UCF College of Medicine

UNIVERSITY OF CENTRAL FLORIDA

COMMUNITY OF PRACTICE 2

(2017) UCF by Suhtling Wong-Vienneau

2017-18

PRECEPTOR MANUAL


UCF
College of
Medicine
UNIVERSITY OF CENTRAL FLORIDA

Welcome back to Community of Practice-2!

Thank you for all your support to Community of Practice and confirming your COP-2 participation for the 2017-18 academic year!

We are looking forward to another successful year, giving our students the opportunity to work in an authentic clinical setting that will promote their professional identity formation and hone their clinical skills while working with real patients under your supervision.

As we launch the 2017-18 academic year, we would like to make you aware of a few changes that will take place this year in COP-2:

1. **Your assigned students will keep you as their preceptor for the entire 8 COP sessions.** We will no longer split the year in blocks so your assigned students will remain with you throughout the entire M2 academic year (early September through Mid-March). Hopefully, this will promote a stronger preceptor-student relationship and learning continuity.

2. **From the beginning your assigned students will be provided "suggested weeks" throughout their academic year to help them secure COP sessions early.** However, they will still be asked to work with you to find other mutually-feasible dates/times if those weeks provided cannot fit your busy schedule.

3. **Students will expect an informal face-to-face feedback evaluation around their 4th session (prior to the Thanksgiving Holiday) in relation to their professionalism.** Closer to that time we will provide you via email a professionalism guide and online link to provide us mid-year feedback on any issues or concerns you may have of a student.

4. **Students will not rotate through a hospice or palliative care site.** Regretfully, while we are aware of the value these early experiences add to our students' education, we are not able to offer them this year. We hope to be positioned to offer students these opportunities again in the future.

Please know that your time and commitment to our educational program are deeply valued and appreciated.

Best regards,

Analía Castiglioni, M.D.
COP-2 Co-Director

Caridad Hernández, M.D.
COP-2 Co-Director

Table of Contents

Contact Information

Medical Education Building
6850 Lake Nona Blvd.
Orlando, FL 32827
407-266-1100
www.med.ucf.edu
Office Hours: Monday – Friday, 8 a.m. – 5 p.m.

Analía Castiglioni, MD
Community of Practice 2,
Director
analia.castiglioni@ucf.edu

Caridad Hernández, MD
Community of Practice-2,
Co-Director
caridad.hernandez@ucf.edu

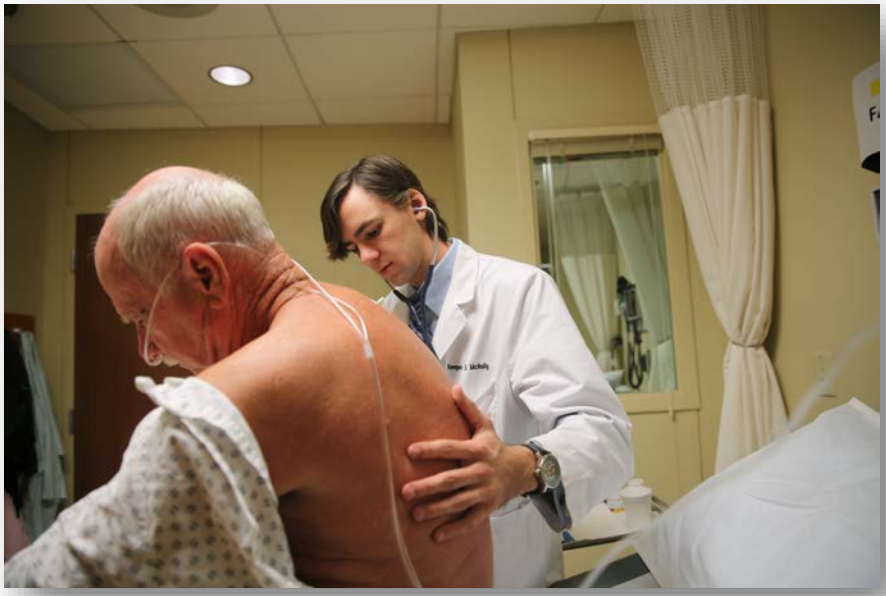
Abnel Rodríguez-Castro
Community of Practice 1 & 2,
Coordinator
abnel@ucf.edu
407-266-1160

Kim Martinez
Practice of Medicine 1 & 2,
Coordinator
kim.martinez@ucf.edu
407-266-1156

Andrea Berry
Faculty Development,
Director
Andrea.berry@ucf.edu
407-266-1115

Monica Bailey
Faculty Development,
Assistant Director
monica.bailey@ucf.edu
407-266-1120

(2017) UCF by Suhtling Wong-Vienneau



(2016) UCF by Suhtling Wong-Vienneau

"Have a heart that never hardens, a temper that never fires, and a touch that never hurts."
- Charles Dickens (1812-1870)

I. Practice of Medicine-2 (P-2) Module Overview

The aim of the Practice of Medicine continuum is to ***prepare students for the clinical aspects of medicine*** including doctor-patient communication, medical interviewing and physical examination skills while also taking into consideration the psychosocial influences that impact the clinical encounter.

The P-2 module builds upon physical examination and medical interviewing skills learned in the P-1 module. Key areas of learning include advanced oral presentation and medical documentation skills, development of basic clinical decision-making and application of selected diagnostic tests. Integration with the Systems (S) modules highlights the link between foundational knowledge and clinical practice while promoting intellectual curiosity, self-directed learning and clinical reasoning skills.

P-2 module instructional activities incorporate a variety of modalities to promote skill acquisition and mastery. These include interactive presentations, small group sessions, student-directed independent learning tasks and Clinical Skills and Simulation Center (CSSC) exercises. As in P-1, the CSSC provides the setting for student encounters with Standardized Patients (SPs), high-fidelity simulators and task trainers as well as web-based activities for the learning, practice and assessment of clinical skills.

Figure on Left. "Graduation cap and textbooks" (Unknown) *123RF.* http://www.123rf.com/photo_334796_graduation-cap-and-textbooks.html

Figure on Right. "Blood Pressure" (Unknown) *HealthMED.* http://healthmedinc.org/wellness-solutions/health-screenings/

II. P-2 Community of Practice Program

The Community of Practice-2 (COP-2) program, a key component of the Practice of Medicine-2 (P-2) module, consists of a longitudinal clinical experience that provides students with an authentic clinical context to promote deeper learning, professional identity formation, and adoption of the values of the profession. These early, immersive, and participatory clinical experiences help students to contextualize foundational knowledge and hone their clinical skills while working with real patients under the supervision of a practicing physician. Students also gain an understanding of the complexities of physicians' work and the distributive nature of learning and knowledge.

COP-2 Clinical Setting: COP-2 clinical experiences take place in either an acute (inpatient wards, emergency room, urgent care) or long-term care setting (nursing home, skilled nursing facility, etc.). Students are randomly assigned to a preceptor in either setting to complete a **total of 8 sessions throughout the academic year.** These sessions will have specific learning objectives and requirements for the students.

Student pairs: In COP-2 students are grouped in pairs. A student-pair constitutes the student-unit used to facilitate scheduling and preceptor assignments throughout the year. A student pair will complete all clinical sessions together and will use the benefits of peer support and feedback when interacting with patients and families. Even though students are assigned to preceptors in pairs, it is at the discretion of preceptors to assign patients individually or to the pair of students depending on setting, patient availability and other time and physical constraints. When seeing a patient as a pair, students will take turns in interviewing and examining patients, but will be expected to ***complete their assignments individually***. Even if based on shared patient notes, the History and Physical write-ups (H&Ps) and narrative reflection should reflect the individual work of each student.

COP-2 Evaluation: During COP-2 all students are expected to adhere to the UCF Honor Code and Guidelines of Professional Conduct as found online at https://med.ucf.edu/media/2012/08/UCF-COM-Honor-Code-2014-20151.pdf. Halfway through the year, students should receive formative, face-to-face feedback from their preceptor on professionalism and overall performance based on the expectations of the Community of Practice program (attendance, timeliness, professionalism, etc.). At the end of the year, preceptors evaluate students utilizing the Preceptor Evaluation of

Student Professionalism form that is found at the end of this manual. The COP-2 preceptor evaluation counts towards the final P-2 grade.

III. COP-2 Specific Goals and Learning Objectives

1. Interview patients (complete and problem-focused histories)
2. Practice physical examination skills (both complete and problem-focused)
3. Observe and provide acute and chronic care to patients
4. Observe the social, financial, and ethical aspects of a medical practice
5. Read about patients' problems
6. Practice case presentations
7. Observe and assist with common bedside procedures
8. Utilize sources of evidence-based medicine to learn about patients' condition and management
9. Observe preceptor interacting with patients, colleagues and staff
10. Reflect on interactions with patients, colleagues and staff
11. Understand the various approaches to the organization, financing, and delivery of health care in different patient care settings.
12. Identify and understand the roles of different members of the Health Care Team (nurses, pharmacists, social workers, chaplains, etc.).
13. Express an understanding of the care of special populations such as the elderly, the chronically ill and disabled patients.

IV. Role of a Community of Practice Faculty Preceptor

Community faculty preceptors like you are central to the COP-2 experience --which provides our students with role models and a clinical setting for experiential learning and instruction. As role models, preceptors help students develop the values of the profession, learn the clinical skills of patient communication, physical examination, and begin to develop the habits of inquiry and self-improvement that promote excellence throughout a lifetime of practice.

As Alguire et al, states in the book, *Teaching in Your Office*, "the most powerful influence on a novice learner is a preceptor who provides a positive role model of the doctor-patient relationship." So, we hope that you will share your love of medicine and the rewards of caring for patients, as well as the real-world challenges and opportunities with your student(s).

The University of Central Florida College Of Medicine thanks you for your commitment and dedication to the important mission of training our next generation of physicians.

COP expectations of preceptors include:

- Availability – being available to students 8 half-day sessions between September and March.
- Reviewing goals and expectations
  - Review the students' Personal Development Plan and their learning goals (session 1).
  - Review educational objectives and students' requirements for each session.
- Observing the student regularly and providing feedback regarding their performance.

- Being a role model and demonstrating clinical skills.
- Assessing students' professionalism halfway through COP sessions and completing a COP-2 evaluation at the end of the academic year.
- Notifying the COP Coordinator at any point if there are any issues or concerns with a student.
- Arranging in advance for alternative scheduling options if planning to be out of the office. If this is not possible, preceptors should contact the COP Coordinator for temporary re-assignment of the student.
- Not being involved in the medical care of students they supervise in compliance with the following LCME statement:
    - *The Liaison Committee on Medical Education (LCME) requires that faculty/preceptors are not to provide medical care (including psychiatric/psychological counseling) to learners who they are responsible for evaluating. A statement certifying that you have not at any time, previously or currently, provided healthcare to your assigned student(s) will be included in our COP preceptor evaluations.*

V. Students' Requirements

A. Attendance

- Students are expected to attend all **eight (8) scheduled COP-2 sessions** and remain for the entire scheduled time.
- Students may not request "time off" from the COP experience without permission from the COP Director. Please contact our COP Coordinator to verify all absence requests.

B. Assignments

Students are expected to complete and submit a series of assignments throughout the COP-2 experience. Each assignment is summarized below to provide preceptors with guidance as to the expected level of participation for the student, classroom content and suggested structure of each session.

a. Personal Development Plan (PDP):

- Students are asked to develop and document a PDP at the beginning of COP-2. In the PDP students will summarize their personal learning goals for the COP-2 experience. The formulation of a PDP requires that students reflect and make explicit their goals for learning.
- Students should arrive at their first COP session prepared to share and discuss their already-formulated Personal Development Plan. This allows an opportunity for the preceptor to also express their expectations of the students.

b. Completion of Patient Encounter Logs (PELs):

- Students are required to complete 1 PEL per COP-2 session, for a total of 8 PELs by the end of the year.

- At the end of each session, students should complete the corresponding PEL. This log will record the number of patients seen at each session, including the student's level of participation with that patient's care and portions of the care that they performed. This log should be completed **the day of each COP session** (optimally, it should be completed before leaving the session).
- Patient Encounter Logs (PELs) are completed via Qualtrics® on any mobile device. Students receive one individualized link to Qualtrics® via email to be used for all PELs to submit.

c. History and Physical Exam Write-ups (H&Ps)

- Documenting the full History and Physical Examination in the format of a write-up is a core component of clinical rotations and a Core Entrustable Professional Activity (EPA) for entering residency, as defined by the AAMC. Despite the time and effort required, this exercise is essential to the clinical learning experience. The process helps the student organize thoughts and develop a differential diagnosis and plan. The final product can assess a student's ability to not only gather, but also to interpret and synthesize data.
- All students are required to write five (5) History and Physical (H&P) patient write-ups from their COP-2 experience and submit them to their portfolio. Portfolio advisors provide written formative feedback on 2 of these H&Ps (Formative H&Ps 1&2), based on a pre-defined rubric (H&P Rubric, Appendix E). **Summative H&P write-ups are submitted for summative assessment**, and count towards the final COP-2 and P-2 grade.

- ✓ *Student are expected to familiarize themselves with materials and review the **Guide to the Comprehensive Adult H&P Write-Up** (Appendix C), **Guide to the Comprehensive Pediatric H&P Write-Up** (Appendix D) as well as a **Sample H&P** (Appendix E) prior to attending COP-2 sessions. This will facilitate the collection of enough information and data from the patient and the medical record at the time of the patient encounter.*
- ✓ *Preceptors should facilitate the identification of "best patients" for students to perform a complete history and physical. Even though not all clinical settings are conducive to a full H&P, efforts should be made to accommodate this as best as possible.*

d. Narrative Reflection

- Students utilize self-reflection skills to complete a narrative reflection based on a COP-2 patient experience

e. Preceptor Evaluation

- Students evaluate their preceptors at the end of the academic year.

C. Professionalism

Students are always expected to:

- Arrive on time and be prepared to every COP-2 assignment.
- Demonstrate professional behavior with students, faculty, medical professionals and members of the health care team with regards to punctuality, reliability, contribution to team efforts, respect for team members, and acceptance of constructive advice.
- Demonstrate honesty and integrity in all interactions with patients, families, colleagues, and others with whom physicians must interact in their professional lives.
- Adhere to the UCF Honor Code and Guidelines of Professional Conduct (see Domains of Professionalism on page 32) and uphold the values of integrity and commitment to self-improvement.

D. Hospital Credentials

- All students assigned to hospital clinics or to preceptors who round at hospitals must be credentialed according to the hospital's graduate medical policy**. Students should not round at a hospital without appropriate credentials.**
- Students are required to work with Student Affairs and COP Coordinator to complete credentialing requirements. It is imperative that all paperwork is completed and submitted in a timely manner.
- Students are required to dress professionally to all orientations.

(2017) UCF by Suhtling Wong-Vienneau

VI. Community of Practice Preceptor Requirements

A. Preceptor Requirements

- Be available for at least 8 half-day sessions with your students.
- At the beginning of the rotation discuss educational objectives and student expectations. This will be an opportunity to review the student's Personal Development Plan (PDP).
- Review and discuss the session goals with your student at the beginning of each session.
- Meet regularly with the student to provide feedback regarding their performance.
- Provide guidance on student H&P writing and choice of best patients to write H&Ps.
- Notify the COP Coordinator at any point if there are any issues or concerns with a student.
- Make arrangements in advance for alternative scheduling options if you will be out of the office. If this is not possible, please contact the COP Coordinator for temporary re-assignment of the student.

Please Note: Students may not request "time off" from the rotation without permission from the COP Director. Please call our COP Coordinator to verify all absence requests.

B. Benefits of Being a Preceptor

- Volunteer and affiliated faculty members are entitled to the following privileges and benefits offered by the University of Central Florida:
- Designation as a UCF College of Medicine faculty member
- Participation in departmental and COM academic activities
- Participation in faculty development events
- Access to the College of Medicine Harriet F. Ginsburg Health Sciences Library resources and services (98% of which are online)
- Discounts on purchases from the UCF Computer Store and main campus bookstore

VII. COP-2 Session Scheduling

Once students receive their COP-2 preceptor assignment, they are responsible for contacting their preceptor to schedule COP-2 session dates. The COP Coordinator will provide students with preceptors' contact information and preferred methods to be reached (e.g., email, texts, office assistant, etc.). Students are expected to contact preceptors directly to introduce themselves and to confirm the meeting place and time. Students are asked to work with their preceptors to find mutually-feasible times while not conflicting with their curriculum obligations. Students are encouraged to discuss session scheduling as early as possible at the start of COP-2.

IMPORTANT REMINDER: Students MUST NOT schedule COP-2 time during scheduled module time even if they typically do not go to class.

VIII. M-2 Weekly Schedule Template

The blocks of time highlighted in blue indicate potential COP-2 days and times and serve as a guide for you to indicate which days work best with your schedule.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8 am	Systems	P-2 CSSC/Flex-time	P-2 CSSC/Flex-time	Flex-time	Systems
9 am	Systems	P-2 CSSC/Flex-time	P-2 CSSC/Flex-time	Flex-time	Systems
10 am	Systems	P-2 CSSC/Flex-time	P-2 CSSC/Flex-time	Flex-time	Systems
11 am	Systems	P-2 CSSC/Flex-time	P-2 CSSC/Flex-time	Flex-time	Systems
12 pm	Lunch	Lunch	Lunch	Lunch	Lunch
1 pm	P-2 Didactic	Systems	Systems	Systems	Flex-time
2 pm	P-2 Didactic	Systems	Systems	Systems	Flex-time
3 pm	Flex-time	Systems	Systems	Systems	Flex-time
4 pm	Flex-time	Systems	Systems	Systems	Flex-time

Systems= Systems Module, P-2 = Practice of Medicine Year 2, CSSC= Clinical Skills Center and Simulation, Flex-time= to attend Community of Practice or work on FIRE (research) projects

IX. Teaching at Your Site

"Front Desk" (2011) UCF Marketing

A. Two-to-Four Weeks Before the Student Arrives

1. Review COP-2 learning goals and objectives.

2. Review the student's information.

3. Plan time at the end of the session for case discussion and learner feedback.

4. Consider adjusting your schedule for the precepting experience (e.g., extending patient visits or scheduling patients for you and the student to see simultaneously). If possible, schedule patients seen by the student for a follow-up visit when the student is present (only applicable to some preceptors).

5. Check your schedule for any upcoming trips, days away from the office, etc.

B. One Week before the Student Arrives

1. Remind your staff and partners of the impending arrival of the learner.
2. Distribute copy of the learner's personal information (if available) to staff and partners.
   a. Brief the staff on the learner's responsibilities.
   b. Review with the staff their role with the learner.
   c. Coach the staff on how to present the learner to patients.
3. Identify a parking place for the learner and an area for storing personal items while they are working with you.
4. Identify a workspace for the learner.
5. Generate list of staff, their locations, and a short description of their responsibilities.
6. Review session goals.

C. Selecting Patients for the Student to See

- Please refer to session goals for suggestions on selecting patients for the students to see.
- Inform your patients that you are providing a learning experience for medical students.
- Ask the patient's permission before bringing the learner into the examining room or before allowing the learner to see the patient independently.

When introducing the student use positive language: "I have a medical student with me today. If it's OK I'd like him/her to talk to you and examine you first. I will come in and see you afterwards."

D. Optimizing the student-patient encounter

Organize the visit for the learner prior to her or him seeing the patient:

- **Prime** the learner by providing patient-specific background information, e.g., *"Mrs. Martínez is a 42-year-old woman and is here for follow-up of her poorly controlled diabetes." What aspects of the history and physical exam do you think are important to address in this visit?"*
- **Frame** the visit by focusing on what should be accomplished at this visit, e.g., *"This patient has several problems but today I'd like you to focus on the patient's care of her diabetes."*
- **Specify** allotted time: instruct the student on how much time will be allotted to the visit, e.g., *"I want you to spend 15 minutes taking a focused history and then come find me."* Indicate whether you will be having the student present in front of the patient or outside the exam room.

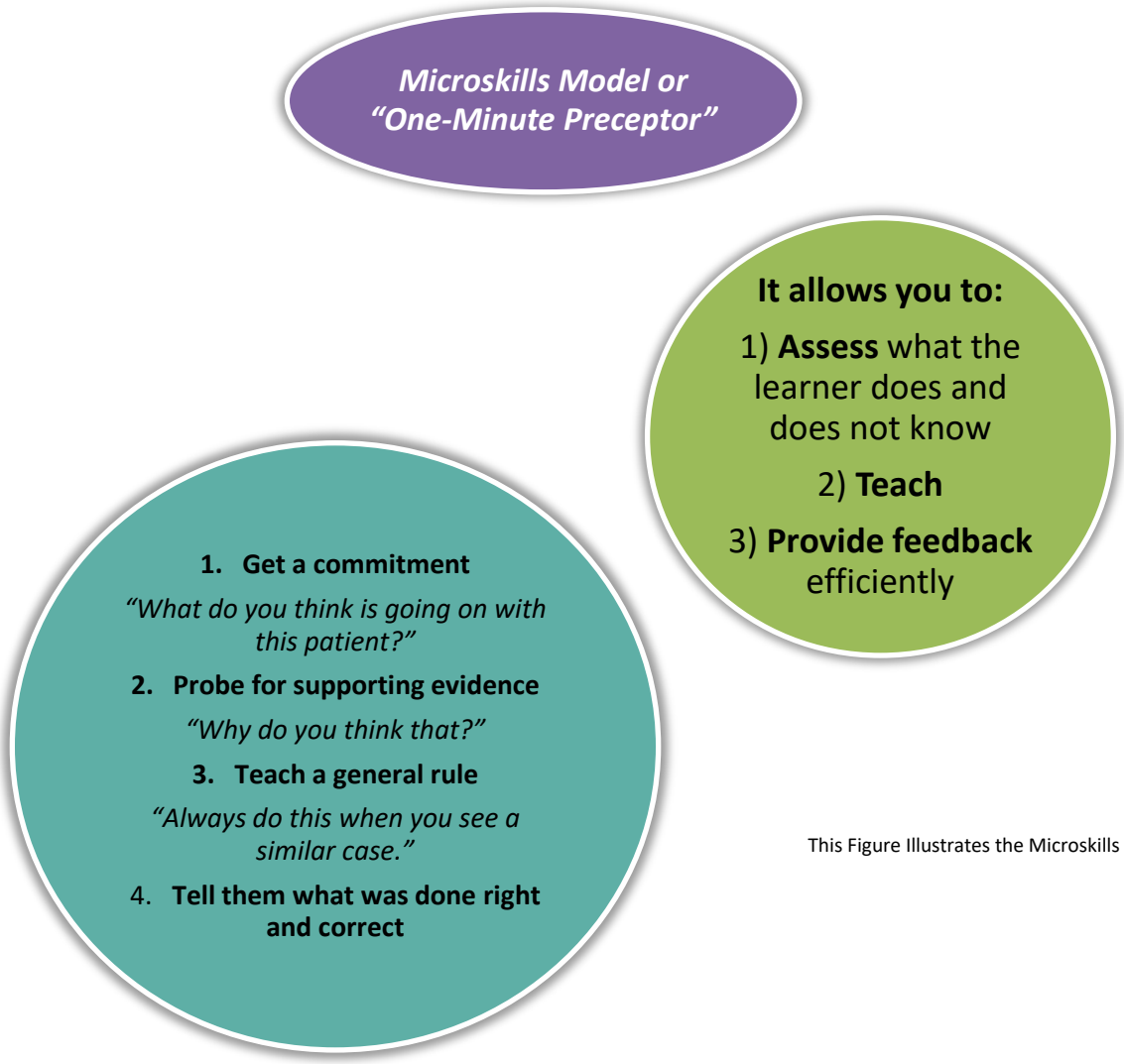
(2017) UCF by Suhtling Wong-Vienneau

X. Case-based Learning

We encourage preceptors to familiarize themselves with the following precepting models used to teach students both in the inpatient and outpatient setting.

A. The Microskills Model or "One-Minute Preceptor"

The Microskills Model evolved as a time-effective way to "diagnose" the learner while also caring for the patient.

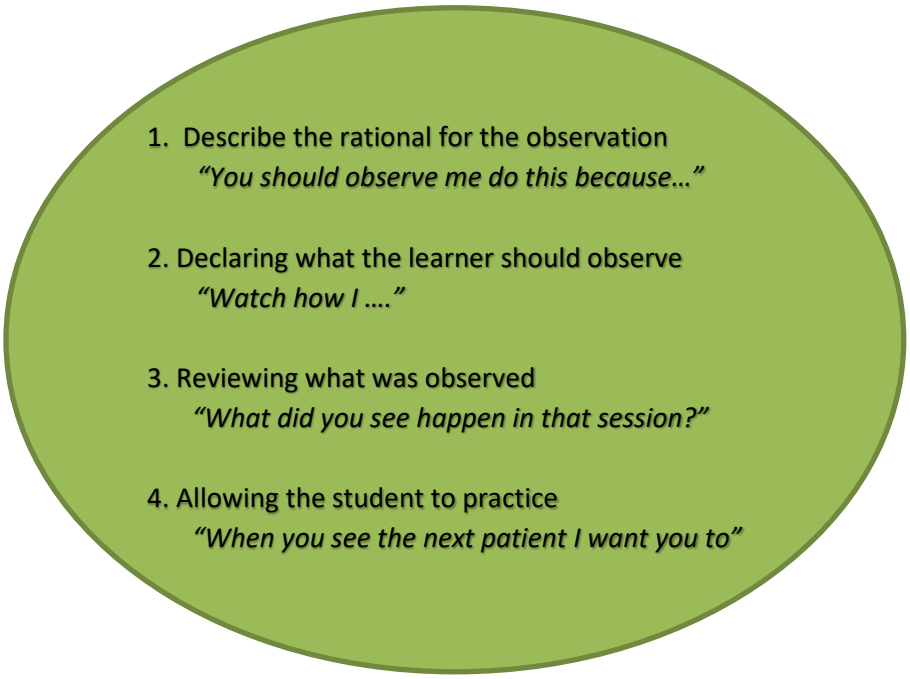


This Figure Illustrates the Microskills Model

B. "Active observation"

This strategy is most useful for the novice learner who has had no previous patient-related experience. You may choose to have the student accompany you as you see patients, during the learner's first session, and engage the learner in "active observation" **(not just "shadowing," which implies a passive process)**.

For active observation to be effective, the following critical elements must occur:



C. Physical Exam Skills Instruction

We encourage you to demonstrate as well as observe students performing elements of the physical examination.

In order to best prepare students for the Clinical Skills Exam given by USMLE, students are instructed in the physical exam techniques expected for exam performance. These often differ, in flow and degree of detail, from what doctors do in the "real world" on a day-to-day basis. We do not expect you to change your practice, but rather ask that you acknowledge this distinction for learners.

XI. Session Goals

Sessions 1 – 8

(2017) UCF by Suhtling Wong-Vienneau

"Wherever the art of Medicine is loved,
there is also a love of Humanity."

— Hippocrates

A. Session 1

Session Goals:

- *Meet the learners*
- *Orient the learners to the clinical setting and introduce learners to the staff*
- *Discuss learners' previous patient care or clinical experiences*
- *Address your expectations for the learners*
- *Review the learners' "Personal Development Plan" (PDP) (documents expectations and learning goals for the COP-2 experience)*
- *Interview and/or examine a minimum of 2 patients*

Session Overview:

Students will work in pairs while interviewing and examining patients. One student should conduct the history and the other the physical exam. These roles will alternate on consecutive patients. The student not directly interviewing should still take notes because all students will be expected to write and submit an H&P to the electronic portfolio. The entire patient encounter should take no more than one hour.

Preceptors should consider observing at least one student-patient interaction. This will provide the opportunity to assess the students' degree of comfort with patient interactions as well as their level of competence. Students may participate in any of the following activities based on the patient availability and preceptor's assessment of students' level of comfort and competence:

- Taking a focused/full history (interviewing a patient, family member or caregiver)
- Performing a focused/full examination
- Counseling a patient

After the history and physical are complete, the group should meet for approximately 30 minutes to discuss the encounter. Attention should be given to techniques of interviewing and examination. The discussion may also begin to address the patient's problems, incorporating clinical reasoning skills.

✓ *The purpose of this discussion is to get the students on the right track with their clinical reasoning. Do NOT give them the problem list as you see it. Rather, begin the discussion, allowing the students to think through the patient's problems and how they will begin to approach the assessment and plan. Their "homework" for the next session is to write up this patient encounter, concluding with their assessment, including the problem list, the differential diagnosis as well as the plan.*

✓ *The preceptor should use this session to give immediate feedback and guide the students when deficits are noted at the time of the history and physical. You may want to take a 5-minute break between the history and physical exam to debrief and give the patient a break as well. This will allow for more immediate feedback on the history-taking component.*

B. Sessions 2-8

Session Goals:

- *Students perform a focused/detailed history and/or physical examination on 2 patients*
- *Students receive direct observation and/or feedback on the history and physical exam techniques from the preceptor and peer immediately following the encounter*
- *Students practice oral patient presentations*
- *Students begin to utilize clinical reasoning skills*
- *Students write a full H&P (individually) and submit to the learning portfolio*

Session overview:

Preceptor and students should meet and review appropriate patients for students to interview and/or examine. Students will work in pairs while interviewing and examining patients. One student should conduct the history and the other the physical exam. These roles will alternate on consecutive patients. The student not directly interviewing should still take notes because all students will be expected to write and submit an H&P to the electronic portfolio. The entire patient encounter should take no more than one hour.

Preceptors should consider observing at least one student-patient interaction. This will provide the opportunity to assess the students' degree of comfort with patient interactions as well as their level of competence. Students may participate in any of the following activities based on the patient availability and preceptor's assessment of students' level of comfort and competence:

- Obtaining patient's vital signs
- Taking a focused/full history (interviewing a patient, family member or caregiver)
- Performing a focused/full examination
- Counseling a patient
- Completing a SOAP/progress note

After the history and physical are complete, the group should meet to discuss the encounter. Attention should be given to techniques of interviewing and examination. The discussion may also begin to address the patient's problems, incorporating clinical reasoning skills.

- ✓ *The purpose of this discussion is to get the students on the right track with their clinical reasoning. Do NOT give them the problem list as you see it. Rather, begin the discussion, allowing the students to think through the patient's problems and how they will begin to approach the assessment and plan.*
- ✓ *The preceptor should use this session to give immediate feedback and guide the students when deficits are noted at the time of the history and physical.*
- ✓ *Students' "homework" for the next session is to write up a patient encounter (H&P) and submit it to the learning portfolio. The H&P should include their assessment, problem list, the differential diagnosis as well as their plan.*
- ✓ *Preceptors may want to review the student's write-up at next session (optional).*

XI. Preceptor and Student Session Expectations

Student Expectations:

- Practice obtaining a history and/or physical examination on 2 patients per session
- Receive direct observation and feedback from the preceptor and peers
- Discuss techniques of the history and physical immediately following the encounter
- Begin to utilize clinical reasoning skills
- Follow proper dress code
- Professionalism code

Preceptor Expectations:

- Arrange in advance for suitable patient(s) for the History and Physical (H&P).
- Role-model doctor-patient communication
- Role-model the flow of the physical exam
- Demonstrate physical exam findings (ascites, asterisks, edema, etc.)
- Demonstrate clinical maneuvers
- Provide verbal feedback to the students
- Evaluate student professionalism at the end of the rotation

Suggested Session Structure:
Students are expected to work with preceptors for four-hour sessions. It will be at the discretion of the preceptors (taking into consideration the session and clinical setting) to organize each session differently with some time dedicated to patient interview and exam, oral presentations, and/or patient discussion, management, etc.

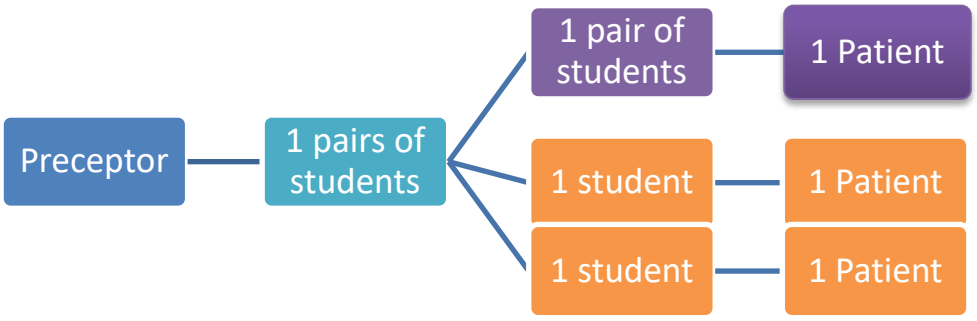


Figure. Illustrates the options for student-pair to patient assignments in either acute or long-term care settings

XII. Student Feedback, Assessment & Grading

A. Student Feedback:

We ask that during COP-2 sessions preceptors provide feedback to medical students on an ongoing basis. Despite conventional wisdom, feedback should not be reserved to address poor performance only; on the contrary, feedback should be used to highlight students' positive behaviors, strengths and successes.

To be most effective, feedback should be:

Timely:

- ✓ Feedback must be given immediately after the good or poor performance occurs.

Specific:

- ✓ The dialogue should focus on specific performance, not generalizations.

"Owned" by the Giver:

- ✓ Use the words "I" and "my" to make the feedback less threatening. By using "you," the student may feel accused. For example, instead of saying, "You did not make that patient feel very comfortable," say, *"I think that the patient might have been uncomfortable with your exam. Let's talk about ways to put patients at ease."*

Understood by the Receiver:

- ✓ Ask the student to rephrase the feedback to make sure they understand the intent and future expectations in the situation.

Delivered in a Supportive Climate:

- ✓ Give feedback in a private location and give the student the opportunity to talk about what happened.

Followed-up with an Action Plan:

- ✓ Formulate a strategy with input from the student for improving his or her performance.

How to Provide Meaningful Feedback to Medical Students using Two-Minute Observations

Purpose:

- Discuss the purpose of the observation with the student.
- Do you expect them to obtain a complete history or a focused history to assist in a specific diagnosis?
- Should the student perform a complete or limited physical exam?

How:

- Explain to the student how the observation will be conducted (e.g., you will enter the room at some time during the student's history or exam to observe the student, but the student should proceed uninterrupted).

Explain:

- Explain to the patient or have the student explain to the patient what will take place.

Observing:

- When timely, enter the room for a 2-minute observation of the student-patient encounter without interrupting the process.
- Leave the patient room without disrupting the student/patient exchange.

Feedback:

- When the student has finished, provide feedback to the student based on your observations. This may include interview, physical examination and documentation skills. Try to provide a positive comment, followed by constructive suggestions, and end with another positive comment.

Agenda Setting:

- Set an agenda and opportunity for future learning. You may suggest additional reading or ask the student to spend some time in the clinical skills center to practice certain skills.

B. Assessment & Grading

The longitudinal evaluation of students during COP-2 will be achieved through two different assessment processes:

1. **Preceptor Evaluations:** COP-2 community preceptors will evaluate students' professionalism and overall performance at the end of the year. Preceptors play a unique role as a role model and source of professionalism feedback and evaluation during the COP-2 clinical sessions.

2. **Electronic Learner Portfolio**: In COP-2, the COP e-Portfolio will serve as a means to track core competencies such as self-directed learning as well as a vehicle for **longitudinal, multi-source assessment** of students' achievements. Students will be charged with completing and submitting activities and pre-defined exercises such as learning goals, H&Ps, and reflective exercises for formative feedback and summative assessment.

   Core COM clinical faculty will serve as Portfolio Advisors. Each portfolio advisor will be assigned a group of students and will provide ongoing formative feedback to students both individually and in group sessions throughout the year. Summative assessments will be conducted by the P-2 Module Directors.

C. Professionalism

Students are expected at all times to:

- Adhere to the UCF Honor Code and Guidelines of Professional Conduct as found online at https://med.ucf.edu/media/2012/08/UCF-COM-Honor-Code-2014-20151.pdf.
- Arrive promptly and prepared for all scheduled activities and COP-2 sessions
- Appear in professional attire (Refer to the "Dress Code for Patient Care and Clinical Activities" section of the UCF College of Medicine Dress Code Policy found via the following online link: http://med.ucf.edu/media/2012/08/DRESS-CODE-POLICY.pdf)
- Bring all relevant medical tools to COP sessions
- Demonstrate honesty and integrity in all interactions with patients, families, staff and colleagues
- Maintain the highest standards of patient confidentiality. This includes, but is not limited to, the following:
  - Adhere to HIPAA Standards in all patient interactions and communications
  - Refrain from any digital, video or audio recording of patients
  - **Never post any patient-related or course material on any social media site.**

Please contact the Module Director or COP Coordinator immediately if you encounter any of the following incidents:

CRITICAL INCIDENT REPORT

- Habitual tardiness
- Unscheduled absences
- Unprofessional attire (based on practice preferences)
- Unprofessional interactions with staff or patients
- Inability to accept feedback
- Inadequately prepared (no stethoscope, etc...)

Analía Castiglioni, MD
Community of Practice 2, Director
analia.castiglioni@ucf.edu

Abnel Rodríguez-Castro
Community of Practice 1&2, Coordinator
abnel@ucf.edu
(407) 266-1160

"Preceptorship" (2013) UCF by Angelica Partridge

UCF COM Domains of Professionalism

Students are expected to adhere to the UCF Honor Code and Guidelines of Professional Conduct and uphold the values of integrity, commitment to self-improvement and respect as evidenced by:

Category 1: Medical Student Principles

- Demonstrating honesty, integrity, and reliability in interactions with patients, colleagues, faculty, and staff.
- Contributing to an atmosphere conducive to learning.
- Respecting diversity and dignity of each individual.
- Maintaining patient confidentiality.
- Professional attire (refer to "Dress Code for Patient Care and Clinical Activities").

Category 2: Reliability

- Following through on assignments and commitments in a timely manner.
- Arriving on time and prepared for scheduled class activities, including all COP sessions.
- Honest representation of actions and information.

Category 3: Improves & Adapts

- Being receptive to feedback and acting upon it.
- Recognizing limitations and seeking help when appropriate.
- Accepting responsibility for deficiencies and/or lapses and taking corrective steps.
- Striving to improve knowledge, skills and attitudes.
- Maintaining calm and rational demeanor in times of stress.

Category 4: Interpersonal Skills

- Demonstrating the ability to establish rapport and employ active listening to communicate effectively with patients, colleagues, and staff.
- Providing compassionate treatment of patients and respect for the privacy and dignity of all individuals.
- Demonstrating patience and respect in interactions with patients, colleagues and staff.
- Relating well to faculty and staff in the learning environment.

Category 5: Positive Relations with Team

- Demonstrate the traits of collegiality, flexibility, adaptability, reliability, punctuality, and responsibility, and work effectively with others as a team member.

Category 6: Commitment to Learning

- Demonstrates a commitment to learning by being prepared for and engaged in learning activities.
- Engages in self-directed learning and contributes to the learning of others.

XIII. Important Information

A. Malpractice Coverage

All students in officially-sponsored UCF COM teaching activities are provided student professional liability protection by the University of Central Florida College of Medicine Self-Insurance Program. As this is an approved module, the protection afforded students is described below.

The University of Central Florida College of Medicine does not provide insurance coverage for the professional services of members of the volunteer and affiliated faculty. It is the individual responsibility of the faculty member to maintain her or his own professional liability insurance coverage and to comply with state laws pertaining to professional liability insurance coverage.

Appointment of individuals to the volunteer and affiliated faculty in no way implies that the University of Central Florida, College of Medicine takes upon itself responsibility or liability for the professional services of these individuals.

Volunteer and affiliated faculty members in some departments may participate in and/or supervise in outpatient, inpatient and operating room facilities. Proof of licensure and appointment to the faculty must be completed prior to performance of professional services as defined above.

B. HIPAA

All UCF COM medical students undergo HIPAA training during their orientation.

C. Student Injuries and Accidental Exposures

OSHA's Bloodborne Pathogen Standard (29CFR 1910.1030) applies to persons (students and employees) at risk of acquiring on-the-job bloodborne pathogen infection. Personnel who require this training include any person who, in the normal course of his/her job, has the potential for exposure to blood, body fluids, body tissues or sharps. All medical students are at risk and must complete the OSHA Bloodborne Pathogen (BPP) training upon enrollment and annually thereafter to meet the OSHA Bloodborne Pathogen Standards.

D. FERPA Reference Sheet for UCF Faculty

FERPA, the Family Educational Rights and Privacy Act of 1974, as Amended, protect the privacy of student educational records. It gives students the right to review their educational records, the right to request amendment to records they believe to be inaccurate, and the right to limit disclosure from those records. An institution's failure to comply with FERPA could result in the withdrawal of federal funds by the Department of Education.

As a Faculty Member, you need to know the difference between **Directory Information** and **Personally Identifiable Information or Educational Records.**

- **Directory Information** may be disclosed, unless the student requests otherwise. *Please refer such requests to your department office or to the Registrar's Office.*
  - Name
  - Current Mailing Address
  - Telephone Number
  - Date of Birth
  - Major
  - Dates of Attendance
  - Enrollment Status (Full/Part-time)
  - Degrees/Awards Received
  - Participation in Officially
  - Recognized Activities and Sports
  - Athletes' Height/Weight

- **Personally Identifiable Information or Educational Records <u>may not</u>** be released to **anyone** but the student and only then with the proper identification.

Personable Identifiable Information

*Including, but **not** limited to:*

- Social Security Number
- Student ID-PID (PeopleSoft)
- ISO Number
- Residency Status
- Gender
- Religious Preference
- Race/Ethnicity
- Email Address

Educational Records

*Including, but **not** limited to:*

- Grades/GPA
- Student's Class Schedule
- Test Scores
- Academic
- Academic Transcripts

*Parents and spouses must present the student's written and signed consent **before** the University may release Personally Identifiable Information or Educational Records to them.*

(Please refer callers to the COM Registrar's Office 407-266-1397, UCF COM, Room 115F)

General Practices to Keep in Mind:

- Please do not leave exams, papers, or any documents containing any portion of a student's Social Security Number, Personal Identification Number (PID), grade or grade point average outside your office door or in any area that is open-access.
- Please do not record attendance by passing around the UCF Class Roster, which may contain the student's PID.
- Please do not provide grades or other Personally Identifiable Information/Education records to your students via telephone or email.

E. POSTING GRADES

According to FERPA, student grades must not be released or made available to third parties. UCF policy restricts instructors from posting grades in classrooms (except as follows), or on websites unless the student's identity is concealed by a secure password-entry interface (i.e., OASIS). Please refrain from posting grades by **Name** or any portion of the **SSN** or **PID**.

RECORDS ACCESS BY UNIVERSITY PERSONNEL: As a faculty member, you may be allowed access to a student's Educational Records if you can establish legitimate educational interest for the request, meaning that you need the information to fulfill a specific professional responsibility.

The following is a list of information items that **are not** considered Educational Records and not subject to a student's request for review:

- Law-enforcement records and medical treatment records;
- Records maintained exclusively for individuals in their capacity as employees. Records of those who are employed as a result of their status as students (work-study, student workers, graduate assistants, etc.) are considered Educational Records;
- Alumni records; and,
- Sole-source/Sole-possession documents: these are notes (memory joggers-not grade or GPA related) created and maintained by you, meant for your personal use exclusively. So long as no one else ever sees these notes, they remain private and are not subject to FERPA. If you share them with someone, these notes no longer are considered "sole source." They become part of the student's educational record and are subject to disclosure under FERPA.

Gradebooks are not considered "sole source" documents under FERPA and so must be made available to written student requests for record disclosure.

If a student requests Gradebook disclosure, all notations pertaining to other students would be stripped out of the copy provided for review.

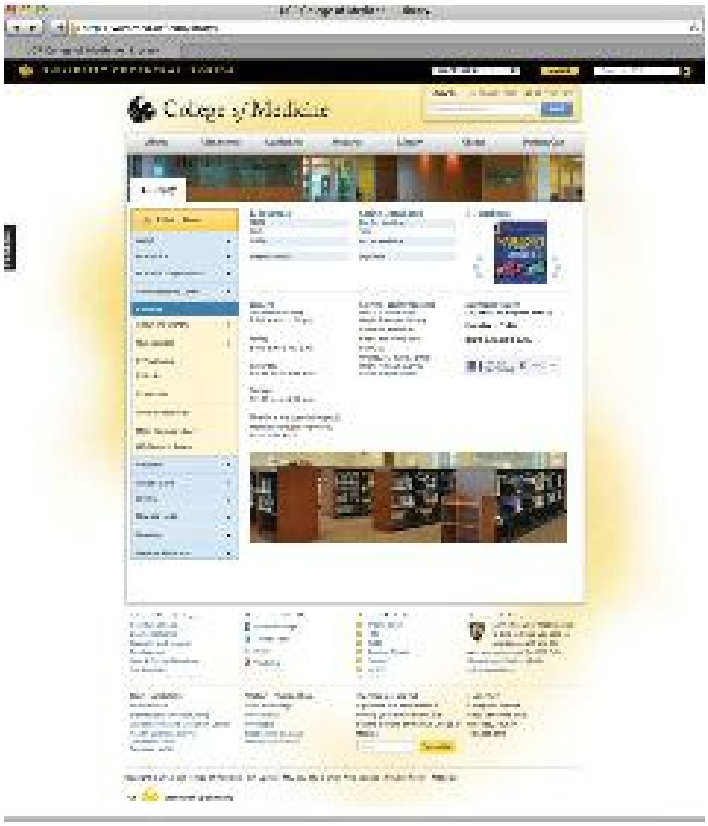
FOR MORE INFORMATION: http://registrar.ucf.edu/ferpa

UCF COM Registrar's Phone: 407-266-1371

F. Library Link


Figure 15 & 16. "Library" UCF by Alexis

The University of Central Florida College of Medicine (UCF COM) Website



http://med.ucf.edu/library/

You can find information on the MD Program curriculum and specific modules, as well as the COM's goals, vision and mission on this website.

G. Module Descriptions

Cardiovascular and Pulmonary Systems Module

The Cardiovascular and Pulmonary Systems module is designed to serve as an introduction to the disease processes, which affect the cardiovascular and pulmonary systems. This module builds upon an understanding of the structure and function of the cardiovascular and pulmonary systems, and enables students to integrate basic science and clinical concepts related to these systems, with emphasis on the pathology, pathophysiology, diagnosis and treatment of patients with cardiovascular and pulmonary diseases. Appropriate examples of medical imaging and diagnostic techniques are introduced, including pulmonary function testing and basic ECG recording and interpretation.

Endocrine and Reproductive Systems Module

The Endocrine and Reproductive Systems block in the 2nd year at UCF provides an overview of Endocrine, Reproductive and Genitourinary disorders, focusing on major disease classification and terminology, signs and symptoms, methods of diagnosis, and differential diagnosis as supported by evidence-based medicine. Basic science and clinical concepts from the first year are applied to the understanding and treatment of disease of these systems. This module focuses on molecular and cellular pathology, clinical, pathologic, and laboratory findings, as well as treatment and management of patients with common metabolic and endocrine disorders such as diabetes mellitus, growth and pubertal development, endocrine and hormonal causes of hypertension, pancreas, parathyroid, thyroid, adrenal and neuroendocrine disorders. In addition, this module covers the pathophysiology and pathology of nutritional inadequacies or excesses, their clinical manifestations, prevention and treatment.

Gastrointestinal and Renal Systems Module

The Gastrointestinal and Renal module focuses on diseases of the gastrointestinal tract, including the hepatobiliary system, and nephrology, including diseases of the urinary tract. These areas focus on the pathology, pathophysiology, signs and symptoms, diagnostic methods, and drugs used for the treatment of GI and urinary tract diseases. The basic science and clinical concepts of Year 1 are expanded to include the pathology and pathophysiology, as well as the pharmacological treatments of diseases of these systems. This module emphasizes the molecular and cellular pathology, clinical, pathologic, and laboratory findings, treatment and management of patients with GI, hepatic, and genitourinary disorders.

Skin and Musculoskeletal Systems Module

The Skin and Musculoskeletal Systems module is focused on the pathology, diagnosis and treatment of disorders of the skin and the musculoskeletal systems. Students build on basic science and clinical concepts from year 1 to understand common presenting complaints, diagnostic techniques, and treatment methods for cutaneous and musculoskeletal disorders. This module emphasizes the molecular and cellular pathology, clinical, pathologic, and laboratory findings, treatment and management of patients with diseases of the skin and musculoskeletal system. Treatment methods include pharmacological, physical, and surgical modalities.

Brain and Behavior Module

The Neuroscience module emphasizes the molecular basis and pathophysiological processes of common neurological disorders. The module focuses on basic and common neurologic issues, integrated with an understanding of their effects on other physiologic systems. The module includes an overview of neuroanatomy and neurophysiology, with correlation to disorders of the central and peripheral nervous system. This module offers an in-depth understanding of the molecular basis of neurologic disorders, pathology, pathophysiology, diagnosis and treatment. Inclusive in the study of nervous system disorders is the study of developmental and psychiatric disorders along with their pathology, diagnosis and treatment.

Focused Inquiry Research Experience 2 (F.I.R.E.)

During year 2 of the "Keep the Dream Alive" module, students complete their projects initiated during year 1 and present them to faculty and peers during a mini-conference highlighting their work. It is expected that projects result in a scholarly presentation or publication. The conference is scheduled so that both first-year and second- year students can attend, providing opportunity for second-year students to serve as role models for their classmates. Projects and research may extend into the third and fourth years, and for students continuing their research, additional opportunities for presentation are available.

Practice of Medicine 2 Module

The goal of the Practice of Medicine continuum is to help students develop the essential knowledge and skills to optimally participate and learn in clerkship-level clinical care environments.

Practice of Medicine-2 (P-2) is a year-long module, integrated with the organ systems (S) modules, which teaches advanced clinic skills and stresses the development of clinical reasoning. The P-2 module builds upon physical examination and medical interviewing skills learned in the P-1 module. Key areas of learning include advanced oral presentation and medical documentation skills, development of basic clinical decision-making and application of selected diagnostic tests. Integration with the Systems (S) modules highlights the link between foundational knowledge and clinical practice while promoting intellectual curiosity, self-directed learning and clinical reasoning skills.

P-2 module instructional activities incorporate a variety of modalities to promote experiential learning and skill acquisition. These include interactive presentations, small group sessions, student-directed independent learning tasks and Clinical Skills and Simulator Center (CSSC) exercises. As in P-1, the CSSC provides the setting for student encounters with Standardized Patients (SPs), high-fidelity simulators and task trainers as well as web-based activities for the learning, practice and assessment of clinical skills.

The Community of Practice component, a longitudinal clinical experience, is integrated within P-2 as students continue to work with preceptors throughout the Central Florida medical community, expanding their experiences in a clinical setting. Longitudinal Curricular Themes (LCT) are

interwoven throughout the course with the aim to help students appreciate the complexity and interdisciplinary nature of caring for patients.

APPENDIX

A. Personal Development Plan (PDP) Student Instructions

An important aim of the Community of Practice (COP) e-portfolio is to promote life-long learning by encouraging you to reflect on your own learning needs and to identify specific personal learning goals, i.e., your Personal Development Plan (PDP). Reflecting on your learning may be quite new to you but developing self-directed learning skills is an important tenet of medical professionalism and is essential to continuous professional development both during medical school and throughout your career.

The COP-2 PDP represents a way in which you can identify your own specific learning needs (i.e., what you need to learn) and strategies (i.e., how you are going to learn and how you will know that you've learned) while receiving guidance from your portfolio advisor. Asking you to develop a PDP puts you, the learner, at the center of the learning process as you participate in the planning and assessment of your own individual learning during the COP clinical experience.

You will develop and document your Personal Development Plan at the beginning of the COP year. In your PDP you will summarize your personal learning goals during the COP-2 experience.

Step 1: Identify learning needs
Consider if there are clinical skills or other competencies that you would like to enhance during the COP clinical experiences. Write down the areas that you would like to work on.

Step 2: Identify and document your learning goals
Select 2-3 goals that you would like to work on. You can use the" I-SMART" criteria to help you develop specific goals (see next section in Appendix).

Step 3: Determine the strategies and resources that you will employ to achieve your goals. Define your time management and deadlines.

Step 4: Share and/or discuss your learning goals and PDP with your portfolio advisor.

Step 5: Refer to your PDP throughout COP-2 to assist you in reaching your goals.

B. Writing Learning Goals: I-SMART Tool

Writing an Effective Goal Statement

Tips for writing goal statements:

1. Use clear, specific language
2. Start your goal statement with TO + a VERB
3. Write your goal statement using SMART Goal Criteria
4. Avoid using negative language. Think positive!

An example of a goal statement:

- *"**To** master performing the complete "Head-to-Toe" Physical Exam and do well on the final exam in March, I need to **perform** at least one complete PE during each of my COP sessions".*

  Note how the above example begins with the word "To", includes the verb "perform", and tells what (Physical Exam), why (to do well on the final exam) and when (March).

I-SMART Breakdown

I - Important: Have you identified a goal or competency that is important for you to master at this stage of your medical education? Is there an important competency that you need to master prior to progressing to the next level that you have not yet developed?

S - Specific: Be specific with your goals. Specific goals are much more likely to be achieved than non-specific goals.

a. What do you want to accomplish during the COP-2 clinical experience?
b. Why? Specific reason, purpose, or benefits of achieving a goal.
c. What steps or strategies will you take to achieve your goals? How will you determine that you have achieved your goals?

M - Measurable: Measuring progress towards a goal helps you stay on track. Staying on track results in a cycle that continually motivates you to put forth the effort toward reaching your goal.

a. How will you measure/monitor your progress?
b. How will you keep yourself motivated to work towards your goal?

A - Attainable: If a goal may seem too overwhelming to tackle, try breaking it down into steps.

a. Are the goals you have outlined attainable?
b. Can your goals be broken down into steps that can make it more manageable and facilitate your success?
c. What steps and/or strategies you will take to achieve your goals?

R - Realistic: Personal, situational, and time factors may influence your ability to reach your goal. Consider your schedule, COP-2 dates and requirements, and other time demands and commitments when determining your goals.

a. What may have seemed realistic at the beginning of COP may not seem so at halfway through the year. At this point, "pause and think" and re-evaluate your learning goals and strategies and modify them as necessary.

T - Timebound: Define start and end points to your goals and maintain a commitment to these deadlines. Goals without deadlines or schedules for completion tend to be put aside for the day-to-day crises that invariably arise in a person's life.

I-SMART Activity Worksheet

Use the following I-SMART worksheet to write your learning goals and develop your PDP. Repeat this exercise as needed to write other goal statements. Once you have identified your goals, complete your PDP.

What is/are your learning goal(s)? _____

1. Is it important?

I _____

2. Is it specific?

S _____

3. Is it measurable? How will I measure or monitor progress?

M _____

4. Is it attainable? (Can this really happen? Attainable with enough effort? What steps are involved?)

A _____

5. Is it realistic? (What knowledge, skills, and resource are necessary to reach this goal?

R _____

6. Is it time bound? (Can I set fixed deadlines? What are the deadlines?)

T _____

C. Guide to Comprehensive Adult H&P Write-Up

(Adapted from D Bynum MD, C Colford MD, D McNeely MD, University of North Carolina at Chapel Hill, North Carolina)

Chief Complaint	Include the primary symptom causing the patient to seek care. Ideally, this should be in the patient's words.
Source & Reliability	If the patient is not the source of the information state who is and if the patient is not considered reliable explain why (e.g., "somnolent" or "intoxicated")
History of Present Illness	First sentence should include patient's identifying data, including age, gender, (and race if clinically relevant), and pertinent past medical history Describe how chief complaint developed in a chronologic and organized manner Address why the patient is seeking attention at this time Include the dimensions of the chief complaint, including location, quality or character, quantity or severity, timing (onset, duration and frequency), setting in which symptoms occur, aggravating and alleviating factors and associated symptoms Include the patient's thoughts and feelings about the illness Incorporate elements of the PMH, FH and SH relevant to the patient's story. Include pertinent positives and negative based on relevant portions of the ROS. If included in the HPI these elements should not be repeated in the ROS The HPI should present the context for the differential diagnosis in the assessment section
Past Medical History	Describe medical conditions with additional details such as date of onset, associated hospitalizations, complications and if relevant, treatments Surgical history with dates, indications and types of operations OB/Gyn history with obstetric history (G,P – number of pregnancies, number of live births, number of living children), menstrual history, birth control Psychiatric history with dates, diagnoses, hospitalizations and treatments Age-appropriate health maintenance (e.g., pap smears, mammograms, cholesterol testing, colon cancer) and immunizations Describe any significant childhood illnesses
Medications	For each medication include dose, route, frequency and generic name Include over the counter medications and supplements; include dose, route and frequency Do not use abbreviations
Allergies	Describe the nature of the adverse reaction
Family history	Comment on the health state or cause of death of parents, siblings, children

	Record the presence of diseases that run in the family (e.g., HTN, CAD, CVA, DM, cancer, alcohol addiction)
Social history	Include occupation, highest level of education, home situation and significant others Quantify any tobacco, alcohol or other drug use Include relevant sexual history Note any safety concerns by the patient (domestic violence, neglect) Note presence of advance directives (e.g., living will and/or health care power of attorney) Assess the patient's functional status – ability to complete the activities of daily living Consider documentation of any important life experience such as military service, religious affiliation and spiritual beliefs
Review of Systems	Include patient's Yes or No responses to all questions asked by system Note "Refer to HPI" if question responses are documented in the HPI **Review of Systems**: *Include in a bulleted format the pertinent review of systems questions that you asked. Below is an example of thorough list. In a focused history and physical, this exhaustive list needn't be included.* ***skin*** *bruising, discoloration, pruritus, birthmarks, moles, ulcers, decubiti, changes in the hair or nails, sun exposure and protection.* ***hematopoietic*** *spontaneous or excessive bleeding, fatigue, enlarged or tender lymph nodes, pallor, history of anemia.* ***head and face*** *pain, traumatic injury, ptosis.* ***ears*** *tinnitus, change in hearing, running or discharge from the ears, deafness, dizziness.* ***eyes*** *change in vision, pain, inflammation, infections, double vision, scotomata, blurring, tearing.* ***mouth and throat*** *dental problems, hoarseness, dysphagia, bleeding gums, sore throat, ulcers or sores in the mouth.* ***nose and sinuses*** *discharge, epistaxis, sinus pain, obstruction.* ***breasts*** *pain, change in contour or skin color, lumps, discharge from the nipple.* ***respiratory tract*** *cough, sputum, change in sputum, night sweats, nocturnal dyspnea, wheezing.* ***cardiovascular system*** *chest pain, dyspnea, palpitations, weakness, intolerance of exercise, varicosities, swelling of extremities, known murmur, hypertension, asystole.*

	gastrointestinal system *nausea, vomiting, diarrhea, constipation, quality of appetite, change in appetite, dysphagia, gas, heartburn, melena, change in bowel habits, use of laxatives or other drugs to alter the function of the gastrointestinal tract.* ***urinary tract*** *dysuria, change in color of urine, change in frequency of urination, pain with urgency, incontinence, edema, retention, nocturia.* ***genital tract (female)*** *menstrual history, obstetric history, contraceptive use, discharge, pain or discomfort, pruritus, history of venereal disease, sexual history.* ***genital tract (male)*** *penile discharge, pain or discomfort, pruritus, skin lesions, hematuria, history of venereal disease, sexual history.* ***skeletal system*** *heat; redness; swelling; limitation of function; deformity; crepitation: pain in a joint or an extremity, the neck, or the back, especially with movement.* ***nervous system*** *dizziness, tremor, ataxia, difficulty in speaking, change in speech, paresthesia, loss of sensation, seizures, syncope, changes in memory.* ***endocrine system*** *tremor, palpitations, intolerance of heat or cold, polyuria, polydipsia, polyphagia, diaphoresis, exophthalmos, goiter.* ***psychologic status*** *nervousness, instability, depression, phobia, sexual disturbances, criminal behavior, insomnia, night terrors, mania, memory loss, perseveration, disorientation*
Physical examination	Describe what you see, avoid vague descriptions such as "normal"; The PE that relates to the chief complaint may need to be MORE detailed than the sample below; record any "advanced" findings/lack of findings that are pertinent (for example, presence or absence of egophany, shifting dullness, HJR) Physical Examination: Always begin with the vital signs. These should include; o Temperature o Pulse o Blood pressure o Respiratory rate o Pain (10-point scale rating) Pulse oximetry when available: include the percentage of supplemental O2. If room air, document this. *EXAMPLE:* *O2 Saturation: 88% on room air, 95% on 2 liter nasal canula.* General appearance: include information on the patient's overall condition. It is appropriate to comment on level of comfort or distress, as well as general grooming and hygiene. Example: • Mr. Smith is a well appearing elderly gentleman in no acute distress. • Mr. Smith is a frail appearing elderly gentleman in significant respiratory distress at the time of examination.

	Next should follow the individual body systems in discreet subheadings. Traditionally, systems are listed in a top down fashion when performing a full physical examination. This may vary in subspecialty examinations such as ophthalmology or orthopedics. In general, the format should be as follows HEENT: Neck: Heart: Lungs: Abdomen: Extremities: Neurological: MSK Vascular: Skin: Example: HEENT: Head: no evidence of trauma Nares: normal pink mucosa, no discharge Eyes: no scleral icterus, normal conjunctiva Ears: TM's show normal light reflex, no erythema, normal l landmarks OP: moist mucus membranes; OP with no erythema or exudate. Oral exam with no lesions. Neck: Supple, No thyromegaly, no lymphadenopathy, normal range of motion; JVP estimated to be 7 cm. Heart: PMI nondisplaced and normal size; No thrills or heaves; RRR, S1S2 with no s3 or s4, no murmurs, rubs or gallops Lungs: No increase work of breathing, lungs clear to auscultation, no wheezes or crackles Abdomen: Non distended, no scars, normoactive bowel sounds, no bruits, non-tender to palpation, no hepatosplenomegaly, no masses

	Exteremities: No clubbing, cyanosis or edema; Vascular: pulses are 2+ bilaterally at carotid, radial, femoral, dorsalis pedis and posterior tibial; no bruits Neuro: alert and oriented x 3 (person, place and time), CN II-XII intact; Motor 5/5 in all extremities. Reflexes 3+ and equal throughout. Sensory testing normal to light touch, pinprick, proprioception, and vibration. Finger-nose and Heel to shin/point to point testing normal. Rapid alternating movements normal; Gait: normal get up and go, normal heel-toe and tandem gait MSK: good tone throughout, no swelling/synovitis or limitation of flexion at any joint Skin: normal texture, normal turgor, warm, dry, no rash
Data collection	Include lab and radiological data appropriate for the HPI (include YOUR interpretation, not just copy/paste from medical record report) Labs: Chest xray or other xrays/scans EKG:
Problem List	List all problems, most important first; You will use this to then begin to combine/lump problems to then create your Assessment/Plan by problem list For example: Problem list: Chest pain Fever Shortness of breath Hemoptysis Elevated creatinine
Summary Statement	Label as summary **(" *In summary….)*** Include 1-2 sentence impression restating basic identifying information (***The patient is a 45 year old male****),* Most pertinent information related to the medical/family/social history (***with a history of tobacco use and family history of early CAD****),* Expanded chief complaint and most pertinent review of systems on presentation (***who presents with substernal chest pressure, nausea and diaphoresis***)

	Most important findings on physical, labs, data (***and is found to have an S4, bilateral rales, and JVD on exam with evidence of pulmonary edema on CXR***) **Pertinent information is that which contributes directly to building the case for your differential diagnosis….** ***<u>In summary</u>, the patient is a 45 year old male <u>with a history of</u> tobacco use and family history of early CAD <u>who presents with</u> substernal chest pressure, nausea and diaphoresis <u>and is found to have</u> an S4, bilateral rales, and JVD on exam with evidence of pulmonary edema on CXR…*** ***Key phrases and structure for summary statement:*** ***In summary, this is a …*** ***With a history of…*** ***Who presents with….*** ***And is found to have…***
Assessment/Plan	**<u>Organize plan by problem: Label, Assessment/Plan by problem list</u>** **Include at least 3 diagnoses for your differential potentially associated with the patient's chief complaint** **Include the Most Likely diagnosis/diagnoses on your differential** **Include the DO NOT MISS diagnoses on your differential** **Order your differential to reflect most likely diagnoses or most serious diagnoses first** For each diagnosis discuss physiologic disease basis relevant to the patient and elements from the patient's history and physical that either support or refute the diagnosis. For each item on your differential, explain what makes it likely AND what makes it less likely. It is OK to include less likely items on your differential – explain why it is important to consider but less likely the diagnosis (*PE may be considered frequently when a patient presents with shortness of breath and should be on the differential because it is a Do Not Miss diagnosis – but if the patient has a high white count, cough with sputum and infiltrate on exam, it is LESS likely)* For each problem, discuss the diagnostic plan, treatment plan and patient education. *Outline of what this should look like…* **Summary Statement…** **A/P by Problem List:** 1. **Problem # 1:** **Differential Dx includes…. List at least 3 items for your differential, explain what is most likely and why, what is a must not miss, and what is less likely and why….**

	Diagnostic Plan will be… **Treatment plan will include…** **Patient education…. Instructions to patient include…** 2. **Problem # 2:** **Differential….** **Diagnostic Plan…** **Treatment plan…** **Patient education** 3. **Problem # 3:** **Differential…** **Diagnostic plan…** **Treatment plan…** **Patient education…** For the main problem(s) identified in your problem list, you are expected to identify a **topic or clinical question** that would help you advance your knowledge in that specific area to help you provide better care of patients presenting in a similar way in the future. The topic or clinical question can focus on an epidemiologic, diagnostic, therapeutic, pharmacologic, etc. aspect of patient care. In order to review the topic/answer your question, you should: 1) perform a literature or textbook review to answer your clinical question, 2) incorporate your findings into the assessment and plan of your write-up in the form of 1-2 paragraphs and 3) list the resources used. COM Library resources are strongly encouraged, for suitable resources based on topic of interest please see P2 LibGuide.
Format	Goal is a concise write up with your thought processes documented in logical and organized manner Avoid spelling or grammatical errors Use only commonly accepted abbreviations
HIPAA	Remove patient identification from write up (e.g., name, address, medical record number)

D. Guide to Comprehensive Pediatric H&P Write-Up

INSTRUCTIONS FOR USE OF THE SECTION ON PEDIATRIC HISTORY AND PHYSICAL EXAM

The following outline for the Pediatric History and Physical Examination is comprehensive and detailed. In order to assimilate the information most easily, it is suggested that you read through the whole section before examining your first patient to get a general idea of the scope of the pediatric evaluation. Then, as you encounter patients with specific problems, you may return to the individual sections most pertinent to these patients to absorb the information in detail. Repeat practice with a variety of patients of different ages is crucial to the acquisition of skills in data collection. You should use every opportunity possible to evaluate patients in order to develop a sense of normal growth and development and appreciate the variations in patient encounter that is necessary to perform appropriate evaluation children of different ages.

OUTLINE FOR PEDIATRIC HISTORY

HISTORY

I. Presenting Complaint (Informant/Reliability of informant)

Patient's or parent's own brief account of the complaint and its duration. Use the words of the informant whenever possible.

II. Present Illness

Begin with statement that includes age, sex, color and duration of illness, ex.: This is the first APH admission for this 8 year old white male who has complained of headache for 12 hours PTA. When was the patient last entirely well? How and when did the disturbance start? Health immediately before the illness. Progress of disease; order and date of onset of new symptoms. Specific symptoms and physical signs that may have developed. Pertinent negative data obtained by direct questioning. Aggravating and alleviating factors. Significant medical attention and medications given and over what period.

Use day of admit (DOA) as the reference point for your timeline of present illness. Ever event/symptom that occurs leading up to DOA should listed as # day prior to admission (PTA)

In acute infections, statement of type and degree of exposure and interval since exposure.

For the well child, determine factors of significance and general condition since last visit.

III. Past Medical History

- **Birth**

  A. Antenatal: Health of mother during pregnancy. Medical supervision, drugs, diet, infections such as rubella, etc., other illnesses, vomiting, toxemia, other complications; Rh typing and serology, pelvimetry, medications, x-ray procedure, maternal bleeding, mother's previous pregnancy history.

  B. Natal: Duration of pregnancy, birth weight, kind and duration of labor, type of delivery, presentation, sedation and anesthesia (if known), state of infant at birth, resuscitation required, onset of respiration, first cry.

C. Neonatal: APGAR score; color, cyanosis, pallor, jaundice, cry, twitchings, excessive mucus, paralysis, convulsions, fever, hemorrhage, congenital abnormalities, birth injury. Difficulty in sucking, rashes, excessive weight loss, feeding difficulties. You might discover a problem area by asking if baby went home from hospital with his mother.

A common way to document birth history is as follows:

3445 g full term infant born to a 28 yo G2P2 O+ mother via normal spontaneous vaginal delivery after a pregnancy where mother received prenatal care in the first trimester whose prenatal labs were GBS-, HIV-, GC-, chlamydia -, RPR nonreactive. Mom reports no medications taken during pregnancy or delivery. Delivery was uncomplicated. No resuscitation was required. APGARs were 8 at 1 min and 9 at 5 min. Nursery course was uncomplicated and infant went home with mom on DOL#2.

- **Past Illnesses**

A comment should first be made relative to the child's previous general health, and then the specific areas listed below should be explored.

A. Past medical history: including all diagnoses, infections, Accidents and Injuries (include ingestions): Age, type/nature, severity, sequelae.

B. Past Hospitalizations: including operations, age. Include place of hospitalization and duration of hospitalization.

C. Past Surgeries: where and by whom for what diagnosis

D. Allergies, with specific attention to drug allergies: detail type of reaction. Results of allergy testing gif performed.

E. Medications patient is currently taking- prescribed, OTC, homeopathic. Include dose, formulation, route and frequency.

- **Immunizations and Tests**

Be familiar with Advisory Committee on Immunization Practices (ACIP) recommendations for immunizations. List date and type of immunization, facility providing immunization as well as any complications or reactions. DO NOT LIST “Up to date per parent report” If no immunization record is available, include this as a problem in the assessment and plan so it will be followed up.

- **Growth and Development**

A. Development
  - Motor and Mental Development First raised head, rolled over, sat alone, pulled up, walked with help, walked alone, talked (meaningful words; sentences), formal screening when appropriate.
  - Urinary continence during night; during day
  - Control of feces.
  - Comparison of development with that of siblings and parents.
  - School grade, quality of work.

B. Physical Growth including menarche and other pubertal developments

C. Behavioral History
  - Does child manifest any unusual behavior such as thumb sucking, excessive masturbation, severe and frequent temper tantrums, negativism, etc.?

- Sleep disturbances.
- Phobias.
- Pica (ingestions of substances other than food).
- Abnormal bowel habits, ex. - stool holding.
- Bed wetting (applicable only to child out of diapers).

- **Nutrition**

A. Breast or Formula: Type, duration, major formula changes, time of weaning, difficulties. Be specific about how much milk or formula the baby receives. How does caretaker mix the formula?
B. Vitamin Supplements: Type, when started, amount, duration.
C. "Solid" Foods: When introduced, how taken, types.
D. Appetite: Food likes and dislikes idiosyncrasies or allergies, reaction of child to eating. An idea of child's usual daily intake is important.

IV. Family History - use family tree whenever possible

A. Age and health of family members (parents, grandparents, siblings)
B. Stillbirths, miscarriages, abortions; age at death and cause of death of immediate members of family
C. Known genetic diseases
D. Diseases with a genetic contribution: allergy, blood dyscrasias, mental or nervous diseases, diabetes, cardiovascular diseases, kidney disease, rheumatic fever, neoplastic diseases, congenital abnormalities, cancer, convulsive disorders, others
E. Health of contacts- ill exposures (tuberculosis….)

V. Social History

A. Type of habitat. Age of habitat, number of people in home and relationship to patient
B. Marital status of parents and involvement with child
C. Parents employment
D. Child care or school

VI. Environmental History

A. Environmental tobacco smoke
B. Water source to home
C. Pets
D. Smoke and CO detectors
E. Firearms

VII. System Review

A system review will serve several purposes. It will often bring out symptoms or signs missed in collection of data about the present illness. It might direct the interviewer into questioning about other systems that have some indirect bearing on the present illness (ex. - eczema in a child with asthma). Finally, it serves as a screening device for uncovering symptoms, past or present, which were omitted in the earlier part of the interview. There is no need to repeat previously recorded information in writing a Review of Systems. Questions about health maintenance may be included here such as last dental visit, last ophthalmology visit...

A. General: Unusual weight gain or loss, fatigue, temperature sensitivity, mentality. Pattern of growth (record previous heights and weights on appropriate graphs). Time and pattern of pubescence.

B. Eyes: Have the child's eyes ever been crossed? Any foreign body or infection, glasses for any reason.

C. Ears, Nose and Throat: Frequent colds, sore throat, sneezing, stuffy nose, discharge, post-nasal drip, mouth breathing, snoring, otitis, hearing, adenitis.

D. Teeth: Age of eruption of deciduous and permanent; number at one year; comparison with siblings.

E. Cardiorespiratory: Frequency and nature of disturbances. Dyspnea, chest pain, cough, sputum, wheeze, expectoration, cyanosis, edema, syncope, tachycardia.

F. Gastrointestinal: Vomiting, diarrhea, constipation, type of stools, abdominal pain or discomfort, jaundice.

G. Genitourinary: Enuresis, dysuria, frequency, polyuria, pyuria, hematuria, character of stream, vaginal discharge, menstrual history, bladder control, abnormalities of penis or testes. Details of menarche and menstruation for adolescent females

H. Neuromuscular: Headache, nervousness, dizziness, tingling, convulsions, habit spasms, ataxia, muscle or joint pains, postural deformities, exercise tolerance, gait.

I. Endocrine: Disturbances of growth, excessive fluid intake, polyphagia, goiter, thyroid disease.

J. Hematologic: Bruise easily, difficulty stopping bleeds, lumps under arms, neck; fevers, shakes, shivers

K. Rheumatologic: Joints: pain, stiffness, swollen, variation in joint pain during day, fingers painful/ blue in cold, dry mouth, red eyes, back, neck pain

L. Skin: Ask about rashes, hives, problems with hair, skin texture or color, etc.

OUTLINE FOR PEDIATRIC PHYSICAL EXAM

PHYSICAL EXAMINATION

Every child should receive a complete systematic examination at regular intervals. One should not restrict the examination to those portions of the body considered to be involved on the basis of the presenting complaint.

Approaching the Child

Adequate time should be spent in becoming acquainted with the child and allowing him/her to become acquainted with the examiner. The child should be treated as an individual whose feelings and sensibilities are well developed, and the examiner's conduct should be appropriate to the age of the child. A friendly manner, quiet voice, and a slow and easy approach will help to facilitate the examination.

Observation of the Patient

Although the very young child may not be able to speak, one still may receive much information from him/her by being observant and receptive. The total evaluation of the child should include impressions obtained from the time the child first enters until s/he leaves; it should not be based solely on the period during which the patient is on the examining table. In general, more information is obtained by careful inspection than from any of the other methods of examination.

Sequence of Examination

Skill, tact and patience are required to gather an optimal amount of information when examining a child. There is no routine one can use and each examination should be individualized. Ham it up and regress. Get down to the child's level and try to gain his trust. The order of the exam should conform to the age and temperament of the child. For

example, many infants under 6 months are easily managed on the examining table, but from 8 months to 3 years you will usually have more success substituting the mother's lap. Certain parts of the exam can sometimes be done more easily with the child in the prone position or held against the mother. After 4 years, they are often cooperative enough for you to perform the exam on the table again.

Wash your hands with warm water before the examination begins. You will impress your patient's mother and not begin with an adverse reaction to cold hands in your patients. With the younger child, get to the heart, lungs and abdomen before crying starts. Save looking at the throat and ears for last. If part of the examination is uncomfortable or painful, tell the child in a warm, honest, but determined tone that this is necessary. Looking for animals in their ears or listening to birdies in their chests is often another useful approach to the younger child.

If your bag of tricks is empty and you've become hoarse from singing and your lips can no longer bring forth a whistle, you may have to turn to muscle. Various techniques are used to restrain children and experience will be your best ally in each type of situation.

Remember that you must respect modesty in your patients, especially as they approach pubescence. Sometime during the examination, however, every part of the child must have been undressed. It usually works out best to start with those areas which would least likely make your patient anxious and interfere with his developing confidence in you.

General Physical Examination

I. Vital Signs and Measurements

Temperature, pulse rate, and respiratory rate (TPR); blood pressure (the cuff should cover 2/3 of the upper arm), weight, height, and head circumference. The weight should be recorded at each visit; the height should be determined at monthly intervals during the first year, at 3-month intervals in the second year, and twice a year thereafter. The height, weight, and head circumference of the child should be compared with standard charts and the approximate percentiles recorded. Multiple measurements at intervals are of much greater value than single ones since they give information regarding the pattern of growth that cannot be determined by single measurements.

II. General Appearance

Does the child appear well or ill? Degree of prostration; degree of cooperation; state of comfort, nutrition, and consciousness; abnormalities, gait, posture, and coordination; estimate of intelligence; reaction to parents, physician, and examination; nature of cry and degree of activity, facies and facial expression. Be as descriptive as possible in this section so that your patient “can be picked out of a crowd.”

III. Skin

Color (cyanosis, jaundice, pallor, erythema), texture, eruptions, hydration, edema, hemorrhagic manifestations, scars, dilated vessels and direction of blood flow, hemangiomas, cafe-au-lait areas and nevi, Mongolian (blue-black) spots, pigmentation, turgor, elasticity, and subcutaneous nodules. Striae and wrinkling may indicate rapid weight gain or loss. Sensitivity, hair distribution and character, and desquamation. Be particularly careful in this section to describe your physical exam findings instead of just listing a diagnosis. Also pay particular attention to details that will help determine progression or resolution of lesion at subsequent visits for example, size and location…

***Practical notes:**

A. Loss of turgor, especially of the calf muscles and skin over abdomen, is evidence of dehydration.

B. The soles and palms are often bluish and cold in early infancy; this is of no significance.

C. The degree of anemia cannot be determined reliably by inspection, since pallor (even in the newborn) may be normal and not due to anemia.

D. To demonstrate pitting edema in a child it may be necessary to exert prolonged pressure.

E. A few small pigmented nevi are commonly found, particularly in older children.

F. Spider nevi occur in about 1/6 children under 5 years of age and almost ½ of older children.

G. "Mongolian spots" (large, flat black or blue-black areas) are frequently present over the lower back and buttocks; they have no pathologic significance.

H. Cyanosis will not be evident unless at least 5 gm of reduced hemoglobin are present; therefore, it develops less easily in an anemic child.

I. Carotenemic pigmentation is usually most prominent over the palms and soles and around the nose, and spares the conjunctivas.

IV. Lymph Nodes

Location, size, sensitivity, mobility, consistency. One should routinely attempt to palpate occipital, preauricular, anterior cervical, posterior cervical, sub mandibular, submental, axillary, epitrochlear, and inguinal lymph nodes.

***Practical notes:**

A. Enlargement of the lymph nodes occurs much more readily in children than in adults.

B. Small inguinal lymph nodes are palpable in almost all healthy young children. Small, mobile, non-tender shotty nodes are commonly found in residue of previous infection.

V. Head

Size, shape, circumference, asymmetry, cephalhematoma, bosses, craniotabes, control, molding, bruit, fontanel (size, tension, number, abnormally late or early closure), sutures, dilated veins, scalp, hair (texture, distribution, parasites), face, transillumination.

***Practical notes:**

A. The head is measured at its greatest circumference; this is usually at the midforehead anteriorly and around to the most prominent portion of the occiput posteriorly.

B. Fontanel tension is best determined with the quiet child in the sitting position.

C. Slight pulsations over the anterior fontanel may occur in normal infants.

D. Although bruits may be heard over the temporal areas in normal children, the possibility of an existing abnormality should not be overlooked.

E. Craniotabes may be found in the normal newborn infant (especially the premature) and for the first 2-4 months.

F. A positive Macewen's sign ("cracked pot" sound when skull is percussed with one finger) may be present normally as long as the fontanel is open.

G. Transillumination of the skull can be performed by means of a flashlight with a sponge rubber collar so that it forms a tight fit when held against the head.

VI. Face

Symmetry, paralysis, distance between nose and mouth, distance between eyes, depth of nasolabial folds, bridge of nose, distribution of hair, size of mandible, swellings, hypertelorism, Chvostek's sign, tenderness over sinuses.

VII. Eyes

Photophobia, visual acuity, muscular control, nystagmus, Mongolian slant, Brushfield spots, epicanthic folds, lacrimation, discharge, lids, exophthalmos or enophthalmos, conjunctivas; pupillary size, shape, reaction to light and accommodation; media (corneal opacities, cataracts), fundi, visual fields (in older children). At 2-4 weeks an infant will follow light. By 3-4 months, coordinated eye movements should be seen.

*Practical notes:

A. The newborn infant will usually open his eyes if he/she is placed in the prone position, supported with one hand on the abdomen, and lifted over the examiner's head.

B. Not infrequently, one pupil is normally larger than the other. This sometimes occurs only in bright or in subdued light.

C. Examination of the fundi should be part of every complete physical examination, regardless of the age of the child; dilatation of pupils may be necessary for adequate visualization.

D. A mild degree of strabismus may be present during the first 6 months of life but should be considered abnormal after that time.

E. To test for strabismus in the very young or uncooperative child, note where a distant source of light is reflected from the surface of the eyes; the reflection should be present on corresponding portions of the two eyes.

F. Small areas of capillary dilatation are commonly seen on the eyelids of normal newborn infants.

G. Most infants produce visible tears during the first few days of life but consistent tear production occurs after the first 4-6 weeks of life.

VIII. Nose

Exterior, shape, mucosa, patency, discharge, bleeding, pressure over sinuses, flaring of nostrils, septum.

At birth the maxillary antrum and anterior and posterior ethmoid cells are present. At 2-4 years pneumatization of the frontal sinus takes place but is rarely a site of infection until the 6th - 10th year. Though the sphenoid sinus is present at birth, it does not assume clinical significance until the 5th to 8th year.

IX. Mouth

Lips (thinness, down turning, fissures, color, cleft), teeth (number, position, caries, mottling, discoloration, notching, malocclusion or malalignment), mucosa (color, redness of Stensen's duct, enanthems, Bohn's nodules, Epstein's pearls), gum, palate, tongue, uvula, mouth breathing, geographic tongue (usually normal).

X. Throat

Tonsils (size, inflammation, exudate, crypts, inflammation of the anterior pillars), mucosa, hypertrophic lymphoid tissue, postnasal drip, epiglottis, voice (hoarseness, stridor, grunting, type of cry, speech). The number and condition of the teeth should be recorded. (A child should have 20 teeth by age 2½ years. When the teeth begin to erupt is quite variable but most infants have their two lower central incisors by 8-10 months.

A. Before examining a child's throat it is advisable to examine his mouth first. Permit the child to handle the tongue blade, nasal speculum and flashlight so that he/she can overcome his fear of the instruments. Then ask the child to stick out his tongue and say "Ah" louder and louder. In some cases this may allow an adequate examination. In others, if the child is cooperative enough, he/she may be asked to "pant like a puppy;" while he/she is doing this, the tongue blade is applied firmly to the rear of the tongue. Gagging need not be elicited in order to obtain a satisfactory examination. In still other cases, it may be expedient to examine one side of the tongue at a time, pushing the base of the tongue to one side and then to the other. This may be less unpleasant and is less apt to cause gagging.

B. Young children may have to be restrained to obtain an adequate examination of the throat. Eliciting a gag reflex may be necessary if the oral pharynx is to be adequately seen.

C. The small child's head may be restrained satisfactorily by having the mother place her hands at the level of the child's elbows while the arms are held firmly against the sides of his head.

D. If the child can sit up, the mother is asked to hold him erect in her lap with his back against her chest. She then holds his left hand in her left hand and his right hand in her right hand, and places them against the child's groin or lower thighs to prevent him from slipping down from her lap. If the throat is to be examined in natural light, the mother faces the light. If artificial light and a head mirror are used, the mother sits with her back to the light. In either case, the physician uses one hand to hold the head in position and the other to manipulate the tongue blade.

E. Young children seldom complain of sore throat even in the presence of significant infection of the pharynx and tonsils.

XI. Ears

Pinnas (position, size), canals, tympanic membranes (landmarks, mobility, perforation, inflammation, discharge), mastoid tenderness and swelling, hearing (including hearing screen).

*Practical notes:

A. A test for hearing is an important part of the physical examination of every infant.

B. The ears of all sick children should be examined.

C. Before actually examining the ears, it is often helpful to place the speculum just within the canal, remove it and place it lightly in the other ear, remove it again, and proceed in this way from one ear to the other, gradually going farther and farther, until satisfactory examination is completed.

D. In examining the ear, as large a speculum as possible should be used and should be inserted no farther than necessary, both to avoid discomfort and to avoid pushing wax in front of the speculum so that it obscures the field. The otoscope should be held balanced in the hand by holding the handle at the end nearest the speculum. One finger should rest against the head to prevent injury resulting from sudden movement by the child.

E. The child may be restrained most easily if he/she is lying on his abdomen.

F. Low-set ears are present in a number of congenital syndromes, including several that are associated with mental retardation. The ears may be considered low-set if they are below a line drawn from the lateral angle of the eye and the external occipital protuberance.

G. Congenital anomalies of the urinary tract are frequently associated with abnormalities of the pinnas.

H. To examine the ears of an infant it is usually necessary to pull the auricle backward and downward; in the older child the external ear is pulled backward and upward.

XII. Neck

Position (torticollis, opisthotonos, inability to support head, mobility), swelling, thyroid (size, contour, bruit, isthmus, nodules, tenderness), lymph nodes, veins, position of trachea, sternocleidomastoid (swelling, shortening), webbing, edema, auscultation, movement, tonic neck reflex.

*Practical notes:

In the older child, the size and shape of the thyroid gland may be more clearly defined if the gland is palpated from behind.

XIII. Thorax

Shape and symmetry, veins, retractions and pulsations, beading, Harrison's groove, flaring of ribs, pigeon breast, funnel shape, size and position of nipples, breasts, length of sternum, intercostal and substernal retraction, asymmetry, scapulas, clavicles.

*Practical notes:

At puberty, in normal children, one breast usually begins to develop before the other. In both sexes tenderness of the breasts is relatively common. Gynecomastia is not uncommon in the male.

XIV. Lungs

Type of breathing, dyspnea, prolongation of expiration, cough, expansion, fremitus, flatness or dullness to percussion, resonance, breath and voice sounds, rales, wheezing.

*Practical notes:

A. Breath sounds in infants and children normally are more intense and more bronchial, and expiration is more prolonged, than in adults.

B. Most of the young child's respiratory movement is produced by abdominal movement; there is very little intercostal motion.

C. If one places the stethoscope over the mouth and subtracts the sounds heard by this route from the sounds heard through the chest wall, the difference usually represents the amount produced intrathoracically.

XV. Heart

Location and intensity of apex beat, precordial bulging, pulsation of vessels, thrills, size, shape, auscultation (rate, rhythm, force, quality of sounds - compare with pulse as to rate and rhythm; friction rub-variation with pressure), murmurs (location, position in cycle, intensity, pitch, effect of change of position, transmission, effect of exercise).

***Practical notes:**

A. Many children normally have sinus arrhythmia. The child should be asked to take a deep breath to determine its effect on the rhythm.

B. Extra systoles are not uncommon in childhood.

C. The heart should be examined with the child recumbent.

XVI. Abdomen

Size and contour, visible peristalsis, respiratory movements, veins (distension, direction of flow), umbilicus, hernia, musculature, tenderness and rigidity, tympany, shifting dullness, tenderness, rebound tenderness, pulsation, palpable organs or masses (size, shape, position, mobility), fluid wave, reflexes, femoral pulsations, bowel sounds. If the liver is palpable below the right costal margin, its total span must be recorded. A deep abdomen palpation must be done on every child.

***Practical notes:**

A. The abdomen may be examined while the child is lying prone in the mother's lap or held over her shoulder, or seated on the examining table with his back to the doctor. These positions may be particularly helpful where tenderness, rigidity, or a mass must be palpated. In the infant the examination may be aided by having the child suck at a "sugar tip" or nurse at a bottle.

B. Light palpation, especially for the spleen, often will give more information than deep.

C. Umbilical hernias are common during the first 2 years of life. They usually disappear spontaneously.

XVII. Male Genitalia

Circumcision, meatal opening, hypospadias, phimosis, adherent foreskin, size of testes, cryptorchidism, scrotum, hydrocele, hernia, pubertal changes.

***Practical notes:**

A. In examining a suspected case of cryptorchidism, palpation for the testicles should be done before the child has fully undressed or become chilled or had the cremasteric reflex stimulated. In some cases, examination while the child is in a hot bath may be helpful. The boy should also be examined while sitting in a chair holding his knees with his heels on the seat; the increased intra-abdominal pressure may push the testes into the scrotum.

B. To examine for cryptorchidism, one should start above the inguinal canal and work downward to prevent pushing the testes up into the canal or abdomen.

C. In the obese body, the penis may be so obscured by as to appear abnormally small. If this fat is pushed back, a penis of normal size is usually found.

XVIII. Female Genitalia

Vagina (imperforate, discharge, adhesions), hypertrophy of clitoris, pubertal changes.

***Practical note:**

Digital or speculum examination is rarely done until after puberty.

XIX. Rectum and Anus

Irritation, fissures, prolapse, imperforate anus. The rectal examination should be performed with the little finger (inserted slowly). Note muscle tone, character of stool, masses, tenderness, sensation. Examine stool on glove finger (gross, microscopic, culture, guaiac), as indicated.

XX. Extremities

A. General: Deformity, hemiatrophy, hemihypertrophy, bowlegs (common in infancy), knock-knees (common after age 2), paralysis, edema, coldness, posture, gait, stance, asymmetry.

B. Joints: Swelling, redness, pain, limitation, tenderness, motion, rheumatic nodules, carrying angle of elbows, tibial torsion.

C. Hands and feet: Extra digits, clubbing, simian lines, curvature of little finger, deformity of nails, splinter hemorrhages, flat feet (feet commonly appear flat during first 2 years), abnormalities of feet, dermatoglyphics, width of thumbs and big toes, syndactyly, length of various segments, dimpling of dorsa, temperature.

D. Peripheral Vessels: Presence, absence or diminution of arterial pulses.

XXI. Spine and Back

Posture, curvatures, rigidity, webbed neck, spina bifida, pilonidal dimple or cyst, tufts of hair, mobility, Mongolian spots, tenderness over spine, pelvis or kidneys.

XXII. Neurologic Examination

A. Cerebral Function: General behavior, level of consciousness, intelligence, emotional status, memory, orientation, illusions, hallucinations, cortical sensory interpretation, cortical motor integration, ability to understand and communicate, auditory-verbal and visual-verbal comprehension, recognition of visual object, speech, ability to write, performance of skilled motor acts.

B. Cranial Nerves:

1. I (olfactory) - Identify odors; disorders of smell

2. II (optic) - Visual acuity, visual fields, ophthalmoscopic examination, retina.

3. III (oculomotor), IV (trochlear), and VI (abducens) - Ocular movements, ptosis, dilatation of pupil, nystagmus, pupillary accommodation, and pupillary light reflexes.

4. V (trigeminal) - Sensation of face, corneal reflex, masseter and temporal muscles, maxillary reflex (jaw jerk).

5. VII (facial) - Wrinkle forehead, frown, smile, raise eyebrows, asymmetry of face, strength of eyelid muscles, taste on anterior portion of tongue.

6. VIII (acoustic) -
    a. Cochlear portion - Hearing, lateralization, air and bone conduction, tinnitus.
    b. Vestibular - Caloric tests.

7. IX (glossopharyngeal), X (vagus) - Pharyngeal gag reflex, ability to swallow and speak clearly; sensation of mucosa of pharynx, soft palate, and tonsils; movement of pharynx, larynx, and soft palate; autonomic functions.

8. XI (accessory) - Strength of trapezius and sternocleidomastoid muscles.

9. XII (hypoglossal) - Protrusion of tongue, tremor, strength of tongue.

C. Cerebellar Function: Finger to nose, finger to examiner's finger, rapidly alternating pronation and supination of hands; ability to run heel down other shin and to make a requested motion with foot; ability to stand with eyes closed; walk; heel to toe walk; tremor; ataxia; posture; arm swing when walking; nystagmus; abnormalities of muscle tone or speech.

D. Motor System: Muscle size, consistency, and tone; muscle contours and outlines; muscle strength; myotonic contraction; slow relaxation; symmetry or posture; fasciculations; tremor; resistance to passive movement; involuntary movement.

E. Sensory System: Hearing, vision, light touch, pain, position, vibration.

F. Reflexes:

1. Deep reflexes - Biceps, brachioradialis, triceps, patellar, Achilles; rapidity and strength of contraction and relaxation.

2. Superficial reflexes - Abdominals, cremasteric, plantar, gluteal.

3. Pathologic reflexes - Babinski, Chaddock, Oppenheim, Gordon.

G. Newborn Neurological Examination

***Practical Points:**

Observe the normal flexion of the term infant in contrast to the non-flexed, even flaccid appearance of the normal resting premature. The shape of the premature skull is usually dolichocephalic (long and narrow). Elicit the normal reflexes of grasping (hand and foot), sucking, rooting, Moro and automatic walking. Palpate the head to identify the anterior and posterior fontanelles as well as the sagittal, coronal, metopic and lambdoid sutures.

Impression and Plan

I. Problem List

The problems can be definite diagnoses, symptoms, abnormal findings, or other concerns. Probable or possible diagnosis ("rule out") should not be listed as problems. If your problem list contains a number of symptoms or signs that initially do not fit together each should be listed separately. They may on subsequent days be seen as manifestations of the specific disease. They may then be combined into one problem.

Health Maintenance should be included on the problem list for all children. We list it as a problem to remind us that our major goal is to not let the immediate disease obscure our view of the whole patient. Include here the follow up plan, even from the start. That will help remind the inpatient care team to communicate with the primary care provider.

An example of a problem list follows for a child who is hospitalized with fever, vomiting and pyuria. You find in the past history that he had an allergic reaction to penicillin 6 months ago. In this case the problem list might be put in the chart as:

Fever
Vomiting
History of penicillin allergy
Health Maintenance
Any new problems can be added as the database expands.

II. Impression

A diagnostic impression should be developed. A problem list can be useful for beginners to try to synthesize a patient's findings into a coherent diagnosis and is highly encouraged in your formal write ups. One useful way to synthesize this information is to first describe the anatomy of each abnormality, then to describe the pathologic process (e.g., neoplastic, inflammatory, infectious), finally arriving at a coherent diagnosis. The cycle of data collection, hypothesis setting, hypothesis testing, and action is put into place. The selection of a diagnostic pivot, or unique finding, may assist in narrowing down the differential diagnosis. The rules of parsimony, chronology, and plausibility should be remembered. Common diagnostic errors, such as premature closure (i.e., reaching a conclusion before there is enough data to support it) should be avoided. Common and catastrophic diagnoses are the most important ones to address.

III. Plan

A diagnostic and therapeutic plan should address each diagnostic impression. Tests should be ordered only if the result will alter the plan. Pediatricians tend to be fairly conservative in prescribing medication, especially for self-limited diseases, such as the common cold. One useful way to delineate a plan is by systems (e.g., cardiovascular, pulmonary, hematologic, infectious, fluid/electrolytes/nutrition, etc.).

IV. Discussion

A concise discussion of one or more aspects of our patient's medical problem should follow. The topic should be pertinent to your patient. The goal is not to exhaust the medical literature on a given topic, but to stimulate patient-oriented reading and to encourage you to synthesize your thoughts.

For example, on a patient admitted with sickle cell disease and fever, you might choose to discuss the immune problems of children with sickle cell and their clinical importance. You would not be expected to discuss the molecular biology of sickling and all the various problems this creates.

After you have demonstrated outside reading on a topic, the most important step in the discussion is to apply that reading to the care of your patient. Write at least a concluding paragraph in your discussion that directly relates what you have read to the care of your patient. For example, when writing about immune problems in sickle cell disease, you might conclude with a paragraph of your patient's probable immune problems given his sickle cell disease. This will show interpretation of your reading and application to your patient's care based on his age, past medical history, and current presenting symptoms.

If you are unsure about a topic, or need help with sources, discuss this with your attending.

Include a list of references used at the end of your discussion. At least one basic text and in addition one recent article from the peer reviewed literature should be included as references.

References

Barness LA in McMillan JA, ed., Oski's Pediatrics, 3rd ed., Philadelphia:Lippincott, 1999, pp. 39-52.

Boyle WE and Hoekelman RA, in Hoekelman RA, ed., Primary Pediatric Care, 3rd ed., St. Louis:Mosby, 1997, pp. 45-54.

Department of Pediatrics, USUHS. Outline for Pediatric Data Base. USUHS brochure.

Gundy JH, in Hoekelman RA, ed., Primary Pediatric Care, 3rd ed., St. Louis:Mosby, 1997, pp. 55-97.

Hartman AL, Problem Solving in Medicine, lecture notes 12/99, NMCSD.

Hoekelman RA, in Bates B, A Guide to Physical Examination and History Taking, 4th ed., Philadelphia:Lippincott, 1987, pp. 525-597.

Weston WL, Lane AT, and Morelli JG, Color Textbook of Pediatric Dermatology, 2nd ed., St. Louis:Mosby, 1996, pp. 11-13.

Zitelli BJ and Davis HW, Atlas of Pediatric Physical Diagnosis, St. Louis:Mosby-Wolfe, 1997.

E. Sample History and Physical Write-up

This sample summative H&P was written by a second-year medical student from UCF COM Class of 2017 at the end of COP-2. While not perfect, it best exemplifies the documentation skills students are expected and able to acquire by the end of P-2: organization, thoroughness, relevance, chronology, integrated topic review, documentation of references, etc. For additional H&P samples go to P2 Webcourses home page and click on the COP/Portfolio Resources page.

01/09/2014 9:00 AM
Mr. WA is a pleasant, 67-year-old African American male currently residing at Guardian Care Nursing Home in Orlando FL. Source and Reliability. Long-term care; seems reliable.

***CC**: "I have a dry cough and my nose is runny"*

History of Present Illness (HPI):
Mr. WA presented to the facility's doctor this morning with occasional dry cough and a white towel that shows stains of yellowish mucus spots which he claims he produces when he sneezes. The cough and runny nose began a week ago. They worsen during the day time and when the patient is supine. Nothing improves them. The patient experienced one episode of vomiting that was induced by the cough last night. The patient claimed that the cough is not associated with any pain on the pain scale.
Mr. WA denies dizziness, shortness of breath, palpitations, or edema. He has experienced similar episodes of cough, congestion and heartburn over the past few years.

Medications.
Montelukast (Singulair). 10-mg QD
Aspirin 81-mg QD.
Omeprazole (Prilosec) 15-mg QD.
Acetaminophen (Tylenol) 325-mg prn

***Allergies.** No known drug or seasonal allergies.*
Tobacco. About 1 pack a day for the last 45 years. (45 pack-year).
Alcohol/drugs. Currently does not consume alcohol, but has a history of alcohol abuse. No illicit drugs.

Past Medical History (PMH):
Adult illnesses. ***Medical:***

1. *Left-sided atherothrombotic stroke, 2012.*
2. *Dysphagia, 2012.*
3. *Bronchitis, 2012.*
4. *Allergic rhinitis, 2012.*
5. *Alcoholism, 2004.*
6. *Pneumonia, at age 6.*

***Surgical:** Left thigh bone spur removal, 1972. Appendectomy, 1972. Cataract surgery, 2009.*
***Psychiatric:** None.*
Health Maintenance:
***Immunizations:** Patient is up to date on vaccinations with the exception of the flu shot.* ***Screening tests:** Normal colonoscopy results 9 months ago. Patient does not recall having a prostate exam during his last physical. No EKG included in the patient's chart.*

Family History:
Father died at 93 from lung disease. Father was hypertensive and abused alcohol. Mother died at 79 with a myocardial infarction.
One brother died at 68 with lung disease. He was a smoker
No family history of tuberculosis, cancer, kidney disease, hematologic disorders, or mental illness.

Social History:
Prior to his stroke two years ago, Mr. WA lived with his brother, worked as a surgical technician and did roofing construction part-time. He is single and has no children.
Exercise and diet. Uses a wheel chair to move around the facility, but does not actually need it to walk. He attends regular physical therapy sessions. Diet is balanced.
Safety measures. Reports feeling safe and happy at the facility and was observed socializing with other residents in the smoke designated area playing board games.

Review of Systems (ROS):
- *Constitutional: denies chills, fatigue, fever, and night sweats. Reports 28 lbs loss in the last two years.*
- *Skin: Denies redness, swelling, atypical moles, dry skin, itching or rashes.*
- *HEENT: Head: Denies history of head injury. Eyes: Denies eye pain, eye drainage, and eye irritation. Reports blurred vision. Ears: Denies ear pain. Good hearing. Nose: Denies bloody nose, reports one week history of nasal congestion and yellow mucus. Throat: Denies hoarse voice and sore throat.*
- *Neck: Denies lumps, goiter, pain and swollen glands.*
- *Respiratory: Denies dyspnea, TB exposure, hemoptysis, and wheezing. Reposts occasional dry cough.*
- *Cardiovascular: Denies chest pain, orthopnea, palpitations, and PND.*
- *Gastrointestinal: Denies abdominal pain, constipation, and nausea. Reports occasional heartburn, blood in stool 2 months ago, occasional vomiting episodes when coughing at night and occasional gas episodes not associated with any particular types of foods.*
- *Genitourinary: Denies hematuria, nocturia, and incontinence. Reports hesitation, polyuria in the mornings and difficulty to initiate urination.*
- *Peripheral Vascular: Denies history of varicose veins, edema, or peripheral ulcers.*
- *Musculoskeletal: Denies back pain, and joint stiffness. Reports fatigue in the left hand since the stroke and also fatigue when walking for more than two minutes. He needs to stop and rest his leg muscles every so often.*
- *Psychiatric: Denies history of depression or treatment for psychiatric disorders.*
- *Neurologic: Denies ataxia, fainting, headaches, seizures. Reposts weakness in his left hand.*
- *Heme/lymphatic: Denies bruising or bleeding and adenopathy.*
- *Endocrine: Denies hair loss, heat or cold sensitivity, and polydipsia*

Physical Exam:
Mr. WA is an average-height thin elderly AA male who spends most of his day in a wheel chair in the smoke designated area of a nursing home. He is alert, smiling, very friendly and cooperative with answering questions.
- ***Vitals:***
  Temp: 90.8 FPulse: 71 Resp. Rate: 18 BP: 138/80
- ***General:***
  Alert, calm, well-developed. No acute distress.
- ***Skin:***
  No rashes, lesions, or suspicious moles. Nails without clubbing or cyanosis.

- ***HEENT:***
  Head: Male-pattern hair balding. Scalp without lesions. Eyes: Not performed. Ears: Not performed. Nose: Mucosa pink, septum midline, yellow nasal discharge. No sinus tenderness. Mouth: Mucosa pink. Poor dentition. Tongue midline. Throat: Tonsils present. No exudates.
- ***Neck:***
  Neck supple. Trachea midline. Thyroid isthmus barely palpable, lobes not felt. No LAD. Full range of motion. No carotid bruit.
- ***Respiratory:***
  Thorax symmetric with equal bilateral excursion. Reduced lung sounds bilaterally. Breath sounds are shortened with slight wheezing. Diaphragm descend 3 cm bilaterally.
- ***Cardiovascular:***
  No noticeable JVD. Normal PMI Good S_1, S_2; No S_3 or S_4. Regular rate and rhythm with normal S1 and S2. No murmurs, rubs or gallops.
- ***Gastrointestinal:***
  Recommended but not performed. Patient was in a wheel chair outdoors.
- ***Genitourinary:***
  Recommended but not performed.
- ***Rectal:***
  Recommended but not performed.
- ***Extremities:***
  Warm without edema or ulcerations. Weakness in left hand.
- ***Peripheral vascular:***
  No varicosities in both legs. No stasis pigmentations or ulcers

	Radial	*Femoral*	*Popliteal*	*Dorsalis Pedis*	*Posterior tibial*
Rt	*2+*	*2+*	*2+*	*3+*	*2+*
Lt	*2+*	*2+*	*2+*	*2+*	*2+*

- ***Musculoskeletal:***
  No joint deformities. Good range of motion in all joints (right hand, right wrists, elbows, shoulders, and spine). Reduced range of motion in left hand and left wrist.
- ***Neuro:***
  Mental Status: Alert and oriented to person, place, and time. Able to communicate well in English. Cranial nerves: Not performed. Motor: patient uses a wheel a chair but claims can walk on his own. Sensory: Pinprick, light touch, position sense, vibration and stereognosis intact. . Reflexes: Not performed.

***Pertinent Diagnostic Tests**:*

None.

Summary Statement:

Mr. WA is a hypertensive 67-year-old elderly AA male residing at a nursing home who presents with symptoms of allergic rhinitis, persistent cough, GERD, blood in stool, enlarged prostate, and effects of CVA hemiparesis.

Problem List:

1. *Chronic cough/Allergic Rhinitis*
2. *BPH*
3. *GERD*
4. *Peptic Ulcer*
5. *HTN*
6. *Patient Education*

Assessment and Plan (problem based):

- ***Chronic cough:*** *Mr. WA has had chronic recurrent episodes of dry cough and rhinitis for as long as he resided at this nursing facility. Chronic cough is usually defined as a cough that lasts for eight weeks or longer. 90% of cases of chronic cough are caused by postnasal drip, asthma, and acid reflux. Mr. WA has already been diagnosed with Allergic rhinitis and is currently taking medication for his allergies. He was also diagnosed with GERD and is currently on medication for it. Mr. WA was also diagnosed with bronchitis in the past which can also exacerbate his cough. In a long term smoker like our patient chronic cough could also be a sign of lung cancer, so the proper work-up needs to be done to rule this diagnosis out.*
  Plan:
  - *Recommend lung imaging to assess the condition of the patient lung as a smoker and rule out lung cancer.*
  - *Recommend lung function test to measure the pattern of airflow into and out of the lung and assess the patient lung function. This will also reveal the presence of obstructive or restrictive lung disease.*
  - *Maximize the patient's allergy and GERD medication to alleviate postnasal drip and reflux.*
  - *Advise the patient against high fat foods, acidic juices, excessive alcohol, eating 2-3 hours before lying down, and smoking.*
  - *If cough persists after all major illnesses have been ruled out, a cough suppressant such as dextromethorphan can be used to suppress the cough reflex and alleviate the symptoms.*

- ***Benign Prostatic Hyperplasia****: Mr.WA is displaying signs of an enlarged prostate which becomes increasing common in older men. There are multiple treatments for BPH including medical and surgical depending on the severity of the symptoms and the extent of the enlargement.*
  Plan:
  - *Recommend digital rectal exam to assess the condition and size of Mr. WA.*
  - *Recommend PSA blood test. PSA values can be elevated in BPH and prostate cancer.*
  - *If prostate is proven to be enlarged on physical exam, perform a transrectal ultrasound to obtain a better image of the prostate size and the location of the enlargement.*
  - *Perform a urinalysis to rule out infectious conditions.*
  - *Perform a neurological exam to rule out any neurological reason that can cause urinary symptoms since Mr. WA has had a pervious stroke.*

- ***Gastroesophageal Reflux Disease****: Mr.WA has been diagnosed with GERD and is currently taking a proton pump inhibitor (omeprazole). Conditions that can increase the risk of GERD include obstructive lung disease and smoking. Mr. WA has a 45-year history of smoking and was diagnosed with bronchitis at a young age.*
  Plan:
  - *Since Mr. WA has already been diagnosed, no additional diagnostic tests are needed.*
  - *Advise Mr. WA to avoid foods and drinks that trigger heartburn such as high fats, fried foods, tomatoes, alcohol, chocolate… Etc. Also advise the patient against lying down after eating. Recommend elevating the head of the bed at night, eating smaller meals, maintaining healthy weight; avoid tight-fitting clothing and smoking.*

- ***Peptic Ulcer:*** *Mr. WA reported seeing blood in his stool 2 months ago, despite having had a normal colonoscopy 9 months ago. Blood in stool in Mr. WA's case can be due to his long history of smoking, alcohol abuse, GERD or chronic medication use such as pain relievers.*
  Plan:
  - *The supervising physician (Dr. J) has determined to switch Mr. WA from regular aspirin to the enteric coated formula.*
  - *An occult blood test should also be performed.*
  - *If conditions does not improve with the enteric coated medication, or blood continued to be seen in the stool, an endoscopy of the upper digestive system should be performed.*

- ***Hypertension****: According to Dr. J, Mr. WA's BP reading of 138/80 was considered too high. As a former stroke patient, according to Dr. J, Mr. WA BP needs to be lower but not below 110/60 to maintain adequate perfusion. High blood pressure has many risk factors, and unfortunately Mr. WA meets many of them. Age (higher risk at older age), gender (men are at higher risk), race (blacks are at higher risk), family history, lack of physical activity, using tobacco, excessive alcohol use, stress, and chronic health condition.*

Plan:

- *Dr. J has determined to place Mr. WA on a low dose of Metoprolol (a beta blocker) to aid with his high blood pressure and as cardio-protective measure.*
- *Mr. WA was also advised on the measures he needs to take to maintain a healthy blood pressure which include eating a healthy diet, decreasing sodium in diet, maintaining healthy weight, increasing physical activity, limiting alcohol, managing stress, and taking his blood pressure readings frequently.*

- ***Patient Education****: It seems that many of Mr. WA problems are stemming from his chronic use of tobacco and alcohol and exacerbated by his recent stroke. Smoking is also a major risk factor for ischemic strokes, so by not ceasing to smoke, Mr. WA is placing himself at risk of future catastrophic health events and worsening of his current symptoms.*

  Plan:

  - *Inform Mr. WA that smokers are 2-4 more likely to develop CAD than non-smokers. They are also 4 times more likely to suffer from a stroke. Men who are smokers are 23 times more likely to develop lung cancer.*

Sources:

UpToDate: Adult Chronic Cough
http://www.uptodate.com/contents/chronic-cough-in-adults-beyond-the-basics#H1
Mayo Clinic: BPH
http://www.mayoclinic.org/diseases-conditions/benign-prostatic-hyperplasia/basics/tests-diagnosis/con-20030812
Mayo Clinic: GERD
http://www.mayoclinic.org/diseases-conditions/gerd/basics/lifestyle-home-remedies/con-20025201
Mayo Clinic: Peptic Ulcer
http://www.mayoclinic.org/diseases-conditions/peptic-ulcer/basics/tests-diagnosis/con-20028643
Mayo Clinic: HTN
http://www.mayoclinic.org/diseases-conditions/high-blood-pressure/basics/lifestyle-home-remedies/con-20019580
Center for Disease Control: Smoking Cessation
http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/#children

F. History & Physical Write-Up Assessment Rubric

	Component of Write-up	Incomplete	Developing I	Developing II	Developing III	Advanced
Subjective	**Chief Complaint 0-2 points**	None [0 points]		Present		Includes patient's main complaint, in patient's words, and no additional information/patient information/other non-pertinent wording [2 points]
	Opening Sentence 0-5 points	None [0 point]		present but lacks appropriate important information, or includes information that is not important to the differential		includes appropriate history and not distractors [5 points]
	HPI (0-10 points, 2 for each component below)					
	HPI Organization	Not organized		Partially organized		Well organized
	HPI Thoroughness	Not thorough		Partially thorough		Very thorough
	HPI Includes pertinent positive ROS	Does not include pertinent positive ROS		Includes some pertinent positive ROS		Includes most pertinent positive ROS
	HPI Includes pertinent negative ROS	Does not include pertinent negative ROS		Includes some pertinent negative ROS		Includes most pertinent negative ROS
	HPI Includes pertinent past history/ family history/social history	Does not include pertinent past history/ family history/social history		Includes some pertinent past history/ family history/social history		Includes most pertinent past history/ family history/social history
	PMH 0- 2 points	None [0 points]		Disorganized, incomplete, paragraph format		Organized, thorough, bulleted format (includes surgical history, ob/gyn history if appropriate, vaccinations & developmental history if a child) [2 points]
	Medications 0-2 points	nothing written (if no medications, must state so) [0 point)		medications listed but uses abbreviations, trade names		Medications listed, no abbreviations, generic names, or no meds listed as "no medications" [2 points]
	Allergies 0-2 points	Nothing listed (if no allergies, must indicate such) [0 point]		Allergies listed but not reactions		Allergies and reactions listed, or no allergies listed as "no known drug allergies" [2 points]

	Social History **0-1 points** *Point system does NOT reflect a lack of importance to this!!!*	None [0 point]		Includes some but not all of alcohol, tobacco, drug use, living situation/social support		Includes alcohol, tobacco, drug use and living situation/social support [1 points]
	Family History **0-1 points** *Point system does NOT reflect lack of importance*	None [0 point]		Includes partial family history		Includes family history [1 points]
	ROS **0- 5 points** General; Skin; HEENT; Respiratory; Cardiac; GI; GU; GYN; Musculoskeletal; Vascular; Neurological; Psychiatric; Endocrine; Hematologic.	None [0 points]		Lists only a few, not organized, includes PE or other findings, repeats information already described in HPI		Thorough, excludes information written in HPI with "as in HPI" references, does not include any PE findings in ROS [5 points]
Objective	**Physical Examination** **0-10 points** Vital Signs, General Appearance, Skin, HEENT, CV, Respiratory, GI, GU, Musculoskeletal, Neurologic, Psychiatric	None [0 points]		Incomplete, Unorganized		Includes vitals, organized in appropriate order, thorough [10 points]
Summary	**Summary Statement** **0-10 points**	None [0 points]		Present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect		Organized, includes pertinent HPI, PE and data leading to differential diagnosis [10 points]
TOTAL FOR ABOVE: 50 POINTS						
Assessment and Plan	**Problem List** **0- 5 points**	None listed [0 points]		Present but incomplete		Organized, thorough, complete; includes chief complaint [5 points]
	Differential diagnosis **0-20 points**	None [0 points]		Less than 3 items on differential		At least 3 items on the differential, includes the cc as a problem for clinical reasoning [20 points]

	Clinical Reasoning **0- 25 points**	None [0 points]	Minimal reasoning, does not list most likely diagnosis or "must not miss" diagnosis	More thorough, but not organized into "differential, work up, treatment" „	Thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes "must not miss" diagnoses when appropriate; organized into "differential, work up, treatment plan" format	Differential and clinical reasoning "wows"; reasoning is advanced; [25 points]
TOTAL FOR ABOVE: 50 POINTS						

G. Community of Practice-2 Preceptor Evaluation of Student Professionalism

Please provide feedback on your assigned student for Community of Practice:

1) Integrity

- **Exemplary**: Student demonstrated exemplary interactions with patients, colleagues, faculty and staff.
- **Meets Expectations**: Student demonstrated integrity in interactions with patients, colleagues, faculty and staff.
- **Does Not Meet Expectations**: Student lacked integrity in interactions with patients, colleagues, faculty and staff even after feedback was provided.

2) Patient Confidentiality

- **Meets Expectations**: Student maintained patient confidentiality and showed respect to all individuals.
- **Does Not Meet Expectations**: Student did not maintain patient confidentiality and/or showed disrespect.

3) Appearance and Attire

- **Meets Expectations**: Student was dressed professionally at all times.
- **Does Not Meet Expectations**: Student did not dress professionally. Student was notified more than once of this expectation.

4) Reliability

- **Exemplary**: Student consistently completed assigned tasks (readings, write-ups) and arrived in a timely manner. Student was always well prepared for COP sessions.
- **Meets Expectations**: Student completed assigned tasks (readings, write-ups) on time, arrived in a timely manner and was prepared for COP sessions.
- **Does Not Meet Expectations**: Student did not follow through on assigned tasks (readings, write-ups), was frequently late, cancelled sessions or came unprepared for COP sessions.

5) Adaptability and Receptivity to Feedback

- **Exemplary**: Student actively sought feedback and incorporated suggestions. Student proactively created a plan to improve knowledge and skills.
- **Meets Expectations**: Student was receptive to feedback when appropriate. Student was responsible for deficiencies and took corrective steps.
- **Does Not Meet Expectations**: Student was not receptive to feedback when appropriate. Student did not take responsibility for deficiencies or take corrective steps.

6) Interpersonal Skills

- **Exemplary**: Exemplary interpersonal skills. Consistently demonstrated the ability to establish rapport and employ active listening to communicate effectively with patients, colleagues and staff. Always demonstrated patience and respect in interactions with patients, colleagues and staff.
- **Meets Expectations**: Student demonstrated the ability to establish rapport and employ active listening to communicate effectively with patients, colleagues and staff. Demonstrated patience and respect in interactions with patients, colleagues and staff.
- **Does Not Meet Expectations**: Student did not demonstrate the ability to establish rapport and employ active listening to communicate effectively with patients, colleagues and staff.

7) Relations with Team

- **Exemplary**: Active team member. Consistently worked effectively with others as a team member.
- **Meets Expectations**: Student worked effectively with others as a team member.
- **Does Not Meet Expectations**: Student had difficulty working effectively with others as a team member.

8) Commitment to Learning

- **Exemplary**: Student always displayed interest and enthusiasm in learning and patient interactions. Consistently contributed to an atmosphere conducive to learning. Consistently engaged in self-directed learning and demonstrated intellectual curiosity. A role model to fellow students.
- **Meets Expectations**: Student usually displayed interest and enthusiasm in learning and patient interactions. Contributed to an atmosphere conducive to learning. Student mostly engaged in self-directed learning.
- **Does Not Meet Expectations**: Student displayed little to no interest in learning and patient interactions. Did not contribute to an atmosphere conducive to learning. Student did not engage in self-directed learning.

9) Do you have any confidential feedback about this student? (Students will see your above responses but will NOT see your comments to this question)