- More emphasis should be placed on the implementation of medication reconciliation processes in ambulatory care settings.
When performing medication reconciliation, multiple sources of information should be used to obtain accurate and complete medication histories (e.g., electronic medical records, pharmacy records, and patient/family history).

12. **Recurrent Hypoglycemia: A Care Transition Failure?**
   - Understand the complementary abilities of an electronic health record and a personal health record in promoting a safe care system.
   - Understand the value of patient and family involvement throughout the care process, enabled by this technology.
   - Learn about the impact of changing Internet access across population groups, and new entrants into the personal health record space.

13. **Discharged Blindly**
   - Clinicians must observe and proactively and respectfully ask patients about any factors that might affect their ability to perform self-care tasks. Clinicians should not assume that all patients can read, understand, and follow written instructions.
   - When patients identify factors that might impede self-care, clinicians must ask patients about their preferences for accommodating their needs.
   - Clinicians should observe patients performing manual tasks independently and without coaching before completing initial training.
   - Clinicians should follow up with patients shortly after discharge, to determine whether they are successfully performing self-care activities and to identify any questions or problems.

14. **Discharge Fumbles**
   - List the types of adverse events that occur at discharge
   - Identify the characteristics that identify patients at high risk for errors at discharge
   - Understand the provider's role in reducing adverse events at discharge
   - Create an action plan for patient, provider and institutions to improve patient safety at discharge

15. **Treatment Challenges after Discharge**
• Understand types and frequencies of adverse events occurring between patient discharge from the hospital and first outpatient appointment.
• Appreciate the unique challenges posed by transition in care from the hospital to outpatient physician.
• Appreciate the problems related to tests pending at hospital discharge and best practices to address them.
• Describe current best practices for reducing patient safety risks associated with hospital discharge.
1. Provide brief clinical summary of case
2. Provide a brief review of the clinical problem
3. **ASK**: Define clinical question
4. **ACQUIRE**: Find the evidence (must provide search strategy and references)
5. **APPRaise the literature**
6. **APPLY**: Use relevant literature to answer clinical question
7. Summarize patient evaluation/management plan and provide clinical outcome
8. Identify 2-3 take-home teaching points

**Case Summary**: Mr. J is a 92 year old woman who was admitted with mental status changes and a history of decreased po intake for one week. He has a history of hypertension and was taking clorthaladone 25 mg daily. Initial blood pressure was 110/60 with P 100, wt is 63 kg. On exam he was lethargic. Mucous membranes were dry. There were no other abnormalities noted. Initial serum sodium was 158. K was 4.0.

**Clinical Review**: Hypernatremia is common in the elderly and is seen on 2% of hospitalized patients. The elderly are at high risk for hypernatremia secondary to decreased appreciation of thirst as well as use of large numbers of medications. Thiazide diuretics result in hypotonic fluid losses. Volume loss may be incompletely replaced with free water resulting in hypovolemic hypernatremia.

The approach to hypernatremia involves should focus on identifying the causative factor(s) and on safely correcting fluid deficits and associated electrolyte disturbance. The first step in evaluation is to obtain a urine sodium and urine osmolality.

**Clinical question**: What is the best initial fluid for initial treatment of the hypernatremia?

**Literature Appraisal**:
According to a classic article in the NEJM, “Isotonic saline is unsuitable for correcting hypernatremia.” The article goes on to state that, “Although the sodium concentration of the infusate is lower than the patient's serum sodium concentration, it is not sufficiently low to alter the hypernatremia substantially. Furthermore, ongoing hypotonic fluid losses might outpace the administration of isotonic saline, aggravating the hypernatremia. The sole indication for administering isotonic saline to a patient with hypernatremia is a depletion of extracellular-fluid volume that is sufficient to cause substantial hemodynamic compromise. Even in this case, after a limited amount of isotonic saline has been administered to stabilize the patient's circulatory status, a hypotonic fluid (i.e., 0.2 percent or 0.45 percent sodium chloride) should be substituted in order to restore normal hemodynamic values while correcting the hypernatremia. If a hypotonic fluid is not substituted for isotonic saline, the extracellular-fluid volume may become seriously overloaded.” (N Engl J Med 2000; 342:1493-1499). Recent reviews reiterate that hypotonic fluid is the fluid of choice “unless the patient is facing hemodynamic compromise” (J of Intensive Care Med, published online ahead of print, 16, May 2011).

http://jic.sagepub.com/content/early/2011/05/13/0885066611403994

Clinical Application:

We calculated Mr. J’s water deficit using the formula below

Water deficit = total body water × (1−[140 ÷ serum sodium concentration])

Total body water = weight x .5 (for elderly man) = 64 kg x .5 = 32 litres

Water deficit= 3.2 (1- [140/158])= 3.6 lites

This patient was hemodynamically stable. Therefore normal saline was not required. The goal is replacement is to replace serum Na safely which means correcting no more than 0.5 /hour and no more than 10mmol/liter per day.

We calculated that one liter of .45 NS would decrease the serum Na by 2.5 (see below)

\[
\text{Change in serum Na} = \frac{\text{infusate Na} - \text{serum}}{\text{total body water} + 1}
\]

\[
= \frac{77-158}{32} = -2.5 = \text{change in serum sodium with infusate of one liter of .45 NS}
\]

To decrease the serum Na by 5 mmole over 12 hours we would have to give 2 liters of .45 NS. Additional fluid may be needed to account for ongoing losses. However, we were concerned about our patient’s underlying heart function. We calculated that to give our patient 2 liters over the first 12 hours a rate of 175 cc/hour was needed. We decided to be conservative and give him 150 cc/hour.
After 4 hours his serum had increased by 2 mmole. At 12 hour his serum Na came down to 154. We continued the same rate of infusion and after 24 hours his serum sodium was 149. At this point we contemplated changing to D5 but decided to be patient. By this point the patient was more alert and drinking. At 48 hours his Na was at 142. His diuretic was discontinued.

**Take home points**

1. Most patients with hypernatremia should receive hypotonic fluid replacement (e.g. .45NS, .2NS or D5W).

2. Normal saline should be reserved for those patients with hemodynamic compromise secondary to severe volume depletion. Once volume is replaced hypotonic solutions should be used to correct hypernatremia.

3. It is important to calculate the water deficit and replace at a rate that decreases sodium by no more than 10 mmoles /24 hours.
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 I: 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/Progress 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.
Please use the most recent editions of the following

**Major Textbooks** (recommended for reading about specific assigned patients)

Harrison's Principles of Internal Medicine.


**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.


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

**Question Books**

MKSAP for Students

**EKG Interpretation**

Dubin, Dale, , Cover Publishing Company

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


**Chest X-ray Interpretation**

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

….Talk to an Internal Medicine Advisor

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DESCRIPTION OF ROTATION
DEPARTMENT OF NEUROLOGY

INTRODUCTION
The clinical specialty of Neurology is chiefly concerned with disorders of the nervous system: the brain, spinal cord, nerve roots, nerves and muscles. Because of the critical role played by the nervous system in biology and behavior, such disorders rapidly impair a patient’s ability to function. Further, not only is the nervous system subject to its own diseases, it is exceptionally sensitive to disruption of normal metabolic processes controlled by other organs. While it is sometimes considered to be the most complex of the diagnostic specialties, Neurology lends itself to a straightforward and logical approach that is distinct from those used in branches of Internal Medicine. This clerkship is meant to provide a framework upon which the students can build an understanding of neurological function and pathophysiology.

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**MT. CLEMENS GENERAL HOSPITAL/ST. JOSEPH'S MERCY HOSPITAL**
Coordinator | Jay Kaner, D.O. |  
Contact | Sarina Kaner | (586) 286-2770
**ST. JOSEPH'S/MERCY HOSPITAL – PONTIAC**
Coordinator | Bharat Tolia, M.D. |  
Contact | Janell/Leah | (248) 334-0115
**CRITTENTON HOSPITAL**
Coordinator | Cesar Hidalgo, M.D. |  
Contact | Leslie Zubeck | (248) 852-1777
**HENRY FORD HOSPITAL**
Coordinator | Bruce Silver, M.D. |  
Contact | Debbie Barnette | (313) 916-9107

**EXPECTATIONS**

The ultimate goal of the Neurology clerkship is to teach an approach to the neurological patient rather than a collection of facts. Accordingly, students should become comfortable in taking concise history, performing and interpreting a neurological examination. Next, through a logical, ordered process, they should be able to anatomically localize the site of neurological lesions and identify potential pathophysiologic mechanisms of dysfunction. Students will be exposed to diagnosis and treatment of major neurological diseases in both inpatient and outpatient settings. Critical areas in Neurology will be discussed in tutorial sessions led by attending neurologists and senior residents.

**ON THE FIRST DAY OF THE ROTATION, PLEASE REPORT TO THE UNIVERSITY HEALTH CENTER, CROCKETT C OR D AT 8:00 AM, REGARDLESS OF HOSPITAL ASSIGNMENT.**
Because students are distributed among a number of different hospitals, under the supervision of neurologists with distinctive teaching styles, the experience will vary according to placement. Students in community hospitals are expected to follow the patients of the private attending neurologist through both inpatient consultation and outpatient office visits. Students at the DMC hospitals will have a faculty attending neurologist as a tutor. They will be assigned to a senior resident-led team at either Detroit Receiving Hospital or Harper Hospital where they are expected to work-up and follow patients requiring neurological consultation or care. Students at the VA Medical Center will divide their time between Neurology Clinic, the consultation service and inpatient service. Modifications have been made to ensure an equivalent, although not identical experience among all locations.

EVALUATION AND FEEDBACK
The supervising attending or tutor will evaluate students with input from senior residents, when appropriate. When multiple neurologists participate in student supervision, the evaluators may submit a unified evaluation form with feedback from the senior resident.

At the end of the rotation, at the final exam and accompanying the answer sheet, students are required to complete an evaluation form. Students are asked to comment on any and every aspect of the course including house staff, attendings, hospitals and quality of teaching. Evaluations may be anonymous or signed, as long as the hospital is identified. The clerkship director reads each of these and in the past, when appropriate, has made changes in the course to correct deficiencies. Under no circumstances is primary data shared with either house staff or faculty. Confidentiality is sacrosanct and ensures an honest evaluation process. Composite evaluations may be made and used, however, if a consistent pattern emerges that requires correction. In addition, students will be given a general course evaluation developed by the Medical School for the entire clerkship experience.

EXAMINATION
A final examination is given at the end of each month. Dates and times will be announced at orientation. The examination is the Neurology Clerkship Subject Exam (SHELF), will consist of 100 multiple-choice questions and you will have 2 hours and 10 minutes to complete.

MINIMUM PROFICIENCY STANDARD - YEAR III STUDENTS
By the end of the clerkship, each student should be able to take an appropriate clinical history and perform a complete and orderly neurological examination as well as pertinent aspects of a general physical examination (e.g. carotid artery examination in a patient with a stroke). Students are expected to be able to localize the most likely site of the problem within the nervous system and to justify their opinion. Students are also expected to approach patients with appropriate sensitivity and to respect the patient’s dignity. There is a Neurology passport that must be completed by the supervising attending or the senior resident and must be returned at the end of the clerkship. (The clerkship will not be complete without returning this passport). The passport involves performing a history and a Neurological exam on a patient.

GRADING PROCESS
When multiple neurologists participate in student supervision, one evaluation form may be submitted after obtaining input from the supervising neurologists and the senior residents. Evaluations will consider a student’s participation in clinical rounds, presentations, neurological assessments, ethic, and student’s interaction with patients, families, staff and team members.

The clerkship director determines final grades with assistance from a grading committee consisting of the Departmental Chairman and Associate Chairman. All grades may be appealed to the committee. Students receiving a failing clinical grade must repeat the course.
Students who receive a Satisfactory or honors clinical grade but fail the final examination will receive a grade of unsatisfactory and must retake the written exam. If a student fails the retake exam he/she must meet with the Clerkship director to determine the next step, as the student may have to repeat the clinical rotation. Students who fail the clinical rotation will receive unsatisfactory grade for the course and must repeat it.

ATTENDANCE POLICY

Daily attendance is mandatory. No more than two days absence are permitted unless medically excused including a written explanation from a physician, or previously arranged with the attending physician with approval of the clerkship director. Extended absences must be made up or will result in an incomplete clinical grade. Final decisions will be made by the Year III Neurology Committee.

GRADING CRITERIA AND FINAL GRADES

The SHELF exam began to be given instead of the departmental exam in 2004 - 2005; the grading of this test is determined by the mean and the standard deviations. The passing grade is the national mean for the quarter of the previous academic year minus 1 ½ the standard deviation, and the honors passing grade is the national mean for the quarter of the previous academic year plus one standard deviation. (The criteria are consistent with the SOM guidelines).

Students receiving both an Honors clinical evaluation and Honors final exam grade will receive an Honors grade for the course.

Students receiving an Honors clinical evaluation and a satisfactory final exam grade will receive a course grade of Satisfactory with Commendation.

Students receiving a satisfactory clinical evaluation and an Honors final exam grade will receive a course grade of Satisfactory with Commendation.

Students receiving both a satisfactory clinical evaluation and satisfactory final exam grade will receive a satisfactory grade for the course.

PASSPORT:
Each student will be a given a Passport at the orientation. The passport is a document to be filled out by the supervising neurologist as he/she observes the student taking the history and performing the neurological exam. The Clerkship will be incomplete without returning the passport completed and signed at the end of the clerkship.

PRACTICAL NEUROLOGY DVD REVIEW:
Starting in 2006 – 2007 each student will receive a copy of “Practical Neurology DVD Review” (2005) to be used during the Clerkship. This is a book of case vignettes with video clips of real patients on a CD. It is recommended that students read and watch most of the cases and answer the related questions for each case. The book with the accompanied CD and a list of required cases to be read (represent common problems in neurology) will be given to the students at the orientation. The students are required to read the cases on the list and sign and date next to each case when read. The book, the accompanied CD and the required case list need to be returned at the end of the clerkship (no later than the exam date, as the next students group will be using the same books), if not returned the clerkship will be incomplete.
Most students have found Neurology for the House Officer useful although it serves more as an outline than a textbook. Merritt’s Textbook of Neurology edited by Lewis Rowland is the gold standard for Neurology textbooks and should be purchased by any student interested in diseases of the nervous system. In general, the Neurology sections of both Harrison’s and Cecil’s textbooks of Internal Medicine are useful at a student’s level and may be used.

NEUROLOGY BIBLIOGRAPHY

BOOKS:


**Weiner and Levitt’s Neurology (House Officer Series)**

INTERNET:

http://www.emedicine.com/neuro/contents.htm (Good review of different Neurology topics)

http://www.neuropat.dote.hu/neurology.htm (Internet textbook of Neurology with many links)

**PDA (E-BOOKS):**

[www.skyscape.com](http://www.skyscape.com) (Click on Products, then Specialty, Neurology)

**MGHNeuro™** (The Massachusetts General Hospital Handbook of Neurology) by Alice W. Flaherty, MD, PhD


**Harrison’s (Harrison’s Manual of Medicine, 16th Ed.).** (The Neurology section in this e-book is very good and you would also use Harrison’s for other rotations)
1. Introduction

Up to 10% of patients seen by family practitioners present with neurologic symptoms and pose neurologic questions to their physicians. Only 16% of the 45 million Americans who visit a physician for a chief complaint referable to the nervous system are ever evaluated by neurologists. Clearly, primary care physicians are routinely called upon to evaluate and manage patients with neurologic disease. Practicing physicians require a firm understanding of the general principles of clinical neurology. The most suitable setting in which to lay the foundation for that understanding is in a neurology clerkship in the clinical phase of medical school. This document outlines the desirable components of a clinical neurology clerkship.

2. Goals and Objectives of the Clinical Neurology Clerkship

A. Goal

To teach the principles and skills underlying the recognition and management of the neurologic diseases a general medical practitioner is most likely to encounter in practice.

B. Objectives

1. To teach or reinforce the following PROCEDURAL SKILLS:
   a. the ability to obtain a complete and reliable history
   b. the ability to perform a focused and reliable neurologic examination
   c. the ability to examine patients with altered level of consciousness or abnormal mental status
   d. the ability to deliver a clear, concise, and thorough oral presentation of a patient's history and examination
   e. the ability to prepare a clear, concise, and thorough written presentation of a patient's history and examination
   f. [Ideally] the ability to perform a lumbar puncture

2. To teach or reinforce the following ANALYTICAL SKILLS:
   a. the ability to recognize symptoms that may signify neurologic disease (including disturbances of consciousness, cognition, language, vision, hearing, equilibrium, motor function, somatic sensation, and autonomic function)
   b. the ability to distinguish normal from abnormal findings on a neurologic examination
   c. the ability to localize the likely site or sites in the nervous system where a lesion could produce a patient's symptoms and signs
   d. the ability to formulate a differential diagnosis based on lesion localization, time course, and relevant historical and demographic features, an awareness of the use and interpretation of common tests used in diagnosing neurologic disease
   e. an awareness of the principles underlying a systematic approach to the management of common neurologic diseases (including the recognition and management of situations that are potential emergencies)
g. an awareness of situations in which it is appropriate to request neurologic consultation.

h. The ability to review and interpret the medical literature (including electronic databases) pertinent to specific issues of patient care.

3. Content of subjects to be taught

A. The Neurologic Examination (as an integral component of the general medical examination)

1. how to perform a focused but thorough neurologic examination
2. how to perform a screening neurologic examination
3. how to perform a neurologic examination on patients with an altered level of consciousness
4. how to recognize and interpret abnormal findings on the neurologic examination

B. Localization - general principles differentiating lesions at the following levels:

1. Cerebral hemisphere
2. Posterior fossa
3. Spinal cord
4. Nerve root/Plexus
5. Peripheral nerve (mononeuropathy, polyneuropathy, and mononeuropathy multiplex)
6. Neuromuscular junction
7. Muscle

C. Symptom Complexes - a systematic approach to the evaluation and differential diagnosis of patients who present with:

1. Focal weakness
2. Diffuse weakness
3. Clumsiness
4. Involuntary movements
5. Gait disturbance
6. Urinary or fecal incontinence
7. Dizziness
8. Vision loss
9. Dysarthria
10. Dysphagia
11. Acute mental status changes
12. Dementia
13. Headache
14. Aphasia
15. Focal pain (facial pain, neck pain, low back pain, neuropathic pain)
16. Numbness or paresthesias
17. Transient or episodic focal symptoms
18. Transient or episodic alteration of consciousness
19. Sleep disorders
20. Developmental disorders

D. Approach to Specific Diseases - general principles for recognizing, evaluating and managing the following neurologic conditions (either because they are important prototypes, or because they are potentially life-threatening):

1. Potential emergencies
- Increased intracranial pressure
- Toxic-metabolic encephalopathy
- Subarachnoid hemorrhage
- Meningitis/Encephalitis
- Status epilepticus
- Acute stroke (ischemic or hemorrhagic)
- Spinal cord or cauda equina compression
- Head Trauma
- Acute respiratory distress due to neuromuscular disease (e.g., myasthenic crisis or acute inflammatory demyelinating polyradiculoneuropathy)
- Temporal arteritis

2. Strokes
3. Seizures
4. Alzheimer's disease
5. Parkinson's disease
6. Essential tremor
7. Multiple sclerosis
8. Migraine
9. Bell's palsy
10. Carpal tunnel syndrome
11. Diabetic polyneuropathy
12. Brain death
Neurology Clerkship Passport

Name:

Month/Year:

Site:

Supervising physician:

**History:**

**Neurological Exam:**

Mental Status:

Cranial Nerves:

Motor:

Reflexes:

Sensory:

Coordination:
The supervising Neurologist should fill out this passport by placing his initials next to each element and commenting on how the student did.

The history taking should be supervised, if not, students need to present to the supervising physician how the history was obtained, e.g. how the symptoms develop (sudden/gradual i.e. temporal profile), the duration of the symptoms………etc. Each part of the neurological exam must be supervised and initiated and feedback given by the supervising attending Neurologist or the senior resident (junior residents are not allowed to complete this passport).

The Clerkship will be incomplete without returning this passport properly filled out by the supervising Neurologist.
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

YR III CURRICULUM GUIDE

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

2011-2012

Satinder Kaur, MD, MHA
Carl Christensen, MD, PhD
Juan Gonzalez, MD
Cathy Rutkowski, Education Coordinator

Division of Medical Education
Department of Ob/Gyn
313-993-4032
INTRODUCTION

Welcome to the OB Gyn Clerkship! The main function of our rotation is to expose all students to an overview of women’s health care. Although few students will enter Ob Gyn as a specialty, nearly everyone will need an understanding of women’s health care in their chosen specialty.

OVERVIEW OF THE CLERKSHIP

Your time in Obstetrics and Gynecology will be divided between clinical exposure and experience (in the office, operating room, delivery suite, and emergency department and hospital room) and didactic lectures covering core subjects. We understand that few will choose Obstetrics and Gynecology as a career path. However, it is still important that all physicians understand the unique diseases and health concerns of the female population, no matter what their medical discipline. The goal of this clerkship is to help you achieve that understanding. Lectures and reading assignments encompassing these core subjects have been chosen to meet this broad clinical goal. The core curriculum and specific enabling objectives to help you meet this goal will be provided at the start of the clerkship. Please pay careful attention to these objectives and use them to plan and guide your study.

Students will be assigned to Hutzel Women’s Hospital or one of the other affiliated hospitals, based upon schedules prepared through the School of Medicine. All junior students, regardless of assigned hospital, are to report to Hutzel Women’s Hospital, Morse or Kresge Auditorium, the first day of the Obstetrics/Gynecology rotation. At that orientation session, logistical aspects of the clerkship will be reviewed including grading policies, exam dates, and lectures, etc.; the objectives of the clerkship, terminology and procedures will be reviewed; and information for all hospitals will be distributed. Didactic presentations will begin that day as well. The remainder of the lecture series is held in the Morse or Kresge Auditorium. You will receive a mass email informing you of the date, time, and location of orientation. Please make sure that when you receive this email that you open and read the instructions before orientation day.

You will work both with general obstetrician/gynecologists and subspecialists in OB/GYN. Subspeciality areas for which physicians can attain additional board certification include Maternal-Fetal Medicine, Gynecologic Oncology, Reproductive Endocrinology and Infertility, Urogynecology, and Reproductive Genetics. If you have particular interests in these areas, contact Dr. Kaur or Cathy to arrange some additional exposure, if possible. In addition, an optional elective experience with the nurse midwifery service at Hutzel Women’s Hospital is available for those students wishing to have clinical exposure to our excellent certified nurse midwives.
# Key Personnel

**Hutzel Hospital**
- **Department Chairman (Interim)**: Elizabeth Puscheck, M.D.  
  - 313-993-4513
- **Clerkship Director**: Satinder Kaur, M.D.  
  - 313-993-4032
  - (Beeper #3647)
- **Associate Clerkship Director**: Carl Christensen, MD, PhD  
  - 313-993-4032
  - (Beeper #3479)
- **Education Coordinator**: Ms. Cathy Rutkowski  
  - 313-993-4032

**Sinai-Grace Hospital**
- **Chief, OB/Gyn**: Andi Coleman, MD  
  - 313-966-3246
- **Coordinator**: Ronald Cheek, M.D.  
  - 313-966-3246
- **Education Coordinator**: Ms. Cathy Rutkowski  
  - 313-993-4032

**Providence Hospital**
- **Department Chairman**: Robert Welch, MD  
  - 248-849-3048
- **Coordinator**: Paul Schnatz, MD  
  - 248-849-3048
- **Secretary**: Ms. Ellen Kleiman  
  - 248-849-3014

**Oakwood Hospital**
- **Department Chairman**: Thomas Meyers, MD  
  - 313-593-7819
- **Program Director**: Todd Allen, MD  
  - 313-593-7819
- **Coordinator**: Amy Kerner, DO  
  - 313-593-7819
- **Secretary**: Ms. Michelle Gavrila  
  - 313-436-2582

**St. John Hospital**
- **Department Chairman**: Mitchell Dombrowski, MD  
  - 313-343-7798
- **Co-Associate Coordinator**: Cassie Laasch, MD  
  - 313-343-7798
- **Co-Associate Coordinator**: Carole Kowalczyk, MD  
  - 313-343-7798
- **Residency Coordinator**: Patti Quinn-Shaheen  
  - 313-343-8306
- **Student Site Director**: Anne Schneider, MD  
  - 313-343-3576
- **WSU Student Coordinator**: Ms. Val Kociaj  
  - 313-343-3576

**Henry Ford Hospital**
- **Department Chairman**: Adnan Munkarah, M.D.  
  - 313-916-2464
- **Coordinator**: Jennifer Milosavljevic, MD  
  - 313-282-0559
- **Medical Student Coordinator**: Ms. Dianne Weiland  
  - 313-916-1465

**William Beaumont Hospital-Troy and Royal Oak**
- **Department Chairman**: Stanley Berry, MD  
  - 248-551-0427
- **Coordinators**: David Seubert, MD  
  - 248-551-0471
  - Brian Torok, MD  
  - 248-992-6538
STUDENT EXPECTATIONS – WHAT WE EXPECT OF YOU DURING THIS CLERKSHIP

ON THE FIRST DAY OF THE ROTATION, ALL STUDENTS ARE TO REPORT TO EITHER THE KRESG or the MORSE AUDITORIUM WHICH IS LOCATED AT HUTZEL WOMEN’S HOSPITAL FOR ORIENTATION AT 8:00 AM. ATTENDANCE AT THIS DEPARTMENTAL ORIENTATION IS MANDATORY, REGARDLESS OF THE HOSPITAL YOU ARE ASSIGNED FOR THE REMAINDER OF THE CLERKSHIP. IF YOU ARE NOT AT ORIENTATION, YOU MUST CONTACT THE COURSE DIRECTOR at 313-993-4030 PERSONALLY AND ALSO CONTACT YOUR COUNSELOR AT THE SCHOOL FOR AN EXCUSED ABSENCE.

- The student is responsible for learning the material specified in the Course Objectives of the Department of Obstetrics and Gynecology Junior Clerkship. These objectives will be distributed and reviewed at the clerkship orientation, and they comprise your learning objectives for this clerkship. The textbook and lectures are all correlated to these objectives, and together they cover the material in appropriate depth and breadth. Experience has shown that students who master these objectives do well both in clinical and testing situations.

- Attend all scheduled core lectures on Tuesdays and as scheduled throughout the week. ATTENDANCE AT ALL OF THE TUESDAY LECTURES IS MANDATORY.

- Attend all other teaching sessions (rounds, lectures, seminars, conferences, etc.) scheduled at your individual clerkship site.

- Except on Tuesday mornings, arrive at and then remain at your hospital or clinical site as scheduled until completion of all assigned duties and responsibilities, including night-call as scheduled. Note that after Tuesday morning lectures (which generally end at noon), you are to report back to your hospital for assigned activities in the afternoon. You are to report back in a timely fashion.

- WHEN REVIEW SESSIONS ARE SCHEDULED OR TUESDAY LECTURES ARE SCHEDULED, YOU ARE ALLOWED TO LEAVE BY 11 PM ON MONDAY, IF YOU ARE ON CALL, YOU ARE NOT REQUIRED TO MAKE ROUNDS BEFORE COMING TO LECTURE. IF YOU HAVE ANY DIFFICULTY WITH THIS, ASK THE RESIDENT/ATTENDING TO CONTACT THE SITE DIRECTOR OR DR. KAUR (#3647).

- When assigned patients (in labor and delivery, from the operating rooms, during the day, when on call, etc.) the student will write progress notes at the appropriate interval depending upon the patient’s clinical condition, e.g., daily for postoperative patients, more frequently for patients in labor, at each outpatient clinic visit, etc.

- The student is required to prepare discussions and reports as assigned by your Faculty/Resident team.
Use of web-based case entries is mandatory. **STUDENTS ARE EXPECTED TO SUBMIT 2 to 4 CASES IN EACH CATEGORY OR A MINIMUM OF 25 CASES.** These numbers will be given to you during the rotation. You are responsible for logging the cases on a regular basis, and are not permitted to log only at the close of the clerkship. Students who complete the rotation with insufficient (or) no/LOW number of cases will be given an incomplete, and may need to repeat part of the clerkship to get adequate numbers. If you do not log any cases, you will have an **Incomplete** grade for the clerkship.

- Students will evaluate the course, its faculty and residents. Failure to complete this requirement will result in an incomplete grade, and final grades will not be released to the School of Medicine until this record is completed.

- The live female and male pelvic model sessions, known as the Gynecologic Teaching Associate program, are to be scheduled in the evening at the beginning of your clerkship. **These are required experiences.** If you do not attend the entire 4 hour session your grade will be incomplete for the clerkship until you make-up the session on the established schedule. This opportunity to makeup may occur during the following clerkship and your grade could be incomplete until that time.

**EVALUATION AND FEEDBACK**

1. Students are evaluated by the residents and faculty to which they are assigned at each hospital. Comments from faculty and residents are compiled onto a single evaluation form which is then submitted to the School of Medicine via the Clerkship Director. A separate evaluation form is NOT submitted to the School of Medicine from each faculty member or resident.

2. Midway through the clerkship, faculty and residents are asked to evaluate each student and report back to the coordinator at each site and the Clerkship Director. **If any problems are encountered or if the student is at risk of receiving an unsatisfactory clinical evaluation,** the student will be informed and remedial action will occur. Note that this midterm evaluation is designed to identify students with significant **deficiencies**; no grade is recorded at this time, and a satisfactory or honors midcourse evaluation does not imply or guarantee that this final grade will be awarded. You will also have an opportunity to evaluate yourself. You will review this form with your site director, preceptor, or clerkship director. You may also review your self-evaluation with your senior resident.

3. The final clinical clerkship evaluation is submitted on forms specified by the School of Medicine. We use the same evaluation form as all the other clinical clerkships. Examinations at the end of the clerkship, and grading policies for the clerkship, are described below. **Each individual site director does the final clinical evaluation. It is obviously beneficial for you to acquaint yourself with your site director!**

4. At the completion of each scheduled Tuesday lecture, there will be evaluation forms for each faculty/lecture for you to complete and leave in the basket on the table as you leave lecture the auditorium.

5. At the end of the rotation, students are asked to evaluate each faculty member and house staff with whom he or she worked during the clerkship. These forms, developed by the Department of Obstetrics and Gynecology, are designed to evaluate the teaching effectiveness of the faculty or residents. They will be available to the students at the beginning of the rotation on blackboard
and on Campus Mobility. Submission of the faculty/resident evaluation by the final examination is mandatory, and an incomplete grade will be submitted for any student who has not completed the course evaluation.

6. Students will complete a course evaluation of the clerkship developed both by the School of Medicine and the Department of Obstetrics and Gynecology. This form is also available on Blackboard and completion of the general course evaluation form and its submission by the final examination are mandatory.

EXAMINATIONS

- Written Examination (Shelf exam) - The Obstetrics and Gynecology Subject Examination prepared by the USMLE/National Board of Medical Examiners is the final written examination of the course. This exam is a 100 item two (2) hours and (10) ten minute test used by many medical schools for clerkship testing. The content area of the test closely matches the Course Objectives referenced above. The test is closely proctored, test books and answer sheets are collected before leaving the room, seating is controlled, etc. You are graded against the national curve and not against your classmates. Cutoffs are normally defined as 58 points (passing) and 78 points (Honors). Remember that since this is a curved exam, the exact number of correct answers is not known.

- Clinical Skills Exam: an OSCE based exam is given before the end of the rotation, usually during week 7 or 8. The OSCE exam is divided into two portions: part one is an interview of a patient (no physical exam is performed during this time), and part two is the pelvic exam performed on a pelvic model. Dr. Kaur (or designated attending) will supervise the pelvic exam. Your interview of the patient will be videotaped. The purpose of this exam is to evaluate not only your knowledge data base, but your communication skills and history taking ability. More details of this exam will be announced at the beginning of each rotation. The OSCE is graded only as satisfactory/unsatisfactory. Those students with an unsatisfactory performance on the OSCE will not be penalized, but asked to return later for additional help with performing a history and/or physical exam. **If you fail or miss the OSCE exam you will be required to pass the OSCE before your grade is complete, even if you are Honors or Satisfactory for your exam and clinical grade.** Right now we are considering adding an oral question and answer session at the conclusion of the physical exam part. This will take place no later than the middle of the academic year.

MINIMUM PROFICIENCY STANDARD

To receive a satisfactory clinical evaluation for the Obstetrics and Gynecology clerkship, the student must demonstrate the knowledge, attitudes and skills referred to in the Course Objectives in the care of patients and performance of clinical duties at a level expected for a junior medical student.

To receive a satisfactory examination grade for the Obstetrics and Gynecology clerkship, the student must demonstrate the knowledge, attitudes and skills referred to in the Course Objectives on a written exam at a level expected for a junior medical student.
If at any time professionalism is breached on your part, this is grounds for failure even if you have received a passing grade in the mid-clerkship evaluation.

**GRADING PROCESS**

Your grade in the Obstetrics and Gynecology clerkship is derived from two (2) components, each weighted equally: clinical performance and examination grade. These components of your grade are discussed in detail below.

1. **Clinical Evaluation 50% of grade**

Your clinical performance will be assessed using criteria established by the School of Medicine. You will be graded on various competencies including data gathering skills (histories, physical examinations, laboratory, radiology, etc.), ability to synthesize data (differential diagnosis, diagnosis), recommend treatment and follow-up, manual skills in the operating and delivery room, and interpersonal skills. As described in the section entitled Minimum Proficiency Standard (above), the Course Objectives form the list of cognitive, attitudinal and skill areas to which these criteria are applied in evaluating the student.

**Honors:** at least seven of the eleven competencies must be “outstanding”; with three of the five “critical” competencies “outstanding”

**Satisfactory:** all competencies must be “satisfactory”

**Unsatisfactory:** any competency is “below expectations”. The Site Director will counsel the student before this grade is given, unless the student’s performance is grossly negligent or endangers patient safety. **Professionalism is the most common reason for intervention during the clerkship.**

The clinical evaluations will be completed at the site where the student was assigned, by faculty and residents who interacted with and supervised the student. A single clinical evaluation will be submitted for the 8 week rotation. Your participation in and evaluations from tutorials will also be included in your clinical grade.

**YOUR CLINICAL EVALUATION MAY BE SIGNED ONLY BY THE SITE DIRECTOR. YOU MAY NOT SEE THE INDIVIDUAL INPUT FROM FACULTY AND RESIDENTS. THIS IS NOT CONSIDERED GROUNDS FOR AN APPEAL!**

2. **Examination Grade - 50% of grade**

The examination grade you attain for the course will be derived from your performance on two written examinations at the end of the clerkship.

- **Shelf examination** results are reported using a two-digit score which “resembles” (but is not actually) the percent of items answered correctly. This score is normalized to a national reference group of students taking this examination at the end of their clerkship. The mean is set at 70, and the standard deviation is 8.

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3 Even though the weights of the clinical and written portions are described as “50%”, both must be successfully passed (or Honored) to receive S and H, respectively.
• Students who score less than 1.5 standard deviations below the mean (approximately lower 10% of scores) will be given an unsatisfactory grade on the written exam, which must be remediated as described below.

• Students who score at least 1.0 standard deviation above the mean (approximately upper 16% of students) will be given an honors grade on the written exam.

• For example, using the standard “scaled” test scores with a mean of 70 and standard deviation of 8, a written exam of 78 or better with passing of the oral exam earns an honors examination grade. A score of 57 or below is an unsatisfactory exam grade.

3. Course Grades

To pass the Obstetrics and Gynecology clerkship, students must pass the clinical portion of the course and pass both the written and OSCE. Each student must also attend the mandatory Tuesday morning lectures and the GTA program. Failure in any of these areas must be remedied to complete the clerkship.

To receive honors for the course, students must receive an honors evaluation for the clinical portion and honors on the examination portion. An honors score on the examination portion requires Honors on the Shelf exam. A student, who receives honor for either the clinical or examination portions, but not both, will receive a grade of satisfactory and a letter of commendation from the Clerkship Director will be placed in the students' file at the School of Medicine.

If the student fails the written examination, he or she will have the opportunity to retake the examination at a later time based upon the rules of the medical school. If the student passes the repeat examination, a grade of S* (formerly U/S) will be given. Even if other grades were honors, failure on the written exam excludes the possibility of an honors grade no matter what grade is attained on the repeat examination. If the student fails the repeat examination, he or she will be required to repeat 4 or 8 weeks of the clinical portion of the clerkship before repeating the written examination, as determined by the Department of Obstetrics and Gynecology (see below).

A student will be required to pay additional tuition charges if required to repeat clinical time.

The following may require the student to repeat some or all of the entire clerkship:

1. Failure of the clinical portion of the clerkship - based upon the individual evaluation comments submitted, whether 4 or 8 weeks will be required in repeating the clinical portion of the course. All repeat clinical rotations will be completed at Hutzel Hospital with the Clerkship Director acting as the student's preceptor. 100% attendance at lectures will be required.

2. Failure of a repeat written examination - based upon the individual evaluations and comments submitted, whether 4 or 8 weeks will be required in repeating the clinical portion of the examination. All repeat clinical rotations will be completed at Hutzel Women's Hospital with the Clerkship Director acting as the student’s preceptor. 100% attendance at lectures will be required. This clinical time will be completed before the student is allowed to retake the deficient exam.
When repeating clinical time for a clinical or examination failure, credit will be given for previously passed examinations. No examinations for which a satisfactory grade is obtained will have to be repeated.

To summarize, if the clinical portion is failed, time in the hospital must be repeated. If an examination is failed, the first attempt to retake the exam is allowed without additional clinical time. If this repeat exam is not successfully passed, additional clinical time will usually be required before the deficient exam is retaken.

The Clerkship Director reserves the right to require a student to repeat clinical time should an egregious professionalism violation take place.

GRADE APPEALS

- Grade appeals should first be sent to the Clerkship Director, Dr. Kaur.
- Do NOT contact any faculty or residents that have written your evaluation. This could result in your appeal being rejected.
- The Clerkship Director will contact your site director about the appeal. If it is accepted, the grade will be changed at the next Year III meeting.
- If the appeal is rejected by the site director, you will need to appeal to the Year III committee. Please be sure that your counselor is involved at this step.
- For Departmental or OSCE exams, decisions made by the Clerkship Director/Associate Director are final.

ATTENDANCE

Clinical attendance is mandatory, and absenteeism will affect the student’s grade. A student who has an unexcused absence will not be a candidate for an honors grade; a second unexcused absence may be grounds for a clinical unsatisfactory grade with the requirement that the student repeat the entire 8 week clerkship. Absences MUST be reported to:

(1) the coordinator at your hospital site,
(2) to the office of the Director of Undergraduate Medical Education, Cathy Rutkowski, Education Coordinator at Hutzel Women’s Hospital, 313-993-4032,
(3) the student's counselor in the Office of Student Affairs
(4) the resident on your team at your assigned hospital site

An unexcused absence is a large amount of work for all involved. Repeat unexcused absences will also be reported to the Professionalism Committee.

Lectures are an important part of the teaching experience in Obstetrics and Gynecology, since they reinforce the objectives, clinical experience and reading assignments. All lectures are on Tuesday from 8:00 AM/9:00AM to 12:00PM Noon at Hutzel Hospital. Lectures are arranged in blocks, reflecting related content areas and objectives. The content areas of the lectures are as follows:

First Lecture Block
Normal Obstetrics

Second Lecture Block
General Gynecology
A review session(s) will be scheduled each rotation to highlight material and answer questions before the exams. All students are excused from clinical activities on the mornings of scheduled lectures and review. Again, your attendance at lectures and seminars is expected!

If a student is absent from core lectures, an approved excuse must be submitted. Failure to attend **ALL** core lectures could result in the requirement for extra work. **Students will be excused from any clinical duties at 11:00 PM the Monday evening before lectures, but will have to return to their respective hospitals on Tuesday afternoon DIRECTLY after lectures.**

**TEXTBOOKS**

The required textbook for the clerkship is *Obstetrics and Gynecology* by Beckman, Ling, Barzansky, Bates, Herbert, Laube, and Smith, 6th edition, published by Williams and Wilkins. This book is written to cover the material required by the APGO Objectives, i.e., it is written specifically for students on an obstetrics and gynecology clerkship or those studying for standardized examinations in obstetrics and gynecology. It also includes over 2,000 questions with answers for self-assessment.

Other good introductory texts include *Essentials of Obstetrics and Gynecology* by Hacker, published by W.B. Saunders; and *Obstetrics and Gynecology* by Beck, published by Wiley Medical. A Pretest book with study questions has also been found useful by some students.

Other texts the interested student may find useful include the following:

- *Danforth's Obstetrics and Gynecology*, Scott, Disaia, Hammond, Spellacy (Lippincott)
- *Williams Obstetrics*, Pritchard, MacDonald, Gant, (Williams and Wilkins)
- *Current Obstetric and Gynecologic Diagnosis and Treatment*, Benson, (Lange)
- *Principles and Practice of Clinical Gynecology*, Kase (Wiley Medical)

**SCHEDULES**

Schedules with the lecture topics and objectives for each Tuesday, review sessions, holidays, and examination days will be distributed at the start of each rotation during orientation. Your clinical sites will provide schedules of all activities during the course at that site, such as clinical assignment, on-call, weekend rounds, lectures, etc. Details of the program will be discussed at orientation.
CONCLUSION

All members of the Obstetrics and Gynecology Department look forward to helping you make the best of your time in our department. Please call upon the Clerkship Director at any time if I can help you both during your clerkship and in any other way during medical school. Enjoy your time with us, and good luck!
DEPARTMENT OF PEDIATRICS

YEAR III CURRICULUM GUIDE

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

PIEDMATIC CLERKSHIP KEY PERSONNEL

Ms. Lynn Scott
Undergraduate (Medical Student) Education Coordinator
Department of Pediatrics
Telephone 745-5751
Take main elevators to 3rd floor. Make a right turn out of the elevator. Make a right at the first corridor; corridor “G”. The office is to the first door on the left in corridor G 32.

Yvonne M. Friday MD
Director, Undergraduate Education
Beeper # 2000  Office 745-5751
yfriday@med.wayne.edu

Latisha Carter-Blank
Assistant Director, Undergraduate Education
Beeper #16400  Office 745-4891
lcarterb@med.wayne.edu

Joshua Evans MD
Assistant Director, Undergraduate Education
Beeper 7363 Office: 745-4323
jevans3@dmc.org

Charles Pelshaw MD
Associate Director, Undergraduate Education
Beeper # 4515 Office: 993-2757/7455751
cpelshaw@dmc.org

Rosemary Shy
General Pediatrics Coordinator
Beeper: #3541  Office: 966-0613
rshy@med.wayne.edu

Bonita Stanton MD
Professor and Chairman
Pediatrician-in-Chief
Telephone 745-5870
bstanton@dmc.org
PEDIATRIC CLERKSHIP ORIENTATION

Orientation is held on the first day of the rotation at Children’s Hospital Of Michigan in the auditorium. One month prior to the beginning of the clerkship, you will receive an email confirming the time and place of the orientation. If you are not contacted, please call the Undergraduate Education Office for clarification at 313/745-5751.

ORGANIZATION OF CLERKSHIP

The 8 week pediatric clerkship is divided into inpatient and outpatient rotations. Each rotation is approximately 4 weeks in duration.

During your inpatient rotation you will be assigned to an inpatient ward team consisting of 4-5 interns, 1-2 senior pediatric residents, 1-2 faculty attendings. You are responsible for patients you pick up while on call.

During the outpatient rotation, you will rotate through Primary Care, Emergency Medicine, Newborn Nursery and a Specialty Site. An additional orientation for the ambulatory experience will be held prior to beginning that part of the clerkship.

MID-ROTATION INSTRUCTIONS

At the mid-portion of your clerkship, students will switch rotations; the students on the ambulatory service will go to the in-patient service and the in-service students will begin their ambulatory rotation.

Those students switching to the in-patient service should report to their designated ward at 7:00 am on that morning. The Senior Resident, will introduce the student to the interns and assign them to patients. The shift/call schedule is given to the students at orientation. We also have an inpatient re-orientation to reiterate responsibilities for inpatient.

Those students switching to the ambulatory service should report for Ambulatory Pediatrics as indicated during the general orientation. The Clerkship Director must be informed if a student cannot make it to the orientation.

DIDACTIC RESPONSIBILITIES

Mandatory attendance is required at Orientation, Procedure Fair, Student Report, Neonatal Exam and Rash Review. Please remember to "sign-in" when indicated. If anything prevents your attendance at didactic sessions, please inform the student coordinator in the Pediatric Education Office: 745-5751.

We provide the following didactic experiences:

$Student Report, 1-2 pm selected afternoons
$Children Are Different, 1:00-2:30, First or Second day of Clerkship
$Procedure Fair 3-5 pm, Second day of Clerkship
$Mock Student Report, usually the first week of the Clerkship
$Fluid Management, usually the first week of the Clerkship
$Primary Care Pediatrics 1-3 pm, selected Wednesdays (Immunizations, Nutrition, Well Child Care, Growth Assessment, Development Assessment, Rash Review).
$Professor Rounds - 2:00 pm, Selected Thursdays
STUDENT EVALUATIONS and FEEDBACK:
Student clinical evaluations are based on your clinical performance. Students are judged on the completeness and accuracy of history and physical exam data acquisition, clinical knowledge application; communication skills, and diagnostic and problem-solving skills.

Mid-Rotation Review
A "Mid-Rotation Review" is submitted during your in-patient month. The review simply states whether the student is satisfactory or unsatisfactory in the following areas:

- Attendance
- Appearance
- Motivation
- Historical data acquisition
- Physical exam accuracy
- Data integration
- Differential diagnosis formulation

If the student is unsatisfactory in any component, a formal meeting will be held with the student to advise him/her of suboptimal performance and to provide suggestions for remediation prior to the end of the clerkship.

GRADING PROCESS

Clinical Evaluations
A. In-Patient Preceptor Evaluations
Formal end-rotation School of Medicine Evaluations are completed by your Intern(s), Senior Resident(s) and Floor Attending(s). These evaluations are submitted to the clerkship director in order to compute the student’s final clinical evaluation.

B. Ambulatory Pediatric Preceptor Evaluations
A composite evaluation will be completed based on Primary Care, Specialty Site and Emergency Medicine evaluations. These evaluations are submitted to the clerkship director in order to compute the student’s final clinical evaluation

C. Observed Clinical Evaluation
The Observed Clinical Evaluation is based on your Pediatric OSCE; Oral Presentations - Student Report and Rash Review; Written History and Physical Exam critiques – Inpatient and Outpatient; Observed Physical Exam sessions.

D. Professionalism
Evaluation is based on “degree of effort” as evidenced by timely completion of assignments; patient encounter volumes, core patient documentation on campus mobility; student report attendance.

**Written Exam:**
An NBME shelf exam is given at the end of the clerkship. In preparation for the exam, students are expected to complete the study modules and work through the differential diagnoses for common pediatric problems and diseases. A Clerkship Review packet and relevant web based resources are also provided.

Most questions are in "vignette" format; i.e. you will be given data in a narrative format and be asked to select either the most appropriate diagnosis, select the most appropriate diagnostic work-up, the most likely causative agent, or the most appropriate management plan. There are usually 100 questions. This is a timed exam of 2 ½ hours (150 minutes). The exact date and site can be found on your lecture schedule.

Please visit the NBME website for information and content of Pediatric Exam [www.nbme.org](http://www.nbme.org)
- On the Left handed menu select “Services for Medical Schools”
- On the top menu select “Subject Exams”
- Download “Content Outlines and Sample Questions”
- Use the index to go to “Pediatric Subject Exam”

**The standardized mean = 70 test score.**
**Satisfactory/Pass = 60 test score.**
**Honors = 80 test score.**

**OSCE (Objective Structured Clinical Evaluation):**
The OSCE is used to verify pediatric competencies. The OSCE is one of the determinants of the Observed Clinical Evaluation.

The OSCE will evaluate the following competencies:
- Anticipatory Guidance provision (safety, nutrition, injury prevention etc.)
- Development Assessment
- Focused History acquisition
- Growth evaluation
- Heart and lung sounds interpretation
- Immunization analysis/management
- Physical Exam/Vital Signs acquisition
- Radiograph interpretation
- Visual Diagnosis

The Pediatric OSCE consists of:
- An audiovisual knowledge exam - physical exam models, computers, video clips, graphs and photographs
- A clinical patient exam consisting of 6 stations that include a standardized parent/patient and an observer.
You will receive a copy of your graded OSCE answer packet within 4 days.
You are graded either A Satisfactory or A Incomplete at each station.
An A Incomplete station score identifies a deficiency that needs to be reviewed by the student prior to the end of the pediatric clerkship. Review options are listed on the graded exam.
**GRADE COMPUTATION:** Your final grade will be computed on the basis of the following criteria:

- Final Clinical Evaluation – preceptor evaluations and observed clinical evaluation
- NBME Shelf Exam
- Professionalism

**Grades honored at WSU School of Medicine:**

- Honors - Outstanding Final Clinical Evaluations, Outstanding Knowledge, Outstanding Professionalism
- Satisfactory with Commendation - Outstanding Clinical Evaluation, Knowledge Exam score of at least 70 (70=standardized mean), and Outstanding Professionalism
- Satisfactory- Satisfactory Final Clinical Evaluations, Satisfactory Knowledge and Satisfactory Professionalism
- Unsatisfactory- Needs Improvement or Unsatisfactory in either Clinical Evaluations OR Knowledge OR Professionalism
- Satisfactory - Satisfactory Final Clinical Evaluations, Satisfactory Knowledge and Satisfactory Professionalism
- Unsatisfactory - course work not completed by the student
- Pending
  - Administrative - pending completion of evaluations or grade computation by clerkship faculty
  - Hold - student needs to return non-course work items (e.g. pager)

**REPORTING OF GRADES:**

Per policy of WSU Medical School, the Office of Student Affairs is responsible for reporting grades to medical students. Review of faculty evaluations is considered an essential component of your clinical work. Therefore, grades will not be reported over the telephone to medical students.

**PEDIATRIC GRADE APPEALS**

- GRADE APPEALS MUST BE INITIATED WITHIN 4 WEEKS OF GRADE REPORTING.
- Initiation of an appeals request is made by first scheduling an appointment with the Clerkship Director or designee. Please email Dr Friday at yfriday@med.wayne.edu or call the Pediatric Undergraduate Education Office at 745-5751 to schedule your appointment.
- After discussion, the student must complete an appeal letter to the Undergraduate Pediatric Education Committee. The Clerkship Director or designee will provide recommendations regarding the content of the appeals letter as well as the time and date of the next scheduled Undergraduate Pediatric Committee meeting.
- The student will be informed by email, of the Committee's decision within three weeks of its decision. The information will be emailed to the student’s School of Medicine email address.
- If the student's appeal is denied, and the student desires to pursue the matter further, the student should then appeal to the School of Medicine Third Year Committee.
GENERAL GOAL STATEMENT: The 8 week clerkship in Pediatrics will give you an opportunity to integrate your knowledge of pathology and physiology with the processes of growth and development of the child and to observe how these processes are affected by disease states. More than in any other rotation the student will have an opportunity to use preventive medicine as a device to insure optimal health.

Upon completion of the Junior Pediatric Clerkship, the student should be able to:

1. Serve as an advocate for children in both the public and the medical communities.

2. Obtain pertinent medical, developmental and social historical data from the parent(s) and child, which will provide the basis for comprehensive evaluation and understanding of a clinical problem.

3. Achieve proficiency in the performance of a complete physical examination of an infant, a child and an adolescent.

4. Record accurately the pertinent positive and negative findings from both historical and physical exam data in a clear, concise and detailed manner. Understand the implications of documentation as a medicolegal document.

5. Use medical language specific to pediatrics to present patients and establish dialogue between colleagues and parent/caregivers.

6. Assess the physical growth and psychomotor development of any given infant, child or adolescent.

7. Acquire a fund of knowledge of pediatrics in order to formulate:
   • Differential Diagnoses for common pediatric signs and symptoms;
   • Diagnostic Plans for differential diagnosis
   • Management Plans for common diseases
   • Age appropriate Health Maintenance Plans

8. Understand preventative medicine. Be able to apply its concepts to the optimization of growth and development of the child and to the provision of anticipatory guidance.

9. Apply pathophysiology specific for common disease entities to achieve an understanding of that disease process. Apply this knowledge to understand the effect of a particular disease on growth and development.

10. Identify and efficiently use pediatric resource materials to allow for the immediate, as well as, future acquisition of factual knowledge of pediatrics.
You will receive a copy of Pediatric Case Files for your use at orientation. This book must be returned at the end of the clerkship.


EQUIPMENT
You will need a stethoscope (pediatric size), reflex hammer, bulb insufflator and cloth tape measure.
CONTACT INFORMATION MEDICAL STUDENT CLERKSHIP IN PSYCHIATRY:
Course Director: Mary Morreale, MD
Office: University Psychiatric Center
2751 E. Jefferson, Suite 400
Detroit, Michigan
48207-4166
Fax: (313) 577-2233
Telephone: (313) 577-1779
Email address: mmorreale@med.wayne.edu

EMAIL IS THE PREFERABLE METHOD OF COMMUNICATION

Program Assistant: Yolanda Pitts
Email address: ypitts@med.wayne.edu
Telephone: (313) 577-3130

INTRODUCTION:
Psychiatry is the branch of medicine concerned with the prevention, diagnosis, and treatment of behavioral brain disorders. The educational mission of the Department of Psychiatry and Behavioral Neurosciences at Wayne State University is to teach the knowledge base, skills, and professional attributes in psychiatry and behavioral neurosciences for future physicians to practice competently in any medical specialty.

OVERVIEW OF THE YEAR III CLERKSHIP:
The psychiatry clerkship is one month in length, and is one of the core clerkships for medical students during their third year of medical school. Your time during the clerkship will be divided between clinical experience and didactic lectures covering core subjects. Students are assigned to one site offering a variety of clinical settings, including inpatient, partial hospitalization programs, consultation services, emergency room, and outpatient services.

All students, regardless of site assignment, are to report at 9:30am on the first day of their psychiatry clerkship for a mandatory orientation session, unless notified of a change by our office. At this meeting, logistical aspects of the clerkship will be reviewed (grading policy, exam date, lectures, etc), information regarding the sites will be distributed, and objectives for the clerkship will be reviewed.

EXPECTATIONS:
1. Prior to the start of the clerkship, you will receive an email informing you of the location for orientation. Attendance at this departmental orientation is mandatory, regardless of the site to which you are assigned for the remainder of the clerkship. Please wear professional attire (see WSU SOM dress code policy).

2. You are expected to attend centralized Wednesday meetings scheduled for all students in the psychiatry clerkship. Attendance is mandatory. ***A make-up assignment will be required for any student who has an excused absence from didactics. Any unexcused absences will result in a clinical failure of the rotation, with the need to repeat the entire rotation.
3. When not at central lectures or meetings, you are to arrive at and remain at your clerkship site as scheduled by your site coordinator. You are to complete all assigned duties and responsibilities, including night call and weekends as scheduled. While we strive to provide an equivalent educational experience across the sites, schedules at the various sites are not identical. It is your responsibility to follow the schedule assigned by your site coordinator.

4. Site Assignments: As much as possible, we will attempt to place you at the rotation site to which you were assigned on your schedule at the beginning of the year. However, there are times when students must be reassigned to a different site for administrative or other purposes. You will be notified of any change in rotation site at the orientation session on the first day of the clerkship. Under no circumstances will reassignments be made based on the perception of a more desirable schedule at a particular site or more desirable geographic location.

5. Hospital Attendance: Daily attendance is mandatory, including weekends and nights as per the schedule provided by the site coordinator. All absences must be excused through the Student Affairs Office of WSU School of Medicine. You should also notify your supervising attending/residents, your site coordinator, and Dr. Morreale of all absences (including part of a day) from the rotation site. Extended absences will have to be made up. Unexcused absences from rotation sites will result in a clinical failure of the rotation.

6. You are expected to attend and participate in all didactic sessions including those at the rotation site and centralized lectures or meetings with Dr. Morreale or other faculty.

7. You are required to prepare discussions, assignments and reports as assigned.

8. Because of the special nature of the relationships developed in a psychiatric setting (often referred to as transference and countertransference), you are to refrain from any social activity with your psychiatric patients, or any other activity that might be construed as a nonprofessional relationship. If any specific questions regarding this arise during your clerkship, contact your supervising resident or attending physician immediately.

9. Patients will sometimes request that certain information be kept confidential. Confidentiality is a very important issue, and you should refrain from discussing cases where others may hear (hallways, elevators, etc.), or with people who are not part of the treatment team (friends, family members, etc). However, it is your obligation to inform the patient that you are working as part of a team, and any information disclosed to you will be shared with the team (house staff, attending staff, nursing and social work staff, etc). It is imperative that if any patient gives you any reason to be concerned about dangerousness (suicidality and violence toward others) you immediately report this to your supervising resident or attending physician.

10. Under no circumstances are you to be put into a situation in which you feel you are personally in danger. The overwhelming majority of psychiatric patients represent no
danger to others, but in the unlikely event that you feel you are in a dangerous situation, you are to contact your supervising resident or attending physician immediately.

11. In the event that you are to work with a patient with active tuberculosis, please wear the mask provided for this purpose by the School of Medicine.

12. In the event you feel you are being abused or mistreated, please contact your site coordinator, Dr. Morreale, or the Office of Student Affairs.

13. A student will be assessed tuition charges if required to repeat clinical time.

OBJECTIVES: the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) created the following objectives

The Clinical Learning Objectives are conceptualized to fall into one of four (4) main units:

I. Clinical Skills
II. Psychopathology and Psychiatric Disorders
III. Disease Prevention, Therapeutics and Management
IV. Professionalism, Ethics and the Law

CONTENTS

UNIT I: CLINICAL SKILLS
   A. History-Taking, Examination, and Medical Interviewing
   B. Documentation and Communication
   C. Clinical Reasoning and Differential Diagnosis
   D. Assessment of Psychiatric Emergencies

UNIT II: PSYCHOPATHOLOGY AND PSYCHIATRIC DISORDERS
   A. Cognitive Disorders
   B. Substance Use Disorders
   C. Psychotic Disorders
   D. Mood Disorders
   E. Anxiety Disorders
   F. Somatoform Disorders, Factitious Disorder, and Malingering
   G. Dissociative and Amnestic Disorders
   H. Eating Disorders
   I. Sexual Disorders
   J. Sleep Disorders
   K. Personality Disorders
   L. Disorders in Childhood and Adolescence
   M. Geriatric Psychiatry
   N. Adjustment Disorders
UNIT III: DISEASE PREVENTION, THERAPEUTICS, AND MANAGEMENT
   A. Prevention
   B. Pharmacological Therapies
   C. Brain Stimulation Therapies
   D. Psychotherapies
   E. Multidisciplinary Treatment Planning and Collaborative Management
   F. Complementary and Alternative Treatments

UNIT IV: PROFESSIONALISM, ETHICS, AND THE LAW
   A. Professionalism
   B. Medical Ethics
   C. Medical-Legal Issues in Psychiatry
   D. Cultural Competence and Mental Health Disparities

Unit I: Clinical Skills

Topic Area A: History-Taking, Examination and Medical Interviewing

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Elicit and accurately document a complete psychiatric history, including the identifying data, chief complaint, history of the present illness, past psychiatric history, medications (psychotropic and non-psychotropic), general medical history, review of systems, substance use history, family history, and personal and social history.

2. Perform an appropriate physical exam on patients with presumed psychiatric disorders as described below:
   a) Recognize and discuss bodily signs and symptoms that accompany classic psychiatric disorders (e.g., tachycardia and hyperventilation in panic disorder).
   b) Discuss the extent to which a general medical illness may contribute to the signs and symptoms of a psychiatric disorder.
   c) Recognize and discuss the possible manifestations of psychotropic drugs (e.g., medications and drugs of abuse) in the physical exam.
   d) Make recommendations for further evaluation including appropriate laboratory, imaging, psychometric and other medical testing.
3. Recognize the importance of, and be able to obtain and interpret, historical data from multiple sources including family members, community mental health resources, primary care providers, religious and spiritual leaders, old records, child’s teachers, primary care physician, indigenous and complementary/alternative providers, etc.

4. Perform and accurately describe the components of the comprehensive Mental Status Examination (e.g., including general appearance and behavior, motor activity, speech, affect, mood, thought processes, thought content, perception, sensorium and cognition, abstraction, intellect, judgment, and insight.) Describe variations in presentation according to age, stage of development and cultural background.

5. Describe common abnormalities, and their causes, for each component of the Mental Status Exam.

6. Perform common screening exams for common psychiatric disorders (e.g., CAGE, MMSE, etc.).

7. Discuss and use basic strategies for engaging and putting patients at ease in challenging interviews (e.g., with patients who are disorganized, cognitively impaired, hostile/resistant, mistrustful/fearful, circumstantial/hypervocal, unspontaneous/hypoverbal, potentially assaultive; when being assisted by an interpreter). Describe different interviewing techniques for different ages.

8. Demonstrate an effective repertoire of interviewing skills including: appropriate initiation of the interview; establishing rapport; the appropriate use of open-ended and closed questions; techniques for asking "difficult" questions; the appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence, summary statements; soliciting and acknowledging expression of the patient's ideas, concerns, questions, and feelings about their illness and its treatment; communicating information to patients in a clear fashion; appropriate closure of the interview; and be able to perform these basic interviewing skills in performing a family assessment.

9. Discuss and avoid the common pitfalls in interviewing technique including: interrupting the patient unnecessarily; asking long, complex questions; using jargon; asking questions in a manner suggesting the desired answer; asking questions in an interrogatory manner; ignoring patient verbal or nonverbal cues; making sudden inappropriate changes in topic; indicating patronizing or judgmental attitudes by verbal or nonverbal cues.

10. Discuss indications, challenges and methods for successfully eliciting an accurate history and performing a mental status exam with patients across the lifespan, those with communication impairments (e.g., deafness), and those from diverse ethnic, linguistic and cultural backgrounds;

**Topic Area B: Documentation and Communication**

**Learning Objectives:**

By completion of the clerkship/medical school, the student will be able to:

1. Accurately document a complete psychiatric history and appropriate examination and accurately record and communicate the components of a comprehensive mental status examination.

2. Accurately document the daily or periodic progress of patients’ psychiatric disorders recording mental status changes and diagnostic impressions.
3. Provide a clear and concise oral presentation of a) a complete psychiatric evaluation including relevant history, mental status findings and diagnostic impressions, and b) the daily or periodic progress of patients being treated for psychiatric disorders.
4. Communicate clinical impressions, treatment recommendations including risks and benefits, and other relevant education to assigned patients and their families.
5. Document assessment of patient’s degree of risk to self and others and assessment of competency to participate in medical decision-making.

**Topic Area C: Clinical Reasoning and Differential Diagnosis**

**Learning Objectives:**
By the end of the clerkship/medical school, students will be able to:

1. Use the DSM-IV to identify signs and symptoms that comprise specific syndromes or disorders and construct diagnoses using the five axes system.
2. Formulate a differential diagnosis and plan for assessment of common presenting signs and symptoms of psychiatric disorders (e.g., insomnia, behavioral dyscontrol, confusion, hallucinations, delusions, etc.) including appropriate laboratory, imaging, psychometric and other medical testing.
3. Discuss the indications for, how to order, and the limitations of common medical tests for evaluating patients with psychiatric symptoms including laboratory, imaging, psychometric and other psychological and medical tests.
4. Interpret basic test results and consultant reports relevant to working through a differential diagnosis of designated patients with psychiatric disorders and general medical conditions with psychiatric manifestations.
5. Assess, record and interpret mental status changes of designated patients, and alter diagnostic hypotheses and management recommendations in response to these changes.

**Topic Area D: Assessment of Psychiatric Emergencies**

**Learning Objectives: Core**
By completion of the clerkship/medical school, the student will be able to:

1. Identify and discuss risk factors for suicide across the lifespan.
2. Conduct diagnostic and risk assessments of a patient with suicidal thoughts or behavior and make recommendations for further evaluation and management.
3. Identify and discuss risk factors for violence and assaultive behavior.
4. Discuss signs of escalating violence and review the appropriate safety precautions and interventions.
5. Discuss the differential diagnosis and conduct of a clinical assessment of a patient with potential or active violent behavior and make recommendations for further evaluation and management including appropriate laboratory, imaging, psychometric and other medical testing.

6. Discuss the clinical assessment and differential diagnosis of a patient presenting with psychotic symptoms such as perceptual disturbance, bizarre ideation and thought disorder, and make recommendations for further evaluation and management including appropriate laboratory, imaging, psychometric and other medical testing.

7. Discuss the clinical assessment and differential diagnosis of a patient with impaired attention, altered consciousness and/or other cognitive abnormalities and make recommendations for further evaluation and management including appropriate laboratory, imaging, psychometric and other medical testing.

8. Analyze risk factors and make recommendations for psychiatric hospitalization versus an ambulatory disposition in the management of designated patients.

**Unit II: Psychopathology and Psychiatric Disorders**

The typical signs and symptoms of common psychiatric disorders as outlined below should be learned and understood at each phase of the life cycle (i.e., children, adolescent, adult, and geriatric populations) and across language and cultural groups. The clerkship learning experiences should build on an established understanding of basic principles of neurobiology and psychopathology derived from the pre-clerkship curriculum.

**Topic Area A: Cognitive Disorders**

By completion of the clerkship/medical school, the student will be able to:

1. **Differentiate and discuss the cognitive, emotional and behavioral manifestations of common Cognitive Disorders including Delirium and Dementia syndromes.**

2. **Perform cognitive assessments to evaluate new patients and monitor patients with identified cognitive impairment, and discuss challenges to assessment related to the patient’s cultural background and developmental level.**

3. **Recognize the prevalence of Delirium in various clinical settings and across the lifespan, and discuss the clinical features and differential diagnosis of the delirious patient with recommendations for evaluation and management.**

4. **Differentiate the clinical features and course of the common types of Dementia including Alzheimer’s, Vascular, Lewy Body and those syndromes caused by other neurodegenerative and infectious diseases (e.g., Parkinson’s, HIV infection,**
Huntington’s, Pick’s, Creutzfeldt-Jakob, etc.).

5. Recognize the clinical features and discuss the differential diagnosis of a patient presenting with cognitive impairment and make recommendations for diagnostic evaluation and management including appropriate laboratory, imaging, psychometric and other medical testing.

Topic Area B: Substance Use Disorders

By completion of the clerkship/medical school, the student will be able to:

1. Obtain a thorough substance use history through the use of empathic, nonjudgmental interviewing techniques and established screening instruments (e.g., CAGE), accounting for the patient’s developmental stage and cultural background, and gather and incorporate information from collateral sources.

2. Compare and contrast diagnostic criteria for substance abuse versus dependence.

3. Know the clinical features of intoxication with cocaine, amphetamines, hallucinogens, cannabis, phencyclidine, barbiturates, opiates, caffeine, nicotine, benzodiazepines, alcohol and anabolic steroids.

4. Recognize the clinical signs and recommend management strategies for substance withdrawal from sedative hypnotics including alcohol, benzodiazepines and barbiturates.

5. Discuss the epidemiology, course of illness, and the medical and psychosocial complications of common substance use disorders.

6. Discuss typical presentations of substance use disorders in general medical and psychiatric clinical settings.

7. Discuss management strategies for substance abuse and dependence including detoxification, 12-step programs, support groups (e.g., AA, NA, ALANON), pharmacotherapy, rehabilitation programs, psychotherapies, and family support.
Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Define the term psychosis and discuss the clinical manifestations and presentation of patients with psychotic symptoms.

2. Recognize that psychosis is a syndrome and discuss the broad differential diagnosis, including both primary psychiatric as well as other types of medical conditions, which necessitates a thorough medical evaluation for all patients presenting with signs and symptoms of psychosis.

3. Develop a differential diagnosis and plan for further evaluation of patients presenting with signs and symptoms of psychosis including appropriate laboratory, imaging, psychometric and other medical testing.

4. Compare and contrast the clinical presentation of psychotic disorders in children and adolescents, adults, the elderly, patients in a general medical practice setting, the developmentally disabled, and accounting for cultural diversity (i.e., distinguishing psychotic disorders from culturally appropriate spiritual experiences and healing traditions such as shamanism and faith healing).

5. Compare and contrast the clinical features and course of common psychiatric disorders that present with associated psychotic features.

6. Discuss epidemiology, clinical course, prodromal stages, subtypes, and the positive, negative and cognitive symptoms of Schizophrenia.

7. Recommend management of patients with Schizophrenia and other psychotic disorders including all relevant interventions (i.e., biological, psychological, social).

Topic Area D: Mood Disorders

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:
1. Discuss the epidemiology of mood disorders with special emphasis on the prevalence of depression in the general population and in non-psychiatric clinical settings among patients with other medical-surgical illness (e.g., cardiovascular disease, cancer, neurological conditions) and the impact of depression on the morbidity and mortality of other medical-surgical illness.

2. Compare and contrast the features of unipolar and bipolar mood disorders with regard to clinical course, comorbidity, family history, prognosis and associated complications (e.g., suicide).

3. Discuss the differential diagnosis for patients presenting with signs and symptoms of mood disturbance, including primary mood disorders (e.g., Bereavement, Major Depressive Disorder, Bipolar Disorders, Adjustment Disorder, etc.) and mood disorders secondary to other conditions (e.g., substance use, underlying medical-surgical illness) with regard to clinical course, comorbidity, family history, prognosis, associated complications (e.g., suicide), and plan for further evaluation including appropriate laboratory, imaging, psychometric and other medical testing.

4. Discuss the subtypes of primary mood disorders including unipolar versus bipolar, melancholic versus atypical depressive features, psychotic features, seasonal pattern, postpartum onset, etc.

5. Compare and contrast the prevalence and clinical presentation of mood disorders in children and adolescents, adults, the elderly, patients in a general medical practice setting, the developmentally disabled, and across cultural, economic, and gender groups.

6. Discuss the high risk of suicide in patients with mood disorders, risk assessment and management strategies.

7. Recommend management of patients with primary or secondary mood disorders including all relevant interventions (i.e., biological, psychological, social).

Topic Area E: Anxiety Disorders

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the epidemiology of anxiety disorders with special emphasis on the
prevalence of anxiety in the general population and in non-psychiatric clinical settings and its effect on total health care expenditures in the U.S.

2. Discuss the differential diagnosis for patients presenting with anxiety, including primary anxiety disorders (e.g., Phobias, Panic Disorder, Adjustment Disorder, etc.) and anxiety disorders secondary to other conditions (e.g., substance use, underlying medical-surgical illness) with regard to developmental stage, developmental disability, cultural background, medical practice setting, clinical course, comorbidity, family history, prognosis, associated complications, and plan for further evaluation including appropriate laboratory, imaging, psychometric and other medical testing.

3. Discuss the epidemiology and distinguish the clinical course, co-morbidity, family history and prognosis of Obsessive Compulsive Disorder.

4. Discuss the epidemiology and distinguish the clinical course, co-morbidity, family history and prognosis of Acute and Post-traumatic Stress Disorders.

5. Recommend management of patients with primary or secondary anxiety disorders including all relevant interventions - psychotherapies (e.g., relaxation, exposure-response prevention, etc), pharmacotherapies, etc.

Topic Area F: Somatoform Disorders, Factitious Disorder and Malingering

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Compare and contrast the signs, symptoms, clinical characteristics and course, and prognosis of specific Somatoform Disorders including Somatization Disorder, Conversion Disorder, Pain Disorder, Body Dysmorphic Disorder, and Hypochondriasis.

2. Compare and contrast the characteristic features of Factitious Disorder and Malingering and distinguish these conditions from the Somatoform Disorders.

3. Discuss the principles and challenges to physicians of ongoing evaluation and management of patients with Somatoform Disorders, Factitious Disorder and Malingering.

Topic Area G: Dissociative and Amnestic Disorders
Learning Objectives:
By completion of the clerkship/medical school, the student will be able to:

1. Define “dissociation”.
2. Discuss the hypothesized role of psychological trauma in the development of disorders characterized by dissociation and altered memory (e.g., Acute Stress Disorder, PTSD, Borderline Personality, Dissociative Identity Disorder).

**Topic Area H: Eating Disorders**

Learning Objectives:
By completion of the clerkship/medical school, the student will be able to:

1. Discuss the clinical features, course, complications including mortality, and prognosis of common Eating Disorders (e.g., Anorexia Nervosa, Bulimia, and Obesity).
2. Propose plans for further evaluation, referral, and management, including discussion of clinical features suggesting the need for hospitalization of patients with possible Eating Disorders.

**Topic Area I: Sexual Disorders**

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Obtain and document a sexual history and interpret findings to formulate a differential diagnosis accounting for patient age, developmental stage, sexual orientation, and cultural background.

**Topic Area J: Sleep Disorders**

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:
1. Obtain a complete sleep history and interpret findings to formulate a differential diagnosis.

2. Discuss the signs and symptoms of common sleep disturbances that accompany psychiatric disorders and substance use including dysomnias and parasomnias.

3. Discuss the effects of common psychotropic medications on sleep.

4. Discuss the principles of sleep hygiene and how to counsel patients with sleep complaints.

Topic Area K: Personality Disorders

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the concepts and relevance of personality traits and disorders in providing patient care.

2. Discuss the three cluster conceptualization of personality disorders as outlined in the DSM-IV-TR and describe typical features of each disorder.

3. Recognize and discuss common clinical features and maladaptive behaviors suggestive of a personality disorder and make recommendations for further evaluation, referral, and management.

4. Summarize the principles of management of patients with personality disorders in any clinical setting, particularly those with the most challenging behaviors (i.e., Borderline and Antisocial), including self-awareness of one’s own response to the patient, the benefit of outside consultations, the use of both support and non-punitive limit setting, and the indications for various forms of psychotherapy.

Topic Area L: Disorders in Childhood and Adolescence

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:
1. Compare and contrast the process of performing a psychiatric evaluation of children and adolescents with that of adults, including the need for systems-based assessment and treatment of children within family contexts.

2. Recognize and distinguish the difference between behavior that is culturally appropriate and developmentally normal from behavior that suggests psychopathology (e.g., stranger anxiety versus Panic Disorder).

3. Discuss the clinical assessment and differential diagnosis for children and adolescents presenting with disruptive behavior and make recommendations for further evaluation including appropriate laboratory, imaging, psychometric and other medical testing, referral, and management.

4. Discuss the clinical assessment and differential diagnosis for children and adolescents presenting with developmental concerns including dysmorphia, delayed intellectual/social/motor/language skills, and/or failure to thrive and make recommendations for further evaluation including appropriate laboratory, imaging, psychometric and other medical testing, referral, and management.

5. Discuss the clinical assessment and differential diagnosis for children and adolescents presenting with school performance problems and make recommendations for further evaluation including appropriate laboratory, imaging, psychometric and other medical testing, referral, and management.

6. Discuss the epidemiology, clinical course, family history and prognosis of common psychiatric disorders in childhood and adolescence including Attention Deficit and Disruptive Behavioral Disorders, Learning Disability, Autistic Spectrum Disorders, Mood and Anxiety Disorders, Eating Disorders, and Substance Use Disorders.

7. Recommend management of common psychiatric disorders in childhood and adolescence including all relevant interventions.

8. Discuss the physician’s role in diagnosing, managing and reporting suspected abuse of children and adolescents.

Topic Area M: Geriatric Psychiatry

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Describe issues unique to the psychiatric evaluation of the elderly (e.g., changing sensory perception) and the need for a comprehensive approach to
assessment including physical and mental status exam and appropriate laboratory, imaging, psychometric and other medical testing.

2. Compare and contrast the clinical presentation of psychiatric disorders in the elderly versus other adults (e.g., somatic focus in depression).

3. Discuss the vulnerability and increased incidence of certain psychiatric conditions in the elderly (e.g., cognitive disorders, mood disorders)

4. Discuss and assess the heightened risk of suicide in elderly patients in various cultural groups.

5. Discuss the physiology of aging relevant to the prescribing of psychotropic medications.

6. Discuss the effect of losses in the elderly relevant to the incidence, course and management of psychiatric disorders.

7. Discuss the physician’s role in diagnosing, managing and reporting suspected elder abuse.

Topic Area N: Adjustment Disorders

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Describe the essential features and course of Adjustment Disorders.

2. Compare and contrast Adjustment Disorders with major Mood, Anxiety and Conduct Disorders and normal Bereavement.

3. Recommend plans for further evaluation and management of patients diagnosed with Adjustment Disorders.

Unit III: Disease Prevention, Therapeutics, and Management

Topic Area A: Prevention

Learning Objectives:
By completion of the clerkship/medical school, the student will be able to:

1. Discuss the role of parenting, families, society and elements of attachment theory in the cause and disability of psychiatric disorders.

2. Assess the effects of socioeconomic factors (e.g., language, culture, family stability, divorce, finances, lifestyle, insurance status, poverty, etc.) on the course of psychiatric illness and adherence to treatment and counsel assigned patients and their families.

3. Describe the genetic and environmental risk factors for psychiatric illness including emotional, physical and sexual abuse, domestic violence, and co-morbid substance abuse.

4. Discuss the risks of untreated psychiatric illness and the importance of early identification of major psychiatric disorders in at-risk youth.

5. Perform a behavioral health risk assessment of patients with and without established psychiatric diagnoses and identify and counsel patients regarding behavioral and lifestyle changes to promote mental health.

6. Discuss factors that suggest need for psychiatric hospitalization and inpatient care.

7. Provide education about psychiatric illness and treatment options to designated patients.

8. Discuss concerns related to polypharmacy and methods to increase the safety and effectiveness of psychotropic pharmacotherapy.

**Topic Area B: Pharmacological Therapies**

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the common, currently available psychotropic medications with regard to clinical indications and contraindications, presumed mechanism of action and relevant pharmacodynamics, common and serious adverse effects, pharmacokinetics, evidence for efficacy, cost, risk of drug-drug interactions and drug-disease interactions, and issues relevant to use in special populations (e.g., pregnancy and lactation, childhood and adolescence, the elderly, persons using herbal and over-the-counter treatments).
2. Propose selected psychotropic pharmacotherapy for designated patients and provide clinical reasoning that includes discussion of factors influencing treatment selection (e.g., patient-specific and drug-specific variables, scientific evidence).

3. Discuss the factors relevant to implementing, monitoring and discontinuing psychotropic pharmacotherapy including drug dosing, treatment duration, and adherence, and make management recommendations for dealing with an unsuccessful treatment trial (e.g., lack of efficacy, intolerability).

4. Counsel patients about psychotropic pharmacotherapy including risks and benefits of recommended treatment, treatment alternatives, and no treatment.

5. Identify and discuss resources to maintain an up-to-date knowledge of psychotropic pharmacotherapy.

6. Discuss special issues and concerns related to specific psychotropic drug classes including metabolic, hematologic, hepatic, etc.

**Antidepressant Agents:** Be able to discuss the risks, early detection, relevance and interventions for adverse drug effects (e.g., seizures, electrolyte disturbance, Serotonin Syndrome, Hypertensive Crisis, suicidality, cardiac arrhythmias, etc.

**Antipsychotic Agents:** Be able to discuss the risks, early detection, relevance and interventions for adverse drug effects (e.g., acute Extrapyramidal Side Effects/EPS, Tardive Dyskinesia, Neuroleptic Malignant Syndrome, metabolic derangements, cardiac arrhythmias, anticholinergic toxicity, etc.

**Mood Stabilizing Agents:** Be able to discuss the risks, early detection, relevance and interventions for adverse drug effects of lithium, anticonvulsants, and selected antipsychotic drugs used as “mood stabilizers” (e.g., Stevens-Johnson syndrome, hepatitis, electrolyte disturbance, etc) and the relevance of laboratory tests including plasma level monitoring.

**Anxiolytics and Sedative-Hypnotic Agents:** Be able to discuss the risks, early detection, relevance and interventions for drug toxicity, dependence and consequences of abrupt discontinuation.

**Stimulant Agents:** Be able to discuss the risks, early detection, relevance and interventions for toxicity and abuse.

**Cognitive Enhancers:** Be able to discuss the clinical use, drug interactions and potential adverse effects.

**Topic Area C: Brain Stimulation Therapies.**

Learning Objectives:

**By completion of the clerkship/medical school, the student will be able to:**

1. **Discuss electroconvulsive therapy (ECT) with regard to clinical indications**
and contraindications, presumed mechanism of action, common and serious adverse effects, evidence for efficacy, cost, and issues relevant to use in special populations (e.g., pregnancy, childhood and adolescence, the elderly).

Topic Area D: Psychotherapies

Learning Objectives: Core

By completion of the clerkship/medical school, the student will be able to:

1. Discuss general features of common psychotherapies and recommend specific psychotherapy for designated patients in conjunction with or instead of other forms of treatment and provide clinical reasoning that includes discussion of factors influencing treatment selection (e.g., patient-specific and treatment-specific variables, scientific evidence).

2. Counsel patients, promote the use of healthy coping strategies, provide education about psychotherapy and make appropriate referral for this modality of treatment.

3. Identify and discuss the relevance of potential levels of verbal and non-verbal communication occurring in the uniquely intimate relationship between doctor and patient that occurs regardless of the medical setting or type of medical care being provided including therapeutic boundaries, therapeutic stance, therapeutic alliance, transference and countertransference.

Topic Area E: Multidisciplinary Treatment Planning and Collaborative Management

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the roles of different physician specialties and non-physician healthcare disciplines (e.g., case managers, addiction counselors, interpreters, cultural liaisons, etc), demonstrate respect for these colleagues, and work collaboratively in the care of patients and their families.

2. Discuss the importance of working successfully with patient’s families and other agencies in the patient’s life (e.g., schools, employers, etc) accounting for
cultural diversity, to bring about an optimal clinical outcome.

3. Discuss indications for psychiatric consultation and how to appropriately request and respond to such a consultation.

4. Discuss and propose appropriate community resources as part of a comprehensive treatment plan for assigned patients (e.g., support groups, residential facilities, vocational rehabilitation, etc).

5. Discuss the impact of mental illness on access to appropriate healthcare and make recommendations for addressing these issues in planning treatment for assigned patients.

Topic Area F: Complementary and Alternative Treatments

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the popular use of Complementary and Alternative Modalities (CAM) of treatment and gather and analyze this information when performing a psychiatric evaluation.

Unit IV: Professionalism, Ethics and the Law

Topic Area A: Professionalism

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Identify and account for personal emotional responses to patients.

2. Demonstrate respect, empathy, responsiveness, and concern regardless of the patient’s problems, personal characteristics, or cultural background.

3. Demonstrate sensitivity to medical student-patient similarities and differences in gender, cultural background, sexual orientation, socioeconomic status, level of disability, educational level, political views, and personality traits.
4. Discuss the prevalence and barriers to recognition of psychiatric illnesses in general medical settings and recognition of general medical conditions in patients with known psychiatric illness.

5. Discuss the physician’s role in advocacy for services for the mentally ill.

6. Discuss the concept of boundaries in the doctor-patient relationship and boundary violations.

7. Demonstrate integrity, responsibility and accountability in the care of assigned patients.

8. Demonstrate scholarship in the form of contributing to a positive learning environment, collaborating with colleagues, and performing self-assessment and self-directed learning.

9. Be able to assess one’s strengths, weaknesses and health (physical and emotional), and be willing to seek and accept supervision and constructive feedback.

Topic Area B: Medical Ethics

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Identify and discuss issues of ethical concern in the care of assigned patients (e.g., autonomy versus beneficence and interpersonal boundaries).

2. Identify and discuss ethically risky and problematic situations encountered in healthcare (e.g., duty to warn, reporting child abuse).

Topic Area C: Medical-Legal Issues in Psychiatry

Learning Objectives:

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the risk factors, screening methods and reporting requirements for suspected abuse, neglect and domestic violence in vulnerable populations including children, adults, and the elderly.
2. Discuss the physician’s role in screening for, diagnosing, reporting and managing victims of abuse.

3. Discuss the principles, process and physician’s role in civil commitment, recognizing that there are variations in state law, and the implications of voluntary versus involuntary status of a patient.

4. Discuss the elements of informed consent and evaluation of decision-making capacity (i.e., the right to refuse treatment, assent versus consent in children and adolescents).

5. Discuss the principles and process of the physicians “duty to warn” obligation.

6. Discuss and give examples of when confidentiality may be breached including when treating children and adolescents.

Topic Area D: Cultural Competence and Mental Health Disparities

By completion of the clerkship/medical school, the student will be able to:

1. Discuss the mental health and mental health care disparities experienced by racial and ethnic groups and the factors that contribute to them.

2. Discuss how to elicit the cultural beliefs, preferences and practices that are relevant to making diagnostic assessments and treatment recommendations utilizing various resources (e.g., the patient, family, cultural experts, written literature, etc.).

3. Collect and incorporate cultural information in the assessment and treatment planning of assigned patients while avoiding stereotyping.

4. Identify and account for stereotypes, personal bias and prejudices towards patients from various cultural groups.

STUDENT EVALUATIONS:

1. Formative:
A mid-month evaluation, in the form of an observed clinical interview, is to be filled out by all students. This form is used to promote discussion with your site coordinator or supervising faculty about your performance. Feedback is essential and expected during this rotation. The
observed interview form is used as a tool for students to develop skills for seeking feedback from their supervising attendings. It is your responsibility to ask them for this evaluation. After discussing your performance at the mid-point of the clerkship, you and the attending are to sign the evaluation form. In addition, other methods of formative evaluation may be used at individual sites.

2. **Summative:** (these will be used to determine your final grade)

Clinical Evaluation: Calculation of the final clinical grade will be done by Dr. Morreale based on the student’s overall performance at their rotation site (based on written report by the site coordinators), assignments, presentations, participation, and the clerkship OSCE examination.

   a. The residents and attendings to whom you are assigned at your clerkship site will evaluate your clinical performance. The Clerkship Director will use this composite evaluation as a portion of the student’s final clinical grade, as reported on the WSU Student Clerkship Grade Report Form.

3. **OSCE Exam:** Students will participate in an OSCE examination at the end of the psychiatry clerkship. Students will complete a number of stations to demonstrate their skills and knowledge base in Psychiatry, including the ability to take a focused psychiatric history, the ability to formulate a differential diagnosis, and the ability to formulate a mental status exam. Both written and oral communication skills will be assessed. The interview and oral exam stations will be videotaped. Further information will be given at orientation, and during the month, to prepare students for taking the OSCE examination. Evaluation of student performance on the OSCE examination will be used as a portion of the student’s final clinical grade as reported on the WSU Student Clerkship Grade Report Form. For details, please see the Grading Matrix in the Orientation Section on Blackboard.

4. **The Psychiatry Subject Test** prepared by the National Board of Medical Examiners is the final written exam for the course. It is a standardized test administered on the final day of the clerkship.

5. **Attendance and Professionalism:** An integral part of learning in a clinical setting involves the exchange of information between the clinician and his/her peers. You are expected to attend and participate in lectures to expand both your own knowledge base and the knowledge of your peers. Students with excused absences from lectures will receive an “Incomplete” for the clerkship grade until the make-up assignment for that lecture is completed. Students with excused absences will be given a specific time frame to remediate the absence; failure to remediate absences during this time will result in an unsatisfactory clinical evaluation. Unexcused absences from lectures will result in clinical failure of the rotation.

**GRADING PROCESS:**
Course Grades:
1. **Honors:** To receive a grade of honors for the psychiatry clerkship, you must receive an outstanding evaluation for the clinical portion of the clerkship and receive an outstanding score on the written exam, with no unexcused absences.

2. **Satisfactory:** To receive a grade of satisfactory for the psychiatry clerkship, you must have no unexcused absences and receive:

   - A satisfactory evaluation for the clinical portion of the clerkship, and a satisfactory score on the written exam
   
   - A satisfactory evaluation for the clinical portion of the clerkship, and an outstanding score on the written exam (Satisfactory with Exam Commendations)
   
   - An outstanding evaluation for the clinical portion of the clerkship, and a satisfactory score on the written exam (Satisfactory with Clinical Commendations)

3. **Unsatisfactory:**

   - If a student receives an unsatisfactory score on the written exam but receives a satisfactory or outstanding evaluation on the clinical portion, (s) he will receive a grade of unsatisfactory and will retake the examination based on the rules of the medical school. If the student receives a score of satisfactory or outstanding on the repeat examination, a grade of S will be given. (Even if the clinical evaluation was outstanding, failure on the initial written exam excludes the possibility of an Honors grade, or clinical commendations, regardless of the grade attained on the repeat examination).

   - If a student receives an unsatisfactory score on this repeat written examination (s)he will be given a grade of unsatisfactory, and will be required to repeat the clerkship rotation, including the clinical portion and attendance at Wednesday lectures, before repeating the written examination.

   - If a student receives an unsatisfactory evaluation on the clinical portion of the clerkship (s) he will be required to repeat the clinical portion of the clerkship, including attendance at Wednesday lectures.

**Examination Score:**
Your written examination performance will be assessed using the NBME Psychiatry Subject Test, taken at the end of the clerkship.

- A score of 81 or above will be reported as outstanding.
- A score of 64-80 will be reported as satisfactory.
- A score of 63 or below will be reported as unsatisfactory

*These scores are fixed; no additional work may be done to boost examination scores into a higher category.*
**Clinical Evaluation:**

**Outstanding:**
All of the following must be satisfied for an outstanding evaluation:

- You must have 7 of the 10 competencies rated as outstanding; AND
- At least three of the critical competencies (Application of Knowledge, History Taking, Physical Exam, Communication with Patients/Families, Professionalism) must be rated as outstanding; AND
- No competencies rated as below expectations; AND
- Outstanding performance on the OSCE examination (demonstration of superior knowledge base in psychiatry, superior skills in interviewing and presentation, and demonstration of integration and application of concepts during the OSCE examination), written assignments, professionalism, participation and presentations.

**Unsatisfactory:**
Any of the following are criteria for unsatisfactory:

- Below expectations in any of the five critical competencies (Application of Knowledge, History Taking, Physical Exam, Communication with Patients/Families, Professionalism); OR
- Three or more of the other competencies evaluated as below expectations with a lack of demonstrated progress towards becoming satisfactory. This lack of progress must be explained by the clerkship director in writing. In other words, students may have three or more below expectations in the non-critical competencies and still receive a passing clerkship grade if, and only if, the clerkship director indicates that while those competencies are rated as still below expectations, the student did demonstrate progress toward becoming Satisfactory during the clerkship; OR
- Unexcused absences from clinical duties or lectures.

**Satisfactory:** All other point combinations will be considered satisfactory.

**GRADE APPEALS:**
In accordance with Wayne State University School of Medicine policy, all grade appeals are to be directed in writing to the clerkship director within one month of recording of the grades. This includes the appeal of any part of your final grade (for example, reconsideration of your clinical performance as rated on your clinical evaluation). Students are encouraged to make an appointment with Dr. Morreale to discuss the concerns with their grade when they submit the grade appeal. Under no circumstances should a student contact the attending staff, residents, or site coordinator at the rotation site to request a re-evaluation of their clinical performance. If a student approaches his or her preceptor regarding a change in evaluation, the appeal process will be null and void.
TEXTBOOKS/REFERENCES:

Recommended:
Pocket Handbook of Clinical Psychiatry, Kaplan and Sadock or Concise Handbook of Clinical Psychiatry, Kaplan and Sadock. These give a good overview of the topics you are expected to know, and most students have found that they contain all the material needed for the exam. The pocket handbook is organized more in bullet-point format; the concise textbook is written more in narrative format.

Other books that deserve mention:
Comprehensive Textbook of Psychiatry, Kaplan and Sadock, is considered by most to be the standard text of psychiatry. At over 3000 pages, it is more than you’ll want to read in a month, but you may wish to refer to it as a reference for in-depth information about a specific topic (for presentations, etc). There is a shorter Synopsis of Psychiatry used by most psychiatry residents during training.

DSM-IV-TR: the standard reference for psychiatric diagnostic criteria. It is also more than you’ll want to read this month, but there are pocket versions which some students find useful.

Pocket Handbook of Psychiatric Drug Treatment, Kaplan and Sadock. This provides more depth about the medications; although it may have more information than needed about the meds, it does provide a good overview of side-effects of the different classes of medications, which can be helpful.

Electronic Resources: The blackboard website has many of the references you will need for the clerkship, including Practice Guidelines for major psychiatric disorders. Many students also find the Year II Psychiatry lecture notes helpful.
DEPARTMENT OF SURGERY

YEAR III CURRICULUM GUIDE

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

2011-2012
DESCRIPTION OF ROTATION
DEPARTMENT OF SURGERY

STUDENT EXPECTATIONS

The time spent with the Department of Surgery (8 weeks) includes material presented by the Departments of Orthopedics, Urology, Neurosurgery and the general surgical divisions of General, Cardiothoracic, Pediatric Surgery and Plastic Surgery. The elective surgical assignments as of June 1, 2011 are as follows; Students are assigned to sites by the WSU School of Medicine based on their clinical campus.

- DMC/DRH/Harper/CHM - 8 weeks (4wks. DRH, 4wks. CHM/Harper)
- VA Hospital - 8 weeks
- Oakwood Hospital - 8 weeks
- Providence Hospital - 8 weeks
- Henry Ford Hospital - 8 weeks
- St. Joseph Hospital (Ann Arbor) - 8 weeks
- St. John's Hospital - 8 weeks
- Wm. Beaumont Hospital - 8 weeks

The principle goals when faced with a patient with a surgical condition the surgery clerkship are as follows: upon completion of the surgical rotation, students will be able to take a good history and perform an adequate physical examination, be able to appreciate the use of appropriate investigations in reaching diagnosis and have an understanding of the pathophysiology of disease entities, especially those which are unique to the purview of the general surgeon or surgical sub-specialist. Emphasis is placed on surgical problems commonly seen in primary care settings.

On the first day of each new rotation, Orientation for the entire group of incoming students is held, attendance at Orientation is mandatory. If a student misses, he/she must reschedule the clerkship. At this time, a folder is distributed to each student. This booklet contains much of the information required during any given rotation. The required text, which includes student objectives for each subject area, will form the core of the reading. Additional reading will be necessary based on the patients assigned to the student. Small group didactic tutorials are supplemented by several subspecialty lectures.
A guide to the goals and objectives of the course is available on the Department of Surgery website.

While on the surgical rotation, residents and students make rounds together. The surgical resident team teaches much of the day-to-day care of surgical patients, and is actively involved in student teaching and demonstrating minor surgical procedures necessary for the care of patients on the wards. Students will also make ward rounds with attending surgeons. This provides an opportunity for the teaching of deductive reasoning based on data, which the students have accumulated by examining patients and observing laboratory data assembled in the chart. Although specific operative techniques are not a primary part of the curriculum, the students are expected to demonstrate competence in suturing & knot tying, and to be able to close small incisions. In order to round out the surgical experience students will go to the operating room with their patients (if this does not conflict with a scheduled teaching session.)

Each student will request a mid-term evaluation to assess his/her ward performance. A mid-term examination will be given.

Each hospital to which students are assigned has a faculty member site coordinator and also a “student secretary”, the latter being responsible for day-to-day activities. Student hospital assignments received by the Department of Surgery from the Registrars’ Office are final. At times due to unforeseen circumstances the Department of Surgery may have to change assignments - the decision of the department is final. No requests for changes of site will be accepted or considered.

Attendance at scheduled lectures, ward rounds and other educational sessions is mandatory. Unexcused absences will result in a grade of Incomplete or Fail.

Each clinical site has a schedule of conferences, lectures, and case reviews directed to the student group that will cover the core subjects of Surgery. They are taught by faculty, and thus provide an opportunity to integrate clinical experience, required and optional reading, and the faculty members' experience. Attendance is mandatory without exception. Students who are absent (without being excused by the School of Medicine counselor) will receive an Incomplete grade. The missed lecture will be made up 2 months hence with the next group of students.
At orientation, the course requirements are given. If any of these are not completed, an Incomplete grade is given. Examples include online lectures, computer cases, suture labs, etc.

**SURGERY KEY PERSONNEL**

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<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>Department Chairman</td>
<td>Donald Weaver, M.D.</td>
<td>313-745-8778</td>
</tr>
<tr>
<td>Clerkship Director</td>
<td>Christopher Steffes, M.D.</td>
<td>313-745-8770</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Ms. Karan Crawford</td>
<td>313-577-7803</td>
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**CHILDREN'S HOSPITAL OF MICHIGAN**

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<tr>
<td>Chief of Service</td>
<td>Joseph Lelli</td>
<td></td>
</tr>
<tr>
<td>Site Coordinator</td>
<td>Scott Langenburg</td>
<td></td>
</tr>
<tr>
<td>Admin. Student Coordinator</td>
<td>Kellie Hagel</td>
<td>313-745-5881</td>
</tr>
</tbody>
</table>

**DETROIT RECEIVING HOSPITAL**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Chief of Service</td>
<td>James Tyburski, M.D.</td>
<td>313-745-3487</td>
</tr>
<tr>
<td>Site Coordinator</td>
<td>Alfred Baylor, M.D.</td>
<td>313-745-1350</td>
</tr>
<tr>
<td>Admin. Student Coordinator</td>
<td>Ms. Cindy Luiz</td>
<td>313-745-3487</td>
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</tbody>
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**HARPER HOSPITAL**

<table>
<thead>
<tr>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>Chief of Service</td>
<td>Donald Weaver M.D.</td>
<td>313-745-8778</td>
</tr>
<tr>
<td>Site Coordinator</td>
<td>TBA</td>
<td>313-745-8770</td>
</tr>
<tr>
<td>Admin. Student Coordinator</td>
<td>Ms. Melody Andrews</td>
<td>313-745-8775</td>
</tr>
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**HENRY FORD HOSPITAL**

<table>
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<tr>
<th>Role</th>
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<tr>
<td>Chief of Service</td>
<td>Scott Dulchavsky</td>
<td></td>
</tr>
<tr>
<td>Site Coordinator</td>
<td>Melissa Times, M.D.</td>
<td>313-916-9501</td>
</tr>
<tr>
<td>Admin. Student Coordinator</td>
<td>Ms. Deborah Everson</td>
<td>313-916-6374</td>
</tr>
</tbody>
</table>

**OAKWOOD HOSPITAL**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Chief of Service</td>
<td>John Fath, M.D.</td>
<td>313-593-0810</td>
</tr>
<tr>
<td>Site Coordinator</td>
<td>Hubert Huebl, M.D.</td>
<td>313-593-8660</td>
</tr>
<tr>
<td>Admin. Student Coordinator</td>
<td>Ms. Jill Balazi</td>
<td>313-593-8660</td>
</tr>
</tbody>
</table>
**ST. JOHN'S HOSPITAL & MEDICAL CENTER**

Chief of Service    Larry Lloyd, M.D.  313-343-3360  
Site Coordinator   Donn Schroder, M.D.  313-343-7849  
Admin. Student Coordinator  Ms. Angel Payne  313-343-7846

**ST. JOSEPH HOSPITAL & MEDICAL CENTER (ANN ARBOR)**

Chief of Service    Dan Whitehouse, M.D.  
Site Coordinator   Michael Heidenreich, M.D.  
Admin. Student Coordinator  Trisha Wellock  734-712-2442

**VETERANS ADMINISTRATION HOSPITAL**

Chief of Service    Scott Gruber, M.D.  313-576-3598  
Site Coordinator   Dan Reddy  313-576-4224  
Admin. Student Coordinator  Mr. Robert Guice  313-576-3963

**WM. BEAUMONT HOSPITAL (ROYAL OAK)**

Chief of Service    Charles Shanley, M.D.  
Site Coordinator   James Robbins, M.D.  248-551-2400  
Admin. Student Coordinator  Ms. Emily Anderson  248-551-2540

**EXAMINATIONS**

The final examination is a Shelf examination given on the last day of the rotation and includes general surgery and its specialties. For students who have not passed the written examination, and have not been able to rectify the deficiency by passing one of the regularly scheduled examinations during the year will retake the exam to coordinate with other Year III make-up examinations.

A short oral exam will also be given covering common topics in Surgery. Examination grades (Pass and Honors) are determined by the Surgery Curriculum Committee and examination grades are based on a normative distribution. Evaluation of clinical skills, personal interactions, attendance and ward performances are integrated with the student’s performance on his/her final
examinations (written and oral) in order to arrive at a final grade. Details of the grading procedure are found below.

**GRADING CRITERIA**

In order to arrive at a projected grade for your performance during the surgery rotation, we utilize the following tools for evaluating your performance:

1) Multiple-choice final examination (N.M.B.E. Shelf).
2) Rating scale evaluations of ward performance.
3) A short Oral examination covering common problems in Surgery. This will be graded on an O/P/F basis.

Performance in all categories (multiple choice final examination, Oral Examination and ward performance evaluation) must be satisfactory for a student to be given a passing grade. Good or “superior” ward performance does not compensate for a failing exam score, nor does a high exam score negate inadequate ward performance.

**TEST SCORING**

The grading system as outlined stresses clinical performance. A test score above a fraction of the Standard Deviation above the Mean will be necessary to be eligible for honors. The mean is generated independently for each separate rotation based on the scores of WSU students.

This value (x) will usually be about 0.5 of the Standard Deviation and will be set by the grading committee, whose decisions on this value are final. A score below 1.0 SD of the mean results is a failing test grade. An exception is if the score is 62 or above (alternative minimum pass)

**CLINICAL GRADE**

The site director will award a clinical grade based on any number of evaluations from faculty and residents, along with his/her perspective judgement. The grading committee approves all final grades.
At several sites, there is a required distribution of H&P’s, which must be satisfied. Failure to complete H&P’s will result in an Incomplete grade.

The Department of Surgery Grading & Curriculum Committee will use the method detailed below in reaching a course grade for each student. The information from the examination and rating scales will be recorded in a "Profile" sheet and become part of your student file.

<table>
<thead>
<tr>
<th>CLINICAL/ORAL EXAM</th>
<th>&lt; 1 STD DEV</th>
<th>&lt; MEAN + X</th>
<th>&gt; X ABOVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>O / O</td>
<td>Repeat Exam *</td>
<td>PASS</td>
<td>Honors</td>
</tr>
<tr>
<td>O / P</td>
<td>Repeat Exam *</td>
<td>PASS</td>
<td>PASS</td>
</tr>
<tr>
<td>O / F</td>
<td>Repeat Exam *</td>
<td>Repeat Oral exam</td>
<td>Repeat Oral exam</td>
</tr>
<tr>
<td>P / O</td>
<td>Repeat Exam *</td>
<td>PASS</td>
<td>PASS</td>
</tr>
<tr>
<td>P / P</td>
<td>Repeat Exam *</td>
<td>PASS</td>
<td>PASS</td>
</tr>
<tr>
<td>P / F</td>
<td>Repeat Exam *</td>
<td>Repeat Oral exam</td>
<td>Repeat Oral exam*</td>
</tr>
<tr>
<td>F / *</td>
<td>Repeat ** Clerkship</td>
<td>Repeat ** Clerkship</td>
<td>Repeat ** Clerkship</td>
</tr>
</tbody>
</table>

*Maximum grade to pass after passing repeat exam
**2 Months
1) This grading scale emphasizes clinical performance.

2) The passing/honors exam cutoffs are set on a normal distribution each rotation at the discretion of the grading committee.

3) An alternative minimum pass mark of 62 will exist, i.e. if a score is above 62 or greater, a passing mark will be given on the exam. Lower passing cutoffs are usually made with the standard distribution.

**THUS IT IS POSSIBLE FOR EVERYONE TO PASS THE EXAM.**

**FAILURES**

When retaking the test after a fail, a score of 60 will result in a passing grade. Since this is generous, it is final (59.9 is FAIL). There are NO exceptions. Failing the examination **twice** will require repeating at least one month or two months as scheduled by the Surgery grading committee of the surgical clerkship, passing a written and oral exam an achieving a passing clinical performance evaluation. There are NO exceptions. No electives will be converted. In some cases the department and medical school may decide that repeating the 2month clerkship is in the best interest of the student, and thus will be required. A third failure will necessitate repeating the surgical clerkship and examination.

**ORIENTATION**

All Year III students, regardless of assigned hospitals, are to report as per notification at 7:15a.m. on the first day of the rotation. A Surgery booklet and handouts will be distributed at this time. If you **do not** attend the orientation you cannot continue in the clerkship.

**ATTENDANCE POLICY**

Attendance is required at all scheduled teaching sessions. Excused absences in attendance will be taken into account when ward performance is evaluated. Students who do not attend 100% of scheduled teaching sessions are ineligible for an honors grade.
REQUIRED READING

*Essentials of Surgery—Becker and Stucchi*

This is geared toward nationally derived surgical objectives, and should form the core of learning and self evaluation.

EVALUATIONS

We take your evaluations of the clerkship quite seriously. Since the clerkship is undergoing constant evolution, we pay attention to your suggestions and many of the current practices are direct results from evaluations from your predecessors. Our evaluation form is available on line at a site announced at orientation. You will be required to complete all evaluations or you will receive an *Incomplete grade*. At certain times, the evaluation site may be down. In this event, the secretaries will provide you with a hard copy to fill out.

Please be assured of your anonymity on these evaluations. Comments are welcome and you can tell us anything you want. The list of names of students submitting the evaluation are kept in a separate file and are only used to assure that you did fill out an evaluation and thus can receive a grade.

Clinical Experience Tracking

The School of Medicine will designate a system to be used to track all patient experience. Data must be recorded and synced to receive a grade. Otherwise an *Incomplete* will be recorded.