Internal Medicine Clerkship Facilitator Guide
2018-2019

Clerkship Directors

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- Megan Devine, M.D. (UT Tyler)
- Lary Kupor, M.D. (St. Joseph’s)
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Coordinators

- Christina Johnson (UTMB)
- Fran Dawe (Houston)
- Marivel Lozano (St. Joseph’s)
- Megan McLaughlin (UT Tyler)
- LaCrystal Cruse (Methodist Houston)
Overview

Each student will spend three months on the Internal Medicine Clerkship.

Galveston-based students
Each student will spend one month on a general internal medicine inpatient service, one month on a consult service, and one month on either an ambulatory or inpatient subspecialty service.

Tyler-based students
Each student will spend one month on a general internal medicine inpatient service, one month at a community general internal medicine practice, and one month on a sub-specialty consult rotation. Students will be oriented to specific clinical responsibilities by Dr. Chiagozie Nwasuruba (site director in Tyler) or his designee.

Houston-based students
Each student will spend one month on a general internal medicine inpatient service, one month on a subspecialty service, and one month either at a community general internal medicine practice, or general internal medicine inpatient service. Students will be oriented to specific clinical responsibilities by Dr. Lary Kupor at St. Joseph’s Hospital and Dr. Johanna Clewing at the Methodist Hospital.

Community Rotation
Students may spend 4 weeks on an ambulatory outpatient rotation in the community.
Criteria for Community Rotation:

1. The 4-week block must be a full-time experience - meaning at least 20 days out of the 28 with at least 8 hours per day.
2. The preceptor/attending must be a faculty at UTMB and/or have their credentials reviewed and approved by the local AHEC and course director.
3. The attending physician must agree to the policies and procedures of the clerkship
   a) give mid-month feedback to the student
   b) return their evaluation form within 3-4 days of the end of the rotation
   c) be familiar with and teach towards the learning objectives
4. The student proposing the new rotation must ensure the new attending understands these parameters and agrees that s/he has the time and willingness to take a student for the specified time period. Documentation will be by the signed request form.
Goals and Objectives

The third year is an exciting year for students. This is when all the learning that has been occurring in the first two years begins to make sense. This is when students begin to move from mostly abstract learning to real patients in real situations. This is when students take on responsibility, when what they do matters to their patients and the healthcare team, and they take it on in pace with their gaining of skills.

In this year, students will move from thinking about patients piecemeal or in artificial situations, to interacting with real patients having real problems, usually multiple problems ranging from psychosocial to organ system damage. Students will begin to learn how to apply their basic skills to true situations, integrate them with real patient issues in real situations, and watch their skills grow as they become competent physicians. Students will learn how to gather information in difficult settings (e.g. how to obtain a history and examine a patient with dementia), develop appropriately thoughtful and defensible differential diagnoses (e.g. develop a rational differential diagnosis for a patient with chest pain who has historical and physical exam findings suggestive of both coronary artery disease and musculoskeletal causes), and learn basic diagnostic and therapeutic plans (e.g. criteria for admission to the hospital, urgent treatment of a gastrointestinal bleed, and diagnostic work-up for atypical chest pain).

A. Goals

- Gain knowledge of common medical problems: pathophysiology, presentation, natural history/complications of disease, basic treatment - acute and chronic, and diagnostic work-up.
- Gain the knowledge and skills to gather appropriate information on an adult patient with medical problems, recognize abnormal physical findings, interpret basic lab, x-ray and ECG findings, to develop a defensible differential diagnosis.
- Be able to present relevant patient information in written format (e.g. H&P and daily progress notes), and verbally (e.g. full H&P, daily patient rounds, and focused visits or consults).
- Be able to recommend basic therapeutic plans for common medical problems (e.g. appropriate classes of medication for the treatment of hypertension and why one class would be better than another in different patient situations and rational choices of antimicrobials for specific infectious diseases).
- Be able to recommend basic diagnostic work-ups for common medical problems (e.g. when to do a non-invasive cardiac test for atypical angina and the most appropriate work-up for abdominal pain).
- Be able to communicate instructions/education, difficult information and provide support to patients.
- Understand and be able to act in a professional manner in different clinical situations.

B. Objectives

Knowledge:

- Be able to demonstrate a fund of knowledge in basic science essential to the understanding of disease processes and therapeutics.
- Specific learning objectives by discipline and subject are listed below.
- Be able to demonstrate knowledge of chest x-ray and ECG interpretation.
- Be able to demonstrate the appropriate knowledge of basic patient education for common medical problems and counseling techniques.
- Be able to demonstrate knowledge of psychosocial issues and their impact on health and disease.
- Be able to demonstrate knowledge of medicolegal and ethical issues, and their impact on the practice of medicine.
Skills:
- Be able to perform a competent (i.e. relevant, complete, accurate) history and physical examination on a patient with an acute or chronic problem.
- Be able to gather the appropriate information for a focused problem/visit, consultation, or hospital admission.
- Be able to generate an appropriate differential diagnosis for a patient's problem(s).
- Be able to generate a plan for a patient problem(s) - basic therapeutic and diagnostic work-up.
- Be able to write an appropriately focused (e.g. for consult or ambulatory visit) and an appropriately comprehensive (e.g. hospitalized patient) H&P; be able to write an appropriate (clear, concise, accurate) daily progress note.
- Be able to verbally present both complete history and physical examinations and focused/problem-oriented history and physical examinations.
- Demonstrate appropriate clinical reasoning (problem-solving) skills including the ability to:
  * integrate basic science information into the assessment of the patient's problems/presentation
  * prioritize a patient's signs and symptoms
  * identify patient risks or likelihood of disease
  * identify the pertinent positive and negative information in developing a differential diagnosis
  * develop an appropriate, prioritized differential diagnosis
  * discuss the logical rationale behind the diagnostic rationale
  * recommend appropriate disease screening, health maintenance, and health promotion
  * recommend and discuss appropriate management for common acute and chronic diseases
- Be able to demonstrate appropriate interpersonal and communication skills to provide patient education and information. This would include breaking bad news and discussing end-of-life issues.
- Be able to perform basic procedures, i.e. breast exam, rectal exam including stool guaiac

Attitude:
- Be able to demonstrate appropriate regard for patients (e.g. respect patient belief systems, autonomy, financial situation, education level, self-discipline abilities, etc.)
- Be able to demonstrate respect for the health care team, colleagues and the medical profession.
- Be able to demonstrate appropriate professionalism, i.e. appropriate work responsibilities, civility with colleagues and patients, and ethical behavior (e.g. understand, practice and promote honesty and integrity in the care of patients and interactions with colleagues).
Course Policies

A. Discipline

Students will be governed by the academic rules of UTMB while on the clerkship. Any act of academic dishonesty including recording, transmitting, giving or receiving exam questions or answers, or plagiarism, will result in a report to the Associate Dean for Student Affairs and will be dealt with according to the regulations of the University.

B. Absence Policy

Any planned absence for examinations only must be approved in advance by the Associate Dean for Student Affairs. All other planned absences from the clerkship MUST have prior approval by the clerkship office (see the attached student absence policy). Unexpected absences (e.g., illness) must be reported as soon as possible that day or the next to the clerkship office, the student's attending and resident. Absences that are not approved or that are not reported in a timely manner will be considered "UNEXCUSED". Any unexcused absence from the clerkship or an examination will result in a Failing grade for the clerkship. If a student arrives late to an examination he/she will not be given extra time to complete the examination. Excused absences totaling four or more days will generally result in a grade of "INCOMPLETE"(I) and the student will be required to spend additional time on the clerkship.

C. Days Off Policy

Each student will receive the weekend off in between rotations. For inpatient rotations, it is recommended that students take off one weekend day per week during the month (this includes three day holiday weekends). Each student will receive most weekends off during outpatient and consult rotations. Days off may vary for AHEC sites depending on the practice. The first two rotations will end at 5:00pm on the last Friday. The last rotation will end at 5:00 PM on the last Thursday.

In the event that a call day falls on a Saturday and a post-call day falls on a Sunday, it is recommended that students ask their resident for a compensation day off. Students are strongly encouraged to participate on all call days and post-call days within the confines of the rotation. Weekdays off are strongly discouraged except in the scenario mentioned above involving a weekend call.

NOTE Per the School of Medicine Academic Calendar: Holiday schedules for Year 3 and Year 4 students with clinical responsibilities are determined by each School of Medicine department. Students may be required to attend clinical responsibilities during listed holiday periods. Please check with the clerkship office and your attending physician.

D. Examination Policy

Students are excused from clinical duties on the day of the Shelf exam. Students are excused from call and clinical duties the evening before the shelf examination.
E. Grading Policy

Grades in Internal Medicine are determined as follows:

- **Clinical Performance Evaluations:** 40%
- **Exam Scores:** 35%
  - NBME Shelf Exam 30%
  - EKG and Test interpretation 5%
- **Written Components:** 25%
  - Logbook, Written and Observed H&P’s, EBM Write ups, and CRI’s 15%
  - Challenges in Medicine Essay 10%

**Clinical Evaluations: (40%)**

The attending faculty and supervising resident/fellow will complete written evaluations on students for all three months. (see appendix D) These evaluations, student write ups and presence at all required activities are reviewed by the Course Committee and a clinical grade is assigned. The Committee also takes into account verbal or written information, both positive and negative constructive criticism, about a student’s performance while on the clerkship from any professional source; for example the Chief Residents in preparing students to present at a CPC conference, nursing service comments, and/or course coordinator comments. This committee also takes into account any issues of professional behavior or absenteeism. They assign a grade based on these items. Written comments from the faculty evaluations are edited and submitted to the Office of Student Affairs for inclusion in the Dean’s Letter.

A student’s clinical performance is the most important part of her/his evaluation for competency for the clerkship. It is only here that all the clinical skills are assessed, i.e. data collection, communication, problem-solving, knowledge and professional behavior. This is the key assessment of a student having obtained competency in the required skills. Because of this the Course Committee assigns the scores for this component. The members carefully review **ALL** the information on the evaluation forms from both the faculty and the residents. No single item checked on the form outweighs the other information. In some cases, the faculty or resident may be asked to provide further information that will also be included in the Committee’s deliberations.

It is also very important to recognize that the highest standards of professional behavior are expected from all members of the health care team. Information on professional behavior is part of the clinical evaluation and significant irregularities in behavior may result in a failing clinical score, outweighing other positive demonstration of clinical skills.

After failures have been determined, the students scores will be curved based on the mean and standard deviation of the cohort’s raw scores.

- **Exam Scores (35%)**

**NBME Shelf Exam: (30%)**

Students will take the NBME shelf exam for Internal Medicine at the end of the rotation. The lecture series given during the clerkship and the reading material should prepare the students adequately for passing this exam. The Course Committee will determine the passing score and curve, if applicable, for the examinations.

In order to be eligible for a curved score, a student must be at or above the 5th percentile nationally. A score below the 5th percentile nationally is considered a failing score. Please see the Grade Determination section below in regards to "Partial Competency.” After failures have been determined, the students scores will be curved based on the mean and standard deviation of the cohort’s raw scores.
EKG and Test Interpretation (5%)

Students will participate in a clerkship based assessment on the interpretation of EKG’s and other common diagnostic tests.

- **Written Components (25%)**

Challenges in Medicine Essay Assignment (10%)

As part of the experience on Internal Medicine, we would like you to take some time to reflect on some of the challenges of patient care.

Essay structure: there are many issues that challenge us in the care of our patients. We would like you to select a topic from the list below

1. Rationing healthcare
2. Social determinants of health
3. Truth-telling
4. Medical error
5. Decision-making capacity
6. Impaired colleague
7. End-of-life decisions
8. Informed consent
9. Other as pre-approved by clerkship directors [must propose a topic and get email approval from Dr. Szauter or Dr. Belalcazar]

The essay should be 3-4 typed pages (double spaced; 12-point font; 1.25 inch margins)

The first paragraph should describe a specific patient situation to frame your discussion. This should be a patient that you cared for, or was on your team during the internal medicine rotation. You do not need to present all of the details of the patient’s medical problems; limit the introductory comments to provide enough information as to why this patient’s situation prompted you to reflect on one of the above listed issues. The remainder of the essay should explore your selected topic, and what you learned from the patient interaction or situation surrounding the care of the patient. Please reflect on the topic and explain how this patient interaction has shaped your thoughts about the issue.

You should include at least 2-3 references from the current literature.

This essay will be 10% of your final clerkship grade. The essays will be graded by the internal medicine clerkship committee (UTMB faculty).

The deadline for your essay is the 2nd Monday of the 3rd month of the clerkship.

Logbook, Written and Observed H&P’s, EBM write ups, and CRI’s (15%)

Comprehensive Patient Evaluation:

All students will be required to complete 6 H&P’s during the clerkship. One H&P must be written on a patient ≥ 65 years of age. Each H&P must be reviewed (please submit your H&P to your faculty with the evaluation form provided on our website and signed by your attending physician. (See page 22 of syllabus). It should also be noted that some consult attending physicians require comprehensive write ups. See appendix C for Sample write up. All H&P’s must be uploaded into the assignments section of our website upon completion. Please upload to the appropriate folder.

Preventive Healthcare:

Preventive Health (information provided by Dr. Laura Rudkin)

*You must include a discussion of Preventive Health in all 6 of your H&P’s.*

Must include the general healthcare prevention guidelines for the patient based on age and sex. Must also include a discussion of disease-specific screening recommendations for the specific patient
Observed H&P’s:
During the Internal Medicine Clerkship, you will be required to complete 3 observed H&P's. See form below for **Observed H&P Internal Medicine Clerkship**. Observed H&P's can be signed by Faculty or Resident.

Patient Logbook:
Student expectations will be to perform a history, physical examination, and clinical reasoning concerning diagnosis and/or management on the selected patient. These patient issues do not have to be the presenting complaint; they can be issues that have developed during hospitalization or are a secondary issue where a clinical reasoning activity (e.g., rounds discussion) took place and utilized student data collection. Interaction can occur in any clinical care area. See appendix A for the educational requirements checklist.

Clinical Reasoning Instrument:

- **You must complete one Clinical Reasoning Instrument per week.** The form must be signed by faculty weekly. You will turn these in at the end of each rotation. The goal of this activity is to provide a structure for you to practice oral presentation skills and clinical problem solving. All Clerkships will use the same form.

- After you see a patient and you should use the front page of the Clinical Reasoning Instrument as a “post encounter” note to record your data from the interview and pertinent physical exam. The purpose of page one will be for you to record information for personal use—basically to gather your thoughts and organize yourself.

- On page 2 of the Clinical Reasoning Instrument, you will then be expected to record what you believe to be the appropriate diagnoses; ranking from the most to the least likely. You will then be instructed to list up to three items from the history, physical exam and other available information to support the diagnoses listed in this section.

- Finally, you will be expected to record up to 5 diagnostic tests or procedures that would be indicated to help you rule in or rule out their suspected diagnoses.
Student Expectations

On the inpatient service:
Students should perform the following:
1. Follow 3-5 patients at all times
2. Pre-round on their patients so that they are up to date on rounds
3. Take responsibility for understanding their patients’ care
4. Present their patients on morning rounds
5. Write daily SOAP notes
6. Assist with discharge summaries on their patients
7. Complete 1 observed H&P
8. Complete 2 comprehensive H&P’s for each monthly rotation
   - Complete write-ups as soon as possible after seeing patients
   - Turn in write ups to faculty within 48 hours of seeing the patient
   - Upload H&P’s to Blackboard on time even if not yet evaluated by faculty
9. Attend required student morning report and educational ½ day (Galveston)
10. Complete weekly feedback with Faculty or Resident every Friday
    (Please use the Green Feedback Booklet)

On the outpatient service:
Students should perform the following:
1. Report to clinic on time in the morning
2. Follow directions set forth by clinic faculty
3. Be prepared to see patients throughout the day.
4. Present patients to faculty preceptors.
5. Complete 1 observed H&P
6. Complete 2 comprehensive outpatient H&P’s for each monthly rotation
   - Complete write-ups as soon as possible after seeing patients
   - Turn in write ups to faculty within 48 hours of seeing the patient
   - Upload H&P’s to Blackboard on time even if not yet evaluated by faculty
7. Complete weekly feedback with Faculty or Resident every Friday
   (Please use the Green Feedback Booklet)

On the consult service:
Students should perform the following:
1. Report to the department office on time in the morning
2. Follow directions set forth by consult faculty
3. Be prepared to see patients throughout the day
4. Present to faculty during afternoon rounds.
5. Attend outpatient clinic if so determined by consult faculty
6. Complete 1 observed H&P
7. Complete 2 comprehensive H&P’s for each monthly rotation
   - Complete write-ups as soon as possible after seeing patients
   - Turn in write ups to faculty within 48 hours of seeing the patient
   - Upload H&P’s to Blackboard on time even if not yet evaluated by faculty
8. Complete weekly feedback with Faculty or Resident every Friday
    (Please use the Green Feedback Booklet)
SAMPLE MEDICINE WRITE-UP

Chief Complaint: “Chest pain with excessive sweating and nausea”

History of Present Illness: Mrs. A.L. is a 50-year old white female who presented to the UTMB Emergency Room at 8:00 this morning with the chief complaint of “chest pain, nausea, and sweating” upon waking 1 ½ hours earlier. She describes the pain, which was constant for the 1.5 hours, as “squeezing”. The pain diffusely spread over her upper anterior chest wall. She rates the pain 8/10 with radiation to her left jaw and left arm. She has never experienced this type of pain before. She noted no other associated signs or symptoms other than sweating and nausea and denies dyspnea, tachypnea, and fever. Although nothing relieved the pain at the time, exertion made the pain worse. She denied any previous history of chest pain, orthopnea, paroxysmal nocturnal dyspnea, or edema. Pertinent cardiovascular risk factors include a 45-pack-year smoking history, a family history of premature myocardial infarction, and being menopausal. Her mother and father both suffered MI’s before age 50. This patient does report occasional brief palpitations, chronic dyspnea on exertion, and wheezing with overexertion. Pertinent social history includes a one year history of depression and stress due to the illness and death of her ex-husband.

Past Medical History:


Medical Illnesses: Dyspepsia for the past 3 years.

Injuries: Stabbed with a pencil in the abdomen in 1990. She was treated surgically to close wound, no complications.

Surgeries: Appendectomy (1962), no complications

Ob/Gyn History: G3P3 ABO LC3, all vaginal deliveries, no complications

Menarche at age 10

Menopause at age 48

Psych Hx: Depression since menopause, treated with Prozac by her PCP for the past year.

Other Hospitalizations: none

Medications: Prozac 20 mg PO daily. Multivitamin daily. Antacids prn dyspepsia.

Drug allergies: Penicillin (causes diffuse rash)

Blood transfusion/donation: none

Toxic Exposure: not aware of any

Preventive Care: She sees her family doctor annually and as needed. She receives annual mammograms and pap smears. Patient has not completed colonoscopy yet. Immunizations: Td was given 3 years ago and patient received influenza vaccine last fall.
Family History:
Father passed away at age 46 from an MI. He had his first MI at age 35.
Mother, 75 has heart disease (MI at age 45)
46 yo sister with Type 2 diabetes mellitus
42 yo sister with Type 2 diabetes mellitus
40 yo sister in good health
Daughters: 24, 27 and Son: 29, all in good health
Significant family history for Type 2 diabetes mellitus with maternal grandmother and 2/3 maternal aunts afflicted. No family history of hypertension or cancer.

Social History:
She lives at home with her husband in Galveston and works as a secretary at a local insurance company. Her lifestyle is sedentary, as she works a desk job and does not exercise. Mrs. A. L. was married at 18 and divorced at 28. All three of her children are from that marriage. She remarried at 30 to her current husband and has a good relationship with him. The major stressor in her life is the death of her ex-husband recently. She did not want to elaborate further but mentioned that they were on bad terms when he passed away and she feels guilt. Her social support network is mainly through her husband and friends at church. She also gets stress relief from visiting her children who all reside in Austin. Mrs. A.L. has smoked 1.5 packs a day for 30 years (45-pack-year) and denies any alcohol or drug use. In terms of diet, she eats mainly fried foods and pork but has recently switched to turkey and chicken over the last 3 months.

Review of Systems:
**General:** She has lost 10 pounds over the past year due to diet.
Denies fever, chills, night sweats.
**Skin:** Denies other pruritus, rashes, change in hair, or skin changes.
**HEENT:** Nearsighted since youth, vision corrected with glasses. Denies headaches or vision changes. No hearing loss, ear pain, or tinnitus. Denies epistaxis, nasal discharge, sinusitis, dental problems, mouth ulcers, or sore throats. No hoarseness, neck pain, or stiff neck.
**Breasts:** No breast sores, masses, pain, or discharge
**Respiratory:** Other than the HPI, patient has non-productive cough associated with smoking. She denies hemoptysis.
**Cardiovascular:** Other than the HPI, she denies claudication or syncope.
**GI:** Minor heartburn for the past 3 years, primarily after meals and lasts about an hour. Patient takes antacids as needed but has not had the problem evaluated further. No anorexia, hematemesis, vomiting, dysphagia, odynophagia, abdominal pain, hematochezia, melena, constipation or other changes in bowel habits.
**GU:** No dysuria, nocturia, or hematuria, or pelvic pain. Patient’s age at menarche was 10 and she has been menopausal since January 2001. No vaginal discharge, bleeding, or sexual dysfunction.
**Neurologic:** No past history of seizures, muscle weakness, sensation change, incoordination, or headache.
**Musculoskeletal:** Denies joint stiffness, pain, swelling, or backache.
**Hematologic:** Denies bleeding, easy bruising, infections, or swollen lymph nodes.
**Endocrine:** No history of heat/cold intolerance, excessive sweating, diabetes, polyphagia, polydipsia, polyuria. Denies vasomotor flushing.
**Psychiatry:** Depression over the past year since menopause associated with the illness/death of her ex-husband. Denies anxiety, sleep disturbance, or suicidal ideation.
Physical Examination:

**Vital Signs:** Temp. 37°C. Ht. 64”, Wt. 170 lbs. (BMI=29.2)
BP, left arm sitting, 110/57 mmHg
Pulse: 68/min, regular Respiration: 17/min

**General:** Well-developed white female who appears stated age in mild distress.
Appropriately dressed and groomed.

**Skin:** Few hyperpigmented macules on anterior chest. Few flat pinkish-white skin discolorations on the dorsum of both hands. Lesions are not raised or fluid-filled when palpated. No other skin abnormalities on the back, upper/lower extremities, or scalp. Hair has normal texture.

**Eyes:** Visual acuity reduced without glasses. Patient did not have glasses with her to test corrected vision. Pupils equally round and reactive to light and accommodation. Extraocular muscles intact. Sclerae anicteric and eyelids without lesions. Conjunctiva non-injected. Fundi-discs sharp. Vessels without hemorrhages or exudates on funduscopic exam.


**Neck:** Full range of motion. Thyroid non-palpable. Trachea in midline. No masses or lymph nodes palpable.

**Breasts:** Exam Deferred

**Chest:** Respirations without retractions or use of accessory muscles.
Symmetrical in thoracic expansion. No deformities on posterior chest wall. Lungs resonant to percussion and clear to auscultation bilaterally, without adventitious sounds. Prolonged expiratory phase.

**Heart:** No deformities on anterior chest wall. PMI is in the 5th ICS, mid-clavicular line, 1-2 cm diameter. Regular rhythm, with normal S1, single S2. 2/6 systolic ejection murmur heard best at left midsternal border without radiation. No S3, S4, or rub. No JVD. Carotids 2+ bilaterally without bruits. Femoral arteries 2+ bilaterally without bruits. Dorsalis pedis and posterior tibial 2+ bilaterally.

**Abdomen:** Well-healed surgical scars in RLQ and midline. Bowel sounds normoactive. Abdomen non-tender, without guarding or rebound tenderness to deep palpation. Liver span 9 cm in the mid-clavicular line. Spleen and kidneys not palpable. No hernias palpable. Rectal exam deferred. (Stool was guaiac negative in the Emergency Room.)

**GU:** Deferred

**Psychiatric:** Patient alert, oriented to person, place, and time. Intact memory for remote and recent events. Mood normal and appropriate. Patient able to interpret proverbs (abstraction intact).

**Neurologic:** Cranial nerves II-XII intact. Muscle bulk is appropriate in upper/lower extremities. Motor strength is 5/5 in upper (biceps and triceps) and lower extremities (quadriceps, hamstrings, and ankles). Sensation intact to light touch, temperature, and pinprick. DTR’s 2+ in the biceps, triceps, quadriceps, and ankles. Babinski responses downgoing bilaterally. Gait normal. Romberg negative.

**Extremities** Full range of motion of shoulders, elbows, wrists, fingers, hips, knees, and ankles. No joint deformity, tenderness, or swelling. No cyanosis, clubbing, or edema in the extremities.

**Lymphatic:** No palpable lymph nodes in the neck, axilla, or inguinal region.
Laboratory:

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Problem List:
1. Chest pain
2. Nausea
3. Diaphoresis
4. Tobacco abuse
5. Dyspnea on exertion
6. GERD/Dyspepsia
7. Depression
8. Penicillin allergy
9. Post-menopausal
10. Family Hx of premature cardiovascular disease
11. Family HX of diabetes mellitus
12. Obesity (BMI=29.2, Wt=170, Ht=64 in)
13. Prolonged expiratory phase

Assessment:

1. **Chest Pain:** Based on history and physical exam, the patient’s chest pain is most likely unstable angina. The onset with constant “squeezing” chest pain for 1.5 hours with radiation to the left arm and jaw, quality of the pain, and presence of risk factors (pertinent family history, smoking, menopause, and obesity) are consistent with this etiology. Further laboratory evaluation with ECG, CK-MB, and troponin-I can rule out myocardial infarction. Until proven otherwise, this patient would benefit from beta-blockers, heparin, aspirin, and telemetry monitoring. Other differential diagnoses to consider in a patient with chest pain would include esophageal spasms/GERD, aortic aneurysm, pulmonary embolus, and costochondritis. Aortic aneurysms typically present with pain in the center of the back. This condition can be suggested by chest x-ray/imaging. This patient does not have the classic symptoms for PE: dyspnea, tachypnea, and pleuritic chest pain. Since pulmonary emboli usually impair arterial oxygen saturation, determination of arterial PO₂ in addition to radiographic imaging can make this differential less likely. Pneumonia is less likely since the patient’s lungs are clear to auscultation and she does not have fever. Lastly, diffuse esophageal spasms (DES)/GERD often present with more epigastric pain or dysphagia (in DES). However, this patient has had recent onset of heartburn, and further evaluation with upper endoscopy or imaging may be necessary.
2. **Obesity/Family Hx of Diabetes/Smoking:** With BMI of 29.2, this patient is considered obese. Since obesity is a risk factor for several illnesses including coronary artery disease, hypertension, and diabetes, she should be counseled to lose weight with exercise and diet. Additionally, patient should be closely monitored/educated for diabetic symptoms (polyuria, polydipsia, polyphagia), especially considering her family history. Smoking cessation should be encouraged as she is at risk for cardiovascular, pulmonary, and neoplastic diseases. She might benefit from nicotine patches, which may facilitate her quitting smoking.

3. **GERD/Heart Burn:** The patient has had recurring episodes for the past 3 years. Further evaluation may be warranted as she may benefit from more effective drugs such as proton pump inhibitors/H₂ blockers. She may also be counseled on avoiding foods that exacerbate symptoms. She may later need evaluation with upper GI endoscopy or imaging.

4. **COPD:** The history of dyspnea on exertion, wheezing, and tobacco abuse along with the physical exam finding of prolonged expiratory phase suggest that she has developed COPD. She should be counseled on smoking cessation. Consider PFT evaluation later as an outpatient to quantify pulmonary function.

5. **Depression:** The patient has a history of depression and states that she is currently controlled with Prozac. She should continue follow-up with her PCP.

6. **Post-Menopausal:** The patient has been post-menopausal for one year and has not been taking estrogen replacement. Recent studies have raised concerns over the safety of HRT in women with recent coronary events and in women taking HRT for greater than 5 yrs. The patient should be counseled about osteoporosis prevention or perhaps be screened for osteoporosis at a later time.

7. **Health Maintenance:**
   - **Immunizations:** Td was given 3 years ago and patient was given the influenza vaccine last fall. See below for pneumococcal vaccine. Consider Varicella Zoster Vaccination at age 60.
   - **Cancer screening:** Mammogram was obtained this year and patient will continue with annual screening. Patient does not perform self-breast examination. Her last Pap smear was 2 years ago and patient receives her Pap smear screening every 3 years. She has never had an abnormal Pap smear. Patient is at average risk for colorectal cancer. She is considering colonoscopy and will continue in discussion with her primary care physician as outpatient. Patient should also consider annual FOBT.
   - **Disease specific:** Lung cancer prevention with smoking cessation. Offer nicotine replacement therapy. Patient would benefit from nicotine patch while in hospital. Screen for hyperlipidemia given patient’s presentation with chest pain, it is important to assess further risk for cardiac disease. Will evaluate for COPD and consider pneumococcal vaccine if patient has COPD. Otherwise, the pneumococcal vaccine is given at age 65. May also consider DEXA bone density study to screen for osteoporosis given patient’s smoking history and possible COPD.
Plan:

**Diagnostic Evaluation:**
1. ECG
2. Chest X-Ray
3. CK (with CK-MB fraction), Troponin Enzymes
4. Telemetry monitoring
5. CBC/with differential, Chemistry w/Lipids
6. Cardiology consultation if rules in for MI
7. Echocardiography to assess ejection fraction and wall motion
8. Consider cardiac stress after evaluation with cardiac enzymes.

**Pharmacologic/Therapeutic (In Confirmed Myocardial Infarction):**
1. O₂ 2 l/min per nasal cannula
2. Beta-blocker to reduce myocardial oxygen demand
3. Aspirin/anti-platelet drugs to reduce platelet coagulation
4. Heparin until results of cardiac enzymes rule out MI
5. Proton Pump Inhibitor/H₂ antagonist for GERD
6. HMG CoA Reductase Inhibitor, if dyslipidemia is present

**Patient Education/Counseling:**
1. Education on Smoking Cessation
2. Education on diet/weight management and looking for diabetic symptoms
3. Education on osteoporosis prevention
4. Education on anti-reflux measures
5. Education on Ambulation/Cardiac Rehabilitation
6. Schedule follow-up visit
7. Primary Care Physician to consider outpatient Pap smear, colonoscopy, mammogram, DEXA bone density. Other preventive measures as discussed in Health Maintenance.

# Comprehensive H&P Evaluation Form

<table>
<thead>
<tr>
<th>Student: ___________________________</th>
<th>Faculty: ___________________________</th>
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<table>
<thead>
<tr>
<th>H&amp;P #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Significant Help</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>On Target</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Well Above Expectations</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

## History:

- **CC:** Concise, Uses quotations appropriately
- **HPI**
  - **Onset:** Time prior to admission
  - **Qualifiers:** Duration, Frequency, Location, Radiation, Alleviating, Aggravating Factors, Severity, etc…
  - **Pertinent (+):** Associated Symptoms, relevant PMH
  - **Pertinent (-):** e.g. Pt. Denies possible associated symptoms etc…
  - **Organization:** Easy to read, starts with ID and CC
  - **Chronology:** Logical sequence

## PMH

- **Meds:** Dose, frequency, correctly spelled
- **Allergies:** Type of reaction
- **Hospitalizations:** Dates and reason
- **Surgery:** Dates and reason
- **Medical illnesses:** Duration or date of diagnosis

## SH

- **Home:** Living arrangements, with whom
- **Occupation:** Single, married, partnered, divorced, widowed
- **Marital status:**
- **Alcohol:** Amount, frequency, type
- **Tobacco:** Duration and amount
- **Drugs:** Illicit
- **FH:** Ages and illnesses of relatives

## ROS

- **Must have 3 (+) or (-) per system or refer to HPI**

## Physical Examination:

- **Vital Signs:** Blood pressure, Pulse, Respirations, Temperature
- **General:** Describes patient and mental status
- **Skin:** Rashes, Scars, Tattoos, Piercings etc…
- **Head and Neck:** HEENT, Neck Exam, Thyroid
- **Cardiac:** Auscultation, PMI, Pulses
- **Lungs:** Auscultation and Percussion
- **Abdomen:** Inspection, Auscultation, Percussion, and Palpation
- **Genitourinary:** As indicated for pelvic and rectal examination
- **Extremities:** Joints, ROM, Edema
- **Neurological:** CN, Motor, DTR’s, Sensation
- **Lymph nodes:** Presence or absence

## Laboratory Data:

- Labs formatted and clearly labeled

## Clinical Thinking:

- **Problem list:** Most important first
- **Complete:** All major active medical problems, risk factors
- **Assessment**
  - **Rank order:** Most important first
  - **Discussion:** Incorporates history and PE data
  - **Differential:** Appropriately justified

## Plan:

- **Diagnostic:** Justifies reason based on differential
- **Therapeutic:** Dose, route, duration
- **Pharmacological:** Risk reduction, Counseling etc…
- **Prevention:** Preventive Health Maintenance:
  - Adult Immunizations, Cancer Screening
  - Disease specific recommendations

## Evidence:

- **Evidence-Based Medicine:** (Journal article cited)
Observed H&P Form
Internal Medicine Clerkship

Student Name: _______________________________

Team or Service: ______________________________

Date of Observed H&P: __________________

Component(s) Observed:
Check all that apply

History
O    Full
O    Focused

Physical Exam
O    Full
O    Focused

Counseling
O    Discussion of Diagnosis and Assessment
O    Discussion of Plan of Care

Comments:
________________________________________________________________________
________________________________________________________________________

Observer (Faculty or Resident) Name: ______________________________

Signature of Observer: ____________________________________________

Date: _________________

Students: Please upload your completed and signed H&P observation form to Blackboard.
Clerkship Student Evaluation Form

Students will be evaluated in the following 5 areas. Please use the Link to New Innovations to complete your evaluation online. https://www.new-innov.com/login/
If you have technical issues, please call our office 409 772 3108 or email Dr. Szauter (kszauter@utmb.edu) or Dr. Maria Belalcazar (lmbelalc@utmb.edu)

A. Interview & Examination Skills

✓ Obtained pertinent data relevant to patient problem
✓ Obtained accurate Hx and PE information
✓ Performs PE maneuvers appropriately
✓ Able to distinguish normal from abnormal PE findings

B. Verbal Presentation Skills

✓ Uses proper medical terminology
✓ Presents data in appropriate, logical sequence w/o commentary

C. Writing Skills

✓ Writes complete, thorough, well organized H&P
✓ Incorporates pertinent positive/negative information
✓ Daily notes are accurate, up-to-date, legible

D. Clinical Reasoning

✓ Appropriate knowledge of common problems
✓ Incorporates basic science knowledge
✓ Focus assessment on patient problems
✓ Suggests appropriate diagnostic & therapeutic management
✓ Incorporates team thinking into ongoing care

E. Professional Behavior

✓ Arrives prepared, on time, participates on rounds
✓ Accepts responsibility and criticism
✓ Demonstrates concern for patient.
✓ Conducts self professionally
✓ Works well with team/staff

The following scale will be used for each section above

Un- satisfactory Needs Improvement Competent/ Satisfactory Outstanding

0 0 0 0

Note: Comments from your evaluator should be provided for each section. Please review your evaluation during the last week of each rotation with your attending physician and resident.
Overall Evaluation

Most students will perform at the expected level. Please reserve above average ratings for students that are truly exceptional. The highest rating is reserved for the top 10% of all students you have taught.

Performance consistently above that expected for this level. Excellence demonstrated in ALL skill areas. This category should be reserved for the top 10% of all students you have taught.

Performance above level of training in some areas. Excellence demonstrated in some skill areas, competency in all other areas.

Performance at expected level for training. Competence demonstrated in ALL skills areas necessary to pass clerkship objectives. Most students should fall in this category.

Performance at expected level for training. Competence demonstrated in ALL skills areas necessary to pass clerkship objectives. Most students should fall in this category.

Some weaknesses noted. Performance is below that expected for a student at this level; student might benefit from remediation.

Serious weaknesses noted in one or more areas. Student would clearly benefit from remediation.

Professionalism

The School of Medicine and the Internal Medicine Clerkship hold students to the highest standards of professionalism in all of their patient care activities. This includes interactions with patients, families, staff, peers, faculty and administrators. We encourage faculty to report any concerns about students early so that appropriate discussions and necessary interventions can be undertaken.

Faculty can submit an Early Concern Note (ECN) on students at any time during the clerkship. This information is separate from the end of clerkship evaluation and is handled by the Senior Associate Dean for Education.

The ECN note is completed online. A link is provided below.

https://www.utmb.edu/meded/EdAffairs/ECN/userLogin.asp
Overview of Required Written Assignments

The Students are sent the following email on their first day of the clerkship. Please be aware of their written assignments. You are only responsible for evaluation 2 comprehensive H&P’s each block and signing 4 CRI’s.

Internal Medicine Clerkship
2018-2019

Comprehensive H&P’s

- During the clerkship you will be required to turn in six comprehensive write ups on your patients. One H&P must be written on a patient ≥ 65 years of age. (Please upload this H&P into the Geriatric H&P folder on Blackboard).

- You must include a discussion of Preventive Health in all 6 of your H&P’s. Please upload your H&P’s to the appropriate folder in Blackboard before the deadline.

- Use the Microsoft Word Header function to ensure that your name appears on all pages submitted.

- H&Ps should be given to your faculty attending within 48 hours of the patient evaluation.
  - Faculty will review these and provide feedback
  - We strongly encourage the use of the H&P evaluation form which is available for download from Blackboard. These forms should be uploaded to Blackboard to the Scanned H&P Evaluation Form folder.
  - DO NOT wait until the last week of the rotation to give these to faculty
  - You must complete and upload 2 comprehensive H&P’s per month.

Clinical Reasoning Instrument

- You must complete two Clinical Reasoning Instrument per month. Faculty must sign the form. You will upload these in Blackboard by the end of the clerkship.

- The goal of this activity is to provide a structure for you to practice oral presentation skills and clinical problem solving. All Clerkships will use the same form.
  https://som.utmb.edu/Educational_Affairs/OED/Faculty_Development/CRI.asp

- After you see a patient and you should use the front page of the Clinical Reasoning Instrument as a “post encounter” note to record your data from the interview and pertinent physical exam. The purpose of page one will be for you to record information for personal use—basically to gather your thoughts and organize yourself.

- On page 2 of the Clinical Reasoning Instrument, you will then be expected to record what you believe to be the appropriate diagnoses; ranking from the most to the least likely. You will then be instructed to list up to three items from the history, physical exam and other available information to support the diagnoses listed in this section.

- Finally, you will be expected to record up to 5 diagnostic tests or procedures that would be indicated to help you rule in or rule out their suspected diagnoses.
Observed H&P’s

- During the Internal Medicine Clerkship, you will be required to complete 3 observed H&P’s. See form below for Observed H&P Internal Medicine Clerkship.
- Observed H&P’s can be signed by Faculty or Resident then uploaded to Blackboard.

Preventive Health Care

- **You must address preventive care in all 6 of your H&P’s.**
  - You must see at least one male and one female patient.
  - One H&P must be written on a patient ≥ 65 years of age.
  - Review the guidelines for health care maintenance (example: routine blood tests, immunizations, cancer screenings, and other studies) recommended for each of your patients based on age/sex.
- In your H&P, document what your patient has had done, and what is needed to be in compliance with the current recommendations. This should be discussed in the assessment and plan section of your H&P.

Evidence-Based Medicine (EBM) Theme Write up

- **Two supplemental EBM write-ups must be completed.**
  These are addendums to your H&P. Choose 2 H&P’s.
  - Provide the evidence to support your clinical reasoning
  - Reference your assessment and plan with literature from current journals.
- Consider how your literature review has impacted the care of your patient.
- Turn these in directly to the clerkship office at the end of each rotation.

- **Timeline for completion:**
  - Turn in EBM Addendum #1 by the end of Month 1 (with attached H&P)
  - Turn in EBM Addendum #2 by the end of Month 2 (with attached H&P)
- Clerkship directors will review/grade these.
- Use the Microsoft Word Header function to ensure that your name appears on all pages submitted.

Challenges in Medicine Essay Assignment

As part of the experience on Internal Medicine, we would like you to take some time to reflect on some of the challenges of patient care.

Essay structure: there are many issues that challenge us in the care of our patients.

We would like you to select a topic from the list below

1. Rationing healthcare
2. Social determinants of health
3. Truth-telling
4. Medical error
5. Decision-making capacity
6. Impaired colleague
5. End-of-life decisions
6. Informed consent
7. Other as pre-approved by clerkship directors [must propose a topic and get email approval from Dr. Szauter or Dr. Belalcazar]

The essay should be 3-4 typed pages (double spaced; 12-point font; 1.25 inch margins)
The first paragraph should describe a specific patient situation to frame your discussion. This should be a patient that you cared for, or was on your team during the internal medicine rotation. You do not need to present all of the details of the patient’s medical problems; limit the introductory comments to provide enough information as to why this patient’s situation prompted you to reflect on one of the above listed issues. The remainder of the essay should explore your selected topic, and what you learned from the patient interaction or situation surrounding the care of the patient. Please reflect on the topic and explain how this patient interaction has shaped your thoughts about the issue. You should include at least 2-3 references from the current literature.

This essay will be 10% of your final clerkship grade. The internal medicine clerkship directors will grade the essays.

The absolute deadline for your essay is the 2nd Monday of the 3rd month of the clerkship!!!!!!!

Summary: Requirements for all students to turn in by the end of the clerkship

✓ Logbook documenting patient encounters (New Innovations)
✓ Educational objectives checklist (New Innovations)
✓ Six comprehensive H&Ps (Reviewed by Faculty)
✓ Three Observed H&P’s (Signed by Faculty or Resident)
✓ Six Clinical Reasoning Instruments (Signed by Faculty or Resident)
✓ Two Evidence-Based Medicine write-ups related to your patients
✓ Challenges in Medicine essay (Due on the 2nd Monday of the 3rd month of the clerkship)

Please turn in all assignments on or before due date. Late work will not be graded.
• Please also upload your assignments as discussed below.
  - Upload all of your written assignments to Blackboard.
  - Use the upload link from our websites (click on Upload Assignments).
  - Please place assignments into the appropriate folder.

Summary of Assignments and Due Dates
All assignments must be complete before the end of each Monthly Rotation

<table>
<thead>
<tr>
<th>Month 1</th>
<th>H&amp;P 1 and 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Evidence-Based Addendum # 1</td>
</tr>
<tr>
<td></td>
<td>Observed H&amp;P Form (1 signed by Faculty or Resident)</td>
</tr>
<tr>
<td></td>
<td>Clinical Reasoning Instrument (2 signed by Faculty or Resident)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month 2</th>
<th>H&amp;P 3 and 4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Evidence-Based Addendum # 2</td>
</tr>
<tr>
<td></td>
<td>Observed H&amp;P Form (1 signed by Faculty or Resident)</td>
</tr>
<tr>
<td></td>
<td>Clinical Reasoning Instrument (2 signed by Faculty or Resident)</td>
</tr>
</tbody>
</table>
Mid-Point check of the New Innovations Logbook will occur during Week 7

<table>
<thead>
<tr>
<th>Month 3</th>
<th>H&amp;P 5 and 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observed H&amp;P Form (1 signed by Faculty or Resident)</td>
</tr>
<tr>
<td></td>
<td>Clinical Reasoning Instrument (2 signed by Faculty or Resident)</td>
</tr>
<tr>
<td></td>
<td>Complete Log Book &amp; Educational Objectives Checklist before the end of the clerkship</td>
</tr>
<tr>
<td></td>
<td>Challenges in medicine Essay (due on the 2nd Monday of the 3rd month)</td>
</tr>
</tbody>
</table>

Note: Points will be deducted if your logbook does not have an adequate number of entries for the mid-point of the clerkship

You must pass all components to pass the clerkship!!!

- Failure of the NBME alone results in a “PC”
- Failure of the written components (< 70%) will result in a “PC”
- Failure of clinical performance evaluations results in a “Fail”
- Overall clerkship grade < 70% will result in a “Fail”

Written components include: Essay, Addendums, CRIs, Written Comprehensive H&P’s, Observed H&P’s, and the Logbook. Please note all deadlines for written assignments. Late work will not be graded and you will lose points for your late assignments.

Logbooks will be assessed at the mid-point of the clerkship. Points will be deducted if the logbook is considered unsatisfactory. Late entries into the logbook will not be allowed beyond the last day of the clerkship (i.e. after the final exam).

Honors = a final clerkship grade of 91 and in the top 15% of cohort grades.
High Pass = a final clerkship grade of 86 to the cut point for honors.
Pass = a final clerkship grade of 70 to 85 with all components passed.

To qualify for High Pass, you must have a score of at least 80 in each component.
To qualify for Honors, you must have a score of at least 85 in each component.

Sincerely,
Clerkship Directors

This clerkship information was prepared by

Clerkship Co-Directors
Karen Szauter M.D. (UTMB Galveston)
Maria Belalcazar M.D. (UTMB Galveston)
Clerkship Coordinator
Mrs. Christina Johnson

If you have any questions, please contact
Dr. Szauter (kszauter@utmb.edu) or Dr. Belalcazar (lmbelalc@utmb.edu)
We want to thank for your time and effort with our medical students.

Last Edited on 1/7/19