utmb Health

FAMILY MEDICINE
CLERKSHIP SYLLABUS AND CURRICULUM

FAMILY MEDICINE CLERKSHIP SYLLABUS AND CURRICULUM

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COURSE CALENDAR: PERIODS 01, 02, 03, 04 – ACADEMIC YEAR 2020-2021

FAMILY MEDICINE CLERKSHIP TIMELINE

SUN	MON	TUES	WED	THURS	FRI	SAT
WEEK 1	**1st Day FM Clerkship and Clinical Experience** **Aquifer Opens** **NI Opens**				**NBME FM Practice exam opens**	
WEEK 2 **Logbook Complete – 15 cases logged in NI (Aquifer) and Week 1 patients**	**NBME FM Practice exam Due by Midnight**		**Mid-Clerkship Eval with Preceptor**	**Deadline: Mid-Clerkship Form posted to Bb**		
WEEK 3 **Logbook Complete – 30 cases logged in NI (Aquifer) and Week 2 patients**			**40 Aquifer cases completed**	**Final Clinical Day** **Logbook Complete – 40 Aquifer cases logged in NI, and patient encounters with diagnosis**	**FM AQUIFER EXAM ONLINE** (More info by email)	

CHECKLIST OF REQUIREMENTS

For successful completion of your FM clerkship:

- ☐ Complete the FM NBME practice exam due Monday of Week 2
- ☐ AQUIFER - complete 40 assigned interactive virtual cases by Week 3 Wednesday. As each required case in Aquifer is completed, it should be documented in your New Innovations logbook.
- ☐ New Innovations (NI) Case Logger to document each clinical **patient encounter**, for a minimum of 75 patients.
- ☐ New Innovations (NI) Case Logger documentation for a minimum of one case for every required **diagnosis**. For Aquifer cases select the diagnosis from the dropdown box, participation level (role) as 'Alternate,' case location as 'Virtual' and specifying in the comment section as Aquifer FM Case #01, 02, etc.
- ☐ Mid-Clerkship Evaluation Form by Thursday of Week 2
- ☐ FM Aquifer exam on final Friday of rotation

OVERVIEW OF CLERKSHIP

The discipline of Family Medicine encompasses a body of knowledge and an approach to the practice of medicine which are unique. Family Medicine (FM) considers the patient in a comprehensive and holistic manner. Health care is encompassed within the context of the individual's environment, including family, vocation, culture, beliefs and community, and provides comprehensive, continuous cost-effective care across the age span.

ADMINISTRATION AND CONTACT INFORMATION

The clerkship is under the direction of the Medical Student Education Committee of the Department of Family Medicine at UTMB. The clerkship administrative staff is primarily responsible for the day-to-day administration of the clerkship. The FM Medical Student Education website address is: https://ifammed.utmb.edu/predoc_clerkship/default.aspx Most of our clerkship documents can be found in Blackboard under course IMC 3012 Family Medicine Clerkship.

Location: Department of Family Medicine, 2.234 Primary Care Pavilion, Galveston, TX 77555-1123

Fax: 409-772-4296 https://fammed.utmb.edu/

- Victor Sierpina, MD, Director, Medical Student Education Program: vssierpi@utmb.edu
- Jennifer Raley, MD, Co-Clerkship Director, Medical Student Education: jraley@utmb.edu
- Ms. Layne M. Dearman, Clerkship Coordinator: lmdearma@utmb.edu (direct: 409-772-1395)
- Ms. Shannon Samuelson, Program Manager: sosamuel@utmb.edu

The Department of Family Medicine Medical Student Education Committee determines the goals and objectives for the clerkship and makes decisions about other academic matters related to the course. For a list of members see our website listed above.

CLERKSHIP LOCATIONS

Clerkship opportunities are available in the offices of community-based physicians throughout Texas and the UTMB Family Medicine Clinics.

Offices of Community-based Physicians - At these sites, one student is scheduled full-time with a community-based faculty supervisor who is responsible for the student during the clerkship. The community faculty prepares the schedule and provides other learning opportunities for the student to accomplish the goals and objectives of the course. Physicians who supervise clerkship students have UTMB Department of Family Medicine faculty appointments. Many sites have been developed for the clerkship; some of these are in rural and/or underserved areas. A student may indicate a preference for a physician or a site.

UTMB Family Medicine Clinics at Galveston/Dickinson - The Department of Family Medicine has clinics in Galveston and Dickinson that function as group practices for the faculty and training sites for our residency program. Our FMC Island East located in the Primary Care Pavilion, FMC Island West location at 6710 Stewart Road, and FMC Dickinson are the sites available to take a limited number of clerkship students.

UT-Tyler - The Department of Family Medicine is coordinating training with UT-Tyler campus in Tyler, TX. The site functions as a group practice for the faculty and training site for their residency program. We send a minimum of 2 students per rotation to work with a rotating faculty of 13 appointed preceptors.

CLERKSHIP POLICIES

START OF CLERKSHIP - ORIENTATION

Please log into the FM Clerkship website (FM Clerkship Website) to review information about your assigned site and community faculty. Additional course materials and resources can be found in our course IMC 3012 in Blackboard. Students are encouraged to contact us at any time prior to the start of the Family Medicine rotation for help with problems or questions. The Family Medicine Clerkship does not conduct a formal face-to-face orientation since few students are in the immediate area. You will usually receive an in-person orientation to the unique aspects of your site when you arrive at your assigned start time.

SYLLABUS

Please review the entire clerkship syllabus prior to the start of your rotation. The syllabus contains important FM clerkship policies, requirements, assignments, and learning objectives. Our policies mirror those found in the *School of Medicine Office of Clinical Education Universal Clerkship Syllabus*. Please review OCE's Universal Clerkship Syllabus (***OCE UCS***) on their webpage: OCE Universal Clerkship Syllabus

COMMUNICATION

Please check your email daily, and respond to communications from the clerkship faculty and staff. Email is the primary mode of communication between the clerkship administration and students. You will receive important reminders from the clerkship administration. We encourage you to email us with questions and to let us know how things are going.

If you encounter any problems or conflicts that interfere with learning, discuss them with your community faculty. Most problems or concerns at the practice site should be discussed first with your community faculty. If you continue to have concerns please contact the Clerkship Coordinator or the FM Clerkship Co-Directors at UTMB.

DAILY SCHEDULES

A reasonable workday can begin as early as 7:00 am and may not end until 7:00 pm. Actual hours vary by site and the schedule of your community faculty. Schedules are often variable, with more hours on one day or week and less on another. You are expected to follow the schedule set up by your supervising clerkship physician.

WEEKLY SCHEDULES

The student is expected to see patients in the office of the community faculty no less than 4 and preferably 4 ½ days per week during Weeks 1-3 of the Clerkship (excluding holidays.) The ½-day off each week should be the same as the community faculty. The student should use this time to complete assignments, to maintain the Clinical Encounter Logbook, to read and study. Personal time off requested by the student should be scheduled during the non-clinical time to avoid an absence for the course. Weekdays when students are not in clinic should be spent reading, working on assignments, or meeting clerkship obligations as needed. Students are expected to be in clinic during final week of the rotation until 5:00 PM on Thursday. A weekly schedule should be negotiated with the community faculty at the beginning of the rotation.

ON-CALL SERVICE AND HOSPITAL ROUNDS

At some sites, physicians are interested in having students participate in hospital rounds or be on-call for interesting and educational patients. These can be excellent learning experiences that expand the understanding of continuity of care found in Family Medicine.

HOUSING

Housing is provided at a few sites. If housing is requested and available, students are given information about contacts for housing via our website. Overnight visitors and pets are not permitted. If you have questions, contact the clerkship coordinator.

ATTIRE

Students are expected to dress professionally during the clerkship. The white coat should be clean, pressed, and worn at all times, along with the UTMB badge when involved in patient care. Closed toe shoes must be worn. Nails must be short and artificial nails are not permitted. Hair must be contained. Scrubs may be worn only as directed by the supervising community faculty. They may not be worn as a replacement for clean clothes. Students are expected to conform to the standards of dress at your site and abide by site expectations.

Patients at all sites should be told that students may be involved in their care. The students should introduce themselves as medical students working with the practice as a part of their medical studies at UTMB.

GRADES

RECEIVING YOUR GRADE

Grades for Family Medicine are available three to four weeks after the conclusion of the rotation. You will receive an email advising you when the grades have been posted and are available for your review through MyStar. Your FM grade report will be attached to the email. Your evaluation(s) in New Innovations is released at that time for you to access. Nothing is released prior to grades being posted. For questions after grades are posted, you are encouraged to contact the course Co-Directors. In the unlikely event of a discrepancy, the final grade available through MyStar is the official grade for the clerkship.

GRADE TABULATION

The purpose of the Family Medicine Clerkship is to help you develop an understanding of the delivery of health care which considers the patient in a comprehensive and holistic manner and encompasses the individual's environment, including family, vocation, culture, beliefs and community, and provides comprehensive, continuous cost-effective care across the age span. However, we must certify to the University and national accrediting bodies that you have met the established criteria.

The course is now Pass/Fail. Failure to complete or participate in any of the activities will result in being contacted by the course director and could result in an ECN. Students are expected to meet high standards of professionalism during the Family Medicine clerkship. Failure to receive a satisfactory rating for any aspect of professionalism may result in a grade of “Fail.”

A final grade of 70 or better is necessary to receive a passing grade for the course.

Required Components for Student's Grade	Weight
Clinical Performance Evaluation - completed by Preceptor(s) online. If more than one form is completed, scores are averaged.	45%
Aquifer Exam – Family Medicine – passing at or above the 5th percentile	45%
Professionalism - completion of all assignments ON TIME including: • FM NBME practice test • engagement with Aquifer cases • participation in mid-clerkship feedback • NI case logger documentation: patient encounters plus diagnosis requirements	10%

If you have any questions about your FM grade calculations, please contact the course Co-Directors and copy the Coordinator.

CLINICAL PERFORMANCE EVALUATION SCORE

- The clinical evaluation completed in New Innovations is similar to the one used by all clerkships.
  - The final clerkship evaluation has 11 items. 10 items are worth 4 points each and 1 item is worth 5 points. There are a total of 45 possible points.
  - The 10 – 4-point-items are based on your rating: 1 point for unsatisfactory, 2 points for needs improvement, 3 points for satisfactory, 4 points for excellent
  - The last item is a rating from 1 through 5 in a similar way but is your clerkship global score, not a particular competency.
- Most students should expect to receive a satisfactory (3) rating for average performance in FM for a total of 33 points (worth a grade of 73.) To exceed, a student will have to perform in an outstanding fashion.
- If more than one form is completed, scores are averaged automatically by New Innovations.
- The grade for this component must be 61 or above in order to pass the course.
- Clinical Performance Evaluations are not released prior to grades being posted.
- Do not contact your preceptor after the clerkship regarding your evaluation. This is a breach of protocol and a professionalism issue, which will result in an Early Concern Note.

AQUIFER SUBJECT EXAM SCORE

- Students must score at the 5th percentile of the previous academic year norm on the exam to pass the course. If score is below the 5th percentile, student is notified the week following the exam.
- Students who fail the exam but pass the other graded components of the course will receive an IP pending a re-exam.

PROFESSIONALISM REQUIREMENTS

Professionalism – All of the below assignments must be completed on time to receive the grade points or the student will receive zero points. For specific details for each, read their outlined category.

- NBME FM Practice Exam
- Aquifer – 40 Assigned interactive virtual cases; also document in NI
- Mid-Clerkship Evaluation Form
- Patient Encounter Requirements in NI Logbook (NI Case Logger) Minimum of 75 patients total
- Diagnostic Requirements in NI Logbook (NI Rotation Requirements Summary)

Students who do not meet all these requirements will not receive the points. This is an all or nothing objective.

FM NBME PRACTICE EXAM

- Must be completed online through the NBME website. Assessment is available the first Friday thru the second Monday. You will receive a voucher by email on the first Thursday of the rotation to use to purchase the exam.
- Students who do not meet the requirement may receive an Early Concern Note and/or a course grade of PC.

- This test is highly predictive of your potential success on the FM final. If you fail the practice exam, one of our faculty will contact you regarding your performance. At that time, you will be required to a) create a study plan to submit to faculty and the course coordinator for review and b) you will be required to take the exam again before the end of the course.
- Those that are found to be in the "at-risk" category will be notified by the course coordinator. It will be the student's responsibility to follow the recommended plan for reading to improve the outcome on the NBME Shelf Exam.

AQUIFER CASE ASSIGNMENT

- AQUIFER - complete 40 assigned interactive virtual cases by Week 3 Wednesday. As each required case in Aquifer is completed, it should be documented in your New Innovations logbook.

MID-CLERKSHIP EVALUATION FORM

- **Post a copy of the form** (PDF) to Blackboard by Thursday of Week 2. It should have your signature and that of your supervising physician. The mid-clerkship form is **required** to document feedback for you from your preceptor. Also document in NI as complete.

CLINICAL ENCOUNTER LOGBOOK ASSIGNMENT

- All patient encounters must be accurately recorded in the New Innovations Case Logger
- The logbook must be kept up to date weekly
- A minimum of 75 patient encounters (at any participation level) must be recorded
- At least 1 of each required diagnosis must be documented
- Students who do not meet the requirements may receive an Early Concern Note and/or a course grade of PC.

GRADING POLICIES

The complete Academic Policies of the SOM Educational Affairs are available at **Academic Advancement Policies.** The Family Medicine Clerkship strives to comply with both the letter and spirit of these policies.

Grades are posted to MyStar 3-5 weeks after the end of your rotation. All evaluation forms must be completed before a final grade will be released. You will receive an email once grades are posted which explains how to request a breakdown of the scores that went into your grade and how to access your NI evaluation. Nothing is released prior to grades being posted.

GRADE APPEALS

A student who wishes to contest a grade has the prerogative to write to or schedule an appointment with the Clerkship Director. SOM policy states you must notify the Course Director(s) of your intent to appeal within five (5) working days of the posting of the course grade in MyStar. If the decision is unchanged after review by Family Medicine Medical Student Education Committee, the student also has the right to contest the decision to the Academic Review Committee as described in the Academic Policies.

The electronic **Grade Appeal Form** to use for a grade appeal is posted in our Forms tab in the Black Board course and on our website in the Forms section. The completed form is automatically submitted to the course Co-Directors with a copy to the Clerkship Coordinator.

Do not contact your preceptor after the clerkship regarding your grade. This is a breach of protocol and a professionalism issue, which will result in an Early Concern Note. This is very unfair to the preceptor while currently teaching another student and might actually discourage some from accepting additional students. Any and all contact with the preceptor regarding grades and evaluations will be handled by one of the Clerkship Co-Directors after an appeal form is received.

Academic Advancement Policies 3.3: In general, for a successful appeal, the student will need to demonstrate that a decision of a course committee or the Academic Progress Committee was (a) arbitrary or capricious, (b) made in bad faith, or (c) in violation of the SOM's Academic Policies.

PROFESSIONALISM – UTMB SOM HONOR PLEDGE

As with any clinical clerkship, students are to accept the dual responsibilities of student and trusted member of the health care team.

- **UTMB SOM Student Honor Pledge:** On my honor, as a member of the UTMB community, I pledge to act with integrity, compassion and respect in all my academic and professional endeavors.

This includes being on time, being prepared to learn, checking your email daily, being informed of all expectations, and the timely completion of all assignments including Clinical Encounter Logbooks, DAC Cases, Assessments, and Evaluations.

To become a trusted part of the health care team, please be meticulous about keeping appointments and being on time. When the community faculty feel they can rely on you, they will often give you increased responsibility for patient care and contribute more to your education.

Your professionalism is formally evaluated by your community faculty at the end of the clerkship. Your professionalism is also monitored, and if needed, evaluated by the clerkship administration. Failure to receive a satisfactory rating on all aspects of professionalism may result in failure of the clerkship.

A course/clerkship director or coordinator who either directly experiences, or receives a report of potentially unprofessional behavior is encouraged to discuss the concerns directly with the student, and has the options of

a. including professionalism concerns in the student's formal course/clerkship evaluation; or
b. submitting an Early Concern Note; or
c. including professionalism concerns in the student's evaluation and submitting an Early Concern Note; or determining that no action is indicated.

ABSENCE POLICY

Family Medicine adheres to the UTMB School of Medicine Student Absence Policy (OSE UCS and/or **Academic Advancement Policies** Section 6) Student absences that total no more than two days are a matter between the student, the course co-directors, and their supervising faculty. Absences of more than two days require the student to consult with the Associate Dean for Student Affairs.

Students are expected to attend all required activities. An absence is any instance in which a student is not physically present at an activity. Students should not assume they are allowed any absences at their discretion or for their personal convenience. Absences are considered acceptable only when **unavoidable**, which include two types of circumstances:

1. When unavoidable and anticipated, for example to attend a residency interview or a presentation at a professional meeting. Students are strongly encouraged to schedule interviews during vacation periods to avoid conflict with scheduled courses.
2. When unanticipated, as in personal illness, unavoidable family obligation, or unanticipated delay in transportation.

Actions Required by the Student:

For an anticipated absence, students must request permission in writing from the course directors and the coordinator in advance as soon as the conflict is identified and, if approved, inform their supervising faculty. Students should avoid making travel arrangements until/unless the course director has approved their request.

For an unanticipated absence, a student must notify in writing the course director, course coordinator, and supervising faculty. Except in extraordinary circumstances, notification is expected before the activity begins.

COURSE REQUIREMENTS

FM NBME PRACTICE EXAM

Coordinator will send your voucher with instructions via email the first week. It is composed of 50 questions to be completed in the 1 hour and 15 minute timeframe. You will receive feedback at the end of the assessment. This requirement opens Friday of week one and closes Monday week two at midnight.

AQUIFER CASE ASSIGNMENT

Aquifer Family Medicine (formerly fmCASES) helps students develop clinical reasoning skills critical to becoming a successful practitioner. The virtual cases provide key content correlated to STFM Learning Objectives—a proven path to success in developing clinical reasoning skills. ASSIGMENT: The FM Course in Aquifer is 40 cases which take approximately 30-45 each to complete. Complete 40 assigned interactive virtual cases by Week 3 Wednesday; See calendar for guidelines on case completion. As each required case in Aquifer is completed, it should be documented in your New Innovations logbook.

READING

Family Medicine is a broad and diverse field. It combines the traditional biomedical disciplines with particular skills in the analysis and use of community resources; knowledge and experience of organizational and management techniques for the delivery of medical care; and an awareness and ability to understand, diagnose, and use the psychological and social elements that are concomitant of health and disease. This information may be drawn from many sources.

RECOMMENDED TEXTS

Case Files: Family Medicine (by Toy, Briscoe, Reddy, and Britton: ISBN # 9781259587702, 4th edition, 2016) has been a very popular resource for many students. Access partial book online through the Moody Medical Library (MML) http://guides.utmb.edu/c.php?g=411424&p=2804150 It is available in the campus bookstore and in a Kindle format.

In addition to this book, most students purchase some type of study guide to prepare for the Family Medicine NBME (shelf exam.)

Other possible texts include:

- CURRENT Diagnosis & Treatment in Family Medicine by South-Paul, Matheny, and Lewis; ISBN 9780071827454, 4th Edition, 2015, online through the Moody Medical Library (MML) (http://guides.utmb.edu/c.php?g=411424&p=2804150).
- Textbook of Family Medicine, by Robert E. Rakel, MD and David Rakel, MD; ISBN 0323239900, 9th Edition, 2016 online through the Moody Medical Library (MML) (http://guides.utmb.edu/c.php?g=411424&p=2804150).
- Essentials of Family Medicine by Sloane, Slatt, Ebell, Smith, Power, & Viera; ISBN 9781608316557, 6th edition, 2012.

You are expected to read about the cases in which you are involved and take advantage of the medical library online databases.

FM Clerkship Top 30 Common Conditions and Presentations Guide is found online through the Moody Medical Library. This is an excellent resource to review what you are seeing in clinic.

ADDITIONAL RESOURCES

- Case Files Family Medicine
- NBME Practice Tests
- UWORLD (Internal Medicine, Pediatrics, Dermatology)
- Step Up 2 Medicine
- US Preventive Services Task Force Recommendations
- Blueprints FM
- OnlineMedEd Videos
- Swanson's Family Medicine Review

Helpful Apps:

- Epocrates – medication dosage, side effects, tables, and guidelines
- AHRQ ePSS – Age and gender based recommendations from USPSTF
- Shots by AAFP and STFM
- Preg Wheel

CLINICAL ENCOUNTER LOGBOOK ASSIGNMENT

Students should record all patient experiences in the New Innovations Case Logger.

- New Innovations (NI): New Innovations
- For login: Institution = UTMB, use your UTMB username and email to access
- Run a report showing a summary of your logs to share with your community faculty member at the mid-clerkship conference (Logger>Rotation Requirements>Summary)
- To use the mobile software, select "Mobile Software" in the main section of the menu

Make sure your logbook is current for the preceding week by Sunday – midnight. They will be reviewed Monday morning.

Each patient counts as one encounter. Your goal is to see a minimum of one case for every required diagnosis listed. (See Diagnosis Requirements section of syllabus for the list.) By the second week of the clerkship we hope most of your encounters will be at the Full Participation level.

A minimum of 75 patients must be seen in the outpatient setting during this rotation. Most students will record 100-125 patient encounters. We hope you will see between 5-7 patients per day. If you are seeing more than this recommended number, talk with your preceptor about your needs as a student learner. Most students need time to process what they are seeing and to look up information on the cases to help prepare for the exam. You may want to see every other patient or set up another system that you and your community faculty work out. You are a student learner and time for reading and researching patient problems is important.

Review the report in New Innovations called "Rotation Requirements Summary" to determine if you are missing experience with any required diagnosis. You should fill in any gaps with supplemental reading in the FM Clerkship Top 30 Common Conditions and Presentations Guide online through the Moody Medical Library. These additional experiences should be logged under *Alternate* in NI and include a comment to explain.

Failure to complete the online Clinical Encounters Logbook in a timely and conscientious manner will be reviewed by the Clerkship's administration. Consequences may include an Early Concern Note, and/or an "Unsatisfactory" evaluation of Professionalism and subsequent "Failure" of the Clerkship.

CASE LOGGER ENTRY INSTRUCTIONS

All data entered should be HIPPA compliant using no patient identifiers. Select your preceptor as the supervising physician via the dropdown. If not listed, contact your Clerkship Coordinator.

Student Info:

- Name
- Rotation
- Date = Date of Patient Encounter

PX Info – Procedures:

- For FM, no procedures are required. Unless you are logging a procedure, do not use the dropdown box. Procedures for FM are defined as performing an act beyond the physical exam such as drawing blood, injections, pap smear, splinting, biopsy, wart removal, delivering a baby, suturing, inserting an IV, wound care, colposcopy, inserting a catheter, etc.
- You may only log a procedure if you have actual hands-on participation. Observation is not logged as a procedure.
- Comments are required for procedures to clarify which procedure you participated in.

DX Info – Diagnosis/Problem:

- For each patient encounter you may log up to three diagnoses/problems that are actively addressed. To add up to 3 problems for the same patient, hold down the control key.
- Comments are required for the diagnosis “other” to clarify what you saw
- Your goal is to see a minimum of one case for every required diagnosis listed.

Additional Information:

- Case Location - Clinic (outpatient), Hospital (inpatient), Virtual (Aquifer)
- Role in Case

  - **Full Participation** = elicited history, performed physical exam, and participated in medical decision-making
  - **Partial Participation** = any one or two of the three mentioned previously
  - **Observed/Shadowed**
  - **Alternate** – use this to record any gap learning experiences to cover a diagnosis you did not see in clinic. Use the comments box to record the specifics.

Comments:

- Comments are required for the diagnosis “other,” procedures, and the “alternate” role, however you are welcome to add as much information as you want.

DIAGNOSIS REQUIREMENTS

Each student is required to see a minimum of one of each and provide documentation in their New Innovations logbook during their clinical rotation.

Students may run a report from NI called "Rotation Requirements Summary" to determine if they are missing any. Gaps should be filled with a corresponding and/or supplemental reading in the FM Clerkship Top 30 Common Conditions and Presentations Guide online through the Moody Medical Library. These additional experiences should be logged under ***Alternate*** in NI and include a comment to explain.

Diagnosis Requirements

Diagnosis	Target	Required
Abdominal Pain	1	✓
Anxiety	1	✓
Arthritis and Arthralgias	1	✓
Asthma/Reactive airways disease	1	✓
Back or neck pain	1	✓
Cardiology (chest pain, coronary artery disease, heart failure, etc.)	1	✓
COPD	1	✓
Cough	1	✓
Depression	1	✓
Diabetes Mellitus	1	✓
Dizziness	1	✓
Dyspnea	1	✓
Dysuria	1	✓
Fever	1	✓
Geriatric Problems (delirium, dementia, etc.)	1	✓
Headache	1	✓
Health Promotion and Prevention (annual physical, well child check, etc.)	1	✓
Hyperlipidemia	1	✓
Hypertension	1	✓
Joint Injury	1	✓
Leg Swelling	1	✓
Male urinary symptoms/prostate/acute	1	✓
Obesity	1	✓
Osteoporosis/Osteopenia	1	✓
Other - Not Listed	1	✓
Skin lesions	1	✓
Skin rashes	1	✓
Type 2 Diabetes Mellitus-Chronic	1	✓
Women's Health (gynocological disorders, well woman exam, PAP, pregnancy, etc.)	1	✓

EVALUATIONS

MID-CLERKSHIP FEEDBACK CONFERENCE

You and your community faculty should schedule time together midway through the rotation, on Wednesday of Week 2 to go over the form. **It is your responsibility to make certain this required feedback session is scheduled** - refer to our website or course in Blackboard for the Mid-Clerkship Rating Form. This is an opportunity to assess your progress toward meeting the course objectives and to discuss your personal learning goals. It is also a time to solve any potential problems, to test your self-evaluation against the physician's evaluation, and to make sure you understand the physician's expectations and perceptions of experiences for the final weeks of the clerkship. Take advantage of the time with your preceptor to develop a plan to see at least one of each of the Core Presentations for Acute and Chronic Diseases common to Family Medicine. The mid-clerkship form does not count toward your grade but is **required** to document feedback for you from your preceptor. **Post a copy of the form** to Blackboard by Thursday of Week 2. It should have your signature and that of your supervising physician.

Note: Prior to the Mid-Clerkship Feedback Conference, log in to the NI Clinical Encounter Logbook site, go to the "Reports" tab, and print out a summary of your patient experiences. Review this report with your supervising physician.

New Innovations Midpoint Feedback Documentation: Please confirm the feedback in New Innovations. Log into NI and find this in the Evaluations section.

CLINICAL PERFORMANCE EVALUATION

The clinical performance portion of the grade will be determined from scores on the Clinical Performance Evaluation completed online in New Innovations at the end of the clerkship by your community physician. Any faculty who supervised you at least six half-days during the course may also be asked to complete an evaluation. A sample of this form is included in our Blackboard course. We encourage you to schedule a final evaluation review, similar to the formative mid-clerkship evaluation, on the last Wednesday of the clerkship. Print a sample copy of the online Clinical Performance Evaluation from our website or forms tab in our course in Blackboard. This will allow a final face to face feedback opportunity for you. The form will not be "official" until your preceptor enters the information online. The form becomes available online to the preceptors on Wednesday of Week 3. They receive an email with access information.

STUDENT EVALUATION OF THE COURSE AND FACULTY

You will be asked to answer questions about your experiences, rate the physicians with whom you've worked, and share your opinions. Your honest feedback is needed to make the clerkship experience better. All are reviewed carefully at the end of the rotation. Completing two evaluation forms in New Innovations is required.

Evaluation of the FM Clerkship: This information is compiled and reviewed by our course committee. We appreciate feedback and take any concerns seriously.

Evaluation of your Site and Preceptor: Your responses will remain confidential. Your identity will be protected and no type of identifiable information will be made available to your preceptor. Composite feedback reports are provided to preceptors only when four or more forms have been completed. When four or more evaluations have been completed, a composite report is run at the end of the academic year.

ASSESSMENTS

The specialty of family medicine is centered on lasting, caring relationships with patients and their families. Family physicians integrate the biological, clinical and behavioral sciences to provide continuing and comprehensive health care. The scope of family medicine encompasses all ages, sexes, each organ system and every disease entity. Because of this, the Family Medicine NBME includes a broad spectrum of information.

FM EXAM PREP

In addition to thoroughly engaging with the Aquifer cases, the best approach is to make every patient you see a learning experience. Read about each patient's problems, pathophysiology, epidemiology, appropriate history, physical exam, differential diagnosis, treatment, pharmacology, etc. both at the clinic and that evening while the patient is fresh in your mind.

Given the vast content area of Family Medicine, you will not be able to learn it all in three weeks. You will most likely encounter topics on the test you did not see during the rotation. We are aware of these issues and make appropriate allowances in our grading policies. The Aquifer cases are helpful for the problems they address, as well as preparing you for the exam. Learn as much as possible from your community faculty member; they are a valuable source of information, but they are not a substitute for independent reading and study. In your reading and study, work to become competent on diagnosis, treatment, and prevention of the most common core and acute problems in Family Medicine as listed in your syllabus.

Most students find it helpful to spend some time taking practice tests as these provide not only valuable information but prepare you for the level of questions you will encounter. Previous students have used: *Case Files*, *Pretest,* as well as highly recommending the Ambulatory Medicine Chapter and "Diseases of the Skin and Hypersensitivity Disorders" section of *Step Up to Medicine*. They also suggest a brief review of Pediatrics, Dermatology, IM, and some GYN (well-woman, STDs, etc.) Make adequate time to complete significant reading, the online cases, as well as utilize additional study resources.

Studying should not be cramming information at the last moment before your exam. It should be a well thought out and intentional process. If you follow our suggested reading and incorporate some of the additional resources into a regular study routine, chances of a very successful NBME exam score are much more likely. You should be studying at a minimum 1-2 hours per night in addition to seeking information throughout the day to help your patients. We strongly encourage this study program for all students, especially those who did poorly on the practice exam.

TOP 30 COMMON CONDITIONS AND PRESENTATIONS GUIDE

FM Clerkship Top 30 Common Conditions and Presentations Guide is found online through the Moody Medical Library.

AAFP STUDY QUESTIONS

The American Academy of Family Physicians has a large bank of study questions. These are accessed by joining AAFP, which is free for students. You do have to create an account to access the questions. Complete the online student membership application. They will contact you by email, then you can access the questions. It may take a few days so it is best to do this early in the rotation.

http://www.aafp.org/about/membership/join.html

http://www.aafp.org/about/membership/join/student.html

AQUIFER FM SUBJECT EXAMINATION

- The exam is administered and proctored online.
- The raw score must be at the 5th percentile or above in order to pass the course.
- The exam is made up of 100 questions.
- The exam is 3 hours in length.
- The exam is usually from 9-12 on the final Friday of the rotation

(Updated AY20-21 – June 29, 2020)

CLERKSHIP CURRICULUM

*adapted from the Society of Teachers of Family Medicine (STFM) Clerkship Curriculum

CLERKSHIP OBJECTIVES

The overall goal of the family medicine clerkship is to provide an outstanding learning experience for all medical students.

THE GOALS OF THE FAMILY MEDICINE CLERKSHIP

- Demonstrate the unequivocal value of primary care as an integral part of any health care system.
- To teach an approach to the evaluation and initial management of acute presentations commonly seen in the office setting.
- To teach an approach to the management of chronic illnesses that are commonly seen in the office setting.
- To teach an approach to conducting a wellness visit for a patient of any age or gender.
- Model and discuss the principles of family medicine care.
- Provide instruction in historical assessment, communication, physical examination, and clinical reasoning skills.
- Discuss the principles of family medicine care.
- Discuss the critical role of family physicians within any health care system.

STUDENT LEARNING OBJECTIVES FOR THE FAMILY MEDICINE CLERKSHIP

At the end of the Family Medicine Clerkship, each student should be able to:

- Gather information, formulate differential diagnoses, and propose plans for the initial evaluation and management of patients with common presentations.
- Evaluate patients having one or more common chronic diseases.
- Develop evidence-based health promotion/disease prevention plans for patients of any age or gender.
- Demonstrate competency in advanced elicitation of history, communication, physical examination, and critical thinking skills.
- Demonstrate clinical reasoning and the application of family medicine principles to patient problems through online small group discussions based on assigned readings on common patient presentations in primary care.

PRINCIPLES OF FAMILY MEDICINE

The family medicine method of delivering health care was developed in the late 1960s at the inception of the specialty. The specialty embraced continuity and comprehensiveness and placed an emphasis on the patient's perspective within the context of family and community. These concepts were echoed in the Future of Family Medicine document published in 2004. Most recently, these principles are embodied within the concept of the Patient-centered Medical Home. Medical students should learn this method of care, study our philosophy of practice, and observe our passion for our work.

Teaching in family medicine clerkships focuses on the five primary principles of family medicine as captured in the Family Medicine Curriculum Resource project, shown in Table 1.

TABLE 1
The Principles of Family Medicine
The biopsychosocial model
Comprehensive care
Continuity of care
Contextual care
Coordination/complexity of care

PRINCIPLES OF FAMILY MEDICINE – COMMON LEARNING ISSUES

BIOPSYCHOSOCIAL MODEL

PATIENT-CENTERED COMMUNICATION SKILLS

- Demonstrate active listening skills and empathy for patients.
- Demonstrate setting a collaborative agenda with the patient for an office visit.
- Demonstrate the ability to elicit and attend to patients' specific concerns.
- Explain history, physical examination, and test results in a manner that the patient can understand.
- Explain information obtained by a patient from such sources as popular media, friends and family, or the Internet.
- Demonstrate validation of the patient's feelings by naming emotions and expressing empathy.
- Apply psychological issues in patient discussions and care planning.
- Demonstrate effective listening skills and empathy to improve patient adherence to medications and lifestyle changes.
- Describe the treatment plans for prevention and management of acute and chronic conditions to the patient.
- Reflect on personal frustrations, and transform this response into a deeper understanding of the patient's and one's own situation, when patients do not adhere to offered recommendations or plans.

PSYCHOSOCIAL AWARENESS

- Discuss why physicians have difficulty in situations such as patients' requests for disability documentation, non-adherence, and chronic narcotic use.
- Discuss the influence of psychosocial factors on a patient's ability to provide a history and carry out a treatment plan.

PATIENT EDUCATION

- Discuss mechanisms to improve adherence to and understanding of screening recommendations.
- Identify patient education tools that take into account literacy and cultural factors (e.g. a handout on how to read nutrition labels.)
- Describe the patient education protocols and programs for core chronic illnesses at their assigned clerkship sites.
- Identify resources in a local practice community that support positive health outcomes for diverse patients and families.
- Identify resources for patients with substance abuse problems at their clinic sites (e.g. lists of treatment referral centers, self-help groups, substance abuse counselors, etc.)

COMPREHENSIVE CARE

INFORMATION GATHERING AND ASSESSMENT

- Use critical appraisal skills to assess the validity of resources.

- Formulate clinical questions important to patient management and conduct an appropriate literature search to answer clinical questions.
- Apply evidence-based medicine (EBM) to determine a cost-effective use of diagnostic imaging in the evaluation of core, acute presentations.
- Identify and use high-quality Internet sites as resources for use in caring for patients with core conditions.

LIFELONG LEARNING

- Assess and remediate one's own learning needs.
- Describe how to keep current with preventive services recommendations.

CONTEXTUAL CARE

PERSON IN CONTEXT OF FAMILY

- Conduct an encounter that includes patients and families in the development of screening and treatment plans.
- Demonstrate caring and respect when interacting with patients and their families even when confronted with atypical or emotionally charged behaviors.
- Demonstrate interpersonal and communication skills that result in effective information exchange between patients of all ages and their families.

PERSON IN CONTEXT OF COMMUNITY

- Discuss local community factors that affect the health of patients.
- Discuss health disparities and their potential causes and influences.
- Demonstrate interpersonal and communication skills that result in effective information exchange between patients of all ages and professionals from other disciplines and other specialties.

PERSON IN CONTEXT OF THEIR CULTURE

- Demonstrate effective communication with patients and families from diverse cultural backgrounds.
- Discuss areas where culture can impact the ability of patients to access and utilize health care.

CONTINUITY OF CARE

BARRIERS TO ACCESS

- Describe the barriers to access and utilizing health care that stem from personal barriers.

COORDINATION/COMPLEXITY OF CARE

TEAM APPROACH

- Describe the value of teamwork in the care of primary care patients.
- Discuss the roles of multiple members of a health care team (e.g. pharmacy, nursing, social work, and allied health).
- Demonstrate effective membership of a clinical care team.

QUALITY AND SAFETY

- Recognize clinical processes established to improve performance of a clinical site.
- Describe the use of a quality improvement protocol within a practice and how the protocol might improve health care.
- Describe methods of monitoring compliance with preventive services guidelines.
- Describe how one of the core chronic diseases is monitored in the assigned clerkship site.
- Describe how narcotic use is managed and monitored in the assigned clerkship site.

Health care provided by family physicians has several unique characteristics shown in Table 2. Although many types of physicians provide first-contact care, the characteristics listed below are not always present. Understanding how to provide acute and chronic disease care within this context is of benefit to all medical students.

TABLE 2

Key Characteristics of Family Physicians
Prior knowledge of the patient
Care for a heterogeneous patient population
Multiple settings with different diagnostic prevalence
Multi-purpose visits
Staged diagnostic approach
Opportunity for follow-up care

OVERVIEW OF CLINICAL CARE

In addition to the key principles of family medicine, there are several key messages for students to learn as they gain experience working with family physicians. These include the importance of knowing your patient, provision of care within a community versus tertiary care setting, and having the opportunity to provide different types of care within the same visit.

IMPORTANCE OF PRIOR KNOWLEDGE

Having prior knowledge of a patient presenting to the office influences the diagnosis and provides an advantage in negotiating diagnostic testing and treatment strategies. Diagnostic testing can be conducted in stages. First, the physician considers the most common and any dangerous diagnoses. This approach is more cost-effective than obtaining an extensive work-up initially and is appropriate for the outpatient setting where common diagnoses are common. In addition, the opportunity for patients to follow-up allows the family physician to proceed with diagnosis and treatment in a thoughtful, staged manner taking into account the patient's age, gender, or the presence of pregnancy or any chronic illnesses.

CARE IN THE COMMUNITY SETTING

The prevalence of disease varies greatly based on the care setting. These differences in prevalence change pretest probability, affecting the predictive value of a test, and altering posttest probability of a specific diagnosis. For example, a patient presenting to the family physician's office with chest pain will have a much lower likelihood of experiencing a myocardial infarction than a patient presenting with chest pain to the emergency room or subspecialist's office.

THE MULTIPURPOSE VISIT

For family physicians, an acute visit sometimes presents a highly cost-effective opportunity to address chronic medical problems and health promotion. In addition, family physicians frequently care for an entire family, and many issues for the individual patient or family member often surface in the context of a single office visit.

CORE PRESENTATIONS FOR ACUTE CARE

The suggested topics for core acute presentations are listed in Table 3. Common infectious and non-infectious causes are also listed in addition to any serious conditions that should be considered.

ACUTE PRESENTATION- COMMON LEARNING ISSUES:

At the end of the clerkship, for each common symptom, students should be able to:

- Differentiate among common etiologies based on the presenting symptom.

- Recognize “don’t miss” conditions that may present with a particular symptom.
- Elicit a focused history and perform a focused physical examination.
- Discuss the importance of a cost-effective approach to the diagnostic work-up. (SBP)
- Describe the initial management of common and dangerous diagnoses that present with a particular symptom.

TABLE OF CORE ACUTE PRESENTATIONS

(Reprinted from the Family Medicine Clerkship Curriculum with permission from the Society of Teachers of Family Medicine)

Table 3: Core Acute Presentations With Common Diagnosis, Serious Diagnoses, and Topic-specific Objectives

Topic*	Common	Serious	Topic-specific Objectives	Additional Skills
Upper respiratory symptoms	Infectious (viral upper respiratory infection, bacterial sinusitis, streptococcal pharyngitis, otitis media, and mononucleosis) and noninfectious causes (allergic rhinitis)		• Recognize that most acute upper respiratory symptoms are caused by viruses and are not treated with antibiotics. • Determine a patient's pretest probability for streptococcal pharyngitis and make an appropriate treatment decision (eg, empiric treatment, test, or neither treat nor test). (PBLI)	
Joint pain and injury	Ankle sprains and fractures, knee ligament and meniscal injuries, shoulder dislocations and rotator cuff injuries, hip pain, Carpal Tunnel Syndrome, osteoarthritis, and overuse syndromes (eg, Achilles' tendinitis, patello-femoral pain syndrome, subacromial bursitis/ rotator cuff tendinosis)	Septic arthritis, acute compartment syndrome, acute vascular compromise associated with a fracture or dislocation	• Describe the difference between acute and overuse injuries. • Elicit an accurate mechanism of injury. • Perform an appropriate musculoskeletal examination.† • Apply the Ottawa decision rules to determine when it is appropriate to order ankle radiographs. (PBLI)	Detect a fracture on standard radiographs and accurately describe displacement, orientation, and location (eg, nondisplaced spiral fracture of the distal fibula).
Pregnancy (initial presentation)			• Recognize that many family physicians incorporate prenatal care and deliveries into their practices, and studies support this practice. • Recognize common presentations of pregnancy, including positive home pregnancy test, missed/ late period, and abnormal vaginal bleeding. • Appreciate the wide range of responses that women and their families exhibit upon discovering a pregnancy. (PR)	
Abdominal pain	Gastro-esophageal reflux disease (GERD), gastritis, gastroenteritis, irritable bowel syndrome, dyspepsia, constipation, and depression.	Appendicitis, diverticulitis, cholecystitis, inflammatory bowel disease, ectopic pregnancy, and peptic ulcer disease	• Recognize the need for emergent versus urgent versus non-urgent management for varying etiologies of abdominal pain.	
Common skin lesions	Actinic keratosis, seborrheic keratosis, keratoacanthoma, melanoma, squamous cell carcinoma, basal cell carcinoma, warts, and inclusion cysts		• Describe a skin lesion using appropriate medical terminology.	
Common skin rashes	Atopic dermatitis, contact dermatitis, scabies, seborrheic dermatitis, and urticaria		• Describe the characteristics of the rash. • Prepare a skin scraping and identify fungal elements.	
Abnormal vaginal bleeding			• Elicit an accurate menstrual history. • Recognize when vaginal bleeding is abnormal.	

(Continued on next page)

Table 3: (Continued)

Topic*	Common	Serious	Topic-specific Objectives	Additional Skills
Low back pain	Muscle strain, altered mechanics including obesity, and nerve root compression	Aneurysm rupture, acute fracture, infection, spinal cord compromise, and metastatic disease	• Describe indications for plain radiographs in patients with back pain. (PBLI)	Conduct an appropriate musculoskeletal examination that includes inspection, palpation, range of motion, and focused neurologic assessment.
Cough	Infectious (pneumonia, bronchitis, or other upper respiratory syndromes, and sinusitis) and non-infectious causes (asthma, GERD, and allergic rhinitis)	Lung cancer, pneumonia, and tuberculosis	• Understand how pretest probability and the likelihood of test results altering treatment can be used to guide diagnostic testing. (PBLI) Recognize pneumonia on a chest X ray.	
Chest pain	Gastrointestinal (eg, GERD), musculoskeletal (eg, costochondritis), cardiac (eg, angina and myocardial infarction), and pulmonary (eg, pulmonary embolism, pneumothorax)		• Describe how age and comorbidities affect the relative frequency of common etiologies. • Apply clinical decision rules that use pretest probability to guide evaluation. (PBLI) • Recognize the indications for emergent versus urgent versus non-urgent management for varying etiologies of chest pain.	Recognize cardiac ischemia and injury on an electrocardiogram (ECG).
Headache	Tension, migraine, and sinus pressure headaches	Meningitis, subarachnoid hemorrhage, and temporal arteritis	• Determine when imaging is indicated.	
Vaginal discharge			• Discuss the interpretation of wet prep and potassium hydroxide (KOH) specimens.	
Dysuria	Urethritis, bacterial cystitis, pyelonephritis, prostatitis, and vulvovaginal candidiasis			Interpret a urinalysis.
Dizziness	Benign positional vertigo (BPV), labyrinthitis, and orthostatic dizziness	Cerebral vascular disease (CVA), brain tumor, and Ménière's Disease		
Shortness of breath/ wheezing	Asthma, chronic obstructive pulmonary disease (COPD), obesity, angina, and congestive heart failure (CHF)	Exacerbations of asthma or COPD, pulmonary embolus, pulmonary edema, pneumothorax, and acute coronary syndrome		Recognize typical radiographic findings of COPD and CHF.
Fever	Viral upper respiratory syndromes, streptococcal pharyngitis, influenza, and otitis media	Meningitis, sepsis, fever in the immunosuppressed patient	• Describe a focused, cost-effective approach to diagnostic testing. (SBP) • Propose prompt follow-up to detect treatable causes of infection that appear after the initial visit. (SBP)	

(Continued on next page)

Table 3: (Continued)

Topic*	Common	Serious	Topic-specific Objectives	Additional Skills
Depression (initial presentation)			• Appreciate the many presentations of depression in primary care (eg, fatigue, pain, vague symptoms, sleep disturbance, and overt depression). • Use a validated screening tool for depression. (SBP) • Assess suicidal ideation. • Recognize when diagnostic testing is indicated to exclude medical conditions that may mimic depression (eg, hypothyroidism). • Recognize the role of substance use/abuse in depression and the value of identifying and addressing substance use in depressed patients. • Recognize the potential effect of depression on self-care and ability to manage complex comorbidities.	
Male urinary symptoms/ prostate			Select appropriate laboratory tests for a male patient with urinary complaints.	
Dementia			• Perform a screening test for cognitive decline (eg, the clock drawing test or the Mini-Mental Status Examination). • Select appropriate initial diagnostic tests for a patient presenting with memory loss, focusing on tests that identify treatable causes.	
Leg swelling	Venous stasis and medication-related edema	Deep venous thrombosis (DVT), obstructive sleep apnea, and CHF	• Recognize the need for urgent versus nonurgent management for varying etiologies of leg swelling, including when a Doppler ultrasound test for DVT is indicated.	

* Ordered from most to least common based on numbers of ambulatory care visits to primary care offices according to diagnostic groups, United States 2005–2006 (National Health Statistics Reports No.8, August 2008).

† Musculoskeletal examination to include inspection, palpation, range of motion, assessment of commonly injured structures (eg, ligaments of the ankle and knee, rotator cuff in the shoulder), and assessment of neurovascular integrity.

PBLI—problem-based learning and improvement, PR—professionalism, SBP—systems-based practice

CORE PRESENTATONS FOR CHRONIC DISEASES

The percentage of patients who have chronic diseases is large and increasing with the aging of the population. Care for patients with chronic diseases requires substantial health care resources. Family physicians provide a large proportion of this care, often coordinating this care among many types of subspecialists. Every student benefits from learning about chronic disease management. Important characteristics of chronic disease management provided by family physicians are shown in Table 4.

TABLE 4

Key characteristics of Chronic Disease Management by Family Physicians

Key characteristics of Chronic Disease Management by Family Physicians
Chronic disease management knowledge and skill
Attention to co-morbidities
Continuity context
Relationship with the patient
Patient empowerment and self-management support

An introduction to a Chronic Care Model, such as the one developed by Wagner, is appropriate for a third-year medical student. Wagner's model has six fundamental areas: self-management, decision support, delivery system design, clinical information system, organization of health care, and community. In this section, most objectives center around self-management and decision support.

KEY MESSAGES FOR CHRONIC DISEASE CARE

A similar approach can be applied to most chronic diseases. General components of this approach, appropriate for a third-year medical student, include diagnosis, surveillance, treatment, and shared goal-setting. Chronic disease management involves empowering patients to engage in their own care and working as the leader or member of a team of professionals with complementary skills such as nurses, physical therapists, nutritionists, and counselors.

Many patients have more than one chronic disease. In caring for these patients, continuity increases efficiency and improves patient outcomes. Similar to diagnosis in acute care, continuity allows the family physician to address multiple issues in stages. Students should understand, however, that a follow-up visit with a patient is different than the initial visit with a patient and also different from an acute problem visit.

Students should also learn that a therapeutic physician-patient relationship facilitates negotiation and improves physician and patient satisfaction and outcomes. Relationships with patients are rewarding.

CHRONIC DISEASE PRESENTATIONS- COMMON LEARNING ISSUES:

At the end of the clerkship, for each core chronic disease, students should be able to:

- Find and apply diagnostic criteria.
- Find and apply surveillance strategies.
- Elicit a focused history that includes information about adherence, self-management, and barriers to care.
- Perform a focused physical examination that includes identification of complications.
- Assess improvement or progression of the chronic disease.
- Describe major treatment modalities.
- Propose an evidence-based management plan that includes pharmacologic and non-pharmacologic treatments and appropriate surveillance and tertiary prevention.
- Communicate appropriately with other health professionals (e.g. physical therapists, nutritionists, counselors).
- Document a chronic care visit.
- Communicate respectfully with patients who do not fully adhere to their treatment plan.
- Educate a patient about an aspect of his/her disease respectfully, using language that the patient understands. When appropriate, ask the patient to explain any new understanding gained during the discussion.

(See Table 5 next page.)

TABLE OF CORE CHRONIC DISEASE PRESENTATIONS

(Reprinted from the Family Medicine Clerkship Curriculum with permission from the Society of Teachers of Family Medicine)

Table 5: Core Chronic Disease Presentations With Topic-specific Objectives

Topic*	Topic-specific Objectives
Multiple chronic illnesses (eg, depression, hypertension, hypothyroidism, type 2 diabetes mellitus)	• Assess status of multiple diseases in a single visit. • List important criteria to consider when prioritizing next steps for management of patients with multiple uncontrolled chronic diseases. • Document an encounter with a patient who has multiple chronic diseases using a SOAP note and/or chronic disease flow sheet or template.
Hypertension	• Take an accurate manual blood pressure. • Recognize the signs/symptoms of end-organ disease.
Type 2 diabetes mellitus	• Perform a diabetic foot examination. • Document an encounter using a diabetes mellitus flow sheet or template. (SBP) • Recognize the signs/symptoms associated with hypoglycemia or hyperglycemia.
Asthma/chronic obstructive pulmonary disease (COPD)	• Discuss the differences between asthma and COPD, including pathophysiology, clinical findings, and treatments. • Elicit environmental factors contributing to the disease process. • Recognize an obstructive pattern on pulmonary function tests. • Recognize hyperinflation on a chest radiograph. • Discuss smoking cessation.
Hyperlipidemia	• Determine a patient's cholesterol goals based on current guidelines and the individual's risk factors. • Interpret lipid laboratory measurements.
Anxiety	• Describe how an anxiety disorder can compromise the ability for self care, function in society, and coping effectively with other health problems.
Arthritis	• Guide a patient in setting goals for realistic control of pain and maximized function.
Chronic back pain	• Obtain a medication use history. • Anticipate the risk of narcotic-related adverse outcomes. • Guide a patient in setting goals for pain control and function.
Coronary artery disease	• Identify risk factors for coronary artery disease. • Use an evidence-based tool to calculate a patient's coronary artery disease risk. • Counsel patients on strategies to reduce their cardiovascular risks.
Obesity	• Obtain a dietary history. • Collaborate with a patient to set a specific and appropriate weight loss goal.
Heart failure (HF)	• List underlying causes of HF. • Recognize the signs/symptoms of HF. • Recognize signs of HF on a chest radiograph.
Depression (previously diagnosed)	• Assess suicide risk. • Describe the impact of depression on a patient's ability for self care, function in society, and management of other health problems.
Osteoporosis/osteopenia	• Recommend prevention measures.
Substance use, dependence, and abuse	• Obtain an accurate substance use history in a manner that enhances the student-patient relationship. • Differentiate among substance use, misuse, abuse, and dependence. • Discuss the typical presentations for withdrawal from tobacco, alcohol, prescription pain medications, and common street drugs. • Assess a person's stage of change in substance use/abuse cessation. • Communicate respectfully with all patients about their substance abuse. (PR)

* With the exception of multiple illnesses (unknown) and osteoporosis (estimate), these are ordered from most to least common based on numbers of ambulatory care visits to primary care offices according to diagnostic groups, United States 2005–2006 (National Health Statistics Reports No. 8, August 2008).

PR—professionalism, SBP—systems-based practice

HEALTH PROMOTION AND DISEASE PREVENTION

Health promotion is an essential component of every person's health care. Family physicians provide health promotion to all patients regardless of life stage or gender. Family physicians provide health promotion in at least three ways—during office visits for health promotion, during office visits for another purpose, and outside of office visits in other health care settings such as extended care facilities and hospitals and partnerships with community agencies or public health officials. Important characteristics of preventive care provided by family physicians are shown in Table 6.

TABLE 6

Characteristics of Preventive Care by Family Physicians
Evidence-based
Individualized
Opportunistic
Prioritized

KEY MESSAGES FOR PREVENTIVE CARE

There is an evidence base behind health promotion recommendations, but different organizations have different recommendations. The United States Preventive Services Task Force recommendations are the most appropriate for students to learn in the family medicine clerkship.

Each patient will have a unique combination of primary, secondary, and possibly tertiary prevention recommendations based on his/her risk factors and current diseases. In addition, patient preferences, time constraints, and variability in insurance coverage limit the ability to provide all recommended clinical prevention services for every patient. Creating an individualized health promotion plan requires a preventive medicine knowledge base and skills in negotiation and patient education. Family physicians are skilled in prioritization and must partner with patients to determine which preventive services are appropriate, important, and affordable.

It should be stressed that clinical prevention can be included in every office visit. Learning to "juggle," ie, prioritize or co-manage, acute, chronic, and prevention agendas, is an advanced skill.

ADULT PREVENTIVE CARE PRESENTATIONS- COMMON LEARNING ISSUES:

- Define wellness as a concept that is more than "not being sick."
- Define primary, secondary, and tertiary prevention.
- Identify risks for specific illnesses that affect screening and treatment strategies.
- For women: elicit a full menstrual, gynecological, and obstetric history.
- For men: Identify issues and risks related to sexual function and prostate health.
- Apply the stages of change model and use motivational interviewing to encourage lifestyle changes to support wellness (weight loss, smoking cessation, safe sexual practices, exercise, activity, nutrition, diet).
- Provide counseling related to health promotion and disease prevention.
- Discuss an evidence-based, stepwise approach to counseling for tobacco cessation.
- Find and apply the current guidelines for adult immunizations.
- For each core health promotion condition in Table 7, discuss who should be screened and methods of screening.
- Develop a health promotion plan for a patient of any age or either gender that addresses the core health promotion conditions listed in Table 7.

TABLE 7
Core Health Promotion Conditions for Adults
Breast cancer
Cervical cancer
Colon cancer
Coronary artery disease
Depression
Fall risk in elderly patients
Intimate partner and family violence
Obesity
Osteoporosis
Prostate cancer
Sexually transmitted infection
Substance use/abuse
Type 2 diabetes mellitus

WELL CHILD AND ADOLESCENT PREVENTIVE CARE PRESENTATIONS- COMMON LEARNING ISSUES:

- Describe the core components of child preventive care—health history, physical examination, immunizations, screening/diagnostic tests, and anticipatory guidance (see Table 8).
- Identify health risks, including accidental and non-accidental injuries and abuse or neglect.
- Conduct a physical examination on a child.
- Identify developmental stages and detect deviations from anticipated growth and developmental levels.
- Recognize normal and abnormal physical findings in the various age groups.
- Find and apply the current guidelines for immunizations and be able to order them as indicated, including protocols to “catch-up” a patient with incomplete prior immunization.
- Identify and perform recommended age-appropriate screenings.
- Provide anticipatory guidance based on developmental stage and health risks.
- Communicate effectively with children, teens, and families.

TABLE 8

Core Health Promotion Conditions for Children/Adolescents
Diet/exercise
Family/social support
Growth and development
Hearing
Lead exposure
Nutritional deficiency
Potential for injury
Sexual activity
Substance use
Tuberculosis
Vision

THE ROLE OF FAMILY MEDICINE

Family physicians provide the bulk of primary care in the United States. Primary care is undervalued in our health care system and underrepresented in many teaching settings. All students benefit from understanding the value that family physicians bring to a health care system.

KEY MESSAGES ON THE ROLE OF FAMILY MEDICINE

Health systems based on primary care, compared to those not based on primary care, have better medical outcomes, lower medical costs, improved access, and decreased health disparities.

Discussions about the value of primary care and the provision of primary care by family physicians can be incorporated into acute symptom, chronic illness, or prevention encounters. They can also be discussed separately. Many of these concepts are appropriately introduced in the preclinical curriculum and reinforced during clinical training.

THE ROLE OF FAMILY MEDICINE- COMMON LEARNING ISSUES:

At the end of the family medicine clerkship, students should be able to:

- Compare medical outcomes between countries with and without a primary care base.
- Compare the per capita health care expenditures of the United States with other countries.
- Discuss the relationship of access to primary care and health disparities.
- Describe the components of the Patient Centered Medical Home and its role in the future of primary care.