



Longitudinal Integrated Clerkship Learning Objectives

Presenting Symptom or Concern (acute or initial presentation): Insert Condition Here (e.g. Chest pain)

- History and Physical: Perform an appropriate medical history and physical examination of a patient with an acute or chronic symptom.
- Medical Knowledge: Outline the common etiologies, epidemiology, pathophysiology, natural history, and sequelae of a patient with an acute or chronic symptom.
- Clinical Reasoning: Interpret clinical information to formulate a prioritized differential diagnosis of a patient with an acute or chronic symptom.
- Illness Acuity and Severity: Identify the acute and/or severe conditions for a patient with an acute or chronic symptom.
- Diagnostic Work-up: Justify an evidence-based and cost-effective approach to the diagnosis of an acute or chronic symptom.
- Treatment: Outline the initial and subsequent treatment plan for a patient with an acute or chronic symptom.
- Oral Presentation: Present concise, thorough, and accurate patient findings including information, justification for the diagnosis, and a clear management plan of a patient with an acute or chronic symptom.
- Documentation: Document a medical encounter of a patient with an acute or chronic symptom.
- Patient Communication: Demonstrate a culturally mindful, patient-centered approach to information exchange and decision making, using appropriate and respectful language understandable by the patient/family.

Cross references to the “Presenting Symptom or Concern” set of the Required Experiences, Skill, and Procedures List”.

Acute Abdominal Pain	Dyspnea/Respiratory Distress	Overdose
Altered Mental Status	Edema	Pain, Chronic
Altered Mood	Failure to Thrive	Perianal Problem
Arthralgia	Fertility and Associated Problems	Red Eye
Back Pain	Fever	Sexual Dysfunction
Breast Problem	Gastrointestinal Bleed	Trauma, Multisystem
Chest Pain	Headache	Vaginal bleeding
Constipation	Heart Murmur	Vaginal discharge
Cough	Incontinence	Vomiting
Dehydration	Jaundice	Weakness/Hypotonia (generalized and focal)
Diarrhea	Liver Abnormality	Wounds/Ulcers
Dizziness/Syncope	Mass Evaluation	

Acute Condition: Insert Condition Here (e.g. Fracture Extremity)

- History and Physical: Perform an appropriate medical history and physical examination of the patient with an acute medical condition.
- Medical Knowledge: Outline the common etiologies, epidemiology, pathophysiology, natural history, and sequelae of a patient presenting with an acute medical condition.



- Clinical Reasoning: Interpret relevant clinical information to formulate a prioritized differential diagnosis of an acute medical condition.
- Diagnostic Work-up: Justify an evidence-based and cost-effective approach to the diagnosis of an acute medical condition.
- Treatment: Outline the initial and subsequent treatment/management plan for an acute medical condition.
- Oral Presentation: Present concise, thorough, and accurate patient findings orally including information, justification for the diagnosis, and a clear management plan of an acute medical condition.
- Documentation: Create appropriate documentation of an encounter for a patient with an acute medical condition.
- Patient Communication: Demonstrate a culturally mindful, patient-centered approach to information exchange and shared decision making, using appropriate and respectful language understandable by the patient/family.

Cross references to the “Condition or Diagnosis” set of the Required Experiences, Skill, and Procedures List” when patient presents with a *new, acute, or decompensating* diagnosis.

Abuse/Neglect	Dementia	Neurodevelopmental Disorders
Acid Base Disturbance	Depressive Disorders	Obesity
Anemia	Dermatoses	Obstructive Pulmonary Disease
Anxiety Disorders	Eating Disorders	Osteoporosis
Arrhythmia	Electrolyte Disorder	Personality Disorder
Arthritis	Fracture, Extremity	Pregnancy Complications
Attention Deficit Disorder/ADHD	Genitourinary Infections	Sepsis
Blood Pressure, High	Heart Failure	Soft Tissue Infection/Abscess
Blood Pressure, Low and Shock	Hepatico-Pancreatico-Biliary disease	Substance Use/Withdrawal
Cancer/Malignancy	Hernia	Thyroid Disorders
Carbohydrate Metabolism Disorder (included Diabetes)	Hyperlipidemia	Trauma-related Psychiatric Disorders
Cerebrovascular Disorders	Kidney Disease	Upper Respiratory Infection
Chronic Back Pain	Lower Respiratory Tract Infection	Venous Thromboembolism
Congenital Disease (Genetic, Syndrome, etc)	Malnutrition	Vision Disturbance
Coronary Artery Disease	Neonatal Complications	

Chronic Condition: Insert Condition Here (e.g. Carbohydrate Metabolism Disorder (including Diabetes Mellitus))

- History and Physical: Perform a problem-focused medical history and physical examination relevant to a chronic condition that includes information about adherence, self-management, barriers to care, identification of complications, and improvement or progression of a chronic medical condition.
- Treatment: Interpret clinical information to formulate an evidence-based, compassionate, appropriate and cost-effective treatment/management plan with the appropriate surveillance, and considering secondary and tertiary prevention options for the patient with a chronic medical condition.



- Interprofessional Collaboration: Demonstrate appropriate information exchange and collaboration with other health professionals to support and implement a care plan for a patient with a chronic medical condition.
- Patient Communication: Demonstrate a culturally mindful, patient-centered approach to information exchange and decision making, using appropriate and respectful language understandable by the patient/family.
- Oral Presentation: Present concise, thorough, and accurate patient findings orally, including pertinent information and a clear management plan of a chronic medical condition.
- Documentation: Document a medical encounter of a patient with a chronic medical condition.

Cross references to the “Condition or Diagnosis” set of the Required Experiences, Skill, and Procedures List” when patient presents with a *chronic* diagnosis in follow-up.

Abuse/Neglect	Dementia	Neurodevelopmental Disorders
Acid Base Disturbance	Depressive Disorders	Obesity
Anemia	Dermatoses	Obstructive Pulmonary Disease
Anxiety Disorders	Eating Disorders	Osteoporosis
Arrhythmia	Electrolyte Disorder	Personality Disorder
Arthritis	Fracture, Extremity	Pregnancy Complications
Attention Deficit Disorder/ADHD	Genitourinary Infections	Sepsis
Blood Pressure, High	Heart Failure	Soft Tissue Infection/Abscess
Blood Pressure, Low and Shock	Hepatico-Pancreatico-Biliary disease	Substance Use/Withdrawal
Cancer/Malignancy	Hernia	Thyroid Disorders
Carbohydrate Metabolism Disorder (included Diabetes)	Hyperlipidemia	Trauma-related Psychiatric Disorders
Cerebrovascular Disorders	Kidney Disease	Upper Respiratory Infection
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Health Promotion and Prevention: Insert Topic Here (e.g. Patient Safety Assessment)

- History and Physical: Perform a complete (or problem-focused when applicable) medical history and physical examination appropriate to age, gender and reproductive status of the patient that incorporates all Health Promotion and Prevention elements necessary for the care of a patient.
- Medical Knowledge: Define the necessary elements for the delivery of patient care used in clinical practice to promote wellness.
- Patient Communication: Demonstrate a culturally mindful, patient-centered approach to information exchange, decision making and counseling, using appropriate and respectful language understandable by the patient/family considering the age, gender and reproductive status of the patient, applying where appropriate the Stages of Change model and motivational interviewing.
- Oral Presentation: Present concise, thorough, and accurate provision of care orally, including communication of a clear management plan, for a Health Promotion and Prevention encounter.
- Documentation: Document a medical Health Promotion and Prevention encounter.



- Evidence-Based Care: Describe current controversies related to the delivery of certain aspects of Health Promotion and Prevention care, appraise the merits for providing care, and apply a rational approach to clinical practice based upon these merits.
- Disease Prevention: State the morbidities that may be prevented by providing Health Promotion and Prevention care.

Cross references to the “Health Promotion and Disease Prevention” set of the “Required Experiences, Skill, and Procedures List”.

Anticipatory Guidance, Pediatrics
Developmental Assessment
End of Life Care
Family Planning
Perinatal Counseling
Peri-operative Counseling
Patient Safety Assessment
Screening for Disease Risk Factors
Vaccinations
Wellness Education

Procedures: Insert Procedure Here (e.g. Arthrocentesis/Joint Injection)

- Procedural Knowledge: List the patient-specific factors, associated equipment, indications, contraindications, risks, benefits, alternatives, and complications of a clinical procedure.
- Informed Consent: Demonstrate a culturally mindful, patient-centered approach to information exchange with the patient and family using understandable, respectful language to ensure shared decision-making and informed consent, including their understanding of the indications, risks, benefits, alternatives, potential complications and adverse events, both short term and long term, of a clinical procedure, while encouraging the patient and family to ask questions.
- Procedural Skills: Demonstrate the necessary preparation and manual skills required for level-appropriate performance of a clinical procedure.
- Self-Awareness: Identify circumstances or situations beyond the learner's knowledge/abilities.
- Patient Safety: Demonstrate the use of universal precautions, aseptic technique, and use of procedural checklists (including safety time-outs and team-based protocols) when appropriate for a clinical procedure.
- Documentation: Prepare appropriate documentation pertaining to the discussion of informed consent, procedural indications, findings, technique, and disposition for a clinical procedure.
- Patient Communication: Demonstrate a culturally mindful, patient-centered approach to information exchange and decision making, using appropriate and respectful language understandable by the patient/family, while encouraging them to ask questions.

Cross references to the “Procedures & Skills” set of the “Required Experiences, Skill, and Procedures List”.



Airway Management (including pre-anesthesia assessment)	Incision and Drainage
Arthrocentesis/Joint Injection	Injections (SC, IM, IV push, Intradermal PPD)
Anorectal Exam, Digital	Lumbar Puncture
Arterial Puncture	Nasogastric Tube Insertion
Biopsy of Lesion of Integumentary System	Regional Anesthesia
Blood Product Administration	Surgery, Open
Cardiopulmonary Resuscitation (CPR)	Surgery, Minimally Invasive
Cast/Splint	Suture Laceration/Wound Repair
Cryodesiccation of Lesion of Integumentary System	Urinary Catheter Insertion and Removal
Electrocardiogram	Vaginal Delivery
Endoscopy	Venipuncture/Intravenous Insertion (IV)

Skills (interpretation and counseling): Insert Skill Here (e.g. Fluid Assessment)

- History and Physical: Describe the medical history and physical examination elements relevant to performance of a skill.
- Medical Knowledge: List relevant components to the performance of a skill and illustrate how findings, and comparative studies or examinations guide management.
- Documentation: Document findings, interpretation and conclusions of the performance of a skill.
- Patient Communication: Demonstrate a culturally mindful, patient-centered approach to information exchange with the patient and family using understandable, respectful language to ensure shared decision-making and informed consent, including their understanding of the indications, risks, benefits, alternatives, potential complications and adverse events, both short term and long term, of performance of a skill.
- Challenges: Describe specific challenges unique to performance of a skill and explain how to overcome these challenges.

Cross references to the “Procedures & Skills” set of the “Required Experiences, Skill, and Procedures List”.

Blood Gas Interpretation	Motivational Interviewing
Airway Management (including pre-anesthesia assessment)	Newborn Examination
Anorectal Exam, Digital	Oral Presentation
Breast Exam	Ophthalmic Exam
Cardiopulmonary Resuscitation (CPR)	Otoscopic Exam
Chest X-Ray Interpretation	Comprehensive Pelvic Exam
Cognitive Assessment	Physical Exam, Observed and Evaluated
Electrocardiogram	Post-operative Wound Assessment
Fluid Assessment	Psychiatric Interview
History-Taking, Observed and Evaluated	Screening for Occult Gastrointestinal Bleeding
Labor Assessment	Urine Dipstick
Measure and Plot Growth, Pediatric	Wound Care
Meter-Dose Inhalation	