Welcome to the Introduction to Clinical Medicine – Manual 2020

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Goals

Welcome to the Introduction to Clinical Medicine. The goals of this course are to acquire the necessary skills to complete a patient history and physical examination and to organize and present the information so that differential diagnosis and treatment plans can be formulated. The skills you acquire from this course lay the foundation necessary for moving on to your clinical clerkships.

Schedule

The course begins on Thursday, January 7, 2020 and ends on Friday, March 27, 2020. Classes are held on Tuesday, Thursday, and Friday. The course is comprised of didactic and interactive lectures, along with patient-centered teaching "clinics." The lectures include a variety of teaching formats such as role-playing, small group discussions, case presentations, and interactive experiences.

Most lectures are case-based and frequently involve patients. ***Attendance at all sessions is essential, particularly for those involving patients. If you require time off it should be requested well in advance of the scheduled session and it must be requested through Kate Hodgins. Your request will be evaluated and approved only if deemed appropriate by course directors***. If you are ill, please notify Kate Hodgins so she can advise you about seeing patients.

Course Content

Medical and Surgical Preceptors

ICM focuses on history taking and physical examination skills in individualized interactions with medical and surgical preceptors. Students are generally assigned to medical and surgical preceptors in groups of two or three. Preceptor assignments are for the duration of the course.

Patient Evaluation

Each student sees one medical and one surgical patient per week, except during Pediatrics at Children's Hospital. Students see a patient in the morning and review the findings of the history and physical examination with their medical or surgical preceptor that same afternoon. Formal written evaluations of each medical patient are submitted each week to the medical preceptor, who returns them to students with written comments. After reviewing written work, Friday afternoon sessions with the medical preceptors are devoted to specific teaching cases and examining patients with physical findings. There is only one meeting per week with the surgical preceptors.

Special Rounds

Special rounds convene Tuesdays and Thursdays from 1-3 PM (see special rounds schedule). The purpose of the special rounds is to enable students to study specific clinical topics in small groups in practical settings.

The areas to be covered include:

- Cardiology Rounds (CAR)
- Diabetes Mellitus (DM)
- Inpatient rounds with faculty (Dr. Daniel Solomon)
- Gynecology (GYN)
- GU Exam
- Medical Simulation (MS)
- Renal (Renal)
- Ultrasound Clinic
- Surgical Presentations with Dr. Jennifer Irani

Friday Clinics

During Friday clinics, students examine volunteer patients with interesting histories or physical findings related to a specific organ system in an outpatient setting. Clinics are scheduled for patients with heart disease, respiratory disease, endocrine disease, and hematologic disease.

Emergency Department Sessions

Each student evaluates medical and surgical emergencies during one 2-hour session in the Brigham & Women's Hospital Emergency Department. Students report to the Physician Assistant assigned to the OBS (observation) unit in the ED. A separate schedule is distributed mid-way through the course. These sessions are in the evening and on weekends. Students will be contacted directly for their availability.

Student Case Presentations

Each student gives a 7-minute case presentation to ICM faculty and receives comments on the presentation using a previous write-up. The presentation should include the chief complaint, summary of the present illness, medications, known allergies, pertinent facts from the past medical/surgical history, review of systems, family and social history, and the highlights of the physical exam. Remember to include pertinent negative findings as well as positive findings. Pertinent laboratory and x-ray findings are also related, where applicable. The presentation should conclude with an assessment of the case and a plan of action.

Pediatrics

The pediatrics portion of this course takes place at Children's Hospital Boston under the direction of Dr. Grace Chi. Students have two full days of clinical pediatrics. Check the calendar for the dates. These sessions are a crucial part of the curriculum. ***Attendance is mandatory.***

Anesthesia Sessions

Goals and Objectives

1) Provide an introduction to the field of Anesthesiology.
2) Provide an opportunity to observe real time applied physiology and pharmacology in the operating room.

3) Provide an opportunity to observe the use of technology in the operating room.
4) Provide an introduction to ongoing research projects in the Department of Anesthesiology, Perioperative and Pain Medicine at BWH.

The date for each session is listed in the syllabus under Anesthesia Assignments. The anesthesia session involves changing into scrubs and seeing patients undergo anesthesia and surgery. On the day of your Anesthesia session, be certain to bring the scrubs you were issued. THERE IS NO WAY TO ISSUE REPLACEMENTS ON THAT DAY. You should receive an email from your anesthesia preceptor a day or two before the assignment. Meet outside the Anesthesia Duty Room, unless another location is determined. Kate will email the students when the scrubs are ready to be picked up from the HST program office.

Orthopedic Sessions

The opportunity to examine the musculoskeletal system is supplemented with sessions led by orthopedic surgeons. Students have a hands-on opportunity to examine joints and muscles from the orthopedic perspective as well as the rheumatologic. There is background material to read in advance of the sessions. Women should wear a tank top or sports bra and all students should bring shorts. Students will practice on each other with faculty guidance.

Breast Exam Clinic Assignments

Working with a model patient, students learn how to perform a breast examination. There are two sessions. Dates for ICM 2020 are Jan. 16 (Group 1) and Jan. 21 (Group 2).

Midcourse Evaluation

Each student will have an opportunity to perform an informal HPE for their preceptors at mid-term that will be used to provide feedback about areas that need additional work.

Final Write-Up and Course Evaluations (Please write your name on the top of the document)

Students should submit their final write-up on the last Friday of the class, March 27, 2020. This write-up should represent your best-written work, not (necessarily) the last patient of the semester. You may submit the write-up to your preceptors for comments and suggestions before submitting it. We encourage you to include assessments and plans, if you wish, but they are not required. Please make this a representation of your best work! **To be HIPAA compliant and preserve patient confidentiality please do not include any ID on clinical write-ups (such as name or identifying numbers).**

The OSCE

This year, the Objective Supervised Clinical Examination (OSCE) is held on Monday, March 16, 2020 from 1:00-8:30pm. The exam is designed to evaluate history taking and physical examination skills in pre-defined exercises, under the supervision and evaluation of HMS faculty. While we report your results, this exercise is not part of your ICM grade, nor does it affect your evaluation for the course. The OSCE is administered to all Patient Doctor II/ ICM students to prepare you for the formal OSCE administered in the 4th year. ***Attendance is mandatory.***

The Final Observed History and Physical Examination

On Tuesday, March 24, 2020 there is a formal observed HPE that counts towards your final evaluation from the Course Directors. In lieu of your patient workup, you are assigned to a preceptor from the course – but unknown to you – who evaluates your performance using the Clinical Skills Assessment Checklist (Appendix 2). You have one hour for the observed HPE. In general, the exam is limited to 45 minutes (20-25 minutes for history taking, and 20-25 minutes for the physical examination). After you finish your patient exam, give the preceptor a 5-minute presentation on the patient and your findings (not at the bedside). The final 10 minutes are spent receiving comments from the preceptor on your performance. This exercise is designed to prepare you for a similar evaluation in your 4th year. No write-up is required for this final patient.

The skills assessment checklist used to evaluate your final HPE is in the appendix.

Final Evaluation and Grading

The final evaluation of each student's performance will be based on:

- Attendance, punctuality and other professional behavior,
- comments from your medical and surgical instructors (evaluation form used by the preceptors is in the appendix),
- submitted written work-up on patients evaluated this term,
- observation by course directors on rounds and during case presentations,
- participation and conduct during lectures, clinics, and special rounds, and
- competence in the conduct of a routine physical examination, medical history, and presentation of these clinical findings, as determined during the final observed HPE.

Resources

Books on Reserve at HST

A checkout system is available for the following books:

Author	Title	Call #
Walker, Hall, & Hurst	***Clinical Methods***	WB141.C638
Delp & Manning	***Major's Physical Diagnosis***	WB200.M235
Cutler, P.	***Problem Solving in Clinical Medicine***	WB141.3.C999
DeGowin & DeGowin	***Bedside Diagnostic Examination***	WB200.D46
Swask & Glynn	***Hutchison's Clinical Methods: an Integrated Approach to Clinical Practice***	
Fisher & Wachtel	***Clinical Procedures***	
Tally & O'Connor	***Clinical Examination, 4th Edition***	

Clinical Skills Lab

The Clinical Skills Center, located on the 1st floor of TMEC, is a valuable resource for practicing many of the exam techniques that you learned during the course. It is particularly useful for additional practice before the OSCE. Be sure that your ID card is validated for access to the clinical skills lab during the first two weeks of the course. Contact the course administrator for further information.

Canvas

Almost all of the course content, information, and resources for ICM can be found on Canvas, the HMS Website listed under the Introduction to Clinical Medicine, course IN710.23: http://canvas.hms.harvard.edu. You need an HMS eCommons ID and password to be able to use Canvas. If you do not already have access to eCommons, please arrange for this. On this site, you can access the course schedule, look up material, cases, and reference, contact course faculty, and look up announcements for the course. This enables us to track the kind of patient interactions and the quality of learning experiences that you are having during the course. We encourage you to explore Canvas and the resources available online.

Course Evaluation

HMS/HST mandates that all students fill out course evaluations as a condition of course completion. This information is used to modify and improve ICM from year to year. When you fill out lecture/clinic evaluations, please provide specific, concise, and constructive comments as to what you liked or did not like.

Final grades will not be released until we confirm that you have submitted all evaluations!

Guidelines for the Evaluation of a Medical Patient

During the medical portion of the course, medical preceptors assist students in learning (1) the proper conduct of a comprehensive clinical history, (2) the performance of a complete physical exam, and (3) the organization and presentation of these findings. Through repeated bedside evaluation of patients, concentration is on the skills of auscultation, orthopedic and neurologic assessment, organ palpation, elicitation of relevant information from patients, and proper conduct of the physician in the clinical setting.

HIPAA Compliance/Patient Confidentiality

To be HIPAA compliant and preserve patient confidentiality please do not include any ID on clinical write-ups (such as name or identifying numbers). Additionally, while you may certainly discuss interesting patients with your classmates, never do so in public places such as elevators or the cafeteria.

Please attach the following quote to all emails you send containing any patient information:

"This communication may contain information that is privileged or confidential, and is intended for the use of only the individual or department to which it is addressed. If you are not the intended recipient, or the employee or agent responsible for delivering this communication to the intended recipient, please notify the sender immediately by telephone at [sender's phone or a site-specific PD II phone number] or via return e-mail. Anyone other than the intended recipient is hereby notified that any dissemination, use, distribution or copying of this communication is strictly prohibited."

Morning sessions

Students spend 1-2 hours each Tuesday and Thursday morning obtaining a history and conducting a physical examination on an inpatient. The balance of the morning should be used to organize and write-up these findings for presentation to the medical preceptors. A list of patient assignments will be available after the morning lecture, on Canvas.

Afternoon sessions

Students meet with their medical preceptor that afternoon to review the patient evaluated that morning. Each preceptor group arranges a mutually convenient meeting place. Students are expected to give a clear, succinct oral presentation of the case (eventually keeping this to 7 minutes or less) and submit a written evaluation at a mutually convenient time after the session. If appropriate and permitted by the patient, the review may be conducted at bedside.

Friday sessions

Each Friday afternoon, students meet with their medical preceptor. These sessions should include a review of the student's written evaluations and supplementary rounds or review of clinical problems, as deemed appropriate by the preceptor. When time allows, preceptors and students are highly encouraged to find a patient.

Write-ups

A write up will be submitted to the medical preceptor each week. One surgical write-up will be submitted to the surgical preceptor during the semester. Note that some surgical preceptors expect a write-up each week. At the end of the term, students will submit one write-up (the one considered the best during the term) to Kate Hodgins, khodgins@hms.harvard.edu. This work-up will be considered toward the student's final evaluation. This write-up may be reviewed by the medical preceptor for "polishing" before submission for final evaluation.

Texts

There is no specific required text for this course, but most students find that a textbook on clinical diagnosis to be invaluable. There are several books on reserve at The HST Society. In addition, any standard textbook of medicine is a useful resource for obtaining a rapid introduction to specific diseases. The course syllabus contains articles and outlines to supplement the material found in these texts. Over the years, students have found the following books particularly useful:

- LS Bickley. ***Bates' Guide to Physical Examination and History Taking 12th edition***. Lipincott, Williams & Wilkins 2008. Classic text with many excellent pictures and diagrams. ISBN: *9781469893419*
- RF LeBlond, DD Brown, RL DeGowin. ***DeGowin's Diagnostic Examination, 10th edition***. Another classic, comprehensive text which serves as an excellent reference. ISBN: *9780071814478*
- JD Sapira, JM Orient. ***The Art and Science of Bedside Diagnosis, 5th edition***, Lipincott, Williams & Wilkins 2005. Covers both the history of and evidence base for exam techniques. Each section includes discussion aimed at three levels: medical student, resident, and attending, making this a reference for years to come. ISBN: *9781975117993*
- RM Macklis, ME Mendelsohn and GH Mudge. ***Manual of Introductory Clinical Medicine***. Little Brown, 1998 (No longer in print). Provides an outline of History, Physical Exam and use of the Clinical Laboratory. Special features include practical tips from other medical students. Also has outline of pathophysiology containing common diseases.
- Ml Swash, M. Glynn. ***Hutchison's Clinical Methods: an Integrated Approach to Clinical Practice, 24nd Edition***. Much of the material of a standard physical diagnosis text but also includes tests analysis, certain invasive techniques such as lumbar puncture. Practical, well written. ISBN: *9780702067396*
- UHoang, DHRosen. ***Patient Centered Medicine; A Human Experience***. 2017. This comments in a reasonable way about dealing with patients and the doctor-patient interaction.
- JA Billings, JD Stoeckle. ***The Clinical Encounter: A Guide to the Medical Interview and Case Presentation*** YearBook Medical Publishers, Inc. 2002.

Guidelines for the Evaluation of a Surgical Patient

During the surgical portion of ICM, students are introduced to the methodology used in solving surgical problems. Surgical preceptors emphasize the clinical evaluation and pathophysiology of specific surgical ailments; unlike the medical portion of the course, students are not required to conduct a comprehensive history and physical examination on each patient. The students learn to:

- Acquire historical data
- Distinguish between normal and abnormal physical findings
- Organize and interpret clinical information
- Enumerate a differential diagnosis
- Formulate plans to more clearly define the diagnosis
- Present the clinical findings in a logical and concise manner

A list of patient assignments will be available after the morning lecture, on Canvas.

Morning sessions

During the morning surgical session, the student should spend 1-2 hours with his/her assigned patient obtaining a limited history and physical exam, concentrating on the findings that relate to the known major surgical problem(s). Any remaining time should be spent organizing the clinical data for presentation, considering a differential diagnosis, and reviewing the major problem in a standard surgical text.

Afternoon sessions

During the afternoon session, each student presents his/her patient to the other students and surgical preceptor, and a critique of the presentation is offered. Students and instructors review important aspects of the clinical examination at the bedside. The group discusses the pathophysiology and differential diagnosis of the conditions seen. Meeting locations are arranged by each preceptor.

Write-ups

One write up is required during the surgical part of the course. This write up is assigned and evaluated by the surgical instructor.

Texts

Recommended surgical resources and texts are:

- Mulholland. **Greenfield's Surgery, Scientific Principles & Practice, 4th Edition**, Lippincott, Williams, and Wilkins
- Townsend. **Stabiston Textbook of Surgery, 18th Edition**, Saunders
- Brunicardi. **Schwartz's Principles of Surgery, 8th Edition**, McGraw Hill
- Souba. **ACS Surgery, Principles & Practice, 2008**, BC Decker Inc.
- UpToDate.com is an excellent source for a range of topics

Sample Write-ups

Sample #1

DATE: May --, 2011

Patient: Mr. X, 69 year old man in no acute distress.

Chief Complaint: The patient is a 69 year old man who presents with sudden onset of shortness of breath that proceeded to loss of consciousness.

History of Present Illness: Mr. ------ was brought to the BWH ED in May -- by ambulance after experiencing shortness of breath that progressed to loss of consciousness. On Saturday, he lay down to sleep after his shower and began experiencing shortness of breath. After a few moments of this, he rose to go upstairs to seek help from his wife. By the time he reached the top of the stairs he had blurry vision, was light headed and diaphoretic. He does not recall any nausea, vomiting, palpitation or chest pain. At this time he lost consciousness and his wife helped him to a chair. Mr. ------ then regained consciousness and his wife called the ambulance.

The patient reports increased shortness of breath and weakness with exercise or stair ascent during the week prior to admission. He experienced no light headedness, diaphoresis, chest pain, palpitations, vision changes, nausea or vomiting during this time. He noticed no swelling of the extremities. The SOB was relieved by rest. This SOB had prevented him from his normal work as a carpenter throughout this week.

He reports some dyspnea on exertion during the past year, but with no associated symptoms and not interfering with work. Rest has alleviated the dyspnea.

The patient has a prior history of DVT in the R leg 4 years ago after a driving trip to Virginia. He was treated with coumadin at that time. The patient remained on coumadin until one year ago. He currently takes one aspirin per day.

CARDIAC RISK FACTORS: male > 45, 8 pack year smoking history, but he is not obese, has no family history of heart disease, not diabetic, normal lipid levels and no hypertension.

Past Medical/Surgical History:

1. DVT – R leg, 1997
2. BPH – diagnosed 1998
3. Appendectomy - 1985

Allergies: no known drug allergies

Medications: Aspirin 325 mg po qd

Terazosin 10 mg po qd

Denies multivitamin or herbal supplement use

Social History:

Home & Support:	Mr. X moved to Boston from Haiti 30 years ago. He currently lives at home with his wife and daughter. His 5 other children are grown and living on their own. His wife is present at the time of the interview.
Occupation/Activities:	Carpenter. Active in church.
Animal Exposures:	None
Travel:	None
Diet/Exercise:	Lifts weights/walks occasionally
Sexual History:	Deferred
Tobacco/Drug Use:	8 pack year history. Quit in 1961. No drug use.
Alcohol:	No alcohol

Family History: Patient's family remains in Haiti, and he is unaware of their medical history.

ROS:

General:	No change in body weight, fever or chills.
Dermatology:	No itching or rashes
HEENT:	No headaches, congestion, vision changes, hearing changes
Pulmonary:	No shortness of breath at present, cough or sputum production. See HPI
Cardiac:	No chest pain, palpitations. See HPI
GI:	No abdominal pain, constipation, diarrhea, nausea, vomiting
GU:	No dysuria, urinary frequency, hematuria, incontinence
Musculoskeletal:	No muscle weakness
Neuro:	No problems walking
Psych:	No depression, changes in sleep
Hematologic:	No bruising or bleeding

Physical Exam:

General:	The patient is a well-nourished male in no acute distress who looks younger than his stated age.
Vital Signs:	Temp: 97.7F HR: 68 BP: 120/72 Resp: 20 O2 sat: 94% on RA
HEENT:	No apparent deformities Normal fundi, clear tympanic membranes. Mucosa of oropharynx is moist and pink, no exudates. Missing dentition on most of upper palate. Sclera and conjunctiva non injected. Arcus senil present bilaterally. Clear raised nodule on right sclera.
Neck:	Supple. Thyroid not palpable. Normal flexion, extension, rotation.
Lymph nodes:	No cervical, submandibular, supraclavicular, or axillary lymphadenopathy.
Back:	No scoliosis or kyphosis. No masses, tenderness.
Pulmonary:	Clear to percussion, Auscultation revealed rales at the base bilaterally, but no wheezes or ronchi.
CV:	Soft S1, louder S2 with physiologic split. No S3/S4, Regular rate, rhythm. No rubs, gallops or murmurs. PMI at slightly lateral to mid clavicular line. No RV heave. Radial, dorsalis pedis pulses symmetric and regular. Carotid pulse 2+, no bruits. JVP 7 cm
Abdominal:	Normoactive bowel sounds in all 4 quadrants. No tenderness, nondistended. No hepatosplenomegaly.

Extremities: No clubbing, cyanosis or edema. No palpable cord. No calf tenderness.
Genital: Deferred
Musc: Strength 5/5 and symmetric in major muscle groups of arms and legs. Joint ROM symmetric and intact.
Neuro: Patient is alert, oriented, and attentive. CN 2-12 tested and intact, see below:
II: Visual fields intact, acuity 20/20
III, IV, VI: PERRLA, EOMI
V: Light touch intact bilaterally, corneal reflex intact, muscles of mastication intact
VII: Muscles of facial expression intact
IX, X: Palate raises symmetrically, gag reflex intact
XI: Shoulder elevation, head rotation intact
XII: Tongue movement intact
Reflexes: Biceps, triceps, Brachioradialis, Knee and Ankle 2+ bilaterally
Gait normal.
Cerebellar exam: heel-shin, finger-nose, rapid alternating movements intact

Assessment:

Mr. X is a 69 year old carpenter who has suffered sudden onset of shortness of breath with loss of consciousness. Cardiac risk factors are significant for him being a male over 45 and past smoker only. He has a history of DVT. Need to rule out cardiac involvement, including cardiac tamponade, congestive heart failure, valvular abnormality, cardiomyopathy and myocardial infarction. Other etiologies contributing to loss of consciousness may include hyperthyroidism, bronchospasm, pneumothorax, pneumonia, airway obstruction or pulmonary embolism. The sudden onset of symptoms, history around the event, prior history of DVT, and rales at the base of the lungs suggest pulmonary embolus. Must also consider malignancy as a contributing factor. See plan.

Plan: Syncope work-up

- Cardiac: rule out MI: Ek6/ check CK q 8 hrs x 3.
  Echocardiogram: assess presence of CHF, cardiomyopathy, tamponade. Evaluation for regional wall motion abnormalities and valvular abnormalities.
- Metabolic: check TSH, rule out hyperthyroidism
  blood glucose – rule out diabetes/hypoglycemia
- Pulmonary Embolism:
  Begin IV heparin - anticoagulant therapy
  CXR – rule out pneumothorax, pneumonia
  Check arterial blood gas
  PE protocol CT scan – look for embolus

Repeat biopsy of prostate – rule out prostate malignancy

Sample #2

Pt ID Ms. Y is an 88 year old retired nurse who presented to the ED with a crushing chest pain.

CC "It felt like I had a Mack truck sitting on my chest"

HPI Ms. Y telephoned paramedics on April --, 2018 with a complaint of crushing chest pain and dizziness. She was taken to ------ Hospital where she reported diffuse substernal pain which she rated 5/10. She also complained of severe dizziness and very mild shortness of breath, but denied nausea or diaphoresis. EKG showed ST-segment elevation and cardiac enzymes were positive. Her symptoms appeared to resolve upon administration of nitroglycerine. She was transferred to BWH on April -- for cardiac follow-up. Angiography on April -- revealed 85% stenosis of the Marginal 1 and Diagonal 1 branches of the LAD. Stent placement restored 100% patency to these vessels. She required oxygen via nasal prongs until April -- after which supplemental oxygen was discontinued. She is currently stable, without pain and in no respiratory or cardiac distress although she does show moderate peripheral cyanosis (digital and perioral). There is no evidence of peripheral edema.

She denies past history of ischemic heart disease but describes 3 pillow orthopnea and dyspnea upon climbing one flight of stairs (both of 3-4 years' duration). She also reports a history of 'irregular rhythms' for which a pacemaker was implanted 4-5 years ago. Her family history is notable for multi-generational coronary disease.

She currently complains only of constipation and associated mild GI discomfort which she has been experiencing for several years.

PMH

- April --, 2010-Commencement of warfarin therapy for (asymptomatic) atrial fibrillation following a routine physical examination.
- 2008-Bacterial pneumonia-3 week hospitalization, Ø intubation.
- 1990?-Throat CA treated with XRT, no known recurrence or spread.
- Intermittent edema of the lower extremities (dating to WWII)-treated with furosemide

PSH

- 2005-2008 (Date unknown) implantation of cardiac pacemaker-(DDD??) For a "bad heart" (sick sinus syndrome?).

Allergies: NKDA

Medications:

- Captopril
- Metoprolol
- Warfarin
- Furosemide
- Omeprazole
- Bisacodyl
- Docusate

Immunizations:

- Influenza and Pneumovax, no recollection of other immunizations.

FHx: Father died of complications of cirrhosis at 92 years old
Mother died from renal failure at 46 years old
Two brothers and one son died from myocardial infarction
FH negative for DM, cancers

SH: Ms. Y, a retired nurse, currently lives alone in M-----, although she states that several other people in her building are available to help her as necessary. She reports a 65 pack-year smoking history, which she quit in 1989. She also reports moderate consumption of alcohol (1-2 drinks/day on average). She reports her diet is well balanced, stating that it consists primarily of microwave dinners and Meals-On-Wheels. She supplements her diet with fiber to try to relieve his chronic constipation.

ROS:

Constitutional: No fever, sweats/chills, anorexia. Reports a 15 lb. weight loss over a period of 3 months commencing in January with onset of furosemide treatment for peripheral edema. Also reports difficulty falling asleep and complains of fatigue resulting from lack of sleep. She denies pulmonary cause for this difficulty (ie. Denies SOB, wheezing, orthopnea), but reports "simply staring at the ceiling for hours on end".

Dtyatologic: No changes in moisture, temperature, color or texture of skin. No additional lesions, rashes or changes in hair or nails.

Hematologic: No easy bruising, bleeding from gums.

Neurologic: No seizures, dizziness, tremor, focal weakness, pain and numbness.

Head: Reports occasional headache (1-2x/month, pain rated as 4/10) which resolves with acetaminophen. No known precipitating causes.

HEENT: No syncope, head trauma;
No Δ vision, blurring, double-vision;
Reports somewhat diminished hearing (more pronounced in left ear) over a period of several years, but no recent significant changes. No pain, tinnitus, vertigo;
No nasal discharge/sinus pain, Δ sense of smell. Reports one incident of epistaxis within previous month which resolved spontaneously. No known precipitating cause.
No pain in mouth/throat, hoarseness or dysphagia.

Pulmonary: No cough, sputum production, hemoptysis, wheezing. Recent very mild shortness of breath reported following M.I. (see HPI). No current respiratory distress.

C/V: See HPI. No difficulty breathing on awakening at night (i.e. PND).

GI: No changes in appetite, nausea, vomiting, hematemesis. Reports frequent and long-standing episodes of constipation for which he has tried several laxatives and dietary supplements with limited success.

GU: No dysuria, frequency, urgency, polyuria, oliguria, hematuria, tenderness in back or costovertebral angle

Musculoskeletal/Extremities: Reports a 60 year history of mild, intermittent (once or twice per year) lower extremity edema with no known precipitating factors. Generally reported to resolve with diuretics. No joint pain or cyanosis (NB see Physical Exam).

Endocrine: No change in sleeping patterns, behavioral changes, sensitivity to heat or cold, abnormal sweating, polydipsia, polyphagia, polyuria or change in size of hands, feet.

Psych: Patient is calm and pleasant. No rapid changes of mood.

Physical Examination:

Appearance: This is an 88 year-old woman in no apparent distress who appears her stated age. During the assessment, she was sitting comfortably in a chair.

Vital Signs: P 64 regular RR 24 unlabored BP 120/78 T 96 SpO2 not obtained

Skin: Normal color, temperature, consistency; without obvious lesions

Head: Normocephalic, atraumatic

Eyes: Normal acuity with corrective eyeglasses. Conjunctivae and sclerae clear. EOM full. PERRLA. Visual fields grossly normal. Fundi benign.

Ears: Cerumen in right and left canals. Left canal almost entirely occluded by cerumen. TMs not visualized. Tuning fork heard @ 1cm in right ear, not heard in left. Weber test revealed mild radiation to left ear.

Nose: No congestion or discharge.

Mouth/throat: Tongue normal and midline. Dentition entirely absent. No pharyngeal injection, erythema or exudate. Mucosa pink.

Neck: Supple without tenderness. No thyromegaly or masses. Trachea midline. JVP elevated to 10 cm. Carotid pulses clearly visible; moderately slowed filling and collapse. "To-and-fro" carotid bruits appreciated bilaterally, slightly louder on right.

Lymphatic: Cervical, supraclavicular and axillary nodes exhibited no lymphadenopathy.

Chest/lungs: Normal A-P diameter. Respirations symmetrical and unlabored with normal excursion. Lung fields clear to auscultation and percussion.

Cardiovascular: Regular rate and rhythm. S1 (soft) and S2 appreciated with physiological splitting. Pansystolic murmur (II/VI) appreciated best at lower-left sternal border. Radial pulses present and equal bilaterally. Pedal pulses not detected.

Abdomen: Flat. Normal bowel sounds. Liver, spleen and kidneys not palpable. No masses or tenderness.

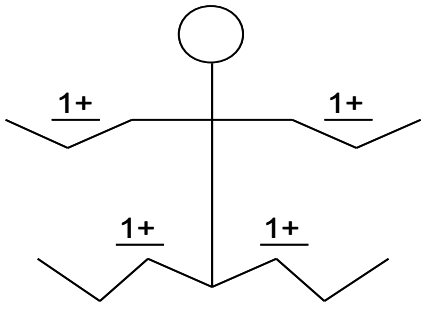
Extremities: No clubbing or edema. Moderate cyanosis of fingers, toes and lips. Severe varicose veins on feet.

Musculo/skeletal: No obvious skeletal deformities. No joint swelling, tenderness, erythema or restriction of motion.

Neuro: Alert and oriented to time, place and person.
Cranial nerves II-XII: intact.
No atrophy, fasciculations or tremors. Normal strength in extremities with no pronator drift. Fine motor skills intact in both hands.

Sensory: Intact to touch on face, arms, legs and torso.

Reflexes:



Assessment and Plan:
This is an 88 year old woman in good general health who presented to the ED on 4/14 with an AMI. Her symptoms resolved upon administration of nitroglycerin. Subsequent angiography revealed two stenotic arteries to which 100% patency was restored upon stent placement. She is currently tachypneic and moderately cyanotic (periorally and bilaterally in fingers and toes. Cyanosis, tachpnea and exercise intolerance are suggestive of mild heart failure. Maintenance of current drug regimen is recommended with possible adjustments to optimize cardiac function (addition of digoxin may be indicated). Prophylactic ASA should be initiated to avoid future occlusive events.

It is notable that Ms. Y's MI occurred one day after commencement of warfarin therapy. It bears consideration that an initial hypercoagulable state (resulting from action of warfarin on Protein C) predisposed to a thrombotic episode that caused the ischemic event. This possibility should be noted and, in the event that Ms. ------ ceases warfarin in the future, pre-heparinization might be considered upon re-initiation of warfarin. As Ms. ------ is currently adequately anti-coagulated, warfarin should be maintained to prevent future thrombotic events resulting from atrial fibrillation and initiation of prophylactic ASA should also be considered.

Other problems include:

- GI - Ms. ------ reports a multi-year history of poorly-controlled constipation and associated GI discomfort. Appropriate work-up should include modification of current diet and drug regimen (bisacodyl, docusate) with GI consult to rule out dysmotility or obstruction.

- Sleep - Ms. ------ reports frequent difficulty attaining sleep. While she reports orthopnea this is corrected by use of several pillows and she denies PND. Consideration should be given to prescription of a sleeping aid (diphenhydramine/ trazodone?). Moreover, COPD and CHF should be ruled out as causes for breathing difficulties (PFTs and exercise stress test).

- Hearing - Ms. ------ exhibits poor aural acuity bilaterally. While this may be due in part to age-related changes, her auditory canals exhibited nearly complete occlusion with cerumen. Removal of cerumen may restore some hearing.

Students' Medical Preceptor Assignments

Group 1: Tuesdays and Fridays

Preceptor(s):	*Students:*
Dr. Christopher Baugh	Angela Zou
Dr. Scott Goldberg	Wan Fung Chui
Dr. Douglas Rubinson	Kathryn Evans
Dr. James Cleary	Andy Binker-Cosen
Dr. Valerie Dobiesz	Julia Schiantarelli
Dr. William Feldman	Minjee Kim
Dr. Timothy Erickson	Quique Toloza
Dr. Cindy Hahn	Isobel Green
Dr. Sarimer Sanchez	Joyce Kang
Dr. Temidayo Fadelu	Alaina Bever
Dr. Anne Liu	Julie Urgiles
Dr. Laura Platt	
Dr. Sue Farrell	Jon Hochstein
Dr. Yiannis Koullias	Nicole Gilette
Dr. Rebecca Sternschein	Alice Bosma-Moody

Students' Medical Preceptor Assignments

Group 2: Thursdays and Fridays

Preceptor(s):	*Students:*
Dr. Matthew Hemming	Nicita Mehta
Dr. Sean-Michael Kivlehan	William Mannherz
Dr. Sylvia Kehlenbrink Oh	
Dr. Jacob Berchuck	Debbie Burdinski
Dr. Mark Leick	James Diao
Dr. Chris Reilly	Atousa Nourmahnad
Dr. Philip Anderson	Chanthia Ma
Dr. Erin Parry	Blake Smith
Dr. Praful Ravi	Emory Werner
	Yichen Zhang
Dr. Sanchit Gupta	Alexander Munoz
Dr. Alex Parent	Christina Zeina
Dr. Fred Tsai	Kameron Kooshesh
Dr. Daniel Abravanel	Leonard Nettey
Dr. Erik Knelson	Samantha Hoffman
Dr. Swalpa Udit	Akansha Tarun

Students' Surgical Preceptor Assignments

Group 1: Thursdays

Preceptor(s):	*Students:*
Dr. Jason Pradarelli	Nicole Gilette Wan Fung Chui
Dr. Martin Kathrins	Joyce Kang Julia Schiantarelli Alaina Bever
Dr. Stanley Ashley Dr. David Brooks	Kathryn Evans Quique Toloza Alice Bosma-Moody
Dr. Stephanie Nitzschke	Minjee Kim Isobel Green Jon Hochstein
Dr. Malcolm Robinson	Andres Binker-Cosen Julie Urgiles Angela Zou

Students' Surgical Preceptor Assignments

Group 2: Tuesdays

Preceptor(s):	*Students:*
Dr. Joel Adler	Nicita Mehta James Diao Emory Werner
Christina Minami	Alexander Munoz Yichen Zhang Akansha Tarun
Dr. Mark Fairweather	Atousa Nourmahnad William Mannherz Samantha Hoffman
Dr. Edward Kwasnik	Kameron Kooshesh Debbie Burdinski Blake Smith
Dr. Danny Mou	Chanthia Ma Leonard Nettey Tina Zeina

Special Rounds – PLEASE refer to SR calendar (by date) in Canvas

NOTE: Do not swap special rounds under any circumstances without permission from Kate.

Special Rounds Meeting Locations and Requirements

Special Rounds start at 1:00 and end at 3:00 PM on Tuesdays and Thursday. Switching Special Rounds sessions is not allowed.

Several Special Rounds have special requirements and assigned reading. Please check this list to be sure you are prepared for your session.

CAR	Cardiology Rounds: Dr. Brian Bergmark & Associates. Meet on the BWH side of the second floor bridge between BWH and the Shapiro Building.
DM	Diabetes Mellitus : Dr Margo Hudson & Associates. Meet on the BWH side of the second floor bridge between BWH and the Shapiro.
DS	Special Rounds with Dr. Daniel Solomon. It is in Building A near 15 Francis Street, 4th floor, my office is the first one on the left after you come in through the double doors. BWH ID Division, PBB4A room 402
JI	Surgical Presentations with Dr. Jennifer Irani. Location Carrie Hall, BWH. *Please note that the session on Tuesday, March 10, 2020 is scheduled for 1:00pm-3:00pm. * -
MS	Introduction to Medical Simulation Experience: Report to Dr. Kathleen Wittels in the STRATUS Center in Neville House, 10 Vining St., Boston. Enter Neville House through the center doors into the main lobby. STRATUS is located through the doors to the left on the first floor.
GU	The genitourinary exam will be held from 1-3 pm in the Clinical Skills Area, 260 Longwood Ave. Please meet in TMEC room 140
GYN	The gynecologic exam will be held from 1-3 pm in the Clinical Skills Area, 260 Longwood Ave. Please meet in TMEC room 140
RENAL	Renal Rounds: Drs. Gearoid McMahon and Melissa Yeung. Meet on the BWH side of the second floor bridge between BWH and the Shapiro Building.

Special Rounds Group Assignments

Group A	Angela Zou
	Wan Fung Chui
	Kathryn Evans
Group B	Andy Binker-Cosen
	Julia Schiantarelli
	Minjee Kim
Group C	Quique Toloza
	Isobel Green
	Joyce Kang
Group D	Alaina Bever
	Julie Urgiles
Group E	Jon Hochstein
	Nicole Gilette
	Alice Bosma-Moody
Group F	Nicita Mehta
	William Mannherz
Group G	Debbie Burdinski
	James Diao
	Atousa Nourmahnad
Group H	Chanthia Ma
	Blake Smith
	Emory Werner
	Yichen Zhang
Group I	Alexander Munoz
	Tina Zeina
	Kameron Kooshesh
Group J	Leonard Nettey
	Samantha Hoffman
	Akansha Tarun

Additional Group Assignments

Breast Exam Clinics

Date:	Students:
January 16, 2020	Group 1
January 21, 2020	Group 2

The Jen Center is located in BWH, main pike, 2nd floor across from the Connors Center for Women's Health and the bridge to Children's Hospital. Students should arrive by 5:20 pm, with white coats and ID badges. Expect sessions to last until 6:30 pm.

GU Exam Clinic Assignments

Working with a model patient, students will learn how to perform the male GU examination. Please note your assigned date and time. Please plan on being available between 12:45 and 3:00 pm.

Date:	Time:	Students:
Thurs., Feb. 13, 2020	1:00 PM	Nicita Mehta, William Mannherz
Tues., Feb. 18, 2020	1:00 PM	Alexander Munoz, Tina Zeina, Kameron Kooshesh
	1:00 PM	Leonard Nettey, Samantha Hoffman, Akansha Tarun
Thurs., Feb. 20, 2020	1:00 PM	Quique Toloza, Isobel Green, Joyce Kang
	1:00 PM	Alaina Bever, Julie Urgiles
Tues., Feb. 25, 2020	1:00 PM	Angela Zou, Wan Fung Chui, Kathryn Evans
	1:00 PM	Andy Binker-Cosen, Julia Schiantarelli, Minjee Kim
Thurs., Feb. 27, 2020	1:00 PM	Jon Hochstein, Nicole Gilette, Alice Bosma-Moody
Tues., Mar. 3, 2020	1:00 PM	Debbie Burdinski, James Diao, Atousa Nourmahnad
	1:00 PM	Chanthia Ma, Blake Smith, Emory Werner, Yichen Zhang

The GU/GYN exam sessions are held under the direction of a monitor in the TMEC, Clinical Skills Center. Students should arrive on time, with white coats, and ID badges. Expect sessions to last two hours.

GYN Exam Clinic Assignments

Working with a model patient, students will learn how to perform the female GYN examination. Please note your assigned date and time. Please plan on being available between 12:45 pm and 3:00 pm.

Date:	**Time:**	**Students:**
Thur., Feb. 6, 2020	12:45 PM –	Angela Zou, Wan Fung Chui, Kathryn Evans
	12:45 PM –	Andy Binker-Cosen, Julia Schiantarelli, Minjee Kim
	12:45 PM	Quique Toloza, Isobel Green, Joyce Kang
Tues., Feb. 11, 2020	12:45 PM -	Alaina Bever, Julie Urgiles, David Cookmeyer
	12:45 PM -	Jon Hochstein, Nicole Gilette, Alice Bosma-Moody
	12:45 PM -	Nicita Mehta, Ellen Yu, William Mannherz
Thurs., Feb. 13, 2020	12:45 PM -	Atousa Nourmahnad, James Diao, Debbie Burdinski
	12:45 PM -	Emory Werner, Yichen Zhang, Blake Smith, Chanthia Ma
	12:45 PM -	Alexander Munoz, Tina Zeina, Kameron Kooshesh
	12:45 PM -	Akansha Tarun, Sam Hoffman, Leonard Nettey

The GU/GYN exam sessions are held under the direction of a monitor in the TMEC, Clinical Skills Center. Students should arrive on time, with white coats, and ID badges. Expect sessions to last two hours.

Anesthesia Assignments

Date:	Time:	Students:
Tuesday, February 11, 2020	6:30 AM	Mehta, Mannherz
Thursday, February 13, 2020	6:30 AM	Burdinski, Diao, Nourmahnad
Tuesday, February 18, 2020	6:30 AM	Munoz, Zeina, Kooshesh
Thursday, February 20, 2020	6:30 AM	Zou, Chui, Evans
Friday, February 21, 2020	6:30 AM	Binker-Cosen, Schiantarelli, Kim
Tuesday, February 25, 2020	6:30 AM	Toloza, Green, Kang
Thursday, February 27, 2020	6:30 AM	Ma, Smith, Werner, Zhang
Friday, February 28, 2020	6:30 AM	Urgiles, Bever
Tuesday, March 3, 2020	6:30 AM	Gilette, Bosma-Moody, Hochstein
Thursday, March 5, 2020	6:30 AM	Nettey, Hoffman, Tarun

The Anesthesia sessions are held under the direction of Dr. Jennifer McSweeney. Students should arrive on time, wearing scrubs, with ID badges, and exam equipment. Expect sessions to last three and a half hours. **DO NOT BE LATE – THESE SESSION CANNOT BE RESCHEDULED.** You should receive an email from your anesthesia preceptor a day or two before the assignment. Meet outside the Anesthesia Duty Room, unless another location is determined.

Medical Case Presentations 2020

Date:	Doctor:	Location:	Time:	Students:
February 11	Rubinson	D-1210K	8:00 am	Ma, Smith, Werner, Zhang
February 11	Rozansky	TMEC 204	8:00 am	Hochstein, Gilette, Bosma-Moody
February 13	Kosowsky	Neville	8:00 am	Nettey, Hoffman, Tarun
February 18	Kosowsky	Neville	8:00 am	Burdinski, Diao, Nourmahnad
February 20	Kosowsky	Neville	8:00 am	Toloza, Green, Kang
February 25	Rubinson	D-1210K	8:00 am	Bever, Urgiles
February 28	Rubinson	D-1210K	8:00 am	Zou, Chui, Evans
February 28	Kosowsky	Neville	8:00 am	Binker-Cosen, Schiantarelli, Kim
March 3	Rubinson	D-1210K	8:00 am	Mehta, Mannherz
March 3	Solomon	PBB4A, 402	8:00 am	Munoz, Zeina, Kooshesh

Each student gives a 7-minute case presentation.

Meetings with Dr. Kosowsky will be in the Neville House Room 320-D, unless otherwise indicated.

Meetings with Dr. Rubinson will be in the Dana Building, DFCI, 12th floor in room D-1210k, unless otherwise indicated.

Meeting with Dr. Solomon will be held in Building A near 15 Francis Street, 4th floor, my office is the first one on the left after you come in through the double doors. BWH ID Division, PBB4A room 402

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To page from outside BWH: 617-732-5700
To page from inside BWH: extension 25700, or use Partners Intranet telephone directory.
At the prompt, enter desired beeper number, and then enter call back number or extension.

Locations

Room Directory and Directions to Participating Hospitals

All locations are in the Brigham & Women's Hospital unless otherwise indicated. Assume directions always begin at 15 Francis St. (near Pat's Place)

Room	Location
Anesthesia Conference Room	Main Pike: Take CWN elevators (near J) to floor L1, turn right off elevators and another right and room is straight ahead.
Bayles Conference Room	Main Pike "C" Elevator 3rd Floor, left off elevator and down hallway through multiple doors; room is on the left
BWH ID Office	Lower Pike, mid-campus: Enter Thorn Building from Shattuck St. and walk straight back to the pike and take a right and office will be on your right.
Jen Center Conference & Exam Rooms	Main Pike, 2nd Floor on the left before J elevators
Bornstein Amphitheater (BORN)	Main Pike, 2nd floor, first double doors on right past the 45 Francis Lobby entrance
Carrie Hall Auditorium	Coming from 15 Francis St. lobby, take right at Main Pike, door to Carrie Hall is straight ahead
Children's Hospital	300 Longwood Avenue, use bridge near Pike Exit 4
Dana Farber Cancer Institute (DFCI)	450 Brookline Ave. (Across from BWH and Children's)
Dr. Goessling's Office	NRB, 77 Avenue Louis Pasteur, Room 458G
Dr. Kosowsky's Office	Neville House 320-D.
Dr. Rubinson's Office	Dana Building, 12th Floor, Room 1210k, 450 Brookline Ave.
Duncan Reid Conf. Room	Main Pike, 2nd floor, K elevators, take a right once past the elevator bank
Dr. Solomon's Office	It is in Building A near 15 Francis Street, 4th floor, my office is the first one on the left after you come in through the double doors. BWH ID Division, PBB4A room 402
Lung Center C	15 Francis St., Main Pike, 2nd floor, down near "C" elevators on right

Appendix

Student Grade Form

HST ICM Student Evaluation Form
Please return no later than April 3, 2020

Student Name:
_____

Course name and number: Intro. to Clinical Medicine. Dates of course: 1/7/2020-3/27/2020

Legend
O = Outstanding **S** = Satisfactory **MS** = Marginal satisfactory
U = Unsatisfactory **UE** =Unable to evaluate with reasonable confidence

A. Clinical Knowledge & Skills	**O**	**S**	**MS**	**U**	**UE**
1. Interview Content					
2. Interview Technique					
3. Physical Examination					
4. Problem Formulation					
5. Understanding of Pathophysiologic Mechanisms					
6. Analysis of Clinical Problems					
7. Record Preparation					
8. Verbal Presentation					
9. Interactions with patients and families					
10. Interactions with the health care team					
B. Learning Skills					
11. Initiative/Self-Directed Learning					
12. Personal Growth					
C. Standards of Professional Conduct and Responsibility					
13. Reliability					
14. Honesty and Integrity					
15. Responsibility in professional relationships					
16. Responsibility with patients and families					
17. Responsibility related to substance abuse					

D. Overall Performance					
18. Final Overall Grade					

Any response above of "Unsatisfactory" or "Marginal Satisfactory" must be explained in formative and/or summative comments on the next page.

Formative Comments

Please offer information that clarifies and justifies your above ratings of the students. Be specific, giving examples where possible and offering recommendations for improvement, when appropriate.

How and when was formal feedback give about issues raised in this evaluation?

Summative Comments

Please write a statement about the student's overall competencies. Please be honest, accurate, and specific as possible.

Signed _____ Date: _____

Please type name: _____

Patient-Doctor II Skills Assessment Checklist

Student:_____ **Evaluator:**_____

Site: _____ _____ **Date:**

_____

CONTENT OF THE INTERVIEW:

Patient as a person	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Who is this person?
- Major concerns elicited?
- Why ill now?
- Coping and support systems identified?

HPI	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Chief Complaint identified?
- Symptoms characterized and explored adequately?
  - Location and radiation
  - Quality or character
  - Chronology (frequency, timing, onset, duration, course)
  - Severity or amount
  - Aggravating or precipitating factors
  - Alleviating factors
  - Associated symptoms
  - Disability and adaptation (impact of illness on job/home life)
  - Attributions/explanatory model
- Elicits pertinent positives and negatives?

PMH	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Major illnesses
- Hospitalizations
- Operations
- Serious injuries
- Present medications and allergies
- Reproductive History
- Vaccinations & preventive interventions
- Occupational and Environmental history
  - Current job?
  - Longest-held job?
  - Have they been exposed to fumes and dusts, chemicals, metals, noise, radiation or musculoskeletal stresses e.g. repetitive motion, vibration?
- Dietary History
  - What is his/her diet like?
  - Is the patient following a special diet? If so, what is it and why?
  - Is the patient aware of the general principles of a "healthy diet"?
- Exercise History
  - Does the patient do any regular physical exercise (including heavy manual work)?
  - If yes, what is it and how often?

PMH (continued)

- Cigarette Smoking
  - How long has the patient smoked? (or did the patient smoke?)
  - How many packs per day?
  - If s/he smokes, is the patient interested in quitting?

- Screening for Injury Prevention
  - Does the patient use seat belts and bicycle helmets?
  - In the workplace or at home, does s/he take precautions against injury?

- Screening for Domestic Violence?
  - Is the patient in a relationship where s/he has been hit, hurt or threatened?
  - Has s/he ever been in such a relationship?

- Alcohol and other drugs
  - On a typical day, how many drinks does the patient have?
  - How many days of the week does s/he drink?
  - What is the maximum number of drinks s/he has had on any one occasion in the
  - Last month?
  - Does the patient use other substances? If so, which ones and how much?
  - If no current use, did s/he ever have a problem with alcohol or drugs?

- Sexual History
  - Is the patient currently sexually active?
  - Does s/he have sexual relationships with men, women, or both?
  - Does s/he have any concerns about his/her sexual life?
  - Does s/he know how to protect him or herself from unwanted pregnancy (if appropriate to patient's age and sexual preference)?
  - Does s/he know how to protect him or herself from sexually-transmitted diseases?

Social History	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

- Important relationships
- Financial or insurance issues presenting obstacles to accessing care?
- Cultural factors related to healthcare
- Religious or spiritual beliefs or supports

Family History	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

- Present age and state of health, or Age at death and cause
- Major medical or psychiatric problems
- History of breast, ovarian, colon, prostatic cancers, hypertension, heart disease, diabetes, alcoholism, or depression

Review of Systems	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

INTERVIEWING SKILLS:

Builds a Relationship	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Greets and shows interest in patient as a person
- Displays openness to patients' emotions/makes empathic statements
- Uses words that show care and concern throughout the interview
- Uses tone, pace, eye contact and posture that show care and concern

. Opens the Discussion	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Allows patient to complete opening statement without interruption
- Asks "is there anything else" to elicit full set of concerns
- Explains and/or negotiates an agenda for the visit

Gathers Information	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Begins with patient narrative using open-ended questions ("tell me about…")
- Clarifies details as necessary with more specific or "yes/no" questions
- Summarizes and gives patient opportunity to correct or add information
- Transitions effectively to additional questions

Understands the Patient's Perspective	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Asks about life events, circumstances and other people that might affect health
- Elicits patient's beliefs, concerns and expectations about illness and treatment
- Responds to patient statements about ideas and feelings

Shares Information	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Explains using words that are easy for patient to understand
- Asks if patient has any questions

Provides Closure	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Asks if patient has any questions, concerns or other issues
- Summarizes
- Ends interview warmly

Adapted from: Makoul G, Rider EA, Gordon GG, Kurf LS, Lang F, Novack D, et al. Essential elements of communication in medical encounters:
the Kalamazoo consensus statement. Academic Medicine 2001;76:390-393.

PHYSICAL EXAMINATION

General Physical Exam	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

	Comment on the examiner's specific strengths and weaknesses
Demonstrate concern for the patient's comfort and modesty	
Demonstrate proper hygienic practices (i.e. hand washing) including the use of standard precautions when examining a patient	
Be able to perform a complete examination of all organ systems in sufficient detail to be certain there are no substantial abnormalities, particularly with respect to those areas implicated in the HPI	
Be able to properly position and drape patient maximizing ease of exam and patient comfort	
Be able to perform exam in a thorough, organized and logical sequence	
Be able to perform a more detailed exam of any organ system when a cursory or screening evaluation suggests an abnormality	
Be able to recognize the range of normal findings and be able to recognize abnormal findings when their presence is unequivocal	
Demonstrate the ability to adapt the scope and focus of the exam appropriately to the clinical situation and time available.	

Specific Physical Exam Competencies

To be checked as each procedure is demonstrated during a physical examination. These maneuvers should be done in an orderly manner but do not have to follow a special format.

Patient Sitting	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Inspect general appearance
- Palpate, compare and count radial pulses
- Measure respiratory rate
- Measure blood pressure
- Inspect skin, hair, nails, hands
- Inspect face and head, eyes, earsevics and oral cavity
- Measure visual acuity, pupillary size/reactivity and perform fundoscopic exam
- Palpate lymph nodes (cervical, auricular, occipital submandibular, supraclavicular)
- Palpate thyroid/trachea

Back of Patient	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Palpate thyroid (if not done from the front)
- Observe chest expansion symmetry
- Percuss and auscultate lungs
- Percuss spine, check costovertebral angle tenderness

Front of Patient	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
	1	**2**	**3**	**4**	**5**

- Complete anterior chest examination, auscultate lungs
- Examine carotid pulses and auscultate for bruits
- Use appropriate maneuvers to elicit heart murmurs (i.e. leaning forward if concern for AI)
- Examine jugular venous pulse
- Examine upper extremity joints (can also be done after supine exam)
- Test upper extremity and neck strengths (can also be done after supine exam)

Patient Supine	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

- Reauscultate heart
- Check venous pulse and pressure
- Localize PMI
- Palpate breasts/axillae
- Inspect abdomen
- Auscultate abdomen
- Palpate abdomen for tenderness and for organomegaly or masses
- Percuss liver and flanks
- Examine for hernias (and in male patients: examine genitalia)
- Palpate inguinal nodes and femoral pulses
- Check pedal pulses
- Check for edema
- Examine lower extremity joints and inspect feet
- Test lower extremity strength
- Test heel to shin
- Test pin, light touch, vibration and position sense in all extremities

Patient Sitting	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

- Cranial nerves if not done earlier as part of ENT exam
- Test finger-to-nose
- Elicit tendon reflexes in arms and legs, and plantar reflexes
- Test mental status

Patient Sitting	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

- Examine lower spine
- Observe stance, regular gait and tandem gait
- Perform Romberg test

COMMENTS:

CASE PRESENTATION

Case Presentation	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

	Comment on specific strengths and weaknesses
Assess the importance of relevant data in the history	
Assess the importance of relevant data in the physical exam	
Use terminology that is meaningful and unambiguous	
Present information concisely and logically	
Report accurately the observations made during the physical exam	
Relate information about major problems in adequate detail without significant omissions	
Present within constraints of time limit	
Assess the important problems and develop pathophysiologic correlation	

COMMENTS:

OVERALL ASSESSMENT

Overall Assessment	Poor	Fair	Good	Very Good	Excellent
	1	2	3	4	5

Additional Comments:

EXAMPLES OF STRONG POINTS	EXAMPLES OF POINTS FOR IMPROVEMENT