Stanford University School of Medicine

Practice of Medicine
(INDE 205)

Course Syllabus
2010-2011

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**Course Staff**

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<thead>
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<th>Kambria Hooper, MEd</th>
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<tbody>
<tr>
<td>Year 2 Course Manager</td>
<td>Evaluations Specialist</td>
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<tr>
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Practice of Medicine (POM)
Course Information
About the Practice of Medicine (POM) Course

POM is a six-quarter preclinical 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/Introduction to the Management of the Ill Patient (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 can expect to practice and improve 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 year one.

The clinical exam skills components are designed to refine students' skills in the medical interview and physical exam through clinical experience. Students can expect to practice and improve such skills as they work weekly with a clinical preceptor at a hospital or out-patient clinic site. The first part of Quarter 5, “The Brain and Behavior Block,” integrates neurology and psychopharmacology taught in HHD by reinforcing and advancing principles through clinical applications of psychiatric and behavioral medicine taught in POM. The first part of the quarter will focus on the psychiatric interview and exam, followed by general history and physical exam sessions for the remainder of the quarter just as students did during practicum in Quarter 4.

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)
- Psychiatry
- Advanced clinical skills sessions
- Teaching Rounds and small group clinical reasoning sessions (CRS)

* The first 2 weeks of the block have Tuesdays and Thursdays focus on the psychiatric interview and practice sessions. Following this, Group A & B alternate on Thursdays between clinical practicum and advanced clinical skills beginning January 20, 2011. Each student will receive an individualized copy of their 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 Tomiko Nguyen-Trung, the POM Year 2 curriculum manager.
Learning objectives for Q5:

- Employ explicit methods for developing and refining a differential diagnosis
- Distinguish the roles of problem lists in different clinical care settings
- Relate 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 patient either during a full H & P encounter or focused encounter

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 continually check for email notifications, phone messages, or CWP 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 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 5 (INDE 205). You will complete each component below during INDE 205. 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 plan of remediation will be required (see School of Medicine Grading Policy). Final grades include active participation throughout the quarter in all POM large and small group sessions, satisfactory attendance for all POM class sessions, satisfactory completion of the standardized patient (SP) assessment, and satisfactory completion of the Q5 written final exam.

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
- Completion of one learning journal entry every other week (see clinical practicum student guide)
- Successful completion and submission 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 that prepare students
- Completion of peer and preceptor evaluations
- Attendance and satisfactory participation in teaching rounds sessions

Psychiatry

- Satisfactory attendance and participation in all scheduled psychiatry lecture and practicum sessions
- Completion of one learning journal entry every week (see clinical practicum student guide)
- Successful completion and submission assignments
**POM and HHD Integrated Brain & Behavior Block Exams**

The Q5 Brain & Behavior block exam, scheduled on Monday, January 31, 2011, will be a combined HHD and POM exam. The exam will cover all of the topics presented in both the POM course in the first half of the Winter quarter (i.e. weeks 1-2 in January 2011) and the HHD course in the entire Brain and Behavior block (weeks 1-4 in January 2011). Students are responsible for all of the content in the brain block in both HHD and POM: clinical neurology, psychiatry, neuropharmacology, neuropathology, and CNS infections. Clinical applications of concepts learned in HHD and POM will be included on this exam. There will be patient interview videos, clinical vignettes, multiple choice and/or short answer questions.

**Nutrition**

Satisfactory completion of online nutrition modules on coursework.stanford.edu by Sunday, March 20, 2011 at 11:59 pm.

- Unit 9. Nutrition Modifications for Cancer Therapy
- Unit 10. Enteral and Parenteral Nutrition Therapy
- Unit 11. Contemporary Trends

**Standardized Patient (SP) Assessment**

The SP Assessment will include a four-hour multi-station standardized patient assessment. Students will be evaluated on their history taking and physical examination skills, as well as their clinical reasoning and oral presentation skills. Each student will be assigned to one of six half-day time slots on one of the following dates: Monday, March 14; Tuesday, March 15; or Wednesday, March 16.

All students are required to achieve a passing score on the standardized patient assessment in order to successfully pass the course and to be permitted to proceed to clinical rotations. Those who do not score within the passing range (>65% or ≥ at least 2 standard deviations below the class mean) will need to complete additional requirements in the spring quarter. The SP assessment is directed by Dr. Andrew Nevins, Medical Director of the SP Program and POM Associate Course Director.

**POM Q5 Final Exam**

- Students must earn a passing grade (> 65% or ≥ at least 2 standard deviations below the mean of the class) on the POM final exam. If performance is deemed insufficient, remediation may be assigned by the course director. Examples of unsatisfactory performance include: poor performance on a particular section of the final exam, a grade 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. Preetha Basaviah), and Tomiko Nguyen-Trung. Only one absence per quarter is permitted for POM (see specific course sections for absence notification and remediation 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. 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 the 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), IMIP (Introduction of the Management of the Ill Patient) 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 Nguyen-Trung (POM Year 2 Curriculum Manager) as soon as possible (tnguyen9@stanford.edu).

- OPTION 1: You may defer taking INDE 204, 205, 206 until 2011-2012 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. Hence, 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 (Health Insurance Portability and Accountability Act) 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 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. The student should find a student in the desired group to switch with. There will be no “just joining” another group.
3. If the group switch is approved, the student should inform the POM staff 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 Winter Quarter Schedule

**2010-2011**

## Week 1: 1/3-1/7

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<thead>
<tr>
<th>Monday</th>
<th>Location</th>
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<tr>
<td>1/4</td>
<td>LK120, Assorted Locations</td>
<td>1:15-3:05pm: Lecture</td>
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<td>1pm-2pm</td>
<td>3:15-5:05pm: Psych Practicum</td>
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<td>2pm-3pm</td>
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<tr>
<td>1/6</td>
<td>M-112, Assorted Locations</td>
<td>1:15-3:05pm: Lecture</td>
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<tr>
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## Week 2: 1/11-1/15

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<td>LK120, Assorted Locations</td>
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## Week 3: 1/18-1/22

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## Week 4: 1/25-1/29

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Practice of Medicine, INDE 205, 2010-11: Page 14
### Week 5: 2/1-2/5

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### Week 11: 3/14-3/18

**Mini-CPX**

**Practice of Medicine Final Exam**

- **Mini-CPX**
  - LKSC Immersive Learning Center (ground floor)

- **Practice of Medicine Final Exam**
Advanced Clinical Skills Sessions
Advanced Clinical Skills

Dates: Alternate Thursdays, January 20, 2011 to March 10, 2011 (specific Thursday date dependent on group assignment)
Time: 1:00-5:00 pm
Location: M-112, and Fleischmann Lab Rooms, CCSR Basement Rooms or Stanford Hospital
Responsible Faculty: Ian Tong, MD
TA: Nina Patel

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, 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 application exercises that strengthen abilities in the areas of medical interview, physical examination, clinical problem solving, diagnostic interpretation (EKG, etc.) and clinical practice.

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.

Required activities for the advanced clinical skills sessions
• Dress appropriately (wear white coat, dress in business/ professional attire).
POM: Advanced Clinical Skills
Neurology Exam Revisited

| Date:   | Group B: Thursday, 1/20/11
|         | Group A: Thursday, 1/27/11
| Time & Location: | 1:15pm – 2:15pm, LKSC room LK101
|         | 2:30pm – 5:05pm, LKSC seminar rooms
| Faculty: | Ian Tong, MD; Neil Schwartz, MD; and small group faculty

**Session Goal(s):**
1. Review the use of the reflex hammer, tuning forks, cotton swab, and cotton tipped applicator
2. Review the neurologic examination
3. Integrate physical examination of the neurologic system with students’ knowledge of gross anatomy.
4. Introduce abnormal findings and proper measurement and documentation of neurologic deficits.

**Learning Objectives for Neurology Exam:**
At the end of the session the students will be able to:
1. Perform focused neurologic examination related to specific patient complaints
2. Identify gross abnormalities in Cerebellar, Motor and Sensory function
3. Perform complete Cranial Nerve Exam
4. Elicit reflexes with appropriate use of reflex hammer

**Key Words:**
Romberg Sign  Kernig/Brudzinski  Altered Mental status
Babinski sign  Dysphasia/Dysarthria  Somnolence
Cogwheel rigidity  Strength grading  Clonus
Nystagmus  Amaurosis Fugax  Tinel’s/Phalen’s signs

**Special Instructions:**
- Bring your reflex hammers, tuning forks, Snellen charts and ophthalmoscope to class.
- Professional dress (including white coat).

**Required Reading Assignment:**
- *Bates Guide to the Physical Examination, 10th edition*
  - Cranial Nerves pp 656, 672-678
  - Muscle Strength p 680
- *Deep Tendon Reflexes pp 696-701*
- *Levels of Consciousness p 706*
- *Documenting Neurologic Exam pp 710*
POM: Advanced Clinical Skills
Musculoskeletal Exam

| Date:            | Group B: Thursday, 2/03/11  
|                 | Group A: Thursday, 2/10/11  
| Time & Location:| 1:15pm – 2:15pm, LKSC room LK101 
|                 | 2:30pm – 5:05pm, LKSC rooms  
| Faculty:        | Ian Tong, MD and small group faculty |

**Session Goal(s)**
1. Review the physical examination of the upper/lower extremities and spine;
2. Introduce special maneuvers for shoulder, spine, and knee

**Learning Objectives**
At the end of the session the students will be able to:
1. Describe the components of the rotator cuff and action of muscles within this group;
2. Assess for localization of injury within rotator cuff;
3. Describe some components of the knee examination;
4. Assess for miscellaneous musculoskeletal injuries (e.g. Achilles tendon rupture).

**Key Words:**
- Thompson test
- Anterior drawer sign
- Tinel’s test
- Phalen’s test
- Straight leg raise
- Sciatica
- Rotator Cuff
- Iliotibial band tract
- Empty can sign
- Unhappy triad
- McMurray test
- Ballotable patella

**Special Instructions:**
- Review videos before session - to be announced

**Required Reading Assignment:**
- Bates Guide to the Physical Examination, 10th edition
  - Shoulder pp 588-599
  - Spine pp 609-617
  - Wrist and Hands pp 601-609
  - The Heart, pp 354-370.
POM: Advanced Clinical Skills
Advanced Presentations and SOAP Notes + Heart Sounds Revisited

Date:  
Group B: Thursday, 2/17/10  
Group A: Thursday, 2/24/10

Time & Location:  
1:15pm – 2:15pm, LKSC room LK101  
2:30pm – 5:05pm, LKSC seminar rooms

Faculty:  
Ian Tong, MD and small group faculty

Session Goal(s):
At the end of this session, students should be able to perform the following clinical tasks:

CV
1. Review cardiac exam and identification of heart sounds

Oral Presentations & SOAP Notes
1. Identify the type of presentation appropriate to a given clinical situation
2. Begin to practice the short/interval visit presentation
3. Introduce SOAP note structure

Learning Objectives for Oral Presentation:

CV
1. Review abnormal cardiac physical findings and learn to correlate them with potential disease states in patients

Oral Presentations & SOAP Notes
1. Review methods to practice oral presentations and present efficiently and with confidence
2. Review developing an assessment and plan
3. Outline the basic structure of and construct a SOAP note
4. Describe the required flexibility in oral presentations across clinical specialties
5. Differentiate between new patient or admission presentations from focused daily rounds or interval visit outpatient presentations

Key Words

CV
MR/AS/AR/HOCM  S1, S2  Physiological Splitting S2  S3, S4 Gallop
Systolic Murmur  Diastolic Murmur  Grade Murmurs

Session Activities
1. Observe and analyze a video of a standardized patient interview in a small group
2. Construct a SOAP note, including assessment and plan
3. Debrief and provide feedback amongst peers and faculty
4. Present focused case presentations orally
5. Receive and provide feedback to peers

Required Assignments
1. Readings:
   • Syllabus section on “Oral Presentations”
2. Review the website: http://meded.ucsd.edu/clinicalmed/oral.htm

Web links:
   • Blaufuss Heart Sounds Tutorial http://www.blaufuss.org/tutonline.html. Audio files of selected basic heart sounds and murmurs. Available on computers in the Fleischmann lab rooms (M208, M212, M214, M218) and the CCSR basement rooms.
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 others, from medical students to attendings, give presentations. Can you tell the difference between those that are concise and well organized, and those that are confusing?
   d. Know the expectations. If you aren’t certain what your audience wants, make sure to 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)
        15. Assessment
        16. Plan
        17. 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.

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
a. Abbreviations are for writing – not for speaking
b. If you don’t know the jargon, don’t use it
c. Don’t invent new words
d. Pay attention to your audience
e. 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
f. 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

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<th>DO NOT USE</th>
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<td>Write out/say international unit</td>
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<td>U (for unit)</td>
<td>Write out/say unit</td>
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<tr>
<td>TIW (for three times a week)</td>
<td>Write/say 3 or three times weekly</td>
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<td>MS or MSO₄ (for Morphine Sulfate)</td>
<td>Write/say Morphine</td>
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<td>MgSO₄ (for Magnesium Sulfate)</td>
<td>Write/say Magnesium</td>
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<td>QD (Latin for once daily)</td>
<td>Write/say once daily or daily</td>
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<td>QOD (Latin for every other day)</td>
<td>Write/say every other day</td>
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<td>QID (Latin for four times daily)</td>
<td>Write/say 4 or four times daily</td>
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<td>μg (microgram)</td>
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<td>QHS (Latin for at bedtime)</td>
<td>Write/say at bedtime</td>
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<td>HS (for half strength)</td>
<td>Write/say half-strength</td>
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<td>Trailing zero (X.0 mg)</td>
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<td>Lack of leading zero</td>
<td>ALWAYS use a zero before a decimal point (0.X mg)</td>
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V. Oral Presentations: How to WOW your audience
a. 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 . . .
b. Be confident: avoid too many uhs & ums. Do not second guess yourself. Even if you don’t feel confident, practice looking that way.
c. NEVER make up information. It is not safe for the patient, and you will get caught. Physicians respect an “I don’t know” much more than someone who feels the need to make up information.
d. Try to anticipate what your audience will want. If you don’t know, ask. Error on the side of too much information rather than not enough. 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.

f. Discuss your assessment and plan with a member of the team BEFORE you are expected to give your formal presentation.
g. 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 are significant for a temperature of 36.8, a blood pressure of 144/75, a heart rate of 95, and a respiratory rate of 14 with a room air oxygen saturation of 96%. He is pleasant and in no acute distress
His neck is supple and his JVP is at 8 cm
Chest exam is clear
Cardiac exam reveals a regular rate and rhythm with normal S1 and S2. No murmurs, rubs or gallops are heard
Abdominal exam was significant for the absence of bowel sounds, tenderness in the right lower quadrant, and some 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 appendicitis 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.*
PATIENT WRITE-UP FORM

CC:

HPI:

PPI:

PMH:
  MEDICAL:

SOCIAL:

Surgical:

Meds:

SH:

FH:

ROS:
PE:
  GEN’L:
    HEENT
    NECK
    LUNG
    CV
    ABD
    EXT
    NEURO
    DERM

DATA:

IN SUMMARY:

A/P:

  PROBLEM #1

  PROBLEM #2

  PROBLEM #3
**Medicine:** Example of a follow up note on a regular medicine clinic patient who presents to outpatient medicine clinic with a new concern

**Date**

**S:** Mrs. W is a 26yo woman complaining of “dark or bloody urine.” She was in her USOH until 1 month ago when she began experiencing dark urine generally in the morning or upon nocturnal awakening. She denies fevers, dysuria, oliguria, polyuria, abdominal trauma or surgical Hx. She also denies recent h/o long periods of travel, denies Family Hx of clotting d/o, and is not on birth control. She smokes 1 pack of cigarettes/wk, drinks EtOH 2x/wk, and is sexually active with 1 partner. Normal menses, regular, no metrorrhagia, menorrhagia, no pregnancies, no hx of UTIs or pyelonephritis.

**O:** Vitals: T:98.0  BP: 120/70  HR: 60  RR: 16

PE:
- General: appears stated age, no acute distress.
- Abdominal exam was remarkable for splenomegaly with no hepatomegaly, masses or cva tenderness. normal bowel sounds, non-tender, non-distended
- Extremities: no edema, no bruising, no purpuric lesions

**Labs:** Pending

**Impression:** Pt is a 26yo with 1 mo of early morning or nocturnal dark or bloody urine with an exam notable for hematuria and data notable for …. 

**A/P:**

1. **Hemoglobinuria:**
   - A: Ddx includes Paroxysmal Nocturnal Hemoglobinuria, Masses, infections, or stones in the ureter, kidney, or bladder. Splenomegaly and nocturnal hemoglobinuria suggest a potential hemolytic etiology that needs to be further investigated. Given the stable vital signs and lack of CVA tenderness, infections in the kidney are less likely.

2. **Splenomegaly:**
   - A: DDx of splenomegaly in this patient includes hemolytic process, primary blood disorder like lymphoma or lymphoproliferative disorder, portal hypertension, or infiltrative disease from infection, connective disease.
   - Plan: Abdominal imaging to further evaluate splenomegaly (US versus CT). Rest as above in problem #1.

**RTC in 1-2 days as this workup is completed to follow up or sooner if new symptoms arise such as fever, decreased urine output, jaundice.**
ED patient SOAP note example - Pulmonary Edema

S: Mr Leno is a 72yo veteran presenting to the ED visibly short of breath with several weeks of worsening SOB. He notes that he has had a mild cough productive of white sputum for 2 days and reports retrosternal chest pressure with strenuous exertion, but not while walking at normal pace. Pt feels SOB after walking 100ft, a marked deterioration from his USOH. He has had some difficulty sleeping at night, and has to prop himself up with two pillows. He reports a diet with frequent fast food, reporting eating a bucket of KFC the day before presenting at the ED. Pt also has a h/o smoking cigarettes at 1.5packs/day for 50yrs.

    PE: Gen: 72 y.o. male in moderate respiratory distress, posturing on the exam table.
    HEENT: moist mucous membranes.
    CV: Regular rate and rhythm, normal S1, S2 splits on expiration, S4 at the apex, with a non-displaced apical impulse. JVP 14cm Late peaking systolic murmur noted, radiates to the carotids.
    Extremities: 2+ pedal edema
Data: CXR and EKG pending

Impression: Pt is a 72yo presenting to the ED visibly SOB with a h/o 2 days of productive cough with white sputum and increasing dyspnea on exertion, exam notable for respiratory distress, bilateral inspiratory crackles, S4, split S2 on expiration, edema and elevated JVP.

1. dyspnea on exertion: The symptoms and physical exam findings, patient’s diet, smoking, use of pillows at night and SOB on exertion is suggestive of a progressive congestive heart failure. The presenting symptoms of white sputum, crackles, elevated JVP is suggestive of acute right-sided heart failure. Regular rate and Rhythm lowers the concern for acute MI. Other Ddx includes Bronchitis or Lung Cancer given the h/o smoking and Angina given his poor diet.

P: Admit Pt to medicine for observation and stabilization
    Obtain CXR, CBC, Chem7, EKG to evaluate for CHF, pneumonia or acute coronary syndrome. Culture Sputum sample to assess for infectious etiology, BNP and echocardiogram. Recommend treatment with diuretics lasix 40mg IV x1 now.
Neurology outpatient SOAP note example: Stocking Glove Neuropathy

S: Mr. Hansen is a 56-year-old M with complaints of tingling and numbness in his hands and feet (R>L) for the past 7 months. He says it feels like his feet are burning all the way up to his kneecaps, which makes it hard to walk. He has a 35 yr history of hypertension and a 27 yr history of hypercholesterolemia. He also has occasional double vision, decreased vision, and droopy eyelids at night with normalization by morning. He notes that he has not been able to achieve an erection for the past year. He has smoked 1.5 packs of cigarettes per day for 30 years and drinks a pack of beer a day and has been a vegan since his college days. He reports some polyuria and polydypsia, but denies polyphagia.

O: Vitals- T: 37.1, BP: 140/90, RR: 16-18, HR 97

Physical Exam:
Gen: 56 y.o. obese male no acute distress.
HEENT: PEERLA, No fundoscopic abnormalities
Pulm: Clear to auscultation bilaterally.
CV: RRR, Normal S1 and S2. No murmurs.
Extremeties: 2+ pulses in distal extremities. Several ulcers located on the plantar surface of his feet bilaterally.
Neuro: Strength 5/5 in bilateral lower extremities. DTRs symmetric 2+ knee jerks. Ankle jerks are absent bilaterally. Babinski negative bilaterally. Decreased pinprick, soft touch, vibratory, and position sense in the lower extremities bilaterally.

Impression: Mr Hansen is a 56yo presenting with a 7mo h/o burning and tingling in his distal extremities with a distal numbness and tingling (stocking glove).

A/P:
1. Neuropathy: Patient’s history and exam which exhibits a stocking glove, rather than a dermatomal distribution, with a negative Babinski suggests a Ddx including:
   - Type 2 DM associated neuropathy – common with obesity, HTN and Hypercholesterolemia, consistent with vision Sx and foot ulcers
   - B12 deficiency – more common among Vegans, but could also be secondary to EtOH dependency
   - Myasthenia Gravis/Hypothyroid – consistent with ptosis at end of the day
   - Heavy Metal or CO exposure – less likely due to Hx

P: Neuropathy - Obtain Labs: Chem20 including B12 and B6 to investigate vitamin deficiency, Fasting Glucose and hgba1c to assess for diabetes value greater than or equal to 6.5 favoring diabetes.

   Depending on results of labs, consider a tensillon test to r/o Myasthenia Gravis
   Counsel pt on diet and EtOH

2. HTN –
   A: Currently not well controlled htn. Stage 1 htn with goal for type 2 DM (being evaluated) is less than 130/80.
   P: will recheck BP at next appt. and consider antihypertensives depending on presence or absence of diabetes. (diagnosis of hypertension will require serial documentation of elevated bp on 3 visits). Counseling provided on exercise 3x / week for 20 minutes.
ED or Surgery SOAP note example – RLQ Pain

S: Ms. Anderson is a 21-year-old woman presenting with strong, steady, cramp-like pain in the right lower abdomen for the past few hours. The pain is exacerbated by movement, is a 7/10, and is getting worse by the minute. She was in excellent health prior to the onset of this pain. She has felt nauseated since waking up this morning and has vomited three times. Her emesis was bilious and non-bloody. Her stool has been loose for the past two days. Her last menstrual period was five weeks ago and she has recently had some vaginal spotting. Her periods occur every four weeks and usually last for 7 days. She takes oral contraceptive pills and uses condoms occasionally. She has had 5 sexual partners in the past month.

O: Vitals- T: 38.1, BP: 118/95, RR: 21-23, HR 100

Physical Exam:
Gen: 21 yo F in extreme pain, lying curled up on her side on the exam table.
Pulm: No tenderness, clear breath sounds bilaterally.
CV: RRR, Normal S1 and S2. No murmurs.
Abdomen: Soft, nondistended. +Bowel sounds. RLQ guarding and tenderness. Palpation of the LLQ elicits pain referred to the RLQ. With patient supine, raising her legs up in the air while flexing her hips elicits extreme pain.
GU : cervix non-tender, manual exam negative for masses

Data: Pending

Impression: Pt is a 21yo woman presenting with acute and severe RLQ pain on exam and by history with negative GU exam manually.

A/P:
1. Acute RLQ abdominal pain: Given the location, timing and severity of pain and the h/o sexual activity, late menses, and vaginal spotting, pt's ddx includes an ruptured vs. unruptured ectopic pregnancy, pregnancy with hemorrhage, herniation with intestinal strangulation and appendicitis.

P: Will perform pregnancy test and beta HCG levels to determine the hormonal nature of the d/o
UA, urine culture and consider CT scan vs. Transvaginal ultrasound to assess for tubal pregnancy vs. appendicitis
NPO, referral surgery consult
Surgery prep pending imaging and labs.
POM: Advanced Clinical Skills
Review Exam

Date: Group B: Thursday, 3/3/11
       Group A: Thursday, 3/10/11

Time & Location: 1:15pm – 2:15pm, LKSC room LK101
                 2:30pm – 5:05pm, LKSC rooms

Faculty: Ian Tong, MD and small group faculty

Session Goal(s)
1. Review the complete physical examination.
2. Review the chief complaint related focused physical examination.
3. Practice identification of heart sounds

Learning Objectives
At the end of the session the students will be able to:
1. Perform a focused physical exam related to specific organ systems
2. Perform a complete physical examination from head to toe
3. Complete heart sounds quiz computer program and review answers

Key Words:
Please review the key words for the past two quarters. They will include terms related to the Cardiac, Pulmonary, Abdominal, Endocrine, Neurologic, Dermatologic, Musculoskeletal and Renal systems.

Special Instructions:
• Bring your stethoscope, tuning forks, and any other tools necessary to perform a complete physical exam to class.
• Casual dress will suffice. Students will be performing the entire physical exam on one another (with the exception of breast, rectal, groin and urogenital exams).

Session Summary:
No large group teaching rounds for this session. Students will begin in small groups and participate in two stations. (A) Station A: Heart Sounds Quiz: students will take a heart sounds quiz and review their answers in-class. (B) Station B: Physical Exam Station: Students will perform physical exams for two or three rotations at this station.

Required Reading Assignment:
• Bates Guide to the Physical Examination, 10th edition
• Please take care to review any portions of the exam that you have struggled with or that you typically forget.
• Review the Physical Exam checklist and feel free to bring to class for reference.
Complete Physical Examination Checklist
[exam maneuvers grayed out are optional; please demonstrate if time permits]

**Wash Hands**

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<thead>
<tr>
<th>Done</th>
<th>Inadequately Done</th>
<th>Not Done</th>
<th>Comments</th>
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**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. Respiratory/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.
### 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.

**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)

<table>
<thead>
<tr>
<th>Cranial Nerve XII (Hypoglossal)</th>
<th>Stick out tongue - deviation, atrophy</th>
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<tbody>
<tr>
<td>Inspect Wharton's (submandibular) and Stenson's (parotid) ducts</td>
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</tr>
<tr>
<td>Inspect posterior pharynx and tonsillar area. Use tongue blade to gently depress tongue, if necessary. Ask patient to say &quot;ah&quot;.</td>
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<tr>
<td>Palpate gums, tongue, floor of mouth (remember to glove)</td>
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<tr>
<td>Palpate TMJ (remember to de-glove)</td>
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<tr>
<td>Cranial Nerve VII (Facial)</td>
<td>Muscles of face (raise eyebrows, show teeth, smile, frown, close eyes) taste ant. 2/3 tongue (not necessary to test)</td>
</tr>
</tbody>
</table>

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

### Neck: Lymph, Neurological, Musculoskeletal

#### 1. Neck (Anterior)

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<tr>
<th>Inspect:</th>
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<tr>
<td>• For symmetry</td>
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<tr>
<td>• Trachea in midline</td>
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<tr>
<td>• Thyroid: Ask patient to swallow and observe for thyroid enlargement (offer glass of water if needed).</td>
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<tr>
<th>Palpate:</th>
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<tr>
<td>• Lymph nodes in anterior triangle, posterior triangle, post-auricular, occipital, pre-auricular and supraclavicular area (may be done from behind).</td>
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<tr>
<td>• Trachea</td>
</tr>
<tr>
<td>• 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]</td>
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| 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>
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<tbody>
<tr>
<td>• Respiratory Pattern - rate, rhythm, depth, effort</td>
</tr>
<tr>
<td>• Thoracic structures including chest diameter, shape, symmetry, deformities</td>
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</tbody>
</table>
Palpate:
- Bony structures for tenderness
- **Respiratory excursion**: 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.
- **Tactile fremitus**: Ask patient to say "99" 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.

Percuss:
- **Resonance**: 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.

Cardiovascular

Auscultate:
- **Breath sounds**: 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 their 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.
- **Egophony**: Ask the patient to say "eee..." out loud; auscultate both sides. Normal is muffled "eee..."; abnormal is "ay", or E to A egophony. Usually done if history or exam suggests pulmonary concerns. May demonstrate if time permits.
- **Whispered pectoriloquy**: Asks the patient to whisper "99" or "1-2-3"; 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.

2. Chest Anterior

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

Inspect:
- Respiratory pattern

Palpate:
- Bony structures for tenderness
- **Respiratory excursion** (as done in posterior chest)
- **Tactile fremitus** (as done in posterior chest)

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 "eee....".
- **Whispered pectoriloquy**: Ask patient to whisper "99" or "1-2-3".
**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

**Abdomen**

**Inspect:** Abdominal wall and flanks for contour, masses, and movements

**Auscultate** prior to palpation or percussion; one quadrant on skin for bowel sounds
Percuss:
- **Liver** along right mid-clavicular line to determine liver span. Normal span at right mid-clavicular line is 6-12 cm
- **Splenic borders** - In lowest intercostal space in left anterior axillary line, first percuss in full expiration and then in full inspiration.
- **All four quadrants**, including above symphysis for bladder distention.
- For shifting dullness (done if history or exam suggestive of ascites)
- For fluid wave (done if history or exam suggestive of ascites)
- Costovertebral angles for tenderness (can be done here or with pulmonary exam)

Palpate:
- **All four quadrants** for tenderness, mass, or rigidity; both superficial and deep.
- **Liver** - for enlargement, tenderness, consistency
- **Spleen** - using bimanual technique
- **Kidneys** - using bimanual technique
- **Inquinal areas**
- **Aorta** - estimate size

Musculoskeletal Exam Checklist

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

Inspect for symmetry, deformity, redness, swelling or signs of effusion, atrophy, or skin changes and palpate for tenderness, crepitation, or warmth.

Inspect:
- Fingers (DIP’s), (PIP’s)
- Hands (MCP’s)
- Wrists
- Elbows
- Shoulders (Sternoclavicular, AC joints, biceps tendons)
- Neck
- TMJ
- Spine
- Toes
- Feet
- Ankles
- Knees for signs of effusion (ballottement, Bulge and Balloon sign)
- Hips

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.
### 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 (20); 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**

### Deep Tendon Reflexes: (Use reinforcement techniques as needed. Test 4)

- Biceps (C5, 6)
- Brachioradialis (C5,6)
Triceps (C6,7,8)  
Patellar (L2,3,4)  
Ankle (Primarily S1, S2)  
Use reflex hammer appropriately  

**Superficial Reflexes:**  
Abdominal (T8-10 above); (T10-12 below) (time permitting)  
Cremasteric (Students may explain test.)  

**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);  
  - Planter 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
Clinical Practicum Sessions
Clinical Practicum

Dates: Alternate Thursdays
September 2 - November 18, 2010
Jan 20, 2011 - March 10, 2011
Time: 1:00-5:00 pm or 1:30-5:30 pm
Location: Various local hospitals and clinics
Responsible Faculty: Lisa Shieh, MD, PhD, Jeff Chi, MD, and Preetha Basaviah, MD
TA: Chris Hemond (Q4) and Jonathan Kleinman (Q5)

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:
   ✓ Perform physical examinations under observation of a preceptor
   ✓ Complete a learning plan and online assignments
   ✓ Submit two patient H&P write-up assignments in Q4 and one in Q5
   ✓ Submit one SOAP note write-up in Q5
   ✓ Complete end-of-practicum preceptor evaluation on E-Value
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. Preetha Basaviah and/or Tomiko Nguyen, if there are concerns about site rules, regulations or student responsibilities.

Required activities for the clinical practicum
During the practicum, students should perform the following activities:

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 week. Students must perform at least 3 full history and physicals (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.

Practicum Handbooks
Students received a Clinical Practicum Student Guide: a pocket-sized book that includes the guidelines and requirements for the clinical practicum, additional resources that will serve as a quick reference for you during the practicum sessions, and a practicum handbook.

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 (11/11/10 or 11/18/10), 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.
Assignments

- Submit assignments online via Coursework, including patient write-ups and Learning Plan
- Write-ups will be returned to students for review, and is 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

Attendance

**Students are expected to attend all scheduled clinical practicum sessions.** Absences must be cleared with the preceptor, the course director, Dr. Preetha Basaviah, and Tomiko Nguyen, year 2 curriculum manager. Arrangements for making up missed sessions are at the preceptor’s discretion.

**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.

**E4C CISL Videotaping Project**

**Goals and Objectives**

The E4C faculty have designed an important complement to the Clinical Practicum curriculum for 2009-2010, using mini-video cameras and pre-defined learning points for three domains:

a) Improve physical examination mechanics at the bedside, especially for patients with limited mobility

b) Foster students’ comfort, confidence, and skills in addressing patients who present with pain, fear, sadness, or non-engagement

c) Facilitate clinical reasoning skills in:
   1) linking presenting symptoms to key physical exam maneuvers and findings
   2) compiling a succinct, prioritized problem list
   3) performing a focused, concise oral presentation

Students assigned to Stanford Hospital and Clinics for the Clinical Practicum will participate in this program on a pilot basis with an opt-out option. We plan to expand the training and techniques to all students in the months to come.
# 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  
lshieh@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).

**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  
lshieh@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.

## Outpatient Locations

Various internal medicine and family practice clinics and inpatient sites in the peninsula area participate as practicum sites.
POM: Clinical Practicum Session #7
Focused H&P with Differential Diagnosis
Group A: 1/20/11  Group B: 1/27/11

Session Learning Objectives:
Students should be able to:
- Develop history-taking and physical exam skills. Spend no more than 30 minutes on your history and physical exam.

Session Activities and Advice:

1.) Perform a complete history and relevant physical examination (a complete exam of the system related to the chief complaint, and at least a few components of the remaining organ systems), observed by your preceptor in 30 minutes or less. Have the preceptor complete the physical exam checklist if possible, and provide feedback to you.

2.) If you are able to determine the chief complaint from your patient assignment sheet, it may be helpful to think of the type of questions you will want to ask ahead of time.

3.) One of the session goals is to increase your efficiency. Some patients may want to focus most of their time on a specific part of their history when you may want information on another part. Think carefully of ways to guide the interview so that you are able to obtain all the information you need. This may be difficult to do without feeling abrupt as if you are cutting off your patient. Consider asking your preceptor or students for tips on redirecting patients so that you stay on track.

4.) Meet one-on-one with your preceptor to receive feedback on your practicum experience and review your revised your learning plan.

Assignments:
- Prepare your revised learning plan and submit this to your preceptor via coursework (Assignments section) and/or other method your preceptor requests (e.g. email, submit paper copy in person) before this session
POM: Clinical Practicum Session #8
Assessment and Plan
Group A: 2/03/11  Group B: 2/10/11

Session Learning Objectives:
Students should be able to:
- Practice taking a medical history, while maintaining and advancing your communication skills.
- Practice and improve your physical examination skills
- Decrease the time of your history and physical exam to less than 30 minutes.

Session Activities and Advice*:
1.) Perform a full medical history (HPI, PMH, SH, FH, HRB, and ROS).
2.) Continue to advance presentation skills with a full H&P presentation
3.) If you are having difficulty with limiting your encounter to 30 minutes, consider combining your ROS questions with your physical exam. It may be difficult for some to keep track of what questions they have asked and what they have examined, but it is a useful technique that many physicians use.
4.) Try not to repeat your ID or Chief Complaint as your Impression. They can often sound similar, but remember that the Impression should reflect your interpretation of the patient's condition after you have synthesized the information you have gathered. The Impression statement (“In summary…”) includes only the most relevant historical, physical exam, and lab elements in one to two brief sentences.
5.) The Assessment and Plan is a separate section that comes after the Impression. There should be an assessment and plan for EACH problem. There are different styles of describing the plan. One example is provided below:

<table>
<thead>
<tr>
<th>Impression:  In summary, Mr M is a 60 year old male with a history of hyperlipidemia, CAD s/p prior MI and 2 months of worsening exertional tolerance due to chest discomfort who presents today with 20 minutes of severe chest pressure and shortness of breath. Exam is notable for high blood pressure and an S4; data is notable for an EKG for tachycardia.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain: Patient is currently free of chest pain. Symptoms are likely secondary to ischemia, but PE should also be considered given his overseas flight two days ago. Other possibilities include pneumonia but this is less likely given no fever and normal wbc. Musculoskeletal pain or costochondritis is possible but the exertional nature and cardiac risk factors make unstable angina one of the most concerning priorities.</td>
</tr>
<tr>
<td>-Check EKG</td>
</tr>
<tr>
<td>-Obtain cardiac enzymes</td>
</tr>
<tr>
<td>-Schedule stress test tomorrow morning.</td>
</tr>
<tr>
<td>-Consider CT scan for PE if cardiac workup is negative</td>
</tr>
</tbody>
</table>

6.) Note that sometimes it is easier to organize the plan by symptoms. Other times it is easier to organize by diagnoses. In extremely complicated patients, the plan is organized by organ systems. However, this is generally reserved for patients who are hospitalized in the intensive care unit.

*Please refer to Advanced Clinical Skills session on “Oral Presentations” from Q4: Thursday 9/2/10 and 9/9/10

Assignments:
You will complete a full H&P write-up (with differential diagnosis, assessment and plan) based on this week’s patient. Prior to your next clinical practicum session (2/17/11 for Group A and 2/24/11 for Group B), submit this write-up to your preceptor via coursework (Assignments section) and/or other method your preceptor requests (e.g. email, submit paper copy in person).
Session Learning Objectives:
Students should be able to:

- Practice taking a medical history, while maintaining and advancing your communication skills
- Practice and improve your physical examination skills
- Continue limiting the time of your history and physical exam to less than 30 minutes
- Learn how to present and write in SOAP format

Session Activities and Advice:
1.) Perform a full medical history (HPI, PMH, SH, FH, HRB, and ROS).
2.) You will learn to present in SOAP note format and present your patient in this format.
3.) Complete a sample SOAP note
4.) The SOAP note is primarily a daily update to the H&P. The SOAP note generally begins with any events since the last note was written (typically 24 hours ago), followed by vitals, the exam, and any new labs or tests. The focus of the SOAP note is the Assessment and Plan. The Assessment can change day to day as a patient gets better (or worse). It can also change if the diagnosis is changed or reconsidered. When you are a 3rd year, remember that your problem list should continue to be updated in your SOAP notes each day, and the plan should also change every day as progress is made.
5.) SOAP note presentations are much shorter than a full H&P. They typically do not last more than ~5 minutes. Like the note, the focus is on the Assessment and Plan since it is presumed that the patient has already been presented and everyone is familiar with their HPI.

Assignments:
- Complete a SOAP note write-up to be handed in during your next practicum session (3/3/11 for Group A and 3/10/11 for Group B),
- You will obtain a focused history and physical exam on next session’s patient, and present in a concise manner as you will be expected to for your year-end practical exam with standardized patients.
Session Learning Objectives:
Students should be able to:
- Obtain a focused history based on chief complaint
- Perform a focused physical exam
- Present the above in a concise manner

Session Activities and Advice:
1) Spend no more than 30 minutes on a focused history and physical exam.
2) Spend no more than 10 minutes presenting a focused H&P including assessment and plan based on the patient seen that day
3) Review your SOAP note from 2/17/11 or 2/24/11 practicum session
4) You will meet one-on-one with your preceptor and receive feedback on your practicum experience this quarter. Encourage your preceptor to provide feedback that will be helpful for you next year, and to identify areas to focus improvement while on rotations.
5) Please also provide preceptor feedback if there are things you think went particularly well or things that could be improved. Our preceptors are always looking to make practicum a more positive learning experience!
6) Remember to thank your preceptor and TA’s for working with you this quarter. Their hard work is what makes this program run!

Assignments:
-Congratulations on completing Practicum!
-Get ready for rotations!
Clinical Reasoning Sessions
# Clinical Reasoning Sessions

<table>
<thead>
<tr>
<th>Dates:</th>
<th>Tuesdays: 1/18; 1/25, 2/1; 2/8; 2/15; 2/22; 3/1; 3/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>1:15-5:05 pm</td>
</tr>
<tr>
<td>Location:</td>
<td>LKSC lecture room LK120 / LKSC Seminar Rooms</td>
</tr>
<tr>
<td>Faculty:</td>
<td>Clinical Reasoning Small Group Preceptors</td>
</tr>
<tr>
<td>TA:</td>
<td>Sarah Jane Selig (<a href="mailto:sselig@stanford.edu">sselig@stanford.edu</a>)</td>
</tr>
</tbody>
</table>

**About the clinical reasoning sessions**

Clinical Reasoning Sessions occur each Tuesday afternoon from 1:15pm to 5:05pm. Afternoons sometimes 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 coursework.stanford.edu 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.

**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, and
3. Expand your clinical knowledge base

You will learn to effectively gather, organize, synthesize, interpret and communicate clinical information. We have selected common clinical problems in order to start the development of a solid foundation of clinical thinking upon which to build in future years—in clinical clerkships, residency and practice.

**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.

Absences and Make-up Work
1) The student must notify their clinical reasoning preceptor and either Dr. Basaviah or Tomiko Nguyen-Trung in advance.
2) Students must review the lecture video on coursework, once available.
3) 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.
Session Learning Objectives:
Students will be able to:
1. Understand the broad differential diagnosis of the patient with confusion or an altered level of consciousness
2. Evaluate and initiate the diagnostic workup and therapeutic treatment options for the patient with an altered level of consciousness
3. Distinguish the numerous infectious etiologies of the acute confusional state from other causes

Required Online Assignment:
• Course I - Communication: (PEN101) Giving Bad News

Reading Assignment:
• Young GB. Stupor and coma in adults. UpToDate 2009.  
  (http://www.uptodate.com.laneproxy.stanford.edu/online/content/topic.do?topicKey=genneuro/7735&selectedTitle=1~150)  
  (http://www.uptodate.com.laneproxy.stanford.edu/online/content/topic.do?topicKey=cns_infe/2328&selectedTitle=1~150)

Recommended Reading:
• Harrison's Textbook of Medicine, Chapter 26: Confusion and Delirium  
• Harrison's Textbook of Medicine, Chapter 268: Coma  
• Harrison’s Textbook of Medicine, Chapter 376: Meningitis, Encephalitis, Brain Abscess, and Empyema  
• Harrison’s Textbook of Medicine, Chapter 377: Chronic and recurrent meningitis  

Session Activities:
A clinical vignette will be presented in stages; questions will guide the discussion and emphasize the key learning points. The assignments for this week are:
(1) to prepare a differential diagnosis to be turned in during class;
(2) to prepare a discussion of an issue related to this week’s case for next week’s session. See case handouts in class for details.
Session Learning Objectives:
Students should be able to:
1. Construct a differential diagnosis for a patient presenting with acute mental status changes
2. Identify an appropriate diagnostic strategy when a hospitalized patient experiences acute confusion
3. Interpret results of laboratory tests
4. Discuss initial management and follow-up for the patient who experiences confusion

Reading Assignment:

Recommended reading:

Session Activities:
A clinical vignette will be presented in stages; questions will guide the discussion and emphasize the key learning points. The assignment for this week is to prepare a differential diagnosis to be turned in during class.
Session Learning Objectives:
Students will be able to:
1. Interpret results of laboratory tests
2. Suggest additional data that would be helpful in reaching a final diagnosis
3. Describe the study methodology useful in identifying the source of a local outbreak of illness in a community

Reading Assignment: None

Session Activities:
(1) A clinical vignette will be presented in stages. Questions will guide the discussion and emphasize the key learning points.
(2) Teaching rounds will be held after the small group session.
(3) There is no assignment for this week.
POM: Clinical Reasoning Session  
Teaching Rounds and Small Group  
Session #13: 2/8/2011

Session Learning Objectives:  
Students will be able to:  
1. Understand the broad differential diagnosis of the patient with headache  
2. Evaluate and initiate the diagnostic workup and therapeutic management plan for patients with a headache  
3. Compare and contrast the clinical presentation, etiologies, diagnostic workup, and therapeutic management of meningitis and encephalitis  
4. Understand the cost-effectiveness of medical decision-making

Reading Assignment:  
• Stern SDC, Cifu, AS, Altkorn D: Symptom to Diagnosis, Chapter 15: Headache

Recommended Readings:  
• Harrison’s Textbook of Medicine, Chapter 376: Meningitis, Encephalitis, Brain Abscess, and Empyema. (http://www.accessmedicine.com.laneproxy.stanford.edu/content.aspx?aid=2906668)

Session Activities:  
A clinical vignette will be presented in stages; questions will guide the discussion and emphasize the key learning points. The assignment for this week is to prepare a differential diagnosis to be turned in during class.

Next week: Mid-Quarter Clinical Reasoning Assessment
Session Learning Objectives:
Students will be able to:
1. Interpret the report of a history physical examination of a patient
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

Reading Assignment: None

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.
POM: Clinical Reasoning Session  
Teaching Rounds and Small Group  
Session #15: 2/22/2011

Session Learning Objectives:  
At the end of this session students will be able to:  
1. Interpret the report of a history and physical examination of a patient  
2. Understand and evaluate the causes of fatigue in adults  
3. Generate a problem list and a differential diagnosis for the primary condition  
4. Suggest additional data that would be helpful in reaching a final diagnosis  
5. Interpret results of laboratory tests  
6. Evaluate the causes of: anemia, hypercalcemia, elevated serum creatinine, elevated serum proteins

Reading Assignment:  

Recommended Reading:  
• Fosnocht KM, Ende J. Approach to the adult patient with fatigue. UpToDate 2009.  
  (http://www.uptodate.com.proxy.stanford.edu/online/content/topic.do?topicKey=genr_med/5648&selectedTitle=1~150)

Session Activities:  
A clinical vignette will be presented in stages; questions will guide the discussion and emphasize the key learning points. The assignment for this week is for students to write and submit a differential diagnosis of the case based on what is known at the end of part 1..
Session Learning Objectives:
Students will be able to:
1. Understand the major etiologies of fever in an adult patient
2. Know how to conduct a history and physical examination for an adult patient with fever
3. Construct an appropriate plan for diagnostic evaluation of an adult patient with fever

Reading Assignment:
• Bor DH. Approach to the adult with fever of unknown origin. UpToDate 2008. (http://www.uptodate.com.laneproxy.stanford.edu/online/content/topic.do?topicKey=othr_inf/19230&selectedTitle=1~150&source=search_result)
• Bor DH. Etiologies of fever of unknown origin in adults. UpToDate 2008. (http://www.uptodate.com.laneproxy.stanford.edu/online/content/topic.do?topicKey=othr_inf/20191&selectedTitle=2~55&source=search_result)

Session Activities:
A clinical vignette will be presented in stages. Questions will guide the discussion and emphasize the key learning points. The assignment for this week is for students to write and submit a differential diagnosis of the case based on what is known at the end of part 2.
Session Learning Objectives:
Students will be able to:
   1. Interpret the report of a history and physical examination of a patient
   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 laboratory tests

Reading Assignment:

Session Activities:
A clinical vignette will be presented in stages; questions will guide the discussion and emphasize the key learning points. There is no assignment for this week.

Next Week: Mini Clinical Performance Examination (Mini-CPX)
ED Shifts
ED Shifts during Q5

Emergency Department (ED) shifts provide the opportunity to apply newly learned skills to clinical situations. Now that you have completed your Q4 EMED sessions, you are required to complete at least two 8-hour shifts in the ED, which may be done any time from November 20, 2010 until the end of winter quarter (March 20, 2011). Go to coursework.stanford.edu (“Sign up” on left) to assign yourself to your two shifts.

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 aggressive and to hunt for procedures, but don’t be in the way and don’t 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. In order to maximize your learning experience, we ask that you do not overlap with other students.

You may drop, add or change shifts on the course calendar 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). 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 the charge nurse in the ED (650-723-7337).

Before you head to your EMED shift, please look over the part of the syllabus that discusses what to expect during your shift and review the procedure notes in your syllabus and the lecture powerpoints on Coursework.

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 syllabus and on coursework) The Summary Report should be filled out completely and initialed by the nurse mentor, resident, or attending physician. There is also a section for your comments on the back. When you have completed both shifts, please return the form to Tomiko Nguyen-Trung at MSOB x3c57.

WHAT TO WEAR:

Class Sessions: Dress for class should be comfortable and casual. On those days that we are doing casting, please wear shorts and a T-shirt. On the days we are drawing blood (peripheral venipuncture and arterial puncture), please wear old clothes.

Emergency Department Shifts (During Q5): Name tags (with a piece of red tape on the bottom left corner) must be worn during the rotation. Again 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!
ADDITIONAL INFORMATION FOR SHIFTS IN THE EMERGENCY DEPARTMENT

1. **CLOTHING:** Appropriate clothing (See WHAT TO WEAR) and your name-tag are mandatory.

   Additionally, place a red piece of tape 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, i.e., A PROCEDURE HUNTER.

   ![Lee V. Ditti](image)

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, etc.).

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 turn them into Tomiko x3c57)

   **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 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 are 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 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 occurs. Identify yourself to the attending before the code arrives and make yourself available to do compressions- you will learn a lot and they will 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 do not feel comfortable with a patient, leave. REPORT ALL NEEDLE STICKS AND FLUID CONTACT WITH MUCOSAL SURFACES AND OPEN WOUNDS TO THE ATTENDING PHYSICIAN IMMEDIATELY.
- And most importantly, enjoy yourselves and have a good shift!!
Introduction to the Management of the Ill Patient (IMIP)
Introduction to the Management of the Ill Patient (IMIP)

**Date:** Friday 02/04/2011, Monday 02/07/2011, Wednesday 02/09/2011, Monday 02/14/2011, and Wednesday 02/16/2011  
**Times:** 10am-noon (on 2/9 and 2/16 only), 1-3pm, 3:30p-5:30p  
**Location:** LKSC Immersive Learning Center (ground floor)  
**Responsible Faculty:** Rebecca Smith-Coggins, MD

**About the IMIP session**  
Students enrolled in EMED are required to complete one IMIP session. During this session, students will participate in a medical simulation room in which they will be presented with different scenarios created through using a controlled dummy serving as the patient. The students will play different roles such as the doctor, nurse, etc. in order to assess problems presented in each scenario, and will debrief with the attending faculty member.

**Goals for the IMIP session**  
Students will be able to recognize and manage patients with potentially life-threatening pathophysiologic derangements, including hypotension, shock and cardiac arrest.

**Learning objectives for the IMIP session**  
At the end of the session the students will be able to:  
- Recognize some patients with potentially life-threatening conditions  
- Apply knowledge of anatomy, physiology, pathophysiology and pharmacology to the management of these conditions  
- Develop a differential diagnosis and treatment options for various clinical presentations

**Student roles and responsibilities**  
**Attendance**  
- Students are required to attend and sign in for your scheduled IMIP session  
- Absences must be cleared with Dr. Rebecca Smith-Coggins and the POM course director, Dr. Preetha Basaviah  
- **Failure to attend your session and complete the above requirements prevents the student from passing the course**
Nutrition Online Modules
Nutrition Online Modules

Dates: January 3 – March 20, 2011
Location: coursework.stanford.edu
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 Sunday, March 20, 2011 at 11:59 pm. 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 (Sunday, March 20, 2011 at 11:59 pm). The following are the on-line nutrition modules to complete:

- Unit 9. Nutrition Modifications for Cancer Therapy
- Unit 10. Enteral and Parenteral Nutrition Therapy
- Unit 11. Contemporary Trends
Standardized Patient Assessment: MINI-CPX
Standardized Patient Assessment
Mini-CPX

| Dates: | Monday March 14, 2011, Tuesday March 15, 2011, or Wednesday March 16, 2011 |
| Time: | A 4-hour block of time in either the morning or afternoon |
| Location: | LKSC Immersive Learning Center (ground floor) |

Session activities and learning goals:
The Mini-CPX is a 4-hour inter-station comprehensive assessment composed of a combination of standardized patient encounters and computer-based exercises. The goals of this exercise are to evaluate your history and physical examination skills, communication (oral presentation) and patient interaction skills, clinical reasoning, and overall knowledge. This assessment is cumulative, so the best preparation is to have been actively prepared and participating for your sessions in POM throughout the first and second years of medical school.

Just as clinical reasoning cases, exams, teaching rounds, clinical practicum, advanced clinical skills, and EMED have incorporated multiple aspects of the course, so too will this assessment. Aspects have ranged from ethical/policy/quantitative medicine/EBM aspects of cases to specific questions about physical examination findings, interpretation of data (for example, laboratory data, EKGs, imaging studies, micro), problem lists, and initial assessment/plan.

You will be assigned to one of six 4-hour time slots over the above listed three days. There will be 4 stations, and each station is 22 minutes.

The mini-CPX is an assessment independently created, conducted by the Standardized Program that is directed by Dr. Drew Nevins. POM prepares the students with the clinical skills and Stanford SOM includes this assessment as part of final completion criteria for POM. Furthermore, the medical school requires that students successfully complete and pass mini-CPX (passing grade >65% or >at least 2 standard deviations below the class mean) prior to entering clerkships. When a student does not pass, he or she is required to develop and successfully complete a remediation plan with the E4C advisor in conjunction with POM prior to entering clerkships.

Session learning objectives:
Students will be able to:
1. Take a focused history and perform a focused physical examination in a limited amount of time;
2. Communicate clearly with your patients and build rapport;
3. Synthesize relevant patient information;
4. Describe the management and treatment plans for your patients;
5. Interpret relevant data;
6. Perform a clear oral presentation to a faculty member.

Key words: Assessment, Differential diagnosis, Management plan, Treatment plan, Communication skills

Preparation: Active preparation and participation for your sessions in POM throughout the first and second years of medical school.
Evaluation Forms
I. Clinical Practicum Evaluation Forms (3)

(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 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.

<table>
<thead>
<tr>
<th>MEDICAL INTERVIEW</th>
<th>How often did you directly observe the student do a medical interview?</th>
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<tbody>
<tr>
<td></td>
<td>If you feel insufficiently able to judge, please check here ______</td>
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<tr>
<td><strong>Below Expectations</strong></td>
<td>Often disorganized, misses key information, inaccurate, not well focused. Problems not well characterized.</td>
</tr>
<tr>
<td><strong>Meets Expectations</strong></td>
<td>Usually thorough, reasonably organized, usually accurate. Addresses pertinent positives, negatives and psychosocial issues in a logical manner. Detects most findings.</td>
</tr>
<tr>
<td><strong>Exceeds Expectations</strong></td>
<td>Consistently comprehensive, accurate, well organized. Addresses issues in a logical and insightful manner. Elicits subtle findings.</td>
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Summative Comments (including descriptive examples):

<table>
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<tr>
<th>PHYSICAL EXAMINATION</th>
<th>How often did you directly observe the student do a physical examination?</th>
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<td>If you feel insufficiently able to judge, please check here ______</td>
</tr>
<tr>
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<tr>
<td><strong>Exceeds Expectations</strong></td>
<td>Consistently comprehensive, accurate, well organized. Elicits subtle findings.</td>
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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>
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<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
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<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, 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>
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**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 ______

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<tr>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
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<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>
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**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 ______

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<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
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<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>
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Summative Comments (including descriptive examples):

## PROFESSIONALISM

Collegiality, initiative, dependability, attitude
If you feel insufficiently able to judge, please check here ______

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<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
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<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>
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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: ___________________________

<table>
<thead>
<tr>
<th>(1) Preceptor availability and time spent teaching</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<tr>
<th>(2) Preceptor quality of teaching</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<tr>
<th>(3) My preceptor was a role model for effective patient care.</th>
<th>Not Applicable / Unable to rate</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<th>(4) My preceptor was compassionate and caring toward patients.</th>
<th>Not Applicable / Unable to rate</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tr>
<th>(5) Feedback: Quantity</th>
<th>Not Applicable / Unable to rate</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>(I received sufficient amount of feedback from my practicum preceptor.)</td>
<td>0</td>
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<td>5</td>
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<th>(6) Feedback: Quality</th>
<th>Not Applicable / Unable to rate</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>(The feedback I received from my practicum preceptor was helpful and substantive.)</td>
<td>0</td>
<td>1</td>
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<tr>
<th>(7) Direct Observation</th>
<th>Not Applicable / Unable to rate</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tr>
<td>(There was sufficient direct observation by my preceptor when I was working with patients, conducting histories, physical exams, etc.)</td>
<td>0</td>
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<td>5</td>
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<tr>
<th>(8) Overall rating of the clinical practicum preceptor</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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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.
(c) How will I be evaluating my clinical practicum site via E-Value?

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

Clinical Practicum Site: _____________________________

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

<table>
<thead>
<tr>
<th>(1) Orientation</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<table>
<thead>
<tr>
<th>(2) Practicum goals: Communication</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>(How well were practicum goals communicated?)</td>
<td></td>
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<tr>
<th>(3) Organization (of the practicum)</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<td>2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(4) Patient interviewing</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Effectiveness of the clinical practicum in improving your patient interviewing skills)</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

<table>
<thead>
<tr>
<th>(5) History-taking</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Effectiveness of the clinical practicum in improving your history-taking skills)</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<table>
<thead>
<tr>
<th>(6) Physical Examination</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Effectiveness of the clinical practicum in improving your physical examination skills)</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
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<table>
<thead>
<tr>
<th>(7) Case write-ups</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Effectiveness of the clinical practicum in improving your case write-ups)</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
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<table>
<thead>
<tr>
<th>(8) Common problems</th>
<th>Not Applicable / Unable to rate</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Effectiveness of the clinical practicum in exposing you to a variety of common problems)</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>(9) Medical literature</td>
<td>Effectiveness of the clinical practicum in improving your ability to interpret and apply literature to patient care</td>
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<tr>
<td>Not Applicable / Unable to rate</td>
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<td>Very Good</td>
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<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(10) Learning Plan</th>
<th>Helpfulness of the preceptor reviewing my learning plan with me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Unable to rate</td>
<td>Poor</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(11) Activities</th>
<th>This clinical practicum offered meaningful, educationally-valuable activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Unable to rate</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(12) Overall rating of the clinical practicum site</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable / Unable to rate</td>
<td>Poor</td>
</tr>
<tr>
<td>0</td>
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</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.

(1) Please comment (positive or negative) on any aspects of your experience in this clinical practicum site.
(e.g., POM staff, site preceptor, distance to site/transportation, Learning Plan, Learning Journal)

(2) Suggestions for how to improve the clinical practicum.
(e.g., POM staff, site preceptor, distance to site/transportation, Learning Plan, Learning Journal)
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>
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</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>Often does not meet expectations</td>
<td>Usually meets all expectations</td>
<td>Consistently meets all expectations</td>
</tr>
</tbody>
</table>

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

**ACADEMIC**

1. **(1) Improvement over course**

<table>
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</tr>
</thead>
<tbody>
<tr>
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<td>Exceeds Expectations</td>
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2. **(2) Attendance**

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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1 to 3 = Below Expectations</th>
<th>4 to 6 = Meets Expectations</th>
<th>7 to 9 = 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 rationales. 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.</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>

<table>
<thead>
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4. **(4) Fund of Knowledge:**
*Demonstrate knowledge of core topics and resourcefulness in using current technologies to find information*

<table>
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<th>7 to 9 = 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</td>
<td>Consistently demonstrates wide-ranging understanding of pathophysiology, diagnosis, and management.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
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</table>
a variety of sources; regularly uses Medline searches, evidence-based medicine and current technologies to answer patient driven questions.

<table>
<thead>
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<th>1</th>
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**INTERPERSONAL**

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

<table>
<thead>
<tr>
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<th>4 to 6 = Meets Expectations</th>
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</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; 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>
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**Overall Performance Rating**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td>Fail (-)</td>
<td>Marginal Pass (+)</td>
<td>Pass (+)</td>
</tr>
</tbody>
</table>

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>
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<td></td>
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</tbody>
</table>

CIRCLE ONE NUMBER IN EACH ROW

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

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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>1. Learning climate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Showed enthusiasm for topic and learners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Involved learners; encouraged participation</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>
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<tr>
<td>2. Control of session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Adapted his/her leadership style to educational purpose</td>
<td></td>
<td></td>
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<tr>
<td>*Used appropriate pace of session</td>
<td></td>
<td></td>
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<tr>
<td>*Focused the session; set an agenda</td>
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<tr>
<td>3. Communication of goals</td>
<td></td>
<td></td>
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<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>
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<tr>
<td>4. Promoting understanding and retention</td>
<td></td>
<td></td>
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<tr>
<td>*Was well prepared; material was organized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Provided assignments and readings that were relevant to session</td>
<td></td>
<td></td>
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<tr>
<td>*Provided handouts that were concise, relevant, helpful</td>
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<td>*Fostered active learning</td>
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</table>
| 5. Evaluation | * Observed learner performance  
* Asked recall questions, synthesis questions, and application questions  
* Asked learners to self-reflect |
| 6. Feedback | * Gave behavioral feedback  
* Offered suggestions for improvement  
* Developed action plan with learners |
| 7. Promoting self-directed learning | * Asked learners to define their own goals and needs  
* Modeled use of resources or provided resources |
IN RECOGNITION

OF THE CONTRIBUTION OF

TO THE TEACHING OF STANFORD MEDICAL STUDENTS.

BY THIS GENEROUS CONTRIBUTION OF YOUR TIME AND YOUR WILLINGNESS TO SERVE THE NEEDS OF OTHERS, YOU HAVE DEMONSTRATED GENEROSITY OF SPIRIT, HUMANITY, AND COMPASSION. FOR THIS, WE GRATEFULLY AWARD THIS

CERTIFICATE OF APPRECIATION

DATE
IN RECOGNITION
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OF THE CONTRIBUTION OF

TO THE TEACHING OF STANFORD MEDICAL STUDENTS.

BY THIS GENEROUS CONTRIBUTION OF YOUR TIME AND YOUR WILLINGNESS TO SERVE THE NEEDS OF OTHERS, YOU HAVE DEMONSTRATED GENEROSITY OF SPIRIT, HUMANITY, AND COMPASSION. FOR THIS, WE GRATEFULLY AWARD THIS

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