Rationale and discussion: course proposal for Introduction to Clinical Medicine I and Introduction to Clinical Medicine II, and the name change for Introduction to Clinical Medicine III

Brief Summary:

The course changes involve a change in sequencing and combining aspects of 3 courses in the first and second years of medical resulting in 2 separate courses and a name change of another course.

Proposed changes:

1. Combination of Patients, Physicians and Society I (MD 810), Patients, Physicians and Society II (MD 820), and parts of Patient-Centered Medicine (MD 815) into one course taught in the first-year called Introduction to Clinical Medicine I (ICM I).
2. Physical examination and the remaining components of Patient-Centered Medicine (MD 815) will be a separate course taught in the second-year called Introduction to Clinical Medicine II (ICM II)
3. The current second-year course Introduction to the Medical Profession (MD 821) will be virtually unchanged, but the name will be changed to Introduction to Clinical Medicine III (ICM III) to be consistent with the sequencing of the above 2 courses.

Background

Five years ago, the "afternoon curriculum" of first and second-year medical school featured courses that focused on clinical, social, and behavioral dimensions of medicine. These courses, (Healthy Human, Patients, Physicians and Society, Communication and Interviewing, Physical Diagnosis, Introduction to Medical Practice, and Clinical Decision Making) had been developed or modified during the Robert Wood Johnson Curriculum initiative that took effect in the early 90's. As the curriculum evolved, a type of gridlock had developed, in which students were participating in multiple small groups in multiple courses, limiting the amount of time available to engage in clinical experiences and active learning opportunities.

Three years ago, Patient Centered Medicine (MD815), was proposed and approved as a substantive revision of a portion of that curriculum. This course combined Healthy Human with Introduction to Medical Profession I. It created a single small-group course that featured "patient-centered care" as the central focus of the course, and incorporated early clinical exposure with concepts of normal growth and development, and introduction to communication and interviewing.

The first iteration of MD815 was taught three years ago. Despite logistical problems, there was general agreement that the course was an improvement over the previous organization. The second and third iterations of the course involved experimentation
with new course structures and pilot integration of PPS I (MD810) into the PCM framework. The proposed structure focuses on integrating clinical placements, on-line learning and small group seminar experiences across an entire academic year in a single course structure. Such a course allows the possibility for increased integration of material, innovation, and provides a platform for testing curricular development.

What we are proposing in this fourth iteration is a set of course revisions that move toward reorganization issues for the afternoon courses of the first and second year of medical school.

The following overall objectives formed the basis for the course structure and revisions described below.

Curricular:
- Promote development of life-long learning and thinking skills
- Promote development of students' critical thinking and writing skills
- Emphasize stage-appropriate competencies in line with ACGME competencies

Pedagogical:
- Maintain a true small group (8 student maximum) experience
- Balance in and out of classroom learning
- Focus in-class learning on integrative discussion or on specific skill learning
- Provide out of class clinical opportunities that are "applied laboratories"
- Provide an integrated longitudinal small-group experience over the first year of medical school arranged in one course structure to allow better integration and evolution.
- Improved sequencing of physical exam (from beginning of M1 to beginning of M2) when students have already completed anatomy and physiology and closer proximity to the physical diagnosis course (November M2 year).

Assessment:
- Make testing and assessment a positive teaching and learning exercise
- Focus on what students have learned (competencies) rather than on what they have been taught

General academic environment:
- Promote team and inter-professional awareness
- Provide opportunities for independent learning
- Provide a venue to teach others as well as to learn
- Provide incentives for service learning and leadership legacy activities
- Provide an interface for clinical and basic science integration

The courses (ICM I, II, and III) are part of the following plan:
• Merge the interviewing, growth and development elements, and Clinical-Decision Making of PCM and components of second year interviewing with PPS1 and PPS2, taught as one graded first year course, Introduction to Clinical Medicine (ICM I).
• Move the physical examination component of PCM to the second year as a stand-alone course (to be called Introduction to Clinical Medicine II (ICM II)).
• Keep IMP II (physical diagnosis) essentially the same, now renamed Introduction to Clinical Medicine III (ICM III).

HISTORICAL AND PROPOSED CREDIT HOUR OVERVIEW OF AFTERNOON COURSES

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Year One</td>
<td>Credit Hrs</td>
</tr>
<tr>
<td>IMP I</td>
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<td>7</td>
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<tr>
<td>Healthy Human</td>
<td></td>
<td>2</td>
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<tr>
<td>PPS I (MD810)</td>
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<td>4</td>
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<tr>
<td>Total hours=13</td>
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</tr>
<tr>
<td></td>
<td>Year Two</td>
<td>Credit Hrs</td>
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<tr>
<td>IMP II</td>
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<tr>
<td>Total YR 1 and 2</td>
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Legend for Course abbreviations:
IMP (Introduction to the Medical Profession)
ICM (Introduction to Clinical Medicine)
PPS (Patients, Physicians, and Society)

Course Overview Map for new ICM I: Allocation categories are listed not sequenced:

SMALL GROUP MEETINGS/WEEKS OF ASSIGNMENTS/ASSESSMENT:

The course is based on a nine month curriculum -- with 36 functional "weeks" or units apart from vacation breaks.

• 2 weeks of group or team development activities (Discovery interviews, simulator labs)
• 4 weeks with 2 hour small group meeting devoted to Foundational Interviewing Skills with standardized patients.
• 4 weeks of Interviewing labs (one hour lab experiences with multiple SPs providing repetition and feedback cycles to build skills.
• 1 week Basic Interviewing Assessment Practicum
• 2 weeks Pain, Suffering, and Healing
• 2 weeks Self-Care, Nutrition, and Health Promotion with one week on Obesity/Motivational Interviewing.
• 2 weeks Grief and Loss with one SP session on "Bad news" training
• 2 weeks Addictions with one SP on Alcohol/Motivational Interviewing
• 2 weeks of seminars on Developmental Pediatrics
• 2 weeks of Stress, Trauma, and Depression with one week of SP on challenging emotional issues with patients
• 1 week of Adolescence with sub-focus on focused sexual history skills
• 1 week of geriatrics with sub-focus on medication history/adherence skills counseling
• 2 weeks of clinical ethics/case discussions / with interviewing skills focus on
• 1 week DNR education and informed consent
• 2 weeks of shelf examination and OSCE and OSVE Competency Assessments
• 6 weeks allocated to independent learning

EXPERIENTIAL LEARNING:

• 6 half-days of placement in a practice or clinic setting
• 3 half- days of placement in a selective interprofessional clinical setting

REQUIRED INDEPENDENT LEARNING:

These are specific on-line links or blackboard based modules with assessments to demonstrate basic competency. Requirements amount to approximately 20 CME hour equivalents.

• Medical informatics
• Research ethics and clinical ethics
• Cultural and social aspect of health care competency
• Health Systems
• Health Psychology

16 ELECTIVE INDEPENDENT LEARNING:

• Medical Humanities (4 CME equivalent hours)
• 12 Elective independent learning credits (approximately 12 CME hours)
Credit Hour Calculation using contact hours/equivalents:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Contact Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture/large group</td>
<td>9 x 2 hours = 18</td>
</tr>
<tr>
<td>Small group seminar</td>
<td>25 x 2 hours = 50</td>
</tr>
<tr>
<td>INTVW practicum</td>
<td>4 x 1 hour = 4</td>
</tr>
<tr>
<td>Drexel on-line modules</td>
<td>15 x 1 hour = 15</td>
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<tr>
<td>Assigned on-line</td>
<td>20 x 1 hour = 20</td>
</tr>
<tr>
<td>Individual meeting</td>
<td>2 x .5 = 1</td>
</tr>
<tr>
<td>Clin. practicum 1 (Ice)</td>
<td>30 x 1 = 30</td>
</tr>
<tr>
<td>Clin. practicum 2 (SCE)</td>
<td>15 x 1 = 15</td>
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<tr>
<td>Written MCE</td>
<td>2</td>
</tr>
<tr>
<td>Elective On-line</td>
<td>20 x 1 = 20 = 175 Hours</td>
</tr>
</tbody>
</table>

This approximates 13 credit hours (13.11 by calculation)

Course Overview Map for new ICM II: Allocation categories are listed, not sequenced:

**PHYSICAL EXAMINATION**

**LECTURES**

<table>
<thead>
<tr>
<th>Core PE Lectures</th>
<th>Contact Time (hrs)</th>
</tr>
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<tbody>
<tr>
<td>General Appearance and Vital Signs</td>
<td>1</td>
</tr>
<tr>
<td>Skin exam</td>
<td>1</td>
</tr>
<tr>
<td>The Musculoskeletal Exam</td>
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</tr>
<tr>
<td>Cardiovascular Exam</td>
<td>1</td>
</tr>
<tr>
<td>Pulmonary Exam</td>
<td>1</td>
</tr>
<tr>
<td>Peripheral Vascular Exam</td>
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</tr>
<tr>
<td>The Abdominal Exam</td>
<td>1</td>
</tr>
<tr>
<td>The Pediatric Exam</td>
<td>1</td>
</tr>
<tr>
<td>The Geriatric Exam</td>
<td>1</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>1</td>
</tr>
<tr>
<td>ENT exam</td>
<td>1</td>
</tr>
<tr>
<td>Neurological exam</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total Core PE lectures:** 12

**Clinical Correlation Lectures**

<table>
<thead>
<tr>
<th>Clinical Correlation Lectures</th>
<th>Contact Time (hrs)</th>
</tr>
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<tbody>
<tr>
<td>Neck and back</td>
<td>1</td>
</tr>
<tr>
<td>The Shoulder &amp; Elbow Exam</td>
<td>1</td>
</tr>
<tr>
<td>Brachial plexus and forearm</td>
<td>1</td>
</tr>
<tr>
<td>Clinical correlation: Abdominal Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Cranial nerves</td>
<td>1</td>
</tr>
<tr>
<td>The Foot/Ankle Exam –</td>
<td>1</td>
</tr>
<tr>
<td>Clinical correlates ENT surgery</td>
<td>1</td>
</tr>
</tbody>
</table>
Total Clinical Correlation lectures 7

Review lectures
- Review for written exam 2
- Review for practical exam 2

Total Review Lectures 4

Small group/workshops
- Introduction, instruments, vital signs 1
- Musculoskeletal 2
- Pulmonary 1
- Cardiovascular 2
- Abdominal 1
- Peripheral vascular 1
- Neurological 2
- Eye 2
- ENT 1
- Regional approach 2
- Workshop with SPs 2

Total small group/workshops 17

Physical examination assessment
Multiple choice examination 2
Clinical skills assessment 2

Total Physical Examination Assessment 4

Total Physical Examination 44

HEALTHCARE COMMUNICATION

Healthcare communication lectures
Smoking cessation 1
Charts and progress notes 1
Case presentation 1
Team communication 1

Total Healthcare communication lectures 4

Healthcare communication workshops
Smoking cessation 1
Case presentation/note writing  2  
Team communication/simulator  2  

Total Healthcare communication workshops  5  
Healthcare communication assessment OSCE  2  

Total Healthcare communication  11  

PRACTICE AND SCIENCE OF MEDICINE  
Clinical and translational research lectures  6  
Preventive medicine lectures  2  
Patient safety/ Quality lectures  2  
Practice and science of medicine  2  
Take home examination  

Total practice and science of medicine  12  

Summary of contact time:  
Total Physical Examination  44  
Total Healthcare communication  11  
Total practice and science of medicine  12  

Total ICM II  67  

This equals 5 credit hours
Assessment Modalities, Quality assurance and quality improvement approaches:  
The following are Assessment Modalities used to demonstrate competencies:

**MCQ** – Traditional multiple choice question format (primarily in on-line Drexel interviewing assessments and other on-line CME packages).

**EMCQ**—Elaborated Multiple choice question format: Traditional framework with addition of requirement to “show your work”, to provide an explanation of why that response was chosen. Primarily to be used in the written examination at the end of the course, prior to the OSCE exam.

**DQ**: Discussion question. 1/2 page answers to discussion questions focused on specific topic areas, intended to foster higher-order learning objectives. Becomes part of student’s written portfolio. Also used in Drexel interviewing modules to complement MCQ questions.

**PORT**: Portfolio Entries: Journal entries, essays, and exercises related to the clinical practicum experiences, selected learning modules, and elective activities approved by preceptors that become part of the student’s portfolio.

**CME**: Continuing medical education certification documents used to assign credit for some on-line elective training modules (e.g., Medscape, and CITI NIH certification sites).

**LAB**: Coaching documents and self-assessments from the interviewing practicum experiences with standardized patients.

**OSCE**: Focused interactions with standardized patients to demonstrate specific skills.

**OSVE**: Response to video-taped patient situation triggers to demonstrate specific knowledge or skills.

Quality assurance processes include documentation of competencies through the above methods. Quality Improvement plans include standard course evaluations, focus groups with students, and intensive learning audits of selected course topics. Based on our current estimate of resources, we should be able to revise three areas, produce two prototype new learning experiences each year, and do a qualitative and quantitative coding of one course area, based on the following learning objectives map, an elaboration of the Bloom taxonomy. Our goal is to track the extent to which our students go beyond factual knowledge to conceptual knowledge and from cognitive process dimension of simple memory to application, analysis, evaluation, and creation of knowledge.

**Cognitive process dimension**

**Knowledge dimension**
APPENDIX 1: Behavioral Sub-Competencies for Basic Interviewing

A. Be able to conduct an effective interview with a clinic outpatient at a level appropriate to a third year medical student;

BASIC COMMUNICATION SKILL COMPONENTS; Assessed through interviewing LAB, VIDEO, and year-end OSCE:

1. Competently elicit the patient’s story of illness:
   a. Detailed delineation of symptoms
   b. Exploration of broader life setting in which symptoms occur
   c. Consider influence of family, social, and psychological factors

2. Express interest in and commitment to the patient
   a. Verbal Behaviors:
      o Introduce self; attend to physical comfort of patient;
      o elicit patient’s view of the problem, patient’s priorities,
      o elicit and discuss questions,
      o offer support, partnership, and respect.
   b. Non Verbal behaviors:
      o hand-washing if appropriate
      o maintain comfortable positioning,
      o appropriate touch
      o eye contact.

3. Facilitate communication;
   a. Verbal behaviors;
      o Allow patient to tell illness story
      o balance open and closed ended questions
      o use non-biasing questions
      o seek clarification
      o summarize periodically,
      o appropriate use of empathy
      o adopt nonjudgmental attitude.
   b. Non-verbal factors:
      o Arrange space relationships
      o nod and facilitate appropriately, adopt nonjudgmental attitude
      o positive regard
      o appropriate vocal tone.

4. Avoid Communication blocking behaviors
   a. Blocking Verbal Behaviors;
      o Use of technical language
      o biased phrasing
      o false or premature reassurance
      o refusing to talk about difficult topics
      o discounting or dismissing patient’s concerns
      o frequent interruptions.
   b. Blocking Non-verbal behaviors;
      o Disinterested posture
focus on notes/computer rather than on patient
  breaking eye contact inappropriately.

5. Assess contextual communication barriers (deafness, literacy, language, culture)

6. Summarize effectively for presentation to attending physician.

**Basic Communication: Knowledge base components; Assessed through Drexel module MCQ, examination EMCQ**

1. Understand the stages of an interview and their management;
   a. Opening
   b. Agenda Setting
   c. Characterization of present concerns and life setting
   d. Gathering History of present illness
   e. Medicine summary
   f. Gathering Family History
   g. Gathering Social History
   h. Appropriate Review of Systems
   i. Summary feedback
   j. Appropriate closing transition for 3rd yr Student

2. Understand the functions of the interview;
   a. Developing a working relationship
   b. Communicating interest and commitment
   c. Assessing and overcoming communication barriers
   d. Prioritizing concerns

3. Define and be able to cite appropriate use for types of questions;
   a. Open-ended
   b. Closed-ended
   c. Directive

4. Understand biasing characteristics of direct question structure

5. Understand dimensions of non-verbal behavior (patient and physician).

6. Differentiate between mechanistic, paternalistic, and collaborative dr/pt models.
Appendix 2  Drexel University Interviewing Program
This resource provides users with knowledge, skills review, and opportunities for reflection. It also fosters learning about complex communication and relationship challenges. Each of 40 learning modules presents key principles, evidence-based recommendations, and a skills checklist. Authors demonstrate key skills in video encounters with standardized patients and provide video and text commentary on the interview. The on-line assessment system uses both multiple-choice and open-ended discussion questions. Students complete these assessments and receive immediate feedback on the multiple choice questions, with explanations for each question. Responses to open-ended questions are also available to small group leaders, who can also respond on-line and have their feedback available to students.
There are 41 modules, approximating the Calgary-Cambridge Interviewing framework. All of the modules are available to our students:
Listing of Drexel Modules

01 Overview*
Geoff Gordon MD, Oregon Health & Science University, Portland

02 Mindfulness and Reflection in Clinical Training and Practice
Ronald Epstein MD, Rochester University

03 Therapeutic Aspects of Medical Encounters
David Brody MD, Dennis Novack MD, Drexel University College of Medicine, Philadelphia

04 Balance, Self-Care
John F. Christensen, Ph.D., Legacy Health System, Portland, Oregon

05 Integrated Patient-centered and Doctor-centered Interviewing - Structure and Content of the Interview*
Auguste H. Fortin VI, MD, MPH, Yale University; Francesca Dwamena, MD, Michigan State University; Robert C. Smith MD, ScM, Michigan State University

06 Build a Relationship*
Julian Bird, M.D Kings College, London; Steve Cole MD, SUNY, Stony Brook

07 Open the Discussion*
Beth Lown MD, Harvard University; Ron Saizow, University of Oklahoma

08 Gather Information*
Beth Lown MD, Harvard University

09 Understand the Patient’s Perspective*
Beth Lown MD, Harvard University

10 Share Information*
Beth Lown MD, Harvard University

11 Reach Agreement*
Beth Lown MD, Harvard University

12 Provide Closure*
Beth Lown MD, Harvard University

ADVANCED ELEMENTS

13 Responding to strong emotions*
Barry Egner MD, Legacy Health System, Portland, Oregon

14 It Goes without Saying: Nonverbal Communication in Clinician-Patient
Relationships*
Cecile A. Carson, MD; Jeannette M. Shorey II, MD, University of Arkansas Medical School

15 Understanding Difference and Diversity in the Medical Encounter: Communication across Cultures*
Calvin Chou MD PhD; University of California, San Francisco; Ellen Pearlman MD, New York University; Cathy Risdon MD, McMaster University

16 Promoting Adherence and Health Behavior Change*
Michael Goldstein MD, Brown University; F. Dan Duffy MD, U Oklahoma; Rob Shochet MD, Johns Hopkins University

17 Informed Decision-Making
Clarence H. Braddock III, MD, MPH, Stanford University

18 Exploring Sexual issues
Rich Frankel PhD, Indiana University; Elizabeth Edwardsen MD, Rochester University, Sarah Williams MD

19 Exploring Spirituality & Religious Beliefs
Shimon Waldfogel, Thomas Jefferson University

COMMUNICATING IN SPECIFIC SITUATIONS

20 Family Interview/
Kathy Cole-Kelly Case Western, Tom Campbell, Rochester University

21 Communication and Relationships with Children and Parents
Elizabeth Rider MSW, MD, Harvard University

22 The Adolescent Interview
Ken Ginsberg MD, Oana Tomescu MD, University of Pennsylvania

23 The Geriatric Interview*
Brent C. Williams, MD, MPH and James T. Pacala, MD, MS

24 Tobacco Intervention
Michael Goldstein MD, Brown University and Institute for Healthcare Communication, and Susan Swartz Woods MD, Oregon Health & Sciences University

25 Motivating Healthy Diet and Physical Activity*
Geoffrey Williams MD, Rochester University

26 Anxiety and Panic Disorder
Steven Locke MD, Harvard University

27 Communicating with Depressed Patients*
Steven Cole MD, SUNY, Stony Brook

28 Domestic Violence
Nielufar Varjavand MD and Dennis Novack MD, Drexel University

29 Alcohol: Interviewing and Advising*
William Clark MD, Harvard Medical School; and Sharon Parish MD, Albert Einstein College of Medicine

30 Drug Abuse Diagnosis and Counseling
Barbara A. Schindler, Drexel University College of Medicine, and Ted Parran MD, Case Western Reserve

31 Medically Unexplained Symptoms and Somatization
Francesca Dwamena, MD, Michigan State University; Felice Milan MD, Albert
32 **Advance Directives***
Robert Arnold MD, University of Pittsburgh, and Krista Hirschmann, PhD, Lehigh Valley Hospital Network

33 **Giving Bad News***
Timothy Quill MD, University of Rochester

34 **Communication near the End of Life***
Muriel Gillick MD, Harvard University

35 **Dialog about Unwanted Outcomes***
Peter Barnett MD, University of New Mexico

36 **Ending Doctor-Patient Relationships***
Peter Lichstein MD, Wake Forrest University

**COMMUNICATING WITH COLLEAGUES**

37 **The Oral Presentation***
Alicia Monroe, M.D. Brown University

38 **Communication on Healthcare Teams***
Cathy Risdon MD, McMaster University, Marla Rowe MD, Wayne State University, Zeev Neuwirth MD PhD, Harvard University, Anthony Suchman MD, Rochester University

39 **Talking with Impaired Physicians***
Peter Barnett MD, University of New Mexico

40 **Giving Effective Feedback: Enhancing the Ratio of Signal to Noise***
Burton Landau PhD, Drexel University College of Medicine

41 **Professionalism: Boundary Issues***

**Modules with an Asterisk are required modules for IMP1. Others are available for use as independent learning credits.**

**Edited sample Drexel Unit:**

Learning objectives, curriculum map, and assessment questions for Drexel Module #33 (Giving Bad News). By Timothy Quill, M.D., University of Rochester.

**At the conclusion of this module, learners will be able to:**

- Identify the six-step protocol for delivering bad news
- Name 4 ways of responding to the emotional response of a patient receiving bad news, and give an example of each
- Name 4 common barriers or pitfalls in delivering bad news
- Demonstrate the ability to deliver bad news using the six-step protocol

**Key Principles:**

- Communicating bad news is a core clinical skill.
Bad news is defined by the person receiving the news.

The way bad news is delivered has a powerful impact on the clinical relationship.

The way bad news is delivered will always be much affected by the feelings of providers (often negative) and by their competence (often lacking) in responding to the reactions of their patients’.

Knowing the framework for communicating bad news allows providers to attend to the patient’s

### Relevant verbal behaviors

- Ask what the patient and family already know and what they expect.
- Ask before telling.
- Use a “warning shot;” such as, “I do not have good news.”
- Use simple, straight-forward language.
- Say it, then stop and listen.
- Give the patient and family time to respond to each piece of information.
- Acknowledge, legitimate, and explore strong emotion before reassuring or moving on
- Describe a range of time when communicating prognosis; allow for exceptions
- Establish a concrete plan for immediate next steps.
- Reassure the patient and family that they are not being abandoned.

### Relevant non-verbal behaviors

Be prepared

- Find a private space and uninterrupted time
- Sit down, shake hands, and check in with patient and family
- Listen carefully to the verbal responses, and watch carefully the nonverbal responses
- Allow silence.

### POTENTIAL PITFALLS

- Delivering news in a noisy public place. Find a quiet, private location.
- Turn off your pager. Avoid other interruptions.
- Using imprecise language to soften the blow leading to incomplete understanding
- Too much information in the early going, with too little attention to emotional responses
- Physicians talk too much when they are nervous or uncomfortable. Allow silence.
- Avoid being overly optimistic or overly pessimistic; patients and families usually value truthfulness with compassion
- Communicating news over the telephone. Avoid if possible unless the patient or family is prepared ahead of time

SAMPLE SCREEN SHOT FROM MODULE 33.
Sample MCQ Exam Feedback: Sample of 5 questions from assessment

Before giving bad news, you should do all of the following except:

- Ask the family if it is okay to tell the patient
- Confirm the medical facts of the case
- Find a private place with adequate seating
- Identify people who should be present for support

Unless there are circumstances when a patient might not be able to comprehend the news (children, developmentally disabled, cognitively disabled), patients generally should be given the news without asking the family if it is okay. In pre-test counseling, it is useful to ask the patient how he or she would like to get the news if it is likely to be adverse. There are some cultures where families are told and the patient is not, and this needs to be explored and adapted to when present. Items 2-4 are all part of routine preparation.

Question 2

An example of a useful opening statement when discussing bad news is:

- I never give up on my patients
- Tell me what you understand about your illness
- Your cancer is incurable
- You must always have hope
It is always wise to start with the patient’s perspective, and to try to build whatever additional information you have on what the patient already knows. Sometimes the patient has already been told the bad news, and other times he or she may not have a clue. The other statements would not be opening statements. Statement 3 is too blunt, and 1 and 4 might be said at some point depending on the context, but not as an opening statement.

**Question 3**
Before delivering bad news, it is important to find out how much a person wants to know because

- limiting the information that you discuss reduces your legal liability.
- some patients prefer to designate a family member to receive information
- you can save time by avoiding lengthy discussions
- you are only obligated to give information that is specifically requested

If a patient specifies that he would not want to get bad news himself, why he feels that way should be explored and understood, but ultimately respected. There is no evidence that limiting information limits legal liability. There is evidence that most patients will not retain a lot of detailed information in the early going, so it is wise to follow the patients lead as to the amount of information that is desired.

**Question 4**
Which of the following is the best example of a “warning shot” to quickly prepare a patient to receive bad news?

- I have some bad news
- I have your test results
- You must have a lot of questions
- The biopsy showed cancer

A “warning shot” lets the patient know that something is coming that is “bad”. Statement 2 might be used before statement 1, but statement 1 leaves little doubt as to the realm the following information will be in. Statement 4 might then follow statement 1, as a clear articulation of the problem, and statement 3 might follow later in the interview.

**Question 5**
Which one of the following is the best way to give a new cancer diagnosis?

- The biopsy appears to show cancer
- The biopsy showed that you have cancer
- The biopsy was malignant
- The biopsy was positive for a malignant tumor

When delivering bad news, it is useful to use clear, unambiguous language that cannot be easily misinterpreted. Words like “tumor” are not clear enough, and words like “malignant” are too medicalized for most patients. If we try to soften the blow as in statement 1, which hedges on the certainty (eg “appears” instead of “showed”), the patient may not understand how clear the diagnosis is.

**Discussion Question 2:**
Choose the question from below that you find most compelling and write, in one or two paragraphs, your thoughts in answer to the question. Be sure to reference the number of the
question that you are answering.

1. How do you feel when you need to tell someone bad news?
2. What have been your reactions or your family’s reactions when you have heard bad news in the past?
3. What might the bearer of bad news do to help you hear it?
4. In thinking about the communication of bad news, what makes it go well? What makes it go poorly? From whose standpoint are you answering this question?
5. How can you take care of yourself while attending to the needs of your patient and his or her family when delivering bad news?
Appendix 3

Longitudinal Clinical Experience (LCE):

• **Introduction:**
  During the LCE you will spend 6 afternoons with a doctor in his/her clinical practice. These doctors are either UK clinical faculty or UK community-based faculty members who have volunteered to host a first-year student in their practices. Experience in a clinical setting allows students to begin to apply and integrate their knowledge of basic science and to observe the process of care and the role of ethical and social issues in medicine.

• **The goals of the LCE are as follows:**
  o To gain broader perspectives on the practice of clinical medicine and the role of other health professionals.
  o To observe and interact with physician role models and patients.
  o To practice/observe interviewing skills
  o To understand the knowledge, skills, and attitudes required to successfully practice medicine in today’s health care environment.

• **Logistics for the LCE:**
  You will be assigned to a physician. The site of the physician's practice, and the nature of that practice will vary. You will be given a listing of every student's placement. **If you want to trade with one of your classmates you may do so, but Stephanie King Bays will need to know a final listing by Wednesday 11/12 at noon.** Timing of visits is dependent on the practice site.

• **What students are required to accomplish during the LCE:**
  • Make six visits to the practice.
  • Complete a Learning Log for your portfolio with a reflective entry for each visit
  • Complete a patient write-up for one patient
  • Complete one short (1-2 page) essay of your choice
  • Complete one short-answer evaluation form for your portfolio
  • Six visits to the practice.

• **The Learning Log for the LCE:**
  A learning log entry must be made for each LCE visit, describing your experiences and observations that day.
  o **Purpose:**
    The learning log is a communication tool intended to document what you have learned and what questions you may have. You are the primary audience for your learning log. It will also be reviewed by your small group facilitator and discussed with you. It is basically your “notes” about what you observed. In addition, you will be discussing aspects of the LCE in your small groups. The learning log will be a useful resource for your discussions. Sharing your experiences, observations, and thoughts will be very valuable to the rest of the group.
  o **Writing Tips:**
    The learning log is a recording of your personal observations, thoughts, questions, and answers to some of the questions. The following suggestions may serve as a guideline.
    ▪ What did you observe and experience?
    ▪ What was the most impressive and/or important to you?
    ▪ What were your thoughts, feelings or personal reactions?
    ▪ What questions do you have?

• **How to keep a learning log:**
  ▪ Make an entry for every LCE encounter
  ▪ Date each entry
  ▪ Write as soon as possible following your experience
  ▪ Develop your thoughts more than just a cursory listing of events?
• **Patient write-up for the LCE:**
  Use your most interesting patient encounter and create a patient write up for that patient similar to what you would do in third year:
  - Chief Complaint
  - History of Present Illness
  - Prior Medical History
  - Family History
  - Social History
  - Review of Systems
  - Assessment and Plan.

• **Essay Topics for LCE:**
  The essays are assigned to allow you to personalize and develop the one or two most interesting or meaningful aspects of the clinical experience. Here is a list of potential essay topics. You are not required to use these topics; they are just suggestions.
  Tips on how to write these questions are in a separate document that will be sent to students and posted on blackboard.
  1. Patient's perspective interview
  2. What is a good doctor?
  3. The role of religion or spirituality in medicine
  4. The patient-physician relationship
  5. The office visit experience
  6. The physician as a person
  7. Critical Incident
  8. Ethical issue(s)
  9. Role of “self” in the practice of medicine
  10. Rural medicine
  11. Professionalism in practice
  12. Complementary or alternative medicine
  13. Healthcare disparities
  14. Health literacy

• **Short-answer questions for LCE:**
  Please respond in your portfolio to all of the questions listed below after you finish your 6 LCE visits. One or two line responses are adequate.
  1. My most rewarding experience during the LCE
  2. The most difficult encounter (patient or otherwise)
  3. The most important thing I learned about patients
  4. The most important thing I learned about being a physician
  5. The most important thing I learned about the health care system
  6. The most important thing I learned about myself
  7. The most important barrier your LCE physician faces in providing effective health care today
Appendix 4: Selective Clinical Experiences

A catalog of clinical selective experiences is offered to students, and a match process tries to maximize the student's preferences. Listed below is the overall catalog index and a sample of one of the descriptions of the clinical sites.

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Experience #1

Bluegrass Farm Worker Health Center
1306 Versailles Road, Suite 120
Lexington, KY

Goal: The general goal for these clinical experiences is for students to have an opportunity in a variety of clinical settings to learn about the illness experience of patients and families and to interact with the clinical team and the families as the health condition is addressed. In this experience, students will have the opportunity to work in a clinic setting focused on the delivery of health care to migrant and non-migrant Hispanic patients in our area. Students with Spanish language skills may also elect an experience as an interpreter in the clinic for other students. It is possible to place a limited number of students without Spanish language skills in the clinic through the use of interpreters.

I. Qualification(s):
   A. Membership in first or second year of UK College of Medicine
   B. No prior work/volunteer experience with this clinic.

II. Logistics:
   A. Three visits to the clinic over a period of 3-4 weeks, with each lasting several hours.
      Appropriate clinic hours:
      M-F: 4:00-7:00
      Sat: 9:00-1:00
   B. Responsible for own transportation.

III. Requirements:
   A. Prior to clinic visits:
      1. Visit clinic web site and become acquainted with the history and mission of this clinic and the demographics and health needs of populations it serves.
      2. View DVD Beyond the Border. (Dr. Wiese)
      3. View Communicating through an Interpreter (Dr. Wiese)
      4. Review major current immigration laws for this population.
      5. Read Title VI of the 1966 Civil Rights Act.
   B. At the clinic:
      1. Interview patient/family
         a. Take a Chief Complaint and History of Present Illness
         b. What does the patient believe is causing the problem?
         c. What the patient hopes will happen at this visit.
         b. Learn about the impact of this condition on daily life
      2. Sit in on actual physician/patient consultation
      3. Interview a patient/family on a “follow-up” visit
         a. How is the condition changing?
         b. How is it affecting daily life?
         c. Any problems taking care of the condition at home?
IV: Objectives:
At the end of this experience, the student will:
A. Know the basic demographics of the various cultural groups represented in the “Hispanic” populations, both migrant and non-migrant, of both Central Kentucky and the US in general
   1. What are the various cultures represented in the “Hispanic” population of Lexington?
   2. How these populations are similar and how they differ, i.e., reasons for immigrating, experiences along the way, continuing threats once here.
B. Know the special health needs of this population.
C. Understand the ripple effects of current immigration laws.
D. Understand the barriers created by culture and language issues.

V. Final product
   1. Log of experiences and thoughts for each visit in portfolio
   2. One or two page essay on what she or he found to be the important learning issues from this experience.