Stanford University School of Medicine

Practice of Medicine
(INDE 204)

Course Syllabus
2011-2012

Preetha Basaviah, MD
Course Director, Practice of Medicine
Clinical Associate Professor of Medicine (General Internal Medicine)

Peter Pompei, MD
Associate Course Director, Practice of Medicine
Quarter 4 Faculty Lead
Associate Professor of Medicine (General Internal Medicine)

Tomiko Oskotsky, MD
Curriculum Manager, Practice of Medicine Year 2
Office of Medical Education

Kambria Hooper, MEd
Evaluations Specialist, Practice of Medicine
Office of Medical Education
# TABLE OF CONTENTS

About the Practice of Medicine Course ....................................................................................... 7  
Course Requirements........................................................................................................ ......... 9  
General Course Calendar........................................................................................................ 16  
Orientation and Physical Exam Demonstration .......................................................................18  

**Essential Procedures in Emergency Medicine Sessions**  
About procedural skills sessions............................................................................................. 24  
Goals of the procedural skills sessions..................................................................................... 24  
Required activities for the procedural sessions......................................................................... 24  

EMED Session Calendar........................................................................................................... 30  

**Clinical Practicum Sessions**  
About the clinical practicum sessions..................................................................................... 32  
Goals of the clinical practicum sessions.................................................................................... 32  
Student roles and responsibilities for the clinical practicum.................................................... 32  

**Advanced Clinical Skills**  
About the clinical skills sessions............................................................................................. 51  
Goals of the clinical skills sessions............................................................................................ 51  
Student roles and responsibilities for the clinical skills session............................................... 51  

**Clinical Reasoning Sessions (CRS)**  
About the clinical reasoning sessions..................................................................................... 70  
Goals of the clinical reasoning sessions.................................................................................... 70  
Required activities for the clinical reasoning sessions............................................................... 70  

**Nutrition Modules**  
About the Online Nutrition Modules....................................................................................... 85  
Goals and learning objectives................................................................................................... 85  

**Genitourinary (G/U) and Breast Examination Skills Training Sessions**  
About the G/U and breast exam skills training sessions.......................................................... 87  
Goals and learning objectives................................................................................................... 87  
Student roles and responsibilities.............................................................................................. 87  

**Evaluation Forms**  
End of Clinical Practicum Evaluation Form ............................................................................. 106  
Clinical Practicum Site & Preceptor: End of Practicum Evaluation Form.................................. 110  
Clinical Reasoning Sessions: Preceptor Evaluation of Student Performance........................... 112  
Small Group End Quarter Peer Evaluation Form ....................................................................... 114  
Small Group End Quarter Preceptor Evaluation Form ................................................................ 116
Course Contacts

**Course Director**
Preetha Basaviah, MD
Clinical Associate Professor of Medicine (General Internal Medicine)
pree@stanford.edu
(650) 724-9621

**Associate Course Directors**
Laurence Baker, PhD
Professor of Health Research and Policy
Faculty Lead, Health Care Policy and Quarter 2
lcbaker@stanford.edu
(650) 723-4098

Andrew Nevins, MD
Clinical Assistant Professor (Medicine, Infectious Disease)
Faculty Co-Lead, Clinical Reasoning and Quarter 5
anevins@stanford.edu
(650) 354-8115

Peter Pompei, MD
Associate Professor of Medicine (General Internal Medicine)
Faculty Co-Lead, Clinical Reasoning and Quarter 4
pompei@stanford.edu
(650) 498-7417

Erika Schillinger, MD
Clinical Associate Professor of Medicine (Center for Education in Family and Community Medicine)
Faculty Lead, Clinical Skills and Quarter 1
erikas@stanford.edu
(650) 736-1447

Laurel Dawson, MD
Clinical Assistant Professor of Medicine
Faculty lead, Quarter 3
ldawson@stanford.edu
(650)725-1367

**Course Theme Leads**
Charles DeBattista, MD - Psychiatry
Associate Professor of Psychiatry and Behavioral Sciences
debattista@stanford.edu
(650) 723-8324

Jessica Ngo, MD – Clinical Procedures
Clinical Instructor in Surgery (Emergency Medicine)
jango@stanford.edu

Ian Brown, MD – Clinical Procedures
Clinical Assistant Professor of Surgery (Emergency Medicine)
ipbrown@stanford.edu

Lisa Shieh, MD – Clinical Practicum
Clinical Associate Professor of Medicine (General Internal Medicine)
lshieh@stanford.edu
(650) 724-2917

Jeff Chi, MD – Clinical Practicum
Clinical Assistant Professor in Medicine (General Internal Medicine)
Jeffrey.chi@stanford.edu
Ian Tong, MD – Advanced Clinical Skills
Clinical Assistant Professor of Medicine
ianlafitte.tong@va.gov
(650)493-5000 ext.65505

Christopher Gardner, PhD
Associate Professor (Research) of Medicine (Stanford Prevention Research Center)
cgardner@stanford.edu
(650) 725-2751

VJ Periyakoil, MD – Palliative Medicine
Clinical Associate Professor; Director, Stanford University Hospice and Palliative Medicine Fellowship Program
periyakoil@stanford.edu
(650) 723-8222 ext. 13115

Lauren Maggio – Information Management
Information Services Librarian - Medical Student Liaison
lmaggio@stanford.edu
(650) 725-5493

Keith Posley – Evidence-based Practice
Clinical Assistant Professor of Medicine (General Internal Medicine)
kposley@stanford.edu
(650) 493-5000, ext.66705

Rebecca Smith-Coggins – Introduction to the Medically Ill Patient (IMIP)
Professor of Surgery (Emergency Medicine)
smithcog@stanford.edu

Course Staff

<table>
<thead>
<tr>
<th>Tomiko Oskotsky, MD</th>
<th>Kambria Hooper, MEd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Curriculum Manager</td>
<td>Evaluations Specialist</td>
</tr>
<tr>
<td><a href="mailto:toskotsky@stanford.edu">toskotsky@stanford.edu</a></td>
<td><a href="mailto:khooper@stanford.edu">khooper@stanford.edu</a></td>
</tr>
<tr>
<td>(650) 725-7673</td>
<td>(650) 725-8803</td>
</tr>
</tbody>
</table>

Teaching Assistants

Danica Lomeli
Lead Clinical Reasoning & EMED TA
dalomeli@stanford.edu

Morgan Theis
Lead Advanced Clinical Skills TA
mktheis@stanford.edu

Jonathan Kleinman
Lead Clinical Practicum TA (Q4)
jkleinm1@stanford.edu

Sarah Jane Selig
Lead Clinical Practicum TA (Q5)
sselig@stanford.edu

Ruo Zhu
Lead Bedside Rounds TA (Q6)
rzhu@stanford.edu
Practice of Medicine (POM)
Course Information
About the Practice of Medicine (POM) Course

POM is a six-quarter pre-clerkship course providing clinical preparation for first- and second-year medical students. Participation in this course will give students a foundation in health policy, medical ethics, clinical epidemiology and biostatistics, behavioral medicine, nutrition and quantitative medicine. Additionally, students will learn the basics of the medical interview, physical examination, clinical reasoning, and procedural skills. This longitudinal preparation is designed and intended to prepare students for clerkships.

In second-year POM, there are two major educational categories: **clinical reasoning** and **clinical exam** skills. These two components are taught within five curricular components that include clinical reasoning teaching rounds and small group, clinical practicum, clinical procedures/IMIP, advanced clinical skills, and psychiatry.

During the **clinical reasoning** component, students will develop skills in gathering, organizing, synthesizing, interpreting, and communicating clinical information. Students will practice and advance these skills as they work through weekly clinical cases in a small group learning environment and inpatient rounds setting. Within these settings, students will also revisit essential dimensions of medical practice, including ethics, nutrition, health policy, evidence-based practice, and public health that were taught during POM year one.

The **clinical exam skills** components are designed to refine students’ skills in the medical interview and physical exam through clinical experience. Students will practice and improve these skills as they work weekly with a clinical preceptor at a hospital or outpatient clinic site. Students will also have the opportunity to develop their procedural skills in a monthly small group learning environment. In addition, students will participate in the psychiatric and behavioral medicine curriculum as part of this course.

Over the course of second year POM, all students will complete the same course requirements and participate in the same basic set of activities. However, students will be participating in these activities during different weeks depending on the schedule to which they are assigned. Activities that will take place on a rotating schedule include:

- Clinical skills review
- Clinical practicum site experiences (both at on-site and off-site hospitals and clinics)
- Clinical procedures (last Tuesday of each month: August, September, October, November)
- Advanced clinical skills sessions
- Teaching Rounds and small group clinical reasoning sessions (CRS)

* Group A & B alternate on Thursdays between clinical practicum and advanced clinical skills.

Each student will receive a copy of the schedule. Please review your schedule in advance—and on a weekly basis—and take note of any irregularities. If you have any questions about the schedule, please contact Pree Basaviah, MD (pree@stanford.edu), Course Director, or Tomiko Oskotsky (t.oskotsky@stanford.edu), the Year 2 curriculum manager.
Learning objectives for Q4:

- Employ explicit methods for developing and refining a differential diagnosis
- Distinguish the roles of problem lists in different clinical care settings
- Apply findings from the history and physical examination to diagnostic considerations
- Interpret laboratory results and relate them to diagnostic considerations
- Propose an initial management plan for selected problems
- Interview and examine patients / standardized patients during full history and physical as well as focused encounters

Please note: We believe it is important that students have as much opportunity as possible to gain “real-world” experience working in clinical settings. However, the very nature of working in clinical settings and with practicing physicians results in unexpected situations leading to last-minute scheduling changes. We hope students will be patient and understanding if scheduling changes do arise and we will do our best to inform students of any changes as soon as we are aware of them. However, students must also regularly check for email notifications, phone messages, or announcements for schedule changes. We also encourage students to work together to share information. Students assigned to the same groups or the same practicum experiences should consider setting up email groups or phone trees in order to quickly pass on information.

The POM curriculum is based on these learning principles:

- Learners are not empty vessels to be “filled” by the teacher but are active participants in their own learning.
- Learning occurs more quickly when learners develop independent, self-directed learning skills that allow them to set their own learning goals (“What am I going to try and learn?”); select learning strategies (“How am I going to achieve these goals?”); and monitor their own goal achievement (“Did it work?”)
- Learning is enhanced in collaborative learning environments where learners are exposed to the points of view of faculty members and students, and are encouraged to question, explain, challenge, examine values and attitudes, and promote skills in teamwork.
- Learning is fostered when learners try out a new skill or concept, reflect on these experiences, and apply what they learned to other situations.
POM Course Requirements

The following are course requirements for POM Quarter 4 (INDE 204). You will complete each component below during INDE 204. Please refer to your individual course schedule for specific details. Satisfactory and timely completion of all assignments is required to pass the course. A "marginal pass" will be given to students failing to satisfactorily complete all assignments. A marginal pass means that a course of remediation will be required (see School of Medicine Grading Policy).

Advanced Clinical Skills

- Satisfactory attendance and participation in all scheduled skills sessions, as determined by preceptor. Failure to attend all sessions and to complete make-ups or remediation as determined by course director prevents the student from passing the course.

Clinical Practicum

- Satisfactory performance in the Clinical Practicum, as determined by the end-of-quarter practicum preceptor evaluation
- Completion of clinical practicum learning plan prior to the start of practicum sessions
- Successful completion and submission of assignments. See practicum syllabus assignment information.

Clinical Reasoning Sessions

- Satisfactory participation in clinical reasoning sessions (determined by preceptor assessments and group case submissions). Preceptors will be recording your attendance and evaluating students on their active participation. Performance that does not meet course expectations may result in failure to pass the course. Satisfactory completion and submission of assignments are also required. Assignments include such items as: write-ups of assessment/plans, differential diagnosis, clinical questions, and readings.
- Completion of peer and preceptor evaluations
- Attendance and satisfactory participation in teaching rounds sessions which either introduce or conclude the clinical reasoning sessions

Essential Procedures in Emergency Medicine (EMED)

- Mandatory attendance and performance in clinical procedure skill sessions. Failure to attend all sessions and complete make-ups as determined by EMED faculty, prevents the student from passing the course.

Male GU and Female Breast and Pelvic Exam Sessions with Project Prepare

- Satisfactory attendance and participation in three scheduled skills session.
- Students are expected to be prompt, and to conduct themselves with the utmost professionalism and decorum.
- Failure to attend your sessions and complete the above requirements may result in a student not passing the course.

Nutrition

- Satisfactory and timely completion of online nutrition modules

Final Exam

- Students must earn a passing grade (≥ 65%) on the POM final exam. If performance is deemed insufficient, remediation may be assigned by the course director. Examples include: poor performance on a particular section of the final exam, a grade approximating two standard deviations below the mean, or concerns about professionalism as demonstrated on exam responses.
Attendance Policy and Remediation
Students are required to attend all scheduled POM sessions.

FAILURE TO ATTEND ALL SESSIONS AND COMPLETE THE BELOW REQUIREMENTS IS CONSIDERED A BREACH OF PROFESSIONALISM AND WILL PREVENT THE STUDENT FROM PASSING THE COURSE.

Students who need to miss a session must notify their preceptor, the course director Dr. Pree Basaviah (pree@stanford.edu), or Tomiko Oskotsky (t.oskotsky@stanford.edu). Only one pre-approved absence per quarter is permitted for POM (see specific course sections for absence notification and make-up procedures).

- Students are allowed ≤1 pre-approved absence for each quarter in POM.
  - Student will be given a make-up assignment for completion (See specific course session pages).
- Students with >1 excused absence for each quarter in POM or ≤1 unexcused absence for each quarter in POM.
  - Student will be given a make-up assignment for completion (See specific course session pages).
  - Student will be given an “Early Warning” – an informal note, raising concerns about student absences, will be sent to the student and their advisor.
- Students with >2 excused absences for each quarter in POM or >2 unexcused absences for each quarter in POM.
  - Student may be given a “Marginal Pass” or a failing grade at the discretion of the Course Director, based on performance in all components of the course.

Assignment Due Dates and Late Assignments
As discussed above, required assignments will be expected by the due date, and failure to turn in assignments on time would normally constitute a failure to complete a course requirement. Failure to complete a course requirement (even if you receive an approved assignment extension that falls after the grade submission deadline) will result in a Marginal Pass (MP) or (N) grade submitted to the registrar, dependent on your overall performance in the quarter. This grade submission will result in a required meeting with your advisor and a review by the CP3 committee. If you anticipate circumstances that will lead to late assignments, please be aware of the possible grade submission, review by CP3 and please contact the course director and course administrator to obtain pre-approval and arrange for any necessary remediation.

Evaluations
In accordance with LCME and as part of our professional responsibility to complete evaluations as part of the continuous learning process, POM will wait until at least 80% of INDE 204 students have completed evaluations before releasing final grades. We respect and value your opinions, feedback, and suggestions.
Teaching Assistants

For students who are teaching assistants for courses at Stanford University, your schedule as a TA may directly conflict with the 2nd year required Practice of Medicine course (INDE 204, 205).

If your teaching assistantship requires attendance at lectures and/or lab teaching on Tuesday and Thursday afternoon, this will directly conflict with sessions in the POM year 2 curriculum. As a result, you will not be able to take POM Q4 or Q5 with your classmates. Of note, the POM curriculum consists of clinical reasoning (small group, case-based, integrated discussions), EMED (hands on learning of clinical procedures), and Clinical Practicum (small group live-patient tutorial in clinical skills, including interview, physical examination, case presentations, and write-ups).

There are two options from which you will need to choose for POM, listed below. We strongly recommend that you consult with your academic advisor and/or TAs from prior years in making this selection. Once you have made your selection, please notify Tomiko Oskotsky (POM Year 2 Curriculum Manager) as soon as possible (t.oskotsky@stanford.edu).

- **OPTION 1**: You may defer taking INDE 204, 205, 206 until 2012-13 academic year, so that you may benefit from the POM curriculum in its entirety, hence avoiding any schedule conflict.

- **OPTION 2**: Simultaneously take your teaching assistantships and POM. Once we know if there are students who seek this option (and how many), we will work with the medical school leadership to devise specific plans. Although we CANNOT guarantee that you will receive the same POM curricular sessions as your peers, we will make every effort to provide the core curriculum, albeit in a different format. You may receive summary sessions that include the essential elements of those sessions. For hands on sessions, the workshop format may be replaced with a different teaching format (online, case discussion, or review sessions later in the year). In some cases, small group sessions on other days can be arranged with POM faculty, though this is difficult because of teaching commitments with the first year POM course (Monday & Friday). If you choose this option, you will need to be available on Monday, Wednesday, or Friday afternoons for make-up sessions that can be arranged; no other times will be available for make-up. Thus, you will have to carefully select your elective course schedules.

Please note that selecting OPTION 2 means that it is likely that certain portions of the POM curriculum that cannot be replicated will be omitted from your experience. Please keep this in mind when selecting from the options above.
Additional Requirements:

On-Line Confidentiality Tutorial (HIPAA)
All students are required to complete this online tutorial and be certified as trained in principle of patient confidentiality **required by law**. Students should have completed this training in their first year. Those who have not must successfully complete the HIPAA training modules **before first contact with patients**. Patient contact will not be allowed without completion of this requirement.

Dress Code
Any time students see patients, they must adhere to the dress code described below. **Dress code guidelines must be followed during all Clinical Practicum sessions and all Common Clinical Problems Sessions.**

Students are expected to dress professionally and conservatively. Attire typically worn to class or lecture will in many cases not be appropriate.

For All Students
- **Always bring your white lab coat.** Your coat must be clean, pressed and worn at all times, unless you are directed otherwise by the supervising physician.
- Do not wear jeans, shorts, flip-flops, tennis-shoes or open-toed shoes.
- Do not wear cologne or perfumes.
- Tattoos should be covered.
- Jewelry should be minimal and understated.
- Clothing should not have rips, tears or frayed edges.
- Do not expose your midriff.
- Clothing should allow for an appropriate range of movement, and should not be flashy or draw attention.

For Men
- Button-down shirts and ties should be worn, along with pants or slacks.
- Khakis are appropriate.

For Women
- Slacks, pants and modest skirts or dresses are appropriate.
- Skirts should hit close to the knee or below.
- Low heels or flats should be worn; no open-toed sandals.
- Tops and blouses should have modest necklines.
- Thin or “spaghetti-style” straps on tops are not appropriate.
Professionalism
Students are expected to act in a professional manner in all class activities, activities— in the classroom, outside the classroom, with patients, standardized patients and community members. **Failure to act professionally in POM can be grounds for failing the course.** While precise standards of professionalism can vary from situation to situation, professionalism would nearly always include the following:

1. Be on time.
2. Prepare for class, small groups, clinic, and rounds.
3. Treat all patients, faculty, staff, class guest speakers and patients, classmates, medical providers, and other health care team members with respect and consideration, without regard to gender, age, race, religion, ethnicity, class or sexual orientation.
4. Dress appropriately. (see section below)
5. Respect that faculty have devoted their time to teaching medical students in lectures, small groups, clinics, and hospitals.
6. Respect that invited guests and speakers have generally volunteered to come and share their knowledge and perspective with the class.
7. Commit to lifelong learning.
8. Assist others.
10. Fulfill responsibilities assigned with careful consideration of consequences to both patients and colleagues.
11. Consult with those more knowledgeable when necessary.
12. Adhere to the highest standard of integrity and honesty in all professional relationships, including those with pharmaceutical and industry representatives.
13. Show respect in all oral, written, and e-mail communications, including patient presentations, course / faculty / peer evaluations, and test question challenge forms.

Clinical Problem-Solving Group Switch Policy
Students who switch groups without previous arrangement will be marked absent from their primary group, which may result in not passing the course. We do understand that there are certain circumstances that can lead to students requesting to switch groups. Students who wish to switch group assignments should follow the following process:

1. Students who have adequate reason to switch groups should discuss the circumstances with the assigned group preceptor and the Course Director. It is very possible that circumstances can be alleviated through this step.
2. If the group switch is approved, the student should inform the POM 2 curriculum manager, Tomiko Oskotsky, to make certain all group assignments are up-to-date.

Policy on Hospitalized Patients
Interactions with hospitalized patients will be coordinated through the course. Students should not initiate contact with hospitalized patients in the absence of faculty coordination and observation.
Universal Precautions:

FOR ADDITIONAL INFORMATION AND RECOMMENDATIONS REGARDING TREATMENT CALL THE NEEDLESTICK AND EXPOSURE HOTLINE: (650) 498-4000.

Universal Precautions apply to the handling of all blood, body fluids, and human tissue. Body fluids, also known as other potentially infectious material (OPIM) include: semen, vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids, feces, urine, sputum, nasal secretions, saliva, tears, vomitus, or any other body fluid or tissue that is visibly contaminated with blood.

Hand washing: Hands and other skin surfaces contaminated with blood or body fluids must be immediately and thoroughly washed. Gloves must be changed and hands washed between patient contacts.

Protective Barriers: Protective barriers will be worn to prevent exposure to blood or body fluids during procedures where splashing or aerosolization may occur. Individual departments/units will specify the type of protective barrier(s) to be used during any specific procedure, according to the type of exposure anticipated. Barriers such as gloves, gowns, plastic aprons, masks, protective eyewear, or face shields may be required.

Gloves: Gloves will be worn during phlebotomy, finger or heel sticks, when starting or manipulating intravascular lines, or during any procedure involving a potential exposure to blood or OPIM:

1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Use examination gloves involving contact with mucous membranes or for other patient care.
3. Change gloves and wash hands between patient contacts.
   Do not wash or disinfect surgical or examination gloves for reuse (deterioration may result).
4. Use general-purpose utility gloves (e.g., rubber household gloves) for housecleaning chores and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused, but should be discarded if peeling, cracked, torn, or damaged.

Preventing Penetrating Injuries: Gloves will reduce the incidence of contamination of the hands, but they cannot prevent penetrating injuries from needles or other sharp instruments.

1. NEVER RECAP NEEDLES BY HAND; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand.
2. Place used disposable syringes, needles, scalpel blades, and other sharp items in red puncture-resistant containers for disposal. Containers should be located at the bedside or as close to the areas as practical.
3. Take care, both during and after procedures, to prevent injuries from needles, scalpels, or other sharp instruments or tools. Always maintain eye contact with these devices.

Use of Needleless Systems, Safe Needles and Non-Needle Sharps: Needleless systems are used during:

1. Withdrawal of body fluids after initial venous or arterial access is established;
2. Administration of medications or fluids; and
3. Any other procedure involving the potential for an exposure incident for which a needle less system is available as an alternative to the use of needle devices.
**Safe Needle Devices:** When needle less systems are not used or cannot be used, needles with engineered sharps injury protection are to be used during:

1. Withdrawal of body fluids;
2. Accessing a vein or artery;
3. Administration of medications or fluids; and
4. Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.

**Non-Needle Sharps:**
If sharps other than needle devices are used, these items shall include engineered sharps injury protection.

**Preventing Contamination:**
Observing these additional procedures can prevent unnecessary contamination to yourself and others:

- Always clean up spills of blood or OPIM promptly and disinfect the spill site.
- Decontaminate workbench and laboratory equipment after liquid spills.
- Place contaminated disposable items in appropriate containers (red bags or sharps container).
- Shield machines and equipment, which could emit aerosols or splashes. Use biological safety cabinets for all research procedures involving blood or OPIM.
- Decontaminate reusable instruments and devices before reprocessing.
- Choose a suitable specimen container. Avoid contaminating the outside of the container and be sure the lid is on tight. Decontaminate the outside of the container before transporting.
- Never pipette by mouth. Use a pipetting aid.

**HAD A SIGNIFICANT EXPOSURE?**
If you believe you’ve had a significant exposure to blood or OPIM at Stanford proceed immediately to the Stanford Emergency Department. If the exposure occurs at one of the School’s affiliated hospitals go immediately to that hospital’s Emergency Department.

Tell the admitting clerk you have had an occupational exposure to blood or OPIM. The staff will know you need to be seen promptly. After this initial evaluation and management, follow-up care will be carried out at Vaden Health Center; call 498-2336 and request an appointment for post-exposure care. Records are strictly confidential.

There is no charge for blood tests, medications, or follow-up care following a blood or OPIM exposure. Call Dr. Preetha Basaviah after the visit to the Emergency Department: (415) 516-8105 (C) or Stanford page, 723-8222, #13462.

**FOR ADDITIONAL INFORMATION AND RECOMMENDATIONS REGARDING TREATMENT CALL THE NEEDLESTICK AND EXPOSURE HOTLINE:** (650) 498-4000.
### Practice of Medicine, INDE 204, 2011-12: Page 16

**Practice of Medicine Fall Quarter Schedule 2011-2012**

#### Week 1: 9/1/11

<table>
<thead>
<tr>
<th><strong>THURSDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: M120</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
</tr>
</tbody>
</table>

#### Week 2: 9/5-9/9

<table>
<thead>
<tr>
<th><strong>TUESDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Holiday: 9/6</td>
</tr>
<tr>
<td>Location: F-Labs</td>
</tr>
<tr>
<td>1pm-2pm, 2pm-3pm, 3pm-4pm, 4pm-5pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>THURSDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
</tr>
</tbody>
</table>

#### Week 3: 9/6-9/10 thru Week 5: 9/20-9/24

<table>
<thead>
<tr>
<th><strong>TUESDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Holiday: 9/13, 9/20, 9/27</td>
</tr>
<tr>
<td>Location: Teaching rounds: LK120, Break-out: LKSC</td>
</tr>
<tr>
<td>1pm-2pm, 2pm-3pm, 3pm-4pm, 4pm-5pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>THURSDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
</tr>
</tbody>
</table>

#### Week 6: 9/27-10/01

<table>
<thead>
<tr>
<th><strong>TUESDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Holiday: 10/4</td>
</tr>
<tr>
<td>Location: F-Labs, LKSC</td>
</tr>
<tr>
<td>1pm-2pm, 2pm-3pm, 3pm-4pm, 4pm-5pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>THURSDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
</tr>
</tbody>
</table>

#### Week 7: 10/04-10/08 thru Week 9: 10/18 - 10/22

<table>
<thead>
<tr>
<th><strong>TUESDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Holiday: 10/11, 10/18, 10/25</td>
</tr>
<tr>
<td>Location: Teaching rounds: LK120, Break-out: LKSC</td>
</tr>
<tr>
<td>1pm-2pm, 2pm-3pm, 3pm-4pm, 4pm-5pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>THURSDAY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
</tr>
</tbody>
</table>

---

* EMED occurs first Tuesday of each month in Quarter 4

** Group A B alternate between clinical practicum and advanced clinical skills on Thursdays (See individual schedule)
<table>
<thead>
<tr>
<th>Week 10: 10/25 - 10/29</th>
<th>TUESDAY</th>
<th>THURSDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/1</td>
<td>EMED</td>
<td><strong>Clinical Practicum</strong></td>
</tr>
<tr>
<td>11/3</td>
<td><strong>Advanced Clinical Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Holiday</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>11/7, 11/8, 11/15, 11/22</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 11: 11/1 - 11/15 thru Week 12:11/14 - 11/18</th>
<th>TUESDAY</th>
<th>THURSDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/1</td>
<td>EMED</td>
<td><strong>Clinical Practicum</strong></td>
</tr>
<tr>
<td>11/3</td>
<td><strong>Advanced Clinical Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>11/8, 11/15, 11/22</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 13: 11/21-11/25</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THANKSGIVING BREAK</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 14: 11/28-12/2</th>
<th>TUESDAY</th>
<th>THURSDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/29</td>
<td>EMED</td>
<td><strong>Clinical Practicum</strong></td>
</tr>
<tr>
<td>12/1</td>
<td><strong>Advanced Clinical Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Holiday</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>12/6</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 15: 12/5-12/9</th>
<th>TUESDAY</th>
<th>THURSDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/6</td>
<td>EMED</td>
<td><strong>Clinical Practicum</strong></td>
</tr>
<tr>
<td>12/8</td>
<td><strong>Advanced Clinical Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Holiday</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>12/6</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 16: 12/12-12/16</th>
<th>TUESDAY</th>
<th>THURSDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td><strong>FINAL EXAM</strong></td>
<td>PRACTICE OF MEDICINE</td>
</tr>
<tr>
<td>12/12</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>12/14</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>12/15</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
<tr>
<td>1:15pm-5:05pm</td>
<td>Location</td>
<td>Assorted Locations</td>
</tr>
</tbody>
</table>

* EMED occurs first Tuesday of each month in Quarter 4
** Group A B alternate between clinical practicum and advanced clinical skills on Thursdays (See individual schedule)
POM: Practice of Medicine
Orientation and Physical Exam Demonstration

<table>
<thead>
<tr>
<th>Date</th>
<th>Thursday 9/11/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>1:15-5:05pm</td>
</tr>
<tr>
<td>Session Type</td>
<td>Lecture, Clinical Skills session</td>
</tr>
<tr>
<td>Responsible faculty</td>
<td>Basaviah, POM theme leads, Osterberg</td>
</tr>
<tr>
<td>Video-captured</td>
<td>yes</td>
</tr>
<tr>
<td>Professional dress</td>
<td>no</td>
</tr>
</tbody>
</table>

Session Goals
- Provide an overview of course activities, expectations, and requirements.
- Demonstrate how a full history and physical examination is performed

Session Learning Objectives:
Students should be able to:
- Identify learning goals and participation expectations for the quarter
- Anticipate quarter benchmarks in skills assessments
- Observe a clinician taking a history and physical exam and reflect on approaches used

Key Words:
Medical History Taking
Physical Examination
Communication

Reading Assignment:
Stanford History and Physical Exam checklist – See Appendix

Session Activities:
- Welcome and Q4 overview
- Practicum orientation
- History and physical exam demonstration
- Demonstration debrief

1.) In today’s session, you will observe an in-class interview coupled with a full physical examination. As you observe, note the basic elements of interviewing, not only in terms of the temporal order of the encounter, but also in terms of the three functions of the interview.

2.) Consider the following questions:
   a. What information gathering techniques did the physician use?
   b. List two specific nonverbal methods the physician used to establish rapport with the patient.
   c. List two specific questions or statements the physician used to establish rapport with the patient.
THREE FUNCTION MODEL TO THE MEDICAL INTERVIEW

A. **Information Gathering:** Eliciting information from the patient by starting with open-ended questions and then refining diagnostic thinking with close ended questions.

B. **Rapport Building:** Building a relationship with the patient through a combination of non-verbal and verbal techniques

C. **Patient Education:** Managing a patient’s problems, most effectively done using the method ASK-TELL-ASK.
   1. **Ask** the patient about their understanding of the issue at hand
   2. **Tell** the patient additional information
   3. **Ask** the patient to repeat for you their understanding of what you just said

TEMPORAL ORDER OF A MEDICAL INTERVIEW

A. Chief Complaint
B. History of Present Illness
C. Previous Medical History
D. Medications (Prescription, over the counter, herbal), Allergies
E. Family History
F. Social History
G. Health Related Behaviors
H. Review of Symptoms
I. Physical Examination
J. Impression/Summary Statement
K. Assessment / Plan: Problem list with each problem having an Assessment and Plan (Plan includes diagnostic, therapeutic management, and patient education items)
Past Medical Hx:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Allergies:

☐ NKDA

Medications:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Family Hx:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Social Hx:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

<table>
<thead>
<tr>
<th>ROS: (Describe if abnormal)</th>
<th>Pulm</th>
<th>Hema/Lymph</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>GI</td>
<td>Neuro</td>
</tr>
<tr>
<td>Eyes</td>
<td>GU</td>
<td>Endocrine</td>
</tr>
<tr>
<td>ENT</td>
<td>Skin</td>
<td>Psych</td>
</tr>
<tr>
<td>CV</td>
<td>Musculoskeletal</td>
<td>Allergic/Immuno</td>
</tr>
</tbody>
</table>

☐ All other systems are negative except as stated above.
PHYSICAL EXAM:

VS: T _____ BP _______ P _______ R _______ O₂ sat _______ on ________ 0₂ Wt _______

General Appearance:

HEENT: ☐ Atraumatic ☐ EOMI ☐ PERRL ☐ Solera Anicotic ☐ Oropharynx Clear
Neck: ☐ Supple ☐ No Thyromegaly ☐ No Cervical Adenopathy ☐ No JVD
Lungs: ☐ Clear Auscultation ☐ Clear Percussion ☐ Normal Symmetry & Expansion
Cardiac: ☐ Regular Rhythm & Rate ☐ No Murmurs/Rubs/Gallops
Abdomen: ☐ Nont B.S. ☐ Soft ☐ Nontender ☐ No Organomegaly ☐ No Masses Palpable
GU/Rectal: ☐ Normal Tone ☐ Guanule Negative Stool ☐ Normal External Genitalia ☐ No Inguinal Adenopathy
Extremities: ☐ No Cyanosis ☐ No Clubbing ☐ No Edema ☐ Pulses +2
Neuro: ☐ Alert & AX3 ☐ Cranial Nerves Intact ☐ Motor Exam Norntal ☐ Sensation Intact ☐ Coordination Intact
Musculoskeletal: ☐ No Atrophy ☐ Normal Muscle Tone ☐ Normal Gait
Back: ☐ No Costovertebral Angle Tenderness
Psych: ☐ Normal Mood/Affect
Skin: ☐ Warm ☐ Dry ☐ Clear
Other: ☐ Foley Catheter ☐ Central IV Line

PROBLEM LIST / IMPRESSION / PLAN:

Code Status
☐ Full ☐ DNR/DNI
☐ Other: ____________________
Emergency Medicine Procedures
### Essentials in Emergency Medicine Procedures

**Dates:** Tuesdays: 09/6/11, 10/4/11, 11/1/11, 12/6/11  
**Time:** 1:15-5:05 pm  
**Session type:** Clinical Skills session  
**Location:** Fleischmann Labs (M208, M212, M214, M218)  
**Lead Faculty:** Ian Brown, MD; Jessica Ngo, MD  
**Lead TA:** Danica Lomeli  
**Video-captured:** no

#### About the EMED Sessions
EMED Sessions occur the first Tuesday afternoon of each month (September, October, November, and December) from 1:15pm to 5:05pm. Material in this class is presented in lecture, laboratory, and clinical formats. Student evaluations will be based on performance in laboratories.

#### Goals for the EMED sessions
- Gain experience performing procedures, that will translate into confidence when interacting with patients and performing procedures on patients
- Learn how to perform commonly done procedures and understand indications, contraindications, and complications associated with each procedure

#### Learning objectives for these sessions are to:
1.) Learn indications, contraindications, anatomy, and steps to perform the procedure correctly  
2.) Successfully perform procedures on one another, mannequin, or cadaver  
3.) Gain confidence interacting with patients and colleagues when preparing for or performing procedures  
4.) Gain understanding of how a procedure feels to the patient

#### Required activities for the EMED sessions
**Attendance**
1.) Students are expected to attend all scheduled EMED sessions.  
2.) Any absences must be approved in advance by both the small group facilitator and the POM course director. **Failure to attend all sessions and complete the related requirements prevents the student from passing the course.**

#### Key Words:
- Clinical Medicine  
- Clinical Skills  
- Procedures

#### Advance Preparation:
**Equipment to bring:** None  
**Dress code:** Casual. Formal attire not required.  
**Required Reading:**
- Refer to reading list on coursework

#### Assignment:
none
**Emergency Department Shifts**

<table>
<thead>
<tr>
<th>Dates &amp; Times</th>
<th>Two 8-hour shifts during Q4 and/or Q5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session type</td>
<td>Clinical Skills session</td>
</tr>
<tr>
<td>Location:</td>
<td>Stanford Hospital ED</td>
</tr>
<tr>
<td>Lead Faculty:</td>
<td>Ian Brown, MD; Jessica Ngo, MD</td>
</tr>
<tr>
<td>Lead TA:</td>
<td>Danica Lomeli</td>
</tr>
<tr>
<td>Video-captured</td>
<td>No</td>
</tr>
</tbody>
</table>

**Goals for the EMED sessions**
- Provide opportunity for performing commonly done procedures on patients in the Emergency Department

**Learning objectives for these sessions are to:**
- Practice perform procedures in a clinical setting
- Gain confidence interacting with patients when preparing for or performing procedures
- Enhance understanding of how a procedure feels to the patient

**Key Words:**
- Clinical Medicine
- Clinical Skills
- Procedure

**Advance Preparation:**
- **Equipment to bring:** Stethoscope
- **Dress code:** Name tags (with a piece of red tape on the bottom left corner) - must be worn during the shifts. Scrubs are the preferred clothing, but male students may wear slacks, shirt, tie, and a white coat. Female students may wear comparable clothing. ABSOLUTELY NO JEANS IN THE EMERGENCY DEPARTMENT!

**Required Reading:**
- none

**Assignment:** complete ED Summary Report, obtain supervisors’ signatures, submit to Tomiko
Session Activities:
Emergency Department shifts provide the opportunity to apply newly learned skills to clinical situations. Emergency Department shifts are from 8AM-4PM, 4PM-12AM, and 12AM to 8AM. Students will be paired with a nurse mentor for each shift. It is important to be assertive and to be on the lookout for opportunities to perform procedures. However do not obstruct patient care or processes in the ED and do not be afraid to ask for help. The nurse will understand that you may leave his/her supervision to practice a procedure with the attending or a resident. Students must sign up for at least two shifts. The sign-up will be coordinated by the TAs and will be done on-line.

After everyone has had the chance to sign up for two shifts students may add or change shifts on the sign-up sheet by noon on the Thursday prior to a shift for the following week (the week begins with the 8 AM to 4 PM shift on Monday). Students may (and are encouraged to) sign up for additional shifts. Once scheduled, you must show up for your shift. In the exceptional instance that you cannot attend a shift, you must either find a classmate to replace you or notify one of the TAs AND the charge nurse in the Emergency Department at 723-7337.

Students should report to the attending physician and locate their nurse mentor upon arrival in the Emergency Department. Students must leave at the end of their scheduled shift. Furthermore, students are required to fill out a Summary Report for each shift in the Emergency Department. (These are located in the back of the syllabus; a sample is included.) The Summary Report should be filled out completely and initialed by the nurse mentor or the attending physician. There is also a section for your comments on the back.

ADDITIONAL INFORMATION FOR SHIFTS IN THE EMERGENCY DEPARTMENT
1. **CLOTHING:** Appropriate clothing (See Dress Code) and your name-tag are mandatory.
   Additionally, place a red piece of tape (provided in your binder) on the left bottom corner or your name-plate, as shown below. In this way, everyone will know that you are a pre-clinical student taking Surgery 221, i.e., A PROCEDURE APPRENTICE.

   ![Name Tag Example]

2. **WHEN YOU ARRIVE:**
   Report to the attending physician and locate your nurse mentor at the beginning of the shift.
   **Note:** There are three attending physicians, one in pediatrics, one in the middle, and one in the front, for the trauma and medicine rooms. It’s a good idea to introduce yourself to as many people in the E.D. as possible (residents, students, nurses, technicians...).

3. **WHEN YOU LEAVE:** You must:
• leave at the end of your shift,
• have the attending or your nurse mentor fill-out and initial your evaluation
• fill out the Summary Report for your shift
  (be sure to give these to the lead EMED TA Sarah Jane Selig)

Please thank those people in the ED who were helpful to you before you leave.

4. **WHO ARE ALL THE PEOPLE IN THE ED?** Here’s a brief run down of the people you are likely to interact with:

**MEDICAL:** Attending (supervising) Physician, House staff (interns, residents, and fellows from medicine, surgery, pediatrics, trauma, etc.)

**NURSING:** Charge nurse (also called resource nurse) -- he/she coordinates the other nurses for that shift and facilitates patient flow, communication among the doctors, nurses, etc. Staff nurses taking care of the patients -- they are generally assigned to work specific rooms.

**OTHER:** ED technicians -- assist the nurses with patient care including some procedures (e.g. blood drawing). USA’s (Unit Service Assistant) and admitting clerks - responsible for paperwork, getting samples to the lab, etc.

5. **LAYOUT OF THE ED:**

Room 1 - major medical patients,
Room 3 - isolation,
Room 5 - trauma,
Room 7 - less severe medical patients,
Room 8 - psychiatric or isolation patients
Room 9 - ENT

Middle Hall - includes prompt care and special rooms
  (casting, gynecology, pediatrics)

Peds 1-3 & 8 – General Peds
Peds 4 & 5 – Peds Critical Care Beds
Peds 6 & 7 – Peds Isolation Beds

6. **YOUR ROLE IN THE ED:** (these are just a few suggestions)

- Do the procedures that you learned in the classroom on patients. If you're not yet comfortable solo, ask to be supervised.

- This is still a great time to talk with patients, and their families: so jump in, learn, and enjoy.

- Continue to familiarize yourself with the ED and the exciting field of emergency medicine.
• Watch carefully: Keep your eyes and ears open at all times. An extra body might observe something that no one else does.

• DON’T BE SHY!! Introduce yourself to the attending physicians, and other staff, including the house staff (fellows, residents, interns), nurses, technicians, medical students, etc. They can be a tremendous resource.

• Since you’ve undoubtedly taken BLS already, you have the chance to join in on CPR if a code comes in. Identify yourself to the attending before the code arrives and make yourself available to do compressions— you’ll learn a lot and they’ll usually appreciate the help.

• Feel free to follow the patient to X-ray or surgery (if it’s O.K. with the person in charge).

• Remember to be sensitive to the other people working around you. They are generally eager to answer your questions, but sometimes they’re quite busy.

**SAFETY: PROTECT YOURSELF**

• Be cautious of blood, secretions, and patients when necessary, wear gloves, goggles, and protective wear.
• It’s a good idea to keep a couple pairs of gloves in your pocket.
• Be aware of your gut feelings with patients—if you don’t feel comfortable with a patient, leave.
• REPORT ALL NEEDLE STICKS AND FLUID CONTACT WITH MUCOSAL SURFACES AND OPEN WOUNDS TO THE ATTENDING PHYSICIAN IMMEDIATELY.
• Portable X-Rays:
  • Lots of portable x-rays are taken in rooms 1, 3 and 5 of the ED. Keep an eye out for the arrival of the machine.
  • In general, it is considered safe if you are standing at least 6 feet from the machine, particularly if it is pointed away from you (which it will be since the patient is usually away from the center from the center of the room.
  • Listen for the warning of the tech. Usually they will only say “X-ray” once.
  • The tech will not shoot the x-ray if someone is likely to be exposed, unless that person says “OK.” (We’ve all done it in some critical situations.)
  • We have lead aprons available for anyone.
  • Pregnant or potentially pregnant students should pay close attention to the above.

• And most importantly, enjoy yourselves and have a good shift !!!
Emergency Department Shift Summary Report

Student Name: __________________________ Shift Date: ________________

Shift Attended (please circle one): 4pm-12m 12m-8am 8am-4pm

Procedures Performed: ________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Attending/Resident Name (please print): ________________________________

Attending/Resident Signature and Date: ________________________________
## EMED Session Calendar

### Session Reminders:
- Don’t switch assigned group without approval from EMED faculty and POM staff
- Sessions topics are subject to change

<table>
<thead>
<tr>
<th>Session #1: 09/06/11</th>
<th>Room Location: M208 Group A</th>
<th>Room Location: M212 Group B</th>
<th>Room Location: M214 Group C</th>
<th>Room Location: M218 Group D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Procedure(s): Suturing</td>
<td>Procedure(s): Airway, ABG, Pulse Oximetry</td>
<td>Procedure(s): Sutile gloves, Foley, NGT, Phlebotomy</td>
<td>Procedure(s): IV, EKG</td>
</tr>
<tr>
<td></td>
<td>Advanced Suturing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #2: 10/04/11</th>
<th>Room Location: M208 Group D</th>
<th>Room Location: M212 Group A</th>
<th>Room Location: M214 Group B</th>
<th>Room Location: M218 Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Procedure(s): Suturing</td>
<td>Procedure(s): Airway, ABG, Pulse Oximetry</td>
<td>Procedure(s): Sutile gloves, Foley, NGT, Phlebotomy</td>
<td>Procedure(s): IV, EKG</td>
</tr>
<tr>
<td></td>
<td>Advanced Suturing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #3: 11/01/11</th>
<th>Room Location: M208 Group C</th>
<th>Room Location: M212 Group D</th>
<th>Room Location: M214 Group A</th>
<th>Room Location: M218 Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Procedure(s): Suturing</td>
<td>Procedure(s): Airway, ABG, Pulse Oximetry</td>
<td>Procedure(s): Sutile gloves, Foley, NGT, Phlebotomy</td>
<td>Procedure(s): IV, EKG</td>
</tr>
<tr>
<td></td>
<td>Advanced Suturing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session #4: 12/06/11</th>
<th>Room Location: M208 Group B</th>
<th>Room Location: M212 Group C</th>
<th>Room Location: M214 Group D</th>
<th>Room Location: M218 Group A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Procedure(s): Suturing</td>
<td>Procedure(s): Airway, ABG, Pulse Oximetry</td>
<td>Procedure(s): Sutile gloves, Foley, NGT, Phlebotomy</td>
<td>Procedure(s): IV, EKG</td>
</tr>
<tr>
<td></td>
<td>Advanced Suturing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical Practicum
**Clinical Practicum**

| **Dates:** | Alternate Thursdays  
Q4: September 8 - November 24, 2011  
Q5: Jan 26, 2011 - March 8, 2012 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time:</strong></td>
<td>1:15-5:05 pm or 1:30-5:30 pm</td>
</tr>
<tr>
<td><strong>Session Type:</strong></td>
<td>Clinical Skills sessions</td>
</tr>
<tr>
<td><strong>Location:</strong></td>
<td>Various local hospitals and clinics</td>
</tr>
<tr>
<td><strong>Responsible Faculty:</strong></td>
<td>Lisa Shieh, MD, PhD, Jeff Chi, MD, and Preetha Basaviah, MD</td>
</tr>
<tr>
<td><strong>TAs:</strong></td>
<td>Jon Kleinman (Q4), Sarah Jane Selig (Q5)</td>
</tr>
<tr>
<td><strong>Videotaping:</strong></td>
<td>No</td>
</tr>
</tbody>
</table>

**About the Clinical Practicum**

The Clinical Practicum is a two quarter longitudinal training and mentorship experience at a hospital or out-patient clinic site in the peninsula and south bay.

The student will spend half-day sessions during Q4 and Q5 with experienced clinician preceptors. During these sessions, students will have the opportunity to practice their clinical skills under direct observation and receive constructive feedback on their performance. Students should expect to receive regular verbal feedback as well as written evaluations of their performance.

The practicum is also designed to allow the student to develop a relationship with an attending physician who will serve as a role model, mentor and educator.

**Goals of the clinical practicum**

The overarching goal of the clinical practicum is to provide mentored practice and growth in students’ skills in the medical interview, physical examination, clinical problem solving, and clinical practice.

**Learning objectives of the clinical practicum**

During the clinical practicum, students should:
- Gain experience and expand their skills in the medical interview.
- Gain experience and expand their skills in the physical examination.
- Learn to accurately generate a problem list and differential diagnosis of common clinical problems.
- Learn to clearly present and articulate their observations and assessments verbally and in writing.
- Learn effective verbal and nonverbal communication skills in all interactions with patients and staff.

**Student roles and responsibilities for the clinical practicum**

1.) Learn and follow all guidelines in the clinical practicum student guide.
2.) Learn and follow rules and code of conduct as demonstrated by preceptor.
3.) Complete HIPAA training prior to the first site visit.
4.) Attend all scheduled clinical practicum sessions.
5.) Arrive at each session on time.
6.) Do not leave the assigned facility during assigned hours for any reason, unless the supervisor has approved the absence.
7.) Satisfactorily complete all clinical practicum requirements.
8.) Seek ongoing feedback and incorporate suggestions for improvement into ongoing assignments and projects.
9.) Adhere to academic and professional standards. Conduct while on clinical assignment should be civil and professional at all times. Behaviors reflecting negatively on the University, the assigned site, or the supervisory clinical educators will be reported to University committees for review.
A student should not:
✔ Alter or falsify a patient’s chart or record,
✔ Present him/herself as a graduate or licensed physician,
✔ Allow him/herself to be presented as a graduate or licensed physician.

10.) Dress appropriately (wear white coat, dress in business/professional attire).

11.) Students are responsible, at all times, to the physician supervisor or their designee at the site and are required to comply with the rules and regulations of the clinical site. Students should:
- Learn and follow the rules, code of conduct, and professional mode of implementing care at the site.
- Refrain from performing procedures beyond their skill or comfort level.
- Obtain specific charting instructions from the supervising physician. (Sign all entries on a medical record and indicate educational status, e.g., MS2.)

Contact Dr. Pree Basaviah (pree@stanford.edu) or Tomiko Oskotsky (t.oskotsky@stanford.edu), if there are concerns about site rules, regulations or student responsibilities.

**Requirements for the clinical practicum**

**Clinical Skills**
To receive credit for the practicum, **students must perform a patient interview and physical examination (full or focused) under their preceptors’ direct observation each session**. Students must perform at least 3 full history and physicals along with write-ups and oral presentations (two in Q4 and one in Q5) and a SOAP note (Q5) during Practicum. This enables the preceptor to provide performance feedback, giving both written and verbal constructive feedback. Additional write-ups can be done for practice and submitted to their preceptor for additional feedback.

**Required Assignments**
- Submit assignments online via Coursework, including patient write-ups and Learning Plan.
- Follow up on write-ups, which will be returned to students for review, and are part of the constructive feedback students can expect to receive during the practicum experience.
- Complete a clinical practicum site and preceptor end-practicum evaluation on E-Value.

**Learning Plan:**
The “learning plan,” is a product of each student’s reflection on areas of clinical skills for which they seek improvement (see more details below under assignments). The learning plan should be based on self-assessment and preceptor feedback from INDE 203. The learning plan should be completed prior to the first practicum session. The learning plan should also be reviewed with the practicum preceptor during the first session.

Each activity should be noted by the preceptor as performed, and feedback given either in writing or verbally. Criteria for successful completion of the patient interview and physical examination are based on Bates Introduction to the Physical Examination, and can be found below (see “Physical Examination Checklist”).

During the last fall quarter session (11/17/11 or 11/24/11), students and their preceptors should meet face-to-face to discuss and complete a revised practicum learning plan. During this feedback session, preceptors should review the student's progress and identify areas students should focus on during the second half of the practicum experience (Q5 Winter Quarter). Students will be expected to revise their learning plan based on their discussion with their preceptor.
Attendance
Students are expected to attend all scheduled clinical practicum sessions. Absences must be cleared with the preceptor, the course director Dr. Pree Basaviah (pree@stanford.edu) or Tomiko Oskotsky (t.oskotsky@stanford.edu), year 2 curriculum manager. Students are responsible for following through on communications and for completing make-up practicum sessions.

**FAILURE TO ATTEND ALL SESSIONS IS CONSIDERED A BREECH OF PROFESSIONALISM AND WILL PREVENT THE STUDENT FROM PASSING THE COURSE.**

Students who do not attend all scheduled sessions will be responsible for making alternative arrangements as needed in order to complete the requirements. It may be possible for students to arrange a make-up session with the preceptor or site director. However, all such arrangements must be made by the student. Practice of Medicine coordinators will not be responsible for scheduling make-up sessions. Sites are under no obligation to offer make-up sessions and may not be able to accommodate all requests.

Resources:
**Practicum Electronic Resource Guide**
Throughout the course, students will receive chapters from the Practicum Resource Guide which includes the guidelines and requirements for the clinical practicum and additional resources that will serve as a quick reference during the practicum sessions.

**Practicum Handbook**
The handbook is the printed version of the electronic resource noted above. Each student will be provided one copy at the beginning of quarter 4. These handbooks provide helpful examples of presentations, resource information about history and physical exam, as well as space to document learning goals and feedback throughout the quarter. Students should bring the handbook to practicum sessions in their white coats in order to keep track of feedback and progress longitudinally. Faculty can also view the handbook to help guide feedback discussions each session.
Hospital Sites and Clinics

**Palo Alto VA**

3801 Miranda Avenue  
Building 5  
Palo Alto, CA 94304-1290  
Approximately 4 miles from Stanford  
Main phone: (650) 493-5000

**Contact:**  
Dr. Lisa Shieh  
Ishieh@stanford.edu  
(650) 724-2917

The VA Palo Alto Health Care System (VAPAHCS) is a major tertiary care referral center with three hospital based divisions and a network of six community based outpatient clinics. VAPAHCS provides primary, secondary and tertiary care within a large geographical region encompassing a 10-county, 13,500 square mile catchment area. Approximately 325,000 veterans reside within VAPAHCS’ primary service area (PSA).

**Redwood City Kaiser**

1150 Veterans Boulevard  
Redwood City, CA 94063-2087  
Approximately 6 miles from Stanford  
Main number: (650) 299-2000

**Contact:**  
Dr. Henry Braa  
Henry.Braa@kp.org  
Dr. Eric Mebane  
eric.mebane@kp.org

Founded in 1945, Kaiser Permanente is one of the nation’s largest not-for-profit health plans, serving more than 8.8 million members, with headquarters in Oakland, Calif. The Permanente Medical Groups, which provide care for Kaiser Permanente members, continuously develop and refine medical practices to help ensure that care is delivered in the most efficient and effective manner possible.

**Santa Clara Valley Medical Center**

751 South Bascom Avenue  
San Jose, CA 95128  
Approximately 21 miles from Stanford  
Main number: (408) 885-5000

**Contact:**  
Dr. Yi-Chao Huang  
YiChao.Huang@hhs.co.santa-clara.ca.us

Every year, Santa Clara Valley Medical Center (SCVMC) cares for thousands of patients and provides for over a half-million outpatient and emergency visits. SCVMC is the only hospital in Santa Clara County with an open door policy guaranteeing residents access to needed medical care, regardless of ability to pay. SCVMC’s range of services, national recognition, and commitment to quality make it a valuable community resource. SCVMC has forged a long tradition of service and as mission states, is “Dedicated to the Health of the Whole Community.”
Stanford Hospital and Clinics

Contact:
Dr. Preetha Basaviah
pree@stanford.edu
(650) 724-9621

Dr. Lisa Shieh
lishieh@stanford.edu
(650) 724-2917

Dr. Jeffrey Chi
jeffrey.chi@stanford.edu
(203) 451-6521

Stanford Hospital and Clinics (SHC) is known worldwide for the advanced patient care provided by our staff, particularly for the treatment of rare, complex disorders in areas such as cardiac care, cancer treatment, neurology, neurosurgery and organ transplants. In recognition of SHC’s excellent care, our hospital and physicians consistently rank among the top in the nation in surveys by consumers and health care professionals.

Optional Outpatient Locations

Various internal medicine and family practice clinics around the peninsula area.
SAMPLE PATIENT WRITE-UP FORM (* Students should develop their own template that works for their needs and style)

Chief complaint (CC):

History of present illness (HPI):

Patient’s perspective of illness (PPI):

Past Medical History (PMH):
  MEDICAL:
    Psychiatric:
    Surgical:
    Gynecologic:

Meds:

Social history (SH) / Health-related behaviors (HRB):

Family history (FH):

Review of Systems (ROS):
PE:
   GEN'L:
   HEENT
   NECK
   LUNG
   CV
   ABD
   EXT
   NEURO
   DERM

DATA:

IN SUMMARY:

A/P:

   PROBLEM #1: Assessment and plan for each

   PROBLEM #2: Assessment and plan

   PROBLEM #3: Assessment and plan
POM: Clinical Practicum Session #1
Group A: 9/08/11  Group B: 9/15/11

Introduction to the Hospitalized Patient

Session Learning Objectives
Students should be able to:
- Review learning plan with practicum preceptor
- Identify specific parts of the history and physical exam that need extra practice
- Develop history-taking and physical exam skills.

Session Activities
- Arrive on time to your clinical practicum session, have your stethoscope, and be in professional dress. Introduce yourself to your preceptor and staff.
- Spend 15 minutes to review your learning plan with your preceptor. Review the areas of the history and physical exam you would like to focus on. Be sure to practice these skills today.
- Perform a complete basic history and physical examination, including the patient history, current medical problems (i.e. HPI), the PMH, FH, SH, HRB and/or ROS.
- Spend no more than **75 minutes** on your history and physical exam.
- Present your patient to your preceptor.

Key Words:
- Clinical Skills
- Communication
- Medical History Taking
- Physical Examination

Advance Preparation:
**Videos:** on coursework ‘materials’ section -> ‘videos’ folder -> ‘oral presentations’ folder
**Reading:** ‘Oral Presentations’ pages for the first Advanced Clinical Skills session (9/8 & 9/15)
**Equipment to bring:** Stethoscope, turning fork, reflex hammer, other physical examination equipment
**Dress code:** Professional attire, white coat, ID badge
**Required assignment:** Complete the learning plan prior to the first practicum session, and review with the practicum preceptor during the first session. The “learning plan,” is a product of each student’s reflection on areas of clinical skills for which they seek improvement, and should be based on self-assessment and preceptor feedback from INDE 203.

Homework Assignment:
- Set goals and expectations for the quarter

Tips to Remember:
- Assume that you are meeting the patient on the first day of their hospitalization. **Avoid gathering information related to symptoms, events, or tests during the patient’s hospitalization.** Please continue this practice for all future Practicum patient encounters.
• It may help to open up with a statement like the following:

“My job is to listen to the story of how and why you came to the hospital/clinic and perform an exam. Feel free to include any medical information before your first day here, but none after your admission, unless I specifically ask about it. Hopefully I’ll be able to reach the same diagnosis as your doctors.”

• Information from prior hospitalizations can be included since this may be relevant to the HPI or PMH.

• Familiarize yourself with the layout/geography of your Practicum site.

• Review the syllabus in preparation before each practicum session. Although you will be interviewing and examining patients each week, each session will have a different area of focus.

**Tips on the H&P of the Hospitalized Patient**

Emotional and physical barriers can blunt success in gathering data from patients and inhibit their willingness to collaborate for best clinical outcomes. Examples of barriers include the following:

1) PHYSICAL:
   a) Equipment: IV lines, dressings, compression stockings, Foley urinary catheter, etc.
   b) Position Constraints: Timed limitations after procedure (e.g., supine after lumbar puncture), symptom-limitation (e.g., Trendelenberg after hypotension)

2) EMOTIONAL & COGNITIVE
   a) Pain
   b) Depression, sadness, hopelessness
   c) Fear, anxiety
   d) Confusion, poor memory, short attention span

For the **physical barriers**, the best approach involves

- Define the most important outcomes for the current patient encounter
  - Rapport-building with critical need for detailed physical exam at this moment
  - Essential exam findings to guide patient management (e.g., fluid status via jugular pressure)
  - Other
- Adjust the data-gathering steps to minimize patient discomfort while concentrating on the defined task(s)
- Consider awaiting the most difficult part of the exam until other decision-makers can accompany your efforts to minimize patient distress (e.g., move the patient against restraints only once)
For the emotional barriers, using empathy effectively can not only help the patient but can also help build trust so the patient will more likely be forthcoming with useful information about current symptoms and medical history. One acronym to help remember effective strategies for emotional barriers is PEARLS*:

- **Partnership**  “We are going to get through this together”
- **Empathy**  “You seem pretty frustrated”
- **Acknowledgement**  “I understand you don’t feel like you are getting any better since you have been in the hospital so long”
- **Respect**  “I give you a lot of credit. It’s hard to stay motivated.”
- **Legitimation**  “Most people I know would be distressed about that kind of reaction to the medication”
- **Support**  “I can see how scared and alone you feel here in the hospital, but I can come back to visit you if you like.”

The following common scenarios in hospitalized patients offer opportunities to practice useful maneuvers, seeking a high quality work-up without compromising the comfort and safety of your patient.

### The patient with congestive heart failure who cannot lie flat
- Perform the abdominal examination in the semi-recumbent position (30° elevation).
- Slowly lower the head of bed as tolerated by the patient until threshold is tolerated and then proceed promptly with the abdominal exam.
- Re-elevate promptly if the patient becomes uncomfortable.

### The patient in pain
- Assess for pain early in contact and determine if the patient has covering orders for pain control, whether routine or to have as needed (prn).
- If needed, ask the responsible nurse if the patient may have additional analgesics while you take the history, allowing better pain relief when you are ready to examine them.
- Determine the areas and motions linked to the patient’s pain to minimize movements that cause pain.
- Minimize movement of painful areas and, if movement needed, make slow, gentle movements.
- Alert patient you before you move or examine an area reported as painful.

### The patient who is fearful, sad, disengaged (e.g., not wanting to offer much history)
- Work on extra rapport building to gain their trust.
- Acknowledge the emotion and attempt to find out the reason behind the patient’s emotion.

### The patient with lower limb cast or other limb coverings, limiting patient mobility/examination
- Consider “log-roll” patient on side to listen to lungs if unable to sit upright.
- Ask nurse if possible to remove dressings or equipment (e.g., UNNA boot, SCDs) temporarily to assist examination.

*Adapted from The American Academy on Communication in Healthcare c. 2008*
POM: Clinical Practicum Session #2
Group A: 9/22/11   Group B: 9/29/11

Taking a History

Session Learning Objectives:
Students should be able to:
• Practice taking a history, while maintaining and advancing your communication skills
• Extend skills in the medical history write-up
• Develop physical exam skills.

Session Activities:
• Please spend 15 minutes with your preceptor discussing any questions you may have based on your first Practicum session.
• Perform a complete basic history and physical examination under observation
• Imagine you are meeting the patient on their first day at the hospital. Do not include history from this current hospitalization.
• Spend no more than 60 minutes on your history and physical exam.
• Present your patient to your preceptor and receive feedback. Make note of the areas for improvement in preparation for your next Practicum session.

Key Words:
• Clinical Skills
• Communication
• Medical History Taking
• Physical Examination

Advance Preparation:
Equipment to bring: Stethoscope, turning fork, reflex hammer, other physical examination equipment
Dress code: Professional attire, white coat, ID badge

Homework Assignments:
• Complete a patient H&P write-up, including vital signs, from the patient you saw today and submit by your next session
• Review the feedback that your preceptor has provided and be prepared to incorporate into your next Practicum session.

Tips to Remember:
• Pay special attention to your bedside manner, format of questions, use of jargon and medical terms, and thoroughness.

• Sometimes it helps to gauge your patient’s level of understanding. Some are very savvy and well informed about their medical conditions. Others may have little insight. This may affect the way you ask questions. Some patients may need questions and explanations simplified to an elementary level.
• When you identify an abnormal symptom, be sure to ask any appropriate follow-up questions. Identify the onset, location / position,, quality, severity, duration, timing, modifying factors, and context if applicable. This could be a clue to the underlying diagnosis.

• Remember to ask pertinent positives. If you are convinced your patient has heart failure because they already carry this diagnosis and presents with shortness of breath and leg swelling, you will still need to confirm with additional questions. Does the patient have PND or orthopnea? Why are they worse now? Did they stop taking their medications? Did they start eating a lot of fast food? What is their exercise tolerance like?

• Remember to ask pertinent negatives. In the case above, even though you are convinced the patient is presenting with a CHF exacerbation, you will want to support this by excluding other causes for shortness of breath. Do they have cough or fever (pneumonia)? Do the have a family history of blood clots or recently take a long international plane flight (pulmonary embolus)? The questions that the patient answers “no” to are reassuring and can be just as important as those to which they answer “yes.”
Session Learning Objectives:
Students should be able to:
• Develop history-taking and physical exam skills.
• Learn how to obtain a history relevant to a patient’s chief complaint.
• Adapt to gain information from a poor historian

Session Activities:
• Please spend the first 15 minutes of this session reviewing last session’s feedback and discuss how you plan on incorporating into this patient encounter.
• Perform a complete history and physical examination under observation.
• Obtain a history with focus on the patient’s chief complaint.
• Spend no more than 50 minutes on your history and physical exam.
• Present to your preceptor and receive feedback on your history taking and presentation in general.

Advance Preparation:
Equipment to bring: Stethoscope, turning fork, reflex hammer, other physical examination equipment. Ophthalmoscope and blood pressure cuff are optional - a limited number can be signed out from office D-ground Room HD014, or from Tomiko Oskotsky if not at SUHC
Dress code: Professional attire, white coat, ID badge
Required Assignment: Your H&P write up from last session should be submitted online and to your preceptor before this session begins.

Homework Assignments:
Your preceptor will make corrections to your H&P write-up and return to you before the next session with comments and feedback on your write-up. Review their comments and feedback before your next session.

Tips to Remember:
• In order to manage your time more efficiently and to guide the interview as you start with open ended questions and narrow down to specifics

• As you obtain more information from your patient, think about what diagnosis they may have and the questions that will follow. Begin grouping your interview questions together. For example, if your patient reports a cough, you should begin to instinctively follow-up with questions about dry vs. productive, color of sputum, presence of fever, duration, sick contacts, etc… when thinking about pneumonia. You might then follow-up with questions about weight loss, night sweats, foreign travel, and hemoptysis to evaluate TB.

• When asking a patient a question, think about why you are asking that particular question. What diagnosis are you trying to get at? How will the patient's answer guide your future line of questioning?
• Anticipate whether your questions will narrow your differential diagnosis and lead you to the underlying disease. For example, if you are trying to decide between kidney stones, appendicitis, and pancreatitis for causes of abdominal pain, blindly following a checklist of predetermined questions may not yield additional useful information because the answers are unlikely to help you frame your next question. Asking questions about whether the pain occurs after meals, changes with positioning, and the quality of the pain may be more helpful.

• If your patient in unable to provide a reliable history (i.e. secondary to illness or dementia), you may have to rely on family members if present, or focus on their present symptoms. You may even have to construct a timeline of events based on what they are able to recall.
POM: Clinical Practicum Session #4
Group A: 10/20/11  Group B: 10/27/11

Presenting the HPI

Session Learning Objectives:
Students should be able to:

- Practice taking a medical history, while maintaining and advancing your interview and presentation skills.
- Present an organized and focused HPI

Session Activities:

- Please spend the first 15 minutes of this session reviewing your previously submitted H&P with your preceptor.
- Perform a complete history and physical exam under observation.
- Decrease the time of your history and physical exam to 45 minutes.
- Present to your preceptor with emphasis on the HPI.
- Please reserve 15 minutes at the end of this session for Mid-Quarter Feedback

Advance Preparation:

Equipment to bring: Stethoscope, turning fork, reflex hammer, other physical examination equipment
Dress code: Professional attire, white coat, ID badge
Required Assignment: Review your H+P write-up feedback and be prepared to discuss at the beginning of this session.

Homework Assignments:

- Write up your second H&P, which should include a differential diagnosis and a brief explanation supporting your rationale
- Keep in mind, your feedback from the first write-up. Your preceptors will be looking for improvements where you incorporated feedback on this write-up

Tips to Remember:

- Chronology is extremely important. Presenting a HPI is like telling a story. The HPI should ideally be in chronological order, include key events, be well organized, and include only the most relevant information. The HPI starts from when “the patient was in their usual state of heath”, and ends when he shows up at the clinic or hospital.
- When presenting a patient’s symptoms, remember to describe the location, quality, duration, severity, timing, context, modifying factors, and any associated signs and symptoms.
- Attempt to group symptoms by diagnosis. For example, when describing a patient’s shortness of breath, you might report the patient’s productive cough, fever, and sick contacts (pneumonia). You could then report the absence of PND, orthopnea, weight gain, and pedal edema (CHF).
• When presenting the HPI, remember to focus on the most relevant information. Other information that is unrelated can be mentioned at the very end of the HPI or as part of the ROS.

• Remember to keep your presentation structured and report only the history. Resist the temptation to digress into physical exam findings unless the patient specifically refers to them when describing their symptoms.
POM: Clinical Practicum Session #5
Group A: 11/03/11  Group B: 11/10/11

Physical Exam Skills

Session Learning Objectives:
Students should be able to:
• Practice taking a medical history, while maintaining and advancing communication skills.
• Practice and improve physical exam skills
• Perform a focused physical exam and present exam findings in detail.

Session Activities:
• Spend the first 15 minutes to review the physical exam checklist from the Practicum Resource Guide with your preceptor and determine how to practice on areas of improvement during your practicum sessions.
• Perform a full medical history (CC, HPI, PMH, FH, SH, HRB, ROS).
• Take focused histories as appropriate to patient needs.
• Focus upon and practice physical exam skills, paying special attention to exam findings relevant to your patient’s history or chief complaint.
• Decrease the time of your history and physical exam to 30-45 minutes.
• Present to your preceptor, with an emphasis on the physical exam in detail.
• Discuss/review physical findings.
• Participate in physical exam finding rounds with your group as time allows

Advance Preparation:
Equipment to bring: Stethoscope, turning fork, reflex hammer, other physical examination equipment
Dress code: Professional attire, white coat, ID badge
Required Assignment: Review Bates Introduction to the Physical Examination and the Practicum Resource Guide “Physical Examination Checklist” in preparation for this session

Homework Assignment:
• Before your next session, submit to coursework and your preceptor your second H&P write-up, which should include a differential diagnosis and a brief explanation supporting your rationale

Tips to Remember:
• Remember to obtain vital signs. These are part of the physical exam. You should try to obtain them yourself. If your patient is on a telemetry unit, you may be able to confirm your measurements with the monitor.
• Remember that medical conditions may manifest many different physical exam findings. For example, if you suspect liver disease because of signs of jaundice and ascites, remember to also check for asterixis, caput madusae, spider angiomas, palmar erythema, etc…). Even if the patient does not have all these findings, it is still relevant to comment that you did not appreciate these findings. Sometimes a negative finding is just as important as a positive one.
• You may find it helpful to reference an online source after your patient encounter for physical exam findings that you may not have thought of before. Consider revisiting your patient before meeting with your preceptor if time allows.
POM: Clinical Practicum Session #6
Group A: 11/17/11 Group B: 11/24/11

Differential Diagnosis

Session Learning Objectives:
Students should be able to:

• Practice taking a medical history, while maintaining and advancing your communication skills.
• Practice and improve your PE skills
• Form a differential diagnosis and explain based upon the patient interview and physical exam.

Session Activities:

• Please spend the first 15 minutes of this session to review your second H&P write-up with your preceptor. In particular, focus on the differential diagnosis and identify areas for improvement.
• Take focused histories and practice physical examination skills appropriate to patient needs.
• Limit the time of your history and physical exam to 30-45 minutes.
• Present to your preceptor and include a differential diagnosis.
• Support your differential diagnosis and explain your rationale.
• Review your fall quarter practicum experience with your preceptor.
• Thank your preceptor for working with you during fall quarter and advise you will meet up with them again in late January 2010.

Homework Assignments:

• Have a great break! See you next quarter!

Tips to Remember:

• You may find it helpful to reference online sources shortly before meeting with your preceptor in order to help expand your differential diagnosis.

• Consider whether your differential diagnosis is applicable to your patient. While the differential diagnosis for shortness of breath may include PE, pneumonia, CHF, COPD, interstitial lung disease, etc... it will be more helpful to your audience if you are able to prioritize which you think is most likely. It is often helpful to include a few statements to support or argue against each diagnosis on the differential. For example:

“The most likely cause of this patient’s shortness of breath is CHF because of his known history of heart failure, his high salt diet, and his presentation of lower extremity edema along with his elevated neck veins and S3 on exam. Pneumonia is also on the differential, but this is less likely since he is afebrile, he denies cough, and had no sick contacts.”
Advanced Clinical Skills
POM Advanced Clinical Skills

Dates: Alternate Thursdays, September 8 to December 1, 2011 (specific Thursday date dependent on assignment to group A or group B)
Time: 1:15-5:05 pm
Location: LKSC room LK101, and LKSC Seminar rooms (2nd or 3rd floor) or Immersive Learning Center rooms (ground floor)
Responsible Faculty: Ian Tong, MD and Preetha Basaviah, MD
Lead TA: Morgan Theis

Background
The advanced clinical skills sessions comprise a two–quarter, theme-based series that correlates with the basic science block. The workshops are designed to enhance students’ basic clinical skills developed during the first year of POM. Sessions focus on revisiting and strengthening techniques including communication skills, sensitive topics, physical exam, and interpretation of diagnostic tests, hypothesis formulation, and clinical reasoning.

The student will spend half-day sessions every other week during Q4 and Q5 with experienced clinician preceptors and patients. During these sessions, students will have the opportunity to develop their clinical skills under direct observation and receive constructive feedback on their performance. Material in this component is presented in didactics, online applications of physical exam findings, clinical work with patients, and review of diagnostic studies.

Goals of the advanced clinical skills sessions
The overarching goals of the advanced clinical skills sessions are to provide opportunities for second year students to complete exercises that strengthen abilities in the areas of medical interview, focused physical examination, clinical problem solving, diagnostic interpretation (EKG, radiography), oral presentations, and clinical practice (time management, real time problem list formation).

Learning objectives of the advanced clinical skills sessions
During these sessions, students should:
• Gain experience, refine, and expand skills in the medical interview (basic and sensitive topics)
• Practice key questions to ask a patient related to a specific system
• Gain experience, refine, and expand skills in the physical examination
• Learn to accurately generate a problem list and differential diagnosis of common clinical problems
• Learn to clearly present and articulate their observations and assessments verbally and in writing
• Interpret diagnostic studies related to a particular patient, case, or system
• Learn effective verbal and nonverbal communication skills in all interactions with patients and staff
• Understand and practice basic principles of universal precautions in all settings

Student roles and responsibilities for the advanced clinical skills sessions
• Learn and follow all guidelines in the clinical practicum student guide
• Complete HIPAA training prior to the first site visit
• Attend all scheduled advanced clinical skills sessions
• Arrive at each session on time
**POM: Advanced Clinical Skills Session #1**  
**Introduction to Oral Presentations & Write-Ups**

| Date: | Group B: Thursday, 9/08/11  
| Group A: Thursday, 9/15/11 |
| Time & Location: | 1:15pm – 2:15pm, LKSC room LK101  
| 2:30pm – 5:05pm, LKSC Seminar rooms |
| Session Type: | Lecture, Clinical Skills Session |
| Faculty: | Ian Tong, MD; Preetha Basaviah, MD; and small group faculty |
| Videotaping? | Lecture: Yes / Clinical Skills Session: No |

**Session Goals:**
1. Review the history and physical, formal/complete presentation, and short/interval visit presentation
2. Provide opportunities to strengthen students’ abilities in the area of medical communication, specifically oral and written presentations

**Lecture Learning Objectives:**
At the end of the session the students will be able to:
- Identify components and organization of medical presentations

**Clinical Skills Session Learning Objectives:**
At the end of the session the students will be able to:
1. Identify methods to practice oral presentations and present efficiently and with confidence
2. List and discuss the components and organization of a standard medical patient presentation
3. Practice documenting the physical examination
4. Develop an assessment and plan

**Session Activities:**
- 1:15-2:05p: Lecture
- 2:15-5:05p: Clinical Skills Session
  1. Observe and analyze an in-class interview of a standardized patient in a small group
  2. Debrief, receive and provide feedback amongst peers and faculty
  3. Present case presentations orally, both full and focused
  4. Construct a patient write-up, including assessment and plan

**Key Words:**
- Communication
- Medical Records
- Clinical Skills

**Advance Preparation:**
- **Equipment to bring:** None
- **Dress code:** Casual. Formal attire not required.
- **Required Reading:**
  - Syllabus section on “Oral Presentations” (next page)
- **Optional Reading:**
  - website: [http://meded.ucsd.edu/clinicalmed/oral.htm](http://meded.ucsd.edu/clinicalmed/oral.htm)

**Assignment:** none
Oral Presentations

I. Oral Presentations: Overview
   a. Presentations serve the following functions:
      i. Rapid communication of information to other health care professionals
      ii. Organization and prioritization of patient data
      iii. Patient advocacy
      iv. Demonstration of your thought process and hard work

II. Oral Presentations: General Principles
   a. Nerves or trepidation are normal
   b. It takes practice – no one gives a perfect presentation on their first attempt
   c. Listen to other presentations, from medical students to attendings. Can you tell the difference between those that are concise and well organized?
   d. Know the expectations. If you aren’t certain what your audience wants, ask them.
      i. Do you want the full H&P?
      ii. How long do you want the presentation to be?
      iii. Do you want the whole exam, or just the pertinent positives & negatives?
      iv. Do you want the whole review of systems, or just the pertinent positives & negatives?
      v. Do you want the full medication list?
   e. Regardless of the type of oral presentation, make sure you have all the information at your fingertips.
   f. Speak efficiently and confidently. Don’t second guess yourself during the presentation.

III. Oral Presentations: Organization and Format
   a. There is a basic format that all oral presentations follow. If you stick to it, you will shine.
      i. Full H & P:
         1. ID (identification)
         2. CC (Chief Complaint)
         3. HPI (History of Present Illness)
         4. PPI (Patient’s Perspective of Illness)
         5. PMH (Past Medical History)
         6. ALL (Allergies)
         7. MEDS (Medications – prescribed, over the counter, herbal/alternative)
         8. FH (Family History)
         9. SH / HRB (Social History / Health-Related Behaviors)
        10. ROS (Review of Systems)
        11. PE (Physical Exam)
        12. Labs (Laboratory data, x-rays, other information)
        13. Impression statement (“In summary…”)
        14. Problem list (with each problem having an assessment and plan)
           a. Assessment
           b. Plan
        15. Signature – make sure to list your status (MS I, II, III, IV, V, etc.), your beeper number. (You don’t need to orally present this part.)
      ii. Follow ups – the SOAP format
         1. Subjective: State a one liner about the patient’s history, how the patient feels, changes in symptoms.
         2. Objective: List pertinent vitals signs, physical exam findings, laboratory data, and interim tests.
3. **Assessment:** Go through your problem list and modify it to drop resolved problems and to add any newly identified issues. Each problem needs and assessment and plan. The assessment includes the differential diagnosis, status of the problem (i.e., resolving, improving), and possibly goals (i.e., hypertension: Not yet at goal of < 130/80 given the patient's history of diabetes).

4. **Plan:** Go through problem by problem and state any needed diagnostics, changes in therapeutic interventions, and needs for patient education.

### IV. Oral Presentations: Avoiding common mistakes

- **Abbreviations are for writing – not for speaking**
- Use the duration of symptoms in the chief complaint (e.g., shortness of breath for 1 day; intermittent chest pain for 1 week)
- If you don’t know the jargon, don’t use it
- Don’t invent new words
- Pay attention to your audience
- If someone uses an abbreviation that you are not familiar with, ask them. If you read one, there are many resources: Bates, medical dictionary, internet
- Be aware of the fact that there are abbreviations that can cause confusion and errors. Below is a list of those abbreviations that should NEVER be used. Keep in mind, this is more for written than oral presentations, but some can be used both ways

<table>
<thead>
<tr>
<th>DO NOT USE</th>
<th>PREFERRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>IU (for international unit)</td>
<td>Write out/say international unit</td>
</tr>
<tr>
<td>U (for unit)</td>
<td>Write out/say unit</td>
</tr>
<tr>
<td>TIW (for three times a week)</td>
<td>Write/say 3 or three times weekly</td>
</tr>
<tr>
<td>MS or MSO₄ (for Morphine Sulfate)</td>
<td>Write/say Morphine</td>
</tr>
<tr>
<td>MgSO₄ (for Magnesium Sulfate)</td>
<td>Write/say Magnesium</td>
</tr>
<tr>
<td>QD (Latin for once daily)</td>
<td>Write/say once daily or daily</td>
</tr>
<tr>
<td>QOD (Latin for every other day)</td>
<td>Write/say every other day</td>
</tr>
<tr>
<td>QID (Latin for four times daily)</td>
<td>Write/say 4 or four times daily</td>
</tr>
<tr>
<td>μg (microgram)</td>
<td>Write/say microgram</td>
</tr>
<tr>
<td>QHS (Latin for at bedtime)</td>
<td>Write/say at bedtime</td>
</tr>
<tr>
<td>HS (for half strength)</td>
<td>Write/say half-strength</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)</td>
<td>NEVER write a zero by itself after a decimal point</td>
</tr>
<tr>
<td>Lack of leading zero</td>
<td>ALWAYS use a zero before a decimal point (0.X mg)</td>
</tr>
</tbody>
</table>

### V. Oral Presentations: How to WOW your audience

- **Practice:** in front of a mirror, while showering, to the intern or resident on your team, to your significant other (leave out the name or other identifying patient info, please), to your mom over the phone, in your dreams at night...
- Be confident: avoid too many uhs & ums. Do not second guess yourself. Even if you don’t feel confident, practice looking that way.
- NEVER make up information. It is not safe for the patient. Physicians respect an “I don’t know” much more than someone who feels the need to make up information.
- Try to anticipate what your audience will want. If you don’t know, ask. For shortened presentations, make sure that you HAVE all the information, even if you will not be presenting it all.
- Prior to your presentation, try to think about what you want to convey to your audience.
- Discuss your assessment and plan with a member of the team BEFORE you are expected to give your formal presentation.
- Read up on your patient’s condition so that you can contribute to the assessment and plan.
VI. Oral Presentations: Take Home Points
a. It is ok to be nervous
b. Practice, practice, practice
c. Know the expectations
d. Be organized
e. Don’t invent words. If in doubt, spell (or say) it out.
f. Ask for feedback. The earlier you ask, the sooner you improve.

Full H&P (New Patient Presentation)

Note: This is spoken. Your write up would look much different. You would not state “Identification and Chief Complaint” but rather launch into “Mr. Smith is a . . .” You can highlight each section to help with transitions: “Past medical history is significant for…”

Identification and Chief Complaint (ID/CC): Mr. Smith is a 55 year old man with a past medical history significant for peptic ulcer disease and hypertension who presents with abdominal pain, nausea and vomiting since last night.

History of Present Illness (HPI): Mr. Smith was in his usual state of health until last night when he developed nausea and vomiting one to two hours after dinner. Thereafter, he developed mild to moderate mid abdominal pain. The pain worsened as the night went on and eventually radiated to his right lower abdomen. Movement increases the pain. Nothing makes it better. He has tried Tums, Tylenol, and Pepto-Bismol. Currently, his abdominal pain is accompanied by anorexia, nausea and vomiting. His emesis is non-bloody and non-bilious. He last had a bowel movement yesterday morning, which was without melena or hematochezia.

At dinner, he ate escargot and raw ostrich meat, and had four glasses of wine. He feels as if he may have food poisoning, and reports the pain is much different that the pain he suffered when he was diagnosed with an ulcer.

Past Medical History (PMH): Past medical history is significant only for peptic ulcer disease which was diagnosed and treated more than 20 years ago. He has never had any abdominal surgeries. He has borderline hypertension.

Meds: His current medications include Tylenol and Pepto-Bismol.

Allergies (ALL): Mr. Smith is allergic to sulfa, which causes a rash.

Social History (SH). He lives in San Francisco. He has been divorced for fifteen years. He works for SBC doing telephone repair.

Health Related Behaviors (HRB): Mr. Smith has a 35 pack year history of tobacco use but quit smoking 20 years ago. He drinks socially, about 1-2 times per week. He has a history of cocaine and methamphetamine use, last 20 years previously.

Family History (FH): Family history is significant for an uncle with some type of hepatitis. No other significant family history.

Review of Systems (ROS): Other than the abdominal complaints listed above, Mr. Smith’s review of systems is notable for occasional palpitations resolved with rest and history of knee pain with bending exercises. Otherwise the remainder of ROS was non-contributory.
Physical Exam (PE):
Vital signs: Temperature-36.8 Blood Pressure-144/75 Heart Rate-95 Respiratory Rate-14, oxygen saturation 96% on room air
General: He is pleasant and in no acute distress
HEENT: Normocephalic, Atraumatic, neck is supple, JVP is at 8 cm
Pulm: clear to auscultation
Cardiac: normal S1 and S2 No murmurs/rubs/gallops, JVP 8 cm, non-displaced PMI
Abdomen: absent bowel sounds, tenderness in the right lower quadrant, (+) rebound tenderness
Extremities show 2+ pulses throughout and are without edema.

Lab/other data: Labs were significant for an elevated white blood cell count of 14.3, liver function tests are normal, as are the electrolytes.

CT showed evidence of acute appendicitis

Impression: In summary, Mr. Smith is a 55-year-old man with acute onset of right lower quadrant pain with nausea, vomiting, elevated white blood cell count and evidence of inflammation around the appendix per CT scan.

Problems:
1. Abdominal pain
2. Probable appendicitis
3. Peptic ulcer disease
4. Borderline hypertension

Assessment / Plan:
1. Abdominal pain: Given his acute presentation, RLQ tenderness and CT findings, appendicitis is most likely. Other things to considering include diverticulitis, ileitis (IBD), abscess in light of the elevated wbc.

   Plan:
   - We will treat his abdominal pain with IV medications such as morphine.
   - We will admit the patient, make him NPO (nothing by mouth) and prepare him for appendectomy.
   - We will continue IV proton pump inhibitors for his peptic ulcer disease.

2. Hypertension: Currently borderline hypertensive in the setting of pain. Plan is to monitor blood pressures closely, though there is no indication for urgently starting anti-hypertensives at this time.

3. Peptic ulcer disease: History of PUD currently under control with daily PPO. Plan is to continue PPI but in IV form, given he is NPO for upcoming appendectomy.
Let's pretend things didn’t go so well with your patient and that he ended up in the ICU. The ICU has patients who are quite ill and quite complicated. Typically, to help organize things, presentations are done in a “by systems” format like the one below.

ID/CC: Mr. Smith is a 55 y/o man with a past medical history significant for peptic ulcer disease and hypertension who presents with abdominal pain and hypotension.

HPI: Mr. Smith was in his usual state of health until about four days ago when he noted the gradual onset of nausea, vomiting, and mid abdominal pain about 2 hours following a dinner of escargot, raw ostrich and 4 glasses of wine. Initially, the pain was mid abdominal and mild. Over the course of that evening, the pain intensified, and localized in the right lower quadrant. He tried taking Tylenol, Tums and Pepto-Bismol, without relief. Movement made the pain worse. Nothing made the pain better. His emesis was non-bloody and non-bilious. He had a normal bowel movement earlier in the day and had not had any diarrhea following the onset of his symptoms. He denied melena or hematochezia. He was seen in the emergency room the morning following the onset of his symptoms, was diagnosed with gastroenteritis, and sent home.

Over the next two days, his pain continued to worsen. This morning, he had temporary relief in his abdominal pain. However, shortly thereafter he noted that he was having a high temperature to 102.3, was shaking, and that he was very dizzy whenever he tried to get out of his bed and walk around. His ex-wife called 911 when she couldn’t contact him by phone and found him passed out on the bathroom floor. Upon arrival, the paramedics noted a temperature of 103.2 degrees, a heart rate of 130 beats per minute, and a blood pressure of 83/47. An IV was started and normal saline was given en route to the emergency room.

In the emergency room, the patient was given 4 more liters of IV fluid with continuing low blood pressures. He was given Tylenol per rectum for his fever, as well as broad spectrum antibiotics. He was thereafter transferred to the ICU for further evaluation and management of persistent hypotension.

Past Medical History is significant for peptic ulcer disease and borderline hypertension.

Allergies include sulfa, which causes rash.

Mr. Smith lives in San Francisco. He has been divorced for 15 years. He works for SBC doing telephone repairs.

Health-Related Behaviors: He has a 35 pack year history of tobacco use, as well as a history of meth and cocaine use. Last use of any of these was 20 years ago. He drinks socially about 1-2 times per week.

Family History is significant only for an uncle with an unknown type of hepatitis.

In addition to the above, the review of systems is significant for fevers, chills, sweats, anorexia, and dizziness with positional changes. He has also noted decreased urination and darker color of his urine.

Neurologically, the patient is complaining of diffuse abdominal pain. He is somewhat sleepy, but arousable with minimal stimuli.
From a cardiovascular perspective, the patient remains hypotensive. After five liters of IV fluid and the initiation of dopamine at 5 micrograms per kilogram per minute, his blood pressure remains 92/53, and his heart rate is 140 beats per minute. His cardiac exam is significant for tachycardia, but is otherwise unremarkable.

From a respiratory standpoint, the patient had an oxygen saturation of 96% on room air at the time of presentation. However, over the last 30 minutes, his saturations have been dropping and he is now “sitting” 92% on 6 liters of oxygen per minute by face mask. His respiratory rate has increased from 14 to 22 breaths per minute. An ABG (arterial blood gas) is pending.

Gastrointestinal exam is significant for rebound tenderness, guarding, and absence of bowel sounds. Liver function tests are normal. Amylase is mildly elevated at 263. The patient is NPO and a KUB of the abdomen shows free air under the diaphragm.

From a renal standpoint, Mr. Smith has been making very little urine since the time of admission. He has made a total of 20 mL of urine over the last 2 hours despite IV fluids. His BUN is elevated at 42, and his creatinine is 2.3. His baseline creatinine is 0.7. Urinalysis shows hyaline casts.

Hematologically, the patient has a normal hematocrit of 42.3% as well as normal platelet count. His INR is mildly elevated at 1.4. PTT is within normal limits.

From an infectious disease standpoint, two sets of blood cultures are pending. The patient remains febrile with a temperature of 102.7. His white blood cell count is 22.6 with more than 20% bands.

The patient has no active endocrine issues.

My assessment is that this is a 55 year old patient with history of peptic ulcer disease and borderline hypertension who presents with septic physiology and possible acute lung injury versus ARDS in the setting of peritonitis.
Plan:

1. Neurologically: We will continue to treat this patient’s pain and closely monitor his mental status.
2. Cardiovascular: We need to support this patient’s blood pressure with additional IV fluids as well as pressors. He may benefit from a central line so that we can more accurately measure central venous pressures and administer appropriate amounts of IF fluid. He will also likely benefit from an arterial line for closer blood pressure monitoring.
3. Respiratory status is concerning for ARDS or ALI in the setting of peritonitis. We will continue to supply supplemental oxygen, place an arterial line so that we can follow ABGs as necessary. He may require intubation if his respiratory status continues to decline.
4. From a GI standpoint, we will keep the patient NPO in anticipation of surgery for appendicitis.
5. From a renal standpoint, it is likely that this patient’s renal failure is secondary to a combination of dehydration and hypotension leading to acute tubular necrosis. We will continue to provide IV fluids as well as to support his blood pressure and monitor both his urine output as well as his electrolytes/creatinine.
6. From a hematological standpoint, patient is stable.
7. From an infectious disease standpoint, we will wait for blood cultures, continue to treat with broad spectrum antibiotics to cover peritonitis, and will attempt to stabilize the patient so that he may be taken to the operating room for appendectomy.

As you can see, this is pretty complicated. No one will expect you to be able to rattle this type of thing off without quite a bit of practice. This is here to provide you a reference for when you rotate through the ICU during clinical rotations as well as to demonstrate the wide variety of oral presentations.
SAMPLE PATIENT WRITE-UP FORM (* Students should develop their own template that works for their needs and style)

Chief complaint (CC):

History of present illness (HPI):

Patient’s perspective of illness (PPI):

Past Medical History (PMH):
   MEDICAL:

      Psychiatric:

      Surgical:

      Gynecologic:

Meds:

Social history (SH) / Health-related behaviors (HRB):

Family history (FH):

Review of Systems (ROS):
PE:
   GEN'L:
   HEENT
   NECK
   LUNG
   CV
   ABD
   EXT
   NEURO
   DERM

DATA:

IN SUMMARY:

A/P:

PROBLEM #1: Assessment and plan for each

PROBLEM #2: Assessment and plan

PROBLEM #3: Assessment and plan
POM: Advanced Clinical Skills Session #2
Cardiopulmonary Exam Revisited

Date:
- Group B: Thursday, 9/22/11
- Group A: Thursday, 9/29/11

Time & Location:
- 1:15pm – 2:05pm, LKSC room LK101
- 2:15pm – 5:05pm, LKSC Seminar rooms

Session Type: Lecture, Clinical Skills Session
Faculty: Ian Tong, MD; Preetha Basaviah, MD; and small group faculty
Videotaping?: Lecture: Yes / Clinical Skills Session: No

Session Goals:
1. Review components of the cardiac and pulmonary exams, and the use of the stethoscope.
2. Provide opportunities to strengthen students’ abilities in the areas of medical interview, physical examination, presentations, and clinical practice

Lecture Learning Objectives:
At the end of the session the students will be able to:
1. Distinguish systole from diastole, S1 from S2
2. Understand the location and character of heart sounds
3. Identify carotid pulse and apical impulse
4. Use the stethoscope to examine the heart and lungs as well as body positioning and other maneuvers to elicit sounds

Clinical Skills Session Learning Objectives:
At the end of the session the students will be able to:
1. Practice key questions to ask a patient regarding cardiopulmonary symptoms
2. Demonstrate the cardiovascular examination
3. Perform auscultation of the lungs
4. Identify abnormal heart sounds (e.g. systolic vs diastolic murmurs) and cardiac and pulmonary physical findings and learn to correlate them with potential disease states in patients
5. Assess their knowledge of cardiac exam skills and ability to discern heart sounds via an online quiz

Session Activities:
1:15-2:05p: Lecture on Heart Sounds & cardiac exam quiz
2:15-5:05p: Clinical Skills Session
   - Rotate through advanced clinical skills stations
   - Demonstrate focused cardiac and pulmonary physical exams
   - Practice presenting specific cardiac and pulmonary exam findings

Key Words:
- Physical Examination
- Respiratory Sounds
- Heart Sounds
- Heart Auscultation
- Clinical Skills
Advance Preparation:

**Equipment to bring:** Stethoscope

**Dress code:** Professional dress (including white coat).

**Required Video and Tutorial:**
- Bates heart exam video (on coursework)
- Blaufuss online tutorial – [http://www.blaufuss.org/tutonline.html](http://www.blaufuss.org/tutonline.html)

**Optional:**
- *Bates Guide to the Physical Examination, 10th edition*
  - pp.318-321 (chest findings)  pp.326-330 (heart sounds)
  - pp.334-336 (JVP)  pp.296-308 (lung exam)
- Additional Blaufuss online tutorial available on computers in the Fleischmann lab rooms and the CCSR basement rooms
- Bates video of the pulmonary physical examination, on coursework
- [http://depts.washington.edu/~physdx/pulmonary/index.html](http://depts.washington.edu/~physdx/pulmonary/index.html) (This site has great examples of the various abnormal pulmonary sounds that we will talk about.)
- University of Utah, Review of Cardiac Physiology ([http://www-medlib.med.utah.edu/kw/pharm/hyper_heart1.html](http://www-medlib.med.utah.edu/kw/pharm/hyper_heart1.html), need Shockwave installed)
  Cartoon depicting relationship between mechanical, electrical, and audiologic events during the normal cardiac cycle.
- Heart Sounds and Murmurs, University of Washington School of Medicine ([http://depts.washington.edu/physdx/heart/demo.html](http://depts.washington.edu/physdx/heart/demo.html)).
  Audio files of selected normal and abnormal heart sounds and murmurs.

**Assignment:** none
POM: Advanced Clinical Skills Session #3
Abdominal Exam Revisited

Date: Group B: Thursday, 10/06/11
Group A: Thursday, 10/13/11

Time & Location: 1:15pm – 2:05pm, LKSC room LK101
2:15pm – 5:05pm, LKSC Immersive Learning Center rooms

Session Type: Lecture, Clinical Skills Session

Faculty: Ian Tong, MD; Preetha Basaviah, MD; and small group faculty

Videotaping? Lecture: Yes / Clinical Skills Session: No

Session Goal(s):
• Review and advance physical examination of the abdomen with students’ knowledge of gross anatomy
• Provide opportunities to strengthen students’ abilities in the areas of medical interview, physical examination, presentations, and clinical practice

Lecture Learning Objectives:
At the end of the session the students will be able to:
• Identify the components of the abdominal exam

Clinical Skills Session Learning Objectives:
At the end of the session the students will be able to:
1.) Perform specific physical exam techniques to identify pathologic findings on the abdomen (pending patient availability):
   a. Ascites (shifting dullness, fluid wave)
   b. Splenomegaly
   c. Hepatomegaly
2.) Identify sequelae of liver cirrhosis (encephalopathy)
3.) Practice key questions to ask a patient regarding abdominal or renal symptoms

Session Activities:
1:15-2:05p: Lecture Didactic on GI exam
2:15-5:05p: Rotate through advanced clinical skills stations, practice focused abdominal exam. Present significant physical findings for cardiac, pulmonary and abdominal exams

Key Words:
• Physical Examination
• Auscultation
• Palpation
• Percussion
• Clinical Skills
• Ascites
• Splenomegaly
• Jaundice
• Hepatic
• Encephalopathy
• Gastrointestinal Hemorrhage
• Dialysis
• Hepatomegaly

Advance Preparation:
Equipment to bring: Stethoscope
Dress code: Professional dress (including white coat).
Required Readings and Videos:
• Bates Guide to the Physical Examination, 9th edition
  • Bates videos (https://coursework.stanford.edu/access/content/group/F11-INDE-204-01/Course%20Resources/batesVideos-QT.html) on the abdominal examination, on coursework

Optional Reading:
• Bates Guide to the Physical Examination, 9th edition
  • pp. 415-417 (the abdomen)
  • pp. 434-451 (techniques of examination w/ examples of abnormalities)
• Bates Table p. 454-5

Assignment: none
POM: Advanced Clinical Skills Session #4
Mid Quarter Assessment: Physical Exam & EKG Lab

| Date:          | Group B: Thursday, 10/20/11
                  | Group A: Thursday, 10/27/11 |
|---------------|---------------------------|
| Time & Location: | 1:15pm – 2:05pm, LKSC room LK101
                           | 2:15pm – 5:05pm, LKSC rooms LK101/102, Immersive Learning Center rooms |
| Session Type: | Clinical Skills Session |
| Faculty:      | Ian Tong, MD; Preetha Basaviah, MD; and small group faculty |
| Videotaping? | Clinical Skills Session: No |

**Session Goals:**
1. Review the pulmonary, cardiac and abdominal examination
2. Review EKG interpretation
3. Provide opportunities to strengthen students’ abilities in the areas of medical interview, physical examination, presentations, and clinical practice

**Learning Objectives:**
At the end of the session the students will be able to:
1. Demonstrate eliciting a chief complaint and history of present illness from a patient
2. Practice the Review of Systems for the pulmonary, cardiac and abdominal systems, and
3. Demonstrate a targeted physical exam based on a chief complaint (involving the cardiovascular, pulmonary and/or gastrointestinal system)
4. Integrate the pulmonary, cardiac and abdominal examinations into one coordinated exam
5. Identify EKG characteristics of rhythm and axis, and interpret for patterns of chamber enlargement and myocardial infarction, injury, and ischemia

**Session Summary:**
1:15-5:05p: Peer to peer practice of focused history and physical (within 20-25 minutes) under the supervision of a faculty
            Practice presentation
            Students will self-assess and peer-assess using checklists
            Practice interpretation of EKG’s

**Key Words:**
- Physical Examination
- Auscultation
- Palpation
- Percussion
- Clinical Skills
- Communication

**Advance Preparation:**
- Equipment to bring: Stethoscope, otoscope and ophthalmoscope
- Dress code: Casual attire
- Required Readings and Videos:
  - Bates Guide to the Physical Examination, 10th edition

**Assignment(s):** None.
Session Goals:
- Review the physical exam findings associated with endocrine pathophysiology
- Review dermatological manifestations of disease
- Increase proficiency in performing thyroid exam and distinguishing abnormal Exam

Lecture Learning Objectives
At the end of the session the students will be able to:
- Identify the components of the thyroid, skin and diabetic foot exam

Clinical Skills Session Learning Objectives
At the end of the session the students will be able to:
1. Prepare for the diabetic foot examination with monofilament, drape or blanket for feet and patient in sitting position and
2. Demonstrate the thyroid and foot examination
3. Describe common skin findings

Session Activities:
1:15 - 2:05p - Didactic on thyroid and diabetic foot
2:15 - 5:05p - Rotate through advanced clinical skills stations
- Practice focused skin and thyroid exam
- Practice presenting specific dermatologic lesions and thyroid exam findings
- Peer-to-peer practice of diabetic foot exam

Key Words:
- Physical Examination
- Auscultation
- Palpation
- Percussion
- Clinical Skills
- Exophthalmos
- Diabetic Neuropathies
- Goiter
- Hirsutism
- Myxedema

Advance Preparation:
- Equipment to bring: Stethoscope
- Dress code: Professional dress (including white coat).
- Required Readings and Videos:
  - Bates Guide to the Physical Examination, 10th edition
Optional Reading:
- *Bates Guide to the Physical Examination, 10th edition*
  - pp. 240-242 (The trachea and thyroid)
  - pp. 255 (bottom of page, table 7-6: variations and abnormalities of the eyelids)

Assignment(s):
None.
POM: Advanced Clinical Skills Session #6
Advanced Male and Female Exam Session

| Date:          | Group B: Thursday, 11/11/10 |
|               | Group A: Thursday, 11/18/10  |
| Time & Location: | 1:15pm – 2:05pm, LKSC room LK101 |
|               | 2:15pm – 5:05pm, LKSC Immersive Learning Center rooms |
| Session Type: | Lecture, Clinical Skills Session |
| Faculty:      | Ian Tong, MD; Preetha Basaviah, MD; and small group faculty |
| Videotaping?  | Lecture: Yes / Clinical Skills Session: No |

Session Goals:
1.) Review foundations of the male physical examination (e.g. prostate, testes) and introduce identification of abnormal findings in the genitourinary exam
2.) Review foundations of the female physical examination (e.g. breast, pelvic exams) and introduce identification of abnormal findings in the breast and pelvic exams

Lecture Learning Objectives:
- Identify the components of the prostate exam, testicular exam, breast exam, and female pelvic exam

Clinical Skills Session Learning Objectives:
At the end of the session the students will be able to:
1. Practice exam techniques of the male prostate and testes exam on models and mannequins
2. Practice exam techniques of the female breast and pelvic exam on models and mannequins
3. Prepare for upcoming Project Prepare sessions (female breast/pelvic exam and male genitourinary exam with educators)

Session Activities:
1:15 – 5:05p - Review foundations of relevant anatomy, physiology, and approach to the pelvic, breast, and prostate exam
2:15 – 5:05p - Practice physical exam on trainers
Practice proper informed consent of GU exam, mechanics, use of equipment

Key Words:
- Physical Examination
- Clinical Skills
- Gynecological Examination
- Breast
- Digital Rectal Examination
- Testis

Advance Preparation:
- Equipment to bring: none
- Dress code: Professional dress not required
- Required Readings and Videos: none
Clinical Reasoning
Clinical Reasoning Sessions (CRS)

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>1:15-5:05 pm</td>
</tr>
<tr>
<td>Session Type:</td>
<td>Lecture, Problem-Based Learning</td>
</tr>
<tr>
<td>Location:</td>
<td>LK120 / LKSC Seminar Rooms</td>
</tr>
<tr>
<td>Responsible Faculty:</td>
<td>Pree Basaviah, Peter Pompei and Clinical Reasoning Small Group Preceptors</td>
</tr>
<tr>
<td>Videotaping?:</td>
<td>Lectures: Yes / Small Group sessions: No</td>
</tr>
</tbody>
</table>

About the Clinical Reasoning Sessions
Clinical Reasoning Sessions occur each Tuesday afternoon from 1:15pm to 5:05pm. Afternoons usually begin with a required large group session from 1:15pm to 2:05pm entitled ‘POM Teaching Rounds.’ These interactive sessions are led by core faculty or invited experts in the field. Formats vary and include didactic and case based discussions, board review type questions with answers / rationale reviewed by discussants, a clinicians approach to common problems, and demonstrations of clinical skills in interviewing and examination. For details about assignments, readings, and assessments, please review the coursework site weekly.

Following the teaching rounds, you will proceed to your assigned small group. Small group sessions involve analysis of case vignettes representing common and important problems in clinical medicine. The selection of cases is made to complement the Human Health and Disease (HHD) course. For example, during the endocrinology block of HHD, students will review vignettes of common problems faced by patients with diabetes mellitus. During the 4th quarter, the main organ systems studied are renal, gastrointestinal, and endocrine (including the reproductive systems)

Goals for the clinical reasoning sessions
Our overarching goals of these sessions are for you to:
1. Apply basic science knowledge of physiology and pathophysiology to patient problems
2. Develop clinical reasoning skills
3. Expand your clinical knowledge base

During Q4 you will advance your preparation for patient care responsibilities by synthesizing, interpreting and analyzing clinical information presented as case vignettes, patient encounters, SP encounters, and procedures as they interrelate with content specific to each block (eg. GI, nephrology, endocrinology and women’s health).

Learning objectives for these sessions are to:
1.) Identify key clinical elements of a case
2.) Interpret the key clinical elements of a case
3.) Create a problem list
4.) Develop a differential diagnosis
5.) Develop an initial approach to diagnostic testing
6.) Create an initial clinical management plan
7.) Identify clinical questions to guide further learning
8.) Find relevant resources to answer the clinical question(s)
9.) Critically apply clinical evidence to patient care management
10.) Recognize health system issues that arise in patient care

These goals must be interpreted as dynamic: the students’ ability to perform in these areas should increase over time. For example, the ability to propose specific diagnostic tests should increase as students learn more about the different types of diagnostic tests; the ability to propose initial management steps will increase with increased knowledge of pharmacology, intravenous fluid replacement, and many other aspects of management. **The specific expectations and complexity of case analysis assignments will, therefore, increase over time.**

**Required activities for the clinical reasoning sessions**

**Attendance**
1.) Students are expected to attend all scheduled clinical reasoning sessions.
2.) Any absences must be approved in advance by both the small group facilitator and the POM course director. **Failure to attend all sessions and complete the related requirements prevents the student from passing the course.**

**Excused Absences and Remediation**
1) The student must notify their clinical reasoning preceptor and Dr. Basaviah and Tomiko Oskotsky in advance.
2) If there are in-class assignments during the session, the student will be required to complete them.

**Peer evaluation**
Group participation is an essential element of problem-based, team learning. Each student will complete an anonymous, end-of-quarter assessment of each of the team members, specifically rating them on several dimensions of team work and collaboration.

**Group participation**
As an additional evaluation of group participation and teamwork, each small group facilitator will be asked to evaluate students’ interpersonal and academic performance.
POM: Clinical Reasoning Session #1
Teaching Rounds and Small Group

Date & Time: Tuesday 9/13/11, 1:15-5:05 pm
Session Type: Lecture, Problem-Based Learning
Location: LK120 / LKSC Seminar Rooms
Responsible Faculty: Pree Basaviah, Peter Pompei and Small Group Preceptors
Videotaping?: Lecture: Yes / Small Group session: No

Teaching Rounds Learning Objectives:
1.) Review some key clinical reasoning steps: identifying key features, problem representation, developing a differential diagnosis, comparing illness scripts and interpreting clinical information within the context of a case
2.) Gain familiarity with the concept for elements of assessment (interpretive summary, differential diagnosis with commitment, explanation of reasoning, alternative diagnoses).

Small Group Session Learning Objectives:
For a patient who presents with edema, students will be able to:
1.) Interpret the presenting history, identifying key features and semantic qualifiers
2.) Propose an initial differential diagnosis for edema and identify key additional questions to narrow that differential diagnosis
3.) List specific physical findings useful in informing the diagnostic considerations
4.) Interpret the physical examination findings relating them to what was expected
5.) Develop and refine the differential diagnosis as new information emerges
6.) List additional data necessary to establish a diagnosis and recommend initial management plans
7.) Create an illness script for the “typical” patient with the condition ultimately diagnosed

Session activities:
1:15-2:05p: Teaching rounds
2:15-5:05p: Small group – Faculty will play the role of the patient in the case. Students will be divided into three teams, and each team will be assigned one diagnosis being considered. They will ask the “patient” questions related to the diagnosis they are considering. A table comparing symptoms (and signs and labs) for the three competing diagnoses will be generated.

Key Words:
• Problem-Based Learning
• Decision Making
• Diagnosis, Differential
• Clinical Medicine
• Edema (for small group)

Advance Preparation:
Required Readings (on coursework):
• Dhaliwal, Gurpreet: NEJM CPS Chapter February 2006
Assignment: The assignment for this week is to write a list of personal learning goals related to clinical reasoning and to write a problem list, initial differential diagnosis and illness script for this week’s case to be turned in next week.
POM: Clinical Reasoning Session #2
Teaching Rounds and Small Group

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Tuesday 9/20/11, 1:15-5:05 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Type:</td>
<td>Lecture, Problem-Based Learning</td>
</tr>
<tr>
<td>Location:</td>
<td>LK120 / LKSC Seminar Rooms</td>
</tr>
<tr>
<td>Responsible Faculty:</td>
<td>Pree Basaviah, Peter Pompei,</td>
</tr>
<tr>
<td></td>
<td>David Magnus, Manjula Tamura</td>
</tr>
<tr>
<td></td>
<td>and Small Group Preceptors</td>
</tr>
<tr>
<td>Videotaping?</td>
<td>Lecture: Yes / Small Group session: No</td>
</tr>
</tbody>
</table>

Teaching Rounds Learning Objectives:
1.) Inspect health policy issues around renal replacement therapy, including organ transplantation

Small Group Session Learning Objectives:
1.) Summarize the presenting history and physical emphasizing semantic qualifiers and key features
2.) Abstract clinical information and re-formulate into a concise representation of the problem following the traditional sequence of components
3.) Identify clusters of laboratory data useful in defining major syndromes in nephrology
4.) Distinguish pre-renal, renal and post-renal causes of kidney failure
5.) Discuss the initial management of acute kidney failure

Session Activities:
1:15-2:05p: Teaching rounds
2:15-5:05p: Small group – Students will be divided into 3 groups and each will be asked to develop from their readings a brief case of either pre-, intra-, and post-renal kidney failure and present this to their colleagues; students will also be asked to write a problem representation that is concise, includes all the key features and is presented in the expected order. An ECG will also be provided for students to interpret.

Key Words:
• Problem-Based Learning
• Decision Making
• Diagnosis, Differential
• Clinical Medicine
• Kidney Transplantation (for teaching rounds)
• Ethics, Medical (for teaching rounds)
• Acute Kidney Injury (for small group)

Advance Preparation:
Required Readings (on coursework):
• Stern SDC, Cifu AS, Altkorn D: Acute Renal Failure, Chapter 20 in Symptom to Diagnosis: an evidence-based guide pp 339 - 351.

Optional Readings:
• Harrison’s on-line: Chapter 44: Azotemia and Urinary Abnormalities (http://www.accessmedicine.com/content.aspx?aid=9097568)

Assignment: none
Characteristics of the ECG:

<table>
<thead>
<tr>
<th>Rate:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhythm:</td>
<td></td>
</tr>
<tr>
<td>QRS axis:</td>
<td></td>
</tr>
<tr>
<td>Intervals:</td>
<td>PR:</td>
</tr>
<tr>
<td>P waves, QRS</td>
<td></td>
</tr>
<tr>
<td>forms, ST</td>
<td></td>
</tr>
<tr>
<td>segments</td>
<td></td>
</tr>
<tr>
<td>Diagnosis/</td>
<td></td>
</tr>
<tr>
<td>interpretations,</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
</tr>
<tr>
<td>observations:</td>
<td></td>
</tr>
</tbody>
</table>
POM: Clinical Reasoning Session #3
Teaching Rounds and Small Group

Date & Time: Tuesday 9/27/11, 1:15-5:05 pm
Session Type: Lecture, Problem-Based Learning
Location: LK120 / LKSC Seminar Rooms
Responsible Faculty: Pree Basaviah, Peter Pompei, Walter Park, and Small Group Preceptors
Videotaping?: Lecture: Yes / Small Group session: No

Teaching Rounds Learning Objectives
1) Discuss what diarrhea is, the mechanism involved, classifications (by characteristics and by mechanism), conditions associated with diarrhea, tests to distinguish the various causes

Small Group Learning Objectives:
1) Propose a differential diagnosis for chronic diarrhea
2) Distinguish functional from organic and infectious from non-infectious causes
3) Enumerate useful physical diagnosis maneuvers and diagnostic tests and their interpretation
4) Outline therapeutic approaches for patient management

Session Activities:
1:15-2:05p: Teaching rounds
2:15-5:05p: Small group – Students will develop an illness script (given a template for the major categories) of a metabolic disorder of interest to them.

Key Words:
- Problem-Based Learning
- Decision Making
- Diagnosis, Differential
- Clinical Medicine
- Diarrhea

Advance Preparation:
Required Readings (on coursework):
- Harrison’s Online: Chapter 40: Diarrhea and Constipation
  (http://www.accessmedicine.com/content.aspx?aid=9112979)

Assignment:
The assignment for this week is for you to identify a genetic or metabolic condition of interest to you and to develop an illness script for this condition. This can be submitted next week using the format provided for the session 1 case.
POM: Clinical Reasoning Session #4
Teaching Rounds and Small Group

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Tuesday 10/11/11, 1:15-5:05 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Type:</td>
<td>Lecture, Problem-Based Learning</td>
</tr>
<tr>
<td>Location:</td>
<td>LK120 / LKSC Seminar Rooms</td>
</tr>
<tr>
<td>Responsible Faculty:</td>
<td>Pree Basaviah, Peter Pompei, and Small Group Preceptors</td>
</tr>
<tr>
<td>Videotaping?:</td>
<td>Lecture: Yes / Small Group session: No</td>
</tr>
</tbody>
</table>

Teaching Rounds Learning Objectives:
1) Identify basic cross-sectional anatomy of the abdomen
2) Develop a basic approach to analyzing plain film and CT images
3) Perform directed examination of radiological images based on clinical history
4) Be able to recognize grossly abnormal findings in several commonly encountered disease entities

Small Group Learning Objectives:
1) Propose a differential diagnosis for epigastric pain and nausea
2) Identify symptoms and signs that help distinguish among the common causes of this syndrome
3) Recognize clusters of diagnostic test abnormalities useful in narrowing the differential diagnosis

Session Activities:
1:15-2:05p: Teaching rounds
2:15-5:05p: Small group – Persuade the doctor exercise: Students will be divided into 3 groups and each will be assigned a common condition causing abdominal pain and nausea. One student from each group will role play the patient as a student from another group takes the history. The goal is to have the “patient” convince the doctor of his diagnosis without naming it. Each group will also be given physical exam findings and lab findings for 1 of the 3 diagnoses, and will work together to match the history with the exam findings and the lab results.

Key Words:
- Problem-Based Learning
- Decision Making
- Diagnosis, Differential
- Clinical Medicine
- Radiography (for teaching rounds)
- Tomography, X-Ray Computed (for teaching rounds)
- Radiography, Abdominal (for teaching rounds)
- Abdominal Pain (for small group)

Advance Preparation:
Required Readings (on coursework):
- Stern SDC, Cifu AS, Altkorn D: Abdominal Pain, Chapter 2 in Symptom to Diagnosis: an evidence-based guide pp 9 - 31

Assignment: none
POM: Clinical Reasoning Session #5
Mid-Quarter Clinical Reasoning Assessment

Date & Time: Tuesday 10/18/11, 1:15-5:05 pm
Session Type: Lecture, Problem-Based Learning
Location: LKSC Seminar Rooms
Responsible Faculty: Pree Basaviah, Peter Pompei and Small Group Preceptors
Videotaping?: No

Session Learning Objectives:
Students will be able to:
1.) Interpret and abstract clinical information and re-formulate into a concise representation of the problem.
2.) Generate a problem list and a differential diagnosis for the primary condition
3.) Suggest additional data that would be helpful in reaching a final diagnosis
4.) Interpret results of initial laboratory tests

Session Activities:
This is an opportunity for each student to practice synthesizing and analyzing clinical information, to formulate a problem list and differential diagnosis, and to recommend and interpret laboratory tests. Students will be given an hour to review and reflect on a case vignette and 15 minutes to present their assessment and request additional diagnostic tests. They will be asked to interpret these results. This will serve as a practice session for the examination given at the end of this quarter.

Your will post your query answers on coursework as an assignment (details to be released near due date). The case release will occur the night before the assignment is due. Your verbal discussion and analysis of the case with your faculty member along with your posted assignment will provide a clear way to assess your mid-quarter progress and areas in which to focus

Key Words:
• Problem-Based Learning
• Decision Making
• Diagnosis, Differential
• Clinical Medicine
• Patient Care Management
• Therapeutics
• Jaundice

Advance Preparation:
Required Readings (on coursework):
• Stern SDC, Cifu AS, Altkorn D: Jaundice and Abnormal Liver Enzymes, Chapter 18 in Symptom to Diagnosis: an evidence-based guide pp 293 - 311.

Assignments due before class session:
• Review part 1 of the case vignette (posted on coursework). Post to coursework your answers to part 1.

Equipment to bring: None
Dress code: Casual. Formal attire not required.

Assignment: none
POM: Clinical Reasoning Session #6
Teaching Rounds and Small Group

Date & Time: Tuesday 10/25/11, 1:15-5:05 pm
Session Type: Lecture, Problem-Based Learning
Location: LK120 / LKSC Seminar Rooms
Responsible Faculty: Pree Basaviah, Peter Pompei, and Small Group Preceptors
Videotaping?: Lecture: Yes / Small Group session: No

Teaching Rounds Learning Objectives:
- Identify and interpret key clinical elements of a case,
- Generate a problem list and a differential diagnosis
- Develop an initial approach to diagnostic testing
- Create an initial clinical management plan

Small Group Learning Objectives:
- List the major etiologies of fever in an adult patient
- Identify key features in the history and physical examination for an adult patient with fever
- Construct an appropriate diagnostic plan for an adult patient with fever
- Contrast the evaluation of fever in an immune competent adult patient with that for a patient with pancytopenia

Session Activities:
1:15-2:05p: Interactive large group session
2:15-5:05p: Small group – Students will develop before the session an illness script for 1 cause of persistent fever. Representative causes can be selected from Table 19-3 in the reading and an effort should be made to select causes from the different categories of infectious, neoplastic, non-infectious inflammatory and miscellaneous. The written illness scripts will be shared among the group and several will be presented in class before beginning the case for this clinical reasoning session.

Key Words:
- Problem-Based Learning
- Decision Making
- Diagnosis, Differential
- Clinical Medicine
- Patient Care Management
- Fever of Unknown Origin

Advance Preparation:
Required Readings (on coursework):

Assignment:
The assignment for this week is for you to provide a written summary after the session (that can be submitted at the following session and could be presented orally in 3 minutes of less) of the key clinical findings from the initial history, physical examination and laboratory studies to demonstrate your ability to abstract information and adequately represent the problem.
# POM: Clinical Reasoning Session #7

## Teaching Rounds and Small Group

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Tuesday 11/8/11, 1:15-5:05 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Type:</td>
<td>Lecture, Problem-Based Learning</td>
</tr>
<tr>
<td>Location:</td>
<td>LK120 / LKSC Seminar Rooms</td>
</tr>
<tr>
<td>Responsible Faculty:</td>
<td>Pree Basaviah, Peter Pompei, Tracey McLaughlin, and Small Group Preceptors</td>
</tr>
<tr>
<td>Videotaping?</td>
<td>Lecture: Yes / Small Group session: No</td>
</tr>
</tbody>
</table>

### Teaching Rounds Learning Objectives:
- Discuss the nutritional management of type 1 and type 2 diabetes

### Small Group Learning Objectives:
- List the criteria used to establish the diagnosis of type 2 diabetes
- Demonstrate key elements of the foot examination in a person with diabetes
- Develop a management strategy for conditions commonly associated with diabetes
- Practice discussing a complex, long-term management strategy with a “patient”

### Session Activities:
- **1:15-2:05p**: Teaching rounds
- **2:15-5:05p**: Small group – Students will divide into pairs and with one playing the patient and the other the doctor. The “doctor” will review the diagnosis and management plan with “patient,” soliciting and answering questions about treatment goals, management strategies, lifestyle changes, natural history of the illness, prognosis and implications for his family.

Roles will be switched in the pairs and now the “doctor” will discuss the importance of weight loss and strategies to successfully lose weight with the “patient.”

### Key Words:
- Problem-Based Learning
- Decision Making
- Diagnosis, Differential
- Clinical Medicine
- Patient Care Management
- Diabetes Mellitus

### Advance Preparation:

#### Required Readings (on coursework):
  ([http://care.diabetesjournals.org/content/33/Supplement_1/S4.full.pdf](http://care.diabetesjournals.org/content/33/Supplement_1/S4.full.pdf))

### Assignment:
- none
POM: Clinical Reasoning Session #8
Teaching Rounds and Small Group

Date & Time: Tuesday 11/15/11, 1:15-5:05 pm
Session Type: Lecture, Problem-Based Learning
Location: LK120 / LKSC Seminar Rooms
Responsible Faculty: Pree Basaviah, Peter Pompei, Christy Dosiou and Small Group Preceptors
Videotaping?: Lecture: Yes / Small Group session: No

Teaching Rounds Learning Objectives:
• Review the process of data gathering and interviewing of a patient with nausea, vomiting, and weight loss

Small Group Learning Objectives:
• Interpret thyroid function tests
• Recognize symptoms and signs of thyroidal disease
• Predict the natural history of common disorders of the thyroid

Session Activities:
1:15-2:05p: Teaching rounds
2:15-5:05p: Small group – After Part 2, each student will write and submit a problem list and differential diagnosis for the primary problem. In addition to the lists, students will submit the following week a brief discussion of the rationale for how their diagnostic considerations are ordered and their recommendations for the next steps in diagnosis based on these considerations.

Key Words:
• Problem-Based Learning
• Decision Making
• Diagnosis, Differential
• Clinical Medicine
• Patient Care Management
• Nausea
• Vomiting
• Thyroid Diseases

Advance Preparation:
Required Reading (on coursework, select one):
• Harrison's On-Line Part 15, Section 1 Chapter 335 Disorders of the Thyroid Gland (sections: introduction; Thyroid hormone synthesis, metabolism, action; Hypothyroidism, Hyperthyroidism, Thyrotoxicosis, Thyroiditis) http://www.accessmedicine.com/content.aspx?aid=9140510 or

Assignment: none
Teaching Rounds Learning Objectives:
Students should be able to:
1) Identify strategies to take an appropriate, comprehensive, and sensitive sexual history
2) Practice techniques and skills to ask specifically about sexual function/ dysfunction, sexual issues in geriatric populations, sexual identity, STI's, high risk sexual behavior, and counseling
3) Understand that sexual complaints can be a marker of significant underlying medical disease
4) Delineate the difference between gender identity, sexual identity and sexual behaviors
5) Identify and challenge your own assumptions, fears and judgments

Small Group Learning Objectives:
1.) Generate a differential diagnosis and optimal management plan for:
   - Symptomatic vaginal discharge
   - Symptomatic penile discharge
   - Infertility in a patient with irregular menses
   - Pelvic pain and uterine discharge
   - Menstrual irregularities, weight loss and bone pain
2.) Recognize commonly occurring pathogens from photomicrographs

Session Activities:
1:15-2:05p: Teaching rounds – Lecture on Advanced Sexual History taking
2:15-5:05p: Small group – Students will divide into small groups to work on solving the problems presented at each station. After each group has been to each station, groups will choose one of the cases to present to the class, discussing the key features and management strategies.

Key Words:
- Problem-Based Learning
- Decision Making
- Diagnosis, Differential
- Clinical Medicine
- Patient Care Management

Advance Preparation:
Required Readings (on coursework):
- From Up-to-Date:


Assignment: none
Nutrition
Nutrition Online Modules

**Dates:** September 1 – December 9, 2011  
**Location:** Online  
**Responsible Staff:** Chris Gardner, PhD, Preetha Basaviah, MD

**Description and Objectives of Topic**
In the Practice of Medicine course, nutrition is taught throughout the two years of the curriculum. There is at least one nutrition session per quarter in POM; however, nutrition principles are integrated into other course topics (e.g., clinical cases).

The primary goals of the Nutrition topic thread are:
1. Elicit a dietary history from a patient using pertinent history taking tools;
2. Describe the key food groups and recommended amounts to meet average nutrient needs.
3. Discuss the benefits of a healthy body weight throughout life to a patient identified as being over or under weight.
4. Advise lifestyle modifications in a clinical setting to improve the health status of a patient.

**Online Nutrition Modules**
Nutrition modules will be completed on-line, and suggested deadlines are listed in the course schedule (always a Monday). All nutrition module quizzes are required to be submitted by **Friday, December 10, 2011 at midnight**. Satisfactory completion of the nutrition modules are defined as missing no more than one (1) question on each module. Students will be allowed to re-take the module as many times as needed to achieve this threshold before the due date (**Friday, December 10, 2011 at midnight**). Following are the suggested due dates for the on-line nutrition modules:

- Clinical Nutrition 2: Pregnancy
- Clinical Nutrition 3: Pediatrics
- Clinical Nutrition 7: Diabetes Mellitus
- Clinical Nutrition 8: Gastrointestinal Disorders
Genitourinary and Breast Examination Skills
Genitourinary and Breast Examination Skills Training Sessions

Dates: November 17 – December 7, 2011
Times: various, see schedule
Location: LKSC Immersive Learning Center rooms (basement floor)
Session Type: Clinical Skills session
Videotaping: no

About the G/U and breast examination skills training sessions
In these training sessions, students will practice performing the genitourinary and breast examinations on both male and female patients. These examinations will be taught by patient-educators from “Project Prepare” who are specifically trained to play the role of the patient while simultaneously teaching each examination.

Each student is required to complete one (1) session of each of the following three examinations: female breast, female pelvic and male pelvic.

Goals and learning objectives for the training sessions
Being able to perform breast and genitourinary parts of the physical exam with proficiency and professionalism is extremely important in clinical practice. In these sessions, students will gain familiarity through practice in the following parts of the examination:

- Breast (male and female)
- Female pelvic (including bimanual exam)
- Male pelvic (including genitalia and rectal)

Each student will attend three sessions covering these skills. During each session, students will work with professional educators from “Project Prepare,” an established and respected Bay Area organization devoted to training health professionals in genitourinary and breast exams. In some sessions, this training will be supplemented by use of simulators.

The practice examinations are on REAL people, hired and trained by Project Prepare for their roles. They have received special training in how to give constructive feedback to students on the skill and technique, during and following each exam.

Student roles and responsibilities
- Students are required to attend all of their scheduled sessions.
- Absences must be approved in advance with both the student’s advising dean and the POM course director.
- Students are expected to be prompt, and to conduct themselves with the utmost professionalism and decorum.
- Students will be expected to be in professional dress, as they will have contact with patient-educators.
The Female Breast Exam
Student Syllabus
Project Prepare © 2006

Introduction

The Project Prepare Breast Exam session increases student confidence by creating a safe space for students to learn to perform a thorough and sensitive exam. You will learn:

- physical examination techniques, including: visual exam, clavicular and axillary node exam, and palpation of the breast tissue;
- patient/physician rapport building skills that increase physical and emotional comfort for provider and patient;
- interview and risk-assessment techniques.

You can expect:

- patience and coaching. Perfection is not the goal, and your educator will not grade you.
- opportunity to ask questions throughout the session. There are no stupid or inappropriate questions.
- verbal and manual guidance throughout the exam. You do not need to fear hurting the educator.

Patient Interview

As the provider, you will practice entering the room and introducing yourself, using your full name.

Interview protocol will vary, depending on the clinical setting, but interview questions are always designed to:

- gather information, and
- alleviate the patient’s anxiety by establishing rapport.

You will practice the following patient interview:

The purpose of a clinical breast exam is to establish a baseline, or what is normal for you, so that I can monitor changes over time.

1. Have you ever had a breast exam before? How was that experience for you?
2. Do you have any history of breast disease in your family?
3. Have you had any breast surgeries?
4. Do you practice monthly breast self exams? Have you noticed any changes? If she has, ask: Will you show me your breast exam technique and what you’ve noticed?
Women of any age may feel embarrassed about having their breasts examined, and may feel frightened about possible clinical findings. An explanation of technique and amount of time for exam may help allay fears. Practice being direct in addressing what you observe:

[normalize] *Many of my patients are nervous about getting a breast exam. Is there any reason that you are particularly nervous about being here today?*

Your educator will discuss using your clinical breast exam time to educate your patient on anatomical landmarks, characteristics of her own breasts, importance and recommended frequency of clinical and self breast exams, technique, and breast cancer risk and preventive factors. It will be helpful to know the resources in your area for referral to breast self exam (BSE) classes.

You will practice continuing taking the history during the entire exam.

**Exam Set-up**

Your educator will review techniques for helping the patient feel more comfortable and for caring for her modesty by offering a gown. During the visual exam, you will ask her to remove the gown to the waist, tying it at the waist. During breast palpation, the gown can cover the breast not being examined.

**Visual Exam**

You will practice telling the patient: *I will begin with a visual exam to make sure your breasts look healthy and normal.*

You and your educator will practice observing the breasts using 3 views for each of 4 positions.

Three views:
1. frontal,
2. lateral,
3. lateral.

Four positions:
1. Arms at side.
3. Pectoral contraction: hands on hips; thumbs on iliac crest; pectorals contracted.
4. Bending forward: observe underside of breast and note direction nipples point. A hand mirror can facilitate visualizing the underside of the breast.

You will practice describing the appearance of the skin, noting color, thickening, rashes, ulcerations, or peau d'orange.
You will practice describing the size and symmetry of the breasts. Some difference in size is usually normal. In elder women, glandular tissue atrophies and is replaced by fat, which causes the breast to hang lower on the chest.

You will practice comparing the contour of one breast to the other, noting any masses, dimpling, or flattening.

You will practice noting your findings by quadrant, clock position, and centimeters from the nipple.

You will practice describing the nipple’s appearance: size, shape, direction in which nipples point, rashes, ulcerations, inversion, and any discharge. Long-standing inversion is usually normal. Since the nipple and areola contain smooth muscle, tactile stimulation and cold temperatures may cause the nipple to become smaller, firmer and more erect. The areola may pucker and wrinkle. This is a normal function and not a sign of breast disease.

You will practice noting any nipple discharge:
- Is it unilateral or bilateral?
- Is it spontaneous or non-spontaneous?
- Is it clear and sticky or bloody?

Your educator will explain the normal occurrence of a supernumerary breast, often mistaken for a mole.

Throughout the visual exam, you will practice patient teaching. You may encourage the patient to stand in front of the mirror to view her own breasts and practice a visual breast self exam with your support.

**Palpation of the Supraclavicular and Infraclavicular Nodes**

You will practice telling the patient: *Now I will be examining the area above and below your collarbone to make sure the tissue is normal and healthy.*

- You will practice palpation using the pads (not tips) of your fingers.
- Your educator will show you how to do clavicular palpation one side at a time to avoid patient anxiety about being strangled, but note that it is quicker to use both hands at once.
- Supraclavicular: press finger pads firmly along the top side of the clavicle, starting at the sternoclavicular joint and walking towards the acromioclavicular joint (a.c.).
- Infraclavicular: press finger pads firmly along the underside of the clavicle, walking towards the sternoclavicular joint.
• Your educator will discuss what to do if you find a node, including examining
nodes for size, shape, mobility, consistency, and any tenderness. Unexplained,
enlarged, or tender nodes require (1) reexamination of the regions they drain,
and (2) assessment of lymph nodes in other areas to distinguish between
regional and generalized lymphadenopathy.

Examination of the Axillae

You will practice telling the patient: *Now I will be examining the area under each arm to make sure the tissue is normal and healthy.*

Your educator will guide you through describing the appearance of the skin of each axilla, noting any rash, infection, or unusual pigmentation.

Your educator will demonstrate the examination of axilla along four axes for nodes.

- To examine the left axilla, support the left elbow and arm of the patient with your left hand and arm. For the right axilla, support the right elbow and arm of the patient with your right hand and arm.
- With trimmed fingernails, cup the fingers of your right hand and reach deeply into the apex of the left axilla. Then drop the arm. Repeat with the left hand for the right axilla.
- Central nodes: pointing towards the mid clavicle, place your fingers lateral to the pectoral muscles as you press and slide your fingers downward, approximately two inches on the chest wall, palpating for central nodes. Return fingers to the apex.
- Pectoral nodes: grasp the anterior axillary fold between your thumb and fingers, and with your fingers, press and slide forward along the underside of the pectoral muscle. Return fingers to the apex.
- Lateral nodes: turn wrist with palm facing the humerus. Press and slide approximately two inches. Return fingers to the apex.
- Sub-scapular nodes: grasp the posterior axillary fold with fingers in apex and thumb on posterior fold. Press fingers and slide outward along the axilla.

Palpation of the Breast

You will practice telling the patient: *Now I will be examining your entire breast to make sure the tissue is normal and healthy.* Many women think of their breasts as what fits in their bra, but in fact, I will examine the breast tissue that extends from under your arm to the center of your chest and from your collarbone to your bra line. If you have any questions about what I am doing, please ask.
Your educator will discuss examining positions. Because breast tissue needs to be equally dispersed to provide adequate palpation, you will ask the patient to put her arm overhead. Then you will assess which position is best for her body type:

- supine: for small breasts, or
- side-roll position: for medium to large breasts. Your educator will show you how to place a pillow or a rolled towel under the patient’s shoulder.

Your educator will demonstrate the perimeter of the breast area: mid-axilla to bra-line (fifth rib), up sternum, across clavicle to mid-axilla. You will learn to include the axillary tail in the perimeter.

Your educator will review palpation techniques and work with you one-on-one to provide immediate feedback while you practice palpation on her breasts.

You will learn to use the pads of your index, middle, and ring fingers to palpate breast tissue.

You will practice relaxing your fingers, hands, wrists, arms, and shoulders while you palpate. This technique increases your sensitivity for a more thorough examination and helps your patient to have a comfortable exam.

You will practice making dime-size circles with 3 levels of pressure:

1. light, that could sense a superficial splinter
2. medium, and
3. deep, that reaches the ribcage.

You will learn one of several acceptable patterns of search for the breast exam, the **vertical strip method**.

Starting in the axilla, you will practice palpating downward to the bra line. Move a finger's width towards the sternum. Then palpate upward, until you reach the clavicle. Repeat the pattern until you’ve palpated all the breast tissue.

You will learn to identify the 3 main types of breast tissue

1. adipose tissue, or fatty tissue, which makes breasts feel soft,
2. glandular tissue, which feels textured and occurs in a system, and
3. ductile tissue

You will learn what to do about findings. Your educator will review notations you can use to describe a lump.

You will also practice **patient teaching** in the breast palpation exam:

- You may ask the patient to place her hand on her breast. Then, place your hand on top of hers to assist her in identifying the 3 types of breast tissue and learning palpation techniques.
Encourage the patient’s awareness of the look and feel of her normal, healthy tissue, so that she can alert a health care provider if she notices any changes.

**Conclusion**

Project Prepare strives to provide students with the most thorough practice exam possible. For this reason, the exam you learn with a Project Prepare educator will include parts of the exam that working physicians don’t practice in every clinical setting because of time constraints or lack of necessity for an individual patient. However, do not be discouraged by the amount of time it may take to complete your first thorough breast exam. Palpation speed and accuracy increases with practice.

Because so many women feel anxious, embarrassed, or negative about breast exams, your educator will discuss issues or fears related to the exam throughout the session. She will also address the diversity of patient population: cultural backgrounds, religious beliefs, levels of comfort with physical touch, attitudes about nudity, body image, sexuality, and language barriers.

Your educator will also address language, literacy, and learning abilities for teaching the exam techniques while you perform the breast exam.

Your participation guides the scope of the class. While the course focuses on practicing the clinical skills for your first breast exam, your educator will invite you to ask questions and share your clinical and personal stories within this confidential teaching environment.
The Female Pelvic Exam
Student Syllabus
Project Prepare © 2006

Introduction

The Project Prepare Pelvic Exam session increases student confidence by creating a safe space for students to learn to perform a thorough and sensitive exam. You will learn:

- physical examination techniques, including: external exam, internal exam with one finger, speculum exam, bimanual exam, and rectovaginal exam;
- patient/physician rapport building skills that increase physical and emotional comfort for provider and patient;
- interview and risk-assessment techniques.

You can expect:

- patience and coaching. Perfection is not the goal, and your educator will not grade you.
- opportunity to ask questions throughout the session. There are no stupid or inappropriate questions.
- verbal and manual guidance throughout the exam. You do not need to fear hurting the educator.

Patient Interview

As the provider, you will practice entering the room and introducing yourself, using your full name.

Interview protocol will vary, depending on the clinical setting, but interview questions are always designed to:

- gather information, and
- alleviate the patient’s anxiety by establishing rapport.

You will practice asking the patient the following questions:

1. *Have you ever had a pelvic exam before? How was that experience for you?*
2. *When was the first day of your last period? Is that normal for you?*
3. *[normalizing statement] I ask this question of all of my patients: do you have any concerns about your sexual health? [Opens the door for patient’s questions about fertility, STDs, sexual function, and well-being if you do not have time for a thorough sexual history interview.]*
4. *Since your last pelvic exam, have there been any changes you would like to discuss with me?*
Your educator will discuss observing the patient’s body language, such as adducting thighs, pulling away, grimacing, or covering her mouth with her hand. These may be signs of sexual or physical abuse. Be direct in addressing what you observe:

[normalize] Most of my patients are nervous about getting a pelvic exam. Is there any reason that you are particularly nervous about being here today?

You will practice continuing the history taking during the entire exam.

Exam Set-up

You and your educator will practice setting up the clinic room, including: vaginal speculum, water-soluble lubricant, gloves (latex and nitrile or vinyl), lab test equipment, and a hand mirror.

You will practice raising the head of the table to allow patient-provider eye contact and to promote relaxation of the abdominal muscles. Ask the patient to void her bladder prior to the exam. Encourage the patient to participate in her exam and health care decisions.

Before putting on gloves, you will prepare everything in the room so that you do not have to change gloves more than necessary during the exam. Remember: LLM – Light, Lubricant, Mirror.

You will practice:
- asking the patient to place the balls or heels of her feet upon the foot-rests. This placement helps to relax the inner thigh muscles.
- asking the patient to place her buttocks just slightly over the edge of the table.
- offering the patient a drape and draping her in a way that cares for her modesty while allowing you to perform a thorough exam. Place the drape over her legs, depress it at the midline, and keep the knees covered.

External Exam

You will practice telling the patient: I will begin with an external exam to make sure everything is healthy and normal on the outside.

Your educator will guide you through these steps:
- Visualize external skin and pubic area for crab lice, scabies, rashes, lesions, etc.
- Inspect the patient's external genitalia:
  - palpate mons pubis and inguinal nodes
  - palpate outer labia
  - retract clitoral hood and visualize clitoris
  - palpate inner labia
  - locate the urethral orifice and ask about incontinence
• inspect the hymenal tags, perineum, and the vaginal opening
• visualize external locations of greater vestibular glands (Bartholin’s Glands)

Internal Exam

Practice telling the patient: *Next I am going to insert one finger to examine some internal structures.*

- **Cystocele:** First you’ll practice visualizing the urethral orifice. With the index finger pressing on the anterior wall, ask the patient to bear down. Note any visual bulging of the bladder, protruding into the vagina, or any palpation of bladder protrusion.
- **Rectocele:** With the index finger pressing on the posterior wall, ask the patient to bear down. Note any visual protrusion of the rectum or any palpation of rectal protrusion.
- **Greater Vestibular Gland (Bartholin's gland):** Insert the index finger into the vagina at five and seven o'clock while placing the thumb on the outside of the outer labia. Then palpate for any swelling or tenderness.
- **PC muscle tone:** Ask the patient to squeeze onto your index finger to assess the strength of the pubococcygeus muscle.
- **Cervix location:** Insert one or two fingers into the vagina with palm up to identify the firm, rounded surface of the cervix.

Speculum Exam

Practice telling the patient: *This is a speculum. It is the instrument I use to see your cervix.*

Your educator will help you become familiar with the speculum you will use. Specula are available in metal or plastic. The narrow-billed Pederson and the wide-billed Graves are available in pediatric, small, medium, large, and extra-large. Your educator will discuss methods of selecting a speculum of appropriate size. You’ll learn to open, close, lock, and release the bills before you practice using the speculum on your educator’s body.

Your educator will also discuss warming and lubricating the speculum. Opinions vary regarding the use of lubricant prior to a pap smear. If lubricant is used, it should be applied *sparingly* to the first 2/3 of bills but not the tip, to avoid touching the cervix with lubricant. In some clinics, you’ll use water instead of lubricant for inserting the speculum.

Your educator will review methods of speculum insertion, such as inserting the middle finger into the introitus and pressing down on the perineum while the index and the ring finger hold the inner labia open, protecting them from invaginating.

You will practice holding the speculum between your index and middle fingers at the base of the bills.
Your educator will instruct you to glide the closed speculum into the vaginal introitus, at either an oblique or horizontal angle, heading downward, following the vaginal canal, and visualizing the direction of the cervix you palpated in the first internal exam.

Your educator will instruct you during this descent, guiding you to remove your fingers, rotate the bills into a horizontal position, and maintain posterior pressure to the point of resistance. Then she'll tell you to depress the thumb lever to open the speculum until you can visualize her cervix. When the cervix is clearly visualized, you'll tighten the thumb-screw to hold the bills open and practice inspecting the cervix and os, noting color, position, any ulcerations, nodules, masses, bleeding, or discharge.

Your educator will guide you through removing the speculum from the vagina. Continue to hold the bills open with your thumb while you loosen the screw. Then, remove the speculum by first pulling away from the cervix so the bills don’t pinch the cervix. Withdraw the speculum slowly, removing your thumb from the lever to allow the bills to close with the help of the vaginal walls. Turning the speculum may assist you in seeing the posterior and anterior walls. You may be able to observe the vaginal mucosa, noting color, discharge, ulcers, masses, and any inflammation. The speculum must be completely closed when you exit from the introitus.

**Bimanual Exam**

Practice telling the patient: *The next part of the exam is called the bimanual exam. I will be inserting two fingers and then pressing down with my other hand on your belly to feel your cervix, uterus, and ovaries.*

Your educator will guide you through **palpation of the cervix**.
- She will demonstrate a helpful standing position: one foot resting on the extended step, with shoulder, elbow, and wrist dropped. You’ll practice inserting your lubricated, gloved index and middle fingers into the vagina with your thumb, ring, and little fingers abducted.
- You will practice noting any tenderness or masses in the vaginal wall.
- You will practice palpation of the cervix. Check for cervical motion tenderness by either moving the cervix from side to side or up and down. Use a 360-degree sweep around the cervix, noting position, shape, consistency, size, and nodularity.
- Your educator will show you how to determine whether the patient’s uterus is anteverted or retroverted by identifying whether her uterus is palpable anterior or posterior to the cervix.

Your educator will guide you through **palpation of the uterus**.
- Your educator will show you how to place your index and middle finger under the cervix. Lifting the cervix this way elevates the uterus.
Your educator will guide your external hand to press with the pads of the fingers into the abdomen, midway between the umbilicus and the symphysis pubis. The abdominal hand palpates her uterus from the fundus downward and from either side to midline.

With the uterus between your two hands, you will practice noting its size, shape, consistency, mobility, and any masses. The position of the uterus will be either anteflexed, anteverted, midline, retroflexed, or retroverted.

Your educator will guide you through **palpation of the ovaries**.

- With your palm upward, your educator will show you how to move your internal fingers into the lateral fornix, where you can feel a pulse.
- Your educator will instruct you to lift your internal fingers anteriorly while pressing gently with your exterior, abdominal hand, forming a cup around the adnexal area.
- You’ll be able to palpate your educator’s ovary while it slips between your external and internal fingers. You’ll practice noting size, shape, consistency, mobility, or any pain. It is normal for ovaries to feel tender.

**Rectovaginal Exam**

Practice telling the patient: **You are almost done! The last part of the exam is called the rectovaginal exam. I will be inserting one finger in your rectum and one finger in your vagina. This is the only way I can feel behind your uterus.**

Your educator will explain that your glove must be changed to prevent any vaginal infection from being introduced into the anus.

Your educator will discuss methods of lubricating and inserting the middle finger into the patient’s anus, including visualizing the anus, asking the patient to take a deep breath, and lubricating the middle finger.

Your educator will instruct you to insert your index finger into the vaginal introitus. You can now palpate the rectovaginal septum between the index and middle fingers.

Your educator will guide you through palpating the uterus again, with the internal fingers lifting anteriorly and the abdominal hand pressing downward.

Your educator will instruct you to slowly remove the vaginal finger, then, with the middle finger, palpate in a 360-degree motion for any rectal masses or other abnormal findings.

You’ll practice offering a tissue-box to the patient, so she can wipe any excess lubricant.
Conclusion

Project Prepare strives to provide students with the most thorough practice pelvic exam possible. For this reason, the exam you learn with a Project Prepare educator will include parts of the exam that working physicians don’t practice in every clinical setting because of time constraints or lack of necessity for an individual patient.

Because so many women feel anxious, embarrassed, or negative about pelvic exams, your educator will discuss issues or fears related to the exam throughout the session. She will also address the diversity of patient population: cultural backgrounds, religious beliefs, levels of comfort with physical touch, attitudes about nudity, body image, sexuality, and language barriers.

Your participation guides the scope of the class. While the course focuses on practicing the clinical skills for your first pelvic exam, your educator will invite you to ask questions and share your clinical and personal stories within this confidential teaching environment.
The Male Breast, GU, and Rectal Exam  
Student Syllabus  
Project Prepare © 2006

Introduction

The Project Prepare Breast, GU, and Rectal Exam session increases student confidence by creating a safe space for students to learn to perform a thorough and sensitive exam. You will learn:

- physical examination techniques, including: supra- and infraclavicular and axillary node palpation, the male breast exam, a thorough genital exam, and a rectal exam, including palpation of the prostate and rectal wall;
- patient/physician rapport building skills that increase physical and emotional comfort for provider and patient;
- interview and risk-assessment techniques.

You can expect:

- patience and coaching. Perfection is not the goal, and your educator will not grade you.
- opportunity to ask questions throughout the session. There are no stupid or inappropriate questions.
- verbal and manual guidance throughout the exam. You do not need to fear hurting the educator.

Patient Interview

As the provider, you will practice entering the room and introducing yourself, using your full name.

Interview protocol will vary, depending on the clinical setting, but interview questions are always designed to:

- gather information, and
- alleviate the patient’s anxiety by establishing rapport.

You will practice asking the patient the following questions:

1. Have you ever had a genital or prostate exam before? How was that experience for you?
2. Since your last medical visit, have there been any changes you would like to discuss with me?
3. [normalizing statement] I ask this question of all of my patients: do you have any concerns about your sexual health? [Opens the door for patient’s questions about fertility, STDs, sexual function, and well-being if you do not have time for a thorough sexual history interview.]
4. **Do you have any other questions you would like to ask me before I begin the exam?**
   
   *Feel free to ask me questions throughout the exam.*

Your educator will discuss observing the patient’s body language for signs of sexual or physical abuse. Be direct in addressing what you observe:

[normalize] **Most of my patients are nervous about getting a genital or prostate exam. Is there any reason that you are particularly nervous about being here today?**

You will practice continuing the history taking during the entire exam.

**Breast Exam**

You will practice telling the patient: **Now I will be examining the area above and below your collar bone, under each arm, and around your nipple to make sure the tissue is normal and healthy.** Though breast cancer in men makes up only 1-3% of total breast cancer cases, the incidence of death is very high because of the poor rate of detection, so screening is important.

Your educator will remove his shirt and guide you through the **visual inspection of the chest.**

Your educator will demonstrate the **examination of supra- and infraclavicular areas for nodes.**

Your educator will demonstrate the **examination of axilla** along four axes to palpate the central, pectoral, lateral and sub scapular nodes.

Your educator will demonstrate the **examination of the breast** for healthy tissue, including how to educate the patient in self-examination.

- Your educator will sit or lie back on the table. Or, if there’s a mirror in the room, he may stand in front of the mirror to demonstrate teaching your patient a self exam.
- Using dime-size circles, you will practice palpating 4 quadrants of the nipple at light, medium, and deep levels of pressure.
- You will practice grasping the educator’s nipple between your index finder and thumb and rolling it, “like a ball of lint in your pocket.”

**Genital Area**

Your educator will explain and demonstrate the four parts of the genital exam: visual, penis, testicles, and inguinal hernia.
Because this exam can be sensitive and embarrassing for many men, your educator will discuss being purposeful, direct, and non-judgmental. For example, it’s important to note that an erection can occur anytime during the exam.

[normalize] Some of my patients experience erections as a natural reflex during this examination.

Practice telling the patient: Throughout the following exams, you will feel pressure, but you should not experience pain. Stop me if you are feeling pain.

Practice asking the patient: Have you noted any change in size, shape, color, skin condition, discharge, erectile function, or urinary function?

Your educator will discuss examining the patient in both standing and reclining positions. A varicocele is often evident only when the patient is in the upright position, but a lipoma of the cord does not change with recumbency.

Your educator will guide you through a visual examination of the genital area.
- You will practice observing skin quality, color, presence or absence of foreskin and frenulum, scars, lesions, discharge, inflammation, masses, or odor. You may try using a magnifier or light.
- Your educator will discuss assessing whether it’s necessary to separate the patient’s pubic hair in order to visualize skin and pubic area for crab lice, scabies, rashes, lesions, etc. You may try using a magnifier or light.
- Your educator will explain and demonstrate the Cremaster reflex examination for nerve integrity.

You will practice examining the penis.
- Your educator will discuss the differences in anatomy and examination techniques for a penis with and without foreskin.
- You will practice inspecting the penis shaft for Peyronnie’s plaques or tumors and asking the patient if there is any bend or curvature during erections. If there is, does this interfere with sexual activity?
- Your educator will guide you through palpation of urethra (“milking the penis”).
- Your educator will show you how to examine the meatus and rule out hypospadias or epispadias.
- You will practice palpation of corpora cavernosa.
- You will learn to check the dorsal pulse for circulatory integrity.

You will practice examining the scrotum (skin, raphe, shape, color, and symmetry).
- Isolate and palpate the testicles, (including self-examination).
- The testes should feel smooth and be approximately the same size on both sides.
- The left testis usually hangs lower than the right. Check for size, shape, irregularities, consistency, and tenderness.
Transluminate the scrotum, to check for hydrocele.
Note if there are any other masses within the scrotal cavity.
Identify the epididymus.
Identify the spermatic cord (vas deferens).

You will practice examining for inguinal hernia.
- Invaginate your index finger through the loose scrotal tissue until the finger tip presses on the external inguinal ring.
- Have the patient strain down or cough (Valsalvar maneuver), turning his head to the side so as not to cough directly on your face. If a direct hernia is present, you will feel some tissue striking the end of the finger. If an indirect hernia is present, you will feel some tissue striking the shaft of the finger.
- Palpate inguinal nodes.

Posterior/Rectal Exam

Practice telling the patient: You are almost done! The last part of the exam is called the rectal exam. I will use plenty of lubricant during the rectal exam to make it as comfortable for you as possible.

Practice telling the patient: Many of my patients experience what feels like a brief impulse to urinate or defecate during the prostate exam. This exam is brief, and the sensation should not persist after the exam.

Your educator will explain appropriate positions for the patient: standing, lying down, or knees to chest.

You will practice a visual examination of the general area: scrotum, perineum, perianal, and anal areas.

You will learn about the bulbocavernosus reflex, elicited by squeezing the end of the penis or by scratching the perineum while another finger is within the rectal vault to check nerve integrity.

You will practice examining the prostate and rectal wall. Your educator will demonstrate first on a silicone model, and then you will practice on your educator’s body.

He will also discuss:
- techniques for helping the patient relax,
- techniques for comfortable entry,
- checking sphincter tone. You will practice saying: Squeeze down on my finger.
- examination of prostate, using a “windshield wiper” motion. In general, a young healthy prostate feels about the size of a walnut.
- examination of the rectal wall, using a 360-degree rotation.
You’ll practice offering a tissue-box to the patient, so he can wipe any excess lubricant.

**Conclusion**

Project Prepare strives to provide students with the most thorough practice exam possible. For this reason, the exam you learn with a Project Prepare educator will include parts of the exam that working physicians don’t practice in every clinical setting because of time constraints or lack of necessity for an individual patient.

Because so many men feel anxious, embarrassed, or negative about pelvic exams, your educator will discuss issues or fears related to the exam throughout the session. He will also address the diversity of patient population: cultural backgrounds, religious beliefs, levels of comfort with physical touch, attitudes about nudity, body image, sexuality, and language barriers.

Your participation guides the scope of the class. While the course focuses on practicing the clinical skills for your first male breast, GU, and rectal exam, your educator will invite you to ask questions and share your clinical and personal stories within this confidential teaching environment.
Course Evaluations
I. Clinical Practicum Evaluation Forms (2)

(a) How will I be evaluated by my clinical practicum preceptor?

END-OF-PRACTICUM EVALUATION FORM

Provide written end-of-practicum feedback by completing the end-of-practicum evaluation form. Your ratings and comments represent the final assessment of the student’s overall performance in the practicum and will be used to determine the final grade in the practicum.

A face-to-face meeting should be held with the student to discuss the final evaluation. This is a last opportunity to review the Online Learning Journal and ensure that all requirements have been met. The mid-practicum Learning Plan should also be reviewed and discussed and the preceptor should provide an overall assessment of the student’s performance and allow the student a chance to comment on and discuss the assessment.

MEDICAL INTERVIEW
How often did you directly observe the student do a medical interview?

If you feel insufficiently able to judge, please check here ______

<table>
<thead>
<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often disorganized, misses key information, inaccurate, not well focused. Problems not well characterized.</td>
<td>Usually thorough, reasonably organized, usually accurate. Addresses pertinent positives, negatives and psychosocial issues in a logical manner. Detects most findings.</td>
<td>Consistently comprehensive, accurate, well-organized. Addresses issues in a logical and insightful manner. Elicits subtle findings.</td>
</tr>
</tbody>
</table>

Summative Comments (including descriptive examples):

PHYSICAL EXAMINATION
How often did you directly observe the student do a physical examination?

If you feel insufficiently able to judge, please check here ______

<table>
<thead>
<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often disorganized, inaccurate, not well focused. Problems not well characterized.</td>
<td>Usually thorough, reasonably organized, usually accurate. Detects most findings.</td>
<td>Consistently comprehensive, accurate, well-organized. Elicits subtle findings.</td>
</tr>
</tbody>
</table>

Summative Comments (including descriptive examples):
# CLINICAL DECISION-MAKING

Clinical Reasoning, Oral Case Presentations, Written Notes, Clinical Work
If you feel insufficiently able to judge, please check here ______

<table>
<thead>
<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorganized approach to clinical data; unable to prioritize problems; generates inadequate differential diagnoses. Presentations often unclear, incomplete, disorganized or inaccurate, lack of syntheses and rationales. Written notes often disorganized, incomplete, superficial, tangential or erroneous; limited formulations; often late. Poor follow-up of clinical problems, little initiative in problem solving.</td>
<td>Usually able to organize and prioritize patient information; generates a well-reasoned differential diagnosis. Presentations usually clear, complete, organized with adequate syntheses and rationale. Written notes usually clear, concise, organized, and timely with rationale. Adequate case formulations and discussions. Appropriate follow-up of clinical problems; shows initiative in solving problems.</td>
<td>Consistently synthesizes and prioritizes patient information. Generates an accurate and comprehensive differential diagnosis. Presentations consistently clear, accurate, well organized and concise with thoughtful rationales and pertinent syntheses. Written notes consistently clear, complete, well organized, with concise formulations. Well-researched discussions using additional resources.</td>
</tr>
</tbody>
</table>

Summative Comments (including descriptive examples):

---

# FUND OF KNOWLEDGE

Demonstrate knowledge of core topics and resourcefulness in using current technologies to find information
If you feel insufficiently able to judge, please check here ______

<table>
<thead>
<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited and fragmented understanding of pathophysiology, diagnosis and management.</td>
<td>Usually demonstrates general understanding of pathophysiology, diagnosis and management. Usually integrates knowledge from a variety of sources; regularly uses Medline searches, evidence-based medicine and current technologies to answer patient driven questions.</td>
<td>Consistently demonstrates wide-ranging understanding of pathophysiology, diagnosis, and management, and integrates knowledge from a variety of sources.</td>
</tr>
</tbody>
</table>

Summative Comments (including descriptive examples):
## COMPASSION/HUMANISM

Demonstrates empathy and respect for patients and families

If you feel insufficiently able to judge, please check here ______

<table>
<thead>
<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate level of respect, compassion, and empathy; fails to instill trust; frequently displays insensitivity and intolerance of patient’s need for comfort and encouragement; fails to recognize and respect cross-cultural/ gender differences.</td>
<td>Usually caring, supportive and respectful; often establishes rapport and trust; usually displays sensitivity and tolerance of patient’s needs; usually recognizes and respects cross-cultural/ gender issues.</td>
<td>Consistently caring, supportive, respectful and empathetic; establishes strong rapport and trust; demonstrates altruism; always respectful of cross-cultural/ gender issues.</td>
</tr>
</tbody>
</table>

Summative Comments (including descriptive examples):

---

## PROFESSIONALISM

Collegiality, initiative, dependability, attitude

If you feel insufficiently able to judge, please check here ______

<table>
<thead>
<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently irresponsible, unreliable, and late; shows disdain for professional colleagues; records frequently tardy and illegible. Uninterested, lacks motivation; unaware of weaknesses, strengths; unable to problem-solve; shows little improvement over the clerkship; insufficiently motivated to acquire knowledge. Unavailable when needed, reacts badly to stress, unwilling to work as part of a team.</td>
<td>Usually responsible and reliable and committed to team of health care professionals; records usually clear and timely; usually motivated; usually reliable and able to be counted on to follow through on tasks, responsibilities; usually available when needed; usually able to handle stress and willing to work as part of a team.</td>
<td>Always responsible, reliable, committed, cooperative and respectful. Shows regard for professional colleagues; displays initiative and provides leadership; records always timely and legible. Enthusiastic, functions independently; self- motivated. Always does what is expected and more; available when needed; always follows through on responsibilities; excellent team player; reacts well to stress.</td>
</tr>
</tbody>
</table>

Summative Comments (including descriptive examples):
FORMATIVE COMMENTS (including descriptive examples):

Formative comments should be geared toward helping the student improve. Please feel free to be candid but constructive in your comments and focus on specific recommendations for areas in need of improvement.

Face-to-Face Discussion with Student

I have discussed this information with the student.

Yes 
No

Preceptor Signature  Student Signature  Date
(b) How will I be evaluating my clinical practicum preceptor via E-Value?

**CLINICAL PRACTICUM PRECEPTOR: END-OF-PRACTICUM EVALUATION FORM**

Clinical Practicum Preceptor: ___________________________

Please rate the effectiveness of your clinical practicum preceptor in the following areas:

<table>
<thead>
<tr>
<th>(1) Preceptor availability and time spent teaching</th>
<th>Preceptor availability and time spent teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Poor</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Preceptor quality of teaching</th>
<th>Preceptor quality of teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Poor</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) My preceptor was a role model for effective patient care.</th>
<th>My preceptor was a role model for effective patient care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(4) My preceptor was compassionate and caring toward patients.</th>
<th>My preceptor was compassionate and caring toward patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(5) Feedback: Quantity</th>
<th>Feedback: Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I received sufficient amount of feedback from my practicum preceptor.)</td>
<td>(I received sufficient amount of feedback from my practicum preceptor.)</td>
</tr>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(6) Feedback: Quality</th>
<th>Feedback: Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>(The feedback I received from my practicum preceptor was helpful and substantive.)</td>
<td>(The feedback I received from my practicum preceptor was helpful and substantive.)</td>
</tr>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(7) Direct Observation</th>
<th>Direct Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(There was sufficient direct observation by my preceptor when I was working with patients, conducting histories, physical exams, etc.)</td>
<td>(There was sufficient direct observation by my preceptor when I was working with patients, conducting histories, physical exams, etc.)</td>
</tr>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(8) Overall rating of the clinical practicum preceptor</th>
<th>Overall rating of the clinical practicum preceptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Un able to rate</td>
<td>Poor</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
COMMENTS (including descriptive examples): Please feel free to be candid but constructive in your comments and focus on specific recommendations for areas in need of improvement.
II. Team-Based Clinical Reasoning Evaluation Forms (3)

(a) How will I be evaluated by my small group preceptor?

**Clinical Reasoning Sessions:**
Preceptor’s Evaluation of Student Performance (Q4, Q5)

Preceptors in the clinical reasoning sessions will use this form to evaluate students in their small groups at the end of the quarter.

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>Student First Name</th>
<th>Group Designation</th>
<th>Evaluation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CIRCLE ONE NUMBER IN EACH ROW**

- 1-3 = **Below expectations**
- 4-6* = **Meets expectations**
- 7-9 = **Exceeds expectations**

**Often does not meet expectations**

**Usually meets all expectations**

**Consistently meets all expectations**

*Note that the typical student will be rated in the 4-6 range

**ACADEMIC**

(1) Improvement over course

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Below Expectations

Meets Expectations

Exceeds Expectations

(2) Attendance

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Below Expectations

Meets Expectations

Exceeds Expectations

(3) Clinical Decision-Making:
Clinical Reasoning, Oral Case Presentations, Written Notes (if applicable)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Below Expectations

Meets Expectations

Exceeds Expectations

1 to 3 = Below Expectations
Disorganized approach to clinical data; unable to prioritize problems; generates inadequate differential diagnoses. Presentations often unclear, incomplete, disorganized or inaccurate, lack of syntheses and rationales. Written notes often disorganized, incomplete, superficial, tangential or erroneous; limited formulations; often late. Poor follow-up of clinical problems, little initiative in problem solving.

4 to 6 = Meets Expectations
Usually able to organize and prioritize patient information; generates a well-reasoned differential diagnosis. Presentations usually clear, complete, organized with adequate syntheses and rationale. Written notes usually clear, concise, organized, timely with rationale. Adequate case formulations and discussions. Appropriate follow-up of clinical problems; shows initiative in solving problems.

7 to 9 = Exceeds Expectations
Consistently synthesizes and prioritizes patient information. Generates an accurate and comprehensive differential diagnosis. Presentations consistently clear, accurate, well organized and concise with thoughtful rationales and pertinent syntheses. Written notes consistently clear, complete, well organized, with concise formulations. Well-researched discussions using additional resources.

(4) Fund of Knowledge:
Demonstrate knowledge of core topics and resourcefulness in using current technologies to find information

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Below Expectations

Meets Expectations

Exceeds Expectations

1 to 3 = Below Expectations
Limited and fragmented understanding of pathophysiology, diagnosis and management.

4 to 6 = Meets Expectations
Usually demonstrates general understanding of pathophysiology, diagnosis and management. Usually

7 to 9 = Exceeds Expectations
Consistently demonstrates wide-ranging understanding of pathophysiology, diagnosis, and
integrates knowledge from a variety of sources; regularly uses Medline searches, evidence-based medicine and current technologies to answer patient driven questions.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Expectations</td>
<td>Meets Expectations</td>
<td>Exceeds Expectations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTERPERSONAL**

**(5) Professionalism:**
Collegiality, initiative, dependability, attitude

1 to 3 = Below Expectations
- Frequently irresponsible, unreliable, and late; shows disdain for professional colleagues; records frequently tardy and illegible. Uninterested, lacks motivation; unaware of weaknesses, strengths; unable to problem-solve; insufficiently motivated to acquire knowledge. Unavailable when needed, reacts badly to stress, unwilling to work as part of a team.

4 to 6 = Meets Expectations
- Usually responsible and reliable and committed to team of health care professionals; records usually clear and timely; usually motivated; usually reliable and able to be counted on to follow through on tasks, responsibilities; usually available when needed; usually able to handle stress and willing to work as part of a team.

7 to 9 = Exceeds Expectations
- Always responsible, reliable, committed, cooperative and respectful. Shows regard for professional colleagues; displays initiative and provides leadership; records always timely and legible. Enthusiastic, functions independently; self-motivated. Always does what is expected and more; available when needed; always follows through on responsibilities; excellent team player; reacts well to stress.

**Overall Performance Rating**

1 | Fail (-) |
2 | Marginal Pass (+) |
3 | Pass (+) |

IDENTIFY THREE STRENGTHS

IDENTIFY THREE IMPROVEMENT OPPORTUNITIES

FACILITATOR NAME
(b) How will I be evaluating (and be evaluated by) my peers via E-Value?

Small Group End-Quarter Peer Evaluation

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>Student First Name</th>
<th>Group Designation</th>
<th>Evaluation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CIRCLE ONE NUMBER IN EACH ROW

<table>
<thead>
<tr>
<th>1-3 = Below expectations</th>
<th>4-6* = Meets expectations</th>
<th>7-9 = Exceeds expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Often does not meet expectations</strong></td>
<td><strong>Usually meets all expectations</strong></td>
<td><strong>Consistently meets all expectations</strong></td>
</tr>
</tbody>
</table>

*Note that the typical student will be rated in the 4-6 range

### INTERPERSONAL

<table>
<thead>
<tr>
<th>Category</th>
<th>Expectation</th>
<th>1 2 3 4 5 6 7 8 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependability</td>
<td>Can be relied on to make high quality, timely contributions</td>
<td>Below Expectations</td>
</tr>
<tr>
<td>Taking initiative</td>
<td>Goes beyond the minimum effort</td>
<td>Below Expectations</td>
</tr>
<tr>
<td>Contributing to group</td>
<td>Makes positive contributions to discussion</td>
<td>Below Expectations</td>
</tr>
<tr>
<td>Relationship with peers</td>
<td>Is respectful, listens well, makes constructive comments</td>
<td>Below Expectations</td>
</tr>
</tbody>
</table>

**OVERALL ASSESSMENT**

<table>
<thead>
<tr>
<th>1 2 3 4 5 6 7 8 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Expectations</td>
</tr>
</tbody>
</table>
**STRENGTHS**

**IMPROVEMENT OPPORTUNITIES:** These will be used for constructive feedback for the student
(c) How will I be evaluating my small group preceptor via E-Value?

**Small Group End-Quarter Preceptor Evaluation**

<table>
<thead>
<tr>
<th>Category</th>
<th>Overall score for each category: (select 1-5)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Learning climate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Showed enthusiasm for topic and learners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Was respectful and provided a comfortable space to express opinions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Was able to admit limitations and invite learners to bring up problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Control of session</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Adapted his/her leadership style to educational purpose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Focused the session; set an agenda</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Communication of goals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Established goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Stated relevance of goals to learners and expected level of competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Promoting understanding and retention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Was well prepared; material was organized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Fostered active learning</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Evaluation

* Asked recall questions, synthesis questions, and application questions
* Asked learners to self-reflect

6. Feedback

* Gave behavioral feedback
* Offered suggestions for improvement

7. Promoting self-directed learning

* Asked learners to define their own goals and needs
* Modeled use of resources or provided resources

Comments on preceptor performance and mentorship: (Question 6 of 9 - Mandatory)

Regarding your personal and professional development, please rate the overall perceived value of your small group preceptor's mentorship and teaching (Question 11 of 11 - Mandatory)

<table>
<thead>
<tr>
<th>N/A</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

COMMENTS ON PRECEPTOR FEEDBACK: (Question 11 of 11 - Mandatory)

Regarding your personal and professional development, please rate your perceived value of peer feedback in your small group (Question 11 of 11 - Mandatory)

<table>
<thead>
<tr>
<th>N/A</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

COMMENTS ON PEER FEEDBACK: (Question 11 of 11 - Mandatory)
Appendix
Tips on the H&P of the Hospitalized Patient

Emotional and physical barriers can blunt success in gathering data from patients and inhibit their willingness to collaborate for best clinical outcomes. Examples of barriers include the following:

1) PHYSICAL:
   a) Equipment: IV lines, dressings, compression stockings, Foley urinary catheter, etc.
   b) Position Constraints: Timed limitations after procedure (e.g., supine after lumbar puncture), symptom-limitation (e.g., Trendelenberg after hypotension)

2) EMOTIONAL & COGNITIVE
   a) Pain
   b) Depression, sadness, hopelessness
   c) Fear, anxiety
   d) Confusion, poor memory, short attention span

For the **physical barriers**, the best approach involves
- Define the most important outcomes for the current patient encounter
  - Rapport-building with critical need for detailed physical exam at this moment
  - Essential exam findings to guide patient management (e.g., fluid status via jugular pressure)
- Adjust the data-gathering steps to minimize patient discomfort while concentrating on the defined task(s)
- Consider awaiting the most difficult part of the exam until other decision-makers can accompany your efforts to minimize patient distress (e.g., move the patient against restraints only once)

For the **emotional barriers**, using empathy effectively can not only help the patient but can also help build trust so the patient will more likely be forthcoming with useful information about current symptoms and medical history. One acronym to help remember effective strategies for emotional barriers is PEARLS*:

- Partnership: “We are going to get through this together”
- Empathy: “You seem pretty frustrated”
- Acknowledgement: “I understand you don’t feel like you are getting any better since you have been in the hospital so long”
- Respect: “I give you a lot of credit. It’s hard to stay motivated.”
- Legitimation: “Most people I know would be distressed about that kind of reaction to the medication”
- Support: “I can see how scared and alone you feel here in the hospital, but I can come back to visit you if you like.”

The following common scenarios in hospitalized patients offer opportunities to practice useful maneuvers, seeking a high quality work-up without compromising the comfort and safety of your patient.

**The patient with congestive heart failure who cannot lie flat**
- Perform the abdominal examination in the semi-recumbent position (30° elevation).
- Slowly lower the head of bed as tolerated by the patient until threshold is tolerated and then proceed promptly with the abdominal exam
- Re-elevate promptly if the patient becomes uncomfortable.

**The patient in pain**
- Assess for pain early in contact and determine if the patient has covering orders for pain control, whether routine or to have as needed (prn).
- If needed, ask the responsible nurse if the patient may have additional analgesics while you take the history, allowing better pain relief when you are ready to examine them.
- Determine the areas and motions linked to the patient’s pain to minimize movements that cause pain
- Minimize movement of painful areas and, if movement needed, make slow, gentle movements
• Alert patient you before you move or examine an area reported as painful

The patient who is fearful, sad, disengaged (e.g., not wanting to offer much history)
- Work on extra rapport building to gain their trust
- Acknowledge the emotion and attempt to find out the reason behind the patient’s emotion

The patient with lower limb cast or other limb coverings, limiting patient mobility/examination
- Consider “log-roll” patient on side to listen to lungs if unable to sit upright
- Ask nurse if possible to remove dressings or equipment (e.g., UNNA boot, SCDs) temporarily to assist examination

*Adapted from The American Academy on Communication in Healthcare c. 2008
### Complete Physical Examination Checklist

*exam maneuvers grayed out are optional; please demonstrate if time permits*

**Wash Hands**

<table>
<thead>
<tr>
<th></th>
<th>Done</th>
<th>Inadequately Done</th>
<th>Not Done</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

#### Vital Signs

1. Blood Pressure
   - Wrap cuff 2-3 cm above antecubital fossa
   - Auscultate over brachial artery while deflating cuff OR, After estimating systolic, deflate cuff and re-inflate while auscultating over brachial artery.
   - **Take blood pressure in both arms if abnormal**

2. Pulse: Palpate correctly and time for at least 15 seconds.

3. Respirator/Rate: Observe respiratory effort and count rate unobtrusively for at least 15 seconds.

4. Temperature

5. Height and Weight: Recognize need for height and weight and measure properly. (If scale is unavailable, student may request information from the patient.

#### Head, Eyes, Ears, Nose, Throat

**1. Head**
   - Inspect scalp and skull
   - Inspect hair
   - Inspect facial features, skin of face
   - Palpate scalp and skull for masses/tenderness

**2. Eye**
   - Inspect
     - Orbits
     - Lids
     - Conjunctivae; Sclera
     - Lacrimal apparatus
   - **Cranial Nerve II (Optic)**, Vision (Acuity, Fields); for acuity test each eye individually and the together. Visual field testing by confrontation

   Obtain **Pupillary Light Reflex**: Ask patient to look into distance. Shine light obliquely into each pupil in turn. Note direct and consensual reaction.

*updated 03/10/2009*
### 2. Eye (continued)

**Pupillary Accommodation:** Ask patient to fix gaze on distant object. Observing eyes, ask patient to quickly focus on nearer object, i.e., examiner's finger.

**Extraocular Movements (Cranial Nerves III, IV, VI Oculomotor, Trochlear and Abducens.) Extraocular muscles (EOM), lid movement, pupillary reaction.**
- Stand 2-3' in front of patient. Has patient look at finger. Move finger slowly to extreme position of each of six cardinal fields of gaze, making a wide "H" in the air.

**Nystagmus:** Check with pausing at end point of upward and lateral gaze.

**Ophthalmoscopic Exam**
- Darken room. Ask patient to fix eyes on a point.
- Start ophthalmoscope at 0 diopters.
- Starting about 15° from patient and 15° lateral to patient's line of vision, shine light on patient's pupil and move slowly towards patient.
- Examine for red reflex; lens for opacities
- Focus ophthalmoscope and examine retina systematically - vessels, disc, macula

### 2. Ear

- Inspect auricle
- Palpate external ear, tragus
- Palpate mastoid area

**Cranial Nerve VIII (Vestibulocochlear).** Hearing; rub fingers, use the Weber and Rinne tests to distinguish conductive vs. neurologic hearing

**Otoscopic Examination:** Grasp top of pinna and pull up and back gently; support hand; inspect external canal and tympanic membrane

**Weber** - Place vibrating fork in middle of patient's head and ask which ear hears the sound louder

**Rinne** - Place vibrating fork on mastoid; ask patient to indicate when patient no longer hears sound; then hold vibrating end of fork near ear. (Do each ear). Compare bone to air ratio.

### 3. Nose

- Inspect nose. Check patency of nares
- Inspect nares - ask patient to look straight ahead; use nasal speculum or otoscope with proper tip.

**Cranial Nerve I (Olfactory).** Smell - Verify patency of nasal passages. Occlude one nostril while testing the other; test each side individually (vanilla, cloves, coffee…)

- Palpate maxillary and frontal sinuses

### 4. Mouth and Throat

Inspect lips, gums, teeth, palate and tongue, using tongue blade and light as needed

**Cranial Nerves IX, X (Glossopharyngeal, Vagus).** Phonation (say "AH"), elevate palate, gag, swallowing, taste posterior tongue (not necessary to test)
# Head, Eyes, Ears, Nose, Throat

## 4. Mouth and Throat (continued)

### Cranial Nerve XII (Hypoglossal).
Stick out tongue - deviation, atrophy

Inspect Wharton’s (submandibular) and Stenson’s (parotid) ducts

Inspect posterior pharynx and tonsillar area. Use tongue blade to gently depress tongue, if necessary. Ask patient to say "ah".

Palpate gums, tongue, floor of mouth (remember to glove)

Palpate TMJ (remember to de-glove)

### Cranial Nerve V (Trigeminal).
Muscles of mastication, facial sensation. Sensory – ophthalmic, maxillary, mandibular divisions.

### Cranial Nerve VII (Facial).
Muscles of face (raise eyebrows, show teeth, smile, frown, close eyes) taste ant. 2/3 tongue (not necessary to test)

### Cranial Nerve XI (Spinal Accessory).
Sternocleidomastoid (turn head) and trapezius (shrug shoulders) muscles

---

# Neck: Lymph, Neurological, Musculoskeletal

## 1. Neck (Anterior)

### Inspect:
- For symmetry
- Trachea in midline
- Thyroid: Ask patient to swallow and observe for thyroid enlargement (offer glass of water if needed).

### Palpate:
- Lymph nodes in anterior triangle, posterior triangle, post-auricular, occipital, pre-auricular and supraclavicular area (may be done from behind).
- Trachea
- Thyroid: Ask patient to slightly flex head; locate thyroid below inferior border of cricoid; palpate lobes using thumb and second and third fingers; ask patient to swallow (offer a glass of water if needed). [some may choose to do posterior palpation]

### Neck, Range of Motion: Ask patient to touch chin to chest (flexion), chin to each shoulder (rotation), ear to corresponding shoulder (lateral flexion), and bend head back (extension).
# Pulmonary

## 1. Chest Posterior

<table>
<thead>
<tr>
<th>Inspect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Pattern - rate, rhythm, depth, effort</td>
</tr>
<tr>
<td>Thoracic structures including chest diameter, shape, symmetry, deformities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Palpate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bony structures for tenderness</td>
</tr>
<tr>
<td><strong>Respiratory excursion:</strong> With hands over lower chest, thumbs medial and fingers lateral, watch for symmetry of chest wall motion during inspiration and expiration; measure expansion with maximal inspiration.</td>
</tr>
<tr>
<td><strong>Tactile fremitus:</strong> Ask patient to say &quot;99&quot; and palpate over posterior and lateral chest using ball of hand or ulnar aspects of hands. Usually done if history or exam suggests pulmonary concerns. May demonstrate if time permits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percuss:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resonance:</strong> Percuss posterior chest, beginning at the top of posterior chest wall and working downward, comparing symmetric points on right and left sides alternately, at least 6 areas, going from side to side.</td>
</tr>
<tr>
<td><strong>Diaphragmatic excursion:</strong> Note distance between levels of dullness at maximal inspiration and expiration; normal is 3cm-6cm. Can demonstrate on one side if time limits.</td>
</tr>
<tr>
<td><strong>Costovertebral angles</strong> for tenderness (can be done here or with abdominal exam)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Auscultate:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breath Sounds:</strong> Apply diaphragm firmly to chest wall. Attempt to warm stethoscope. Warn patient that the stethoscope may be cold. Instruct patient to breathe in and out through his/her mouth and to tell examiner if patient becomes dizzy. Systematically auscultate at apices, over posterior and lateral chest, alternating right and left sides to compare symmetric points. Listen to at least 6 areas on skin of the back, going from side to side, also right middle lobe and anterior apices.</td>
</tr>
<tr>
<td><strong>Egophony:</strong> Ask the patient to say &quot;eee..&quot; out loud; auscultate both sides. Normal is muffled &quot;eee...&quot;; abnormal is &quot;ay&quot;, or E to A egophony. Usually done if history or exam suggests pulmonary concerns. May demonstrate if time permits.</td>
</tr>
<tr>
<td><strong>Whispered pectoriloquy:</strong> Asks the patient to whisper &quot;99&quot; or &quot;1-2-3&quot;; auscultate both sides. Normally can faintly hear whisper; abnormal if whispered sounds are louder and clearer. Usually done if history or exam suggests pulmonary concerns. May demonstrate if time permits.</td>
</tr>
</tbody>
</table>

## 2. Chest Anterior

**[If posterior chest done, including apices, then anterior is optional is time limited].**

<table>
<thead>
<tr>
<th>Inspect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory pattern</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Palpate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bony structures for tenderness</td>
</tr>
<tr>
<td><strong>Respiratory excursion</strong> (as done in posterior chest)</td>
</tr>
<tr>
<td><strong>Tactile fremitus</strong> (as done in posterior chest)</td>
</tr>
</tbody>
</table>
### Percuss:
- **Resonance**: Begin at apices and work downward, comparing symmetric points on right and left side.

### Auscultate:
- **Breath sounds**: Begin at apices; work downward, comparing symmetric points on right and left side.
- **Egophony**: Ask patient to say “eeee....”.
- **Whispered pectoriloquy**: Ask patient to whisper "99" or"1-2-3".

### Cardiovascular

#### Jugular Venous Pressure:
- Examine at patient’s right side. Patient should be lying at a 30° angle, head turned slightly away.
- Identify pulsations of internal jugular vein.
- Identify highest pulsations of int. jug. vertical distance between this point and sternal angle.
- Measure. Add 5 cm to get an estimated jugular venous pressure.

#### Carotid Pulses:
- Auscultate (may have patient hold their breath) with bell of stethoscope.
- Palpate, gently (one at a time)

#### Precordium:
Inspect for chest wall motion; point of maximal impulse (PMI).

#### Palpate:
- PMI — for location and size.
- For heaves and thrills

#### Auscultate 4 areas of heart directly on skin: (with diaphragm in all areas; bell at apex)
- Aortic area
- Pulmonic area
- Tricuspid area
- Left sternal border
- Apex (with bell)

#### Auscultate for gallops or mitral murmurs. Instruct patient to roll onto left side; auscultate mitral apex with bell lightly pressed.

#### Auscultate for aortic and pulmonic murmurs. With patient bending forward, place diaphragm over the aortic, pulmonic, and apical areas, instructing the patient to inhale deeply, exhale and then hold his/her breath. Instruct patient to breathe when necessary.

#### Auscultate femoral arteries

#### Palpate
- Brachial pulse
- Radial pulse
- Popliteal pulse
- Dorsalis pedis pulse
- Posterior tibial pulse
- Check for edema by pressing on skin near ankles

*updated 03/10/2009*
### Abdomen

<table>
<thead>
<tr>
<th>Inspect: Abdominal wall and flanks for contour, masses, and movements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auscultate prior to palpation or percussion; one quadrant on skin for bowel sounds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percuss:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver along right mid-clavicular line to determine liver span. Normal span at right mid-clavicular line is 6-12 cm</td>
</tr>
<tr>
<td>Splenic borders - In lowest intercostal space in left anterior axillary line, first percuss in full expiration and then in full inspiration.</td>
</tr>
<tr>
<td>All four quadrants, including above symphysis for bladder distention.</td>
</tr>
<tr>
<td>For shifting dullness (done if history or exam suggestive of ascites)</td>
</tr>
<tr>
<td>For fluid wave (done if history or exam suggestive of ascites)</td>
</tr>
<tr>
<td>Costovertebral angles for tenderness (can be done here or with pulmonary exam)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Palpate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All four quadrants for tenderness, mass, or rigidity; both superficial and deep.</td>
</tr>
<tr>
<td>Liver - for enlargement, tenderness, consistency</td>
</tr>
<tr>
<td>Spleen - using bimanual technique</td>
</tr>
<tr>
<td>Kidneys - using bimanual technique</td>
</tr>
<tr>
<td>Inquinal areas</td>
</tr>
<tr>
<td>Aorta - estimate size</td>
</tr>
</tbody>
</table>

### Musculoskeletal Exam Checklist

[All maneuvers for pathology are optional: anterior/posterior drawer test, Lachmann’s, rotator cuff, shoulder impingement/tear, carpal tunnel, bulge sign/knee effusion, McMurray’s, etc.]

<table>
<thead>
<tr>
<th>Inspect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fingers (DIP’s), (PIP’s)</td>
</tr>
<tr>
<td>Hands (MCP’s)</td>
</tr>
<tr>
<td>Wrists</td>
</tr>
<tr>
<td>Elbows</td>
</tr>
<tr>
<td>Shoulders (Sternoclavicular, AC joints, biceps tendons)</td>
</tr>
<tr>
<td>Neck</td>
</tr>
<tr>
<td>TMJ</td>
</tr>
<tr>
<td>Spine</td>
</tr>
<tr>
<td>Toes</td>
</tr>
<tr>
<td>Feet</td>
</tr>
<tr>
<td>Ankles</td>
</tr>
<tr>
<td>Knees for signs of effusion (ballottement, Bulge and Balloon sign)</td>
</tr>
<tr>
<td>Hips</td>
</tr>
</tbody>
</table>

Assess Range of Motion (ROM), active. (perform passive ROM only if active is abnormal). The number in parenthesis indicates the degree of expected joint motion.

updated 03/10/2009
**Assess:**
- **Fingers** - Flexion (F); Extension (E), Abduction (ABD), Adduction (Add)
- **Wrists** - F (90); E (30); Radial deviation (20); Ulnar deviation (55)
- **Elbows** - F (160); E (180); Pronation and Supination with elbows flexed at 90 degrees (90)
- **Shoulders** - Forward F (180); E (50); Internal Rotation (IR) (90); External Rotation (ER) (90); Abd(180), Add(50)
- **Back** - F (75); E (30); R&L Lateral Bending (35); R&L Rotation (30)
- **Neck** - F (45); E (55); R&L Lateral Bending (40); R&L Rotation (70)
- **Toes** - F; E
- ** Ankles** - Dorsiflexion (20); Plantar flexion (45); Inversion (30); Eversion (20); Adduction (20); Abduction (10)
- **Knees** - F (130); E (15)
- **Hips** - Flexion with a straight leg (90); Extension with a straight leg (30); Abd (45); Add (30); IR (40); ER (45)

**Special Testing**

**Spine**
- Percuss spine
- Check spine for scoliosis - have patient slowly bend forward and touch toes while inspecting spine.
- Perform straight leg raise (done if history or exam suggest back concerns. May demonstrate if time permits)

**Neurological Exam Checklist**

**Sensory:**

**Light touch** (Instruct patient to close eyes and say "yes" when he/she feels a touch. Use wisp of cotton. Show understanding of dermatomal testing)
- Face
- Trunk
- Extremities

**Pain** (Ask patient to close eyes. Use sharp or dull end of tongue blade or cotton-tipped applicator to touch patient. Instruct patient to identify as sharp or dull.)
- Face
- Trunk
- Extremities

**Vibratory Sense** – (Ask patient to close eyes.)
- Place vibrating 128 or 256 tuning fork in contact with bony prominence and instructs patient to state when vibration stops.
- Move "up" extremity until patient senses vibration.

**Position Sense:** Fingers and Toes. Instruct patient to close eyes.

**Stereognosis**

**Two-point discrimination**

*updated 03/10/2009*
**Deep Tendon Reflexes:** (Use reinforcement techniques as needed. Test 4)

<table>
<thead>
<tr>
<th>Reflex</th>
<th>Nerve Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biceps</td>
<td>(C5, 6)</td>
</tr>
<tr>
<td>Brachioradialis</td>
<td>(C5,6)</td>
</tr>
<tr>
<td>Triceps</td>
<td>(C6,7,8)</td>
</tr>
<tr>
<td>Patellar</td>
<td>(L2,3,4)</td>
</tr>
<tr>
<td>Ankle (Primarily S1, S2)</td>
<td></td>
</tr>
</tbody>
</table>

Use reflex hammer appropriately

**Superficial Reflexes:**

<table>
<thead>
<tr>
<th>Reflex</th>
<th>Nerve Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal</td>
<td>(T8-10 above); (T10-12 below)</td>
</tr>
<tr>
<td>Cremasteric</td>
<td>(Students may explain test.)</td>
</tr>
</tbody>
</table>

**Motor: strength, coordination**

Muscle strength, bulk, tone (May be incorporated into musculoskeletal exam)

- **Fingers** - Abduction, (C8, T1; ulnar)
- **Thumb** - Opposition, (C8, T1; median)
- **Grasp**
- **Wrist** - Extension (C6,7,8 Radial)
- **Elbow** - Extension (C6,7,8) Flexion (C5,6)
- **Shoulder** - Abduction; Adduction
- **Hips** - Flexion (L2,3,4); Abduction (L4,5, Sl), Adduction (L2,3,4), Extension
- **Knees** - Extension (L2,3,4); Flexion (L4,5, Sl,2)
- **Ankles** –
  - **Dorsiflexion** (Primarily L4,5) (heel-walking);
  - **Plantar flexion** (Primarily Sl) (toe-walking)

Observe for involuntary movements - tics, tremors, cogwheeling

**Proprioception and Cerebellar Function:**

Coordination and fine motor skills

- Rapid alternating movement
- **Finger - Nose** — **Finger (Point-to-point)**
- **Heel/Shin**

**Balance**

- **Equilibrium**
  - **Romberg** - eyes open and then closed -stand with feet together and arms at side
  - Hop on one foot- eyes open — 5 seconds
  - Pronator drift
- **Gait**
  - Normal
  - Tandem (heel-to-toe)
  - Heels only/Toes only

---

updated 03/10/2009