

# **Medicine-Geriatrics Clerkship and Medicine Subinternship: Faculty Handbook For House Staff**



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# The Medicine-Geriatrics Clerkship

## A Reference Guide for House Staff

### Structure

Twelve-week core clerkship, two months inpatient, one month outpatient/Geriatrics

### Incoming Proficiency

Students should be aware of how to perform and document a history and physical, but not an assessment or plan. Students know a lot, but have little clinical context for their knowledge

### Goals and Expectations

Major goals are:

- Proficiency at history taking, physical exam, and communication skills.
- The ability to generate reasonable differential diagnoses for common symptoms or abnormal labs.
- Familiarity with the approach to the diagnosis and management of complex medical problems.
- The ability to learn by identifying own knowledge gaps.
- The deepening of the student's identity and responsibility as a medical professional.

Major expectations are:

- Students should take ownership over their patients. They should present at work rounds and attending rounds. They should write admission notes and daily progress notes.
- Students should participate fully in work rounds, attending rounds and other team activities
- Students should read thoroughly on their patients to enhance their knowledge and their ability to participate in the care of the patients.
- Students are required to attend all clerkship didactics.
- Students should demonstrate collegiality with their team members and colleagues, respect for other professionals and paraprofessionals involved in patient care, and compassionate consideration of their patients and patients' families.

R-I-M-E Schema (see Table 2)

All students should be reliable reporters by the end of the clerkship. Some students may reach higher levels.

### Expectations for House Staff

- Communicate goals: both those of the department and clerkship as well as your individual goals.
- Role-model good behaviors: everything you do is teaching
- Teach your students on rounds, at the bedside, and in "micro-lectures."
- Think out loud: make your reasoning about cases explicit to students
- Observe your students
- Give feedback that is timely, explicit, based on observation, and intended to change or perpetuate behaviors

### Evaluation Methods

- Evaluation forms at the end of the rotation
- Evaluation meetings with the clerkship or site director: these will be held once during your time with the student. Each team will spend time reviewing the student performance with the director, filling out evaluation forms, determining where the student falls in the R-I-M-E schema, and deciding what the student needs to do to achieve the next level. The site director will communicate this information to the student.

### Troubleshooting

Let the clerkship or site director know of any problems with your student during the rotation.

# The Medicine Subinternship

## A Reference Guide for House Staff

### Structure

Four-week inpatient clerkship for fourth year students

### Goals and Expectations

Major goals are:

- Develop a sophisticated level of independent thinking, decision-making and action.
- Develop the ability to care for patients efficiently and thoroughly.
- Proficiency in differential diagnoses and management approaches to common medical problems.
- The deepening of the student's identity and responsibility as a medical professional.

Major expectations are:

- Subinterns should have a panel of three to five patients. The patients' care will be the shared responsibility of the subintern and resident. The subintern should not co-manage patients with interns.
- Subinterns should attend all team didactics.
- Students should demonstrate collegiality with their team members and colleagues, respect for other professionals and paraprofessionals involved in patient care, and compassionate consideration of their patients and patients' families.

R-I-M-E Schema (see Table 2)

All subinterns should be reliable interpreters at the end of the clerkship. Some students may reach the level of manager or educator.

### Expectations for House Staff

- Communicate goals: both those of the department and clerkship as well as your individual goals.
- Role-model good behaviors: everything you do is teaching
- Think out loud: make your reasoning about cases explicit to your subintern
- Observe your subintern
- Give feedback that is timely, explicit, based on observation, and intended to change or perpetuate behaviors

### Evaluation Methods

- Evaluation forms at the end of the clerkship.
- Any subintern with a marginal performance (i.e., not able to handle patients without significant input from interns, not functioning as a reliable interpreter on R-I-M-E) will be discussed at the end-of rotation evaluation meetings with the clerkship or site director.

### Troubleshooting

Let the clerkship or site director know of any problems with your student during the rotation.

## Introduction

As an intern or resident in Internal Medicine, your impact upon your third and fourth year students' future career goals and interests is enormous. You will by far have more contact with your student than any other faculty member. This gives you unique insights into the student's abilities, and also places an immense responsibility upon you as a teacher, at a point when you yourself are trying to learn and develop as a physician.

We hope this handbook will be helpful as you undertake this task. It serves only as a rough guideline and orientation to the goals of the Medicine-Geriatrics Clerkship and Medicine Subinternship. We respect your experiences and encourage you to be creative in your approach to teaching.

## Medicine-Geriatrics Clerkship

### Structure of the Medicine-Geriatrics Clerkship

The Medicine-Geriatrics Clerkship is a 12-week core learning experience for the third year students. It is sponsored jointly by the Department of Medicine and the Department of Geriatrics. The entire 12-week clerkship is called a "Module," of which there are four per academic year, with approximately 32 to 36 students in each module. Each module is divided into three, four-week blocks called "Pods." Students spend four weeks on the inpatient Medicine service at Mount Sinai, four weeks on an inpatient service in one of Mount Sinai's affiliate centers (Bronx VA, Elmhurst, Morristown, or Englewood), and four weeks of Geriatrics. The Geriatrics experience is comprised of experiences at an outpatient office-based practice, a house calls program, and an inpatient Palliative Care consult service. The clerkship provides opportunities for students to interact with and participate in the care of patients with complex, multi-system illnesses across the spectrum of care--from inpatient to outpatient to the home environment--and across the spectrum of illness progression--from stable chronic disease, to acute illness, to end-of-life care.

<b>Table 1. Module Periods and Pods</b>		
<b>Module Period</b>		
<b>12 weeks</b>		
<b>Pod A</b>	<b>Pod B</b>	<b>Pod C</b>
<b>4 weeks</b>	<b>4 weeks</b>	<b>4 weeks</b>
Module Period 1 is from July 6 to September 25, 2009		
Module Period 2 is from September 28 to December 18, 2009		
Module Period 3 is from January 4 to March 26, 2010		
Module Period 4 is from April 5 to June 25, 2010		

### Entering Student Proficiency

At the end of their second-year introduction to clinical medicine course (Art and Science of Medicine 2), students should be practiced at obtaining histories and physicals and documenting the findings. Students have been introduced only briefly to the process of making problem lists, assessments and plans. They have been introduced to and completed a curriculum on

diagnostic reasoning. They know a lot, but have little clinical context for their knowledge. Students who have completed other clerkships may have more advanced skills.

## **Goals and Objectives of the Clerkship**

The clerkship is a very broad experience. While there are numerous goals and objectives through the 12 weeks, the principal ones for their patient experiences include the following.

Major goals are:

- Proficiency at history taking, physical exam, and communication skills.
- The ability to generate reasonable differential diagnoses for common symptoms or abnormal labs.
- Familiarity with the approach to the diagnosis and management of complex medical problems.
- The ability to learn by identifying own knowledge gaps.
- The deepening of the student's identity and responsibility as a medical professional.

Major expectations are:

- Students should take ownership over their patients. They should present at work rounds and attending rounds. They should write admission notes and daily progress notes.
- Students should participate fully in work rounds, attending rounds and other team activities
- Students should read thoroughly on their patients to enhance their knowledge and their ability to participate in the care of the patients.
- Students are required to attend all clerkship didactics.
- Students should demonstrate collegiality with their team members and colleagues, respect for other professionals and paraprofessionals involved in patient care, and compassionate consideration of their patients and patients' families.

## The R-I-M-E Schema

Another way we would like to communicate goals is linked to how we also aim to evaluate students and give them feedback, by means of the R-I-M-E schema. The R-I-M-E schema, which was developed by Dr. Lou Pangaro at the Uniformed Services University of the Health Sciences, is a well-publicized descriptive evaluation system. It describes the development of the medical learner in four stages. (See Table 2)

<b>Table 2. R-I-M-E Schema</b>
<b>Reporter</b>
<ul style="list-style-type: none"> <li>• Can accurately gather and clearly communicate the clinical facts on his/her own patients.</li> <li>• Can recognize normal from abnormal and has the confidence to identify and label a new problem.</li> <li>• Displays a sense of responsibility</li> <li>• <i>Passing the clerkship requires mastery at this level</i></li> </ul>
<b>Interpreter</b>
<ul style="list-style-type: none"> <li>• Prioritizes among patient problems</li> <li>• Can generate a reasonable differential diagnosis (offering at least three reasonable diagnostic possibilities for new problems.)</li> <li>• Demonstrates a higher level of knowledge, and more skill in selecting the clinical findings which support possible diagnoses and in applying test results to specific patients.</li> <li>• Demonstrates “ownership”</li> </ul>
<b>Manager</b>
<ul style="list-style-type: none"> <li>• Demonstrates even more knowledge, more confidence and better judgment in deciding when action needs to be taken, and can propose and select among options for patients (at least three options in the diagnostic and therapeutic plan.)</li> <li>• Can tailor the plan to the particular patient's circumstances and preferences.</li> </ul>
<b>Educator</b>
<ul style="list-style-type: none"> <li>• Reads deeply, and shares new learning with others.</li> <li>• Defines important questions to research. Looks for hard evidence on which clinical practice can be based, and has the skill to know whether the evidence will stand up to scrutiny</li> <li>• Shares leadership in educating the team (and even the faculty)</li> </ul>
Pangaro LN. A new vocabulary and other innovations for improving descriptive training evaluations. <i>Acad. Med.</i> 1999; 74:1203-7.

As you can see, the schema serves as a framework for evaluation and also communicates goals for demonstrating certain behaviors relevant to practicing clinical medicine. We expect that all students will be proficient reporters by the conclusion of the clerkship. The major emphasis of the clerkship is making sure that students can report, and helping them to make the transition to interpreter.

This framework should be used to describe what level the student achieves consistently. It has a number of advantages.<sup>1</sup> It is easy to remember, so it can be used more consistently across sites and educators. It facilitates feedback by giving the student a next step to aim for. It also

<sup>1</sup> Pangaro LN. A new vocabulary and other innovations for improving descriptive in-training evaluations. *Acad. Med.* 1999; 74:1203 –7.

has a good track record. It has been shown to have good inter-rater reliability<sup>2</sup> and to produce a more even distribution of evaluations than do number systems,<sup>3</sup> which may be more prone to grade inflation.

## **Role of the Students on the Medical Teams**

Although the role of the student may vary somewhat from site to site, we expect that students will be integrated and become important members of the ward team. We expect that students take a high degree of responsibility, both for the care of their patients and for their own learning. This may take some active effort on your part. Unlike the resident and intern, and even the sub-intern, the job of the third year student is not always obvious. It is like a potential space that both you and the student are in part responsible to define, and it is essential that you and the student are very clear about expectations and responsibilities.

### Taking Admissions

Students should take admissions in order to provide a panel of between two and four patients at a time. If the patient is stable, students should have the opportunity to derive their own history and do a complete physical exam. While it would be ideal if a member of the house staff team can observe this process, this is unrealistic on a busy call day. The student can take admissions on short or long call days, and work with either intern in a two-intern system. Third year students should not share patients with subinterns.

Once the student has completed the history and physical and reviewed the pertinent labs and the medical record, he or she should present his or her findings and discuss his or her understanding of the case with the house staff team. Students' patients need to be also carefully reviewed and followed by an intern on admission and on a daily basis.

### Call Responsibilities

Students are expected to spend every long-call day at the hospital until 10 p.m. On weekend post call days students are expected to see and write notes on their patients. Also on weekends, when students are waiting for an admission or finished their work, involve them in your team's cross-coverage duties. This is good training in thinking about acute, focused problems.

At affiliate hospitals, students should take call, but only until 10 p.m., and then should go to the call room to sleep since they need to attend all didactics the next day. The affiliate sites have call rooms for the students to sleep in. Given the issue of safety, we ask the students not to travel back home at night from the affiliate sites.

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<sup>2</sup> Pangaro L, Jamieson T, Hemmer P, Gibson KF, DeGoes JJ. Descriptive evaluation of clinical performance can achieve reliability comparable to standardized tests . Proceedings of the Association for Medical Education in Europe, Vienna, Austria, 1997.

<sup>3</sup> Battistone MJ, Pendleton B, Milne C, Battistone ML, Sande M, Hemmer PA, Shomaker TS, Global Descriptive Evaluations Are More Responsive than Global Numeric Ratings in Detecting Students' Progress during the Inpatient Portion of an Internal Medicine Clerkship , *Acad Med* 2001 76: S105-S107.

## Work Rounds

Students should present each morning on work rounds. They should pre-round on their patients, gather all appropriate data, and present it cogently and succinctly on work rounds. Students should make an attempt at an assessment and plan for each of their patients. Most students will need careful instruction on how to do this early in the clerkship. Once he or she can generate a reasonable assessment consistently, the focus should shift more toward patient management.

## Attending Rounds

The structure of rounds is different at each inpatient site. Students should be encouraged to present patients and participate in discussions. Students early in the clerkship will need briefing about how to present at attending rounds. (i.e., they may need help in understanding what are the pertinent positives and negatives, or tips on presenting at the bedside.) Students should be advised that they are expected to present without notes.

See Appendix C for some guidelines on oral presentations.

## Student Notes

Policies on student note-writing vary across site. For all sites other than Elmhurst Hospital, students should write an initial history and physical on their patient. Students should be fairly comfortable at constructing the write up down to the problem list, but will need substantial help in coming up with an assessment and plan. Help them to reason through their cases when they first see a patient and give them a roadmap of where the work-up and therapeutic plans are going. Students are expected to write up a full history and physical. At Mount Sinai, they have until the next day to put their notes in the chart. Other hospitals may have different policies about including student notes in the chart.

Students should write daily progress notes on their patients. These should have all the complete data, an assessment and a problem-based plan. (i.e., they should list the plan by the patient's problems, like "pneumonia," "hyponatremia," etc., not by systems like "pulmonary," "renal," etc.) Students should make their clinical reasoning explicit in their notes.

The intern or resident should review all notes, offer feedback, and write a brief addendum summing up the chief findings and essentials of the daily plan. In their addendum they should note that the intern or resident has also examined the patient. It is not sufficient to simply write "agree with above" and sign. At Mount Sinai, interns are responsible for writing a full admission note on the patients that they share with third year students.

Of note, attending physicians, when billing for professional services, may not "link" to student notes. That means that for patients for who the student is the primary documenter, the attending will have to write a full note in order to bill for services.

At Elmhurst Hospital, students have read-only access to the electronic medical record, which means that they cannot write notes on their patients in the medical record. Please have them write admission notes and daily progress notes, either hand written or by computer. While these may not go into the chart, it is essential that students learn proper documentation processes. Review the notes on a daily basis with the students, and give them feedback. Of note, students

are required to hand in four admission notes to their attending preceptor, so they will be receiving feedback on these notes as well.

See Appendix B for some tips on reviewing write-ups.

### Order Writing

Students are encouraged to write orders if the hospital system supports this. At Mount Sinai, students can write orders in TDS. They will remain inactive unless an authorized person (the intern or the resident) activates them. To review and activate, go under “activate orders” in the “master” menu and click on “suspended orders.”

## **Learning in the Clerkship**

### Reading

There is a huge volume of material that the students’ end-of-module exams cover, and students are understandably nervous about this. Students should read in depth about their patients, both the acute and chronic medical problems. Students should also make an effort to review major medical topics in a student-friendly text. We recommend Cecil’s Essentials, 7<sup>th</sup> Edition. Up-To-Date is also a very good source for most purposes. It is best if students read from sources that emphasize pathophysiology, so that students can link their knowledge from the first two years of medical school to the clinical aspects of their third year training. We discourage students from using review books as their initial reading material, because such sources if used for anything but review tend to result in only very superficial understanding.

Asking about and helping direct your student’s reading is a core component of your role as an educator. Also demonstrate how you read and learn from clinical scenarios as well. Show how you identify your own knowledge gaps and make efforts to fill them.

### Didactics

Students have 33 hours of case or problem-based didactics given throughout the 12 weeks of the clerkship. At MSH, we try as much as possible to schedule these at noon, so the students tend to be off the floors at the same time the teams are.

Attendance at the conferences is mandatory. A list of conference and case-based topics is in Table 3.

<b>Table 3. Conference and Case-Based Topics 2009-2010</b>		
<i>Mount Sinai</i>	<i>Inpatient Affiliate</i>	<i>Geriatrics</i>
Arthritis	Congestive Heart Failure	Geriatric Assessment
Acid-Base	Abdominal Pain	Change in Bowel Habits
The Problem Patient	Pneumonia	COPD
Thyroid Disease	GI bleeding	Communicating Bad News
Edema (also includes discussion of DVT and macrocytic anemia)	Fever	Depression in the Elderly and Dementia (online case)
The Cardiac Exam	Chest Pain	Urinary Incontinence
Pressure Ulcers and	Acute Renal Failure	Osteoporosis

Functional Assessment		
Perioperative Care	HIV infection	Low Back Pain
Delirium	Disorders of Glucose Metabolism	Preventative Geriatrics
“Show and Tell”		Pain Management
		Providing Palliative Care Across Cultures
		Falls
		Healthcare Financing
		Durable Medical Equipment

### Preceptor Rounds

Students meet twice weekly, typically in the late afternoon, with an attending preceptor to go over their write-ups, clinical reasoning and physical exams. Preceptor sessions are times for students to talk about their cases apart from the pressures of the floors, at a level appropriate to their experiences, and with other learners at the same level. As mentioned above, students are responsible for handing in four admission notes to the preceptors for feedback.

### **Expectations for House Staff**

Below are some of the things we hope residents and interns will do with their students.

#### 1. Communicate Goals

Residents should orient students on the first day to the working of the team and the call schedule. Let the student know about any individual expectations that you may have (i.e., rounding styles, etc.) Also encourage them to communicate their learning goals to you.

#### 2. Role Model Good Behaviors

Remember that everything you do is teaching. The student may learn as much from you in your demeanor and interaction with others than from your breakdown of the hyponatremia algorithm.

#### 3. Give Feedback

Feedback can be formative, giving specific and immediate attention to a task. (For example, pointing out that the axilla is not where the student should listen for a murmur of tricuspid regurgitation, or telling the student how to improve a presentation.) It can also be summative, providing an evaluation after a certain period of time--for example, sitting with your student at the midway point to review his or her performance so far. The second type of feedback is more difficult, because you have to express your judgment, rather than just give a corrective suggestion.

Feedback is arguably the hardest part of what we do as educators, and probably the most important. Plan your feedback, and make it explicit to the student that you are offering feedback. Remember that the goal of feedback is to perpetuate or change behaviors. It is most effective when it is done frequently, involves specific examples and provides direction for future behavior.

#### 4. Observe your students

You may find that you spend a lot of time with a student, but actually very little time observing them actually doing the things that we hope to teach them—i.e., histories, physical exams, etc. Therefore, it is essential to observe the student on a daily basis. This does not mean that you need to watch them do an entire history and physical, as it is doubtful you will have that kind of time. Do take the time, however, to watch them perform specific tasks. For example, have the student demonstrate a pulmonary exam on a patient during work rounds, or observe the student educating the patient on how to take medication.

Without proper observation, you will have a tough time giving genuine, useful feedback, and your final evaluation of the student will likely overemphasize certain aspects of the student's performance or demeanor.

#### 5. A Note to Wasserman Teams

Wasserman is a challenging service for a student. It may be hard for some students to glean the essential components from what can be very specialized cases. Make an effort to help students with this. If the student is helping to care for a patient with an HIV cardiomyopathy, help direct the student to read about cardiomyopathies in general, and help him or her to understand the general concepts of caring for someone with heart failure. Also, you may find it hard to manage the complicated patients on Wasserman yourself, so how can you assess if your student is a “manager” on the RIME scale? Focus instead on specific problems. For example, ask whether the student can generate an appropriate differential for the patient's new hyperkalemia, and know what to do about it, rather than expecting that he or she know what the next step is in managing the patient's rare cancer.

### **Teaching with Limited Time**

Being an effective teacher is challenging, and doing so with limited time can be especially so. You also may be trying to teach to multiple levels at the same time, further complicating the issue. If you try to carve out teaching time, you will probably get frustrated, since on a busy ward service you can never count on any protected teaching time. Therefore, make the most out of the time you have and work teaching into what you are doing already. The following are some examples of how to do this.

#### Think Out Loud

Work rounds can be fast, and often over the heads of students, who may not feel they have time to ask questions or even know what to ask. Make sure to be explicit in your reasoning and directions, even on patients that the student is not following. For example, explain why you feel one test is superior to another, or what criteria you use to determine if an asthmatic patient is getting better.

#### Make Works Round Efficient and Effective

Dr. Larry Smith, one of the past Program Directors at Mount Sinai, used to say that on work rounds, if an intern does not give the resident a succinct and cogent presentation, then the

resident must spend all of rounds fishing for data and this leaves no time for teaching. Therefore, as a resident, make your expectations very clear and stick to them. Hold your students and interns to your standards. Make sure work rounds run quickly and smoothly. This will give you more time to teach during these hectic rounds. Please see the attached handout in Appendix A about effective work rounds.

### Use RIME

Using RIME on work rounds can accomplish a number of things. As discussed above it defines expectations and provides a common set of terms to measure performance. Think of the RIME criteria as your students present on rounds and use it to “diagnose your learner.”

<b>Table 4. Using RIME to diagnose your student</b>			
	<i>What to look for/ask</i>	<i>Possible issues</i>	<i>Possible Interventions</i>
<i>Reporter</i>	<ul style="list-style-type: none"> <li>• Reports data succinctly and accurately on work rounds.</li> <li>• Identifies abnormal findings/labs and brings them to your attention</li> </ul>	<ul style="list-style-type: none"> <li>• Does not know expectations</li> <li>• Does not know how to pre-round</li> <li>• Does not understand logistics (where vitals are kept, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Clearly orient student to the floors.</li> <li>• Define expectations</li> <li>• Frequent formative feedback</li> </ul>
<i>Interpreter</i>	<ul style="list-style-type: none"> <li>• What do you think is going on?</li> <li>• What is your differential for this new problem?</li> <li>• How do you explain this lab finding?</li> <li>• What is the most important issue to deal with first?</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge</li> <li>• Difficulty prioritizing</li> <li>• Unaware of systems issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify areas for student to read about</li> <li>• Target your teaching toward knowledge deficits</li> <li>• Make explicit how you prioritize</li> </ul>
<i>Manager</i>	<ul style="list-style-type: none"> <li>• What should we do about this problem?</li> <li>• What are challenges to delivering the proper care in this patient?</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge</li> <li>• Lack of confidence</li> <li>• Rigid thinking</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrate how you make patient-centered decisions</li> <li>• Help student anticipate outcomes and potential problems</li> </ul>
<i>Educator</i>	<ul style="list-style-type: none"> <li>• What is the evidence behind your decision?</li> </ul>	<ul style="list-style-type: none"> <li>• Unaware of search engines</li> <li>• Unsure how to apply data</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrate how you use the medical literature to answer questions.</li> </ul>

## **Evaluation Methods**

### Evaluation Forms

The grading form is comprised of a number of domains across which the student is evaluated on a scale of Unsatisfactory/Borderline/Meets Expectations/Exceeds Expectations. Descriptors for each domain help guide how a student should be performing. The domains are: *history-taking skills, physical exam skills, presentation skills: oral, presentation skills: written, knowledge base, knowledge acquisition and application, communication skills with patients, professional behavior with patients, and professional behavior with team, colleagues, and/or staff.* This is an example of a descriptive evaluation that is analytic (i.e., it breaks down performance into

discreet domains, as opposed to the R-I-M-E schema, which is synthetic, integrating these domains into a more global descriptor).

The form has room for written comments. These are the most important part of the form. Please be concrete and specific with your comments and avoid generic terms like “team player” or “solid student.”

Finally the form asks you to rate the student on the R-I-M-E schema. You can use the area between levels—i.e., a student can be a reporter/interpreter, which means that he or she has mastered reporting skills, but is not yet a consistent interpreter.

Both the analytic system and the RIME scale designation will be used to help calculate the student’s final grade.

We obtain a minimum of 10 evaluations on each student across the 12 weeks of the clerkship. No single evaluation makes or breaks the students grade (see below). It is not the job of interns or residents to grade students, but it is their responsibility to record observations accurately and honestly. While it never feels good to evaluate a student harshly, it is at times part of the duty of anyone who teaches. On the flip side, when a student performs in a superlative manner, writing “this is an honors student” is much less useful than pointing out more precisely what the student does well, so he or she knows to continue this behavior in the future.

### Evaluation Meetings

At some point at the end of the largest period of student-resident overlap, one of the clerkship or site directors will sit down with each resident team to discuss the student’s performance. Each evaluator will be given a few minutes to state how well the student performed. The intern will go first so not as to be biased by more senior views. After offering the evaluation, each evaluator will estimate where they think the student is along the R-I-M-E continuum. The director will take notes on each student during the meeting, and collect evaluation forms at the end. The director will also make either phone or email contact with the preceptors to get their feedback. The director will then meet with the students individually and let them know how they are performing and what they need to work on at that point. We estimate that this total process will take about 15 to 20 minutes per team.

The evaluation sessions have a number of advantages. They act as continuous faculty development. It will help orient you to the clerkship goals, and provide a setting where you can learn and model for each other good evaluation processes. For example, if the intern states that the student is “a nice guy and a team player,” the site director may prompt him or her to offer a more substantial evaluation. Likewise if the site director hears a resident report a student’s performance inadequate because the student did not bring in primary articles on a daily basis, he or she can redirect the resident to the fact that this is not a fundamental goal of the clerkship. This kind of redirection may help correct some of the inequities that come from the fact that many of you trained under different systems and may have a different sense of how students should perform.

### Examinations

At the end of the 12-week clerkship, students take the National Board of Medical Examiners Exam in Medicine (the “shelf exam.”) They also have a written exam that tests their knowledge of Geriatric syndromes, which students take at the end of the Geriatrics portion of the clerkship.

In the middle of the clerkship (during Pod B) there is an observed history and physical. The student interviews and examines a patient while being observed by an attending physician. After a brief time to collect his or her thoughts, the student then presents the case back to the attending and discusses his or her assessment and potential initial plans. The observed history and physical is graded on a pass/fail basis. Students who fail must demonstrate proficiency in these skills by the conclusion of the clerkship.

### Grade Determination

Students who complete the clerkship will be graded on the following scale: Honors (about 25% of the class), High Pass (about 20-25% of the class), Pass (about 50-55% of the class) and Fail (usually one to two students a year.) This grade distribution is uniform across the clinical clerkships at the Mount Sinai School of Medicine.

The numerical grade is determined as follows:

#### Clinical Evaluations

3 Preceptors (30% total)

3 Geriatrics/Outpatient Attendings (15% total)

2 residents (20% total)

2 interns (10% total)

#### End-of -module testing/other

Shelf exam (20%)

Geriatric Written Exam (5%)

Observed History and Physical (Pass/Fail)

The final grades (Honors, High Pass, Pass, and Fail) are determined by the numerical grade. A student may fail the clerkship based on numerical criteria, or if his or her performance is felt to be insufficient to justify allowing the student to advance to a sub-internship. For example, even if the student does not numerically fail, if he or she is not able to achieve the criteria to be considered a reliable reporter on the R-I-M-E scale, the student will need to repeat all or part of the clerkship. Students can also fail the course based on unprofessional behavior.

### **Absence Policy**

The clerkship or site director should be notified of all student absences. The student must inform the Dean's Office of absences of two days or longer. Students should inform their ward team as well as the clerkship directors and site directors of any approved absences. Students have no dedicated time off to study for the NBME subject examination (the "shelf.")

### **Troubleshooting**

Please inform the clerkship and/or site directors of any problems with your student. If you feel they are not performing at a passing level, are consistently late, have unexcused absences, or demonstrate any other potentially unprofessional behaviors, please inform the clerkship directors immediately.

## **What if the student is interested in Medicine?**

If your student seems to have a genuine interest in Medicine as a career, please encourage him or her to meet with Dr. Gliatto and Dr. Karani. For those who decide to apply for Medicine residency, he or she will need to meet with Dr. Babyatsky, the Program Director of the Mount Sinai Medicine Residency Program, to arrange for a departmental letter of recommendation and to strategize on the residency application process. These meetings start in late August or early September on the student's fourth year.

## **Resources**

Dr. Lisa Coplit's Teach-the-Teacher and Resident-as-Teacher courses are excellent and have great materials. All MSH residents will go through this course in their PGY-2 year. Residents at affiliated institutions also have access to these materials.

We have the references of this guide, which are good resources.

Some useful Websites:

Clerkship Directors in Internal Medicine (CDIM): <http://www.im.org/CDIM>

Association of American Medical Colleges (AAMC): <http://www.aamc.org>

## **Subinternship in Medicine**

You may also have contact with the subinterns during the year. About 100 students a year elect to do the Sub-internship in Medicine. (The remaining students do a Pediatrics Sub-internship.)

The Subinternship is four weeks long. Students are expected to act as much as interns as possible. Taking a larger number of patients, and taking a higher degree of responsibility for their care are major expectations.

The resident is primarily responsible for the subintern. While interns can certainly help with teaching, the patients that the sub-intern follows are primarily the responsibility of the subintern and the resident.

Subinterns rotate through Mount Sinai, Elmhurst or the Bronx VA.

### **Responsibilities and Expectations**

Subinterns should have a census of three to five patients at any given time. All orders and notes must be reviewed and signed by a resident. Like third-year students, subinterns should present their patients at work and attending rounds. By the end of the subinternship, subinterns should be comfortable formulating differentials for their patients and be making very substantial strides in offering reasonable diagnostic plans consistently. Using R-I-M-E criteria, most subinterns should be between and Interpreter and a Manager. A minimum passing grade is Interpreter. Please refer to Table 2 for definitions of these criteria.

### On-Call Policies

At Mount Sinai most residents have found it more useful to have their subinterns not take overnight call so that they can assist with cross coverage of the post-call intern's patients the next day. This is especially true on Wasserman. At Elmhurst and the Bronx VA, students are expected to stay overnight with their teams on call and to leave with the team on the post-call day.

### Order Writing

Subinterns should be encouraged to write orders as much as they can. Please see the section above on how activate student orders in TDS. Computer systems at some sites may not facilitate this. In this instance, please try to get the subintern's input before entering orders on his or her patients.

### Note Writing

Policies on student note-writing vary across site. At Mount Sinai and the Bronx VA, subinterns write their own admission notes which the resident must addend and co-sign. Interns do not need to write admission notes on the patients covered by a sub-intern. Progress notes written by the sub-intern need a brief addendum and signature by the resident. The attending needs to write a complete note (they can't link to a student note for billing purposes.)

At Elmhurst Hospital, subinterns have read-only access to the electronic medical record, which means that they cannot write notes on their patients in the medical record. Please have them write admission notes and daily progress notes, either hand-written or by computer. While these may not go into the chart, it is essential that subinterns continue to learn proper documentation processes. Review the notes on a daily basis with the subinterns, and give them feedback.

### Didactics

Subinterns are expected to attend all didactics that the house staff teams attend, with the exception of Resident Report and Gallop Rounds. Aside from an orientation session, there are no regularly scheduled didactics specifically for subinterns except for a weekly common calls curriculum that the Senior Education Resident gives.

## **Evaluation and Grading**

### Use of the R-I-M-E schema

The grading from for the sub-internship is very similar to that of the third years. Please see the “Responsibilities and Expectations” section above for direction for how to apply the R-I-M-E schema to the sub-interns.

### Grading

Students who complete the clerkship will be graded on the following scale: Honors, High Pass, Pass, and Fail (usually one to two students a year.) There is no specified grade distribution for the Subinternship. Therefore, achieving a grade is purely based on how the student performs clinically.

The numerical grade is determined as follows:

#### Clinical Evaluations

- 1 ward attending (45% total)
- 1 resident (45% total)
- 1-2 interns (10% total)

There is currently no end-of-the-block testing.

## **List of Appendices:**

Appendix A: Clerkship and Subinternship Faculty and Administrative Staff

Appendix B: Effective Work Rounds: The Three Function Approach

Appendix B: Write-Up Guidelines

Appendix C: Presentation Guidelines

# **Appendix A: Clerkship and Subinternship Faculty and Administrative Staff**

## Clerkship and Subinternship Faculty and Administrative Staff

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<i>Co-Director</i>	Peter Gliatto, M.D. Phone: (212) 241-8139 Email: peter.gliatto@mssm.edu
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# **Appendix B: Effective Work Rounds: The Three Function Approach**

# EFFECTIVE WORK ROUNDS: THE THREE FUNCTION APPROACH:

W. Scott Richardson, MD and Lawrence G. Smith, MD

*Used and adapted with permission from Lawrence G. Smith, M.D.*

Running effective work rounds that include good patient care and good teaching is essential for all medical residents. Residents can learn to improve their rounds by paying explicit attention to some fundamental tasks. In this chapter, we outline an explicit approach to improving resident work rounds.

We define work rounds as that daily activity, attended by all team members and run by the supervising resident, when all the team's patients are seen and cared for and when the daily work and learning are planned. Despite local variability in the structure of rounds (starting time, duration, persons present, etc.), the purpose of work rounds can be divided into three main functions: F1) organize the team's work; F2) care for patients; and F3) learn while you work. What follows is advice that you as Chief Resident can provide your residents, starting with some general notions and then focusing on these three functions.

## Some General Advice

1. Take time on the first day to orient the team. Use this time to outline the team's daily and weekly schedule, what you will expect of each team member and what they can expect of you. This may take twenty minutes on the morning of that first day, but if done well early it will save much time later.

2. Establish a positive atmosphere for learning. Demonstrate this atmosphere by learning about your patients each day. Encourage good questions. Show your intellectual curiosity and *your* willingness to find and fill in any knowledge gaps you have. This learning attitude is fun and contagious, and it will lighten some of the burdens of patient care. Remember, each learner may have different needs.

3. Involve everyone on the team. None of us like to feel left out. Make it feel like a true team effort, independent of personalities. Involve students and interns on each other's patients, while making sure the primary caretaker gets what he or she needs.

4. Leading means showing others how to do their best. As the senior resident, don't try to *do* the work of the interns or students, for they won't learn to do it well themselves. Instead, *show* them how to do their work well, the *allow them to do it*, striking a good balance between supervision and independence. Practice catching your team members doing something right. Give them specific, constructive suggestions on how to improve the things they can't yet do well.

## F1: Organize the Day's Work

1. Each day, start by planning the team's day. After orienting them the first day, start each morning with a concise "briefing". Go over the admission schedule, the conference schedule

and any planned team member absences (e.g. afternoon clinic). Remind your students about any student specific activity they have that day.

2. Prioritize tasks sensibly. Learn to distinguish between urgency and importance. Take care of urgent things first, but don't neglect important things that aren't urgent. When dividing up tasks, make sure each team member understands the priority for each task.

3. Involve everyone and divide the work fairly. Each patient will have one team member who is the primary care giver, so this person should do most of that patient's work. But by spreading some of the tasks around, you can help the team's efficiency and morale. Remember to involve everyone at a level they can handle. Avoid "dumping the scut" on the student. Don't forget to divide both the clinical tasks and the learning tasks.

4. Decide how to deal with interruptions during rounds. While interruptions for emergencies should be dealt with right away, many calls about patients can wait until the team arrives at those patients' rooms. Develop the discipline to rapidly triage interruptions this way, provided of course you *do* follow up on those you put off. If the interruptions are so numerous as to make effective rounds impossible, work with your Chief Residents or Program Director to remedy the situation.

5. Plan follow up and wrap up for the day. On work rounds, plan *when* in the rest of the day the team will do the rest of the work, such as procedures, progress notes, reviewing radiographs, etc. Also plan when you will set aside time for learning. Involve everyone in keeping track of what remains to be done.

## **F2: Care for Patients**

1. Review the chart purposefully, efficiently. Residents often waste time with the chart. Before actually opening the chart, decide what you need to look for. Of course, keep your eyes open for surprises. Try to spend no more than a few minutes per chart, so that you can spend proportionally more time at the bedside.

2. Make each bedside visit match the patient's needs. Since patient needs vary greatly, what you do at the bedside should vary too. Pay attention to the patient as well as the disease. Avoid needless rituals, such as daily heart and lung exams of an otherwise well person with leg cellulitis. At the same time, use "enhanced regional exams" pertinent to the patient's problem. Be aware of whether your patient's needs are being met; .set aside time later in the day if you are too hurried in the morning to meet these needs.

3. Anticipate problems. Every day, spend a few moments looking ahead. Ask yourself what could go wrong with this patient, and how will you watch for it. Learn to anticipate common complications of disease or treatment, and teach your team to do so also.

4. Bring each case to closure and decide what to do. Early in the year, you may feel overwhelmed by the number of decisions you must make and the responsibility for making them. When you don't know what to do for one problem on one patient, make a plan to get help, and then move on to the next problem or patients (for an emergency, get help immediately). Develop the discipline to decide as much as you can, *right then* on work rounds. As your

abilities and confidence grow, you should find yourself making decisions more efficiently, which in turn will make your rounds more effective and efficient.

5. Write the day's orders. As much as possible, the team should write all the orders for the day in the morning on work rounds. While your hospital may differ on this, most hospitals work more efficiently if the doctors' orders are written in the morning, when the most staff is available. Besides, most orders can be "batched", including orders for changes in diet, activity, medications, etc. Obviously, urgent or emergent orders could need to be written at any time, but try to make them the exceptions that prove the rule.

### **F3: Learn While You Work.**

Learning clinical medicine well takes time, but it needn't always take time *away from work*. During work rounds, your team cares for patients and learns by doing this (called "experiential learning"). You can greatly enhance this learning by actively teaching during rounds, especially if you learn to teach in ways that tap the power of work rounds without interrupting the work.

1. Base the learning upon the team's patients. Your team's patients will be the source for your team's most vivid and enduring learning. Your detailed knowledge of the clinical status, the immediacy of their needs and the responsibility for helping them should drive you to focus your learning on their problems. Engage all team members fully into the parallel tasks of caring for the patient and learning about the patient.

2. Center the learning around the learner's needs. Spend a few moments discovering what your team members know about a topic, before teaching them about it. Then, teach them what they need to know next, on the way toward a fuller understanding of solving their patient's problems. What your student or intern may need to learn will probably not be what you need to learn. Make all the learning active.

3. Use teaching tactics that fits work rounds. Recognize that you are constantly teaching, even though you are seldom lecturing. The teaching tactics outlined below fit work rounds because the size of each "unit of learning" is small. This allows learning to occur *while* you work, without slowing you down.

4. Teach your team how to reason through clinical problems. When deciding what to do for a given patient, take time to learn the underlying principles involved. Learn to *reason through your cases*. That way, you can teach your team not only what should be done in this particular care, but also a more general approach to the problem. A void dwelling mistakes others have made when seen in retrospect, emphasizing instead how to learn from errors to do things properly in the future.

5. Articulate clinical questions clearly. For purposes of discussion, most questions that will arise on rounds can be grouped into questions of diagnosis, therapy, prognosis and causation. Learn to recognize these when you hear them, and try categorizing them explicitly. Ask questions that contain three elements: the patient type or problem situations, the specific maneuver (test, treatment, etc.) and the outcome you're interested in. For example, "Will warfarin anticoagulation (the maneuver) for this patient with dilated cardiomyopathy in sinus rhythm (the patient/problem) prevent embolic strokes more than it will cause hemorrhage (the

outcome)?" -- a question of therapy.

6. Use self directed learning skills to close team knowledge gaps. Learn to use the tremendous power of the modern hospital library. Learn to use standard reference texts and how to search the literature for information relevant to your cases. Develop your critical appraisal skills, so that you can judge the validity and applicability of the information you find. Develop the self discipline to actually read rather than photocopy, and to learn something useful each day rather than putting all learning off until later.

### **Some Teaching Tactics that Fit Work Rounds**

1. Clarify or frame the clinical problem. One of the simplest and more powerful ways to teach your team to start solving problems is to help them see the problems clearly. If a team member presents a new development in one of the team's established patients, ask that person to *formulate*, or *name*, or *frame* the clinical problem not a single diagnosis. If they falter, help them do it or demonstrate it yourself. Some examples are: "So we're faced with new confusion, tremors and hallucinations in this alcoholic man admitted 2 days ago for pneumonia," or "From what you tell me, the new problem is sudden severe dyspnea in this elderly woman 3 days after an acute myocardial infarction." Already various diagnoses and plans come to mind, just from saying aloud what you're up against.

2. Ask "teaching questions." The way that you phrase a question suggests the kind of answer you expect. All too often residents intend to teach but end up asking questions that call for simple facts, such as "what is the serum potassium today?" Try instead to ask questions that call for understanding, such as "is today's potassium what you expected it to be, and why?" Ask the question *behind* the question, rather than "is Social Work seeing Mrs. Soong?", ask instead, "what needs to be done to prepare Mrs. Soong for discharge?" This takes some practice, but by asking teaching questions you can stimulate learning without slowing down the work.

3. Think aloud through a problem. When a surprise new problem develops, use the chance to teach the team how to solve it. If they're new to that problem, you'll be doing most of the solving, but you can still teach a lot by thinking aloud. First, frame the problem; then, talk through the important considerations and the initial steps, all the while trying to engage them in your thinking. Speak aloud the things you plan to do and why, so they can absorb your clinical reasoning

4. Extend the case: ask "What if?" Your patient may have a common disease, but you can still teach about important, rarer disease by changing a fact or two and reframing the case. For example, "what if this diabetic woman with heart failure also had bronze skin and cirrhosis -- what diagnosis should we consider?" This is an excellent way to teach your team members to anticipate complications on their patients, such as "what if the nurses call you later today because he's vomiting -- what might be causing that in this man?"

5. Use "teaching moments" or "microlectures." When you find gaps in what your team knows, you have several choices. One of these choices is to fill in the gap on the spot with a "microlecture." This choice is particularly good if you can do this quickly and if you then ask the team to use what you've just taught them to solve a clinical problem. Remember to keep directly on the topic and to keep it short, otherwise you'll get in the way of effective rounds.

6. Prime the next task. This tactic is particularly useful when you're about to go the bedside. As you start to walk, say aloud something like "from what we know, what do we expect to find on the examination of the abdomen today?" Without waiting for the answer, walk in and have a team member examine the patient. This question "primes" the next task, making the team members *think prospectively* about what they're trying to find.

7. Find team knowledge gaps and plan follow-up. Every resident and every team has knowledge gaps. Don't try to hide what you don't know, either from yourself or from your team. Set a good example by acknowledging your own gaps, finding the answers and reporting back to the team. When you find team knowledge gaps, you can either fill them in right then using "micro lecture", or you can plan right then how to fill the gaps in later. Articulate what you need to know as good, three component clinical questions. Then decide how urgently you need the answers and how best to find them. Divide the learning tasks fairly, and plan when you'll follow-up on these assignments.

# Appendix C: Write-Up Guidelines

# Guidelines for Reviewing Student Write-ups

Third year students should write-up an admission note on the patients they admit. At Mount Sinai, these notes should go in the charts by the next morning, after a resident or intern has reviewed and co-signed it. The student has the evening to review the findings, read up on their patients and construct a cogent assessment and plan. A third-year student admission note is not a substitute for an intern admission note.

The fourth year student note can substitute for an intern note as long as the resident reviews the note carefully, annotates it if necessary, and signs it.

When reviewing your student write ups, look for the following.

## **Procedural Matters**

Title, date, time, and sign every page.

Should avoid non-standard abbreviations.

Best if hand-written or a print out for a medical record system (i.e., the real note)

## **Title, Chief Complaint and Comment on Patient Reliability**

Should be present and succinctly stated

## **History of Present Illness**

Chronology. Does the student give a sense of the events as they unfolded?

Symptom characterization. Does the student fully characterize the symptom or symptoms in terms of severity, location, setting, timing, exacerbating and alleviating factors, radiation, and how the patient's function has been altered?

Other information that helps direct thinking about the differential diagnosis. Does the student bring up the appropriate other elements of the social and family history or review of symptoms that help frame a differential?

Other illness-appropriate questions: Does the student document information that is specific to the illness, when appropriate (i.e., documenting an asthmatic's usual triggers.)

## **Past Medical History**

Should be in a list format.

Should include surgical and gynecological history when relevant.

### **Medications**

Should be a list with generic names and dosages  
Also should include relevant over-the-counter products and complimentary and alternative agents.

### **Allergies**

Should document the specific reaction, if known.

### **Social History**

Should include information about living situation, family structure, educational and occupational history, alcohol use, tobacco use, illicit drug use.

### **Family History**

Should document health of first degree relatives and relevant medical conditions in other family members.

### **Review of Systems**

Should be thorough and complete for each system. Students may not abbreviate this section. They should not repeat the information that may have been covered in the HPI.

### **Physical Exam**

Should be a full and thoroughly documented exam.

### **Laboratory and Clinical Data**

Should include all relevant labs. Abnormal values should be compared to pre-existing values for the patient, if available.

Should include EKG data and CXR data unless not available.

### **Problem List**

Students should be able to identify major problems and label them without yet committing to a diagnosis, unless it is obvious. Problems can be anything abnormal or that requires attention from the entire data set. The student should attempt to list these by priority. The problem list can be embedded with in the assessment and plan.

## **Assessment and Plan**

Student should attempt to summarize and synthesize the major clinical findings without simply repeating the HPI in an encapsulated form. For the major new problems student should offer a differential diagnosis and substantiate what he or she feels is most likely and why. This is the place for the student to generate a hypothesis that fits together the pieces of clinical data.

# **Appendix D: Presentation Guidelines**

# Case Presentation Guidelines

The following guidelines were adapted, with permission, from those developed by members of the Boston University's Department of Medicine.

These are general guidelines for a complete presentation for attending rounds. Please be sure to help students also hone their brief presentations on work rounds.

## Overview

- Make a convincing case for the important problems, the differential, and the plan.
- Make it structured, organized and targeted as it should take only 5-7 minutes.

## Opening Statement

- Brief statement of chief complaint and why patient was admitted.
- Include pointed and relevant historical information.

## Source

- Briefly note if/why the patient cannot give reliable history.
- Note any information sources besides the patient.
- No comment assumes that all information came from a reliable patient.

## Present Illness

- The differential diagnosis you considered should guide what you include.
- Consider starting with: "...*usual state of health until...*"
- Be chronologically organized and clear without analyzing.
- Remember OPQRST: Onset, Palliate/Provoke, Quality, Region/Radiation, Symptoms (associated), Temporal aspects.
- Include elements of past history (with supporting studies and therapeutic interventions), meds, family history, social history (including psychosocial factors) that specifically contribute to the Present Illness.
- Pertinent positives and negatives to make the listener understand your DDX.
- Pertinent = relevant to the differential diagnosis and management considered.
- Only include ER course if it *significantly affects/alters triage or immediate treatment decisions prior to coming to your unit*. Report facts and events, NOT ER diagnoses.

## Other History

- Important PMH (with supporting history/data).
- Exclude minor diagnoses without impact on current care.
- Important meds with doses of relevant ones. Omit unimportant medications.
- Allergies
- Focused FH/SH/ROS. Do not repeat previously stated information.

## Physical Exam

- Always include general appearance and specific vitals

- Include pertinent negatives of exam and any abnormal findings.
- Remainder may be noted as “*noncontributory.*”

#### Labs/Data

- Include pertinent or otherwise significant labs/studies
- Start with basic blood tests first. CBC→Chem→Coags→Urine→EKG→Rad→Other
- OK to mention other tests as being “*normal.*”

#### Synthesis

- Consider beginning with: “*And in summary...*” *but...*
- Assess and synthesize, don’t summarize and regurgitate.
- Demonstrate YOUR thinking about the patient specific differential diagnosis.
- If multiple issues present, weave together or discuss lesser issues in problem list below.

#### Enumerated Problem List

- Start with most important problem first.
- Use most specific label for the problem you can.
- Always list problems, not systems.
- Include your understanding of the cause of the problem.
- Include a specific plan for addressing it

## Tips for Evaluating and Giving Feedback on Oral Presentations.

Used and adapted with permission from Linda DeCherrie, M.D.

The following schematics, also from Boston University, depict one framework for giving feedback for student presentations. In terms of the elements of SOAPS (Story, Organization, Argument, Pertinence, and Speech), students entering the third year should be practiced at giving organized patient presentations and should be able to reasonably present the patient's story (HPI) that is organized. While they will need help reining these skills, the attempt to build an argument for a differential diagnosis within the presentation, and the proper use of pertinent positives and negatives will be skills that are introduced in the third year. Therefore, for the majority of students, you will likely need to direct your feedback to these elements.



