

THE LONGITUDINAL PRECEPTOR PROGRAM

Preceptor Packet AY 2018-2019 Year 2



University of Massachusetts Medical School

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Included in the appendices below are protocols that are taught in the Doctoring and Clinical Skills (DCS) curriculum. We have included these as a reference.

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WELCOME BACK TO LPP!

As you know the LPP is designed to give students an opportunity to experience the practice of medicine firsthand as well as to interview and examine real patients. This second year allows you the opportunity to further develop your history and exam skills and to begin to incorporate problem solving into your patient encounters.

It remains important that students maintain good communication with their preceptor. Even though students are returning to your office, they should schedule some time to review goals and objectives for year 2. Students should **schedule meeting times well in advance - plan your whole semester in the beginning, planning ahead will make it easier.** Students are encouraged to remind preceptors of their goals and discuss what they are doing in other courses.

Students are **required** to attend 6 clinical sessions for the fall semester of LPP year 2, and to record those encounters on the LPP2 checklists (bubble sheets) in order to receive course credit. **LPP year 2 checklists will be electronic via OASIS.** There are additional requirements outlined on the next page. **In November, preceptors will receive a link to the preceptor evaluation. Fill out the evaluation of your student and meet with your student to discuss the evaluations (students will be filling out a self evaluation on the LPP experience)**

The learning objectives of the LPP are met by placing students in a variety of clinical settings and specialties. Therefore, *we expect differences* between student experiences. As long as students are having their basic educational goals met, then you are on the right track. If this is not happening, or you are having other difficulties with your LPP student, let us know as soon as possible.

We have created a new website for the Longitudinal Preceptor Program. The site offers information for current and new preceptors (if you know anyone that is interested in becoming a preceptor please share the link with him/her), a link to the monthly email updates and student testimonials. Please feel free to visit it using the link and let us know your thoughts.

<http://www.umassmed.edu/oume/curriculum/longitudinal-preceptor-program/>

Sincerely,

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AY 2018-19 EVALUATION/GRADING

The Longitudinal Preceptor Program (LPP) accounts for 20% of the Doctoring and Clinical Skills 2 (DCS2) course grade. Outstanding performances are taken into consideration in the overall DCS grade. **LPP coursework must be completed by January 21, 2019. Failure to have assignments completed will result in a No Credit grade for the course.** The following components will be used to determine the LPP grade and are **REQUIRED TO PASS:**

Requirements DUE January 21, 2019

1. Attend 6 Preceptor Sessions; complete 6 Checklists (OASIS)-*one for each session*
2. Review the Fall Semester Objectives Guideline (see below)
3. Preceptor Evaluation
4. Self-Evaluation

You must receive a passing LPP grade in order to receive credit for the DCS course.

LPP 2 OBJECTIVES GUIDELINE

The grid below is to be used as a **guide to the objectives**. Below are certain objectives the students are given August- January to focus on.

The learning objectives of the LPP are met by placing students in a variety of clinical settings and specialties. Therefore, *you can expect differences between your experience and those of your classmates. As long as you are meeting your basic educational goals then you are on the right track. If this is not happening, or you are having other difficulties with your LPP assignment, let us know as soon as possible.*

OBJECTIVE
Demonstrate the ability to:
1. Perform a complete history and physical exam over course of the semester
2. Complete History & Screening Exam
3. Gather a focused History (HPI) & perform an Indicated Physical Exam
4. Develop and Discuss Problem Lists (listing findings, group findings, problem list), Assessment & Plans for one patient at each session. Review with your preceptor.
5. Perform an oral presentation to your preceptor for at least one patient you saw during your session.
6. Conduct a counseling encounter with a patient in your preceptor's office.
7. Continuity Patient (if your practice setting is amenable).
8. Demonstrate & Discuss Prescription writing with your preceptor. If possible, observe him/her submitting an EHR (electronic health record) prescription one time for LPP year 2.
9. Write a SOAP note and have your preceptor review it one time for LPP year 2.

10. Describe the role of another member of the patient care team through working with them during one of your sessions.

11. Utilize the patient's Electronic Health Record (EHR).

12. Complete a self-evaluation and discuss with your preceptor (online link for OASIS will be sent in November, due January 2019)

DETAILS OF LPP YEAR 2 OBJECTIVES

1. Complete History and Screening Physical Exam: This includes the complete history and a routine physical exam. A routine exam is a head-to-toe exam aimed at screening for subtle medical problems. Most of these exams are normal as abnormal findings are usually found after symptoms referable to that system are noted. However, some illnesses may only be picked up during a screening exam. The complete history includes the following components:

- Chief Complaint (CC)
- History of Present Illness (HPI) - utilizing 7 cardinal features
- Past Medical History (PMH), medications and allergies
- Family History (FH)
- Social History (SH)
- Review of Systems (ROS)
- Sexual History (SH)

Practice as many parts of this exam or all of it as many times as you can. **Physical examination is a vital and fundamental part of being a physician. The more you do it, the more skilled you become.** Your preceptor will help you define what constitutes a routine medical exam in the office, which will likely be less detailed than the full exam you have learned. You have learned many components that you will not *routinely* use but that you must be familiar with to perform when indicated.

2. Focused History and Physical Exam: This focuses on a single (or sometimes multiple) complaint that the patient has regarding health, and is shorter in scope, but somewhat more complex. You are required to carefully consider the problem and obtain the appropriate history and physical for that particular problem. Once clarifying the chief complaint you will ask the HPI (7 cardinal features) as well as particularly focusing on the ROS for that system and accompanying pathophysiologic features. **Do not forget to ask about PMH, medications, allergies.**

For instance, in a patient with a chief complaint of heartburn, it would be helpful to know if the patient had a PMH of an ulcer or is taking ibuprofen daily for arthritis. A focused history, therefore, requires that you begin thinking about the possible etiologies in order to know what system(s) to ask about and then examine. For the patient with heartburn, it will not be useful to ask about urinary complaints as it is highly unlikely that the genitourinary system is involved.

The physical exam component, therefore, should be relevant to the system(s) that are likely involved. This will not be a head-to-toe exam. The patient with heartburn may only require an abdominal exam, but a rectal exam may also be required depending on the history you obtain.

3. Develop and Discuss Problem List (list findings or group findings), Assessment and Plans: Complete these details on at least one patient per session, as this is your opportunity to use critical thinking skills, i.e. putting it all together in terms of what the patient's problems are, how to evaluate them and how to treat them. Ask your preceptor to review with you. Ask how your preceptor uses the problem list. To help you problem solve a case, you may want to first list your findings and then group common elements so you can better understand what is going on and how best to develop an assessment and plan.

4. Oral Presentation: The format for an oral presentation is in the appendix. This is one of the ways that you will be communicating with others regarding patients. Oral presentation is also one of the most obvious ways you will be assessed. A good presentation reflects a competent student, whereas a

disorganized presentation one will reflect badly on your abilities. You may have already started to do this in LPP I and will have a chance to do it more in the hospital sessions, but now is the time to begin honing your skills for third year. Try to present each patient that you see to your preceptor, if this is not possible at least one patient per session. Get feedback from your preceptor as to how you're doing.

5. Counseling: This will give you the opportunity to utilize the counseling skills you learned in DCS. Please refer to the Health Risk Behavior Assessment in the appendix. Attempt to counsel as many patients on a specific behavior that needs modification as possible. Smoking is very common, but any behavior may be addressed (i.e. on diet, weight loss or exercise). We encourage you to write down what did/didn't work during the counseling so you can refer back to this at a later date. Counseling will become an integral part of what you do regardless of your eventual specialty choice.

6. Continuity Visit: You will want to discuss this patient encounter with your preceptor, so that you may arrange your schedule around the follow-up office visit at a time when you are scheduled to return to the practice. Observe the differences in the encounter when you see the same patient a second or third time. You may also want to see if that patient has other medical appointments within the healthcare system and ask to attend those as well. This could be visits with other specialists or other scheduled tests such as radiology procedures, cardiac testing, or pre-op testing.

7. Prescription Writing: Have your preceptor help you write real or mock prescriptions as many times as you're able (you need to do this once for LPP 2). This will give you a chance to learn medication names and doses. A mock prescription is included. Even if your preceptor uses an electronic prescription writing tool, you should ask if you can practice writing mock prescriptions and have them critiqued for accuracy. Observe them submitting prescriptions in the EHR.

8. Write a SOAP note: Completing a SOAP note will help to familiarize you with a form of written communication that you will utilize thru out your career. **Your preceptor will be responsible for reviewing the note.** See the appendix for more information on this format.

9. Interprofessional Medical Education: Working with members of the patients health care team is a valuable experience. This will help you to understand the team members in your preceptor's office and the role they play in the patient's care. Examples could include spending some time with the triage nurse on the phones, working with the health assistants rooming the patients, spending time in the lab or radiology, or working with the front desk staff at registration.

10. Electronic Health Record (EHR): Most medical offices and hospitals now utilize some record on EHR. Ask your preceptor to guide you through ways he/she uses the EHR in the care of their patients. This will be very helpful as you move into the in-patient setting during your hospital sessions.

11. Preceptor and Self Evaluation: **In November you will receive a preceptor evaluation and self evaluation checklist. These evaluations should be filled out by you and your preceptor and you should** schedule a time to review and discuss your self-evaluation and your preceptor's evaluation at your last LPP session of the fall semester. **Please sure to schedule time for this with your preceptor.** These evaluations are due back no later than 1/22/19.

We wish you the best as you continue your work in becoming doctors!

APPENDIX

GUIDELINES FOR PROFESSIONAL BEHAVIOR

The Faculty and Student Body of the University of Massachusetts Medical School regard the following as guidelines for professional behavior. These areas are derived from the school's Technical Standards (see Student Handbook). Students are expected to show professional behavior with or in front of patients, members of the health care team, and others in the professional environment (school, hospital, clinic, office) including members of the faculty and administration, other students, standardized patients, and staff. Faculty members and administrators are expected to abide by similar standards.

PROFESSIONAL ATTRIBUTES

Displaying honesty and integrity

- Never misrepresents or falsifies information and/or actions (i.e. cheating)
- Does not engage in other unethical behavior

Showing respect for patient's dignity and rights

- Makes appropriate attempts to establish rapport with patients or families.
- Shows sensitivity to the patient's or families' feelings, needs, or wishes.
- Demonstrates appropriate empathy.
- Shows respect for patient autonomy.
- Maintains confidentiality of patient information.

Maintaining a professional demeanor

- Maintains professional demeanor even when stressed; not verbally hostile, abusive, dismissive or inappropriately angry.
- Never expresses anger physically.
- Accepts professionally accepted boundaries for patient relationships.
- Never uses his or her professional position to engage in romantic or sexual relationships with patients or members of their families; never misuses professional position for personal gain.
- Conforms to policies governing behavior such as sexual harassment, consensual amorous relationships, hazing, use of alcohol, and any other existing policy of the medical school.
- Is not arrogant or insolent.
- Appearance, dress, professional behavior follow generally accepted professional norms.

Recognizing limits & when to seek help

- Appears aware of own inadequacies; correctly estimates own abilities or knowledge with supervision.
- Recognizes own limits, and when to seek help.

RELATIONSHIP TO OTHERS

Responding to supervision

- Accepts and incorporates feedback in a non-resistant and non-defensive manner.
- Accepts responsibility for failure or errors.

Demonstrating dependability and appropriate initiative

- Completes tasks in a timely fashion (papers, reports, examinations, appointments, patient notes, patient care tasks).
- Does not need reminders about academic responsibilities, responsibilities to patients or to other health care professionals in order to complete them.
- Appropriately available for professional responsibilities (i.e. required activities, available on clinical service, responds to pager).
- Takes on appropriate responsibilities willingly (not resistant or defensive).
- Takes on appropriate patient care activities (does not "turf" patients or responsibilities).

Interacting with other members of the team

- Communicates with other members of the health care team in a timely manner.
- Shows sensitivity to the needs, feelings, and wishes of health care team members.
- Relates and cooperates well with members of the health care team.

LPP 2 Interview Checklist

(LPP is now on OASIS – this is last year's SAMPLE)

Session Date:

Month

Day

Year

Accomplishments for this LPP session

Please indicate the number of times each of the following occurred.

I observed my preceptor...						I performed...			
0 times	1-2 times	≥3 times					0 times	1-2 times	≥3 times
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	7 Cardinal features of the HPI				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Past Medical History				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Social History (including habits)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sexual History				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Family History/Genetic History				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Meds/Allergies				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Counsel a patient (e.g., smoking, diet, exercise)				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Some portion of physical exam				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Develop a Problem List				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Develop an Assessment/Differential Diagnosis				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Develop a Plan				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oral Presentation				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	0 times	1-2 times	≥3 times
Number of times I was observed by my preceptor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Number of times I was given feedback by my preceptor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No	Yes	Last Session
I developed a learning plan with my preceptor for the next session	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	0 patients	1-2 patients	≥3 patients
Number of patients seen today that I have seen before	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SOAP NOTES

SOAP notes can be used for problem focused outpatient encounters and for daily progress notes on inpatients. These notes can vary dramatically, depending on the situation.

S- Subjective, this is what the patient tells you, the history. When it is a symptom, this portion of the note is the HPI with all the categories of information you need to collect as taught to you in DCS (7 cardinal features, pertinent review of systems, PMH/PSH, FH, SH, and condition specific data). If you are discussing smoking cessation or any other behavior change, the framework you are using for the interview provides you with a structure for what information to collect and then record.

O- Objective, this is the physical examination that you performed, lab data and other medical test data for instance chest x-ray results. In most outpatient encounters or in inpatient follow up visits, a complete physical is not performed. You usually perform and record a **Focused Physical Exam** that consists of

1. General Appearance and Vital Signs
2. Examine systems that could be involved in the disease processes you are considering as potential causes for your patient's symptoms (this is your differential diagnosis) or the systems involved by the problem if you have already established a diagnosis. This allows you to use your physical exam as a problem solving exercise, examining focused areas to allow you to distinguish amongst the possibilities (e.g. heart, lungs, abdomen, and muscles of the chest in a person with chest pain) as well as use the exam to determine if a patient is improving.

Assessment and Plan

Begin with the first problem on your problem list and proceed sequentially. The **problem list** is a series of issues that you need to address over time during a hospital admission or during a continuous relationship with a patient. So for each problem listed, you will end up with an assessment and plan for that problem. Your assessment of the problem will differ slightly if the problem is a symptom or if your problem is a diagnosis.

If your problem is a symptom, your assessment should discuss what the possible diagnosis's are that could cause the symptom (referred to as a differential diagnosis). Then you discuss your most likely diagnosis, and the reason(s) why you think this is the most likely diagnosis. Reasons usually include supporting evidence from the history (the shortness of breath was accompanied by cough, fever, yellow sputum), the physical exam (the patient had rales present in the lower left lobe), x-rays and lab data. You should also briefly discuss the reasons that allowed you to conclude that the other diagnoses in the differential were less likely (i.e. "this patient had no paroxysmal nocturnal dyspnea-waking up in the middle of the night short of breath, leg edema, or orthopnea, making the diagnosis of Congestive Heart Failure unlikely). Finally, **your plan** discusses your decisions about testing and treatment that will allow you to distinguish the various diagnostic possibilities from each other.

If your problem is a diagnosis, your assessment should include how you arrived at the diagnosis and the reason(s) why you think this is the diagnosis. Reasons should be similar to the supporting evidence as above. You should also discuss the other diagnoses that you considered, and how you excluded them. **The plan** is then similar to the above task, but you will concentrate on testing if needed to confirm the diagnosis and treatment of that condition if the diagnosis is certain.

Here is an example:

S – This patient presents today with a complaint of mid sternal chest pain which started 2 weeks ago after eating pizza and has occurred almost daily since, lasts approx. 1-2 hrs., usually occurs after meals particularly caffeine or fatty foods, is burning in quality and relieved by TUMs. The patient denies radiation of pain, shortness of breath, association with exertion, palpitations, nausea, dizziness or sweating. There are no cardiac risk factors (family history, diabetes, hypertension, smoking or cholesterol or male sex). The patient has never had this before.

O - T- 98 BP-110/72 HR- 64 RR- 16

General- Alert, no apparent distress

Cor- regular rate and rhythm, no murmur, rub or gallop

Chest- tender to palpation at costochondral junctions

Lungs- clear to auscultation

Abdomen- normoactive bowel sounds, soft, nontender, no hepatosplenomegaly, no masses

A - Chest pain - atypical in nature, heartburn-like, occurring only supine, easily relieved with antacids. Differential diagnosis includes: GI - probably GERD, most likely because of previous mentioned characteristics, musculoskeletal - less likely than GI but given chest wall tender to palpation on exam suggests component of costochondritis (inflammation of joint spaces between sternum and ribs) as well, cardiac - but less likely because no significant risk factors and atypical pain, pulmonary - very unlikely, no symptoms referable to this system

P -start H2 blocker

-call in 2 weeks to report progress

-will hold NSAIDS for now for costochondritis until reflux improved

-follow-up as indicated, may need UGI if no significant improvement with H2 blocker

GUIDELINES FOR ORAL PRESENTATIONS (for case-type presentation)

Chief Complaint/Opening Line/Orienting Statement , includes identifying information and the chief complaint (see opening line notes below, which chiefly pertain to DCS2)

Your opening line will vary depending on the audience, the situation, and the purpose of the presentation. It should orient the listener to key elements of the chief complaint and how it relates to the broader case. Consider the following situations.

1. In a new patient who presents with symptoms of cough, you should make sure that the chief complaint is in the first sentence of your presentation. "This is a 32 year old man who presents to the hospital with shortness of breath and cough."
2. You do not need to present all the details of the Past Medical History in the first line of the presentation, but you should consider whether some aspects of the medical history would influence the listener's thinking and is **so** important that you should include it in the first sentence. For example, one would think differently if the opening line of the presentation above were: "This is a 32 year old man with a 12 year history of HIV infection and progression to AIDS who now presents with shortness of breath and cough."

HPI-should reflect the chief complaint, its features (7 cardinal features)

You should at least detail:

- The seven cardinal features of the presenting symptom.
- Pertinent Review of Systems (ROS questions from the system(s) in which chief complaint may fall)
- PMH that could be related to diseases that present with the chief complaint
- FH that could be related to the chief complaint
- SH that could be related to the chief complaint
- Condition specific data- detailed (disease based) information about specific conditions that don't fit into above categories (nausea in patient with headache is something that you likely need to think of migraine or elevated intracranial pressure which then makes you ask and then report on nausea.)

NOTE: Risk factors for disorders that could present with the chief complaint is a broad term that includes items from many of the above categories (something from the PMH, FH, SH, or medications that makes a particular diagnosis more likely, i.e. heavy drinking from SH or aspirin from medications are risk factors for a bleeding ulcer. FH of MI or PMH of HTN are risk factors for MI).

NOTE: Collectively, the information beyond the 7 cardinal features represents **pertinent positives** (pertinent positive is a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint that is present in the patient) and **pertinent negatives** (pertinent negative is a symptom, risk factor, or risk behavior associated with pathological conditions presenting with such a chief complaint that is absent in the patient). The pertinent positives and negatives depend on your knowledge of pathophysiology.

Medications*-list the medication and doses that the patient is taking.

Allergies*-list agent and type of reaction.

By the end of the HPI presentation, the listener should have some idea of the diagnostic possibilities that you are considering.

*Some advocate for presenting Meds/allergies in all patients to encourage you to think about whether meds or allergies could be related to HPI

Summary statement

- Must start with pt demographics (Gender, Age)
- Most pertinent PMH, FH, SH, i.e. if it is immediately related to the chief complaint
- End summary sentence with as much of a “commitment” to your proposed diagnosis as you are able to give at your level of training. For instance, in the case above, you may say “32 year old male with a 12 year history of AIDS who now presents with fever and cough (will add physical exam and labs as you perform more complete exams), suspicious for PCP pneumonia”. You may only be able to narrow down your most likely diagnosis after the history and physical (you will likely be doing more, i.e. labs, XRAYs, to further clarify). For instance, “18 month old full term male with 2 days of cough and wheeze, and now 1 day of increased work of breathing, consistent with either asthma or bronchiolitis”
- Do not have your summary statement be a rehashing of the HPI!

Adaptations for the Complete Presentation

If oral presentation is a complete presentation of a full History and Physical (like you will perform in DCS2 Hospital sessions and in the clinical years), you will present full details of PMH, Meds/All, FH, SH, ROS in more complete fashion, but with less detail than information from these categories that are related to the HPI

Review of systems-for the presentation; you should only give those positive symptoms that will need to be addressed during the admission or at the end of the outpatient visit.

Physical Examination-patient’s general appearance (uncomfortable appearing woman in respiratory distress), a complete set of vitals, all parts of the exam that could have abnormalities produced by diseases that are on your differential.

Outline for the *Focused History and Physical Examination*

The History

I. Chief Complaint (cc)

II. History of Present Illness

- A. 7 Cardinal Features of the presenting symptom (cc)
- B. Review of Systems from system(s) in which chief complaint falls (e.g. Cardiac, Pulmonary, Musculoskeletal, and GI ROS for someone with chest pain)
- C. Pathophysiologic Features – report pertinent positive features (symptoms, risk factors or risk behaviors) associated with pathological conditions related to the chief complaint that are present in the patient; and pertinent negative features (symptoms, risk factors, or risk behaviors) associated with pathological conditions related to the chief complaint that are absent in the patient. The following should be included:
 1. Symptoms associated with diseases that could present with Chief Complaint (e.g. *fever* in someone with a cough and sputum production makes you think about pneumonia)
 2. FH of related diseases (e.g. FH of colon cancer in a patient with blood in stool)
 3. Risk Factors for diseases (e.g. hypertension in those with chest pain)
 4. PMH that could relate (e.g. Congestive Heart Failure in a patient with shortness of breath)
 5. Social History related to chief complaint (stress in patient with chest pain, smoking in patient with shortness of breath, alcohol in patient presenting with abdominal pain)

III. Other Core History - while the above emphasizes problem solving history, it is important to report medications that the patient is taking and any allergies. Some would also feel that any significant PMH (e.g. diabetes) should be reported as well.

The Physical Examination

I. General Appearance and Vital Signs

II. Examine Systems that could be involved in the disease processes you are considering as causes of the chief complaint (e.g. heart, lung, abdomen, and muscles of the chest in a person with chest pain)

Outline of the Complete Medical History and Write-up

I. Chief Complaint (CC)

II. History of Present Illness (HPI)

A. 7 Cardinal Features of the presenting symptom (CC)

1. Quality
2. Location
3. Chronology
4. Setting and Onset
5. Severity
6. Modifying Factors
7. Associated Symptoms

Include Pertinent Positives - a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint which is present in the patient.

Include Pertinent Negatives - a symptom, risk factor or risk behavior associated with pathological conditions presenting with such a chief complaint which is absent in the patient.

III. Past Medical and Past Surgical History (PMSH)

- A. Medical Illnesses/ Hospitalizations
- B. Surgical History
- C. Psychiatric History
- D. Childhood Illnesses
- D1. (Add Birth and Developmental History to a Pediatric History)
- E. Injuries
- F. Medications
- G. Allergies
- H. Transfusions
- I. Pregnancies

IV. Social History/Habits and Risk Behavior

- A. Birthplace
- B. Education
- C. Work and Work History including exposure to hazardous materials
- D. Marital/Relationship Status
- E. Quality/Quantity of Social Relationships
- F. Diet
- G. Exercise
- H. Tobacco Use
- I. Alcohol Use
- J. Drug Use
- K. Sexual Behaviors History
- L. Domestic Violence
- M. Injury Prevention (seat belts, bicycle helmets, etc.)

V. **Family History**

- A. Significant **Illnesses** in 2-3 generations of family – Document -
 - Ages and health status of **siblings**
 - Ages and health status of **parents**
 - Ages and health status of **grandparents**
 - Ages and health status of **children**
- B. Ask about Common **Diseases** with known genetic links
 - 1) familial incidence of arthritis, cancer, diabetes, hypertension, myocardial infarction, stroke, mental illness, alcoholism
 - 2) any other illness that **runs in the family**

VI. **Health Care Maintenance (Prevention and Screening)**

- A. Cancer Screening
- B. Immunizations
- C. High Risk Population Screening (e.g. HIV testing for those with high risk behavior)
- D. Other (cholesterol, vision, hearing, dental, sun exposure)
- E. Health Care Proxy

VII. **Review of Systems (ROS)**

- | | |
|---------------------------|---------------------|
| A. Constitutional | B. Skin |
| C. Head | D. Eyes |
| E. Ears | F. Nose |
| G. Mouth | H. Throat |
| I. Breasts | J. Respiratory |
| K. Cardiovascular | L. Gastrointestinal |
| M. Urinary | N. Genital |
| O. Menstrual-Reproductive | P. Endocrine |
| Q. Musculoskeletal | R. Hematological |
| S. Nervous System | T. Psychiatric |

COMPONENTS OF THE MEDICAL HISTORY DESCRIBED

I. Chief Complaint (CC): The patient's stated reason for the medical encounter

II. History Present Illness (HPI): Characterize the chief complaint according to the principles of interviewing that you learned in the Physician Patient and Society course. This includes the 7 cardinal features of the symptom (quality, location, chronology, associated symptoms, modifying factors, setting and onset, and severity) as well as asking all questions in the past medical history (PMH), family history (FH), social history (SH) and review of systems (ROS) that directly relate to the chief complaint. Therefore, if a patient is experiencing shortness of breath, you should characterize the complaint and then include any pertinent PMH, FH, SH, and cardiorespiratory review of systems in your HPI since most causes of SOB can be traced to these two systems. Therefore, at the end of the HPI, it is worthwhile to ask yourself: "*have I characterized the chief complaint and asked the relevant questions from the appropriate past medical history, family history, social history and review of systems?*"

The HPI is the most demanding part of the history. It details completely and concisely all of the features of the illness or symptom complex that brought the patient to the hospital or the physician's office. It should be detailed in chronological order and in literate fashion so that details and time sequence are understandable to the reader. This is a task of potentially extraordinary complexity. It requires that you get the full details as outlined above, as well as the care that the patient has sought for the symptoms, diagnostic tests performed, physician's and patient's impressions of the symptoms and the plan that has been outlined thus far.

While not expected for this course work, keep in mind during the time that you are doing clinical rotations, you will also be asked to review previous medical records to supplement the information that the patient has given you and confirm the details of the tests that the patient has had leading up to the hospitalization. While this list of questions and issues that need to be addressed seem to be daunting, they can all be seen as a part of the time course of the illness for which the patient presents.

Events should be related temporally but attention should be paid to the avoidance of skipping back and forth between the details of symptoms in different organ systems. If a patient has an illness that has multiple symptoms from different organ systems, it is often helpful to detail the symptoms separately followed by their time course, features, pertinent positives and negatives. In addition, if the patient has had multiple episodes of a symptom complex or multiple exacerbations of one disease, it is often helpful to get the full details of a typical episode, record the frequency of episodes and record how the current episode may differ from a typical episode if it does.

There clearly is judgment involved in deciding whether an item belongs in the HPI. A rule of thumb is to include all the symptoms from the Review of Systems in which the patient's chief complaint falls as well as any diseases that relate to that system. As you take the history and form ideas or hypotheses about what disease entities that the symptoms might represent, be careful to then include questions from the systems that these diseases involve. This requires that you begin to integrate the knowledge that you have gained in the Pathophysiology course with the symptoms that the patient reports to you. You should not include the details of illnesses that are not related to the HPI here as this information belongs in the PMH.

III. Past Medical History (PMH): In this section, you should detail the patient's previous medical and surgical problems. To be included in this section, it should be a clear diagnosis, not only a symptom or symptom complex. In addition, if a patient tells you that they have had a certain disease; you should typically ask about the presenting symptoms, diagnostic tests used to arrive at the diagnosis, and subsequent course of the disease. This information allows you to include only clearly established diagnoses. The more varied that the disease presentation can be, the more critical it is that you record the details completely. You can use a short hand method of recording the PMH/PSH by listing the diagnosis followed by the date that the diagnosis was made and the details that you have collected. An example is given below.

- a. Essential Hypertension - 1986, diagnosed on routine PE, without complications, treated with ACE Inhibitor, Vasotec
- b. Systemic Lupus Erythematosus - 1989, presenting with diffuse arthralgia and arthritis as well as skin rash, diagnosed clinically and treated with Naprosyn for his/her joint pain

Also included in this section are numerous subheadings that pertain to previous problems or health history. These include:

- a. Past Illness (examples above)
- b. Past Surgeries
- c. Childhood Illnesses
- d. Injuries
- e. Immunizations
- f. Allergies (include a description of the reaction)
- g. Transfusions
- h. Pregnancies
- i. Medications - include doses and frequency

IV. Family History (FH): Diseases that can be inherited are a critical part of the history. You should record the health status and health problems, concentrating on those that are known to have genetic links, of the patient's grandparents, parents, siblings and children. If any of these persons are deceased, record the cause of death and the age at which that occurred. While history of the grandparents may be hard to obtain, it is important to attempt to get information for at least two generations of the family that have lived long enough to get heritable diseases. This can be recorded in long hand or in family tree format being sure to identify which one is the patient if a family tree is used. In addition to whatever format is being utilized, you should also ask about the major disease categories that are known to have genetic links such as Diabetes Mellitus, Hypertension, Myocardial Infarction, Stroke, Arthritis, Asthma and Cancer.

V. Social History (SH): This section should attempt to detail prominent features in the life of the person that you are examining. It should include a comment on where the person was born, when and how they came to be in their current community, their marital status, current work, some comment on the quality and quantity of their social relationships and their means of emotional support. By convention, this is the section of the write-up where the smoking history, alcohol history, sexual history, and drug use history are recorded.

VI. Review of Systems (ROS): This is a systematic, comprehensive review of multiple symptoms that the patient may have experienced. The areas that you have to question can be conveniently grouped according to the pathophysiological system in which they fall. A list of systems follows this

section. There are several critical items that need to be mentioned with regard to the recording of the ROS in the write-up. If a patient tells you that they have experienced a certain symptom, pursue that positive answer to determine whether it is a current problem, an acute problem that will need attention during this visit, or a fleeting or past problem that does not require attention at all. Do not simply record that symptom as "positive." Conversely, it does not suffice to describe a whole system as negative while not recording the items that you asked the patient. This is the case because recording the system as negative does not adequately characterize what items you asked the patient about. This is generally referred to as "pertinent positive" and "pertinent negative" review of system as applied to the chief complaint.

A NOTE ABOUT TIMING-

ROS questions are asked in many situations. It is important to be clear why you are asking them, and what time period you want the patient to consider in answering the question.

If the patient is an outpatient who you will follow over time, you are really asking whether a patient has had significant symptoms recently (and in some circumstances like hemoptysis or sudden asymmetric weakness or loss of consciousness, ever), and then pursuing enough detail to determine whether you might be able to make a diagnosis or need to do some tests, or be aware of these symptoms for a later visit

If the patient is an inpatient who you will follow during the hospitalization, your question really has to do with whether the patient has experienced symptoms in ROS recently, and significantly enough that you need to focus on it (either testing or treatment) during this hospitalization.

You are not asking whether a patient has ever had a rash, or ever had epistaxis (bloody nose) or heartburn

What follows is a list of questions from various organ systems that should be addressed in the ROS.

1. **CONSTITUTIONAL SYMPTOMS:** Fever, night sweats, chills, fatigue, anorexia, insomnia, weight change, weakness, irritability.
2. **SKIN:** Change in moisture, temperature, color or texture, lesions, rashes, itching, bruising, bleeding disorders, changes in hair or nails.
3. **HEAD:** Change in head size, headache, trauma.
4. **EYES:** Vision changes, glasses, blurring, eye pain, diplopia (double vision), scotomata (blind spots), flashes of lights, injury, irritation, discharge, photophobia, excessive tearing.
5. **EARS:** Hearing loss, pain, infections, discharge, tinnitus, vertigo.
6. **NOSE:** Dryness, bleeding, pain, discharge, coryza, epistaxis, obstruction, sinus pain, change in smell.
7. **MOUTH:** Condition of teeth, pain in mouth or tongue, bleeding gums, lesions in mouth, tongue or lips.
8. **THROAT:** Soreness, hoarseness, dysphagia.

9. **BREASTS:** (both sexes) Pain, swelling, discharge, masses.
10. **RESPIRATORY:** Cough (acute or chronic), sputum production, hemoptysis, dyspnea, wheezing, chest pain, pleurisy, orthopnea.
11. **CARDIOVASCULAR SYSTEM:** Chest pain, exertional dyspnea (shortness of breath), paroxysmal nocturnal dyspnea, orthopnea, palpitations, syncope, peripheral edema, cyanosis, murmur, intermittent claudication, Raynaud's phenomenon, varicose veins, phlebitis.
12. **GASTRO-INTESTINAL TRACT:** Dysphagia, odynophagia, appetite, heart burn (acid indigestion), eructation (belching), regurgitation, bloating, abdominal pain or discomfort, fullness, distention, pain, nausea, vomiting, hematemesis, jaundice, bowel habit change, rectal pain, hemorrhoids, hernia, hematochezia, melena, diarrhea, constipation.
13. **URINARY SYSTEMS:** Dysuria, frequency, urgency, polyuria, nocturia, incontinence, flank pain, hematuria, retention, dribbling, hesitancy, poor stream, back or costovertebral angle (CVA) tenderness.
14. **GENITAL SYSTEM:**
 - a. Gynecological: discharge, itching, genital lesions
 - b. Male Genitalia: pain, lumps, urethral discharge, testicular pain or swelling
 - c. Sexual Problems: dissatisfaction, dyspareunia, potency, recent change in pattern.
15. **MENSTRUAL-REPRODUCTIVE HISTORY:** Dysmenorrhea, intermenstrual bleeding, changes in cycle, amenorrhea, menorrhagia, metrorrhagia. Peri-menopausal symptoms like hot flashes, sweating, post-menopausal bleeding. Emotional reaction to menarche and menopause.
16. **ENDOCRINE SYSTEM:** General (weight change, easy fatigue, behavioral changes), thyroid disease (goiter, heat or cold intolerance, sweating, exophthalmos, tremor, skin and hair changes), diabetes (polyuria, polydipsia, vaginal discharge and itching, skin infections), pituitary disease (change of facial features, hands, feet). Secondary sex characteristics, habitus, hair distribution. Impotence, libido, sterility.
17. **MUSCULO-SKELETAL SYSTEM:** Bone pain, tenderness, swelling, stiffness, limitation of movement of neck, trunk, extremities. Weakness. Trauma, fracture. Swelling backache and leg cramps.
18. **HEMATOLOGICAL:** Lymph node enlargement, pain, bleeding, bruising.
19. **NERVOUS SYSTEM:** Syncope (faint), dizziness, convulsions, vertigo, difficulty with speech or swallowing, localized or generalized symptoms, tremor, weakness, pain, numbness, paresthesia, incoordination, difficulty with bladder or bowel control.
 - a. Cranial nerve symptoms: change in smell, Diplopia, change in vision, blind spots, difficulty with speech, swallowing, or chewing, facial numbness or drooping, change in hearing, tinnitus

- b. Motor system: paralysis, atrophy, involuntary movements, seizures, gait, incoordination
 - c. Sensory system: pain, paresthesia, hyperesthesia, anesthesia
 - d. Mentation: orientation, memory. Reading and writing. Loss of consciousness.
20. **PSYCHIATRIC:** Rapid changes in mood, memory loss, phobias, hallucinations, sleep disturbances, problems with coping, suicide, (attempts or thoughts), anhedonia, frequent crying

Review of Systems - Lay terms

GENERAL: Any problems with your sleep? energy level? appetite? Any recent change in your weight? Any fever, chills? Any problem with excess thirst? Does the heat or cold bother you more than it bothers most people?

SKIN: Any problem with your skin...itching, bruising, growths? changes in moles or a freckle? Any problem with skin moisture...too dry, too oily?

HEAD: Any problem with headaches, dizziness, blackouts?

EYES: Do you have any trouble with your vision? blurred vision? double vision? Do you ever see spots or flashes? Any problem with discharge, redness, itchiness, or tearing?)
Do bright lights bother your eyes?

EARS: Do you have any difficulty with your hearing or ringing in your ears? pain in your ears? itching? drainage? Do you have any difficulty with dizziness? a sensation that the room is spinning around you?

NOSE/THROAT/MOUTH: Any mouth or throat problems...hoarseness, difficulty swallowing, pain, or swelling? Any problems with your teeth or gums?

BREASTS: Any problems with pain, swelling in your breast? Any discharge? lumps?

RESPIRATORY: Do you get short of breath or have pain with breathing? Do you get short of breath with activity? Do you ever wheeze? Do you ever wake up at night short of breath? (Can you go up one/two flights of stairs without stopping? Would you have to stop to catch your breath at the top?)
Do you cough up phlegm or blood?

CARDIOVASCULAR: Do you ever have chest pain? Do you ever wake up in the middle of the night short of breath? Have you increased the number of pillows that you sleep on to help you breath at night? Do you have skipped or rapid beating of your heart? Have you ever passed out? Do you have a problem with swelling or cramping in your legs? Have you ever noticed a color change in your fingers or toes when exposed to cold temperature? Do you have varicose veins

GI: Do you ever have trouble swallowing or painful swallowing? Any problems with heart burn? Have you been sick to your stomach? Have you vomited? ever vomited blood? Do you have belly pain, cramps or bloating? Any problems with bowel movements? (Diarrhea? Constipation? Noticed any blood in your stools or black or tarry stools.

GU: Do you have any problems with urination? (Any burning when you pass your urine? Are you passing urine more frequently? When you feel the urge to urinate, do you feel like you have to go right away? Is the force of your urine stream as strong as it always was? Do you have incontinence...trouble controlling your urine?) Do you have or have you had blood in your urine?

GENITAL SYSTEM:

- a. Gynecological - Do you have any vaginal discharge, itching, growths or lumps?
- b. Male Genitalia - Do you have any discharge from your penis? pain, lumps, or growths? testicular pain or swelling?

- c. Sexual Problems - Are you satisfied with your sexual function? What difficulties do you have, if any? Has your desire for sexual activity changed recently? Do you have pain with intercourse?

MENSTRUAL-REPRODUCTIVE HISTORY: Do you have any difficulties with your periods? pain? bleeding between periods? irregular cycles? intervals without periods? heavy bleeding? prolonged periods? Have your periods stopped? Are you having any hot flashes or sweating as your periods are changing? bleeding after menopause completed? Do you have any emotional reactions to beginning (menarche) or ending your periods (menopause)?

ENDOCRINE SYSTEM: Do you have any change in weight? energy level? unexplained changes in behavior? Any neck growths? feelings of warmth or cold when others are not? excessive sweating? eye bulging? shaking of your hands that is not voluntary? loss or thinning of hair? Any excessive thirst? frequency of urination? Any change in facial features/appearance? size of hands or feet? Any loss of pubic hair? hair growth in locations you haven't had it before?

MUSCULO-SKELETAL SYSTEM: Do you have any bony pain? tenderness? joint pain? swelling? or stiffness? Do you have limited movement of any joint or in neck/back that seems greater than others? Do you have any weakness? back pain?

HEMATOLOGICAL: Do you have any lumps in your neck? under your arms? or in your groin? History of bleeding or bruising?

NERVOUS SYSTEM: Do you have any fainting, dizziness, convulsions/seizures or "fits"? difficulty with or change in speech? swallowing? hand or head shaking that isn't voluntary? localized weakness, pain, numbness or tingling? difficulty with balance? bladder or bowel control?

- a. Cranial nerve symptoms - Do you have any change in smell? vision (double vision, blurry vision?) speech, swallowing, chewing? Any drooping of the face or eyes? change in hearing? ringing or buzzing in your ears?
- b. Motor system - Any paralyzed part of the body? loss of muscle bulk? involuntary movements? difficulty with walking? coordination?
- c. Sensory system - Any pain, numbness, tingling, or increased sensitivity of a body part?
- d. Mentation - Any change in your thinking? sense of where you are? your memory? reading or writing ability?

PSYCHIATRIC: Any change in mood? new fears/phobias? Do you ever see or hear things that aren't there? Do you have any difficulty sleeping? coping with life stresses? feelings about ending your life? plans to end your life? Do you cry frequently and for no reason? Do you no longer get pleasure from things that used to give you pleasure?

Outline of Comprehensive Adult Health Risk Behavior History

Tobacco Use

- Current use
- Past Use

Current Smokers:

- ADVISE TO QUIT
- Quit history
- Use of NRT/Meds for Quitting
- Readiness to Quit**
- Counsel as indicated

Alcohol Use

- Current Use
- Past Use

Possible Problem Drinkers:

- CAGE if indicated
- Readiness to cut down or quit
- Counsel as indicated

Drug Use

- Current Use
- Past Use

Current Users

- Readiness to quit
- Advise to cut down or quit
- Counsel as indicated

Diet

- 24 hour dietary recall
- Frequency of high fat foods
- Frequency of fruits/vegetables**
- Frequency of high calcium foods

High fat or low fruit/vegetable eaters:

- Readiness to change diet
- Advise to change
- Counsel as indicated

Exercise

- Leisure time physical activity
- Work/housework activity

Sedentary patients:

- Readiness to exercise
- Advise to exercise
- Counsel as indicated

Sun Exposure

- History of unprotected sun exposure

Sun exposed patients:

- Advise sunblock
- Counsel as indicated

Injury Prevention

- Seatbelt Use
- Motorcycles/bicycle helmets
- Smoke detectors
- Safe storage of firearms
- Fall prevention (elderly)

Sexual Behavior

- Current sex partners
- Current sex practices
- Current use of contraception
- Past high risk exposures/practices

Having High Risk Sex:

- Advise safe sex
- Advise contraception
- Counsel as indicated

PROBLEM LIST, ASSESSMENT AND PLAN

After you have written up a complete history, ROS, physical exam, and labs, the problem list, assessment and plan is what comes next.

Below is a description and examples for each component.

Problem List

Those issues which the patient and/or you identify as concerns. These may be physical, psychological or social. There may be several at each visit.

Example:

1. Chest pain
2. Weight gain
3. Tobacco Abuse

Assessment

This is what you think is causing the problem (i.e. the diagnosis) or a list of multiple possible causes (i.e. the differential diagnosis).

Example:

1. Chest pain - atypical in nature, heartburn-like, occurring only supine easily relieved with antacids. Differential diagnosis includes: GI - probably GERD, most likely because of previous mentioned characteristics, musculoskeletal - still most likely GI but given chest wall tender to palpation on exam suggests component of costochondritis (inflammation of joint spaces between sternum and ribs) as well, cardiac - but less likely because no significant risk factors and atypical pain, pulmonary - very unlikely, no symptoms referable to this system.
2. Weight gain - patient does not watch diet or exercise regularly. (note - not a diagnosis but a description of the cause)
3. Tobacco abuse - long-time smoker, does not want to quit. (note - not a diagnosis but a description of the pattern)

Plan

This is what you are going to do about each problem. This includes diagnostic test, if indicated, and treatment.

Example:

1. Chest pain
 - start H2 blocker
 - call in 2 weeks to report progress
 - will hold NSAIDS for now for costochondritis till reflux improved
 - followup as indicated, may need UGI if no significant improvement with H2 blocker
2. Weight gain
 - patient interested in starting weight watchers, encouraged to do so
 - patient agrees to daily walking program of twenty minutes
 - return visit 3 months
3. Tobacco abuse
 - long discussion with patient regarding importance of quitting, patient unwilling to quit at this time,
 - will discuss at future appointments

Put it all together and it looks like this:

1. Chest pain - atypical in nature, heartburn-like, occurring only supine, easily relieved with antacids. Differential diagnosis includes: GI - probably GERD, most likely because of previous mentioned characteristics, musculoskeletal - still most likely GI but given chest wall tender to palpation on exam suggests component of costochondritis (inflammation of joint spaces between sternum and ribs) as well, cardiac - but less likely because no significant risk factors and atypical pain, pulmonary - very unlikely, no symptoms referable to this system
 - start H2 blocker
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 - long discussion with patient regarding importance of quitting, patient unwilling to quit at this time, will discuss at future appointments

H2 Blockers – acid blocking medications such as ranitidine (Zantac)

GI - gastrointestinal

UGI – upper gastrointestinal series – x-ray study to rule out ulcers or gastritis

GERD – Gastroesophageal reflux disease

NSAIDs – non-steroidal antiinflammatory drugs – such as ibuprofen (Motrin, Advil).

1. Patient Information – name and age are usually sufficient.
2. Medication name and strength – Prefaced by the **Rx** symbol which is short for *recipe*, the Latin word translated as ‘to take’. A good habit is to write the generic name; most medications come in milligram strengths (mg).
3. Directions: Customarily prefaced by the abbreviation ‘**Sig**’ which is short for *signetur*, a Latin word translated as ‘let it be labeled’. This will be on the label – so this needs to be the same as the directions told to the patient.

Many other Latin abbreviations are traditionally used in the directions, examples listed below:

- BID (bis in die) – twice a day
- TID (ter in die) - 3 times a day
- po (per os) - by mouth
- prn (pro re nata) - as needed
- q 4 h (queaque 4 hora) - every 4 hours

Concern over medical errors has limited the use of such abbreviations, for example qd (once daily), is now a ‘prohibited’ abbreviation and is recommended to be written as ‘daily’.

4. The amount prescribed must also be noted. Typically the number is indicated by the # symbol and the amount prescribed is calculated to cover the expected duration of the treatment. For example if the patient is to take penicillin (an antibiotic) BID for 10 days – then the amount dispensed would be 20, with no refills. If the patient is to atenolol (a blood pressure medication) daily - 30 would be dispensed, with 11 refills (to last the year). (see example below)
5. Finally, the prescription needs to be signed by a licensed physician (your preceptor)

Sample prescriptions

Richard House, MD
55 Lake Ave. N.
Worcester, MA 01655

Name: Michael Smith Age: 42

Rx: Atenolol 30 mg.

Sig: 1 tab daily

#: 30

Refill: X 11

Signature: Richard House, MD Date: 10/1/2008

TEACHING IN THE REAL WORLD

Tips for Integrating Learners into Busy Clinical Settings

Daniel Lasser, MD, MPH

By the end of this session, participants will be able to:

1. List five new ideas for efficient teaching in busy clinical settings;
2. Demonstrate that they can plan ahead for efficient clinical teaching; and
3. Actively participate in clinical teaching to a greater extent than previously.

Sincere thanks to several hundred experienced clinical preceptors, residents and students, who have contributed these “Teaching Tips” at faculty development workshops over more than a decade

Introduction

- I. CAUTION: This session focuses on **Methods**
 - A. By focusing on teaching Methods, we can provide answers to practical questions:
 1. Don't educators know what it's like in the real world?
 2. How can you expect overworked clinicians to implement detailed educational paradigms in busy clinical settings?
 - B. There are many things that experienced preceptors ask learners to do that save them time while adding quality to their practice and their teaching. **However:**
 1. Methods are just one step in the Educational Planning Process
 - a) Goals
 - b) Needs
 - c) Objectives
 - d) Methods
 - e) Evaluation
 - C. One learner's teaching objective may be another learner's scut work.
 1. Be clear about what you are trying to accomplish
 2. Tell the learner that any time s/he helps to save will be made up in dedicated teaching time
 3. At least one experienced preceptor tells us that he says thank you at the end of each session
- II. How can you teach and practice at the same time? Start here: **It's similar to clinical practice: You don't need to do it all at once.**
 - A. Teaching in clinical settings is best accomplished in a longitudinal fashion
 - B. The needs of one's students cannot be fully satisfied at every moment throughout the day any more than the needs of one's patients, or practice
 - C. You don't need to apply all principles learned in faculty development at one time any more than you can do complete histories and physicals on all patients at all times
- III. General Principles
 - A. Plan ahead – work the learner into your weekly schedule
 - B. Plan an Orientation: Make certain all parties know the ground rules
 - C. Have learners do things that save you time and benefit your practice
 - D. Learn things from the student or resident
 - E. Think about the use of space
 - F. Some methods make it possible to teach on the fly
 - G. Tailor the schedule to meet clinical **and** teaching objectives
 - H. Take advantage of unique educational opportunities
 - I. Establish clear guidelines for communication
 - J. Use the medical record, and know the rules for student supervision

Tips for Teaching in the Office

IV. Planning

- A. Work the student into your weekly schedule – if you don’t put it in the schedule, it won’t happen
 - 1. Protected times for orientation, formal teaching, evaluation sessions
 - 2. Alternative activities when you are not available

V. Orientation

- A. Orient the student

- 1. Pre-orientation: Invite the student to visit the practice
 - a) Is this right for you?
 - b) Are there certain criteria for the student (e.g. language skills in a Community Health Center)
 - 2. First day: plan a formal student orientation session
 - 3. Other times: Schedule protected times for teaching, feedback and evaluation
 - 4. Provide prepared materials
 - a) Give the student a written description of the practice – have a student write a description of the practice to be used with future students
 - b) Give the student a copy of your mission statement (larger health centers)
 - c) Establish a web site for students, or mention them on your practice web site
 - 5. Provide a written guideline of expectations
 - a) Logistics, including hours, parking, attire, use of your staff areas (including the refrigerator!), plans for lunch, etc.
 - b) Set progressive goals through the weeks – e.g. shadow, model, function independently, etc.
 - c) Expectations regarding patient confidentiality
 - 6. Orient the student to your life style
 - a) Personal – Bring the student home for dinner; share your personal perspectives with them
 - b) Professional – hospital committees, call, etc.
- B. Orient your patients

- 1. Boast to your patients that you are a part of the medical school
- 2. Put up a plaque, letter from the Dean, etc.
- 3. Put up a notice that you have a student with you
- 4. Provide a handout

- a) “We have been selected as a teaching site by the medical school”
 - b) “You have the right to be seen without the student’s involvement”

- 5. Invite your patients to serve as teachers, and even to participate in evaluation:
 - a) “Can you help me teach this student/resident?”

- b) "This is the way I learned how to be a doctor"
 - 6. Develop a questionnaire (or have a student develop a questionnaire):
Has the student added to the visit?
 - 7. Provide a business card for the student
 - C. Orient your staff
 - 1. Invite them to become active participants in the learning process
 - a) How can each staff member contribute to the learner's education?
 - b) Provide an opportunity for the staff to provide feedback
 - 2. Have a social gathering with the staff to introduce the student
 - 3. Set explicit guidelines for the staff
 - a) How will students be introduced to patients? Several opinions:
 - (1) Have the front desk tell patients about the student
 - (2) Have the front desk hand out a letter from you that explains about the student
 - (3) Have your office nurse handle the introduction
 - (4) Some feel that the physician should be actively involved in inviting the patient to work with the student
 - 4. How will patient permission be obtained?
 - a) Include a permission slip with your introductory letter
 - b) Have the staff do it
 - c) Have the physician get permission
 - D. Orient yourself
 - 1. Read the curriculum, readings
 - 2. Participate in faculty development
- VI. Have learners do things that save you time and benefit your practice:**
- A. Tell the student or resident that anything they can do to save time for both of you will be made up in active teaching time
 - B. Office activities that can save you time:
 - 1. Take vitals
 - 2. Chart notes
 - 3. Talk to patients who are waiting when you are running behind – "it's better than a magazine"
 - 4. Write prescription refills
 - 5. Write out patient instructions
 - 6. Go over written patient education materials
 - 7. Do asthma education
 - 8. Construct a genogram
 - 9. Go through the chart to see if health maintenance guidelines are up to date
 - C. Working with younger patients -- perform Denver Developmental Testing
 - D. Working with older patients:

- 1. Perform minimental status exam
- 2. Interview other caregivers
- 3. Help elderly patients get dressed and undressed
- 4. Talk to elderly patients
- E. Procedures – students need to be allowed to do things
 - 1. Phlebotomy
 - 2. Flushing ears
- F. Have a student do a special project
 - 1. Focusing on a patient or family that has been a puzzle for you
 - 2. Working on a project for your office
 - a) Developing patient education materials
 - b) Developing an evidence-based clinical guideline

VII. **Learn things from the student**

- A. Things the student will know better than you
 - 1. Smart phone medical apps
 - 2. Use of new drugs
 - 3. Issues raised at yesterday's lecture
- B. Personal issues - About their culture, about their own life experiences
- C. Dealing with clinical problems about which you know little
 - 1. "Take a day and get back to me with an answer"
- D. Don't feel threatened by a student who knows something you don't know – neither party should confuse *information* with *knowledge*

VIII. **Think about the use of space**

- A. If an extra exam room is available, you can have the student use it, while you move ahead as needed
- B. Use your consult room for history taking
- C. Clear off a corner of your desk for the student to use
- D. Provide in and out boxes
- E. Use your partners' desks; rotate desks on days off
- F. Get a TV table in your office for the student to use
- G. Move phlebotomy to the exam room

IX. **Some methods make it possible to teach on the fly**

- A. Have the student see the patient ahead of you
- B. Observe the student interviewing the patient
 - 1. Try not to interrupt
 - 2. Stand so the patient has to look at the student

C. Active teaching in front of the patient

1. Works best

- a) Present the history
- b) Demonstrate skills: Physical exam, procedures
- c) Patient education – an audience of two
- d) Modeling

2. Think about how you use questions (Questioning vs. “pimping”)

From *The Art of Pimping* (JAMA 262(1), July 7, 1989): The earliest reference to pimping is attributed to Harvey in London in 1628. He laments his students’ lack of enthusiasm for learning the circulation of the blood: “they know nothing of Natural Philosophy, the pin-heads. Drunkards, sloths, their bellies filled with mead and ale. O that I might see them pimped!

In 1889, Koch recorded a series of ‘Pumpfrage’, or ‘pimp questions’ he would later use on his rounds in Heidelberg. Unpublished notes made by Abraham Flexner on his visit to Johns Hopkins in 1916 yield the first American reference: “Rounded with Osler today. Riddles house officers with questions. Like a Gatling gun. Welch says students call it pimping. Delightful.”

3. Riskier

- a) Complex problem solving
- b) Differential diagnosis
- c) Bad news

X. Tailor the schedule to meet clinical and teaching objectives

A. Schedule events that will help the student

- 1. Review the schedule, charts ahead of time
- 2. Double book the first slot
- 3. Know the curriculum requirements

- a) Required complete H&P – schedule at a special time; have the patient come in early

B. Have the student spend time with others members of your office:

- 1. Have the student spend time with your practice partners, Nurse Practitioners, Physician Assistants

- a) Have one serve as coordinator

- 2. Have the student spend time with people in your office (interprofessional education IPE):

- a) Office nurse -- give immunizations, participate in phone or office triage
 - b) Health Educator
 - c) Phlebotomy
 - d) Health Assistant
 - e) Billing clerk

- f) Referral coordinator
 - g) Receptionist/Appointment clerk
- 3. Have the student spend time with consultants in your building
- 4. Have the student work with community resources, such as:
 - a) Nutritionist
 - b) Social worker
 - c) Visiting nurse
 - d) Outreach worker
 - e) Adult day care center
 - f) Nursing home
 - g) Pharmacy
 - h) Hospice
 - i) Health Department
 - j) Local sheriff, local law enforcement officials

C. Finding respite time

- 1. Send the student to read up on something that will come up later in the day
- 2. Develop a 4 day precepting week, with alternative activities developed by the clerkship during the 5th day
- 3. Have 2 students instead of one! (having a second student may be like having a second child)

XI. Take advantage of unique educational opportunities

- A. Share your own library or other reference resources – reprints, guidelines, etc.
- B. Identify patients with identified problems (diabetes, etc.) who are willing to act as special resources for students to spend time with
- C. Link the student with patients who will present frequently during the clerkship
 - 1. Newly diagnosed patients with diabetes, acutely ill patients with asthma, etc.
 - 2. Prenatal patients
 - 3. Other patients facing a transition in their life status
 - 4. Give the student a beeper to carry, to be available during a critical time
- D. Involve the student as you respond to patients who are acutely ill:
 - 1. Have the student phone patients who are calling in with acute illnesses
 - 2. Have the student make follow-up calls to check on patients you saw earlier
 - 3. Use a speakerphone
 - 4. Manage fewer acutely ill patients over the phone; have them come in
 - 5. When an acutely ill patient is coming in, have the student read up on the topic
- E. Involve the student in after-hours call
 - 1. Use a conference-calling feature
- F. Involve the student as you respond to routine patient care issues:
 - 1. Review phone messages with the student; include him/her in the response

- 2. Review lab work with the student
 - 3. Have the student make phone calls to patients about lab results (first with normal results, then with abnormal results)
 - 4. Have the student respond to letters from the HMO regarding health maintenance, need for follow-up (by performing chart audits, etc.)
- G. Send the student off-site to accompany the patient
- 1. To see consultants
 - 2. To view procedures: Endoscopy, surgery, etc.
 - 3. To Radiology, OT/PT
 - 4. To accompany the visiting nurse
- H. Go together:
- 1. On rounds, to hospital conferences – Tumor conference, Grand Rounds, etc.
 - 2. To a deposition
 - 3. To the nursing home
- a) Issue a challenge: Keep going until you find three medications to discontinue
- I. Community activities
- 1. Have the student write a patient education column for the local paper
 - 2. Have the student do a community project

XII. Establish clear guidelines for communication

- A. Communicate by phone – Give the student your cell number, or the inside line for the practice
- B. Communicate via email – regarding logistics, to provide feedback
- C. Make your expectations explicit in your orientation handout

XIII. Using the medical record

- A. Have the student do chart reviews, or participate in QI projects
Provide an opportunity for the student to try dictation
 - 1. Works best for special projects
- B. Have the student type up notes, email them in
- C. Regarding documentation: Know the rules for student supervision

From the Medicare Carrier's Manual, Section 15016:

”Students may document services in the medical record. However the documentation of an E&M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems, past family, or social history.

”The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E&M

services, the teaching physician must verify and re-document the history of present illness, as well as perform and re-document the physical exam and medical decision-making

activities of the service.”

M. Some use student notes as prompts

XIV. Provide an orientation handout (next page)

Guidelines for Residents/Students Working with Dr. Jones¹

Ambulatory medicine differs from inpatient medicine in several important ways. These guidelines can help make your experience in my office more rewarding.

1. Please read the Curriculum Syllabus before coming to the office.
2. Office hours start at 8:40 am and finish at 5:00 pm. We usually take 45 minutes for lunch. Feel free to use the refrigerator to store a sandwich, etc.
3. Take time to browse through the printout of the schedule. Let us know if there are patients that you would particularly want to see
4. Seeing patients:
 - a. Most patients enjoy spending time with students. The nurse will tell each patient that you are working with us, and obtain permission for you to participate in their care.
 - b. Pay particular attention to the patients' name, age, the diagnosis, medications, and the periodic examinations needed.
 - c. Check the last progress notes in the chart, noting any items we need to check for follow-up; this will help you understand why the patient is here.
 - d. Introduce yourself as A Student Doctor _____, working with Dr. Jones.
 - e. Always examine the patient with me. We can listen to the heart, and to each side of the lungs, and compare notes. We can discuss what your findings, which provides you with immediate feedback.
5. Saving time
 - a. Scheduling impacts doctors as well as patients; we will often feel squeezed for time. Anything you can do to help move things along will allow us more time for discussion.
 - b. Many of my patients are elderly; they may be moving slowly. Please assist them in getting on the exam table, undressing and dressing, and returning to the front desk.
 - c. Always ask if the patient needs prescription refills. If they do, write them out for me to sign.
 - d. When we are giving instructions to the patient, please write them down. Patients appreciate having written instructions to take home with them.
6. Keep an index card or notepad handy so if anything is mentioned you are not sure of, you will be able to research it later in the day.
7. Feel free to take vital signs and mark them in the chart. Many of my elderly patients need blood pressure especially postural blood pressure measurements; orthostatic hypotension is common. The blood pressure and pulse should be measured while the patient is prone as well

Modified from monitoring, orientation sheet provided by Dr. Lynn Li, Primary Care/Geriatrics Division, University of Massachusetts Medical Center

- as sitting up.
8. A complete geriatric assessment includes a medication check, a functional assessment, a life review and social history, a life-values assessment, and mini-mental and geriatric depression screenings. Examples of the Mini-Mental State and Geriatric Depression Scale forms are attached.
 9. You will learn to prioritize multiple needs in a time-limited clinical visit in order to keep to the schedule. You will learn how to deal with the patient's most important issue(s) today, bringing them back for anything else that needs to be dealt with. I set priority according to the following four areas of needs:
 - a. The patient's list of complaints;
 - b. My problem list and agenda;
 - c. Medication adjustments and refills; and
 - d. Health maintenance issues.
 10. When this rotation is finished, you will know how to give patient instructions, update the Problem List, and write progress notes.
 11. Please think about your personal goals and objectives for the rotation. Feel free to discuss issues as they arise. Keep yourself involved and active.

If you ever have questions that we did not answer in the clinic, do not hesitate to contact me in my office at 856-0000. I can also show you relevant reading material.

Have fun! Be active! We are here to work as a team!