Medicine 1

Department of Medicine
MS 310
5/31/2018

Clerkship Director: Sonia Ananthakrishnan, M.D.
Clerkship Coordinator: Kelly Ho
# Medicine Syllabus

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## Medical Education Program Objectives

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<th>INSTITUTIONAL LEARNING OBJECTIVE</th>
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| **B - Behaves in a caring, compassionate and sensitive manner toward patients and colleagues of all cultures and backgrounds. (Interpersonal and Professionalism)** | **B.1** - Apply principles of social-behavioral sciences to provision of patient care; including assessment of the impact of psychosocial and cultural influences on health, disease, care-seeking, care compliance, and barriers to and attitudes toward care. (2.5)  
**B.2** - Demonstrate insight and understanding about emotions that allow one to develop and manage interpersonal interactions. (4.7)  
**B.3** - Demonstrate compassion, integrity, and respect for others. (5.1)  
**B.4** - Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (5.5) |
| **U - Uses the science of normal and abnormal states of health to prevent disease, to recognize and diagnose illness and to provide and appropriate level of care. (Medical Knowledge and Patient Care)** | **U.1** - Perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (1.1)  
**U.2** - Gather essential and accurate information about patients and their conditions through history-taking, physical examination, and the use of laboratory data, imaging and other tests. (1.2p)  
**U.3** - Interpret laboratory data, imaging studies, and other tests required for the area of practice. (1.4)  
**U.4** - Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgement. (1.5)  
**U.5** - Develop and carry out patient management plans. (1.6)  
**U.6** - Provide health care services to patients, families, and communities aimed at preventing health problems or maintaining health. (1.9)  
**U.7** - Demonstrate an investigatory and analytic approach to clinical situations. (2.1)  
**U.8** - Apply established and emerging bio-physical scientific principles fundamental to health care for patients and populations. (2.2)  
**U.9** - Apply established and emerging principles of clinical sciences to health care for patients and populations. (2.3)  
**U.10** - Recognizes that ambiguity is a part of clinical health care and respond by utilizing appropriate resources in dealing with uncertainty. (8.8) |
| **C - Communicates with colleagues and patients to ensure effective interdisciplinary medical care (Interpersonal and Communication Skills; Patient Care)** | **C.1** - Gather essential and accurate information about patients and their conditions through history-taking, physical examination, and the use of laboratory data, imaging and other tests. (1.2h)  
**C.2** - Counsel and educate patients and their families to empower them to participate in their care and enable shared decision making. (1.7)  
**C.3** - Participate in the education of patients, families, students, trainees, peers and other health professionals. (3.8)  
**C.4** - Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds. (4.1)  
**C.5** - Communicate effectively with colleagues within one’s profession or specialty, other health professionals, and health related agencies (4.2, see also 7.3)  
**C.6** - Maintain comprehensive, timely, and legible medical records. (4.5)  
**C.7** - Demonstrate sensitivity, honesty, and compassion in difficult conversations, including those about death, end of life, adverse events, bad news, disclosure of errors, and other sensitive topics. (4.6) |
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<th>INSTITUTIONAL LEARNING OBJECTIVE</th>
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<tbody>
<tr>
<td>A - Acts in accordance with highest ethical standards of medical practice (Professionalism)</td>
<td>A.1 - Demonstrate responsiveness to patient needs that supersedes self-interest. (5.2)</td>
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<td>C.8 - Communicate with other health professionals in a responsive and responsible manner that supports the maintenance of health and the treatment of disease in individual patients and populations. (7.3)</td>
<td>A.2 - Demonstrate respect for patient privacy and autonomy. (5.3)</td>
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<td>A.3 - Demonstrate accountability to patients, society, and the profession. (5.4)</td>
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<td>A.4 - Demonstrate a commitment to ethical principles pertaining to provision or withholding of care, confidentiality, informed consent, and business practices, including compliance with relevant laws, policies, and regulations. (5.6)</td>
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<td>A.5 - Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust. (7.1)</td>
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<td>A.6 - Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients. (8.5)</td>
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<td>R - Reviews and critically appraises biomedical literature and evidence for the purpose of ongoing improvement of the practice of medicine. (Practice-Based Learning and Improvement and Medical Knowledge)</td>
<td>R.1 - Apply principles of epidemiological sciences to the identification of health problems, risk factors, treatment strategies, resources, and disease prevention/health promotion efforts for patients and populations. (2.4)</td>
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<td>R.2 - Locate, appraise, and assimilate evidence from scientific studies related to patients' health problems. (3.6)</td>
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<td>R.3 - Continually identify, analyze, and implement new knowledge, guidelines, standards, technologies, products, or services that have been demonstrated to improve outcomes. (3.10)</td>
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<td>E - Exhibits commitment and aptitude for life-long learning and continuing improvement (Practice-based Learning)</td>
<td>E.1 - Identify strengths, deficiencies, and limits in one's knowledge and expertise. (3.1)</td>
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<td>E.2 - Set learning and improvement goals. (3.2)</td>
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<td>E.3 - Identify and perform learning activities that address one's gaps in knowledge, skills, and/or attitudes. (3.3)</td>
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<td>E.4 - Incorporate feedback into daily practice. (3.5)</td>
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<td>E.5 - Obtain and utilize information about individual patients, populations of patients, or communities from which patients are drawn to improve care. (3.9)</td>
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<td>E.6 - Develop the ability to use self-awareness of knowledge, skills, and emotional limitations to engage in appropriate help-seeking behaviors. (8.1)</td>
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<td>E.7 - Manage conflict between personal and professional responsibilities. (8.3)</td>
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<td>S - Supports optimal patient care through identifying and using resources of the health care system. (Systems-Based Practice and Patient Care)</td>
<td>S.1 - Provide appropriate referral of patients including ensuring continuity of care throughout transitions between providers or settings, and following up on patient progress and outcomes. (1.8)</td>
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<td>S.2 - Systematically analyze practice using quality-improvement methods and implement changes with the goal of practice improvement. (3.4)</td>
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<td>S.3 - Use information technology to optimize learning. (3.7)</td>
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<td>S.4 - Work effectively with others as a member or leader of a health care team or other professional group. (4.3, see also 7.4)</td>
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<td>S.5 - Work effectively in various health care delivery settings and systems relevant to one's clinical specialty. (6.1)</td>
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<td>S.6 - Coordinate patient care within the health care system relevant to one's clinical specialty. (6.2)</td>
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<td>S.7 - Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care. (6.3)</td>
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<td></td>
<td>S.8 - Advocate for quality patient care and optimal patient care systems. (6.4)</td>
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<td><strong>S.9</strong></td>
<td>Use the knowledge of one's own role and the roles of other health professionals to appropriately assess and address the health care needs of the patients and populations served. (7.2)</td>
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<td><strong>S.10</strong></td>
<td>Participate in different team roles to establish, develop, and continuously enhance interprofessional teams to provide patient- and population-centered care that is safe, timely, efficient, effective, and equitable. (7.4)</td>
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**Third Year Learning Objectives**
During the third-year clerkships, students will

- Demonstrate use of patient-centered interviewing and communication techniques (U.2)
- Take a clinical history that demonstrates both organization and clinical reasoning (U.7)
- Perform accurate and relevant physical exam techniques (U.2)
- Demonstrate an ability to synthesize clinical information and generate a differential diagnosis, assessment and plan (U.3, R2, U.5)
- Demonstrate a compassionate and patient-sensitive approach to history taking and physical examinations (B.3)
- Communicate well organized, accurate and synthesized oral presentations (C.1)
- Counsel and educate patients and families (C.3)
- Demonstrate timely, comprehensive and organized documentation (C.6)
- Demonstrate a fund of knowledge in the clinical discipline and apply this to patient care (U.4)
- Demonstrate an awareness of one’s own learning needs and work to address these gaps (E.1, E.3)
- Show respect and empathy for others (B.3)
- Demonstrate accountability to the responsibilities of the student’s role and expectations of a clinical clerk (S.4)
- Communicates effectively with the interprofessional team (S.9)

**Clerkship Learning Objectives**
*(Linked to Medical Education Program Objectives in parentheses)*

**By the end of the clerkship, each student will be able to**

I. Demonstrate **professional and humanistic behavior in clinical and clerkship related responsibilities**:  

- Be present and punctual  
- Proactively clarify your role and responsibilities, and reliably respond to patient care needs  
- Appropriately identify your position as “Student” or “Student Doctor”  
- Maintain confidentiality  
- Be forthright and accept responsibility for errors  
- Ask for help appropriately  
- Build a therapeutic relationship through a **respectful, empathic** approach that gains the **trust** of the patient  
  - Dress and behave in a way that promotes patient comfort, trust and confidence in you
• Demonstrate that the interests of the patient guide your behavior by:
  o Working to meet the patient’s needs - at times this means accepting personal inconvenience
  o Advocating for patient’s needs - eg getting a test, consult or follow-up appointment

(B.3, A.1, A.2)

II. Develop productive, collaborative working relationships with other members of the health care team and system, effectively contribute to the provision of quality patient care, and work toward the improvement of the systems of care.

(S.4)

III. Use proper technique to perform an accurate, appropriately detailed and organized history and physical examination in an efficient and sensitive manner, with a special emphasis on the intermediate and advanced physical diagnosis skills involved in volume assessment, the cardiovascular exam and the chest/pulmonary exam.

(C.1)

IV. Communicate clinical information accurately and demonstrate your understanding of the patient’s problems, through concise, convincing, well-organized patient presentations, admission write-ups, progress notes, and handoffs that are appropriate for the audience, purpose and time available for the communication.

(C.4, C.5, C.8)

V. Identify and prioritize your patients’ problems, formulate an appropriate differential diagnosis and outline an approach to diagnosis and management that is supported by clinical data and sound reasoning.

(U.4, U.5)

VI. Educate patients about their conditions and partner with them to develop and implement a treatment plan.

(C.2, C.4)

VII. Perform the designated procedures with appropriate technical proficiency while demonstrating attention to the patient’s needs and concerns, and describing a clear understanding of benefits/risks, indications/contraindications.

(U.1)

VIII. Demonstrate a core foundation of knowledge (scientific, ethical, socio-cultural) guided by the course objectives that is necessary both to provide high quality patient care and to understand advances in medicine.

(U.9, U.9)
IX. **Identify and address your learning needs** (by asking questions and critically incorporating information from appropriate resources into the decision-making process) and effectively share this information with colleagues. *(R.3, E.1, E.3, E.4)*

X. Solicit and probe for useful **feedback**, and respond with **improved performance**. *(E.2, E.4)*
Contact Information

Clerkship Director
Sonia Ananthakrishnan
Telephone: (617) 358-3522
Email: sonia.ananthakrishnan@bmc.org
Pager: 4435
Office: Evans 122
Office Hours: Students may email to set up an appointment

Associate Clerkship Director
Julien Dedier, M.D.
Telephone: (617) 414-6931
Email: Julien.Dedier@bmc.org
Pager: 5428
Office: Crosstown Center 2nd Floor, Suite 2024
Office Hours: Students may email to set up an appointment

Associate Clerkship Director
Robert Lowe, M.D.
Telephone: (617) 638-6116
Email: Robert.Lowe@bmc.org
Pager: 0028
Office: 85 E. Concord St. 7th Floor
Office Hours: Students may email to set up an appointment.

Associate Clerkship Director
Nicolette Oleng, M.D.
Telephone: (617) 414-6623
Email: noleng@bu.edu
Pager: 0613
Office: CT 1049
Office Hours: Students may email to set up an appointment.
Associate Clerkship Director
Lauren Stern, M.D.
Telephone: (617) 638-7235
Email: lstern@bu.edu
Pager: 4678
Office: Vose 210
Office Hours: Students may email to set up an appointment.

Clerkship Coordinator
Kelly Ho
Telephone: (617) 358-3523
Email: kellyho@bu.edu
Office: Evans 122
Office Hours: 8:30-5:00
Clerkship Description

**Focus of clerkship**
The Medicine 1 Clerkship is an eight-week experience designed to develop your ability to function as a caring, increasingly independent, but supervised, clinician on a multi-professional team. During the clerkship, you will learn clinical medicine while working side-by-side with teams of residents and faculty providing care to a cohort of inpatients. As your knowledge and skills grow, you will earn increasing patient care responsibility. This direct patient care experience is complemented by a unique enrichment in which you also work closely in small groups with a clerkship director and hone essential clinical skills (including intermediate-level communications skills, physical diagnosis, and clinical reasoning), in addition to conferences that focus on core topics. The clerkship is divided into two mini-blocks of four weeks each, and most students spend time at 2 of our clinical sites.

The Big Goal of the Clerkship is to develop someone who we would want to care for our family members, a highly caring, increasingly independent clinician, who is a strong team member.

**The Medicine 1 Clerkship aims to:**
- Introduce you to the world of internal medicine
- Refine your skills as a self-directed learner
- Enable you to become a contributing, collaborating team member
- Develop your skills as a clinician

**The Self-Directed Learner**
You are entering the world of medicine where the growth in the body of knowledge is accelerating at an unprecedented pace, and to thrive in this world, you must take ownership of your learning. The Medicine 1 Clerkship builds upon the learner-centered approach and challenges you to be a self-directed, lifelong learner. The dynamic nature of learning while caring for patients requires that you become adept at identifying your learning needs and acting upon them. You will need to continually ask relevant questions, find credible, evidence-based responses, and integrate this information into patient care.

As a student, you will need to be a flexible learner who employs a variety of appropriate resources ranging from textbooks and the medical literature to consultants, and one who solicits and responds effectively to feedback. The clerkship provides you with many opportunities you to read deeply, to become the “local expert” on your patients, to share your learning with your team, and to continuously improve.

**Contributing, Collaborating Team Member**
Medicine is a team “game” requiring you to work effectively with multiple health care providers from different disciplines and within a complex system. The Clerkship challenges you to “find your niche” from which to consistently contribute to both patient
care and team learning, and to develop the habits of mind and skill sets that will enable you to function effectively within and improve the systems in which our patients receive their care.

**Becoming a Clinician**

The **primary focus of the clerkship** is to increase your ability to function as a caring, increasingly independent but supervised clinician on a multidisciplinary team. By clinician we mean a person who takes care of patients, including all dimensions of such work-communicating, diagnosing, treating, and healing. You will do so by playing a central role in the care of assigned patients and also learn from other patients who are on your team.

**Learning Experiences**

**FOCUS Cards and Internal Medicine Structured Observations of Clinical Skills (SOCS):**

These exercises are designed to assist the student in obtaining ongoing, real-time feedback after being directly observed performing a variety of skills (interviewing a patient, performing physical exam skills, delivering an oral presentation, documenting a clinical encounter). These exercises will be student-initiated and completed on the wards by residents and attendings.

Two of these cards should be completed and upload by the time of the mid-clerkship feedback sessions.

The Internal Medicine SOCS cards will be also reviewed at mid-clerkship feedback and turned in at the end of the rotation as part of the passport. Both the formative assessment exercises of FOCUS cards and Medicine SOCS cards are not included in the calculations of students’ final grades.

Process for Focus Forms:
(Typically a 5-10 minute exercise)

1. Student initiates by speaking with observer (Resident, Attending or Fellow)
2. MD or student can identify patient
3. Hand observer the passport PRIOR to the patient encounter
4. Observation of encounter
5. Feedback on encounter
6. Observer and student sign card
7. Student photographs card and uploads to E*Value.

**Clinical Problem Solving Cases** (see individual case learning objectives)

**Student Report** These group discussions about real patients provide exposure to clinical problems commonly encountered in medicine.

**A mini-course on interpreting the ECG**—Apply a systematic approach to interpret the EKG
Small group sessions with your Clerkship Director. These sessions focus on refining core skills and building advanced skills in:

- The write-up and oral patient presentation
- The interview and physical exam - with a particular focus on the CV exam, Chest/Pulmonary Exam, and Volume Assessment
- Clinical reasoning
- Integrating the medical literature into patient care
- Promoting reflection and professional identity development

Reflection Exercise
Students write and discuss an essay based on a meaningful, real patient encounter or experience during the clerkship. This exercise is designed to promote the reflective process and, through the exploration of issues important to patient care and professional identity, help you appreciate the central role and value of narrative in medicine and employ it in your role as healer. The group discussion of reflection essays is an opportunity to hear the perspectives of student peers in what are likely shared experiences. Students are encouraged to address a topic of your choosing that may include ethical issues, the patient-doctor (student) relationship, frustrations or fulfillment, bad outcomes, mistakes, professional identity and development, or another topic that you find meaningful.

Required Diagnoses/Clinical Presentations

Each student is expected “see” > 15 patients where you serve as the primary student actively caring for the patient, writing notes… (under the guidance of faculty and house staff). Included among the patients you must see are patients with each of the following “Big 10” active problems:

- Fever
- Low Blood Pressure
- The hospitalized patient with best pain
- Shortness of breath
- Lab abnormalities (glucose, acid-base, creatinine, sodium, potassium, calcium, hemoglobin)
- Palpitations
- Extremity Pain/Swelling
- The hospitalized patient with chronic kidney disease
- The hospitalized patient with congestive heart failure
- The hospitalized patient with COPD/emphysema

See “Patient Encounters Log” section for details on documenting required patient encounters.
Strongly Recommended Experiences

In addition to the requirements described above, it is strongly recommended that you care for patients with the attributes or conditions described below, and address the recommendations regarding patient education/counseling, prevention, systems and patient safety and procedures.

Socio-demographics

- Elderly patient - > 75 years of age
- A patient who does not speak English
- A patient with limited access to care
- A patient from a culture not your own

Patient Education/Counseling – Perform the following patient education/counseling interactions as clinically indicated on patients you follow.

- Provide discharge instructions
- Promote behavioral change (e.g. tobacco, alcohol, other substance use, diet, weight loss, exercise)
- Facilitate medication adherence

End of Life and Advance Directives Discussions. Join your attending, resident or the Palliative Care Service to observe and participate in these crucial and powerful discussions with the patient and family in which, through partnership, decisions are made that integrate patient prognosis with patient values, priorities and wishes, to guide care in very ill patients who are near the end of their lives.

Prevention (primary, secondary or tertiary)/health promotion as a major focus of the interaction. Address an issue of prevention with the patients you follow. Prevention interventions may overlap with the patient education/counseling described above.

Systems and Patient Safety

- Identify instances where systems problems or strengths may have impacted on the quality of care your patients received
- Propose ways to improve the microsystems of care with which you interact
- Educate your patient on his major condition and the key medications you are asking him to take

Procedures:

- Observe the following procedures listed below, describe the experience from the patient’s perspective, and interpret and apply the results to the patient.
  - Thoracentesis
  - Paracentesis
• Lumbar puncture
• Cardiac stress test
• Echocardiogram
• Cardiac catheterization
• GI endoscopy
• Bronchoscopy

• In addition, for each of the procedures listed above you are expected to describe:
  • The information it can provide
  • Benefits and risks
  • Indications/Contraindications
  • Potential complications and how to reduce the risk of the complications

Pre-requisite knowledge and skills
Students must have completed their second year curriculum, attended the 3rd year orientation, and have taken the Step-I exam prior to taking this clerkship.

Site Information
Students will work with designated inpatient teams at each site to provide care for and learn from hospitalized patients. Most locations require a car and some provide housing. Most sites provide a complementary set of student conferences while students at some sites return for Wednesday didactics at Boston Medical Center (see below).

Each site has an MD Site Director and Program Coordinator who will partner with you to ensure a great learning experience and will be available to address immediate educational and logistic questions or concerns. The Site Director or designee at each site will function in a role similar to your Clerkship Director at Boston Medical Center, and provide you with feedback on your performance.

Berkshire Medical Center
725 North St, Pittsfield, MA 01201
Site Director: Steven Lamontagne, slamontagn@bhs1.org, (413) 447-2839
Site Administrator: Stephanie Wade, swade@bhs1.org, (413) 395-7879

Located in beautiful Berkshire County, Berkshire Medical Center is a 298-bed community teaching hospital. Berkshire Medical Center provides primary and specialized health care services to the people of Berkshire County and surrounding communities. BUSM students work alongside interns, residents, and attendings, and share experiences with students from the University of Massachusetts Medical School. Housing is provided, conferences take place on-site, and a car is required.
**Beth Israel Deaconess Needham**  
148 Chestnut St, Needham, MA 02492  
Site Director: Jonathan Goldman [jdgoldma@bidmc.harvard.edu](mailto:jdgoldma@bidmc.harvard.edu), (781) 453-6100  
Site Administrator: Kathryn Nardozza [knardozz@bidmc.harvard.edu](mailto:knardozz@bidmc.harvard.edu), (617) 866-9226

Beth Israel Deaconess Needham is a 58-bed (including 7 ICU beds) community hospital. The inpatient service is staffed by attending hospitalists, who are internal medicine trained physicians specializing in the care of inpatients. This means that essentially 100% of your physician interactions will be with attending physicians, which will afford you a higher level of independence and autonomy. You will return to Boston Medical Center for Wednesday didactics and a car is required.

**Beth Israel Deaconess Plymouth**  
275 Sandwich St, Plymouth, MA 02360  
Site Director: Tony Garcia [agarcia@bidplymouth.org](mailto:agarcia@bidplymouth.org), (508) 830-2679  
Site Administrator: Jenna Burton [jburton@bidplymouth.org](mailto:jburton@bidplymouth.org), (508) 830-2679

Beth Israel Deaconess Plymouth is a 150 bed community hospital that provides care to patients and communities on the South Shore and on Cape Cod. Students will work directly with hospitalists in the provision of care (with an opportunity for greater independence and autonomy), and get first-hand experience in an accountable care organization. Housing is provided.

**Boston Medical Center**  
1 Boston Medical Center Pl, Boston, MA 02118  
Site Director: Sonia Ananthakrishnan, sonia.ananthakrishnan@bmc.org (617) 358-2522  
Site Administrator: Kelly Ho [kellyho@bu.edu](mailto:kellyho@bu.edu), (617) 358-3523

Boston Medical Center is a private, not-for-profit, 493-bed, academic medical center located in Boston’s historic South End. An acute care, full-service hospital, BMC provides healthcare to a diverse patient population, including vulnerable, inner-city residents. The primary teaching affiliate for [Boston University School of Medicine](https://www.bumc.bu.edu/), BMC is the largest safety net hospital in New England. Students work on teams composed of interns, residents, attendings, and fellows.

**Kaiser Permanente**  
250 Hospital Pkwy, San Jose, CA 95119  
Site Director: Marina Dergun [Marina.Dergun@kp.org](mailto:Marina.Dergun@kp.org) (408) 972-4576  
Associate Site Director: Subbu Lakshmi [Subbu.Lakshmi@kp.org](mailto:Subbu.Lakshmi@kp.org)  
Site Administrator: Elizabeth Chua [Elizabeth.Chua@kp.org](mailto:Elizabeth.Chua@kp.org), (408) 972-4495
The Boston University Extension Campus at Kaiser Permanente Silicon Valley hosts 3rd year core clerkships up to one year in duration. It is an integrated program where student rotations occur at both Kaiser San Jose and Santa Clara Medical Centers; the Medicine 1 Clerkship takes place at the San Jose campus. This clerkship program offers Boston University medical students an opportunity to train within the nonprofit integrated, managed care system that is often hailed as the health care model for the future. You work directly with hospitalists (there are no residents. Housing is provided, conferences take place on-site, and a car is required.

**MetroWest Medical Center**
115 Lincoln St, Framingham, MA 01702  
Site Director: Nikolaos Mavrogiorgos Nikolaos.Mavrogiorgos@mwmc.com, (508) 383-8799  
Site Administrator: Sharon Dearth Sharon.Dearth@mwmc.com, (508) 383-1572

MetroWest is a community hospital in Framingham, MA with 300 beds. Students join teams composed of one attending/hospitalist, one resident, and one intern. You attend didactics at Metrowest. A car is required.

**Roger Williams Medical Center**
825 Chalkstone Ave, Providence, RI 02908  
Site Director: Gregg Allen gallenjrdo@yahoo.com, (401) 398-7925  
Site Administrator: Sue Saccoccia ssaccocc@chartercare.org, (401) 456-2388

The medical service at Roger Williams Medical Center in Providence, RI boasts a blend of primary and tertiary care in an academic community hospital and also is the site for the state’s only bone marrow transplantation program. Students work alongside interns, residents and hospitalists to provide patient care. You attend didactics at Roger Williams. Housing is provided.

**West Roxbury VA**
1400 VFW Pkwy, West Roxbury, MA 02132  
Site Director: Richard Serrao Richard.Serrao@va.gov, (857) 203-5056  
Site Administrator: Laura Muckerheide Laura.Muckerheide@va.gov, (857) 203-6942

The VA serves as a major teaching affiliate of BUSM, and trainees at the VA are exposed to a challenging and rewarding patient population characterized by a heavy burden of chronic illness, particularly cardiovascular and pulmonary diseases, and medical problems resulting from specific circumstances such as traumatic brain injury or spinal cord injury. The VA system also affords you the unique opportunity to experience a national-scope, single-payer, integrated health system. You work on teams with interns, residents and attendings from both BUSM and Harvard Medical School, and attend didactics at the VA. A car is often necessary.
Clerkship Schedules

Block Schedule
Block schedule dates for all clerkships can be located on the Office of Academic Affairs website: [http://www.bumc.bu.edu/butm/education/academic-affairs/academic-calendars/](http://www.bumc.bu.edu/butm/education/academic-affairs/academic-calendars/)

Didactic Schedule
Didactics take place Monday-Thursday at Boston Medical Center at either 12:00 or 1:00. Students at sites other than BMC are not required to return to Boston. Videos of BMC conferences will be made available to students at all sites on Blackboard in addition to complementary didactic sessions at all other sites.

Daily Schedule at Boston Medical Center

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-rounds</td>
<td>6:45-7:45</td>
<td>Pre-rounds 6:45-7:45</td>
<td>Pre-rounds 6:45-7:45</td>
<td>Pre-rounds 6:45-7:45</td>
<td>Pre-rounds 6:45-7:45</td>
</tr>
<tr>
<td>Work Rounds</td>
<td>7:45-11:00am</td>
<td>Work Rounds 7:45-11:00am</td>
<td>Work Rounds 7:45-11:00am</td>
<td>Work Rounds 7:45-11:00am</td>
<td>Work Rounds 7:45-11:00am</td>
</tr>
<tr>
<td>Didactics</td>
<td>12-1pm</td>
<td>Didactics 12-1pm</td>
<td>CREx/M&amp;M Conference 12-1pm</td>
<td>Didactics 12-1pm</td>
<td>Department of Medicine Grand Rounds 12-1pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Student Report 1-2pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Care and/or Small Group Learning with your CD (2 x/week)</td>
<td>1-5pm</td>
<td>Patient Care and/or Small Group Learning with your CD 1-5pm</td>
<td>Patient Care and/or Small Group Learning with your CD 2-5pm</td>
<td>Patient Care and/or Small Group Learning with your CD 1-5pm</td>
<td></td>
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</tbody>
</table>

- You will round with your team on either Saturday or Sunday; expect to have 1 weekend day off.
- The actual times vary slightly by team, but this gives you a general idea
Call Schedule
Students are in-hospital 6 days/week with 3 exceptions. You finish at 5 pm on the Friday of the 4th weekend and again at 5 pm on the Friday of the final weekend prior to the shelf exam. On both of those weekends, you return to the hospital on the following Monday morning. Finally, you complete in-hospital work by 5 pm on the final Wednesday of the clerkship. You should expect to stay in-hospital until 10:30 pm once /week and leave by 5:30 on the other evenings.

Holidays
Thanksgiving: Wed, Nov 21, 2018 at 12PM – Sun, Nov 25, 2018
Intercession: Fri, Dec 21, 2018 at 5PM – Tue, Jan 1, 2019

Other holidays that occur during specific blocks will be communicated by the clerkship director.

Assessment and Grading

Clerkship Grading Policy

<table>
<thead>
<tr>
<th>HOW MUCH EACH PART OF YOUR GRADE IS WORTH:</th>
<th></th>
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<tbody>
<tr>
<td>Clinical Grade Percentage</td>
<td>65%</td>
</tr>
<tr>
<td>Shelf/Exam Percentage</td>
<td>30%</td>
</tr>
<tr>
<td>“Other” Components Percentage</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW YOUR FINAL WORD GRADE IS CALCULATED:</th>
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<tbody>
<tr>
<td>Honors</td>
<td>≥ 90 Total Points</td>
</tr>
<tr>
<td>High Pass</td>
<td>80 to &lt;90 Total Points</td>
</tr>
<tr>
<td>Pass</td>
<td>56 to &lt;80 Total Points</td>
</tr>
<tr>
<td>Fail</td>
<td>≤ 55 Total Points or clinical grade &lt;48 points on CSEF score/100; or &lt;5th% on subject exam; or &lt;70 points on Formal Evaluation of Write Up and Presentation; or Professionalism Issues</td>
</tr>
<tr>
<td>SHELF/EXAM GRADING</td>
<td>30%</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Exam minimum passing (percentile/2 digit score)</td>
<td>2-digit score that corresponds to 5th percentile national on subject exam</td>
</tr>
</tbody>
</table>

**What is “Other” and what percentage is it worth?**

<table>
<thead>
<tr>
<th>What is “Other” and what percentage is it worth?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Formal Write Up &amp; Oral Patient Presentation</td>
<td>5%</td>
</tr>
<tr>
<td>Professionalism</td>
<td>See below</td>
</tr>
</tbody>
</table>

**Other components that need to be completed in order to pass the clerkship**

<table>
<thead>
<tr>
<th>Other components that need to be completed in order to pass the clerkship</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Encounters Log</td>
<td></td>
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<tr>
<td>FOCUS Forms</td>
<td></td>
</tr>
<tr>
<td>Medicine Structured Observations of Clinical Skills Cards (SOCS)</td>
<td></td>
</tr>
<tr>
<td>Duty Hours log</td>
<td></td>
</tr>
</tbody>
</table>

**Standard Clerkship Clinical Grade Procedures/Policies**

Preceptors will provide clinical evaluations that contain the “raw data” on the student’s clinical performance. Preceptors DO NOT determine the final “word” grade. You are encouraged to regularly ask for specific, behaviorally based feedback on your clinical skills from your preceptors. However, do not ask them what word grade you will get, as that is a multifactorial process of which the clinical evaluation is one component.

The CSEF form will be used to numerically calculate your clinical grade: 1 to 4 points (depending on which box is checked) for each of the 13 items for a total of 52 possible points. Each CSEF will be weighted based on how long the student worked with each evaluator.

**Clerkship Specific Clinical Grade Procedures/Policies**

**Guiding Principles**- We strive to provide a grading system that is:

- Fairly applied- a system that we follow for all students.
- Transparent - students can clearly see the process by which the grade is derived.
- Discriminating- the HONORS grade represents a performance of true distinction.
- Based on your absolute performance. There is no ‘curve’ or fixed percentage about who can/cannot get HONORS.
- Performance –based- what the student does and is reported- not based on potential.

The CSEF score (a total of 52 points) will be converted to a score out of 100 to generate the clinical grade. (Example CSEF score of 42 out of a total of 52 points correlates to 80.7 points out of 100, which would count towards 65% of the final grade).
The CSEF grade is complemented by a narrative description on the E*Value form and by other observations conveyed by instructors. These may be used by the Clerkship Faculty to slightly increase a student’s CSEF score, if and when appropriate.

The Formal Evaluation of the Write-Up and Oral Patient Presentation is graded using a standardized grading rubric.

If the student scores > 5th percentile nationally on the initial attempt at the NBME Shelf Exam, he/she is assigned points for the NBME Shelf Exam component of the final grade in proportion to the 2-digit score. The higher the 2-digit score, the more points the student receives--- see score sheet.

**Integrating the Clinical Performance Score into the Final Grade**
- To achieve a final grade of HONORS, the student must achieve >90 Total Points.
- To achieve a final grade of HIGH PASS, the student must achieve 80 to < 90 Total Points.
- To achieve a final grade of PASS, the student must achieve 56 to < 80 Total Points.

**Deriving the Final Composite Grade from the input. An example:**

A. 65% ---Clinical evaluation---CSEF score 42 out of 52 is converted to score of 80.7 out of 100.
B. 30% ---NBME shelf exam--- 84 points x .30
C. 5% ---Averaged score of the Formal review of 1 write-up and 1 presentation=87 x .05

\[(80.7) \times 0.65 + (84) \times 0.30 + (87) \times 0.05 = 52.4 + 25.2 + 4.4 = 82\]

This student’s final (composite) grade for the clerkship is HIGH PASS.

**Professionalism**

Evaluation of a medical student’s performance while on a clinical clerkship includes all expectations outlined in the syllabus and clerkship orientation as well as the student’s professional conduct, ethical behavior, academic integrity, and interpersonal relationships with medical colleagues, department administrators, patients, and patients' families. Any lapses in professionalism may result in a loss of up to 3% of the total possible clerkship points regardless of performance in other areas of the clerkship. Any professionalism lapses resulting in a loss of clerkship points will require narrative comments by the clerkship director in the professionalism comment section of the final evaluation and a discussion with the student.

**Clerkship-Specific Failure and Remediation Policies/Procedures**

If a student scores < 29/52 (= 55.7/100) on the CSEF, this may result in a failure.

**Fail Clinical**- If the student Fails the clinical portion of the clerkship, or does not meet the standards for professionalism both clinically or within the core clerkship curriculum, the student must retake the clerkship in its entirety.
**Fail Formal Evaluation of Write-Up & Presentation** - If the student fails only the “Formal Evaluation”, the student must repeat the Formal Evaluation. If the student fails a 2nd time, he/she must retake the clerkship in its entirety.

**Fail Shelf only** - For students who meet expectations for all grading elements except that they score < 5th percentile on the subject exam, they may retake the subject exam one time. If the student fails to meet > 5th percentile on the retake shelf exam, the student must retake the entire clerkship, including the shelf exam.

**BUSM Grade Review Process**

**Grade Reconsideration**: The Module, Course, Clerkship, and Rotation Directors determine grades in consultation with the course or clerkship faculty based on the criteria described in the module or clerkship syllabus.

A student who chooses to appeal a grade must follow these procedures:

**STEP 1** Contact the Registrar to review the grade appeal process. The Registrar will serve as a liaison between the student and Department to ensure that all requirements are met.

**STEP 2** Schedule a meeting with your primary associate clerkship director or Dr. Ananthakrishnan

**STEP 3** Submit a written grade appeal to the Clerkship Director, Clerkship Coordinator, & Registrar. The appeal should include your rationale for the appeal (being numerically close to honors is not a rationale in and of itself). The letter should be submitted no more than 15 business days after the date on which the grade is officially recorded in the Registrar’s office.

The Module, Course, Clerkship, or Rotation Director must provide a written decision to the appealing student within 30 calendar days of receipt of the appeal.

**Formative Assessments**

The purpose of formative assessment is to improve student learning by providing feedback on how well they are learning skills and content during the clerkship. Formative assessments are not included in the calculations of students’ final grades. Each clerkship has required BUSM **FOCUS** (Feedback based on Observation of Clinical UME Student) forms which must be completed by the mid/end of the clerkship. These forms will provide formative assessment through direct observation of CSEF behaviors.

In addition, the Medicine clerkship has specific direct observation cards (SOCS) to be filed for review at mid/end of clerkship. Again, these forms are more opportunity for the student to obtain feedback from direct observation of skills that are specific to Internal Medicine.

See ‘Learning Experiences’ for further details.
**Formative Assessment and Feedback Policy**
Boston University School of Medicine (BUSM) ensures that each medical student is provided with formative assessment early enough during each required course or clerkship to allow sufficient time for remediation. Formative assessment occurs at least at the midpoint of each required course or clerkship four or more weeks in length.


**Mid-Clerkship Review**
You and your clerkship director, site director or primary preceptor will complete the BUSM Mid-clerkship Evaluation form at the mid clerkship point.

The purpose of this evaluation is to give the student a chance to understand both their strengths as well as opportunities to improve. The feedback received at the mid-clerkship review is intended to allow the student to improve their clinical skills in real time.

**Best practices regarding feedback include:**
- Start with getting the student’s perspective on how they performed or are performing.
- Feedback should be specific and actionable. What could the student do differently next time?
- Feedback should be based on direct observation. i.e. what you have seen.
- Feedback should be timely (in close proximity to when you observed a behavior).
- Feedback should be respectful and encourage future growth.

**Final Summative Assessments**
The final summative assessment will be based on the clerkship grading policy and include a clinical performance grade with the CSEF (Clinical Student Evaluation Form), a NBME performance grade, and other assessments depending on the clerkship.

**NBME Subject Examination**
Students will take the Medicine NBME Subject Examination on the last Friday of the clerkship (unless otherwise communicated by the Office of Academic Affairs). Students are given a reading day the day before the exam. Students do not report to their clerkship site on the reading day or the day of the exam. As of August, 2018 NBME will incorporate some short answer questions to the exam. There will be three or less of these questions and not all students will receive the new questions on their exam. Students will be given 2 hours and 45 minutes to complete this exam.
Shelf Exam Laptop Certification Process
Students must certify their laptops one week before the NBME Subject Exam and again on the day before the exam. Instructions are provided on the Alumni Medical Library website at: http://medlib.bu.edu/computing/nbmelaptopcertification.php

Exam Policies
http://www.bumc.bu.edu/busm/education/academic-affairs/policies/exam-policies-for-medical-students/

Testing Center Policies
http://www.bumc.bu.edu/busm/education/academic-affairs/policies/l-11-testing-center/

Make-Up Exams
Students needing to make up the exam or remediate only the exam portion of the clerkship must contact the Clerkship Coordinator to arrange for a make-up/remediation date. **Students may not take a make-up or remediation exam during any block they currently have a scheduled rotation.** Make-ups and remediation exams will typically be scheduled at the end of the third year blocks between mid-May and early June.

Roles and Responsibilities

**Clerkship Director**
- Oversee the design, implementation, and administration of the curriculum for the clerkship
- Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
- Ensure student and faculty access to appropriate resources for medical student education
- Orient students to the clerkship, including defining the levels of student responsibility necessary for required diagnoses and procedures
- Oversee teaching methods (e.g. lectures, small groups, workshops, clinical skills sessions, and distance learning)
- Develop faculty involved in the clerkship
- Evaluate and grade students
  - Develop and monitor assessment materials
  - Use required methods for evaluation and grading
  - Assure mid-clerkship meetings and discussion with students
  - Ensure students are provided with feedback on their performance
  - Submit final evaluations for students via E*Value
- Evaluate faculty and programs via peer review and reports from the Office of Medical Education and national reports
- Support each student’s academic success and professional growth and development, including working with students experiencing difficulties
- Participate in the BUSM clerkship peer review process
- Ensure LCME accreditation preparation and adherence
• Adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations

Clerkship Coordinator
• Support the clerkship director in the responsibilities provided above
• Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
• Maintain student rosters and clinical schedules
• Coordinate orientations and didactic sessions
• Liaise with site directors and administrators to coordinate student experiences across all sites
• Verify completion of clerkship midpoint and final evaluations for each student
• Monitor students’ reported work hours and report any work hours violations to the clerkship director
• Coordinate and proctor clerkship exams

Site Directors
• Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
• Orient students to the clinical site
• Sets student expectations for clinical encounters and discusses student role and responsibilities
• Supervises students by observing history taking, physical exam skills and clerkship specific required observations.
• Ensures formative feedback in an appropriate and timely fashion
• Delegates increasing levels of responsibility
• Meets with the student for the Mid-clerkship review
• Meets with the student for the final exit meeting
• Recognize students who have academic or professional difficulties and communicate this to clerkship leadership
• Collects feedback and evaluation data from all physicians who work with the student
• Evaluates students fairly, objectively and consistently following medical school and department rubrics and guidelines
• Ensure student and faculty access to appropriate resources for medical student education
• Adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations

Primary Clinical Faculty/Preceptors/Trainees
• Set and clearly communicate expectations to students
• Supervise students by observing history taking and physical exam skills, and document it on the FOCUS form
• Delegate increasing levels of responsibility to the student within clerkship expectations
• Maintain appropriate levels of supervision for students at site.
• Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
• Recognize student learning or professional difficulties and communicate to clerkship director directly in real time in person or via email or phone
• Give students appropriate and timely formative feedback
• Assess students objectively using the CSEF form
• Adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations

Residents and Fellows
• Supervise students by observing history taking and physical exam skills
• Give appropriate and timely formative feedback
• Delegate increasing levels of responsibility to the student
• Recognize student learning or professional difficulties and communicate to clerkship site director
• Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
• Assess students objectively using the CSEF form

Teaching Expectations “At a Glance” for Residents- Department of Medicine

The Resident ensures that 3rd year students have meaningful involvement in patient care and learning by:

• Setting expectations and supervising the student
• Leading effective Work Rounds and overseeing clinical care during the day that integrates the student into the team and provides multiple opportunities for meaningful involvement in patient care and learning by delegating increasing levels of responsibility
  o Conducting daily ‘CHECK-INS’ in which the student should come with:
    • An organized update on pertinent patient information
    • Interpretation of the information
    • Management recommendations (hopefully)
    • Questions
  Check-ins provide opportunities to provide instruction (especially to ask questions, observe) and feedback.

• Delivering excellent teaching by providing clinical supervision during the day and during dedicated student teaching time (e.g., 20 + minutes ≥2 x /week with students to discuss a ‘case’, critique a presentation, go to bedside…), that emphasizes:
o Setting expectations
  • Integrating the clerkship expectations and your own style and preferences- teams are encouraged to use Team Based Orientation tool in passport

o Providing multiple brief observations of the student doing elements of the history/exam, Pex, etc and able to assist student in completing passport exercises
  • Providing frequent, timely positive and constructive Feedback (and more feedback) and evaluation (on E*Value) using “Ask-Tell-Ask” and the E*Value CSEF frameworks
  • Identifying learning or professional difficulties and questions, and communicate them early to the student education leadership

Supervision
Initially, the primary clinical faculty members should designate time to observe you performing: history taking, focused physical exam, clinical problem-solving and interaction with patients and patient education. Once the supervisor establishes the student’s level of confidence and competency, the student should be delegated increasing levels of responsibility in patient care, as appropriate. Although students may initiate a particular patient encounter on their own and without direct supervision, the faculty must at some point review the encounter with the student and inform the patient in-person that the student’s assessment and management plan has been reviewed and approved by the faculty. The faculty is ultimately responsible for the evaluation, treatment, management, and documentation of patient care. If students have concerns regarding their clinical supervision, the site director and clerkship director should be immediately notified.

Supervision and Delegating Increasing Levels of Responsibility
It is expected that the level of student responsibility and supervision will be commensurate with student’s competency and level of confidence. When the student arrives to a new setting, a faculty may wish to observe you for the first session. Thereafter, you should begin to see patients on your own. In the outpatient setting, the student should initially perform 4-5 focused visits per day in the first week, increasing to 6-12 thereafter. In the inpatient setting, the student should initially follow 1-2 patients and increased to 3-4 thereafter. When a student feels that he or she is being asked to perform beyond his or her level of confidence or competency, it is the responsibility of the student to promptly inform the preceptor. It is then the preceptor’s responsibility to constructively address the student’s concerns and appropriately restructure the teaching encounter to address the student’s learning needs.

Under no circumstances should the following occur:
  • Patient leaves the office/hospital with never having had a direct face-to-face encounter with clinical faculty/ supervising resident.
  • Primary faculty gives “prior approval” for student to perform intervention (order labs, prescribe meds) without satisfactory review.
  • Patient leaves office/hospital without being informed that assessment / management plan has been directly reviewed and approved by the faculty.
- Learning in which a student is expected to perform an intervention or encounter without the prerequisite training and/or adequate supervision.
- Student note provides the only record of the visit. Although all faculty see all patients, faculty must document that they were actually the person responsible for seeing and examining the patient.

**Third Year Student**
The 3rd year student
- Learns through meaningful involvement in patient care and learning with graduated decision-making responsibility
- Is available to help the team but “Learning comes first”
- Is a proactive, self-directed learner

Learns through meaningful involvement in patient care and learning/teaching with graduated decision-making responsibility.
- Sees patients independently
- Pre-rounds and initiates discussion with assigned patients on work rounds
- Formally presents assigned patients each day on work rounds
- Enters patient orders under the supervision of physicians
- Follows-up on labs, imaging, consults
- Updates intern, team and patient (CHECK-IN with team members, see above) as new information emerges
- Speaks with consultants
- Provides initial write-up & daily progress notes
- **Admits ≥ 3 new patients per week** (ideally new admissions and not transfers from ICU), of which at least 1 patient/week is “truly new” (i.e., admitted from the ED or office/clinic; transfer patients and patients initially admitted by night float do not count as “truly new”)
- Provides brief, targeted topic presentations to the team on a regular (at least weekly) basis
- Learns from own patients first but also from all patients on the team
- Participates in discharge planning on patients you directly follow but do not do discharge summaries!

The 3rd year student is available to help the team but learning comes first.

- Learning from direct patient care is complemented by:
  - Attending conferences
  - Observing procedures
  - Reading (at night and during slow periods on some days).
The 3rd year student is a proactive, self-directed learner who:

- Elicits and clarifies expectations from your interns, resident, and attendings
- Addresses questions, concerns, confusion with the team or with your CD ASAP
- Identifies your learning needs and acts upon them
- Solicits feedback from your teachers
- Contacts your Clerkship Director with questions, comments or concerns early
- Adapts to team transitions and realities

See Requirements in the Assignment section of this Syllabus for a listing of responsibilities.

**Professional Comportment**

Students are expected to adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations, located on the Policies page, under “Academic Policies and Information” ([http://www.bumc.bu.edu/busm/files/2015/05/AAMC-Teacher-Learner-Expectations.pdf](http://www.bumc.bu.edu/busm/files/2015/05/AAMC-Teacher-Learner-Expectations.pdf))

Students are expected to be aware of and follow the site expectations on professional comportment, including, but not limited to, dress code and the use of phones, pagers, and laptops. Students must arrive on time at their site and for any scheduled sessions. Any missed sessions and absences must adhere to the Clinical Student Time Off Policy.

Further, below are expectations for student professionalism in the core clerkship curriculum. These include, but are not limited to:

- Treating the clerkship team in a professional and respectful manner
- Engaging in the core curriculum and participating respectfully at all times
- Arriving at clerkship didactic sessions on time
- Requesting faculty and resident evaluations in a timely manner
- Reviewing and responding to e-mail requests in a timely manner.
- Returning borrowed clerkship materials on time
- Handing in all assignments on time
- Completing all logs and FOCUS forms by the clerkship specific deadline
- Inform clerkship leadership and supervising faculty/residents of absences for any amount of time

Feedback on professionalism will be given to students during the mid-clerkship meeting so students will be made aware of any concerns noted by the clerkship directors, clerkship coordinator, faculty or residents.
Positive and constructive comments on professionalism will be included in the narrative of the final clerkship evaluation for each student. Any lapses in professionalism may result in a loss of up to 3% of the total possible clerkship points.


**Ethical Behavior for Examinations and Mandatory Sessions**

- Refrain from any conversation with your peers during exams and as you leave the L-11 testing space, including within the vending room and elevator waiting area, until you are on the elevator.
- Don't seek or receive copies of the examinations.
- Signing in classmates, or signing in yourself and not staying, for mandatory sessions is considered cheating and violations will be referred to Medical Student Disciplinary Committee.
- If you are aware of any violations of the ethical standards listed above, within the Student Disciplinary Code of Academic and Professional Conduct, or otherwise, report it to the Clerkship Director.

**Student Evaluation of the Clerkship**

Student feedback is a highly valued, critical resource for helping us continually improve our curriculum. Evaluation of learning experiences is a requirement of the Liaison Committee on Medical Education. To ensure that we have a representative amount of data on our courses and clerkships, all students are expected to complete an evaluation via E*Value (www.e-value.net) for each of the courses/modules and their instructors. All evaluations are anonymous and aggregate data is only released to clerkship directors after grades have been submitted for the blocks. Please comment freely and honestly about your experience.

**Blackboard**

Students will have access to a Blackboard site for the clerkship. The site is listed under “My Courses” as MS310 A1: Medicine 1 Clerkship on your Blackboard landing page.

All clerkship materials will be available on Blackboard. To make the site more user-friendly, the Home Page includes a Table of Contents to guide you.

Students who have questions about the Blackboard site or find that they do not have access to the site should contact the Clerkship Coordinator for assistance.

Blackboard Learn: [https://learn.bu.edu/](https://learn.bu.edu/)

**Assignments**

1. Complete, sign (along with your observer) and upload to E*value at least 10 FOCUS Forms
   a. Interview and Data Gathering
b. Physical Exam
c. Oral Presentation (4)
d. Documentation (4)

2. Complete, sign (along with your observer) and turn in (as part of passport)
   Medicine Clerkship Structured Observation of Clinical Skills Cards (SOCS)
   a. JVP Exam
   b. Cardiac Exam
   c. Pulmonary Exam

3. Complete the Medical Student Enhanced Patient Education (MSEPE) assignment
   (in passport)

4. Enter your assigned patients into the E*Value patient encounter log and ensure
   that you have seen and documented that you have seen the expected number (> 15)
   and types of patients (Big 10). Provide a paper copy for your Clerkship
   Director/Adviser at your feedback meetings.

5. Write up and present your reflective essay. This typically occurs during weeks 4, 5
   or 6. Check with your CD on timing and format

6. Submit the write-up and presentation for the formal evaluation to the CD
   assigned to review it. Unless informed otherwise, be prepared to submit by the end
   of week 6 (week 5 in a shortened clerkship). Before the formal evaluation, you will
   receive notification that indicates the date of the evaluation and which CD will
   review your work. You are expected to submit the write-up at least 3 full days
   prior to the evaluation session.

7. Participate in the mid-point and end-of-clerkship feedback sessions and sign the
   feedback form confirming so

8. Complete and review Feedback Cards & Preceptor Log with your CD. Additionally,
   submit the preceptor log to Kelly Ho at the end of week 4 and week 8.

9. Complete in E*Value your duty hours that enumerates your in-hospital work hours.
   You are expected to average < 80 hours per week in the hospital. Review the time
   card with your CD/Adviser at your mid-point and end-of-clerkship feedback
   meetings.

10. Complete E*Value and Department of Medicine evaluation of the clerkship and of
    your supervising residents and attendings.

11. Successfully complete the Medicine Subject (“Shelf”) Exam on the final day of the
    clerkship.

Process for the Formal Evaluation of the Write-Up and Presentation

- A list of students and their assigned CD Reviewer will be disseminated in advance,
  and the student will be contacted to schedule the appointment.
• This formal evaluation will be done by a clerkship director (CD) who is not the student’s primary adviser.
• This evaluation will take place during the 5th-8th week of the clerkship, unless extenuating circumstances do not allow.
• The **student will hand in/email the write-up to the CD evaluator 3 or more days in advance** of the meeting with that CD.
• The formal but targeted oral presentation (simulating what would ideally occur on work rounds) should be done for a **newly admitted inpatient who is different from the person described in the write-up**.
• The write-up and oral presentation will each be scored from 0-100 (based on a grading rubric), and the average of the 2 scores make up the contribution from this component of the grading process toward the final grade.
• Failure to meet the expectations outlined above will result in a reduction in the student's score.

**Patient Encounters/Case Logs**
Across the third year there are required patient encounters and procedures that must be logged whenever they are seen. To log the patient encounter, students must have participated in the history, physical exam, assessment and plan development of the patient.

**Required Patient Encounters**

<table>
<thead>
<tr>
<th>Clerkship/Clinical discipline</th>
<th>Patient type/ Clinical condition</th>
<th>Clinical setting</th>
<th>Level of student responsibility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>Fever</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Low blood pressure</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>The hospitalized patient with chest pain</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Shortness of breath</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Lab abnormalities (glucose, acid-base, creatinine, sodium, potassium, calcium, hemoglobin)</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Palpitations</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Extremity pain/swelling</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>The hospitalized patient with chronic kidney disease</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>The hospitalized patient with congestive heart failure</td>
<td>I</td>
<td>All</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>The hospitalized patient with COPD/emphysema</td>
<td>I</td>
<td>All</td>
</tr>
</tbody>
</table>
**Alternative Patient Encounters**

If you do not see a patient with one of the required characteristics noted above, you are expected to speak with your Clerkship Director to identify a “real” or “virtual” patient learning opportunity to meet this Clerkship expectation. The virtual patient may come from the Clinical Problem Solving cases, or other paper of electronic sources approved by the Clerkship Director.

**Patient Encounter Log**

Students are expected to log their patient encounters in E*Value (www.e-value.net). Patient logs help the clerkship ensure that each student is seeing a diagnostically diverse patient population, an adequate number of patients, and performing a sufficient number of required procedures and diagnoses. The directions on how to log patient encounters can be found on the E value help page http://www.bumc.bu.edu/E*Value/students/. Students must bring a printed copy of their patient encounter and procedure log to their mid rotation feedback meeting.

**Policies and Procedures for Evaluation, Grading and Promotion of Boston University School of Medicine MD Students**

**Collaborative Student Assessment System**
http://www.bumc.bu.edu/busm/files/2016/03/OAA_Collaborative_Student_Assessment_System.pdf

**Student Disciplinary Code of Academic and Professional Conduct**

**Attendance Policies**

On-site hours must be limited to 80 hours per week, averaged over a two-week period. Violations should be reported directly to the clerkship director or to an Associate Dean (Academic Affairs or Student Affairs). Time off requests must comply with the Attendance & Time Off Policy. Time off request forms must be submitted for an absence of any amount of time from the clerkship.

- Attendance & Time Off Policy:
  - Time Off Request Form: [www.bumc.bu.edu/busm/files/2015/06/Time-off-Request-Form.doc](www.bumc.bu.edu/busm/files/2015/06/Time-off-Request-Form.doc)
- Work Hours: [http://www.bumc.bu.edu/busm/education/academic-affairs/policies/work-hours/](http://www.bumc.bu.edu/busm/education/academic-affairs/policies/work-hours/)

**Personal Day Policies**
[http://www.bumc.bu.edu/busm/education/academic-affairs/policies/personal-days-policy/](http://www.bumc.bu.edu/busm/education/academic-affairs/policies/personal-days-policy/)

**Clerkship Specific Blackout Dates**
- The first day on a new team or at a new site
- Monday, Tuesday, and Wednesday of the last week of the clerkship.

**Scrubs Policy**

**BUSD Policies**
In addition to the expectations listed above, all students are expected to adhere to BUSM and Boston University policies.
[http://www.bumc.bu.edu/busm/education/academic-affairs/policies/](http://www.bumc.bu.edu/busm/education/academic-affairs/policies/)

**BU Policies and Student Support Services**

**Appropriate Treatment in Medicine**
Boston University School of Medicine (BUSM) is committed to providing a work and educational environment that is conducive to teaching and learning, research, the practice of medicine and patient care. This includes a shared commitment among all members of the BUSM community to respect each person’s worth and dignity, and to contribute to a positive learning environment where medical students are enabled and encouraged to excel.

BUSM has a **ZERO** tolerance policy for medical student mistreatment.

Students who have experienced or witnessed mistreatment are encouraged to report it using one of the following methods:

- Contact the chair of the Appropriate Treatment in Medicine Committee (ATM), Dr. Robert Vinci, MD, directly by email (bob.vinci@bmc.org)
These reports are sent to the ATM chair directly. Complaints will be kept confidential and addressed quickly.


**Needle Sticks and Exposure Procedure**

**Boston University Sexual Misconduct/Title IX Policy**

**Boston University Social Media Guidelines**
http://www.bu.edu/policies/information-security-home/social-media-guidelines/

**Recent Changes to the Clerkship**
- Updated Syllabus using standardized format
- Updated Grading System based on BUSM OME changes
- We have added several new teaching sites during 2016-17, including BID- Needham and Berkshire Medical Center, and expanded the number of students going to Kaiser
- Modified “Weekend off” Policy to provide a full weekend off prior to the shelf exam
- Incorporated BUSM’s new personal day policy
- Added new didactic topics including:
  - Handoffs
  - Abnormal LFTs
  - Glomerulonephritis/Vasculitis
  - Coagulation Disorders/Bleeding
- Moved didactics to one session Monday-Thursday at noon or 1:00
- As of August, 2018 NBME will incorporate some short answer questions to the exam
- Addition of BUSM FOCUS cards
- Change in clerkship leadership- New Clerkship Director, Dr. Sonia Ananthakrishnan, has worked as an Associate Clerkship Director for the past 9 years.

**Learning Strategies and Tools**

**Recommended Texts**

Some Guidelines on reading during the clerkship
- Target-- 10-15 hours of reading per week
- Focus on enduring information—differential diagnosis, pathophysiology, natural history, evaluation of a problem
• Re: Therapy-- understand the details of the common medications/interventions you use with your patients (except chemotherapy) and how to use them. Otherwise, place greater emphasis on the principles of therapy than specifics
• Roughly 75 % Text/ 25 % literature

For Reading, we suggest you:
• Find a textbook(s) you will read
• Identify and use some of the “quick and practical” resources (these should NOT be used alone without a textbook)
• Get a question book

We recommend you choose a textbook that focuses on the needs and realities of the 3rd year clerk. We list below some popular options.
• Internal Medicine Essentials for Clerkship Students. ACP/CDIM. American College of Physicians. 2015. Also, an electronic version is available
• Stern SDC. Cifu AS, Altkorn D. Symptom to Diagnosis. 3rd edition. Lange Medical Books/McGraw-Hill. 2015
• Cecil Essentials of Medicine. WB Saunders Company
• Step-Up to Medicine. 3rd edition. Walters Kluwer. 2015

UpToDate and Access Medicine (including Harrison’s Principles of Internal Medicine. are available on-line through BUSM and BMC and can be helpful.

We suggest you also consider some “Quick and Practical “resources such as:
• Pocket Medicine
• Washington Manual of Medical Therapeutics
• Ferri, “Practical Guide to the Care of the Medical Patient”
• The Sanford Guide to Antimicrobial Therapy
• Programmed ECG text

Practice Questions
We recommend you use a Question Book such as:
• USMLE Step 2 CK QBank
• MKSAP for Students.
• Stern SDC. Cifu AS, Altkorn D. Symptom to Diagnosis. 3rd edition. Lange Medical Books/McGraw-Hill. 2014
• Clinical Problem Solving casebook for Medicine 1.

Evidence-Based Medicine Point-of-Care Resources
Point-of-care tools are reference resources that a clinician can utilize to quickly make evidence-based decisions when interacting with a patient. They usually contain “filtered” information, meaning that the information from primary literature (e.g., randomized clinical trials, cohort studies...) has been critically appraised and synthesized. While they are very useful decision-making aids, they are still subject to bias and other forms of error, and you should learn about their strengths and limitations.

A few useful Point-of-Care Resources include:

- **BMJ Clinical Evidence** - provides systematic reviews that summarize the current state of knowledge – and uncertainty – about the prevention and treatment of clinical conditions, based on thorough searches and appraisal of the literature. They don't tell you what to do.
- **Cochrane Database of Systematic reviews** - Includes the full text of the Cochrane Collaboration's regularly updated systematic reviews of the effects of healthcare interventions. Well filtered but not everything is covered.
- **DynaMed** - evidence-based information resource that is designed to answer clinical questions quickly and easily.
- **USPSTF** -
  https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
The United States Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. These recommendations have been considered the “gold standard” for clinical preventive services.

Other useful EBM resources/sites include the Centers for Disease Control, National Guideline Clearinghouse, and the ACC/AHA Joint Guidelines
[http://professional.heart.org/professional/GuidelinesStatements/searchresults.jsp?q=&y= &t=1001](http://professional.heart.org/professional/GuidelinesStatements/searchresults.jsp?q=&y= &t=1001)

**Additional Online links**

- Clerkship Directors in Internal Medicine (CDIM) is the national organization that supports student education in internal medicine
- The Internal Medicine Clerkship Primer is produced by CDIM and provides a useful overview of the clerkship and suggestions to help you maximize the experience
• Simulated Internal Medicine Learning Experiences at CDIM-SIMPLE.
• Boston University Medical Center Alumni Medical Library- http://medlib.bu.edu/
• ECG Maven – a website that provides a wide variety of ECG’s to learn from and test yourself. http://ecg.bidmc.harvard.edu/maven/mavenmain.asp
• BMC Intranet Home Page- http://www.internal.bmc.org/ - available in-house with access to Harrison’s Online and other Access Medicine Textbooks, UpToDate online, and other resources.
• The American College of Physicians (ACP) is a national organization of internists — physicians who specialize in the prevention, detection and treatment of illnesses in adults. ACP is the largest medical-specialty organization and second-largest physician group in the United States. Its membership of 133,000 includes internists, internal medicine sub-specialists, and medical students, residents, and fellows. The website provides information relevant to education, practice and policy in internal medicine. http://www.acponline.org/
• The Society of General Internal Medicine is a national medical society of 3,000 physicians who are the primary internal medicine faculty of every medical school and major teaching hospital in the United States. It’s mission “is to lead excellence, change, and innovation in clinical care, education, and research in general internal medicine to achieve health care delivery that is comprehensive, technologically-advanced and individualized; instills trust within a culture of respect; is efficient in the use of time, people, and resources; is organized and financed to achieve optimal health outcomes; maximizes equity, and continually learns and adapts.” Good exposure to academic internal medicine. www.sgim.org

Journal articles/Selected High Yield Journals

• Journal articles
• Selected high yield medical journals
  • New England Journal of Medicine- covers all fields of medicine with strong internal medicine influence. The Clinical Problem Solving cases and Clinical Pathologic case discussions are particularly relevant.
  • Annals of Internal Medicine-strong internal medicine (IM) journal.
  • JAMA- general medicine coverage with strong IM influence.
  • Lancet- international general medicine journal with good IM coverage.

E*Value Student Resources
http://www.bumc.bu.edu/E*Value/students/

Echo360/Technology
Echo360 may only be used for streaming captured lecture videos; the videos may not be downloaded. Taking smartphone or digital pictures or videos of any part of the lecture in class, or at home, is similar to downloading and is not allowed. There are a number of reasons for this, including that students and/or the University may be liable for violations of federal copyright and privacy laws as a result of the use of copied material.

If you experience any technical problems, please report the issue in one of the following ways to generate an IT ticket:

- **Echo360 Related Issues**: Create a ticket on the Ed Media site (http://www.bumc.bu.edu/bumc-emc/instructional-services/echo360/): sign in and provide pertinent information that will enable an effective response. Have a link to the problematic video ready to copy/paste into this form.

- **Educational Technology Related Issues**: For assistance with technology supported by BUMC’s Educational Media (e.g. ExamSoft), tickets can be created via their website at: http://www.bumc.bu.edu/bumc-emc/instructional-services/report-an-educational-technology-issue/

- **Other Technology Related Issues**: For assistance with BU-wide technology, such as Blackboard, email an example (e.g. picture or very brief phone video) to ithelp@bu.edu with a descriptive subject line and give as many details as possible on the what, where, how you are using the service and what type of computer, browser, etc. along with type of student (i.e. BUSM III). Always include link(s) to or screen shots of where the issue is occurring.

BUSM Policy on Echo360 Recordings:
http://www.bumc.bu.edu/busm/education/academic-affairs/policies/classroom-recordings-echo360/

Tutoring
Peer tutors may be requested via the Office of Academic Enhancement’s Peer Tutoring Program at: https://www.bumc.bu.edu/busm/student-life/professional-development/academic-enhancement/peer-tutoring-program/

Office of Disability Services
Boston University is committed to providing equal and integrated access for individuals with disabilities. The Office of Disability Services provides services and support to ensure that
students are able to access and participate in the opportunities available at Boston University.
http://www.bu.edu/disability/policies-procedures/academic-accommodations/

Session Learning Objectives and Notes

Clinical Problem Solving Cases, High Priority Reading & other Core Learning

**Chest Pain**
Objectives

- Estimate the probability that coronary artery disease is the cause of the patient's presentation with chest pain. To do this, we consider:
  - Degree to which the *chest pain "syndrome"* is typical for coronary ischemia
  - Probability the “substrate” (i.e., *patient*) has coronary artery disease. This is based on the patient’s CAD risk factors
- Identify and apply the determinants of **myocardial oxygen demand and supply** along with the underlying **pathophysiology** of stable angina and “acute coronary syndromes”, to patient care
- Describe the role of **stress testing** and cardiac catheterization in patients with suspected coronary heart disease
- Outline and apply the **principles of management** of exertional CP (angina) and acute coronary syndromes (unstable angina or acute myocardial infarction-MI)

**Syncope**
Objectives

- Apply the definition of syncope to distinguish syncope from other causes of loss of consciousness and falls ---“the imposters” (eg, seizures, ataxia, cataplexy...)
- Use the history and physical exam to identify possible causes of syncope
- Identify patients at high risk for a cardiac cause of syncope
- Appropriately order and interpret diagnostic tests that are most likely to be helpful in patients presenting with syncope
- Distinguish by physical exam among the causes of systolic ejection and regurgitant murmurs
- Distinguish between supraventricular and ventricular tachycardias based on EKG

**Dyspnea**
Objectives

- Formulate a differential diagnosis for acute dyspnea
- Identify the symptoms and signs of heart failure (HF)
- Distinguish between heart failure due to systolic vs diastolic dysfunction
- Identify a patient’s cardiac functional status (class) and explain its significance
- Provide a prognosis for a patient with HF and identify data that predicts risk
- Articulate the principles of managing a patient with HF and describe the role of the different medication classes used to treat this disorder
- Recognize atrial fibrillation on EKG
- Identify the complications associated with atrial fibrillation and the principles of how to manage them

**Dyspnea After Surgery**

**Objectives**

- Demonstrate a rational approach to diagnose a patient presenting with acute dyspnea
- Utilize the history, exam and simple testing to assess the probability that a patient has venous thromboembolic (VTE) disease
- Describe the strengths, limitations and use of tests commonly used to diagnose VTE
- Weigh benefits and risks of therapeutic options in a patient with likely VTE and recommend a course of action
- List the options available to prevent VTE and apply them in patients with varying risk for this disorder

**Cough/Weight Loss/Hemoptysis**

**Objectives**

- Identify persons at-risk for tuberculosis
- Describe the principles of TB skin testing and to which patients it should be applied
- Describe specific and non-specific symptoms of pulmonary tuberculosis
- Outline criteria and reasons for respiratory isolation of potentially infectious cases of TB
- Describe principles of TB chemotherapy, including factors that affect adherence to treatment and strategies available to enforce adherence
- List the strengths and weaknesses of newer diagnostic tests for TB
- Identify “missed opportunities for: (a) prevention and (b) spread of infection to others

**Rough Breathing in Exam Room 4**

**Objectives**

- Define Chronic Obstructive Pulmonary Disease (COPD)
• Distinguish among Emphysema, Chronic Bronchitis and Asthma
• Describe the pathogenesis of airflow obstruction in COPD
• Appropriately order and interpret pulmonary function tests (PFT’s)
• Describe the principles of managing COPD, both during an acute exacerbation and at times of symptomatic but stable disease
• Identify smoking and other causes in patients with COPD
• Develop an approach to address and assist a patient in stopping smoking
• Define dementia and delirium and describe how you will distinguish between them in a patient presenting with “confusion”
• Identify medications and conditions that can adversely affect the geriatric population

**Diabetes**

**Objectives**

• Correctly apply the diagnostic criteria for type 2 diabetes mellitus to a patient
• Describe methods and reasons for controlling blood glucose
• Identify the components of a routine evaluation of a diabetic patient
• Describe the natural history of type 2 diabetes
• Identify outpatient and inpatient interventions that may alter it

**Fever/Cough/Dyspnea**

**Objectives**

• Recognize a common presentation of a common illness-pneumonia
• Take a focused, but thorough history and physical of a dyspneic patient
• Explain the findings on chest exam that are seen in patients with lobar and other pneumonias
• Appropriately utilize laboratory and radiologic tools in making a diagnosis
• Describe the factors that influence the decision to admit a patient with pneumonia
• Manage a common infection and anticipate potential complications
• Distinguish between a transudative and exudative pleural effusion
• Formulate a differential diagnosis of a pleural effusion based on the history, exam and pleural fluid findings

**Fever and Confusion with Cirrhosis**

**Objectives**

• Identify and recognize the findings of advanced liver disease
• Recognize complications of chronic liver disease
• Assess the prognosis of a patient with chronic liver disease
• In a patient who presents with a change in mental status, demonstrate a mental status assessment, characterize the problem (eg delerium, dementia...), develop a differential diagnosis and outline an approach to evaluation
• For a patient with ascites, describe maneuvers to elicit this finding, develop a differential diagnosis for the ascites, and determine the likely cause, by utilizing findings from the history, exam and paracentesis
• Describe the spectrum of alcohol withdrawal and identify factors that put a patient at high risk for major alcohol withdrawal
• Risk stratify a patient regarding risk for alcohol withdrawal and outline initial management

**HIV infection**
**Objectives**

• Recognize the signs and symptoms of acute HIV seroconversion
• Describe the pathophysiology of HIV infection
• Explain the current concepts concerning who should be treated with antiretroviral drugs, and when to start prophylaxis for opportunistic infection
• Describe the natural history of HIV and the impact that highly aggressive anti-retroviral therapy (HAART) has had

**Vomiting Blood**
**Objectives**

• Localize the site of a gastrointestinal bleed by history
• Accurately assess and stabilize a bleeding patient
• Take a focused, timely, but thorough history on a patient with a GI bleed
• Describe the use, and reliability of laboratory and radiologic data in the assessment of a bleeding patient
• Risk stratify and appropriately treat an upper gastrointestinal bleed
• Describe the key mechanisms that protect against peptic ulcer disease and pathogenic processes and insults that can cause mucosal injury.
• Explain the use of the various diagnostic and therapeutic modalities available for Helicobacter Pylori

**Acute Abdominal Pain**
**Objectives**
• Develop a differential diagnosis appropriate to a patient presenting with acute, severe abdominal pain
• Identify likely causes for this patient’s presentation
• Assess this patient’s risk for a complicated course

**Fatigue and Icterus**

**Objectives**

• Identify the manifestations, causes, and principles of management of chronic liver disease
• For a patient with ascites, describe maneuvers to elicit this finding, develop a differential diagnosis, and determine the likely cause by utilizing findings from the history, exam, and paracentesis
• Identify patients at high risk for hepatitis C, describe its natural history, and, outline the rationale for specific treatment
• Utilize the history to identify patients at high risk for or with problems due to the misuse of alcohol

**Dark Urine and Progressive Fatigue**

**Objectives**

• Identify potential causes of an anemia with a high reticulocyte count
• Describe a diagnostic approach to a patient with anemia and a high reticulocyte count
• Identify the causes of “dark urine” and outline an approach to distinguish among them
• Calculate and interpret the reticulocyte production index

**Renal Physiology**

**Objectives**

• Assess volume status by history, exam and lab testing
• Define the physiologic basis of orthostatic hypotension
• Estimate GFR in chronic renal failure
• Develop an approach to worsening renal function with particular emphasis on distinguishing prerenal causes from acute tubular necrosis
• Identify causes of hypobicarbonatemia
• Calculate the anion gap
• Develop a differential diagnosis for anion-gap and non-gap metabolic acidosis
• Evaluate and treat hyperkalemia
• Identify and treat hypernatremia

**Acid Base**
**Objectives**

• Demonstrate a systematic approach to acid base disturbances
• List a differential diagnosis for the common acidoses and alkaloses

**Ethics**
**Objectives**

• Identify the ethical dilemma in situations
• Discuss techniques to resolve ethical dilemmas
• Discuss resources at BMC to assist providers when in ethical situations

**Breast Cancer, Pain Management and End of Life Issues**
**Objectives**

• Describe an approach to alleviate pain and suffering for a patient with metastatic cancer
• Demonstrate how to safely and effectively employ commonly –used medications in the treatment of mild, moderate, and severe pain
• Discuss options of care we can offer patients and their families at the end of life
• Define palliative care and hospice, and identify situations in which these approaches to care are appropriate

**Hyponatremia**
**Objectives**

• Apply the foundational pathophysiology principles underlying hyponatremia
• List and organize a differential diagnosis for hyponatremia
• Describe an approach to evaluate and manage hyponatremia
• Identify risk factors for osmotic demyelination syndrome (ODS)
• Initiate safe initial treatment in a patient with hyponatremia
• Identify situations when you should promptly seek renal consultation

**Handoffs**

• Understand the importance of structured communication when handing off patients
• Define the components of the IPASS mnemonic
• Critically construct and observe a verbal IPASS handoff
Abnormal LFTS

- Develop a differential diagnosis for the following LFTs patterns:
  - Severely elevated transaminases
  - Severely elevated alkaline phosphatase
  - Mild-moderately elevated transaminases
- Assess the severity of liver dysfunction using clinical, exam, and laboratory features.

Glomerulonephritis/Vasculitis

- Diagnose a patient with glomerulonephritis (GN) from clinical history, exam, and laboratory findings.
- Generate a differential diagnosis for GN and state the key findings and laboratory tests that are used to make these diagnoses.
- Propose a treatment plan for the most common causes of GN.

Coagulation Disorders – Bleeding

- Develop a differential diagnosis and an approach to a patient with a defect in hemostasis, including key history questions, exam findings, and laboratory tests.
- Assess a patient's risk of bleeding based on the level and function of platelets, and the presumed mechanism of thrombocytopenia.

The Art of the Oral Patient Presentation
Objectives

- Identify the key contextual factors that impact on your oral patient presentations
- Describe the key components of an oral patient presentation- SOAPS
- Practice organizing an oral patient presentation

Learning Diagnostic Reasoning
Objectives

- Apply both intuitive and analytic approaches to making a diagnosis
- Both Trust your intuition and then challenge it
• Describe and employ Illness Scripts, Schema and Problem representations in addressing diagnostic dilemmas

**Student Report**

**Objectives**

- For the clinical problem(s) addressed, generate a patient-specific differential diagnosis, explain your reasoning and describe the most important and relevant pathophysiology for the condition(s)
- Identify the most useful diagnostic tests, describe the utility and limitations of these diagnostic tests, and interpret their results
- Recommend initial treatment
- Identify the most important components of the context of care including: patient socio-demographics, language, culture, patient belief system and illness behavior, and the system of care (eg access to care, finances, care coordination)
- Describe how these factors impact patient care and clinical outcomes, and how the system might be improved or the problem prevented

**CV Exam**

**Objectives**

- Describe a 6-step, systematic approach to evaluate a patient with a possible cardiac conditions
- Identify characteristics on physical exam that distinguish between patients who are hemodynamically stable, vasoconstricted, or in pulmonary edema
- Palpate the heart to distinguish PMIs that are normal and 2 prototypical abnormalities: sustained/diffuse, and laterally displaced/ dyskinetic
- Describe how to measure the jugular venous pressure
- Describe how to differentiate the carotid upstroke that is normal and one that is weak and (relative to the PMI) slow
- Recognize and mimic heart sounds to assess: Normal S1 and S2, 2 gallops: S4 and S3, 2 key systolic murmurs: AS and MR, and define and interpret the clinical significance (pathophysiology and impact on differential diagnosis) of the findings noted above.

**ECG Interpretation Sessions**

**Objectives**

- Apply a systematic approach to interpret the EKG
- Recognize common and “can’t miss” EKG diagnoses
**Reflection Exercise**

Objectives

- Share insights with colleagues concerning professional identity and growth, dealing with ethical dilemmas and/or coping in the work setting, that were gained from a narrative approach to a meaningful experience during the clerkship
- Foster a climate and habit of reflection

**Resiliency Curriculum**

Objectives

By the end of the clinical clerkship Resiliency Curriculum, students will:

- Define resiliency and burnout and key features associated with these topics in medicine
- Discuss and reflect upon challenging issues in the clinical years including death and dying, the hidden curriculum, ethical dilemmas, moral distress, and personal countertransference.
- Define strategies to maintain resilience in the face of challenges and failures including the capacity to make realistic plans, a positive view of self, confidence in strengths and abilities, skills in communication and problem solving, and the capacity to manage strong feelings and impulses.
- Practice using resiliency skills across clerkship educational sessions in the 3rd years

Addressing the Hidden Curriculum-The Hidden Curriculum refers to the unwritten, unofficial, and often unintended lessons, values, and perspectives that we as medical students learn through observation and modeling while on the wards. While the formal curriculum consists of didactics and afternoon rounds, the hidden curriculum is based on the unspoken or implicit academic, social, and cultural messages that are communicated to students by their peers and superiors. This session will provide an opportunity to discuss how to not only survive in this culture and environment, but how to thrive while maximizing educational potential.

**CD-Student Small Group Sessions**

Objectives

- Demonstrate the method and be able to provide an estimate of the patient’s JVP
- Distinguish systolic ejection murmurs from regurgitant murmurs
- Perform a systematic CV exam using proper technique
- Demonstrate a systematic chest/pulmonary exam and detect abnormalities
• Describe the elements from the history, physical exam and foundational studies that will enable you to assess the patient’s volume status
• Define and distinguish intravascular volume depletion and reduced effective circulating volume
• Describe the key elements of a strong oral patient presentation of a new patient on Work Rounds
• Deliver a concise, targeted, coherent oral patient presentation that "makes the case" for your assessment and plan
• Provide a well-organized and coherent write-up that ‘makes the case’ for your assessment and plan
• Identify and demonstrate behaviors that promote a strong doctor-patient relationship.
• Demonstrate the ability to obtain the key elements of an HPI
• Provide a differential diagnosis and support for your proposed conditions that is appropriate to the patient being presented
• Identify the common and “don't miss” (diagnostic imperatives) conditions associated with presentations of Chest pain, Dyspnea, Fever, Anemia, Acute Kidney Injury and common Acid-base & Electrolyte disorders
• Describe the illness scripts for common and ‘don't miss’ conditions that often present with: Chest Pain, Dyspnea, Fever, Anemia, Acute Kidney Injury and common Acid-base & Electrolyte disorders and how they differ
• Demonstrate the ability to effectively solicit and incorporate feedback from your supervisors and improve your current performance
• Show the actions of a self-directed learner
• Demonstrate through discussion and behavior what it means to be a physician and how to grapple with the uncertainties and ethical dilemmas
• Critically incorporate the relevant evidence (science/medical literature) into your patient assessments
• Demonstrate an approach to assess the rate and rhythm on ECG

High Priority Conditions you should read about

In addition to the requirement that you see ≥ 15 patients as the primary student caring for the patient, and seeing patients with each of the “Big 10” active problems, it is strongly recommended that you care for real or simulated patients with or read about the conditions described below.

The Big 10 clinical presentations (above) and diagnoses listed below represent a listing of conditions that you should prioritize in your learning. It is not inclusive of all diagnoses/conditions to learn.
For each of the conditions listed below, the student should be able to define/describe:

- **Illness script (IS)**- one way that experts store information (as chunks) about medical conditions in long term memory that enables them to store and readily retrieve that information
  - An Illness Script includes:
    - Who gets the condition? Predisposing factors
    - How does it present? Clinical manifestations- defining,
      - With regard to symptoms, signs, study results
    - Temporal aspects of the presentation- onset, course of the condition
    - Core pathophysiology
  - Differential diagnosis
  - Evaluation/Diagnosis- which tests to order, when to order, how to interpret
  - Initial management
  - Prognosis
  - Prevention

Keep in mind that many conditions may present in several different ways (eg pulmonary embolus may present with chest pain, dyspnea, syncope…). The listing below is designed to help you organize these conditions; the categories are not mutually exclusive.

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**High Priority “Diagnoses” and Problems- See as many as possible and read about these problems**

**Chest pain**

**Diagnostic Imperatives**
- Acute coronary syndromes
- Pulmonary embolism
- Aortic dissection
- Effort rupture of the esophagus (Boerhaave syndrome)
- Tension pneumothorax

**Common causes of isolated chest pain:**
- Chronic coronary disease/angina
- GI causes (esp. GERD, esophageal motility/spasm, peptic ulcer disease)
- Musculoskeletal (e.g., localized, non-rheumatologic syndromes like costochondritis)
- Psychological causes/triggers (panic disorder, depression)
- Unexplained chest pain

**Other**
- Pericarditis

**Dyspnea**
- Asthma
- COPD
- Heart failure
- Interstitial lung disease
- Pleural effusion

**Fever**
- Bacteremia
- Clostridium difficile
- Endocarditis
- HIV- primary infection and opportunistic infections/cancers suggested by CD4 count
- Malaria
- Meningitis/encephalitis
- Noninfectious cause
- Pneumonia
- qSOFA/SIRS/Sepsis/Severe Sepsis, Septic shock or not
- Skin and soft tissue infections/cellulitis
- Spontaneous bacterial peritonitis
- Tuberculosis
- Urinary tract infection

**Anemia**
- Fe deficiency
- Anemia of chronic disease (inflammation)
- B12, folate deficiency
- Acute blood loss
- Glucose-6-Phosphatase deficiency –G6PD
- Thalassemias
- DIC- microangiopathic hemolytic anemias
- Sickle cell trait/disease

**Kidney injury**
- **Acute kidney injury**
  - Prerenal
    - Hypovolemia
- Heart failure
- Cirrhosis with ascites

  o Intrinsic renal
    - Glomerular disease
    - Acute tubular necrosis
    - Contrast nephropathy
    - Allergic interstitial nephritis

  o Post-renal causes

**Acid-base/electrolyte disorders**
- Acid-base
  - Metabolic acidosis
    - Increased anion gap conditions
    - Normal anion gap conditions
  - Metabolic alkalosis
    - Contraction
    - Vomiting
    - Renal acid loss
  - Respiratory acidosis
  - Respiratory alkalosis

- Electrolytes
  - Hyponatremia
    - Hypovolemia, osmotic diuresis
    - Diuretic induced
    - SIADH
    - Adrenal insufficiency
    - Edematous states – Heart failure, cirrhosis, nephrotic syndrome
    - Renal: Acute and chronic kidney disease

  - Hypernatremia
    - Unreplaced water loss - involves loss of thirst or ability to access water
    - Decreased total body water and sodium; relatively more TBW loss than sodium: GI loss, skin loss, renal loss (diuretics, osmotic diuresis)
    - Increased sodium with normal total body water: hypertonic saline, NaHCO₃ administration, mineralocorticoid excess

  - Hypokalemia
    - Reduced intake
    - Increased entry into cells
    - Increased GI loss
• Increased urinary loss
  - Diuretic
  - Mineralocorticoid excess
  - Hypomagnesemia

○ Hyperkalemia
  • Increased K intake: oral, IV (blood transfusion, IVF, TPN)
  • Increased K release from cells
    - Pseudohypokalemia
    - Increased catabolism- tumor lysis
    - Metabolic acidosis
    - Drugs
    - Insulin deficiency (DM)
  • Reduced urinary K excretion
    - Acute and chronic kidney disease
    - Reduced secretion or response to aldosterone (ACEI/ARBs and other drugs, type 4 RTA)

○ Hypocalcemia
  • Hypoparathyroidism
  • Vitamin D deficiency
  • Renal insufficiency
  • Medications
  • Hypomagnesemia

○ Hypercalcemia
  • PTH dependent: Hyperparathyroidism
  • PTH independent:
    - Malignancy
    - Granulomatous disease- eg sarcoidosis
    - Medications – eg thiazides, Vitamin D intoxication, calcium

Other High Priority Conditions that do not fit neatly under one of the Big 10 categories
• Arrhythmia with emphasis on atrial fibrillation, supraventricular tachycardias, ventricular tachycardia, heart block
• Diabetes- with emphasis on ketoacidosis, hyperosmotic hyperglycemic nonketotic state (HHNK)
• Hypertensive urgency/emergency
• Hypoxia- mechanisms, approach to..., common causes
• Substance abuse/overdose/withdrawal with emphasis on ethanol, opiates, cocaine
• Volume depletion

High priority components of the physical exam include:
• Cardiovascular
• Chest/Lung
• Volume assessment

Types of Patients/"Diagnoses"- The Next Tier
In addition to the requirements above, we encourage you to see and read about patients with as many of the following problems, clinical conditions, socio-demographics or learning opportunities listed below:
• Acute joint pain and swelling with emphasis on crystal-induced and infectious causes
• Abdominal pain- Approach to...
• Altered mental status- eg confusion, delirium, dementia
• Amyloidosis
• Cancer (common solid or blood-borne)- eg Lung, breast, colorectal, prostate, Chronic lymphocytic leukemia, multiple myeloma
• Cough
• Chronic kidney disease
• Diarrhea- Approach to... common causes
• Gastrointestinal bleed- peptic ulcer disease, portal hypertension
• Infections
  • Due to resistant organisms- eg, staphylococcus
  • Antibiotic stewardship
  • Immuno compromised states
  • Nosocomial infections- including pneumonia, intravascular catheter infection
  • Liver Disease- emphasizing cirrhosis and its complications
  • Pain management- approach to ...
  • Rash- approach to...
  • Sarcoidosis
  • Syncope- approach to... common causes
  • Systemic sclerosis (scleroderma)
  • Urinary tract infection- upper tract, complicated UTI
  • Valvular disease with emphasis on aortic stenosis, mitral regurgitation, tricuspid regurgitation