FAMILY MEDICINE CLERKSHIP SYLLABUS

Table of Contents:
1. Family Medicine Faculty & Staff......................................................... 2
2. Introduction......................................................................................... 3
3. DO THIS NOW ..................................................................................... 5
4. Clinical Experience and Procedure Goals............................................. 6
5. Medical Student Responsibilities ......................................................... 7
6. Grading............................................................................................... 9
7. Grievance Process ............................................................................... 11
8. Vacation/Leave of Absence ................................................................. 12
9. Proof of Immunization/HIPAA/Liability Insurance............................... 12
10. Policy Regarding Student Work Hours............................................... 12
11. Policy Regarding Student-Teacher Relationship................................. 12
12. Appendix A: Course Competencies .................................................... 13
13. Appendix B: Course Objectives .......................................................... 16
14. Appendix C: Helpful Hints ................................................................. 22
15. Instructions for Note Writing............................................................... 23
16. Cheats for Family Medicine's OSCE.................................................. 25
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INTRODUCTION

Welcome to the Family Medicine Clerkship! We are glad to have you join us for the next four weeks. We want you to have an enjoyable and educational clerkship as you experience the broad, challenging and rewarding specialty of Family Medicine.

What Is Family Medicine?

Family Medicine physicians focus their practice on the long-term care of each patient, providing comprehensive medical care to the whole patient within the context of the patient’s community. Family Physicians do not limit their practices according to patients’ age or gender or by focusing upon a particular organ system or disease state. Family Medicine is a broad specialty combining behavioral medicine with traditional biological and clinical sciences.

Family Physicians serve as the patient’s or family’s advocate. They provide the majority of the care for their patients, referring to specialists for approximately 8% of all office visits. They then coordinate care with these specialists when referral is needed. They assist their patients with navigating and understanding the healthcare environment as well as helping patients accept responsibility for and become proficient with their health-related concerns.

Many Family Physicians continue to provide “cradle-to-grave” medical care and include Obstetrics and Pediatrics, acute and chronic care, and Geriatrics in their practices. Family Physicians often develop special interests and seek additional training to provide care in Sports Medicine, High Risk Obstetrics, Emergency Medicine, Aesthetics and Dermatology, Sleep Medicine and other medical fields.

Most practicing Emergency Room physicians in the United States are actually Board-Certified Family Medicine physicians; and if they ever tire of the ER, they are adequately trained to change careers without requiring re-education in a residency program.

Family Physicians also have excellent business skills; in fact, business training is a required portion of the Family Medicine Residency curriculum at all schools. You may find that your preceptor is able to discuss with you the ins-and-outs of running the business of medical practice at the same time he or she is teaching you about earaches and hypertension.

What Is the Purpose of This Rotation?

Medical education that occurs exclusively in a hospital setting does not prepare you for the “real world” practice of medicine. In addition to hospital-based teaching, a well-rounded medical student will have had an experience emphasizing:

- Ambulatory care
- Longitudinal, comprehensive care of patients
- Development of focused history-taking and probabilistic thinking skills

Only your Family Medicine rotation can currently offer you this education.
The above is a graphic illustration of where “real medicine” happens. As you will see, for every 1000 patients at risk for an illness, just over 200 will seek the care of a physician for a complaint. Over half of the time they see a “primary care physician,” defined as a Family Medicine, general Internal Medicine or general Pediatrics physician. The rest of the time they see a “community-based” specialist. Of the same 1000 patients, only 8 are hospitalized for their symptoms and fewer than 1 in 1000 sick people is transferred to an academic medical center like OU.

You will see from this diagram that whether you choose to become a primary care physician or a specialist, the experiences you have on campus are not representative of what happens in the community. Only during your Family Medicine clerkship will you be able to experience the variety of “real-world” medicine.

Enjoy your rotation! Your preceptors are volunteering their time because they love teaching students – please take full advantage of them and ask lots of questions. I am also glad to answer any questions you may have now or in the future.
**DO THIS NOW: Steps to a Successful Clerkship Experience**

You must follow these steps to be prepared for the first day of your clerkship. Do them now to be ready to succeed:

1. *Sign up for fmCASES:* If you have not yet completed your Internal Medicine or Pediatrics rotation, you will not yet have created the online account you will need to begin the learning modules for the Family Medicine rotation. Go online to [www.Med-u.org](http://www.Med-u.org) and click on the “fmCASES” at the bottom of the screen. Click “go to cases” and register for an account using your OUHSC email address. You will receive an email confirmation and may then begin the cases online.
2. *Start using fmCASES:* It is highly recommended that you start working through these cases prior to the beginning of the clerkship. Each case can be expected to take 30-45 minutes. The REQUIRED cases for Week One are:
   - Case 1
   - Case 2
   - Case 4
   - Case 10
   - Case 11
3. *If you have any trouble, call or email Rita Hains, Clerkship Coordinator:* you can reach her at 619-4722 or at [Rita-Hains@ouhsc.edu](mailto:Rita-Hains@ouhsc.edu)
It is a requirement of our accreditation that students complete an electronic log of clinical experiences. Because Family Medicine is a standardized clerkship, your experience goals are linked directly to your curriculum and we are able to supplement your clinical experience with activities during classroom sessions, online learning modules, case quizzes, OSCE and the written exam. You will find your clinical experience log below.

In addition, please refer to the competency list in Appendix A and to the course objectives in Appendix B for the topics covered during your standardized curriculum. Please refer to these lists when considering your study topics for the written exam and OSCE.

<table>
<thead>
<tr>
<th>FAMILY MEDICINE REQUIRED CONDITIONS</th>
<th>(Syllabus version)</th>
</tr>
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<tbody>
<tr>
<td>LEVEL OF STUDENT RESPONSIBILITY</td>
<td>TULSA OKC</td>
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<tr>
<td>Acute Conditions</td>
<td>Minimum Number</td>
</tr>
<tr>
<td></td>
<td>Minimum Number</td>
</tr>
<tr>
<td>• For each common symptom listed below, students should be able to:</td>
<td></td>
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<tr>
<td>1. Differentiate among common etiologies based on the presenting symptom.</td>
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<tr>
<td>2. Recognize “can’t miss” conditions that may present with a particular symptom.</td>
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<tr>
<td>3. Elicit a focused history and perform a focused physical examination.</td>
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<td>4. Discuss the importance of a cost-effective approach to the diagnostic workup.</td>
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<tr>
<td>5. Describe the initial management of common and “can’t miss” diagnoses that present with a particular symptom.</td>
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<tr>
<td>1. Upper Respiratory Symptoms</td>
<td>1 1</td>
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<tr>
<td>2. Joint Pain and Injury</td>
<td>1 1</td>
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<tr>
<td>3. Pregnancy Presentation</td>
<td>1 1</td>
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<tr>
<td>4. Abdominal Pain</td>
<td>1 1</td>
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<td>5. Common Skin Lesions</td>
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<td>6. Low Back Pain</td>
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<td>7. Cough</td>
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<tr>
<td>8. Chest Pain</td>
<td>1 1</td>
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<tr>
<td>9. Headache</td>
<td>1 1</td>
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<tr>
<td>10. Vaginal Discharge</td>
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<tr>
<td>11. Shortness of Breath</td>
<td>1 1</td>
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<tr>
<td>12. Fever</td>
<td>1 1</td>
</tr>
<tr>
<td>13. Depression</td>
<td>1 1</td>
</tr>
<tr>
<td>14. Leg Swelling</td>
<td>1 1</td>
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</tbody>
</table>

| Chronic Problems                    |                     |
| • For each core chronic disease listed below, students should be able to: | | |
1. Find and apply diagnostic criteria.
2. Find and apply surveillance strategies.
3. Elicit a focused history that includes information about adherence, self-management, and barriers to care.
4. Perform a focused physical exam that includes identification of complications.
5. Assess improvement or progression of the disease.
6. Describe major treatment modalities.
7. Propose an evidence-based management plan that includes pharmacologic and non-pharmacologic treatments and appropriate surveillance and tertiary prevention.
8. Communicate appropriately with other health professionals in a multidisciplinary setting.
10. Communicate respectfully with patients who do not fully adhere to their treatment plan.
11. Educate a patient about an aspect of his or her disease respectfully, using language that the patient understands. When appropriate, ask the patient to explain any new understanding gained during the discussion.

1. Hypertension 1 1
2. Type 2 Diabetes Mellitus 1 1
3. Asthma/COPD 1 1
4. Hyperlipidemia 1 1
5. Anxiety 1 1
6. Arthritis 1 1
7. Coronary Artery Disease 1 1
8. Obesity 1 1
9. Depression 1 1

**Adult Preventive Care**

- Students should be able to identify that preventive care can be included in every office visit. For each preventive service, students should be able to:
  1. Define a concept of wellness as more than “not being sick.”
  2. Define primary, secondary and tertiary prevention.
  3. Identify risks for specific illnesses that affect screening and management strategies.
  4. For women: elicit a full menstrual, gynecological and obstetric history.
  5. For men: identify issues and risks related to sexual function and prostate health.
  6. Apply the stages of change model and use motivational interviewing to encourage lifestyle changes to support wellness (weight loss, smoking cessation, exercise, diet, and so on).
  7. Provide counseling related to health promotion and disease prevention.
  8. Discuss and evidence-based, stepwise approach to counseling for tobacco cessation.
10. For each core condition below, discuss who should be screened and methods of screening.
11. Develop a health promotion plan for a patient of any age or gender that addresses the core health promotion conditions below.
1. Breast Cancer | 1 | 1
2. Cervical Cancer | 1 | 1
3. Colon Cancer | 1 | 1
4. Coronary Artery Disease | 1 | 1
5. Depression | 1 | 1
6. Intimate Partner/Family Violence | 1 | 1
7. Obesity | 1 | 1
8. Osteoporosis | 1 | 1
9. Prostate Cancer | 1 | 1
10. Sexually Transmitted Infection | 1 | 1
11. Substance Use/Abuse | 1 | 1
12. Type 2 Diabetes | 1 | 1

**Well Child and Adolescent Preventive Care**

- Students should be able to identify that preventive care can be included in every office visit. For each preventive service, students should be able to:
  1. Describe the core components of child preventive care – health history, physical examination, immunizations, screening/diagnostic tests, and anticipatory guidance.
  2. Identify health risks, including accidental and non-accidental injuries and abuse or neglect.
  3. Conduct a physical examination on a child.
  4. Identify developmental stages and detect deviations from anticipated growth and developmental levels.
  5. Recognize normal and abnormal physical findings in the various age groups.

- Identify the age-appropriate and risk-based preventive care needs of an individual child or group of individual children:

1. Diet/Exercise | 1 | 1
2. Family/Social Support | 1 | 1
3. Growth and Development | 1 | 1
4. Potential for Injury | 1 | 1
5. Sexual Activity | 1 | 1
Medical Student Responsibilities

General

A. Attend orientation the first day of the clerkship.

B. Be present on time and prepared for all scheduled activities. (i.e., clinics, weekly sessions, etc.).

C. Dress appropriately and conduct yourself professionally at all times.

D. Complete all documentation as required for course completion. (Course Evaluation, Preceptor Evaluation)

E. Sit for the oral exam and be prepared with two patient cases to present.

F. Sit for the written exam.

G. Complete the OSCE and attend the feedback session immediately thereafter with Dr. Mulkey.

Preceptor Clinic

A. Seek out clinical activities, patients, and procedures, based on your goals and the clerkship competencies.

B. The first time you work with a new preceptor, share with him/her the level of patient care responsibility you've had with your other preceptors and ask about the criteria on which s/he will evaluate you, as well as any special "ground rules" (i.e., whether you'll see the patients together vs. you will see the patient first; writing a note in the chart vs. dictating vs. doing neither).

C. Share and review your goals with each preceptor early in the rotation.

D. Evaluate patients assigned in the office—the first office session of the clerkship, you may coattail; thereafter you should be evaluating three to four patients per half day office session on your own (six to eight patients per day).
Medical Student Responsibilities

Preceptor Clinic (cont.)

E. Present patients you have evaluated.

F. Early in the rotation, remember that you must identify two Bedlam patients (clinic patients for PA students) with an undifferentiated complaint whom you can evaluate and for whose care you can prepare a clinical note and present at the oral exam.

G. Midway through the rotation, meet with each preceptor who will be grading you and ask him/her for feedback on your performance so far. The preceptor grading are those working with you three or more sessions during the rotation.

Weekly Sessions

A. Participate in all Weekly fmCASES on-line sessions.

B. The day before the oral exam, turn the notes & write-ups for the patients you plan to present to the clerkship coordinator or director. You must also turn in the following at the end of the written exam:
   - Completed evaluation of clerkship.
   - Completed evaluation of your preceptor. (fill out the evaluation list for each preceptor you worked with at least three sessions, up to a maximum of five preceptors.)
   - Any books checked out to you during the clerkship. (You will be assessed a fee for textbooks not returned or returned damaged and your clerkship grade will be withheld pending the completion and return of all required papers and other materials.)

Policies

Grading

It is College of Medicine policy that students with a "D" or "F" for any component of a clerkship grade must remediate that component before continuing on to their next rotation.
Grade computation

- Your grade distribution is as follows:
  - 30% clinical performance (evaluation by your preceptor)
  - 15% Oral Exam (composite of weekly quizzes, final oral presentations)
  - 5% completion of required components of online fmCASES (all-or-nothing)
  - 40% written exam
  - 10% OSCE

Your clinical performance grade is compiled as follows. After checking off the description most closely approximating your clinical performance in each of the six areas listed on the evaluation form and entering comments for the Dean’s letter, each preceptor will indicate the percentile (0-100%) s/he believes you earned on this clerkship.

For students evaluated by multiple preceptors, we combine overall percent grades awarded by all your preceptors and divide by the number of preceptors to produce a mean percent clinical grade.

Your composite Oral Exam grade (15% of the final grade) is determined on the following factors:

- 2% each week for the Weekly Quiz (8% of your total grade)
- 7% for the faculty facilitator’s rating of your Oral Presentation of your Bedlam/Clinic patients

Five percent of your overall grade is dependent upon your completion of ALL cases in the fmCASES assigned list. The questions are to be accessed at www.Med-u.org and are available from the first day you sign up with Med-U until 8:30AM the final day of the rotation. Failure to complete the questions in time will result in a grade of “zero” for the questions and a loss of 5% of your total grade.

OSCE is a required part of the clerkship. You must complete the OSCE on the date scheduled and attend the feedback session with the Predoctoral Education Director immediately following the exam. Your OSCE grade accounts for 10% of your final grade. Failure to complete your OSCE will result in a score of “zero” for 10% of your grade and an automatic “D” for the rotation (see below).
The OSCE grade is determined as follows:

- The standardized patient will grade you on your interview rating scale and a checklist of history, physical exam and counseling components you are expected to perform (2 components)
- The physician faculty will review your note and grade you accordingly. (1 component)
- The three components of your score are equally weighted and an average of the three scores determines your numeric total score.

- Your clerkship letter grade is determined according to the following scale:
  89.5%-100% = A
  79.5-89.4% = B
  69.5-79.4% = C
  59.5-69.4% = D
  < 59% is an F

"D" grades

- If you fail to pass the written exam or the OSCE with a “C” or above, you must retake the failed exam and cannot progress to your next rotation until you have completed this requirement. Your final score will be the average of your two exam scores. You will be allowed up to one week from the time you are notified of the need to retake the exam to sit for it again. The Dean’s office and the director of the next clerkship you are scheduled to begin will be notified of your need to retake the exam.
- If you make a “D” on the written exam or OSCE, and then make a “D” when you retake the exam in question, you must retake the entire rotation.
- The following will result in a final grade of "D": a score of less than 69.5% on any of the following components of the clerkship grade:
  - OSCE
  - Written exam
  - Preceptor evaluation
  this includes the grade of "0" assigned to anyone with an unexcused absence from the written exam or OSCE and the result of the averaged grade on a written exam or OSCE that is retaken due to failure to pass with a grade of “C” or above on the first attempt.
Grade withheld ("I") and special issues
The following are causes for your grade being withheld.
- Failure to return borrowed materials or make restitution on borrowed materials returned damaged.
- Failure to complete/return evaluation forms.
- Failure to complete assignments.
- Unexcused absence from the written exam or OSCE will result in a grade of “zero,” and a final grade of “D” for the rotation. Refer to “D” grades above for details.

It is College of Medicine policy that students with a "D" or "F" for any component of a clerkship grade must remediate that component before continuing on to their next rotation.

Grievance process
- Since the process described above is clerkship policy, grades determined by this process are considered final. In particular, it is not appropriate for you to approach an individual preceptor to ask him/her to change your clinical grade.
- If you want clarification or to express a grievance about your grade for a particular component of the clerkship, please contact the clerkship director in a note or by e-mail (Louis-Mulkey@ouhsc.edu) or by calling Rita Hains (619-4722) within 14 calendar days of the grade being posted to the Dean’s office, to indicate the nature of your grievance. Include your phone to facilitate our scheduling a meeting if we determine that is necessary. After 14 days your grade will not be changed, but we still encourage you to contact us for clarification if needed.
Vacation/Leave of Absence

It is College of Medicine policy that medical students may not take vacation time during their third year. Leave from the rotation will only be allowed in extreme or unusual circumstances. If you have an emergency, it is your responsibility to notify the clerkship immediately to avoid the withholding of or a reduction of your grade. The written exam is given on the morning of the last day of the rotation (usually a Friday); however, this is subject to change and we recommend you do not schedule travel on the last day of the rotation. PA students will take the final exam on the 2nd to last day of the rotation. Exams will not be rescheduled except in extreme circumstances – please be aware of this prior to purchasing airline tickets or agreeing to attend an out-of-town event.

Proof of Immunization/HIPAA/Liability Insurance

It is your responsibility to provide proof of vaccination, HIPAA training and liability insurance. Failure to do so may result in a delay in your rotation starting and a loss of grade points.

Policy Regarding Student Work Hours

The Family Medicine rotation strictly follows the 80-hour work rule. Students who believe they are being asked to violate the 80-hour work rule must notify the Predoctoral Education Director immediately so that action can be taken to prevent students violating the rule.

Policy Regarding the Student-Teacher Relationship

The Family Medicine rotation adheres to the principles outlined in the University’s Guidelines for the Teacher-Learner Relationship and the Medical Student Mistreatment Plan. Any person, student, or teacher, who believes the principles of the Teacher-Learner relationship have been violated must immediately notify the Predoctoral Education Director so that action can be taken to protect students’ rights and help students honor their responsibilities.
APPENDIX A: Course Competencies

Read on if you would like to know the items you will be taught on this rotation and on which you will be tested. It is our goal to provide your learning in a transparent environment.

OUHSC FAMILY MEDICINE CLERKSHIP COMPETENCIES 2010-11

### Patient Care:
Student provides supervised patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

- Demonstrate compassionate, appropriate, and effective patient care under faculty supervision in an ambulatory primary care office setting;
- Demonstrate efficient focused history-taking and physical examination skills;
- Develop a differential diagnosis and describe the rationale for the diagnosis;
- Identify appropriate diagnostic tests and procedures needed for conditions encountered in primary care settings, including lab studies, EKGs, screening tests and procedures, and radiological studies and procedures performed by specialists;
- Demonstrate understanding of the importance of longitudinal, comprehensive patient care and how it benefits the individual and the community;
- Demonstrate an understanding of the importance of and components of an adequate informed consent discussion;
- Perform/interpret results of procedures commonly performed in the primary care setting, including but not limited to:
  1. injections (subcutaneous, intramuscular, intra-articular)
  2. treatment of skin lesions (cryotherapy, ED&C, excision)
  3. urinalysis (including urine pregnancy test)
  4. rapid strep test
  5. ECG interpretation
  6. interpretation of pulmonary function tests
- Demonstrate understanding of the bio-psychosocial determinants of health and illness and their application to the individual patient's care, including barriers to access
- Demonstrate early recognition of serious complications of patient illness and of therapeutic interventions.

### Medical Knowledge:
Student displays an appropriate level of medical knowledge and applies this knowledge to patient care.

- Diagnose and manage acute problems frequently encountered in the ambulatory primary care setting:
  1. Upper Respiratory Symptoms
  2. Joint Pain and Injury
  3. Pregnancy Presentation
  4. Abdominal Pain
  5. Common Skin Lesions
  6. Common Skin Rashes
  7. Abnormal Vaginal Bleeding
  8. Low Back Pain
  9. Cough
  10. Chest Pain
  11. Headache
  12. Vaginal Discharge
  13. Dysuria
  14. Shortness of Breath
  15. Fever
  16. Depression
  17. Male Urinary Symptoms
  18. Leg Swelling
Diagnose and manage chronic problems (and their exacerbations) frequently encountered in the ambulatory primary care setting:

1. Multiple Chronic Diseases
2. Hypertension
3. Type 2 Diabetes Mellitus
4. Asthma/COPD
5. Hyperlipidemia
6. Anxiety
7. Arthritis
8. Coronary Artery Disease
9. Obesity
10. Heart Failure
11. Depression
12. Osteoporosis/Osteopenia
13. Substance Use/Dependence/Abuse

Identify the age-appropriate and risk-based preventive care needs of an individual adult or group of individual adults:

1. Breast Cancer
2. Cervical Cancer
3. Colon Cancer
4. Coronary Artery Disease
5. Depression
6. Intimate Partner/Family Violence
7. Obesity
8. Osteoporosis
9. Prostate Cancer
10. Sexually Transmitted Infection
11. Substance Use/Abuse
12. Type 2 Diabetes

Identify the age-appropriate and risk-based preventive care needs of an individual child or group of individual children:

1. Diet/Exercise
2. Family/Social Support
3. Growth and Development
4. Hearing
5. Lead Exposure
6. Nutritional Deficiency
7. Potential for Injury
8. Sexual Activity
9. Vision
**Evidence-Based Learning:** Student incorporates evidence-based learning in his or her clinical thought process and patient care.

- Develop probabilistic thinking skills;
- Identify appropriate sources of medical information;
- Apply findings of diagnostic procedures to the evidence-based healthcare management of the patient;
- Identify evidence-based resources that guide screening, diagnosis and treatment recommendations and their application to lifelong learning.

**Interpersonal and Communication Skills:** Student displays interpersonal and communication skills that result in effective information exchange and team building with patients, their families, and other health professionals.

- Demonstrate ability to use effective interviewing and listening skills, and to convey information to the patient in an accurate and understandable manner;
- Demonstrate ability to educate patients about health promotion and disease prevention;
- Perform accurate, complete, succinct and organized oral and written presentations of patient encounters;
- Demonstrate the ability to develop rapport with patients, staff members and others through empathy, sensitivity, respect for others, compassion, integrity and personal accountability.

**Professionalism:** Student behaves in a professional manner with a clear commitment to carrying out his or her responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

- Demonstrate the ability to develop rapport with patients, staff members and others through empathy, sensitivity, respect for others, compassion, integrity and personal accountability.

**Systems-Based Practice:** The student’s actions demonstrate an awareness of and responsiveness to the healthcare system at large and the ability to call on system resources to provide optimal patient care.

- Explain the role of the Family Physician as patient advocate and coordinator of the patient’s health care;
- Identify helpful community resources for patients;
- Explain when to refer patients to specialists;
- Demonstrate coordination of care with consultants and the community-based healthcare team;
- Demonstrate the application of patient case management skills to the individual patient case.
Appendix B: Course Objectives

Preventive Health Care

1. Learn the principles of screening and the characteristics of a good screening test.
3. Be able to individualize the recommendation for cancer screening for common cancers for an adult patient (e.g., lung, cervix, colorectal, breast, and prostate).
4. Learn how to perform a thorough breast exam.
5. Know current recommendations for mammography.
6. Learn the current recommendations for Papanicolaou testing and the different types of testing available.
7. Identify risk factors for osteoporosis and appropriate preventative measures.
8. Be able to recommend timely vaccinations based on age, medical conditions, lifestyle, and environment.
9. Be able to state the significance of nutrition and obesity in health promotion and disease prevention.
10. Learn counseling skills for behavior change.
11. Be able to prescribe an exercise program for a sedentary patient.
12. Be able to perform smoking cessation counseling for patients who smoke.
13. Be able to state principles that guide behavior change counseling.
14. Recognize symptoms of menopause
15. Understand principles of clinical epidemiology regarding screening and apply them to controversies in screening guidelines (e.g. Prostate Specific Antigen testing).
16. Understand the health maintenance visit for an infant or child.
17. Be able to use CDC/ACIP chart in order to determine what immunizations are required based on age of the patient.
18. Know contraindications to immunizations.
19. Understand the recommendations for screening of anemia in children.
20. Demonstrate how to calculate BMI in a child and be able to identify a child at risk for obesity.
21. Learn the fundamental components of an appropriate newborn and infant history.
22. Review proper physical exam techniques for a newborn and learn the basics of growth charting.
23. Become facile with normal newborn and young infant behavioral norms, deviations from them, and signs and symptoms of concern in evaluating a young infant.
24. Become familiar with the fundamentals of screening and assessment of post partum blues and post partum depression.
25. Consider health risk assessment of the young infant and learn the fundamentals of screening for such in the newborn period.
26. Learn the importance of counseling to prevent STDs.
27. Discuss epidemiology and USPSTF recommendations for screening for common testicular cancers.
Musculoskeletal Conditions

1. Create a differential diagnosis for ankle pain.
2. Know how to perform a focused history and physical appropriate for painful joints.
3. Know the signs and symptoms of life/limb threatening injuries.
4. Describe the use of NSAIDS for strains/sprains.
5. Be able to utilize evidence-based medicine indications for radiologic evaluation of ankle injury.
6. Construct a treatment plan for ankle pain, including RICE (rest, ice, compression, elevation).
7. Be able to provide counseling to the patient regarding injury prevention.
8. Understand the role of the family medicine physician in treating ankle injuries
10. Develop physical exam skills in evaluating low back pain.
11. Develop the skills in the diagnosis and treatment of low back pain.
12. Recognize the red flags or alarming symptoms for serious causes for low back pain.
13. Know when imaging studies are indicated.
14. Be able to prescribe treatment for back pain.
15. Know when to refer for consultation and surgical intervention
16. Obtain a thorough history for the chief complaint of knee pain.
17. Name the components of a thorough knee exam.
18. List a differential diagnosis for knee pain in an adult.
19. Develop an appropriate treatment plan for osteoarthritis, including medications and lifestyle modifications.
20. Recognize when imaging and referral to specialists are appropriate.
21. List the different classes of medications useful for the treatment of chronic pain, and recognize their common side effects.
22. Name the USPSTF recommendations for appropriate screenings in adults, including musculoskeletal recommendations.
23. Name the components of a thorough shoulder exam.
25. Develop an appropriate treatment plan for shoulder pain, including home exercises, medications, and injection.
26. Recognize when physical therapy, imaging and referral to specialists is appropriate.
27. Name the components of a thorough wrist exam.
29. Develop an appropriate treatment plan for wrist pain, including bracing, exercises and medications.
30. Recognize when ancillary testing and referral to specialists is appropriate.

Diabetes Mellitus Type 2

1. Collect and incorporate appropriate psychosocial, cultural, health literacy and family data into the management plan of a patient with type 2 diabetes.
3. Make informed decisions about diagnosis, monitoring, and pharmacologic management of type 2 diabetes patients using scientific evidence and clinical judgment.
4. Recognize the barriers to coordination of diabetes care and envision system-wide improvements that could improve coordination of diabetes care.
5. Recognize the importance of an inter-professional team approach in the care of patients with diabetes.
6. Describe the utility of the electronic medical record in the care of your practice population and in the reporting of quality of care measures.
7. Effectively educate the patient about type 2 diabetes with attention to and respect for the patient’s own disease model.

**Elevated Blood Pressure**

1. Define the nationally accepted guidelines for screening, diagnosing, and staging the severity of hypertension (ex. pre-hypertension, essential hypertension, and resistant hypertension).
2. Name proper elements of the hypertensive patient history to identify lifestyle, other cardiovascular risk factors, and assess concomitant disorders that affects prognosis and guides treatment.
3. Identify appropriate elements of a comprehensive physical examination in hypertensive patients including proper techniques in blood pressure measurement.
4. Order recommended laboratory studies on an uncomplicated new hypertensive patient on initial visits.
5. Formulate basic management plans for the longitudinal care of patients with hypertension.
6. Describe elements of lifestyle modification (ex. health education and behavioral change strategies) for hypertensive patients.
7. Reflect on the importance of providing socio-culturally sensitive and responsive education, counseling, and care to patients and their families.
8. Demonstrate awareness of improved patient care outcomes through effective communication with all members of the primary care team such as nutritionists, social workers, and nurses.
9. Develop awareness of practicing cost-effective health care and resource allocation that does not compromise quality of care.

**Respiratory System**

1. Create a differential diagnosis for a patient who presents with a persistent cough and wheezing.
2. Discuss important features of the history and physical examination, which support the diagnosis of asthma/COPD.
3. Explain the key features of the history and physical examination that will determine the severity of asthma/COPD in the patient.
4. State comorbid conditions of asthma/COPD that must be addressed to help the patient control his asthma (Comorbid conditions are those which may also require treatment in order for asthma control to improve).
5. Discuss the available medications available to treat asthma/COPD.
6. Create an appropriate treatment and written asthma action plan for the patient based on his stage of severity.
7. Educate the patient on how to use a peak flow meter, inhaler, and spacer device.

**Undifferentiated Complaints**

1. Understand the differential diagnosis of unilateral leg swelling.
2. Be able to differentiate between DVT, leg ulcer, and peripheral artery disease.
3. Recognize the importance of smoking as a risk factor of vascular disease in the diabetic patient.
4. Understand the impact of socio-cultural factors on the management of chronic disease.
5. Understand the impact of obesity on health.
6. Understand the implications of DVT, its diagnosis, and management.
7. Appreciate the value of team-based approach to chronic disease management.
8. Identify risk factors for coronary artery disease.
9. Elicit a clear history characterizing chest pain and the predictive value of these symptoms in diagnosing the underlying cause.
10. Develop a differential diagnosis for palpitations based on an organ system approach.
11. Conduct a directed physical to search for findings to support or exclude differential diagnoses of atypical chest pain.
12. Interpret target goals for cholesterol and lipoproteins.
14. Learn common causes of insomnia in the elderly.
15. Learn the diagnostic criteria for Major Depressive Disorder (MDD).
16. Learn how to use history, physical and tests to rule out medical causes of depressive symptoms.
17. Understand the effects of depression on the patient's family.
18. Learn the common therapeutic options for Major Depressive Disoder and their side effects.
19. Learn the risk factors for elder abuse.
20. Understand the importance of enquiring about the use of complimentary and alternative therapies use.
21. Understand how culture can affect the evaluation and treatment of conditions.
22. Identify the typical presenting signs and symptoms of migraine headache and contrast these with the typical signs and symptoms of the most common and most serious causes of headache (tension, cluster, brain tumor, intracranial hemorrhage, medication use).
23. Obtain an appropriate focused history on a patient who presents with headache.
24. Perform a reliable focused neurologic exam on a patient who presents with headache.
25. Identify appropriate indications for ordering imaging tests on a patient who presents with headache.
26. Counsel a patient who presents with headache on the appropriate prevention and treatment of the headache.
27. Understand the importance of continuity of care when treating a patient who presents with chronic headache.
28. Demonstrate the use of point-of-care technology when uncertainty regarding diagnosis, appropriate evaluation and/or treatment of a patient arises during the course of an office visit.
29. Create a differential diagnosis for a male patient who presents with epigastric abdominal pain.
30. Highlight key features of the history and physical examination that support the diagnosis of peptic ulcer disease.
31. Describe the differences in diagnostic workup and treatment for peptic ulcer disease due to Helicobacter pylori versus gastroesophageal reflux disease (GERD).
32. Highlight the differences between ulcer and non-ulcer (functional) dyspepsia.
34. Discuss appropriateness of follow-up and testing for eradication in patients with H. pylori gastritis.
35. Provide an overview of potential risks and adverse events associated with non-judicious use of proton pump inhibitors.
36. Learn basics about cultural competency and respect for patients who will require interpreter services.
37. Conduct a culturally sensitive, empathic history.
38. Be aware of the ways in which victims of violence may manifest symptoms/ be alert to clues a patient may give that he/she have been a victim of IPV.
39. Have knowledge of way to assist the patient in developing a safety plan.
40. Be aware of mandatory reporting requirements for your particular state.
41. Be aware of local resources available to survivors of violence.
42. Understand a survivor’s perspective in an abusive relationship and the barriers to his/her seeking help.
43. Apply student’s knowledge of the differential of abdominal and pelvic pain in evaluating the patient.
44. Be able to take a thorough history and perform an appropriate physical exam in the setting of an acute respiratory illness.
45. Be able to order appropriate diagnostic studies, if necessary, to determine cause of illness and severity of illness, and have the knowledge to treat acute respiratory infection.
46. Be able to accurately identify common positive findings on physical exam for pneumonia and acute respiratory infection.
47. Be able to calculate a body mass index, and determine the diagnosis of obesity.
48. Counsel a pediatric patient and his/her family regarding appropriate treatment of obesity including diet and exercise.
49. Be able to discuss the changing pattern of obesity and name three complications of obesity.
50. Evaluate a patient with pharyngitis, including appropriate history and physical examination, use of clinical prediction rules and appropriate antibiotic use.
51. Know the suppurative and non-suppurative complications of Strep pharyngitis.
52. Understand how to diagnose ADHD
53. Learn the differential for fussiness in a young infant and the pathophysiology of colic in infants.
54. Review proper physical exam techniques for a newborn and learn the basics of growth charting.
55. Become facile with normal newborn and young infant behavioral norms, deviations from them, and signs and symptoms of concern in evaluating a young infant.
56. Become familiar with the fundamentals of screening and assessment of post partum blues and post partum depression.
57. Be introduced to fundamental precepts of family systems thinking and practice supportive counselling skills which will empower parents to develop autonomy and mastery as parents.
58. Consider health risk assessment of the young infant and learn the fundamentals of screening for such in the newborn period.
59. Develop a differential diagnosis for a patient presenting with fatigue.
60. Apply a cost-effective strategy when selecting a laboratory evaluation of a patient with fatigue.
61. Use a patient-centered approach to counsel patients regarding recommendations for preventive services.
62. Develop a further evaluation and management plan for an adult male with iron deficiency anemia.
63. Articulate a compassionate approach to delivering bad news to a patient.
64. Recognize the primary care physician’s role in maintaining a longitudinal therapeutic relationship with a patient during the process of consultation and referral.

Reproductive Health and Dermatologic Lesions

1. Establish diagnosis and timing of pregnancy, including week of gestation and estimated delivery date.
2. Describe the common symptoms of pregnancy, from diagnosis through the post-partum period.
3. Understand and describe appropriate responses to common problems that arise during pregnancy, including nausea, back pain, mood changes, and fatigue.
4. Describe and recommend appropriate preventive measures and follow-up during pregnancy, including diet, exercise, immunizations, and diagnostic testing.
5. Understand and recommend appropriate screening tests during and after pregnancy, including genetic, infectious, blood, hypertension, diabetes, domestic violence, and depression screening.
8. Describe and recommend appropriate history, exam, and diagnostic work-up for vaginal discharge in pregnancy.
9. Discuss common etiologies of vaginal bleeding, including placenta previa and placental abruption.
10. Identify appropriate contraceptive options and preventive care in the post-partum period.
11. Discuss family-centered, longitudinal perinatal care.
12. Define menopause and discuss common symptoms and treatment options.
13. Create a differential for postmenopausal bleeding.
14. Counsel a patient about the differential, work-up, and follow-up plan for postmenopausal bleeding.
15. Discuss risk factors for osteoporosis and the recommended screening for osteoporosis.
16. Discuss the recommended cancer screening for a 50+ year-old female.
17. Discuss the risks/benefits of hormone replacement therapy in the postmenopausal female.
19. Elicit focused history of patients presenting with scrotal pain.
20. Perform proficient testicular examination and ability to elicit signs specific to identify or exclude testicular torsion.
22. Order appropriate laboratory and radiological studies as it relates to the differential diagnosis of scrotal pain.
23. Learn the algorithmic approach to testicular pain.
24. Learn the management of testicular torsion.
25. Recognize STDs as a cause of testicular pain among adolescent males.
26. Learn the importance of counseling to prevent STDs.
27. Discuss epidemiology and USPSTF recommendations for screening for common testicular cancers.
28. Learn initial workup and management of BPH.
29. Accurately describe skin lesions.
30. Define terms that describe the morphology, shape and pattern of skin lesions.
31. Know the treatment principles of topical corticosteroid and local and systemic antifungal agents.
32. Apply the ABCDE criteria for the evaluation of hyperpigmented lesions as possible melanoma.
33. Describe common biopsy procedures including shave biopsy, punch biopsy, incisional and excisional biopsies.
34. Discuss the treatment modalities of squamous skin carcinoma.
35. Describe the importance and methods for preventing skin cancers.
Appendix C: Helpful Hints

“There’s an APP for that.”

The reality in medicine is that we are buying fewer textbooks and using more point-of-care technology. Those of you who have smart phones may find the following free apps helpful during your rotation. I encourage you to email me if you discover more helpful apps!

“EPSS” – quick results for the US Preventive Service Taskforce guidelines

“Heart Age” – based on Framingham Heart Study data – plug in the risk factors and get the patient’s risk for heart attack

“STAT Adult Immunization” – CDC 2009 Recommended Adult Immunization Schedule

“Reynolds Risk Score” – another way to view risk for heart attack that incorporates family history and CRP level (FYI – we use Framingham for the clerkship, but this one’s useful too)

“Asthma EPR-3” – helps you classify the severity of a patient’s asthma and shows algorithms for the stepwise approach to therapy

“Clearance” – ACC/AHA 2007 Guidelines for cardiac clearance of a patient prior to noncardiac surgery
**Instructions for Note Writing Session**

1. Students will all be in the same group for the Oral Exam which will be held during the last week of the rotation.
2. Students will be responsible for creating a single progress note, handwritten or printed from an electronic medical record of two Bedlam patients that meets the following criteria (PA students may choose any two patients from their time in clinic):
   - Patients are presenting with an *undifferentiated complaint* (a chief complaint for which no diagnosis has yet been established, *NOT* a follow up on a diagnosed condition)
   - Student directly participated in obtaining the history, performing the exam and developing the differential diagnosis and plan for the patients
   - Student makes certain that no patient Personal Health Information (PHI) is on the note (it *MUST BE* “de-identified”)
   - Note is presented in SOAP format, such that:
     - **Subjective** contains CC, HPI, PMH/PSH, FH/SH, meds, allergies and ROS sufficient for the presenting complaint and appropriate to a new patient
     - **Objective** contains vital signs and physical exam appropriate to the presenting complaint, as well as discussion of ancillary test results available at the time of the visit (strep screen, EKG, x-ray and so on)
     - **Assessment** contains a numbered, bulleted list of the differential diagnoses for the complaint, with each diagnosis followed by a brief discussion of the factors that weigh for and against the differential diagnosis; diagnoses must represent the *most likely AND the “can’t miss”* diagnoses for the complaint
     - **Plan** contains both the additional testing recommended, if indicated (student should state “no additional testing is recommended” if that is the case), and the treatments or interventions the student recommended to the patient
3. Students must email, fax or hand deliver their assigned progress note to Rita Hains (at FAX: 619-4707 or EMAIL Rita-Hains@ouhsc.edu) by no later than 5PM on the day prior to the Oral Exam.
4. During the oral exam session, the faculty facilitator will go through each note with the class, dissecting each note with the group and discussing the process of developing a differential diagnosis and accurately documenting a clinical encounter with each represented patient. Students will actively participate in the process of “thinking through” each encounter.
5. Faculty facilitator will rate each presented note and present his or her ratings to Rita, who will assign each student a grade for the session based upon the faculty’s rating.
6. Grades for the notes will be based on the following scale: (100 points total)
   - **Objective:** (35 points)
     - CC: is an *undifferentiated complaint* stated in *the patient’s own words* (5 points)
     - HPI: contains Onset, Location, Duration, Character, Aggravating/Associated symptoms, Relieving, Timing, Severity and Patient Perception of Problem (20 points)
     - PMH/PSH: contains sufficient information to allow a physician to understand the patient’s background information (chronic health conditions and prior surgeries are a MINIMUM)
     - Meds: include all meds, including over-the-counter and herbal meds
     - Allergies: must include what the reaction was; if NKDA, state so
     - ROS: is appropriate to the chief complaint; include it even if “negative except as per HPI.”
- (PMH/PSH, meds, allergies and ROS together are 10 points)
  - **Objective: (15 points)**
    - Is sufficient to justify the Assessment of the condition
    - Example: for a musculoskeletal complaint, include range of motion (active and passive), inspection, palpation, motor strength, sensation, reflexes and special tests (compression tests, ligamentous laxity and so on) and to examine BOTH sides if applicable
  - **Assessment: (15 points)**
    - Is appropriate to the presenting complaint
    - Includes most common AND “can’t miss” diagnoses
    - Explanation of differential diagnoses is appropriate and well organized
  - **Plan: (15 points)**
    - Is appropriate to the presenting complaint
    - Reflects evidence-based recommendations
    - Is cost-effective
    - Reflects an “informed consent” discussion with the patient about the risks and benefits of the recommended medication or intervention, risks and benefits of alternative options and notation of the patient’s understanding and choice of treatment (even if the patient chooses NOT to follow your recommendations)
    - Discusses both the current plan for care and “next steps,” including instructions to the patient regarding when to follow up and when to seek emergency care if applicable
  - **Overall Quality of the Note: (20 points)** is faculty facilitator’s assessment of the organization, legibility, grammatical quality and spelling accuracy of the note
Cheats for Family Medicine’s OSCE

You are required to pass the Objective Clinical Skills Examination (OSCE) with a composite score of 70% in order to complete the requirements of this rotation. OSCE is worth a total of 10% your final grade. Please see the syllabus for more information about your clerkship final grade computation. All OSCE cases have been reviewed for their validity and tested for inter-rater reliability and we are confident that they accurately and objectively reflect your performance.

The OSCE is given only once per month and absence from the scheduled OSCE will result in a grade of “zero” for the exam.

Your OSCE will be graded in real time, and you are required to return to the Family Medicine Department following the exam in order to receive your feedback for the exam. Failure to remain for the feedback session will result in a grade of “zero” for the OSCE.

Below are my cheats for your OSCE experience in Family Medicine.

- Family Medicine’s OSCE will consist of two stations. You must arrive at Schusterman Center and be ready to begin on time. Failure to be prepared when the exam begins will result in a reduction of time available to complete the exam requirements – which may result in a reduction of your grade.

1. The first station (“counseling”) will require you to take an initial history on a patient, including their preventive health and social histories and provide the patient with counseling regarding either their preventive health care needs or their need to make lifestyle changes (such as alcohol, drug or tobacco use, diet and exercise for heart protection, and so on). This OSCE will be graded by the SP who will comment on your counseling skills and give you immediate feedback.

2. The second station will be a “traditional” OSCE, in which the patient will present with a musculoskeletal symptom and you will be asked to document an appropriate history, physical exam, differential diagnosis and workup.

- The Family Medicine OSCE stations run just like every OSCE on campus: you will have 15 minutes to interview and examine each patient, provide your recommendations to the patient and leave the room. You will then have 10 minutes to write your note in the computer system for the musculoskeletal OSCE. You are not required to write a note for the “counseling” OSCE.

- Your musculoskeletal OSCE is assessed on 3 components. Each component bears equal weight in your score:

1. a physician faculty member rates the quality of information contained in your note,

2. the SP completes a "yes/no" checklist of expected history and exam components you did or did not perform, and

3. the SP completes the interview rating scale you used during PCM (get out those transitional statements and summarizations, and address the primary emotion!).

- Your counseling OSCE will be assessed on 2 components. Each component bears equal weight in your score:
1. the SP completes a "yes/no" checklist of expected history and counseling components you did or did not perform, and

2. the SP completed the interview rating scale you used during PCM

- For the "traditional" OSCE, patients will present with a focused problem: pain, chronic disease recheck/diagnosis, or other focused issue. Your history and physical must obtain adequate information to address this problem. (Example, a patient with cough - do they smoke? do they take medicines or have new exposures?) Watch out for confounders - abnormal lab or vital signs, props, primary emotion and other things that would change your approach if you recognized them.

- To make the “counseling” OSCE easier to perform, consider questions such as: "When is the last time you saw a doctor?" or "Have you seen a doctor to have your preventive health care done?" Expect to advise the patient regarding what preventive care s/he needs (pap, mammogram, colonoscopy, and so on).

- In addition, for both stations, this patient is new to you. Take a brief PMH, PSH, FH and SH and be sure to discuss meds and allergies. The ROS you obtain should be appropriate to the presenting complaint, although if other issues develop during your assessment you should do a brief ROS for those as well.

- Use every piece of information you are given, whether from the patient or from the paper you are given prior to the visit. You may be asked to review x-rays or other studies for the musculoskeletal OSCE station/case.

- Document in your note anything you believe to be of importance in assessing the patient - the faculty note rater does not review your videotape. Your note should be able to stand alone in justifying your thought process.

- Use the Assessment section to list your differential for the presenting complaint just as you would do for Step 2 CS. Use the Plan section as you would the Plan section of a SOAP note - to list any additional studies, labs, and so on you need to narrow your differential AND to discuss anything you recommended to the patient (meds, activities, therapies, when to return for follow up and so on).

I hope you gain confidence from your Family Medicine OSCE experience that will assist you in dealing with patients and in passing Step 2 CS. I also hope you will show me how well you have assimilated the knowledge you have gained while on this rotation. Good luck!