



**College of  
Medicine**

UNIVERSITY OF CENTRAL FLORIDA



## **Community of Practice-2 Portfolio**

Portfolio Advisor Manual

2017-18



# College of Medicine

UNIVERSITY OF CENTRAL FLORIDA

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# Introduction

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## ***Community of Practice: An Overview***

The Community of Practice (COP) program, a key component of the Practice of Medicine 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. This program allows students to work one-on-one with local Central Florida practicing physicians (commonly referred to as preceptors). 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.

During the second year of Community of Practice (COP-2), students are paired up and scheduled to rotate with preceptors in various clinical settings where patients receive care for complex and/or acute medical conditions (e.g., inpatient ward, emergency room, urgent care, nursing home, etc.). The goals are for students to continue to learn and practice their clinical and communication skills, obtain a deeper sense of the complex interaction of medical problems, and appreciate the often complex biological, psychological, social, and/or physical dimensions of patient care.

Student pairs are assigned a preceptor for 8 four-hour sessions throughout the academic year. Each session will have specific learning objectives and requirements for the students, including the completion of assignments through an electronic instrument known as an electronic portfolio (commonly referred to as *e-portfolio*).

## ***Community of Practice-2 Portfolio***

The COP-2 *e-portfolio* is a tool for 2<sup>nd</sup>-year students to chronicle their learning needs, form learning goals and plans, and record their progress towards achieving these as well as towards satisfying each COP-2 assignment. It provides a platform for students to reflect on their learning activities, key events and experiences, as well as assembling a collection of work that demonstrates their achievements of competency goals.

Building a portfolio is an interactive, longitudinal process during which students are encouraged to take ownership of their learning and be proactive in planning and pursuing their educational goals while receiving guidance and feedback from a portfolio advisor.

Learning portfolios have become commonplace in both undergraduate and graduate medical education as an instrument to encourage reflection, self-assessment, and self-directed learning. Portfolios have been shown to increase students' knowledge and understanding, ability to integrate theory and practice, self-awareness and self-regulation, and ability to cope with uncertainty.

Maintaining an e-portfolio will enhance students' preparedness for their future medical training and practice during which the keeping of a portfolio and engagement in self-directed learning and reflective practice represent essential life-long learning skills for physicians.



# The COP-2 E-Portfolio

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## **1. Portfolio Purpose**

The purpose of a COP-2 *e-portfolio* is to provide a vehicle for students to record and track their activities, achievements, and professional development longitudinally and to facilitate students' development of essential life-long learning skills for physicians.

Specifically, it:

- 1.1 Shows the student's progress through the assignments submitted, clinical experience gained, skills learned and assignments completed.
- 1.2 Allows the learner to establish and revise learning plans, time management schedules, and reflective learning.
- 1.3 Reminds the student of the learning objectives of COP-2 and the attributes of a reflective practitioner.
- 1.4 Promotes self-directed learning.
- 1.5 Chronicles evidence of the student's ability to engage in self-assessment by identifying their best work and areas for improvement through artifacts submitted and the Personal Development Plan (PDP).
- 1.6 Provides evidence of self-reflection: document engagement in regular self-reflection on professionalism and humanistic qualities of being a physician, such as empathy, altruism, service and caring.

## **2. Portfolio Objectives**

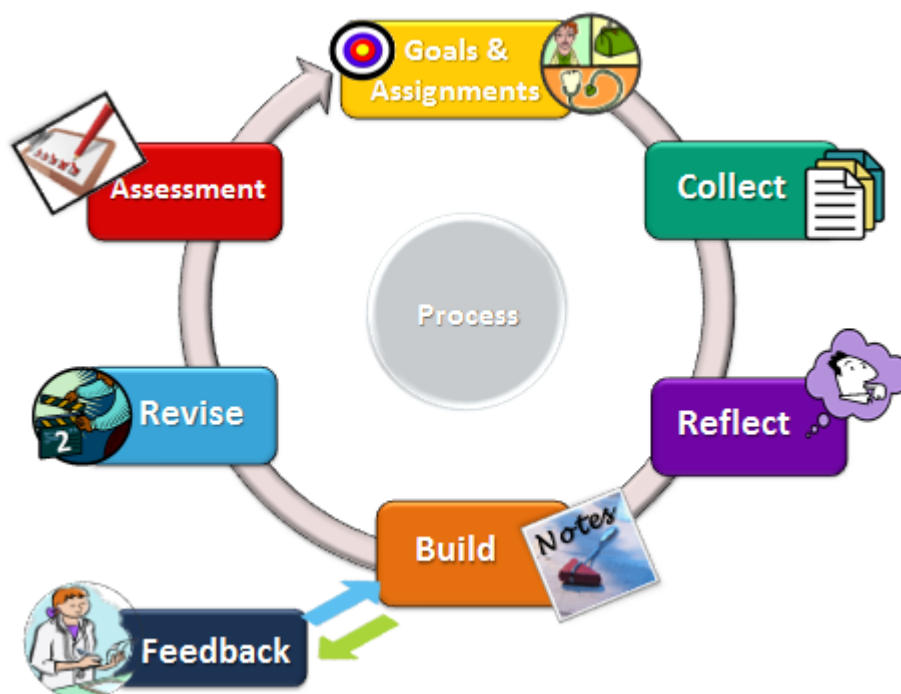
The objectives of the learning portfolio are to:

- 2.1 Document the student's progress through COP-2.
- 2.2 Clarify areas for improvement.
- 2.3 Give greater responsibility to student for their learning experience.
- 2.4 Provide an opportunity for reflective learning.
- 2.5 Provide additional information to faculty regarding students' progress and learning.
- 2.6 Facilitate communication between students and portfolio advisors.
- 2.7 Establish (and allow for revision of) learning plans and time management schedules.
- 2.8 Promote self-directed learning essential for continuing professional development and lifelong learning.

## **3. Portfolio Process**

- 3.1 UCF College of Medicine uses LiveText® as the e-portfolio platform. LiveText® is a customizable, web-based interface that allows students to create, submit and complete assignments; and allows faculty to track and assess assignments as well as evaluate and document course objectives ([www.livetext.com](http://www.livetext.com)).

- 3.2 Students are introduced to the e-portfolio during the first week of the module and are instructed on how to set up a LiveText® account and personalize their profile. The e-portfolio is designed to be centered on the student who owns and fully manages its content. Thus each student is responsible for the maintenance and accuracy of their portfolio.
- 3.3 Students meet face-to-face with their assigned portfolio advisor at the beginning of the year to review the portfolio process, exchange contact information, and agree on best communication method(s) between them. This meeting is also dedicated to discussing the H&P write-up format, content and expectations through a portfolio advisor-lead **H&P Writer's Workshop** (See materials at the end of this handbook).
- 3.4 Students will collect artifacts that represent their work through COP-2, including satisfaction of all assignments and achievements on competency goals.
- 3.5 The COP-2 learning portfolio has the following components:
- 3.4.1 Assignments: These include clinical experience (clinical sessions), learning plans, self-appraisals, assessments and records of completion of each assignment.
  - 3.4.2 Records of professional development
  - 3.4.3 Reflective learning: Reflective learning uses principles similar to quality assurance employing feedback to improve learning and performance.
  - 3.4.4 Students are to constantly review the contents of their portfolios at regular intervals and review progress toward their learning plans and competency goals.



## **4. Portfolio Learning Plans**

**4.1** Students are required to develop and document a Personal Development Plan (PDP) at the beginning of the academic year.

These plans are to identify:

**4.1.1** Student's personal learning needs and learning goals for COP-2.

**4.1.2.** Learning processes: What steps or strategies students will take to achieve their goal?

**4.1.3** How will they determine that they have achieved their goals?

## **5. Time Management and Communication**

Time management on the student's end is an essential component of maintaining a portfolio. This includes allocating appropriate time for COP-2 learning activities, reflection, documentation and maintenance of their portfolio, as well as timely submission of assignments. Students (directly or through the COP Coordinator) are required to notify their advisor via email of assignments submitted for review, specifically after each H&P.

*Given the lack of an instant-messaging feature within LiveText®, students and their assigned advisor will need to agree on a communication means outside of LiveText® to exchange additional comments, questions and ideas outside of their required work.*

## **6. Portfolio Advisor Role**

The e-portfolio will function as a platform for students to chronicle their learning and reflect on their progress; as such it provides an opportunity for students to develop lifelong learning skills. Crucial to this process is the **portfolio advisor**, a faculty advisor who reviews students' assignments and provides formative feedback.

Portfolio advisors' role includes:

- Meet face-to-face with assigned students at the beginning of the year to review the portfolio process, exchange contact information, and agree on best communication method(s) between them. This meeting is also dedicated to discussing the H&P write-up format, content and expectations through the **H&P Writer's Workshop** (details in the Video-based H&P / Writer's Workshop assignment in LiveText).
- Reviewing entries sent to him/her by the student.
- Provide formative feedback on written H&Ps and help students develop documentation and clinical reasoning skills
- Provide detailed constructive feedback on each H&P **within two (2) weeks** of student's submission.
- Being available to meet with students, provide support and coaching, and deal with challenging situations.
- Being a resource to students throughout the COP experience.

- Communicating to module directors any concerns regarding student entries or content not aligned with expectations or the UCF Honor Code as described in the following online document:  
<http://med.ucf.edu/media/2012/08/UCF-COM-Honor-Code.pdf>

## **7. Formative and Summative Assessment**

The electronic portfolio will be utilized as both a learning instrument to stimulate reflection, self-regulation and professional growth, as well as an instrument for assessment. The portfolio will serve as a means to assess 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 H&Ps, reflective exercises, clinical checklists, logbook entries, etc. for formative feedback. For summative assessments, students will have the opportunity to use the feedback received on formative assessments (Formative H&Ps) to complete their summative assessments (Summative H&Ps) and submit this for grading (See Table 1).

Each portfolio advisor is assigned a group of students and provides ongoing non-graded formative feedback to students both individually and (if desired) in group sessions throughout the year.

**Summative assessments are conducted by a dedicated UCF College of Medicine assessment team.**

### **7.1. COP-2 Professionalism Assessment**

Students' professionalism during COP-2 is assessed by their COP preceptors at the end of the academic year. Students are expected to adhere to the UCF Honor Code and Guidelines of Professional Conduct as described in the following online document:

<http://med.ucf.edu/media/2012/08/UCF-COM-Honor-Code.pdf>

### **7.2. COP-2 Portfolio Entries & Assignments**

Portfolio entries will be scored on timeliness, completeness, and quality based on scoring rubrics. Similarly, scoring of reflection and self-assessment assignments, including the Professional Development Plan, will be based on timely completion and submission.

<b>Portfolio Entries &amp; Assignments</b>	<b>Assessment</b>
<b>Personal Development Plan (PDP)</b>	Formative
<b>Written H&amp;Ps</b>	Video-based H&P (Formative) Formative H&P #1 Formative H&P #2 Summative H&P #1 Summative H&P #2
<b>Narrative Reflection</b>	Summative

List of all portfolio assignments and nature of assessment

## **8. Summative Assessment Team (SAT)**

A dedicated summative assessment team composed of UCF College of Medicine core faculty (currently COP Module Directors) will provide rubric-based summative feedback on students' portfolio summative assignments. **Portfolio advisors are only expected to provide formative feedback.**

## **9. Module Directors**

Module Directors oversee all e-portfolios and, at this time, provide summative graded feedback on student-summative assignments. Module Directors also:

- Design the portfolio program and guidelines
- Provide faculty development for portfolio advisors
- Oversee the entire e-portfolio design and coordination process
- Serve as a resource to portfolio advisors
- Constitute the SAT Team



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## **10. COP e-Portfolio Coordinator**

The COP e-Portfolio Coordinator is the primary liaison between first and second-year students and portfolio advisors. Other relevant responsibilities of this role include:

- Assist module directors in managing all aspects of the COP-2 e-portfolio experience
- Serve as liaison between students, faculty and UCF staff, as well as between community practice physicians and the COP program
- Recruit and provide orientation to community faculty directly involved with the COP and Portfolio Advisor programs
- Serve as student advisor when concerns or issues arise

Any questions or concerns regarding the COP program and e-portfolios may be forwarded to the COP e-Portfolio Coordinator directly.



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## **11. Technical Support**

For the resolution of technical issues related to the LiveText platform, please contact our COP Coordinator during regular business hours (Monday through Friday, 8:00-5:00). As an alternative, you may call 1-866-LiveText (1-866-548-3839) during the hours of operation shown below, or email them at [support@livetext.com](mailto:support@livetext.com).

### **LiveText Hours of Operation:**

**Monday to Thursday:** 7:00am to 9:00pm (CT)

**Friday:** 7:00am to 6:00pm (CT)

**Saturday:** Closed

**Sunday:** 12:00pm to 9:00pm (CT)

## 12. Portfolio and COP-2 Calendar: A Year at a Glance

Weeks	Week 1-3	Week 4	Week 8	Week 10	Week 14	Week 17	Week 18-22	Week 23	Week 27	Week 30	Week 32
<b>COP-2 Session</b>	Flex	#1	#2	#3	#4	#5	Flex	#6	#7	#8	
<b>SESSION ACTIVITY</b>	Document PDP  Face-to-face Meeting with Portfolio Advisor	Discuss PDP with preceptor  2 patients  <b>1 PEL</b>	2 patients  <b>1 PEL</b>	2 patients  <b>1 PEL</b>	2 patients  <b>1 PEL</b>	2 patients  <b>1 PEL</b>	Work on Assignments due	2 patients  <b>1 PEL</b>	2 patients  <b>1 PEL</b>	2 patients  <b>1 PEL</b>	
<b>PORTFOLIO ACTIVITY</b>	PDP entry		Video-based H&P entry	Formative H&P #1 student entry		Summative H&P #1		Summative Entry: Narrative Reflection	Formative H&P #2 student entry		Summative H&P #2

**PDP:** Personal Development Plan

**H&P:** History and Physical Write-up

**PEL:** Patient Encounter Log (submitted by students via Qualtrics®)

**Session Activity:** activities students complete as part of their COP-2 clinical sessions

**Portfolio Activity:** activity students are expected to enter in the portfolio based on session activities

**NOTE:** For specific dates on these activities, please refer to your WebCourses calendar.

*Highlighted assignments are the only ones expected to be reviewed by portfolio advisors.*

# Portfolio Assignments

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*The following sections provide details on the different assignments and students' expectations of the COP-2 e-portfolio for information purposes, for the sake of portfolio advisors' understanding of student goals and program expectations, and to help facilitate a better mentoring experience. Portfolio advisors play a very important role in this educational process and are encouraged to provide spontaneous feedback on any of these e-portfolio components at any time.*

Below is a list of COP-2 assignments students are expected to submit to their COP-2 e-portfolio. Portfolio advisors are expected to provide formative feedback on some of the assignments completed by students (bolded below). However, portfolio advisors may choose to review and/or provide formative feedback on any of the assignments listed below at any time. This will help gain insight into students' learning needs, goals and progress throughout the academic year.

e-Portfolio	
Student Assignments	Due Dates for Students
Personal Development Plan (PDP)	8/27/2017
Video-based H&P	10/8/2017
<b>Formative H&amp;P #1*</b>	10/29/2017
Summative H&P #1	12/10/2017
Narrative Reflection	1/14/2018
<b>Formative H&amp;P #2*</b>	2/11/2018
Summative H&P #2	3/11/2018

*\* Assignments reviewed by portfolio advisors*

## 1. Personal Development Plan (PDP)

An important aim of the COP-2 e-portfolio is to promote life-long learning by encouraging students to reflect on their own learning needs and to identify specific personal learning goals, i.e., their Personal Development Plan (PDP).

Students will develop and document their PDP at the beginning of the academic year. In the PDP students will summarize their personal learning goals during the COP-2 experience. A PDP requires that the student reflect and make explicit his or her goals for learning. Students should have uploaded their PDP in the electronic portfolio prior to the first COP session. It is suggested that they review their PDP with their clinical preceptor at the beginning of that session.

### Students' steps to writing a PDP:

#### **Step 1: Identify their learning needs**

Student will consider if there are clinical skills or other competencies that they would like to enhance during their COP-2 clinical experiences. They are to write down the areas that they would like to work on.

#### **Step 2: Identify and document their learning goals**

Student will select 2-3 goals that they would like to work on. They can use the "I-SMART" (see Appendix) criteria to help them develop specific goals.

#### **Step 3: Determine strategies and resources that will employ achievement of their goals**

Student will define time management and deadlines.

#### **Step 4: Share and/or discuss learning goals and PDP with their portfolio advisor**

#### **Step 5: Refer to their PDP throughout COP-2 to assist them in reaching goals**

*Portfolio advisors may review PDPs to gain insight into students' learning needs and identified learning goals.*

*Although not expected, portfolio advisors may choose to provide feedback on PDPs at any time throughout the academic year.*

## 2. History and Physical (H&P) Write-ups

A major component of the Practice of Medicine-2 Module and COP-2 e-portfolio is the development of medical documentation skills. At the beginning of their 2<sup>nd</sup> year, students have had very little practice with history and physical write-ups. Students receive didactic instruction on how to write an H&P as well as several examples of 2<sup>nd</sup>- and 3<sup>rd</sup>-year-level H&Ps as resources. However, it is the portfolio process (particularly the feedback from their portfolio advisor) the primary way students learn and practice medical documentation skills. Most importantly, these

documentation skills contribute to their final module grade, **hence the importance of advisors' detailed and constructive feedback** to help students succeed at this level.

All students are required to write five (5) complete patient write-ups and submit them to their portfolio. Portfolio advisors provide written formative feedback on 2 of these H&Ps (Formative H&Ps #1 and #2), based on a pre-defined rubric (H&P Write-up Assessment Rubric, [Appendix D](#)).

**Summative H&P write-ups are submitted for summative assessment**, and count towards the final COP-2 and P-2 grade.

**Student H&P Assignments are as follows:**

- **(1) Video-based H&P:** Prior to writing an H&P on a “real patient,” students create their first H&P write-up after watching a standardized, videotaped patient encounter. This is followed by participation in a small group **H&P Writer’s Workshop** with their Portfolio Advisor. In this session students and faculty use the [Guide to the Comprehensive Adult H&P Write Up](#) and the [H&P Write-Up Assessment Rubric](#) to assess and give formative feedback to each write-up, discuss the components and structure of a high-quality note as a group, and review a sample note as a reference.
- **(2) Formative H&Ps:** Documenting the full History and Physical Examination in the format of a write-up is learned through practice and feedback from portfolio advisors. **Formative H&P #1 and Formative H&P #2** are reviewed by the portfolio advisor who provides formative, constructive feedback, highlighting areas to improve on future write-ups. Students should keep in mind suggestions on their formative H&Ps when they write their summative ones to be graded by P-2 Module Directors. H&P resources and grading rubric can be found in LiveText within these respective assignments.
- **(2) Summative H&Ps:** Students will write two (2) Summative H&Ps throughout the year to be graded by P-2 Module Directors. Summative H&Ps count towards the P-2 final grade.

### SUGGESTIONS FOR EFFECTIVE H&P FEEDBACK

- ✓ Provide **specific** feedback on each H&P (otherwise mistakes will be repeated).
- ✓ Provide feedback (+ or -) on each component of the H&P (refer to the attached rubric for module expectations).
- ✓ Encourage organization and use of conventional subheadings.
- ✓ Be specific in your comments and suggestions.
- ✓ If writing positive comments, reinforce what was done well.
- ✓ If negative comments, you may give an example of how to re-write a component of the history or physical exam.
- ✓ Consider using track changes and comments in Word; otherwise add comments to the LiveText® rubric.
- ✓ Work with students on Problem List generation and an initial assessment/plan for each problem.
- ✓ Avoid “well done” and “great job” with no additional feedback.
- ✓ Comment on and encourage correction of typos, poor grammar and misspelled words (e.g., looking up spelling of medication names).
- ✓ Encourage student to revise their H&P before submitting for a grade.
- ✓ Comment on their references and encourage use of EMB references.
- ✓ Do not be afraid to give them too many comments at once (there are only 4 H&Ps in the year, so opportunities are limited).
- ✓ Do not hesitate to make comments or suggestions; even on write-ups you believe meet expectations. You are not “marking them down”; your feedback and detailed comments will help students know what to do to get to the next level.
- ✓ It is OK to ask them to re-write the H&P if deficient in any way.
- ✓ **AVOID EXCEEDS EXPECTATIONS UNLESS TRULY OVER THE TOP\*\***
- ✓ Remember this is the only way they learn, by practicing!

*Portfolio advisors are expected to review students' Formative H&Ps (2 per student). Students will submit these H&Ps via LiveText® as a Word document. Portfolio advisors should expect an email notification from either the student or the COP Coordinator right after an H&P has been submitted for review.*

*Portfolio advisors will use the attached H&P Write-up Assessment Rubric to provide formative feedback to their assigned students on LiveText® as well as feedback in the way of comments or tracked changes on the Word document students attach to LiveText® (a LiveText® guide will be available as a separate document close to the first formative H&P to assess upon request).*

### 3. **Narrative Reflection**

An important component of students' COP-2 e-portfolio will be chronicling evidence of reflective capacity. Reflective capacity (i.e., the ability to engage in reflection) is at the core of life-long and self-directed learning practices, which include self-awareness, self-regulation, and self-monitoring. Reflective capacity is vital for meaning-making within the sometimes uncertain, often demanding journey of becoming a physician. Moreover, reflection is considered essential to professional development and the attainment and maintenance of clinical expertise, and physicians need to cultivate their reflective skills throughout their careers.

The COP-2 narrative assignment serves as a stimulus to help students exercise their skills in reflection and use the medium of the written word to portray impactful experiences, processes of learning, and subsequent reflections. This is important for students' professional development and to help them recognize how they "learn from experience."

Students will be **required to submit 1 narrative reflection as part of COP-2.**

The Narrative Reflection Writing Prompts are included in the Appendix. The *expected word count will be between 500 and 1,000 words.*

This narrative assignment will be reviewed by the Summative Assessment Team (SAT) and count towards the COP-2 final grade.

*Portfolio advisors may choose to review their assigned students' narrative reflection. Students will submit their narrative reflection via LiveText® as a Word document.*

# Appendix

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\*The material provided in this appendix is for reference only, most of it extracted from the Student Handbook. Rubrics will be available online via [LiveText.com](https://www.livetext.com).

## **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 your COP-2 academic 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 for Students**

### **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-2 may not seem so halfway through the academic year. At this point, “pause and think” and re-evaluate your learning goals and strategies and modify them as necessary.*

**T - Time bound:** 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 for Students**

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. History and Physical Write-up Assessment Rubric

	Component of Write-up	Incomplete	Developing I	Developing II	Developing III	Advanced
Subjective	<b>Chief Complaint 0-2 points</b>	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]
	<b>Opening Sentence 0-5 points</b>	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]
	<b>HPI (0-10 points, 2 for each component below)</b>					
	<b>HPI Organization</b>	Not organized		Partially organized		Well organized
	<b>HPI Thoroughness</b>	Not thorough		Partially thorough		Very thorough
	<b>HPI Includes pertinent positive ROS</b>	Does not include pertinent positive ROS		Includes some pertinent positive ROS		Includes most pertinent positive ROS
	<b>HPI Includes pertinent negative ROS</b>	Does not include pertinent negative ROS		Includes some pertinent negative ROS		Includes most pertinent negative ROS
	<b>HPI Includes pertinent past history/ family history/social history</b>	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
	<b>PMH 0-2 points</b>	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]
	<b>Medications 0-2 points</b>	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]
	<b>Allergies 0-2 points</b>	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]
	<b>Social History 0-1 points</b> <i>Point system does NOT reflect a lack of importance to this!!!</i>	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]

	<b>Family History</b> <b>0-1 points</b> <i>Point system does NOT reflect lack of importance</i>	None [0 point]		Includes partial family history		Includes family history [1 points]
	<b>ROS</b> <b>0- 5 points</b> 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]
<b>Objective</b>	<b>Physical Examination</b> <b>0-10 points</b> 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]
<b>Summary</b>	<b>Summary Statement</b> <b>0-10 points</b>	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]
<b>TOTAL FOR ABOVE: 50 POINTS</b>						
<b>Assessment and Plan</b>	<b>Problem List</b> <b>0-5 points</b>	None listed [0 points]		Present but incomplete		Organized, thorough, complete; includes chief complaint [5 points]
	<b>Differential diagnosis</b> <b>0-20 points</b>	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]
	<b>Clinical Reasoning</b> <b>0- 25 points</b>	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]
<b>TOTAL FOR ABOVE: 50 POINTS</b>						

#### **D. Student Instructions on their Narrative Reflection**

We want the COP-2 narrative reflection assignment to be a genuinely useful exercise that helps you develop real insights, not just a portfolio exercise that has to be done.

We hope that you will be reflecting everyday on your actions and inactions and those of the people around you. This is how adults learn. We would also like you to develop these skills further by undertaking activities of more critical reflection: by 'stepping back' from events and actions and exploring your personal role or interpretations. This increases the learning potential of these experiences and allows you to recognize events and actions from multiple perspectives.

#### **Narrative Reflection**

For this narrative, please reflect on your experience in COP-2 and **choose a patient, event or circumstance** that affected you strongly, whether positively or negatively. Please consider the writing prompts below as framework for your narrative. The expected word count is between 500 and 1,000 words.

- 1. Describe the experience in detail (while preserving confidentiality of patients).*
- 2. Write why you believe this experience affected you strongly.*
- 3. What key lesson(s) did you derive from this experience?*
- 4. How will you use this experience to help guide your development as a physician-in-training?*

**E. Assessment Rubric for Narrative Reflection**  
*(to be graded by the Summative Assessment Team)*

	<b>Needs Improvement</b>	<b>Effective</b>	<b>Very Effective</b>
<b>Description of Experience</b>	Lacking description of the experience, event or circumstance and reason for selection. Compromises patient confidentiality.	Satisfactory description of the experience, event or circumstance and reason for selection. Maintains patient confidentiality.	Thorough description of the experience, event or circumstance and reason for selection. Maintains patient confidentiality.
<b>Level of Reflection</b>	Superficial descriptive writing approach (fact reporting, vague impressions) without reflection or introspection. No sense of perspective, exploration of feelings and assumptions and/or personal impact.	Moves beyond descriptive writing approach and impressions to reflecting (i.e., attempts to understand, question, or analyze the event). Some sense of perspective, exploration of feelings and assumptions and/or personal impact.	Evidence of introspection, deep reflection (i.e., attempts to understand, question, or analyze the event). Includes a sense of perspective, exploration of feelings and assumptions and personal impact.
<b>Analysis and Lessons Learned</b>	Lack of analysis or clear description of lessons learned. No description of how reflection on experience will inform future actions.	Some analysis and/or description of lessons learned. Little or vague description of how reflection on experience will inform future actions.	Insightful analysis and clear description of lessons learned. Clear description of how reflection on experience will inform future actions.

## **F. Guide to the 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. Every event/symptom that occurs leading up to DOA should be 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.
  - 
  - Physical Growth including menarche and other pubertal developments
  - 
  - 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 1/2 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, epiglottitis, 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 pinnae.

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.

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# **H&P Writer's Workshop**

## **Faculty Packet**

### **2017-2018**

Adapted from Debra Bynum MD, Cristin Colford MD, David McNeely MD  
University of North Carolina at Chapel Hill, North Carolina

# H&P Writer's Workshop: Teaching Preclinical Medical Students the Art of the Patient "Write-up"

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Adapted from Debra Bynum MD, Cristin Colford MD, David McNeely MD. University of North Carolina at Chapel Hill, North Carolina

## **Instructor's Guide**

### **Objectives for this session:**

1. To teach medical students how to create an organized, thorough and thoughtful patient write-up
2. To use a standardized rubric to provide specific feedback to students and more uniform assessment of student write-ups

### **Learning Outcomes for students:**

At the end of this activity, students will be able to:

1. Demonstrate knowledge of the components and structure of a thorough, organized clinical note
2. Apply the principles of structure and components of a written note to demonstrate clinical reasoning and understanding
3. Write a comprehensive note based upon a standardized clinical encounter

Documenting the full History and Physical Examination in the format of a write-up is a core component of clinical rotations. Most students and faculty feel that 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 and plan. The final product can be a useful tool in the assessment of a student's ability to not only gather, but also to interpret and synthesize data. Finally, the ability to communicate and document a clinical encounter is not only a key skill that all medical students must have<sup>3</sup> but also a Core Entrustable Professional Activity for entering residency according to a recent position statement by the Association of American Medical Colleges (AAMC).<sup>4</sup>

Most pre-clinical students struggle to write a clinical note. The complexity of the encounter is often confusing and interferes with the student's ability to understand the basic components of a thoughtful, thorough, and organized note. Given this observation and evidence that student notes can be improved with frequent and high-quality feedback, we will use a set of educational tools that would aid in the teaching and assessment of this important skill.

This writer's workshop utilizes a videotaped encounter with a standardized physician and standardized patient. The videotaped encounter is less than 15 minutes in length, includes enough information to create a complete note, and focuses on a single chief complaint that is straightforward, yet conducive to the development of a differential. Using a *Guide* and a *Grading Rubric*, a sample comprehensive write-up based upon this standardized encounter was created. This sample is then available as a reference for students and faculty.

**Description of Activity:**

Prior to the workshop, students create an H&P write-up based upon a standardized, videotaped encounter. Students bring their H&Ps for peer review in a small group session led by their portfolio advisor. Students and faculty use a guide to the write-up and a grading rubric to assess and give feedback to each other's write-up, discuss the components and structure of a high-quality note as a group, and review a sample note as reference. Given the fact that all of the student notes and the sample note are based upon the same standardized encounter, the focus of the session is placed on the "how to" of the write-up process.

**IMPORTANT:** By the end of the workshop students should have received peer feedback on their video-based H&P using the grading rubric, and be able to submit BOTH documents (the H&P and completed rubric) to the portfolio as required assignments.

**List of resources:**

1. Writer's Workshop Instructor's Guide (this document)
2. Guide to the Comprehensive Adult Write-up/note
3. Grading Rubric for comprehensive write-up
4. Writer's Workshop Video of standardized patient encounter
5. Sample write-up from standardized video encounter (available to students at the time of the workshop)

**Activity Guide:**

1. Students identify one student from the group to contact the advisor to set up a meeting date/time (portfolio advisor groups will be provided to them).
2. Individual preparation required for students to complete before class:
  - a. Review the Guide to the Comprehensive Adult Write-up
  - b. Review the Grading Rubric for the comprehensive adult write-up
  - c. Watch the standardized clinical encounter video
3. Create a full write-up based upon the videotaped encounter and prepare to bring this draft to the small group session. Individual preparation required for faculty leaders to complete before small group meeting:
  - a. Review this Instructor's Guide for a better understanding of the background and process involved in this session
  - b. Review the Guide to the Comprehensive Adult Write-up
  - c. Review the Grading Rubric for the comprehensive adult write-up
  - d. Watch the standardized clinical encounter video
4. Small group session --Groups with 5-7 students and one faculty leader meet (1.5 hours):
  - a. Faculty leader reviews the background and introduces the session
  - b. Faculty provides overview of H&P write-up structure and expected depth of each component

- c. Faculty highlights grading rubric categories and the relative weight of each category, particularly the clinical reasoning portion (50%)
  - d. Students trade write-ups and use the guide and grading rubric to provide peer feedback to each other
    - e. Faculty leader gives feedback, reviews sample write-up, addresses questions, leads discussion.
5. Closing the session:
- a. The highlighted sample reference H&P write-up for the video encounter is distributed to students for future reference.
  - b. Students leave the session with their individual H&P and completed graded rubric for submission **of both** as required via Livetext.

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## **Portfolio Advisor-Students Face-to-Face Group Meeting Checklist**

**Dedicate the first 10 minutes to introductions and setting expectations:**

- ☐ Share each other's backgrounds and interests (recommended ice breaker).
- ☐ Review the COP e-portfolio expectations from both sides, specifically:
  - **Student(s):**
    - ☐ Submit every H&P on time by the due date set.
    - ☐ Notify their advisor via email that their H&P has been submitted for review.
    - ☐ Be proactive when the need arises to communicate with their advisor.
  - **Advisor:**
    - ☐ Expect an email notification from either the student or COP Coordinator that an H&P has been submitted for review.
    - ☐ Provide detailed constructive feedback within two (2) weeks from the notification received.
    - ☐ Feel free to provide formative feedback on any other section of students' e-portfolio, if s/he sees the need.
- ☐ Discuss the type of feedback student(s) will receive and its formative nature.
- ☐ Exchange contact information.
- ☐ Decide on preferred means of communication outside of LiveText®, preferred hours, and deadlines.

**The remainder 80 minutes should be dedicated to the H&P Writer's Workshop activity:**

- ☐ Review Guide to H&P and Rubric
- ☐ Peer H&P assessment and completion of rubric
- ☐ Review of sample reference H&P Write-up and group discussion
- ☐ Consider the option of meeting again later in the academic year individually or as a group.

**IMPORTANT:** By the end of the workshop students should have received peer feedback on their video-based H&P using the grading rubric, and be able to submit BOTH documents (the H&P and completed rubric) to the portfolio as required assignments.

## **Guide to the 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)

<b>Chief Complaint</b>	Include the primary symptom causing the patient to seek care. Ideally, this should be in the patient's words.
<b>Source &amp; Reliability</b>	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")
<b>History of Present Illness</b>	<p>First sentence should include patient's identifying data, including age, gender, (and race if clinically relevant), and pertinent past medical history</p> <p>Describe how chief complaint developed in a chronologic and organized manner</p> <p>Address why the patient is seeking attention at this time</p> <p>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</p> <p>Include the patient's thoughts and feelings about the illness</p> <p>Incorporate elements of the PMH, FH and SH relevant to the patient's story.</p> <p>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</p> <p>The HPI should present the context for the differential diagnosis in the assessment section</p>
<b>Past Medical History</b>	<p>Describe medical conditions with additional details such as date of onset, associated hospitalizations, complications and if relevant, treatments</p> <p>Surgical history with dates, indications and types of operations</p> <p>OB/Gyn history with obstetric history (G,P – number of pregnancies, number of live births, number of living children), menstrual history, birth control</p> <p>Psychiatric history with dates, diagnoses, hospitalizations and treatments</p> <p>Age-appropriate health maintenance (e.g., pap smears, mammograms, cholesterol testing, colon cancer) and immunizations</p> <p>Describe any significant childhood illnesses</p>
<b>Medications</b>	<p>For each medication include dose, route, frequency and generic name</p> <p>Include over the counter medications and supplements; include dose, route and frequency</p>

	Do not use abbreviations
<b>Allergies</b>	Describe the nature of the adverse reaction
<b>Family history</b>	<p>Comment on the health state or cause of death of parents, siblings, children</p> <p>Record the presence of diseases that run in the family (e.g., HTN, CAD, CVA, DM, cancer, alcohol addiction)</p>
<b>Social history</b>	<p>Include occupation, highest level of education, home situation and significant others</p> <p>Quantify any tobacco, alcohol or other drug use</p> <p>Include relevant sexual history</p> <p>Note any safety concerns by the patient (domestic violence, neglect)</p> <p>Note presence of advance directives (e.g., living will and/or health care power of attorney)</p> <p>Assess the patient's functional status – ability to complete the activities of daily living</p> <p>Consider documentation of any important life experience such as military service, religious affiliation and spiritual beliefs</p>
<b>Review of Systems</b>	<p>Include patient's Yes or No responses to all questions asked by system</p> <p>Note "Refer to HPI" if question responses are documented in the HPI</p> <p><b><u>Review of Systems:</u></b></p> <p><i>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.</i></p> <p><b><i>skin</i></b> bruising, discoloration, pruritus, birthmarks, moles, ulcers, decubiti, changes in the hair or nails, sun exposure and protection.</p> <p><b><i>hematopoietic</i></b> spontaneous or excessive bleeding, fatigue, enlarged or tender lymph nodes, pallor, history of anemia.</p> <p><b><i>head and face</i></b> pain, traumatic injury, ptosis.</p> <p><b><i>ears</i></b> tinnitus, change in hearing, running or discharge from the ears, deafness, dizziness.</p> <p><b><i>eyes</i></b> change in vision, pain, inflammation, infections, double vision, scotomata, blurring, tearing.</p> <p><b><i>mouth and throat</i></b> dental problems, hoarseness, dysphagia, bleeding gums, sore throat, ulcers or sores in the mouth.</p>

	<p><b>nose and sinuses</b> discharge, epistaxis, sinus pain, obstruction.</p> <p><b>breasts</b> pain, change in contour or skin color, lumps, discharge from the nipple.</p> <p><b>respiratory tract</b> cough, sputum, change in sputum, night sweats, nocturnal dyspnea, wheezing.</p> <p><b>cardiovascular system</b> chest pain, dyspnea, palpitations, weakness, intolerance of exercise, varicosities, swelling of extremities, known murmur, hypertension, asystole.</p> <p><b>gastrointestinal system</b> 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.</p> <p><b>urinary tract</b> dysuria, change in color of urine, change in frequency of urination, pain with urgency, incontinence, edema, retention, nocturia.</p> <p><b>genital tract (female)</b> menstrual history, obstetric history, contraceptive use, discharge, pain or discomfort, pruritus, history of venereal disease, sexual history.</p> <p><b>genital tract (male)</b> penile discharge, pain or discomfort, pruritus, skin lesions, hematuria, history of venereal disease, sexual history.</p> <p><b>skeletal system</b> heat; redness; swelling; limitation of function; deformity; crepitation: pain in a joint or an extremity, the neck, or the back, especially with movement.</p> <p><b>nervous system</b> dizziness, tremor, ataxia, difficulty in speaking, change in speech, paresthesia, loss of sensation, seizures, syncope, changes in memory.</p> <p><b>endocrine system</b> tremor, palpitations, intolerance of heat or cold, polyuria, polydipsia, polyphagia, diaphoresis, exophthalmos, goiter.</p> <p><b>psychologic status</b> nervousness, instability, depression, phobia, sexual disturbances, criminal behavior, insomnia, night terrors, mania, memory loss, perseveration, disorientation</p>
<b>Physical examination</b>	<p><u>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)</u></p> <p>Physical Examination:</p> <p>Always begin with the vital signs. These should include;</p> <p style="padding-left: 40px;">Temperature</p> <p style="padding-left: 40px;">Pulse</p> <p style="padding-left: 40px;">Blood pressure</p>

	<p>Respiratory rate</p> <p>Pain (10 point scale rating)</p> <p>Pulse oximetry when available: include the percentage of supplemental O2. If room air, document this.</p> <p><i>EXAMPLE:</i></p> <p><i>O2 Saturation: 88% on room air, 95% on 2 liter nasal canula.</i></p> <p>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.</p> <p>Example:</p> <ul style="list-style-type: none"> <li>• Mr. Smith is a well appearing elderly gentleman in no acute distress.</li> <li>• Mr. Smith is a frail appearing elderly gentleman in significant respiratory distress at the time of examination.</li> </ul> <p>Next should follow the individual body systems in discreet subheadings.</p> <p>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.</p> <p>In general, the format should be as follows</p> <p>HEENT:</p> <p>Neck:</p> <p>Heart:</p> <p>Lungs:</p> <p>Abdomen:</p> <p>Exteremities:</p> <p>Neurological:</p> <p>MSK</p> <p>Vascular:</p> <p>Skin:</p> <p>Example:</p>
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	<p>HEENT:</p> <p>Head: no evidence of trauma</p> <p>Nares: normal pink mucosa, no discharge</p> <p>Eyes: no scleral icterus, normal conjunctiva</p> <p>Ears: TM's show normal light reflex, no erythema, normal      landmarks</p> <p>OP: moist mucus membranes; OP with no erythema or exudate. Oral exam with no lesions.</p> <p>Neck: Supple, No thyromegaly, no lymphadenopathy, normal range of motion; JVP estimated to be 7 cm.</p> <p>Heart: PMI nondisplaced and normal size; No thrills or heaves; RRR, S1S2 with no s3 or s4, no murmurs, rubs or gallops</p> <p>Lungs: No increase work of breathing, lungs clear to auscultation, no wheezes or crackles</p> <p>Abdomen: Non distended, no scars, normoactive bowel sounds, no bruits, non-tender to palpation, no hepatosplenomegaly, no masses</p> <p>Exteremities: No clubbing, cyanosis or edema;</p> <p>Vascular: pulses are 2+ bilaterally at carotid, radial, femoral, dorsalis pedis and posterior tibial; no bruits</p> <p>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</p> <p>MSK: good tone throughout, no swelling/synovitis or limitation of flexion at any joint</p> <p>Skin: normal texture, normal turgor, warm, dry, no rash</p>
<b>Data collection</b>	<p>Include lab and radiological data appropriate for the HPI (include YOUR interpretation, not just copy/paste from medical record report)</p> <p>Labs:</p> <p>Chest xray or other xrays/scans</p> <p>EKG:</p>

<b>Problem List</b>	<p>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</p> <p>For example:</p> <p>Problem list:</p> <p>Chest pain</p> <p>Fever</p> <p>Shortness of breath</p> <p>Hemoptysis</p> <p>Elevated creatinine</p>
<b>Summary Statement</b>	<p>Label as summary ("<i>In summary....</i>")</p> <p>Include 1-2 sentence impression restating basic identifying information (<i>The patient is a 45 year old male</i>),</p> <p>Most pertinent information related to the medical/family/social history (<i>with a history of tobacco use and family history of early CAD</i>),</p> <p>Expanded chief complaint and most pertinent review of systems on presentation (<i>who presents with substernal chest pressure, nausea and diaphoresis</i>)</p> <p>Most important findings on physical, labs, data (<i>and is found to have an S4, bilateral rales, and JVD on exam with evidence of pulmonary edema on CXR</i>)</p> <p>Pertinent information is that which contributes directly to building the case for your differential diagnosis....</p> <p><i><u>In summary, the patient is a 45 year old male with a history of tobacco use and family history of early CAD 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...</i></p> <p><i>Key phrases and structure for summary statement:</i></p> <p><i>In summary, this is a ...</i></p> <p><i>With a history of...</i></p> <p><i>Who presents with....</i></p> <p><i>And is found to have...</i></p>
<b>Assessment/Plan</b>	<u>Organize plan by problem: Label, Assessment/Plan by problem list</u>

	<p><b>Include at least 3 diagnoses for your differential potentially associated with the patient's chief complaint</b></p> <p><b>Include the Most Likely diagnosis/diagnoses on your differential</b></p> <p><b>Include the DO NOT MISS diagnoses on your differential</b></p> <p><b>Order your differential to reflect most likely diagnoses or most serious diagnoses first</b></p> <p>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.</p> <p>It is OK to include less likely items on your differential – explain why it is important to consider but less likely the diagnosis (<i>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</i>)</p> <p>For each problem, discuss the diagnostic plan, treatment plan and patient education.</p> <p><i>Outline of what this should look like...</i></p> <p><b>Summary Statement...</b></p> <p><b>A/P by Problem List:</b></p> <ol style="list-style-type: none"> <li> <b>Problem # 1:</b>  <b>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....</b>  <b>Diagnostic Plan will be...</b>  <b>Treatment plan will include...</b> </li> </ol> <p><b>Patient education.... Instructions to patient include...</b></p> <ol style="list-style-type: none"> <li> <b>Problem # 2:</b>  <b>Differential....</b>  <b>Diagnostic Plan...</b>  <b>Treatment plan...</b> </li> </ol> <p><b>Patient education</b></p> <ol style="list-style-type: none"> <li> <b>Problem # 3:</b>  <b>Differential...</b>  <b>Diagnostic plan...</b>  <b>Treatment plan...</b>  <b>Patient education...</b> </li> </ol> <p>For the main problem(s) identified in your problem list, you are expected to identify a <b>topic or clinical question</b> that would help you advance your</p>
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	<p>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.</p> <p>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.</p> <p>COM Library resources are strongly encouraged, for suitable resources based on topic of interest please see <a href="#">P2 LibGuide</a>.</p>
<b>Format</b>	<p>Goal is a concise write up with your thought processes documented in logical and organized manner</p> <p>Avoid spelling or grammatical errors</p> <p>Use only commonly accepted abbreviations</p>
<b>HIPAA</b>	<p>Remove patient identification from write up (e.g., name, address, medical record number)</p>

## **Sample Write-Up for Writer's Workshop**

**Chief Complaint:** “My legs are swollen and I can’t breathe” *chief complaint in patient’s own words, no other demographics or history*

**HPI:** The patient is a 58 year-old female with a history of high blood pressure and high cholesterol who comes to the clinic with a 6-week history of leg swelling and difficulty breathing. *opening sentence that includes most pertinent past history and presenting symptoms* These symptoms have been progressing. She has noticed that she now gets short of breath when walking short distances such as getting up from a chair to the bathroom. She can no longer walk to her mailbox without becoming short of breath and stopping to rest. She has been waking up at night gasping for air, and has been sleeping propped up on 4 pillows because she gets short of breath when she lies down flat. She has a cough that is productive of clear phlegm. *Story of the illness and symptoms, and pertinent positive symptoms/ROS* She has not had any fevers or chills. She denies chest or leg pain. She has had no sick contacts. She has gained 15 pounds in the past two months. She has no abdominal pain but feels full after eating a small amount. *Pertinent positive AND negative ROS based upon your working differential diagnosis; can also include pertinent family history (you could include the family history of heart disease) and pertinent social history (her prior smoking history)*

### **Past Medical History:**

1. Hypertension
2. High cholesterol

**Allergies:** NKDA

### **Medications:**

Aspirin 81mg by mouth daily

Hydrochlorothiazide 25mg daily (note for patient--blood pressure/diuretic)

Lisinopril 20mg daily (blood pressure)

Simvastatin 40mg daily (cholesterol)

**Family History:** Hypertension and high cholesterol

**Social History:** She lives with her husband, who has had to do more of the housework including cleaning and cooking due to her shortness of breath. She did smoke 1 pack of cigarettes daily for 30 years, but quit 20 years ago. She drinks occasional alcohol, but no

more than 1 glass of wine a month. No illicit drug use. She and her husband do not like to cook. They often eat out or prepare frozen meals and soups. She does not get much regular physical activity but is much more limited over the last few weeks.

### **Review of Systems:**

Gen: Positive weight gain, fatigue. No fevers, night sweats

HEENT: No headaches, vision changes.

CV: As per HPI, positive for shortness of breath, orthopnea, LE edema. No chest pain or palpitations

Pulmonary: Cough productive of clear sputum. No wheezing. Positive for orthopnea, dyspnea on exertion.

GI: No abdominal pain, nausea, vomiting, diarrhea or constipation. Mild feeling of distension in stomach and feels full easily.

Psych: No depression, but feeling down that she is not able to be as active as she had been previously.

Endo: No heat or cold intolerance, no polyuria or polydipsia.

MSK: No joint pains or swelling.

Neuro: Mild dizziness when she gets winded. No weakness, numbness. No headaches.

Heme: No bruising or bleeding.

### **Physical Exam:**

Vital Signs: Temp 98 F, pulse 75, Resp Rate 20, Blood Pressure 130/95

Gen: Appears tired but in no acute distress, breathing comfortably

HEENT: No trauma. TM clear. moist mucous membranes, Oropharynx with no exudates or thrush

Neck: JVP measures 12cm, no cervical lymphadenopathy, no thyromegaly

Lungs: Crackles in bottom third of lung fields bilaterally. No wheezing

CV: Displaced PMI, RRR, no murmurs. Normal S1 and S2. Positive S3 gallop.

Abd: Normal bowel sounds. No bruits. Soft, no tenderness to palpation. Normal liver span. No splenomegaly.

Ext: warm and well perfused. 2+ pitting edema to knees bilaterally

Skin: no rashes, redness, or warmth

**Labs/chest xray: pending**

**Problem List:** *includes problems from history, past history, physical exam, labs*

1. shortness of breath
2. orthopnea
3. PND
4. Bilateral edema
5. HTN
6. Hyperlipidemia
7. Prior tobacco use
8. Cough with clear phlegm
9. Family history of heart disease (not early onset)
10. Weight gain
11. S3 on exam
12. Bilateral crackles on exam
13. Bilateral edema on exam
14. JVD

**Summary statement:**

In summary, this is a 58 year old woman with a history of HTN and hyperlipidemia who presents with progressive SOB, orthopnea, and PND and is found to have elevated JVD, s3, basilar crackles and bilateral edema on exam. *Summary statement - unlike opening sentence, summary statement should also include really pertinent findings from the history, PE and labs/data*

*Consider this format for summary statement:*

1. *Basic demographic, advertise the summary statement (In summary, this is a 62 year old woman...)*
2. *Most pertinent history related to your differential (with a history of HTN and hyperlipidemia...)*

3. *List most pertinent presenting chief complaint and other ROS (who presents with progressive SOB, orthopnea, and PND...)*
4. *List pertinent PE, lab, data findings (and is found to have elevated JVD, an S3, basilar crackles and bilateral lower extremity edema on exam)*

*In summary, this is a ....*

*With a history of ...*

*Who presents with...*

*And is found to have...*

**A/P by problem(s) or symptom(s):** You can “lump” problems together that have the same differential (for example, shortness of breath, PND, orthopnea and edema go together for a differential that includes heart failure); Not every item on the problem list you have created above is necessarily included as a separate problem in the assessment/plan section.

Problem/symptom(s) # 1 should include what the patient presents with (the chief complaint) OR symptoms related to a must not miss/could be lethal diagnosis.

1. SOB/orthopnea/PND/edema *(ok to group symptoms together if they “fit”)*: Given the constellation of symptoms and the physical exam findings of elevated JVP, bilateral crackles, S3 and bilateral edema, Congestive heart failure is the most likely on the differential diagnosis. Other less likely processes to consider would be pulmonary embolism with DVTs, pneumonia, interstitial lung disease, and pulmonary HTN. PE and DVTs could cause peripheral edema and shortness of breath, and occasionally can be associated with elevations of JVP if there is associated right heart failure, but this would not explain the s3 and crackles on exam and is much less likely with bilateral lower extremity edema. Pneumonia might explain the crackles on exam, but the time course and history do not suggest an infectious etiology and this would not explain the edema. Interstitial lung disease could explain the lung findings, and could be associated with pulmonary HTN and therefore elevation of JVP and bilateral edema due to right sided heart failure, but would not explain the PND, orthopnea and s3 which are more indicative of left sided heart failure. Anemia might explain the shortness of breath but not the other symptoms. Hyperthyroidism can also be associated with high output heart failure, but the history otherwise is not consistent. Renal and liver failure can be associated with shortness of breath, weight gain, and edema, but again should not present with signs of left sided heart failure. *(differential diagnosis and clinical reasoning—include at least 3 items on your differential, and describe what you think is the most likely and*

*why, and what is less likely and why; remember to clearly state any DO NOT MISS Diagnoses, and explain why they may be more or less likely...*

Given the fact that congestive heart failure, with left ventricular involvement, is most likely on the differential diagnosis, she will need a transthoracic echocardiogram to more fully evaluate her cardiac function. Given the differential that includes anemia and renal failure, will also check basic labs including a chemistry panel and CBC as well as a TSH to rule out hyperthyroidism. Could consider checking a BNP as well. Given the crackles on exam and differential that includes ILD, will check a chest xray. PE and DVTs are less likely so will hold on checking ddimer, dopplers or CT angiogram at this point. **Work up plan**

Once basic labs are reviewed, would continue lisinopril for afterload reduction, and add a diuretic such as furosemide given evidence of volume overload on exam. Although HCTZ is a diuretic, it is not as potent as furosemide. Stop HCTZ if treating with furosemide. Will need to follow K once starting this. Further management will depend upon results from the echocardiogram, but may need further evaluation for underlying ischemic heart disease with cardiology if LV ejection fraction is depressed. Will also need BP control, especially if there is evidence for diastolic dysfunction. **Treatment plan**

In addition, the patient will need counseling and education for congestive heart failure if this is the diagnosis. Careful daily weights and monitoring, and adjusting diet to include less salt (especially with her current diet that includes processed foods) will be important **(Patient education)**

*Keep to the outline/format – differential diagnosis with clinical reasoning, work up plan, treatment plan, patient education*

2. HTN: Given the likelihood of CHF, will need tighter blood pressure control. Will need to hold HCTZ if treating with furosemide. May need additional agent such as beta blocker or spironolactone depending upon results of cardiac echo.
3. Hyperlipidemia: continue current statin, check lipids and LFTs.

## History and Physical Write-up Assessment Rubric 2017-18

Complete this rubric by choosing the descriptor that best describes each category for the H&P reviewed.

	Component of Write-up	Incomplete (0)	Developing I (0.4)	Developing II (0.6)	Developing III (0.8)	Advanced (1.0)
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]
	<b>HPI (0-10 points, 2 for each component below)</b>					
	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 <i>Point system does NOT reflect a lack of importance to this!!</i>	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 <i>Point system does NOT reflect lack of importance</i>	None [0 point]		Includes partial family history		Includes family history [1 points]

	<b>ROS</b> <b>0- 5 points</b> 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	<b>Physical Examination</b> <b>0-10 points</b> 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	<b>Summary Statement</b> <b>0-10 points</b>	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]
<b>TOTAL FOR ABOVE: 50 POINTS</b>						
Assessment and Plan	<b>Problem List</b> <b>0- 5 points</b>	None listed [0 points]		Present but incomplete		Organized, thorough, complete; includes chief complaint [5 points]
	<b>Differential diagnosis</b> <b>0-20 points</b>	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]
	<b>Clinical Reasoning</b> <b>0- 25 points</b>	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]
<b>TOTAL FOR ABOVE: 50 POINTS</b>						