Core Session 1: Introduction

**TOPICS:**
1. Principles of Infection Control / Body Substance Precautions
2. Meeting learning objectives in clinical settings
3. Discussion of patient’s chart and issues regarding confidentiality and the role of the student on the medical ward or clinic.
4. Introduction to the impact of computer systems on patient physician communication and practice of an electronic medical record (EMR) for core sessions 2 – 5.
5. Introduction to the focused history and physical exam
6. Review of the full physical examination

**OBJECTIVES:**

By the end of this session, you should be able to:
1. Know the principles of infection control and know how to use them in various clinical settings
2. Re-familiarized with the hospital ward or clinic environment and how a student can learn in these environments.
3. Know the importance of how an EMR system can affect communication between physician and patient.
4. Know the technique of the focused history and physical.
5. Know the components and organization of the “bedside” oral presentation.
6. Perform components of a complete physical.
TIMETABLE:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>0800-0830</td>
<td>Review of Infection Control Principles</td>
</tr>
<tr>
<td>0830-0845</td>
<td>Group + Teacher Introductions</td>
</tr>
<tr>
<td>0845-0900</td>
<td>Discussion of how to meet learning objectives in clinical settings.</td>
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<td></td>
<td>Review a patient chart and confidentiality issues.</td>
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<tr>
<td>0900-0915</td>
<td>Introduction to the impact of computer systems on patient physician communication, practice using an EMR system for core sessions 2–5.</td>
</tr>
<tr>
<td>0915-1015</td>
<td>Discussion of the purpose and technique of the focused history and physical.</td>
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<td>Discussion of objectives, and differences between written and oral presentation.</td>
</tr>
<tr>
<td>1015-1030</td>
<td>BREAK</td>
</tr>
<tr>
<td>1030-1200</td>
<td>Review the complete physical exam.</td>
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<td>Using real patients, volunteer patients, or students in the ASCM group, the teacher will demonstrate the complete physical exam with emphasis on “how to put it all together” depending on the clinical scenario. Many students will be “rusty” in performing basic physical examination skills and need to review various physical exam skills in order to feel comfortable examining real patients in future sessions.</td>
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</tbody>
</table>

1. BODY SUBSTANCE PRECAUTIONS (THESE PRINCIPLES APPLY TO THE MANAGEMENT OF ALL PATIENTS AND LABORATORY SPECIMENS)

ROUTINE PRACTICES (RP)

Objective:
To prevent the spread of infection within the health care institution from patient to patient, patient to staff, staff to patient, by providing a system that emphasizes the increased use of barrier precautions when in contact with potentially infectious body substances.

Definitions:
Routine Practices (RP) is a system which interrupts cross transmission from colonized and/or infected patients, thus providing increased protection for patients and all health care providers. It emphasizes the need for individual assessment of the degree of exposure anticipated and informed judgment in the use of specific barrier techniques.

Body Substances include blood, oral secretions, sputum, emesis, urine, feces, wound drainage, tissue, and any other moist body substances, but not perspiration.
Basic Principles of Routine Practices (RP):
(These principles apply to the management of all patients and laboratory specimens)

1. Effective **hand hygiene** (hand wash or alcohol-based hand antiseptic) is indicated before and after any type of direct patient contact.

2. **Gloves** are worn for all contact with blood, secretions, mucous membranes, non-intact skin (including rashes) and moist body substances.
   - Gloves are changed after each patient and/or procedure.
   - Hand hygiene is performed after gloves are removed.
   - Gloves are **not** necessary for contact with the intact skin of any patient.

3. **Masks** and **protective eyewear** are worn when body substances are likely to splash skin or mucous membrane, or when within 2 meters of a coughing patient.

4. **Gowns** are worn when body substances are likely to soil clothing or skin.

5. **Recapping needles** is **NOT** recommended. Where recapping is unavoidable, only safety-approved methods are employed. Syringes, needles, sharps and disposable instruments must be discarded in designated puncture resistant containers.

6. **Single room** may be indicated for patients who soil articles in the environment with body substances, and those colonized or infected with organism(s) epidemiologically significant to the institution.

7. Patients with diagnosed or suspected infections transmitted by the **respiratory route** (airborne or droplet) will require a single room. Masks are worn according to hospital policy.
   - **Airborne infections:** Negative pressure room required with the door kept closed. If respiratory protection is required, an N95 respirator is to be used. For some infections, only immune staff may enter.
   - **Droplet infections:** Mask, eye protection, gloves and gown required.

8. **Droplet / aerosol generating procedures:** Mask, eye protection, gloves and gown required.

9. **Healthy workplace:** to protect our vulnerable patient population and your colleagues, do **NOT** come to the hospital if you have symptoms of an acute illness that is probably infectious including cough, vomiting and/or diarrhea, conjunctivitis, skin rash or lesion.
2. DISCUSSION OF HOW TO MEET LEARNING OBJECTIVES IN CLINICAL SETTINGS

The tutor should lead students in a discussion about environment of the wards or clinical settings in which students will be learning. A discussion about how students can maximize the educational experience of seeing real patients should be undertaken. Students are sometimes concerned that since they are not directly contributing to care of patients that their interaction may be an imposition on the patient. A discussion of the need to integrate learner needs into the clinical setting in order to fulfill societal need to train competent physicians should be undertaken.

Consider the following for discussion:

1. Is it acceptable to interview a patient and examine a patient just for the student’s educational benefit?
2. What things should be done in the ward setting to try to ensure the patient’s comfort and sense of privacy when interviews and examinations take place?
3. Do patients need to give explicit consent to participate in the educational sessions of health care professions in teaching hospitals and clinics?
4. What about if the patient seems confused, should the student continue?
5. What is the optimal way for demonstrating or sharing important clinical findings with students? Is it acceptable for six students and a tutor to gather around one patient?
6. Are there any benefits to be had for the patient in an interaction with a student?

Finally, the teacher should go over a chart with the group. A representative hospital chart should be reviewed with the students, and the various components pointed out. Students should be encouraged to read the charts of patients they have interviewed, but only after finishing their workup. Viewing patient’s electronic medical records may not be possible in some institutions at present. Students should be aware that information in the chart may be incorrect and/or incomplete and therefore does not always provide accurate confirmation for the student’s interview or physical exam.

The following questions concerning charts should be discussed:

1. Who can you discuss this information with?
2. Can students read any chart out of interest?
3. Can patients have access to the chart, or information from it?
4. What should the student do if the patient reveals something unknown to the medical team?
5. How should the student reply if the patient asks for information or advice about his or her condition?

General confidentiality rules about patient privacy and hallway or elevator talk should be reviewed. This would be good time to review confidentiality policies of the institution.
3. THE IMPACT OF COMPUTER SYSTEMS ON PATIENT-PHYSICIAN COMMUNICATION – PHASE 2

As you may recall, during ASCM-1 you were introduced to how computer systems like electronic medical records (EMRs) when used in a clinical encounters can disrupt the communication between a patient and a physician. In particular, you had a chance to explore these issues and some of the solutions to compensate for the disruption. The ASCM-1 session on EMR represents the first phase of a three part curriculum that has been developed and is being deployed from 1st - 4th year of your undergraduate medical education. This year in ASCM-2 you will be introduced to Phase 2 of this curriculum.

Phase 2 focuses on practicing the various methods to minimize EMR disruptions during a clinical encounter. There will be no formal didactic sessions on this topic however all of the materials presented to you in Phase 1 (ASCM-1 session) will be made available to you online on the ASCM portal. In order to practice in Phase 2 you will be provided with a pdf based mock EMR system that has been designed for educational purposes. This system will allow you to practice the skills of capturing/entering information into an EMR like system while taking a patient history. This should provide a realistic setting in which to practice the skills to minimize the disruptive effects of these EMR systems while communicating with patients. The EMR systems and educational materials from ASCM 1 are available to you for download from the ASCM 2 portal and it is a mandatory part of the curriculum that all students will use the system while practicing your history-taking skills from core sessions 2 – 5.

You will also be required to be observed using an EMR system during a patient encounter by your tutor. He/she will need to sign off the clinical skills log book indicating that you have done so. This can be done either during any ASCM-2 session or FMLE session and you may use any EMR systems (i.e. the ASCM EMR software or an EMR system in your FMLE tutor’s office) to accomplish this task. It is expected that the introduction of this curriculum will prove to be of significant value towards helping you to develop a set of skills that will make you a proficient communicator despite the introduction of disruptive technologies like EMRs.

<table>
<thead>
<tr>
<th>Session number</th>
<th>Date</th>
<th>Activities &amp; expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core session 1</td>
<td>September 3rd, 2015</td>
<td>Introduction to phase 2 curriculum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Students expected to download the EMR system from ASCM 2 portal.</td>
</tr>
<tr>
<td>Core sessions 2 - 5</td>
<td>Dates vary depending on the ASCM group</td>
<td>Practice history taking skills while using the EMR systems to do documentation</td>
</tr>
</tbody>
</table>
4. THE FOCUSED HISTORY AND PHYSICAL EXAMINATION

TOPICS:
1. The Focused History and Physical
2. The Oral Presentation
3. The Written Presentation

OBJECTIVES:
By the end of this session, you should be able to:
1. Know the technique of the focused history and physical.
2. Know the components and organization of the “bedside” oral presentation.
3. Re-familiarize with the written presentation skills learned in ASCM -1.

The focused history and physical is a technique used by practicing clinicians particularly in situations where the clinician must make an assessment of a specific problem in an efficient manner. The line of questioning will be directed at the specific problem only and include those aspects of the past history and Review of Systems (ROS) that are relevant to the presenting problem (essentially the History of Present Illness, HPI). For example: a patient who presents with chest pain should be asked not only about the characteristics of the pain and associated symptoms but also about risk factors for coronary artery disease including a family history of coronary artery disease. In general, the history should be fairly complete, although some details may be omitted if they are not relevant to the presenting problem. On the other hand, details about social history are often important regardless of the presenting complaint. For example, the home situation may not seem important when seeing an elderly woman in the emergency room with a fractured hip, but after the immediate problem has been dealt with, the fact that she was the sole caretaker for her husband with Alzheimer’s may significantly affect discharge planning. Or, a single mother may be unwilling to come to hospital for tests because she has no one to look after her child. Without a full understanding of typical symptom complexes and physical findings for certain conditions, it may be difficult to focus the history and physical, but as knowledge improves, students will be able to organize and focus the history.

The focused physical is usually abbreviated to include the vital signs, cardiorespiratory system and the system(s) affected by the presenting illness.

WRITTEN AND ORAL PRESENTATIONS

Writing case reports provides students with practice in selecting, organizing and analyzing the relevance of information obtained from the student patient encounter. Oral presentations provide practice in similar skills but to an even greater extent. The format used should be similar to that used in clerkship and residency.
THE WRITTEN CASE REPORT

The general organization of the case write up follows the time honoured formula of chief complaint, HPI, past medical history, etc. The challenge is to take the information obtained from the interview and physical examination, and to reorganize and interpret it into a meaningful story leading to a statement of the main problem (usually, but not always the disease diagnosis), and to a course of action. A meaningful write-up requires at least some knowledge of the disease process, as well as the circumstances of the individual patient. For instance, the effect of diabetes on a child is different than on an 80 year old. Students can get maximum benefit from case reports by reading up on the clinical features of the disease processes in their patient, so that future interviews will be conducted with a larger knowledge base.

A further difficulty is that most interviews will be of hospitalized patients, often with complex and/or chronic problems with a well established diagnosis. A chief complaint becomes somewhat less meaningful here, and might be better termed the “reason for admission”.

COMPONENTS OF THE STANDARD CASE WRITEUP

Identifying Data

Age and sex of patient.

(If additional social information is included here, keep in mind that that information is not obtained at the beginning of the interview, but placed here in the reorganization.)

Chief Complaint (CC)

This is the patient’s perception of what brought them to the doctor or hospital, usually stated in the patient’s own words. It contains the problem and duration. You can edit what the patient says (i.e. “I’ve had terrible pounding headaches for about 2 weeks” becomes “pounding headaches x 2 weeks”).

On occasion, the patient’s CC and your assessment of what is the major problem may be different. If so, indicate this in the CC, or early in the HPI, to avoid confusion.

History of Present Illness (HPI)

This is normally a complete and exhaustive explanation of the CC, or major problem. It often proceeds chronologically, from the onset of first symptoms up to the present. However, the HPI is the interviewer’s interpretation and reorganization of the information obtained from the patient during the whole interview and not simply a word for word regurgitation of the story told by the patient. While the HPI should include the biomedical information relevant to the CC, it may also include precipitating or perpetuating events in the patient’s life that have resulted in the illness at that time. For example, a patient might present with typical anginal chest pain, but later in the interview reveal a history of high blood pressure, a family history of cardiac disease, and recent emotional stresses in life. All of this should be included in the HPI.
In addition, there should be some indication of the effect of the illness upon the patient's life. This may be critical in the plan of action and management of the patient, if not in the actual diagnosis, and may, in some patients become the major problem.

This information may include:

a. patient’s attitude toward the illness
b. patient’s ideas about the causes or reasons for the illness
c. impact of illness on family, occupation, or other significant people

Keep in mind the features of a symptom such as pain that should be inquired about and included, if relevant, in the HPI:

a) pain           g) radiation
b) duration       h) intensity
c) course over time i) exacerbating factors
d) frequency      j) alleviating factors
e) location       k) associated symptoms
f) quality        l) past experience of symptom

A major and frequent defect in most HPIs is the failure to include all relevant data.

Medications and Allergies

Medications may be listed separately or alongside illnesses for which the medication is taken in the PMH.

Social and Family History

This section should contain the other information not relevant to the HPI, such as a general genogram, occupational information, etc. The smoking and alcohol history often appears here.

Past Medical History (PMH)

This is a list of all previous medical problems, operations, hospitalizations, etc., that are not noted in the HPI. In complicated patients, the PMH may appear following the chief complaint as a list of pre-existing problems.

Functional Inquiry (FI) or Review of Systems (ROS)

This should be a screening inquiry about systems not covered in the HPI, to make sure that no significant problems are missed. Information obtained during the review of systems but relevant to the HPI should be included with the HPI not the ROS.
**Physical Examination**

This can be recorded in point form, but with enough information that future readers can correctly interpret findings. The major system(s) involved must be described thoroughly, with both positive and relevant negative findings noted. The amount of detail provided in other systems is a matter of clinical judgement, but at least describe briefly what you did. For example, instead of saying “reflexes normal”, draw a stick man, or indicate “biceps, triceps, knee and ankle reflexes symmetrical and normal”, or “percussion and auscultation of chest normal”. (Never say ‘grossly normal’...that usually means you haven’t done anything.)

**Summary and Diagnostic Impression**

The summary is a selection and interpretation of the relevant information obtained in the interview and examination. Thus, it should contain no new information, although it may be informed by reading the literature. (“Symptom X is very uncommon in disease Y, therefore...) However, the literature should be applied to that particular patient context, and again should not be merely a listing of the features of a disease found in a medical text. Frequently in reading about a disease, one finds that additional information should have been obtained in the interview. If possible, you can return to the patient and ask the questions. At the least, you will now be able to take a more complete history in the next patient with a similar problem.

In interpretation, one does not just repeat what is found in the HPI and Px, but one indicates that in thinking about the meaning of this information, one draws certain conclusions. This leads to the diagnostic impression, differential, or problem list. How one organizes this depends on the situation. Try to commit to a diagnosis, if it is not already established, based on the data you have obtained. Indicate the certainty with which you hold this view in formulating the differential. (“In this patient, all the symptoms are consistent with acute myocardial infarction”, or “Most likely Dx is acute MI, but with the GI symptoms must rule out esophageal spasm and reflux”.). In a patient with complex or multiple problems, one might make a problem list. (“Current Dx is acute MI, but major problem is longstanding, poorly controlled diabetes. Heavy smoking is an additional, contributing issue”).

Your summary and impression should be the logical conclusion of the data you have obtained during the history and physical. If you have not obtained sufficient data to make a summary or impression you should go back to the patient if possible, to obtain more information. Simply stating conclusions taken from the chart may be misleading or even incorrect and may not be supported by the data you have collected.

Organizing the summary and diagnosis in such a way will make it easier and more logical to formulate an investigation and/or management plan. You are not expected to include a management plan in the written or oral reports in ASCM II. You will learn this in clerkship. If you do wish to include these parts of the report, again make sure that they apply to the individual patient and not the disease. (For instance, don’t suggest lifestyle changes in a person who already exercises and follows a good diet.)
THE ORAL PRESENTATION

You will probably give far more oral presentations than written ones during your training and practice. These will vary from a 2 sentence “handover” to another clerk, to a telephone consultation about a patient, to the formal post call morning report or bedside presentation.

The oral presentation is generally shorter than the written and is designed for a listening audience. Therefore, your presentation skills, such as posture, eye contact, tone of voice, and verbal delivery are important. If you get nervous, practice in front of a mirror, or ask a colleague to observe and comment.

Content of oral reports is also different, at least in quantity. Read Billings + Stoeckle, pp 6063, and Chapter 17 for a good description of this topic. The oral report generally includes a brief statement of who the patient is (Mrs. Jones is 50 year old married woman), the presenting complaint (who presented to the emergency room with a 2 day history of progressive dyspnea) and a synopsis of the relevant HPI, past Hx, FI, and physical examination. When you are clerks or residents it will also include relevant laboratory or radiologic data.

Reference

- Introduction to the focused history and physical examination on ASCM 2 Website and Sample oral presentation
- Bates Chapters 1, 2 and 3

5. PHYSICAL EXAM REVIEW

The tutor will review the complete physical examination using either a real patient, a volunteer patient or a student in the ASCM group to re-familiarize students with skills learned in ASCM-1. The tutor is encouraged to demonstrate a comprehensive physical examination that would be typical if one was attempting a “full physical”. The tutor teacher should go over the physical exam in a smooth coordinated fashion to demonstrate how to put it all together and demonstrate appropriate draping. The group may then focus on any specific components requested by the students which they feel particularly week in. Students may practice some components of the physical exam on the patient or on each other.
CORE sessions occur periodically throughout the year.

Suggested topics that should be covered for each of the days are listed below. Consult the timetables for the exact dates for your group.

**NOTE:**

*Tutors should directly observe each ASCM student for at least one half hour with a patient and give formative feedback to students about history and physical examination using feedback form (Appendix 3). Core sessions 2 – 5 should be used for this purpose. Tutors and students should decide on a timetable to coordinate the observation of 2 students each session.*

**OBJECTIVES:**

1. To review and improve general interviewing, communication and examination skills.
2. To practice oral presentation skills.
3. To provide specific practice in physical examination skills.
4. To learn and practice the focused history and examination.
5. To provide opportunity for observation of students by tutors and to provide regular feedback.
6. To begin to formulate a differential diagnosis.
7. In the sessions near the end of the year the teacher will guide the students in preparation for the OSCE, do practice case scenarios, and review physical examination.
8. To provide an opportunity to discuss the role of evidence based physical examination.
SUGGESTED SKILLS THAT SHOULD BE COVERED FOR EACH CORE SESSION ARE LISTED BELOW

Each group should review the systems covered in ASCM 1 which will not be covered by a specific specialty session in ASCM 2. Specific emphasis should be placed on the assessment of the general state of patient, vital signs, volume assessment, respiratory, cardiac, abdomen including spleen and liver. Tutors may bring in outpatients with abnormal physical findings (e.g. a mitral regurgitation murmur, dry crackles of pulmonary fibrosis, an enlarged spleen or nodes) or try to find inpatients with findings. These sessions should be flexible and should be directed at the areas the students feel need additional practice, however, a list of suggested topics to be covered in these sessions is listed below to ensure that there is continuity particularly when there are co-tutors doing different sessions. These sessions are aimed at solidifying history taking and physical examination. Students should have the opportunity to see patients alone if at all possible. Inpatients or outpatients may be used. Students should have the opportunity to present their patient to the group, to practice their oral presentation skills and to review with the tutor any physical findings or examination manoeuvres they feel need to be assessed. Students should have, over the course of the year, gained some skills in time management and efficiency. They should have learned how to do a focused history and physical. The core sessions should be used to practice these skills and gain experience in what components of the history and physical need to be included for a given clinical situation and to begin formulating a differential diagnosis. Teachers should also ensure that students know what constitutes a basic “screening” examination and are facile with it.

**A suggested timetable is listed for each of the core sessions. Please refer to the actual session for the timing.**

LAST 15 minutes of each session should be reserved for feedback to students if this is not already been done. Tutors are encouraged to let the students know what was done correctly, what was done incorrectly and suggestions for improvement.

It will be the responsibility of the core tutor to check off skills observed. It is the responsibility of each student to bring the mandatory observed technical assessment log to core sessions.

Each student and tutors can view a listing of articles appearing in the JAMA series, The Rational Clinical Examination on the ASCM 2 website on the portal. Sometime in the core sessions should be used to introduce and discuss the concept of evidenced-based physical examination.

REFERENCES:
The Rational Clinical Examination Series – See ASCM-2 website

**STUDENTS AND TUTORS ARE ENCOURAGED TO USE THE ASCM WEBSITE on the Portal as all reading reference material are posted online for this year.**
1. THE CARDIOVASCULAR SYSTEM

Review the important historical aspects of the focused cardiovascular history.

Review physical examination

1. Inspection of the precordium
2. Palpation of cardiac pulsations/thrills/heaves
3. Palpation of the apex/PMI supine and left lateral decubitus position
4. Auscultation using diaphragm/bell
5. Positional auscultation/indications – left lateral decubitus, upright forward
6. Expected characteristics and locations of the following murmurs: aortic stenosis, aortic regurgitation mitral stenosis, mitral regurgitation, pulmonary stenosis, tricuspid regurgitation
7. JVP measurement
8. Auscultatory findings in pericardial effusion, pericardial rub
9. Palpation of peripheral pulses: radial, brachial, dorsalis pedis, posterior tibial, poplitieal, femoral
10. Detection of abdominal aortic aneurysm
11. Auscultation of bruits: carotid, renal, femoral

REFERENCES:

- JAMA articles: (See ASCM-2 website)
- “Does this patient have an abdominal aortic aneurysm?”
- “Does this patient have aortic regurgitation?”
- “Is this patient having a myocardial infarction?”
- Bates Chapter 9
2. THE RESPIRATORY SYSTEM

Review the important aspects of a focused respiratory history.

Physical examination

1. Respiratory distress: respiratory rate, use of accessory muscles
2. Chest inspection: deformities, scars, flail segment
3. Surface markings: Right Upper, Middle, Lower Lobes, Left Upper lobe (and lingula), and Left Lower Lobe
4. Tactile and vocal fremitus:
5. Percussion: detect dullness, level of diaphragm
6. Auscultation
7. Findings of: pleural effusion, consolidation, pneumothorax, bronchospasm, pulmonary fibrosis, pulmonary edema, pleural rub

REFERENCES:

- Bates Chapter 8

SUGGESTED TIMETABLE:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>0800-0930</td>
<td>Review of the cardio and respiratory systems</td>
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<tr>
<td>0930-1100</td>
<td>Interview and examine patients</td>
</tr>
<tr>
<td>1100-1200</td>
<td>Oral presentations</td>
</tr>
</tbody>
</table>

DECIDE ON TIMETABLE FOR DIRECT OBSERVATION OF 2 students each session for core 2-5.

**Reminder – please practice using the EMR system during your patient encounter**

Tutor to observe 2 students at bedside
1. THE ABDOMEN

Review the focused history of gastrointestinal and abdominal complaints.

Physical examination
1. Inspection for rigidity, guarding, masses, distension, scars
2. Auscultation of bowel sounds
3. Percussion
4. Palpation – light and deep
5. Detection of abdominal aortic aneurysm
6. Detection of ascites
7. Findings in the acute abdomen
8. Liver – percussion, palpation
9. Spleen – percussion using Castell's method, palpation
10. Inguinal and femoral lymph nodes
11. Inguinal hernia
12. Findings in liver failure

REFERENCES:
- JAMA Articles: (See ASCM-2 Website)
- “Does this patient have splenomegaly?”
- “Does this patient have ascites?”
- Bates Chapter 11
2. PORTFOLIO SESSION: INTRODUCTION TO YEAR 2 PORTFOLIO

Important Note about Portfolio Session Discussions and Stories

In these sessions, you will be telling personal stories about your own clinical development, and listening to those of your colleagues. In these stories, you will hear information pertaining to individual patients and physicians, and other students.

This information must be considered highly privileged and confidential. You are learning to be a professional, who can be trusted by patients and colleagues. You earn and maintain that trust by preserving the confidentiality of what you hear. Any discussions that occur in these groups must stay within the group. Knowingly repeating a story outside of the group may be grounds for a major lapse in professionalism.

Portfolio Session: Introduction to Year 2 Portfolio

Purpose: This session builds upon the first year Portfolio sessions, when you discussed your earliest experiences of taking on the professional role of the physician. In this session you will reflect back on those experiences, and any subsequent ones, as you prepare to continue your development in ASCM 2.

Before Portfolio Session

Task: Pre-session reflection on last year’s key experiences, and how they look to you today, to prepare to share thoughts and reflection during the ASCM 2 session.

Format:

1. Self-reflection: Look back at the notes you took in ASCM 1, and think about the experiences that you had with your patients in that year. Also, think about any other times you have worked in clinical settings, for example over the summer.

2. Consider what you observed and experienced last year during ASCM 1 and reflect on the following:
   - Which experience(s) appear to be the “most important” ones now, in terms of how you see yourself as a physician?
   - Are these different than the ones you chose to discuss in last year’s Portfolio sessions? If so, why?
   - In what ways has your perspective changed about these experiences since then?
   - How do you think you will use these lessons in ASCM 2?

3. Prepare your story (the most important experience) and your reflection on the story (how/why your perspective has changed, and how you will use these lessons in ASCM 2).
4. You may give some background or context, but make sure to tell one central story.
5. The story should be personal (it’s YOUR story, containing YOUR perspective).
6. The central story should describe some personal growth or professional change that happened as a result of the situation it describes.
7. You should follow this with a reflection. In your reflection, explain why this story was meaningful to you and how it will change your professional practice and attitudes.

Suggestions:
- Take time to think through the suggested questions and reflect on your experience, write down a few notes. This will be useful for you to identify your “one central story” and also for your final end of year written reflection that you will be asked to submit as part of the ASCM 2 Course requirement.

**In the Portfolio Session:**

**Tasks:**
Each of you will, in turn, tell your central story and share your reflection with the rest of your group. Each of you will also listen and provide appreciative feedback and comments to others as they tell their stories.

**Format:**
- Tell the one central story - where were you, who was there, and what happened? Lead the rest of the group through your story, and please include any feelings or thoughts that came to you as part of the story.
- The self-reflection is meant to be highly personal, and there can be no “right answer”. You’re on the right track if you can say “The thing I learned about myself as a future doctor from this experience was...” and state something that you feel is authentic and true to you.
- After you have finished, the rest of the group will be invited to comment on what they heard. Comments should focus on what listeners appreciated in the story, and interesting ideas that came to them while listening. Questions may be asked to clarify the story, and you may have new ideas during the discussion.
- Time per student: 5-7 minutes total.
- At the end of the entire session, the facilitator and the whole group will discuss general themes that came out of this activity.
- The facilitator is there to help guide the discussion, and to pose questions, but not to provide “answers”.
- Everyone shares responsibility for keeping the discussion on track and within the time allotted for this activity.
Common Issues:

- “I don’t know the right way to tell my story.” As long as your central story has a beginning, a middle, and an end, involves you and your personal reaction to the situation described and can be linked to a new understanding of your future as a physician, then you will be on the right track.

- “I feel awkward about sharing my perspectives with my group.” That’s normal. This is the first time doing this for everyone. The process gets easier as the session goes on, and soon this type of discussion will become a routine part of how you learn.

- “I don’t have a spectacular story.” It doesn’t have to be dramatic. Most of medical practice is made up of small, but potentially meaningful events. If you thought something was important to you, in some way, then it’s a good enough story to tell.

- “I don’t know how to give feedback to my classmate.” Consider starting with positive feedback and acknowledging the strengths of your classmate’s story. You can then move on to probe for more information. Engage the story teller in a deeper discussion of the story and reflection. Generally, you should avoid criticism and judgmental comments.

**After the session:**

Task: Consolidate your ideas about your story, using the points brought up by your classmates, and any other ideas you had. You will need this for your final reflection later in the year.

Format: To be done as soon as you can after the session. Use whatever format will be easiest for you to follow later. We suggest using the following sheet to organize your observations and ideas so that you can write your final reflection more easily at the end of the year.
Reflection Worksheet

The Central Story I told in this session was:

____________________________________________________________________________________

____________________________________________________________________________________

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The key things I learned about the way that I want to practice medicine were:

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Ideas and feelings that came to me during the group discussion of my story:

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Other ideas and feelings that came to me from listening to other students’ stories:

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**SUGGESTED TIMETABLE:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>0800-0900</td>
<td>Review of the Abdominal system</td>
</tr>
<tr>
<td>0900-1000</td>
<td>Introduction to Portfolio in ASCM-2</td>
</tr>
<tr>
<td>1000-1130</td>
<td>Interview and examine real patients</td>
</tr>
<tr>
<td>1130-1200</td>
<td>Oral presentations</td>
</tr>
</tbody>
</table>

**Reminder – please practice using the EMR system during your patient encounter**

Tutor to observe 2 students at bedside.
THE VITAL SIGNS, GENERAL APPEARANCE, AND VOLUME ASSESSMENT

1. Proper technique for assessing and recording vital signs.
2. When it is appropriate to measure postural blood pressure and heart rate and how to do it.
3. How to look for anemia, jaundice, cyanosis, clubbing, edema
4. How to look for wasting/cachexia.
5. Assessing level of consciousness, orientation.
6. Asterixis
7. Measurement and significance of body mass index (weight kg/height m²) and waist circumference
8. Signs hypervolemia
9. Signs hypovolemia

REFERENCES:

- JAMA articles: (See ASCM-2 Website)
- “Does this patient have clubbing?”
- “Is this patient hypovolemic?”
- Bates Chapter 4

SUGGESTED TIMETABLE:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800-0930</td>
<td>Review of vital signs, general appearance and volume assessment</td>
</tr>
<tr>
<td>0930-1100</td>
<td>Interview and examine real patients</td>
</tr>
<tr>
<td>1100-1200</td>
<td>Oral presentations</td>
</tr>
</tbody>
</table>

**Reminder – please practice using the EMR system during your patient encounter**

Tutor to observe 2 students at bedside.
1. PORTFOLIO SESSION

Important Note about Portfolio Session Discussions and Stories

In these sessions, you will be telling personal stories about your own clinical development, and listening to those of your colleagues. In these stories, you will hear information pertaining to individual patients and physicians, and other students.

This information must be considered highly privileged and confidential. You are learning to be a professional, who can be trusted by patients and colleagues. You earn and maintain that trust by preserving the confidentiality of what you hear. Any discussions that occur in these groups must stay within the group. Knowingly repeating a story outside of the group may be grounds for a major lapse in professionalism.

Portfolio Session:

Purpose: This session focuses on the written reflection you submitted at the end of year 1. In this session you will discuss what it was like to write it, and reflect upon the feedback you received, as you prepare to do one more written reflection in ASCM 2.

Before Portfolio Session

Task: Pre-session reflection on last year’s written reflection and the feedback you received, to prepare to share thoughts and reflection during the ASCM 2 session.

Format:

1. Self-reflection: Look at the written reflection you submitted in OASES, and the feedback you received on it. Think about what you felt or observed about yourself when you wrote it, and how you perceived the feedback. Reflect on the following:
   • How would you describe your experience writing the reflection? (eg. easy, difficult, rewarding, perfunctory, slow, rushed, etc.)
   • Did you notice anything different about how you reflected on your story, after you had written it, compared with before?
   • How did you feel when you read the feedback in OASES?
• Can you link elements of the feedback into the process you used to write the reflection? For example, if you received a comment that something wasn’t clear, was that a result of writing the reflection quickly?
• What is different for you, when writing out a reflection, compared with expressing it orally with your group?

2. Prepare your story (the experience of writing, and of receiving the feedback) and your reflection on the story (what you have learned about your own process of writing reflections).

3. You may give some background or context, but make sure to tell one central story

4. The story should be personal (it’s YOUR story, containing YOUR perspective)

5. The central story should describe some personal growth or professional change that happened as a result of the situation it describes

6. You should follow this with a reflection. In your reflection, explain why this story was meaningful to you and how it will change your professional practice and attitudes.

Suggestions:
Take time to think through the suggested questions and reflect on your experience, write down a few notes. This will be useful for you to identify your “one central story” and also for your final end of year written reflection that you will be asked to submit as part of the ASCM 2 Course requirement.

In the Portfolio Session:

Tasks:
Each of you will, in turn, tell your central story and share your reflection with the rest of your group. Each of you will also listen and provide appreciative feedback and comments to others as they tell their stories.

Format:
• Tell the one central story - where were you, who was there, and what happened? Lead the rest of the group through your story, and please include any feelings or thoughts that came to you as part of the story.

• The self-reflection is meant to be highly personal, and there can be no “right answer”. You’re on the right track if you can say “The thing I learned about myself as a future doctor from this experience was...” and state something that you feel is authentic and true to you.

• After you have finished, the rest of the group will be invited to comment on what they heard. Comments should focus on what listeners appreciated in the story, and interesting ideas that came to them while listening. Questions may be asked to clarify the story, and you may have new ideas during the discussion.

• Time per student: 5-7 minutes total.

• At the end of the entire session, the facilitator and the whole group will discuss general themes that came out of this activity.

• The facilitator is there to help guide the discussion, and to pose questions, but not to provide “answers”.

• Everyone shares responsibility for keeping the discussion on track and within the time allotted for this activity.

**Common Issues:**

• “I don't know the right way to tell my story.” As long as your central story has a beginning, a middle, and an end, involves you and your personal reaction to the situation described and can be linked to a new understanding of your future as a physician, then you will be on the right track.

• “I feel awkward about sharing my perspectives with my group.” That's normal. This is the first time doing this for everyone. The process gets easier as the session goes on, and soon this type of discussion will become a routine part of how you learn.

• “I don't have a spectacular story.” It doesn’t have to be dramatic. Most of medical practice is made up of small, but potentially meaningful events. If you thought something was important to you, in some way, then it's a good enough story to tell.

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**After the session:**

Task: Consolidate your ideas about your story, using the points brought up by your classmates, and any other ideas you had. You will need this for your final reflection later in the year.

Format: To be done as soon as you can after the session. Use whatever format will be easiest for you to follow later. We suggest using the following sheet to organize your observations and ideas so that you can write your final reflection more easily at the end of the year.
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Ideas and feelings that came to me during the group discussion of my story:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Other ideas and feelings that came to me from listening to other students’ stories:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
2. ORAL PRESENTATION

Each student should have their own patient to interview and examine for today's session. Student must present an oral case presentation for evaluation in this session. The oral presentation will count for 7.5% of the final ASCM-2 mark.

SUGGESTED TIMETABLE:

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
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<td>Oral presentations</td>
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</tbody>
</table>

***REMINDER:

Tutor to observe 2 students at bedside

TUTORS: Remember to evaluate students on MedSIS. If you wish to make notes on the presentations before you enter your evaluation online, please print off the blank evaluation you receive. See Appendix for copy of the evaluation.

**Reminder – please practice using the EMR system during your patient encounter**
This session is divided into two parts.

Part A – Sexual History + HIV Counselling

Part B - Female Pelvic Examination

Please note that some groups will begin the session with sexual history + HIV Counselling while others will begin with the female pelvic examination. The medical education coordinators at your hospital site will distribute the timetable on the day of the session.

PART A - SEXUAL HISTORY INTERVIEW AND HIV COUNSELLING

INTRODUCTION

In this session, students will have an opportunity to review the components of the sexual history, and to practice taking such a history with the help of a “patient instructor”. Students will also have an opportunity to practice HIV pre and post-test counselling as well as perform a point-of-care HIV test during this session.

As each student’s own sexuality is personally and culturally determined, students must recognize and reconcile their attitudes and any biases they may have to appropriately and optimally deal with a patient’s concern. This must be done in a context that is non-judgmental. It is the student’s responsibility to help the patient to be at ease to discuss these sensitive issues.

OBJECTIVES

By the end of this session, you should be able to:

1. Obtain a history on health issues of a sexual nature, including:
   - Onset of complaint, precipitating factors, previous management of concern (e.g. investigations, treatment), temporal pattern, etc.
   - Relevant past medical history.
   - Patient’s past sexual behaviours, including the gender of partners and types of sexual activity.

2. Determine a patient’s social and physical sexual development as well as the patient’s sexual orientation.
3. Develop a greater sense of comfort, empathy and compassion in discussing sexual issues with patients whose sexual orientation and practices are different from the student’s.

4. Discuss confidentiality in the context of sexual health issues, particularly in the adolescent population.

5. Develop greater competencies in pre and post test HIV counselling. This would include discussing options and facilitating plan of action, giving adequate information including medical, social, legal, financial and discussing the psychosocial aspects of HIV.

6. Perform a point-of-care HIV test.

**TIMETABLE:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>First 30 minutes</td>
<td>Review of sexual history-taking and components of the sexual history and issues regarding HIV testing and counselling.</td>
</tr>
<tr>
<td>Next 60 minutes</td>
<td>Students will interview a “Patient Instructor” – take a sexual history, perform pre-test HIV counselling, point-of-care HIV testing and post-test HIV counselling.</td>
</tr>
<tr>
<td>Final 30 minutes</td>
<td>Discussion and feedback, including perspectives from the patient instructor</td>
</tr>
</tbody>
</table>
PART 1 – REVIEW OF SEXUAL HISTORY-TAKING AND COMPONENTS OF SEXUAL HISTORY

a. Context of Sexual History

1. When is it appropriate to ask questions regarding someone's sexual health?

2. During a routine annual history and physical
   i. When a patient brings up a concern related to sexuality and/or gender identification
   ii. Sexual dysfunction (male and female)
   iii. Arousal/Desire problems (inhibition of sexual desire)
   iv. Coital pain problems (e.g. dyspareunia)
   v. Orgasm related (e.g. premature ejaculation/ejaculatory failure/anorgasmia)
   vi. Erectile dysfunction (impotence)
   vii. Vaginismus

viii. Sexual phobias
    - Sexually-transmitted infections
    - Gender identity disorders (transgendered/transsexual spectrum)
    - Sexual concerns of lesbian and gay patients
    - Disability and sexuality
    - Child/Adolescent sexuality
    - Ageing and sexuality

3. When the patient presents an issue that the physician thinks may be related to sexual health

b. The sexual history itself

1. Introduction
   - It may not always be clear when a patient's reason for visit is sexual in nature.
   - Some may be coming for an initial visit with a new physician who has little or no information about the patient, while others may be visiting their family doctor for their annual physical. Some patients may have no insight into the association between their reason for the visit and its sexual nature, whereas others may come to specifically discuss a sexual complaint. Some patients request an assessment as they may have specific symptoms and are concerned that they actually have “something.” There are also those who want reassurance that they don't (or they “just want to be sure”), and in particular those who are in a monogamous relationship and want to stop using barrier methods.
   - Depending on the setting and reason for the visit, a basic history of the presenting illness (e.g. OPQRST-type questions) may be needed and should either precede the sexual history or be simultaneously obtained to gather information. Questions on the history of present illness may encourage patients to volunteer information about their own sexual health, thereby making it easier for you to ask subsequent questions.
• If you are initiating the discussion of sexual health, it is generally helpful to introduce it by explaining the importance of the impending questions and that they are standardized. For example,

“Now I am going to ask you a few very important questions about your sexual health and practices that will help me understand your overall health. These are personal questions, but I want you to know that I ask them of all my adult patients regardless of age, gender, or marital status and the answers are kept in strict confidence. Do you have any questions before we get started?”

• Try to use language that mirrors what the patient uses within reason. Note that this is not always appropriate but at least be clear about and comfortable with the terms.

• It is also important for a male physician to reassure a female patient that he will have a female nurse present in the room with him for the examination, and reasonable to ask if she would be more comfortable having a female do the physical exam (if practical), especially if there’s a significant age or cultural difference.

2. Aspects of History
   a. History of Presenting Illness (HPI)
      The general characteristics of any symptoms apply:
      • Onset
      • Triggering events (“Did anything happen at the time this started that could have caused this?”)
      • Aggravating/alleviating factors
      • Chronological history and previous experiences with similar complaints
      • Associated symptoms
      • Will vary greatly on the reason for visit
      • If there is a physical symptom (e.g. lesion, pain, etc.), ask if there are other areas involved
   b. Sexual History
      • If in the HPI the patient did not allude to their sexuality or sexual health, introduce the questions as described above
      • Discuss confidentially
      • Ask about the “5 Ps”
      • Partners
      • Practices
      • Protection
      • Past history
      • Pregnancy prevention
3. Confidentiality

- Assure the patient that their medical history is confidential. Some individuals may find divulging information, such as conflicting thoughts of sexuality or gender, difficult because they think a family member or partner will find out. This is especially true in the era of electronic records that are easily visible in a physician’s office on the computer screen.

- Discuss what information is necessary for you to include for optimal continuity of medical care.

- If a patient requests that the information should not be documented, and the information is RELEVANT to their medical care, then this information should be documented. The physician should explain to the patient the importance of this information to their medical care and also should reassure the patient that this information will always remain confidential. Now, if the information is NOT relevant to their medical care, then the physician can use his or her own discretion not to include it in the records.

- Emphasize that if the patient tests positive for a communicable disease reportable to Public Health, current and past partners must be notified. See Toronto Public Health attachment for list of reportable diseases.

- Adolescents should always be interviewed alone when discussing sexual health. It is recommended that you ask the parent or guardian to leave before you initiate the discussion on sexual health. Again, assure your patients that their medical history is confidential. There are certain circumstances that may require the patient to disclose to their parent/guardian (e.g. filling a prescription, accompanying patient to further tests, etc.) These should be discussed with the patient one-on-one to assess their preference before including others.

- For couples who often accompany each other to appointments, it should be standard to discuss sexual health issues when the patient is alone and free to disclose information without influence from their partner.

4. The Five “Ps”

1. Partners – To assess the risk of contracting an STI, it is important to determine the number and gender of your patient’s sex partners. Remember: *Never make assumptions about the patient’s sexual orientation!*

   - Are you currently sexually active? (Are you having sex?)
     - If no, have you ever been sexually active?
       - Even if the patient is not sexually active now, the sexual history is still important. Many patients are not sexually active secondary to issues preventing them from being sexually active.
     - If yes, in recent months, how many sex partners have you had? In the past 12 months?
     - For individuals in a monogamous or committed relationship, do not assume there have not been additional partners.
- Are your sex partners men, women, or both?
  - If a patient answers “both”, ask about number of partners of each gender.
    - Do not assume that a patient who labels him or herself according to their sexual partners; for example, some men who have sex with men do not consider themselves “gay” or even “bisexual”.
- Assess patient comfort with sexual identity and desire.
  - Do you have any sexual concerns or questions you’d like to ask?
    - Pain or discomfort during intercourse (vaginal or anal)?
    - Problems with ejaculation, erection, or orgasm?
    - Decrease in sexual desire?
  - Do you have any concerns about sexuality and sexual identity?
  - Have you ever been forced to have sex with someone when you didn’t want to?
    - This question is always important, but can impact the therapeutic relationship, so the timing of this question, and a sensitive delivery is vital.

2. Practices - Asking about sex practices will guide the assessment of patient risk, risk-reduction strategies, the determination of necessary testing, and the identification of anatomical sites from which to collect specimens for STI testing.
  - What types of sex have you had over the past 12 months? Give the following examples:
    Vaginal, anal (“insertive or receptive” OR “topping or bottoming”), oral (mouth on penis, vagina or anus, giving or receiving)
    **Please note that not only gay men have anal sex; ¼ to ½ of all women have engaged in anal sex, thus it is important to ask this question to both men and women.
  - If patient drinks alcohol or takes recreational drugs – Have you ever participated in sexual activity under the influence of alcohol or drugs?
  - Do you use lubrication?
  - Do you use sex toys?

3. Protection – The patient’s sexual practices will guide questions around protection. Based on the patient’s responses, the counseling offered around safe-sex practices and risk-reduction will vary.
  - Do you and your partner(s) use any protection against STIs?
    - If not, could you tell me the reason?
    - If yes, what kind of protection do you use?
  - How often do you use this protection?
    - If “sometimes,” in what situations or with whom do you use protection?
4. **Past History**
   - Have you ever been diagnosed with gonorrhoea, Chlamydia, syphilis, Trichomonas, HIV, hepatitis, or any other STI?
     - If yes, when and how were you treated?
     - Have any of your partners been diagnosed with any of these?
     - Have you ever been vaccinated for hepatitis A, hepatitis B or HPV?
   - Do you have any other questions, or are there other forms of protection from STIs that you would like to discuss today?

5. **Pregnancy prevention** – Based on answers to previous questions, the patient may be at risk of becoming pregnant or of fathering a child. If so, first determine if a pregnancy is desired.
   - Are you currently trying to conceive or father a child?
   - Are you concerned about getting pregnant or getting your partner pregnant?
   - Are you using contraception or practicing any form of birth control? Do you need any information on birth control?

3. **Risk assessment**
   - Take into account previous infections (treated or ongoing) and vaccinations. Consider ordering investigations to diagnosis or rule out infection.
   - Unprotected intercourse (i.e. anal-receptive, anal-insertive, vaginal-penile)
     - HIV, gonorrhoea, Chlamydia, HPV, herpes, syphilis, hepatitis B, hepatitis C (low but NOT zero risk)
     - Trichomonas (vaginal-penile only)
   - Protected intercourse (i.e. anal-receptive, anal-insertive, vaginal-penile)
     - HPV, herpes, syphilis
     - Transmitted through skin-to-skin contact from uncovered areas (e.g. base of penis, testicles)
   - Unprotected oral intercourse (i.e. mouth to penis or vagina)
     - HPV, herpes, Chlamydia, syphilis, gonorrhoea; pharyngeal AND genital infections
     - Reported risk of HIV – Grade C evidence (lacking direct evidence)
   - Unprotected oral-anal contact (i.e. mouth to anus; also known as rimming)
     - Hepatitis A, parasites, enteric infections
   - Unprotected sexual contact between women (sharing sex toys, digital-vaginal contact, vagina-vagina contact)
     - HIV, Chlamydia, HPV, genital herpes, syphilis, Trichomonas, bacterial vaginosis
     - Many women who have sex with women have a history of male sexual partners, increasing their risk of STIs
   - Kissing (open or closed mouth)
     - Herpes
     - No known risk of HIV
C. Counselling & Safe Sex Advice

- *Risk reduction* through abstinence, a monogamous** uninfected partner, effective barrier protection, and avoiding sexual activity while under the influence of alcohol or drugs
  - Counsel on correct use of barrier protection
    - Including women who receive insertive anal intercourse who may not consider risk in the absence of pregnancy risk
- Use dental dams for oral-vaginal or oral-anal sex and condoms on sex toys that are shared
  - Clean insertive objects/sex toys with 1/10th bleach/water solution after use
  - Do not use the same object for insertive vaginal and insertive anal sex or clean object between use
- Lubrication helps reduce tears and abrasions, which in turn reduces risk of acquiring STIs
- Educate on availability of post-coital contraceptives (e.g. Plan B, IUD) and post-exposure prophylaxis for HIV in high-risk scenarios

**It’s important to clarify ‘monogamous’. The individual may think he/she is in a monogamous relationship but their partner may not be and he/she may not be aware of this. There have been cases in which an individual acquired HIV in a relationship he/she thought was monogamous.

D. HIV Counselling

Please refer to the document “A Quick Guide to HIV Counselling and Testing”.

REFERENCES

- A Guide to Taking a Sexual History. Atlanta: Centre for Disease Control and Prevention. PDF.
- Guidelines for HIV Counselling and Testing. March 2008. PDF

RESOURCES

Please view the following videos prior to coming to the session:

How to Take a Sexual History Video  [http://youtu.be/xtiwtWuJtTM](http://youtu.be/xtiwtWuJtTM)

Point of Care HIV Test (On ASCM-2 Portal)
PART 2 – STUDENTS TO INTERVIEW A PATIENT INSTRUCTOR

There are three parts to this portion of the session. The initial case scenario (which constitutes a sexual history and pre-test counselling), doing a point-of-care HIV test and the follow up scenario.

In the first part, one student will start the interview while others observe. The student may conduct the entire portion of the initial case scenario interview or they may switch out to allow another student to take over, or have time outs to allow the group to help the student to formulate questions.

In the second part, the tutor should demonstrate the point-of-care HIV test on the patient instructor. A video on how to perform this test is available on the ASCM-2 portal. Both students and tutors should view this video prior to the session.

In the last portion, a different student from the group should start the final part of the interview – follow up scenario, which includes post-test HIV counselling. Once again, the student may conduct the entire interview or they can switch out to allow another colleague to take over. At the end of the interview, feedback will be given by the Patient Instructor, tutor and the rest of the group.

Summary:

a. Sexual history taking and pre-test counselling
   A patient comes to your office requesting a HIV test.
   Students are expected to take a sexual history and perform pre-test HIV counselling.

b. Perform point-of-care HIV test.

c. Post-test counselling

Summary on taking a good sexual history:

1. History of Present Illness
   • Duration of chief complaint, severity of chief complaint, are these symptoms waxing/ waning or constant, does anything make them better or worse, have they tried any home remedies or other treatments?
   • (Many students may be familiar with Onset, Palliating/Provoking Factors, Quality, Radiation, Severity, Temporal factors, patient’s understanding of symptoms, deja Vu (has this happened before) - OPQRSTUV as a framework to help them here.)
   • Associated genital symptoms of STI: pain, penile or unusual vaginal discharge, lesions or sores around the genital area, dysuria, rectal discharge. In female patients - abnormal vaginal bleeding, dyspareunia (pain during intercourse), symptoms of PID (fever, RLQ/ LLQ tenderness and pain). In male patients - dyspareunia, symptoms of epididymitis (testicular pain, swelling).
   • Associated systemic symptoms of STI: fever, weight loss, lymphadenopathy, rash
   • If female with male partner - date of last menstrual period, most recent pap test, ask about pregnancy.
2. Sexual History

- Is the patient sexually active? How many partners have they had in the past six months? Are their partners male, female, or of both genders?

Risk Factors & Prevention

- What is the patient doing to avoid STIs (and/or pregnancy, if relationship is heterosexual)? If they endorse condom use with vaginal intercourse, do they use condoms for anal sex? Condoms for oral sex?
- Does the patient know if any of their partners have tested positive for an STI recently? What about in the past?
- Has the patient ever had an STI before? Which ones/how were they treated? (If they have HIV - are they currently taking medication, which ones. If they have HSV - when was their last outbreak, do they take medication currently.) Have they been vaccinated against Hepatitis B/A?
- This is also a good time to review proper condom use: no oil-based lubricants etc.

3. Other

- Students should also include other elements of a general history - in particular, allergies/medication history, and social history if time permitting.

Risk factors associated with increased risk of STI

- Sexual Contact with persons with a known STI
- Previous STI
- Sexually active and <25 years of age
- New sexual partner
- >2 partners in past year
- Serial monogamy - one partner at present, but multiple one-partner relationships over time
- Non-use of contraception, or reliance on non-barrier contraception (ie, no condoms and sole use of OCP, Depo, IUD)
- Any individual who is engaging in unprotected sexual practices (unprotected oral, anal, or vaginal intercourse, sex with blood exchange including sadomasochism, sharing sex toys)
- Injection drug use
- Substance use (EtOH, marijuana, cocaine, ecstasy, meth, etc) especially if sexually active while under the influence
- Sex workers and their clients
- “Survival sex”: exchanging sex for money, drugs, shelter or food
- Street involvement, homelessness
- Anonymous sexual partnering (ie internet, bathhouse, at parties)
- Victims of sexual assault/abuse
If students or tutors are interested in a more detailed guide on ways to ask about STI risk factors in a clinical setting, the STI Risk Assessment Questionnaire, excerpted from the PHAC Canadian Guidelines on STI is included as Appendix A, and includes an STI risk assessment “script” for clinicians.

REFERENCES

2. Planned Parenthood Toronto http://www.ppt.on.ca/
3. Toronto Public Health Sexual Health Information http://www.toronto.ca/health/sexualhealth/index.htm
4. Check It Out http://www.check-it-out.ca/
5. Check It Out Guys http://www.checkitoutguys.ca/

**This document was prepared by Jane Dunstan (1T2) and Mathew Leonardi (1T2).

Special thanks to Drs. Martin Schreiber, Brian Cornelson, Charlie Guiang and Allison Lou, and Lorena Dobbie from the Standardized Patient Program for their feedback and suggestions.
PART B – FEMALE PELVIC EXAMINATION

OBJECTIVES:

By the end of this session you should be able to:

1. Describe the components of the female external genitalia
2. Understand the screening guidelines for Pap Tests in Ontario
3. Obtain a basic gynecological history
4. Perform a gynecological exam (including the internal exam and bimanual exam) on a pelvic model

TIMETABLE:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 minutes</td>
<td>Discussion of signs and symptoms and risk factors for gynecological disease. View Pelvic Examination Videos (This should be done prior to the session if possible.)</td>
</tr>
<tr>
<td>Next 15 minutes</td>
<td>Pelvic examination demonstration by instructor using pelvic models.</td>
</tr>
<tr>
<td>Next 60 minutes</td>
<td>Students to practice examinations on the pelvic model provided.</td>
</tr>
</tbody>
</table>

Gynaecological History:

Whenever a patient presents with a gynecological problem, it is important to ask about the following:

1. Age at menarche
2. Date of last known menstrual period, regularity, frequency and flow of menstruation
3. The presence of any abnormal menstrual symptoms:
   a. Inter-menstrual bleeding
   b. Post-coital bleeding
   c. Dysmenorrhea
   d. Dyspareunia
   e. Menorrhagia
4. Menopause (depending on age of the woman) and associated symptoms:
   a. Hot flashes
   b. Night sweats
   c. Bladder changes
   d. Vulvar atrophy
   e. Sleep disturbances
f. Mood changes  
g. Osteoporosis  
h. Postmenopausal bleeding  
i. Vaginal dryness  
j. Dyspareunia  

5. Pregnancy (if the woman is pregnant/trying to conceive)  
a. Gravida, Premature, Abortions, Living children (GPAL)  
b. Contraception, or plans for future contraception  

6. Vulvovaginal Symptoms:  
a. Discharge  
b. Itching  
c. Sores/Lumps  

7. Sexual Activity  
a. The 5 P’s:  
   i. Partners (number and gender)  
   ii. Practices (type(s) of sexual activity he/she participates in and with whom)  
   iii. Protection  
   iv. Past History (of STIs specifically and/or treatment/investigations for STIs)  
   v. Pregnancy Prevention (if necessary, based on answers to previous questions)  

It is also important to determine the patient’s risk level for sexually transmitted infections. Please see the sexual history section above for sexually transmitted infection risk factors.
PELVIC EXAM:

Current Ontario Cervical Screening Practice Guidelines (2012):

<table>
<thead>
<tr>
<th>Screening Initiation</th>
<th>Cervical cytology screening should be initiated at 21 years of age for women who are or have ever been sexually active. This includes intercourse, as well as digital or oral sexual activity involving the genital area with a partner of either gender.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Interval</td>
<td>If cytology is normal, screening should be done every 3 years. The absence of T zone is not a reason to repeat a Pap test earlier than the recommended interval.</td>
</tr>
<tr>
<td>Screening Cessation</td>
<td>Screening may be discontinued at the age of 70 if there is an adequate negative cytology history in the previous 10 years.</td>
</tr>
</tbody>
</table>

Qualifying Statements

- Women who are not sexually active by age 21 should delay cervical screening until sexually active.

Screening Women with Special Circumstances:

- These guidelines do not apply to women who have been previously treated for dysplasia. Screening intervals for women with a history of cervical dysplasia should be individualized and should likely be annual.
- Immuno-compromised women should receive annual screening.
- Women who have undergone subtotal hysterectomy and retained their cervix should continue screening according to the above guidelines.
- Pregnant women should be screened according to the above guidelines; however care should be taken not to over screen. Only conduct Pap tests during pre-natal and post-natal visits if the woman is due for screening.
- Women who have sex with women should follow the same cervical screening regimen as women who have sex with men.
- Women who have received the HPV vaccine should continue with screening.
**Preparation**

1. Remind the patient to empty her bladder before the examination. Have the patient lie supine, with her heels in the foot rests. Have her slide down the table until her buttocks is flush with the edge.

2. The examiner explains each step of the examination in advance.

3. As a student you must always be supervised by another healthcare professional during pelvic examinations.

4. When in practice offer the patient to have a chaperone during the examination.

5. Drape the patient from mid abdomen to knees; depress the drape between knees to provide eye contact with patient. Ask the patient to “Let her knees fall apart.” This will help the position the patient with her hips flexed, abducted and externally rotated.

6. Try to avoid unexpected or sudden movements.

7. Always remember to wash your hands and apply gloves!!

8. Warm the speculum with warm water and use a gentle technique; especially when inserting the speculum.

9. Always monitor the comfort of the examination by watching the patients face.

10. Always use professional but not technical terminology. Avoid phrases such as “looks good,” “wow,” “stick in speculum,” “I need a bigger speculum”. Use appropriate terms including: examine, inspect, place, insert, remove, normal, and health.

11. Ensure you have the appropriate equipment before starting the examination:
   - Good light source
   - Appropriately sized and working vaginal speculum
   - Water-soluble lubricant
   - Swabs for pap test and STI cultures

**Inspection of External Genitalia**

1. Skin and Pubic Hair
   - Rashes – could indicate infection, contact dermatitis or lichen sclerosis or planus
   - Excoriations – could indicate scabies infection
   - Lesions
     - Herpes Simplex Virus
     - Human Papilloma Virus
     - Syphilis Chancre
   - Scars, masses
   - Bartholin gland cyst or abscess
   - Crab lice, nits (crab eggs)
2. External Genitalia
   - Labia Minora – altered in female genital mutilation
   - Clitoris – enlarged in masculinising conditions
   - Urethral Meatus – look for evidence of discharge
   - Vaginal opening or introitus – not clearly visible with imperforate hymen
   - Perineal skin and anus – look for visible lesions

Speculum Examination

Preparation
   - Select a speculum of appropriate size and shape and lubricate it with warm water
   - Obtain sterile cotton swabs and transport medium for Gonorrhea and Chlamydia swabs; cervical brush and solution for pap test

Insert Speculum
   1. Separate the labia with your middle and index finger.
   2. Introduce the speculum to the vaginal introitus.
   3. Advance the speculum into the vagina by applying downward pressure and sliding the speculum along the posterior wall of the vagina.
   4. Once the speculum is fully inserted into the vagina, carefully open the speculum.
   5. Adjust the speculum until it cups the cervix and brings it into full view.
   6. Maintain the open position of the speculum by tightening the thumb screw (for metal speculum) or clicking the ratchet mechanism (for plastic speculum). Do not move the speculum while it is locked open.
   7. Position the light source until you can visualize the cervix well.

Inspection of Vagina & Cervix
   1. Visualize vaginal mucosa - should appear pink, and well rugated (pre-menopausal woman); pale, thin and lack rugae (post menopausal woman)
   2. Clearly visualize cervix – should appear smooth, pink with no visible lesions or scars
   3. Examine external os - nulliparous versus multiparous
   4. Check for discharge, lesions, polyps, scars

Pap Smear
   - Broom/Brush and liquid preservative (cervical os) a. Cervical Cancer
STI Swabs

1. Vaginal swab (vaginal vault)
   a. Swabs for Bacterial Vaginosis, Trichomonas & Yeast
2. Cervical swab (cervical os)
   a. Test for Gonorrhea and Chlamydia

When you’re finished with the speculum examination, withdraw the speculum slightly to clear the cervix. Loosen the speculum and allow the “bills” to fall together once past the cervix. Continue to withdraw while again avoiding contact with the anterior structures. It is very important to ensure the blades are completely closed prior to pulling out the speculum.

Palpation of Internal Genitalia (Bimanual Examination)

1. Lubricate the index and middle fingers of one of your gloved hands.
2. From a standing position, insert your fingers into vagina again applying posterior pressure.
3. Your thumb should be abducted with your ring and index fingers flexed into your palm.
4. Advance yours fingers to the posterior fornix of the vagina noting any nodularity or tenderness in the vaginal wall.
5. Palpate the cervix, noting its position, size, shape, consistency, regularity, mobility and tenderness. Normally the cervix can be moved somewhat without pain. Feel the fornices around the cervix. **Cervical motion with adnexal tenderness suggests pelvic inflammatory disease.**
6. Palpate the uterus, place your other hand on the abdomen midway between the umbilicus and symphysis pubis.
7. Elevate your pelvic hand while attempting to press your abdominal hand down and in as you try to grasp the uterus between your two hands. Note its size, shape, consistency, mobility and identify any tenderness or masses. **Uterine enlargement suggests pregnancy or benign or malignant tumours.**
8. Palpate each ovary by angling your pelvic hand to the right lateral fornix. Press your abdominal hand in and down trying to move the adnexal structures towards your pelvic hand. Repeat in the left lateral fornix. **Ovaries are difficult to palpate in obese or poorly relaxed women.**
REFERENCES:
1. APGO Clinical Skills Curriculum – The Pelvic Exam
2. Bates Guide to Physical Examination and History Taking – Female Genitalia
3. Canadian Task Force on Preventative Healthcare - Canadian Cervical Cancer Screening Guidelines

REMINDER:

Please note that the Observed History and Physical will take place next week. (It is denoted as “H&P” on your schedule.) This is a mid-term oral examination which will count for 20% of the final mark.
Session: Observed History and Physical

Students will have a formal assessment of interviewing and physical examination skills with feedback from a tutor other than their own tutor. The student will interview a real patient for 15-20 minutes and will be asked to perform three physical examination manoeuvres. The student will be observed the entire time. Given the time allotted, this will be an opportunity to assess the student's ability to perform a focused history and the student's time management skills. It will also be an opportunity to assess communication, empathy and interpersonal skills.

The goal of this observed history and physical is to assess the student's progress to date and provide formal feedback on areas requiring further work. Verbal and written feedbacks are given on the same day. This observed assessment is also useful in preparation for the OSCE.

This is a summative assessment and will count for 20% of the final ASCM-2 mark.

The med ed coordinator at each of the hospital site will inform the student the exact time and location of the exam.
Core session 7 is divided into three distinct parts

Part A - The Palliative Care Interview

Part B – Portfolio Session – Empathy and Sympathy

Part C - Review of the skin examination, clinical skills log book

Some ASCM groups will begin this session with the Palliative Care Interview (Rotation 1) while others (Rotation 2) will begin with the Portfolio session. The schedule will be distributed by the medical education coordinators at each hospital site on the day of the session.

**SUGGESTED TIMETABLE:**

**Rotation 1:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 – 2:45</td>
<td>Palliative care interview</td>
</tr>
<tr>
<td>2:45 – 3:00</td>
<td>Break</td>
</tr>
<tr>
<td>3:00 – 4:00</td>
<td>Portfolio</td>
</tr>
<tr>
<td>4:00 – 5:00</td>
<td>Review of skin examination</td>
</tr>
<tr>
<td></td>
<td>Signing of clinical skills log book</td>
</tr>
</tbody>
</table>

**Rotation 2:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 – 2:00</td>
<td>Review of skin examination</td>
</tr>
<tr>
<td></td>
<td>Signing of clinical skills log book</td>
</tr>
<tr>
<td>2:00 – 3:00</td>
<td>Portfolio</td>
</tr>
<tr>
<td>3:00 – 3:15</td>
<td>Break</td>
</tr>
<tr>
<td>3:15 – 5:00</td>
<td>Palliative care interview</td>
</tr>
</tbody>
</table>
PART A – PALLIATIVE CARE ASSESSMENT

Objectives:

By the end of this session, you should be able to:

1. Know the components of a palliative care assessment.
3. Discuss the possible goals of care in someone eligible for palliative care.
4. Discuss issues related to end of life care with increased level of comfort.

Timetable for palliative care

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 minutes</td>
<td>Review case scenario and discuss questions with tutor</td>
</tr>
<tr>
<td>Next 45 minutes</td>
<td>Students interview a standardized patient</td>
</tr>
<tr>
<td>Final 30 minutes</td>
<td>Discussion about interview and feedback to students</td>
</tr>
</tbody>
</table>

Required Reading (See ASCM-2 Website)

Leland, J. Advance directives and establishing the goals of care. Primary Care: Clinics in Office Practice 2001; 28 (2): 349-63


References


Chochinov, HM Dignity-Conserving Care- A New Model for Palliative Care; Helping the patient feel valued. JAMA 2002;287:2253-2260.


www.nationalconsensusproject.org

Resources

Video – Introduction to Palliative Care Interview http://youtu.be/NWLcT4JXOh8
INTRODUCTION TO THE PALLIATIVE CARE INTERVIEW

The purpose of this session is to introduce the skill of assessing and discussing goals of care with a patient who has a diagnosis of a life-limiting condition. For the purposes of this session, a standardized patient with a diagnosis of primary lung cancer is being used, but this approach is suggested with anyone who has a life limiting condition such as end-stage COPD, end-stage congestive heart failure etc. A full palliative assessment is comprehensive and will not be attempted in this session.

An approach to Breaking Bad News is covered elsewhere in the curriculum.

A Full Palliative Assessment (often interdisciplinary) would include:

1. Clinical summary (history of all present and past medical conditions, treatments and response)
2. Current physical symptoms and functioning (common complaints in those near end of life include pain, fatigue, anorexia, cachexia/weight loss, nausea/vomiting, constipation, edema, dyspnea, noisy breathing, pressure ulcers, sleep disturbance, delerium, incontinence or retention, treatment side effects)
3. Psychological (cognitive dysfunction, depression, anxiety, coping strategies) and spiritual functioning (beliefs, practices, fears and hopes, care setting for death)
4. Social support and caregiver needs
5. Medications
6. Goals of care/advance care planning
7. Physical Examination
8. Review of laboratory tests

First 30 minutes-prior to interview:

Tutors and students should read the scenario and have a discussion based on the following questions.

You are in a family practice office and about to interview Mr. Vince Leonard, a 59 year old gentleman whose family doctor had initially done a the chest x-ray which revealed a lung mass one year ago and referred him to the local hospital for work up and management. His tumour was not resectable. He underwent a full course of chemotherapy and was doing well for 8 months. However the tumour began to grow again and he just recently underwent 3 cycles of an experimental chemotherapy protocol and completed radiation to his chest wall for Stage 4 bronchogenic carcinoma. He has an adenocarcina in his right upper lobe with pleural metastasis and rib metastasis. His oncologist, Dr. Straus has said that mass has not really responded well to chemotherapy and has actually increased in size. The pain in the right chest wall has improved with radiation treatment but following his third chemo treatment, he developed febrile neutropenia and required hospitalization for 6 days for intravenous antibiotics. Mr. Leonard’s oncologist suggested that since he was not responding to this second round of chemo that they withhold any further chemo treatments. He suggested that Mr. Leonard should come into to talk to his family doctor for follow-up management.
Mr. Leonard has shortness of breath with climbing one flight of stairs but is still able to walk around in his house. He felt better when he was on oxygen while in hospital but when he was discharged home he was told he longer needed it. He has an occasional cough but doesn't have a lot of sputum. He as lost 20 lbs, his appetite is poor and he is occasionally nauseas but doesn't vomit.

His medications include hydromorphone 4 mg every six hours for pain in his chest. He takes a stool softener and lactulose when he gets very constipated.

Mr. Leonard worked as a graphic artist before is illness, is married and has two grown children. He was a lifelong non-smoker and drinks alcohol occasionally.

Mr. Leonard’s family doctor has asked you to start interviewing him to discuss goals of care. She plans to continue to follow him to coordinate his palliative care needs.

For discussion prior to the interview with the standardized patient.

1. What is palliative care?
   A comprehensive interdisciplinary approach to the care of those with advanced disease and their families, aiming to prevent and relieve suffering and to maintain the best quality of life despite stage of disease or need for other therapies. Palliative care can be provided coincident with life-prolonging care is but is generally more important in the continuum of care as the person approaches end of life and also includes the bereavement process.
   www.nationalconsensusproject.org.

2. What do you think this visit is about?

3. What are potential goals of care that need to be explored in anyone with a life limiting illness?

4. What are the difficulties that you may encounter when conducting a discussion about end of life care? For the patient, for yourself?

5. What do you think are the components of a good death?
Possible Goals of Care

- Avoidance of premature death
- Maintenance of function
- Prolongation of life
- Relief or prevention of suffering
- Excellent pain and non-pain symptom control
- Quality of life
- Staying in control
- A good death
- Support for family
- Strengthening relationships
- Preparation for death
- Relieving burden on others
- Avoidance of futile therapies
- Maintaining dignity
- Remaining at home or hospice care

Good Death

- Pain and symptom management – actual and anticipate
- Clear decision making, improved communication
- Preparation for death - arranging personal affairs, saying goodbye
- Completion, meaningfulness, spirituality
- Contributing to others
- Affirmation of the whole person
Interview Mr. Leonard – 45 minutes

One student will start while the others observe. He/she should ask questions to establish goals of care and may switch out of the interview to allow another student to take over the interview, or have time outs to allow the group to help the student to formulate questions.

FRAMEWORK FOR INTERVIEW – BELOW ARE SUGGESTED QUESTIONS THAT STUDENTS SHOULD CONSIDER ASKING:

1. What is your understanding about how the cancer treatment is going and what you might expect? (Establish what the patient know about their diagnosis, prognosis, how much the would like to know)

2. What are the things that are important to you at this point in time? Are there any things that you would especially like to do that we can help you with? (Establish goals of maximizing survival, comfort, being at home, maintaining independence, minimizing burden to others etc.)

3. How can we help you to live well, is there something particular that makes you happy or that you would like to see happen? Is there something you would like to achieve?

4. What concerns you most about your illness? Do you have any particular fears or worries? What would you consider to be a fate worse than death?

5. What are your hopes for your family?

6. Do you have any spiritual or religious beliefs that are important to you?

7. Sometimes people place a lot of importance on living the longest they possibly can, while others place a lot of importance on making sure they have a good quality of life and are comfortable even if for a shorter time. What is more important to you?

8. For many people who are at the very end of their lives, treatments that attempt to sustain life like CPR and intubation (placing a tube down your airway to do the breathing for you) do not really result in prolonging life. What are your feelings about artificial means of prolonging life?

9. If you were unable to make decisions or speak for yourself, have you designated someone to represent your wishes. Have you discussed your wishes with that person?

Final 30 minutes – Closure of the session

Students are asked to summarize what the interview revealed about Mr. Leonard’s goals of care. The standardized patient will give the students feedback on how the interview went.

Feedback from the students who interviewed and from the group about how they thought the interview went should be elicited. As well, a discussion about particular challenges during the interview should take place.
PART B – PORTFOLIO SESSION: EMPATHY AND SYMPATHY (60 MINUTES)

Important Note about Portfolio Session Discussions and Stories

In these sessions, you will be telling personal stories about your own clinical development, and listening to those of your colleagues. In these stories, you will hear information pertaining to individual patients and physicians, and other students.

This information must be considered highly privileged and confidential. You are learning to be a professional, who can be trusted by patients and colleagues. You earn and maintain that trust by preserving the confidentiality of what you hear. Any discussions that occur in these groups must stay within the group. Knowingly repeating a story outside of the group may be grounds for a major lapse in professionalism.

Portfolio Session: Empathy and Sympathy

Purpose: This session uses the experience of interviewing and examining standardized patients to encourage you to think about empathy and sympathy and how your view of being a doctor is evolving.

Before Portfolio Session

Task: Pre-session reflection on “empathy and sympathy” to prepare to share thoughts and reflection during the ASCM 2 session.

Format:

1. Self-reflection: You have had the opportunity to work with standardized and real patients last year and this year where you may have experienced empathy or sympathy. The key question in reflecting on these experiences is: “How will this experience change the way that I think about practicing medicine?”

Consider what you observed and experienced during this experience and reflect on the following:
• “What is the difference between empathy and sympathy?”
• “Did you experience empathy or sympathy in your interaction with this patient?”
• “Did you express this feeling to the patient and if so, how? How did that feel?”
• “What are appropriate ways of displaying empathy and sympathy?”

2. Prepare your story and your reflection on the story

3. You may give some background or context, but make sure to tell one central story
4. The story should be personal (it's YOUR story, containing YOUR perspective)
5. The central story should describe some personal growth or professional change that happened as a result of the situation it describes
6. You should follow this with a reflection. In your reflection, explain why this story was meaningful to you and how it will change your professional practice and attitudes.

Suggestions:
Take time to think through the suggested questions and reflect on your experience, write down a few notes. This will be useful for you to identify your “one central story” and also for your final end of year written reflection that you will be asked to submit as part of the ASCM 2 Course requirement.

In the Portfolio Session:

Tasks:
Each of you will, in turn, tell your central story and share your reflection with the rest of your group. Each of you will also listen and provide appreciative feedback and comments to others as they tell their stories.

Format:
• Tell the one central story - where were you, who was there, and what happened? Lead the rest of the group through your story, and please include any feelings or thoughts that came to you as part of the story.
• The self-reflection is meant to be highly personal, and there can be no “right answer”. You’re on the right track if you can say “The thing I learned about myself as a future doctor from this experience was...” and state something that you feel is authentic and true to you.
• After you have finished, the rest of the group will be invited to comment on what they heard. Comments should focus on what listeners appreciated in the story, and interesting ideas that came to them while listening. Questions may be asked to clarify the story, and you may have new ideas during the discussion.
• Time per student: 15 minutes total.
• At the end of the entire session, the facilitator and the whole group will discuss general themes that came out of this activity.
• The facilitator is there to help guide the discussion, and to pose questions, but not to provide “answers”.
• Everyone shares responsibility for keeping the discussion on track and within the time allotted for this activity.

Common Issues:
• “I don't know the right way to tell my story.” As long as your central story has a beginning, a middle, and an end, involves you and your personal reaction to the situation described and can be linked to a new understanding of your future as a physician, then you will be on the right track.
• “I feel awkward about sharing my perspectives with my group.” That’s normal. This is the first time doing this for everyone. The process gets easier as the session goes on, and soon this type of discussion will become a routine part of how you learn.

• “I don’t have a spectacular story.” It doesn’t have to be dramatic. Most of medical practice is made up of small, but potentially meaningful events. If you thought something was important to you, in some way, then it's a good enough story to tell.

• “I don’t know how to give feedback to my classmate.” Consider starting with positive feedback and acknowledging the strengths of your classmate’s story. You can then move on to probe for more information. Engage the story teller in a deeper discussion of the story and reflection. Generally, you should avoid criticism and judgmental comments.

**After the session:**

Task: Consolidate your ideas about your story, using the points brought up by your classmates, and any other ideas you had. You will need this for your final reflection later in the year.

Format: To be done as soon as you can after the session. Use whatever format will be easiest for you to follow later. We suggest using the following sheet to organize your observations and ideas so that you can write your final reflection more easily at the end of the year.
Reflection Worksheet

The Central Story I told in this session was:


The key things I learned about the way that I want to practice medicine were:


Ideas and feelings that came to me during the group discussion of my story:


Other ideas and feelings that came to me from listening to other students’ stories:


PART C: (60 MINUTES)

A. Skin

Review the important historical aspects of the focused dermatological history.

Students should be able to recognize:

1. Macules, papules, plaques
2. Angiomas
3. Nevi
4. Purpura, petechiae
5. Urticaria

B. Clinical Skills Log Book

Any remaining time should be used to sign off items in the clinical skills log book.

REFERENCES:

JAMA Articles: (See ASCM-2 website)

“Does this patient have a mole or a melanoma?”

Bates Chapters 6
The Written Reflection

Chapter author: Ken Locke and Susanna Talarico

Due Date: May 12, 2016
The final part of the Portfolio portion of the course is to create a short written reflection about how you see your own development as a physician at the end of your second year.

PURPOSE:
To develop students’ skills in creating a structured written reflection which will be submitted for feedback. These skills will help students with reflections to be written in the future Portfolio components and courses in their UME training. Finally, these skills will enable students to develop their reflective practice further than the informal discussions allow.

BACKGROUND:
At the end of your first year of medical school you wrote about your initial experiences in meeting patients, taking a history, and examining them, and how these experiences influenced your development as a clinician.

Your discussions with classmates about your reflections in the various sessions within ASCM 2 gave you a chance to explore more specific themes such as what it means to empathize versus sympathize with someone, what’s its like to do sensitive exam on a patient, or what it feels like to “burn out” as a caregiver. Now, you will develop these ideas further and make connections in terms of how these experiences have influenced your development as a doctor by putting together a more formal reflection, using the structure specified below.

Creating a written reflection is a form of explanation and analysis of your thoughts, feelings and ideas about a personal subject - in this case, you as a developing clinician. You will continue to do this in dedicated Portfolio Courses in Years 3 and 4, so this is a chance to develop your skills. In addition, we find that students gain greater insight into their own self-reflections through the process of formalizing them, and often find themselves taking their ideas further than they had before when they are preparing something to be read by another person.

Remember that the PROCESS of reflection is what we are looking for in these submissions. Your work will not be evaluated based upon the ideas you express, nor upon any conclusions you come to. Rather, we will focus on encouraging you to explore these ideas and conclusions further. The way in which these reflections will be assessed is explained in the “Task” section below.

TASK:

1. Preparation: Go back to your notes from the Portfolio discussions over the last year. Remind yourself of the encounters you described in your Central Stories, and read over the ideas you documented afterward.

2. Choose one of the Central Stories to act as the “base” for your reflection on the questions: How did this story relate to one of the themes above? How did it influence my development
as a doctor over this past year? How did it help me develop the skills necessary to be a doctor and how will I continue to improve these skills in the future?”

3. If you don’t feel that any of the stories are appropriate for this question, you can choose another Central Story to act as the “base” for this reflection.

4. Consider the ways in which you might explain your perspective on the Central Story and its influence on your development. Here are some possible prompts to get you started:
   b. How did you process or understand the situation at the time, and has that changed since then?
   c. What did you change because of the situation you experienced in the Central Story? Has that change been maintained? Has it developed further? Why or why not?
   d. How do you plan to build on the lessons you learned?
   e. How will it affect the way that you practice? How has it affected your behavior, your attitude or your perspective on the way that you want to practice medicine?
   f. And most fundamentally: Why do you believe this story is the best one to tell about how you see yourself developing as a doctor?

5. Make rough notes - jot down any ideas you have, in whatever format works for you - lists, diagrams, word clouds, etc. In doing so, create the relationships between the ideas in some way that will help you to write the reflection.

6. Write the reflection:
   a. **Start with** your Central Story: This must have a beginning, which sets the scene. Where did this take place, who was there, and what else was going on? There must be a middle, which explains what happened, and MUST tell the reader how this involved or affected you. What did you do or say? What were your feelings when this happened? Both the “external story” and the “internal story” are part of the overall Central Story. The Central Story must end by describing how the situation ended, including what you did, and felt, at the end.
   b. **Move on to your Reflection**: The Reflection is fundamentally based upon answering the question, “How did this Story influence my development as a doctor over this year? How did it help me develop the skills necessary to be a doctor and how will I continue to develop and improve these skills in the future?

Go back to the rough notes you prepared and outline, in paragraph form, the ideas you worked out. Be sure to explain why you see one idea leading to another.

Create a summary statement about where you think you will go from here - how you will carry the lessons forward into your clerkship and the rest of your career.

Above all, make sure that the focus is on YOU, the developing doctor.

7. Submit the Reflection using the online submission system, which will be explained to you closer to the time.
STRUCTURE:

Your submission must follow this structure:

1. Start with a Central Story, with beginning, middle, and end, as described above.
2. Move to the Reflection, focusing on the question, “How did this story influence my development as a doctor over this year and how will I continue to develop and improve these skills in the future?”
3. End with a summary statement that explains how you will take the lessons learned into third year.

Suggested length is 250 - 500 words.

CRITERIA:

Your submission will be graded on a Credit/No Credit basis. The following are the standards we will use to evaluate it:

No Credit if:

1. You do not submit anything; or
2. There is no Central Story, containing a beginning, middle and end; or
3. There is no Reflection; or
4. The Reflection does not address the question: “How did this story influence my development as a doctor over this year?”
5. The Reflection does not address the question: “How did this experience help me develop the skills needed to be a doctor and how will I continue to improve on these skills?”

Credit: will be given to submissions described above with a Central Story as described above, and a Reflection addressing the two questions listed above.

In addition, you will be given feedback in all cases. For those who receive No Credit, direction will be given as to how to improve the submission, which you must redo and send to the Portfolio Course directors for review. For those who receive Credit, feedback will emphasize how you can take your ideas further. Please read the feedback as this will help you in the coming years of the Portfolio course.

The written Reflection is a required component of the ASCM 2 course, and you must obtain Credit status in order to achieve the ASCM 2 Course Credit.

The Reflection is due on May 12, 2016.
Core Session 8

Review focused history and physical with standardized patients. Standardized patients will be provided with a rotational schedule for this session. The remainder of the session should be used for review of other clinical scenarios or physical examination.

There are 4 cases which have been designed to provide examples and practice using standardized patients for students in taking focused history and physical examinations. They cover respiratory, cardiovascular, gastroenterological and neurological problems. The case scenarios and physical examination tasks take longer to complete by design than the scenarios that will be examined on the OSCE. The reason for this is to allow the students to explore several aspects of a particular case history. You may also take advantage of the presence of the standardized patient to review any other aspect of the physical examination with the students that you would like as time permits. For example, after the neurologic example is completed, the students should proceed to use the standardized patient to do sensory, motor, cerebellar and gait examinations. Students should be assured that they will have time to complete any tasks required of them on the OSCE.
PRACTICE OSCE - This practice OSCE will be organized by each of the medical education office at the various hospitals. At some of the sites, students may be expected to participate in planning and executing this practice exam. The schedule will be distributed by the medical education office in advance of this session.

**Reminder – Written Portfolio assignment due today**
1. Review and complete mandatory portion of the skills log.

2. Do additional scenarios from Tutor Guide entitled Sample OSCE Scenarios for Use in Core Review Sessions 2015-2016.

3. For the last 30 minutes of this session, core tutors are to give each student individual feedback on their clinical skills and performance over the course of the year. Students are asked to log onto MedSIS to evaluate their tutors.

***REMINDER: Mandatory component of the skills log due before OSCE***
PART 1 FORMATIVE FEEDBACK CHECKLIST

This checklist will provide the student with constructive feedback about the oral presentation. The formal "mark" for the oral report will be generated using Part 2 of this form.

Identifying Data:
- Identifies the patient in appropriate terms. Notes patient's age, sex, and any relevant social or demographic data.

Chief Complaint:
- Correctly identifies main problem(s) or reason for visit; clear brief statement of symptom and duration

History of Present Illness:
- Presents the history in an organized temporal fashion (tells the "story" well)
- Describes and characterizes symptoms clearly:
  - onset, duration, frequency, location, intensity, exacerbating & alleviating factors
- Notes important systemic features of complaint/associated symptoms
- Describes progression
- Describes impact of illness on daily/social activities where applicable
- Describes treatment, response to treatment where applicable
- Mentions complications of disease or treatment
- Mentions pertinent negatives
- Mentions important risk factors

Medications:
- Notes medications and therapies (prescription and non-prescription)

Allergies:
- Type of reaction noted if relevant

Past Medical History:
- Notes important past medical/surgical history briefly (can be done prior to the HPI if understanding the background health of the individual is crucial to put the presenting complaint into context)

Family History
- Notes relevant family history

Social History
- Notes important relationships, occupation, lifestyle and environmental factors
- Notes use of alcohol, smoking, illicit drugs

Functional Inquiry:
- Very brief mention of any other major symptoms that cannot be related to the HPI or PMH

PHYSICAL EXAMINATION (CONTEXT SPECIFIC)
- Presents the physical examination in a logical and systematic fashion
  (only pertinent positive and negative findings may be reported depending on the context and extent of the physical examination)
- Comments on general appearance of the patient
- Vital signs
- Head and neck examination
- Respiratory
- Cardiovascular
- Abdominal
- Genitourinary/Pubertal staging/Breast exam (where applicable)
- Musculoskeletal system (appropriate to context)
- Mental status and Neurological (appropriate to context)
- Developmental (where applicable and appropriate to context)
  - Functional assessment (where applicable and appropriate to context)

**SUMMARY**
- Summarizes the encounter in 2-3 sentences pointing out the most pertinent historical and physical findings.
- Attempts to give a diagnostic impression and differential diagnosis (within the limits of the expected knowledge of the student to date).

**TIMING and PRESENTATION STYLE**
- Presents in an appropriate length of time given the context and complexity of the patient.
- Presents smoothly and without unnecessary repetition.

**PART 2 – This generates a mark for the student.**

<table>
<thead>
<tr>
<th></th>
<th>1 = Unsatisfactory</th>
<th>2 = Borderline</th>
<th>3 = Pass, meets expectations</th>
<th>4 = Exceeds expectations</th>
<th>5 = Far exceeds expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection</td>
<td></td>
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</tr>
<tr>
<td>Student obtains insufficient information to identify the major problem, or is on the wrong track</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Obtains sufficient information to identify the major problem</td>
<td></td>
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<tr>
<td>Obtains complete information including psychosocial context of individual patient</td>
<td></td>
<td></td>
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<tr>
<td>Approach to Clinical Problem</td>
<td></td>
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<tr>
<td>Little or no thinking about the issues; Tangential, repetitious, superficial</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Descriptive, simplistic approach</td>
<td></td>
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<td>Recognizes and addresses the problem</td>
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<tr>
<td>Addresses the problem precisely and perpectively</td>
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<td></td>
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<tr>
<td>Degree of focus and Organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of content knowledge interferes with understanding of clinical problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Sufficient content knowledge to interpret clinical problem</td>
<td></td>
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<td></td>
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<tr>
<td>Substantial content knowledge allows complex in-depth approach</td>
<td></td>
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<tr>
<td>Content Knowledge</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Errors of expressions interfere with understanding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Some errors of expression or language</td>
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<tr>
<td>Exhibits command of language and terminology</td>
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<tr>
<td>Language</td>
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<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
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</tr>
</tbody>
</table>
### FORMATIVE FEEDBACK FORM FOR CORE 2-5

Note that this is *not* a formal evaluation for marks; it is meant to be given to the student to let them know how they are doing and areas which need improvement. Print one for each student.

<table>
<thead>
<tr>
<th>Student:</th>
<th>Tutor:</th>
<th>Please Print</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You may not observe all parts of this history and physical but please comment on those which you observed.

**Part I**

Fill out the first part of this checklist according to the following scale corresponding to your ratings from the descriptors form.

1 = Unsatisfactory  2 = Borderline  3 = Pass, meets expectations  4 = Exceeds Expectations  5 = Far Exceeds Expectations

| 1 | (a) Process of Interview | opening + closure |
| 2 | interview/question technique - verbal |
| 3 | interview/question technique - non verbal |
| 4 | patient centered approach (empathy) |
| 5 | (b) Content of Interview | identification of chief complaint |
| 6 | history of present illness |
| 7 | obtains relevant social/family history |
| 8 | meds/allergies |

**Physical Examination (Record at least three physical examination maneuvers)**

9

10

11

### Global ratings

1. **Information – gathering**

1. Student obtains insufficient information to identify major problem, or is on the wrong track.
2. Obtains sufficient information to identify the major problem.
3. Obtains complete information including psychosocial context of individual patient.

2. **Degree of focus, logic and coherence in the interaction.**

1. Exhibits no recognition of the problem and no plan or approach.
2. Exhibits appropriate response to the medical context, but organizational approach is formulaic and minimally flexible.
3. Exhibits superior judgment and organization, demonstrating both focus and flexibility with respect to the medical context.

3. **Give an overall rating of the student's performance on what you have observed.**

- Unsatisfactory
- Borderline
- Pass, meets expectations
- Exceeds expectations
- Far Exceeds expectations

Please indicate the degree of patient difficulty.  
A = Easy  B = Average  C = Difficult

If difficult indicate reasons why:

**PLEASE USE THE BACK OF THIS FORM TO GIVE STUDENT SPECIFIC INSTRUCTION ON WHAT NEEDS TO WORKED ON TO IMPROVE**
### Preclerkship Professionalism Evaluation Form

**Questions about the form or process?**

<table>
<thead>
<tr>
<th></th>
<th>Meets professional expectations</th>
<th>Observed 1 or 2 minor lapses of professional behaviour</th>
<th>Observed 1 major lapse or 3 or more minor lapses of professional behaviour</th>
<th>Was not in a position to observe professional/unprofessional behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Altruism</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates sensitivity to patients’ and others’ needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes time and effort to explain information to patients and others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes time and effort to comfort others in difficulty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens with empathy to patients’ and others’ concerns</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Gives priority to patients’ interests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows respect for patients’ confidentiality</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Duty: Reliability and Responsibility**

<table>
<thead>
<tr>
<th></th>
<th>Meets professional expectations</th>
<th>Observed 1 or 2 minor lapses of professional behaviour</th>
<th>Observed 1 major lapse or 3 or more minor lapses of professional behaviour</th>
<th>Was not in a position to observe professional/unprofessional behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides appropriate reason for absence or lateness in a timely fashion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usually completes assigned tasks</td>
<td></td>
<td></td>
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<tr>
<td>Fulfills obligations</td>
<td></td>
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<tr>
<td>Takes on appropriate share of team assignments</td>
<td></td>
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</tr>
<tr>
<td>Informs supervisor/course director when faced with a conflict of interest</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Excellence: Self Improvement and Adaptability**

<table>
<thead>
<tr>
<th></th>
<th>Meets professional expectations</th>
<th>Observed 1 or 2 minor lapses of professional behaviour</th>
<th>Observed 1 major lapse or 3 or more minor lapses of professional behaviour</th>
<th>Was not in a position to observe professional/unprofessional behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepts constructive feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizes own limits and seeks appropriate help</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Incorporates feedback to make changes in behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comes prepared to academic and clinical encounters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prioritizes rounds, seminars and other learning events appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Respect for Others: Relationships with Students, Faculty & Staff**

<table>
<thead>
<tr>
<th></th>
<th>Meets professional expectations</th>
<th>Observed 1 or 2 minor lapses of professional behaviour</th>
<th>Observed 1 major lapse or 3 or more minor lapses of professional behaviour</th>
<th>Was not in a position to observe professional/unprofessional behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintains appropriate boundaries in work and learning situations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relates well to fellow students in a learning environment</td>
<td></td>
<td></td>
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<tr>
<td>Relates well to faculty in a learning environment</td>
<td></td>
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<tr>
<td>Relates well to other health care professionals in a learning environment</td>
<td></td>
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</tbody>
</table>
**Honour and Integrity: Upholding Student and Professional Code of Conduct**

<table>
<thead>
<tr>
<th></th>
<th>Meets professional expectations</th>
<th>Observed 1 or 2 minor lapses of professional behaviour</th>
<th>Observed 1 major lapse or 3 or more minor lapses of professional behaviour</th>
<th>Was not in a position to observe professional/unprofessional behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refers to self accurately with respect to qualifications</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Uses appropriate language in discussions with or about patients and colleagues</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Resolves conflicts in a manner that respects the dignity of those involved</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Behaves honestly</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Respects diversity of race, gender, religion, sexual orientation, age, disability, intelligence and socio-economic status</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Maintains appropriate boundaries with others (clients, patients, and hospital staff)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dresses in an appropriate professional manner (context specific)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Critical Event:** ☐ Yes ☐ No

**Critical Comments:** *(note if there was a critical event, please document it here)*

**Areas of praise**

**Areas for improvement**

**Was this discussed with the student?** ☐ Yes ☐ No

**Question about the form or process?**
ASCM 2 PHYSICAL EXAMINATION SKILLS LOG

INSTRUCTIONS

PART 1: SELF-ASSESSMENT LOG

- STUDENTS are responsible for keeping track of the skills themselves and making sure that they have practised these skills and feel that they are confident in their techniques.
- The self-assessment log lists core physical exam skills which ASCM II students are expected to master over the course of the year.
- As much as possible these skills should be observed by tutors but do not need to be signed off by tutors. These skills will be covered in either core or specialty sessions.
- For additional skills pertaining to paediatrics and psychiatry please see these syllabi.
- Students should complete the Self-Assessment Log which they are to keep at the end of the year. The self-assessment log is NOT to be handed in.

PART 2: OBSERVED TECHNICAL ASSESSMENT LOG (MANDATORY)

- CORE TUTORS and STUDENTS are jointly responsible for completing the Observed Technical Assessment Log. The student MUST hand in the completed Observed Technical Assessment Log no later that Friday, May 20, 2016.
- Students must complete and return this log to the Enrolment Services Office in MSB, room 2124 or at the Reception Desk at MAM.
- STUDENTS MUST HAND IN THE OBSERVED TECHNICAL ASSESSMENT LOG ON TIME IN ORDER TO PASS THE COURSE.
- FAILURE TO COMPLETE AND/OR HAND IN THE OBSERVED TECHNICAL ASSESSMENT LOG WILL NORMALY RESULT IN FAILURE OF ASCM II.
- The purpose of this assessment tool is to ensure that certain aspects of the physical examination are observed by tutors and feedback to students about technique. It is not meant to be a complete list of physical examination manoeuvres.
- Students and core tutors should set aside a time each clinic session to ensure that observation and feedback takes place and the log is accurately completed.
- STUDENTS ARE EXPECTED TO BRING THE LOG BOOK TO ALL CORE SESSIONS.
PART 1: SELF-ASSESSMENT LOG
The following are a list of skills that ASCM II students are expected to master and findings that students should be able to detect.

<table>
<thead>
<tr>
<th>STUDENT SELF-ASSESSMENT</th>
<th>START OF YEAR</th>
<th>END OF YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROPRIATE DRAPPING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APPROPRIATE HAND WASHING</td>
<td></td>
<td></td>
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<tr>
<td>VITAL SIGNS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Heart rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rhythm:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bradycardia/tachycardia</td>
<td></td>
<td></td>
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<tr>
<td>regular rhythm with premature/delayed beats</td>
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<tr>
<td>irregularly irregular rhythm e.g. atrial fibrillation</td>
<td></td>
<td></td>
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<tr>
<td>- Respiratory rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>- Postural measurements/indications to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pulsus paradoxus</td>
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<td></td>
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<tr>
<td>GENERAL OBSERVATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anemia</td>
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<td></td>
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<tr>
<td>- Jaundice</td>
<td></td>
<td></td>
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<tr>
<td>- Cyanosis</td>
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<tr>
<td>- Clubbing</td>
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<tr>
<td>- Edema</td>
<td></td>
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<tr>
<td>- Cachexia/Wasting</td>
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<tr>
<td>- Body Mass Index/Waist Circumference</td>
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<tr>
<td>- Volume assessment hypervolemia/hypovolemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEAD AND NECK</td>
<td></td>
<td></td>
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<tr>
<td>- Pupillary responses</td>
<td></td>
<td></td>
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<tr>
<td>- Fundoscopy</td>
<td></td>
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<tr>
<td>- Acuity</td>
<td></td>
<td></td>
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<tr>
<td>- Visual fields</td>
<td></td>
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<tr>
<td>- Extra ocular eye movements</td>
<td></td>
<td></td>
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<tr>
<td>- Otoscopic examination of the ears</td>
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<td></td>
</tr>
</tbody>
</table>

STUDENT SELF-ASSESSMENT

HEAD AND NECK continued
- Weber and Rinne Tests
- Oral cavity
- Nose
- Thyroid examination
- Cervical lymph nodes
- Detect nuchal rigidity

RESPIRATORY
- Respiratory distress: respiratory rate, use of accessory muscles
- Chest inspection: chest deformities, scars, flail segment
- Surface markings of Right Upper, Middle, Lower Lobes
- Surface markings Left Upper lobe (and lingula), and Left Lower Lobe
- Tactile and vocal fremitus
- Percussion: compare sides, diaphragm movement
- Auscultation: breath sounds, adventitious sounds
- Findings of:
  - pleural effusion
  - consolidation
  - pneumothorax
  - bronchospasm
  - pulmonary fibrosis
  - pulmonary edema
  - pleural rub
### Cardiovascular
- Palpation of peripheral pulses:
  - Radial
  - Brachial
  - Dorsalis Pedis
  - Posterior Tibial
  - Popliteal
  - Femoral
- Detection Carotid, Renal, Femoral, Iliac Bruits
- Palpation of Carotid/interpretation of wave form
- JVP measurement and wave forms
- Hepatojugular reflux
- Observation of scars - sternotomy, thoracotomy, abdominal
- Observation of the precordium for pulsations
- Palpation of cardiac pulsations/thrills/heaves/sounds
- Palpation of the apex/PMI supine and left lateral decubitus position
- Auscultation using diaphragm/bell supine
- Positional auscultation and indications – left lateral decubitus, upright forward
- Expected characteristics and locations of the following murmurs:
  - aortic stenosis
  - aortic sclerosis
  - aortic regurgitation
  - mitral stenosis
  - mitral regurgitation
  - pulmonary stenosis
  - tricuspid regurgitation
- Auscultatory findings in pericardial effusion
- Auscultatory findings of pericardial rub
- Expected findings in congestive heart failure
- Expected findings in peripheral venous insufficiency
- Expected findings in arterial insufficiency

### Abdomen
- Inspection
- Auscultation
- Percussion
- Palpation
- Detection of abdominal aortic aneurysm
- Detection of ascites
- Findings in the acute abdomen
- Findings in:
  - Pancreatitis
  - Cholecystitis
  - Appendicitis
  - Diverticulitis
- Liver – percussion, palpation, size measurement
- Spleen – percussion for dullness (Castell’s method), palpation
- Inguinal and femoral lymph nodes
- Detection of inguinal hernia
- Rectal
- Findings in liver failure

### GU
- External Genitalia (Male)
- Findings in end stage renal failure

### Breast
- Clinical Breast Exam
- Axillary lymph nodes

### Musculoskeletal
- Hip
- Knee
- Ankle
- Shoulder
- Back
- Findings of active (inflamed) joints and damaged joints
<table>
<thead>
<tr>
<th>STUDENT SELF-ASSESSMENT</th>
<th>START OF YEAR</th>
<th>END OF YEAR</th>
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</thead>
<tbody>
<tr>
<td>NEUROLOGICAL EXAM</td>
<td></td>
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<tr>
<td>Cognitive Assessment/Mini Mental Status Exam</td>
<td>☐</td>
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<tr>
<td>Determine state of alertness/stupor/coma</td>
<td>☐</td>
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<tr>
<td>Test for asterixis</td>
<td>☐</td>
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<tr>
<td>Cranial Nerve 1</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Cranial Nerve 2</td>
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<td>Cranial Nerve 3</td>
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<td>Cranial Nerve 4</td>
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<tr>
<td>Cranial Nerve 5</td>
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<tr>
<td>Cranial Nerve 6</td>
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<tr>
<td>Cranial Nerve 7</td>
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<td>Cranial Nerve 8</td>
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<td>Cranial Nerve 9</td>
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<td>Cranial Nerve 10</td>
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<tr>
<td>Cranial Nerve 11</td>
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<tr>
<td>Cranial Nerve 12</td>
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<tr>
<td>Motor Exam Inspection for tremor/fasciculation</td>
<td>☐</td>
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<tr>
<td>Bulk</td>
<td>☐</td>
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<tr>
<td>Tone: flaccid/ rigid-spastic vs cogwheel</td>
<td>☐</td>
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<tr>
<td>Power: Grading of motor strength</td>
<td>☐</td>
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<tr>
<td>Sensory Exam – Light touch, pain, temperature, vibration, proprioception</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Two point discrimination, stereognosis, graphesthesia, tactile localization</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Reflexes – Triceps, biceps, brachioradialis, knee, ankle, Babinski</td>
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<tr>
<td>Cerebellar – Finger to nose, heel to knee, rapid alternating movement</td>
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<tr>
<td>Gait Assessment</td>
<td>☐</td>
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<tr>
<td>Romberg test</td>
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<tr>
<td>Findings in:</td>
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<tr>
<td>Hemiplegia/paresis</td>
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<tr>
<td>Paraplegia/paresis</td>
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<tr>
<td>Distal Sensory polyneuropathy</td>
<td>☐</td>
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<tr>
<td>Carpal tunnel syndrome</td>
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<th>STUDENT SELF-ASSESSMENT</th>
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</tr>
</thead>
<tbody>
<tr>
<td>SKIN EXAMINATION</td>
<td></td>
<td></td>
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<tr>
<td>To recognise:</td>
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<tr>
<td>Macules, Papules, Plaques</td>
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<tr>
<td>Angiomas</td>
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<td>Nevi</td>
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<tr>
<td>Purpura, petechie</td>
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<tr>
<td>Urticaria</td>
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</table>
ASC M 2
Observed Technical Assessment Log
2015-2016

Name: ____________________________
Student ID: ________________________

IMPORTANT NOTE:
Please carefully detach the Observed Technical Assessment Log portion (i.e. this page) and return to:

   Enrolment Services Office in the Medical Sciences Building, room 2124
   OR
   The Reception Desk at MAM

Your signature will be required upon submission of your log book. This log must be returned no later than Friday, May 20, 2016 and is required to pass the course.
**PART 2: OBSERVED TECHNICAL ASSESSMENT**

The following skills MUST be marked by your CORE TUTOR. This skill list is VERY SHORT but is designed to ensure that key techniques of physical examination are observed and corrected if necessary. Skills performed below expected level need to be reviewed again by the tutor until expected level is achieved. AIM to complete this assessment by the end of April. It must be submitted by the end of the year.

<table>
<thead>
<tr>
<th>CERVICAL LYMPH NODES</th>
<th>BELOW EXPECTED LEVEL</th>
<th>AT EXPECTED LEVEL</th>
<th>ABOVE EXPECTED LEVEL</th>
<th>CORE TUTOR NAME / DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palpation Technique</td>
<td></td>
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</tbody>
</table>

| THYROID                               |                      |                   |                      |                         |
| Observation Technique                  |                      |                   |                      |                         |
| Palpation Technique                   |                      |                   |                      |                         |

| CHEST                                 |                      |                   |                      |                         |
| Assessment of respiratory distress: RR/accessory muscle use |                      |                   |                      |                         |
| Percussion Technique and Interpretation |                      |                   |                      |                         |
| Localisation of Diaphragm             |                      |                   |                      |                         |
| Localisation of Right Middle Lobe and Lingula |                      |                   |                      |                         |
| Tactile/Vocal fremitus and Interpretion |                      |                   |                      |                         |
| Auscultation Technique/ Placement of stethoscope |                      |                   |                      |                         |

| CARDIOVASCULAR                        |                      |                   |                      |                         |
| Technique for detecting edema         |                      |                   |                      |                         |
| Measurement of JVP                    |                      |                   |                      |                         |
| Palpation of femoral artery           |                      |                   |                      |                         |
| Palpation of pedal pulses             |                      |                   |                      |                         |
| Appropriate placement of stethoscope in precordial exam |                      |                   |                      |                         |
| Appropriate use of diaphragm/bell     |                      |                   |                      |                         |
| Appropriate use of positions-left lateral decubitus/upright |                      |                   |                      |                         |

| NEUROLOGICAL                          |                      |                   |                      |                         |
| Technique of testing light touch      |                      |                   |                      |                         |
| Technique of testing pain sensation   |                      |                   |                      |                         |
| Technique of testing position sense   |                      |                   |                      |                         |
| Technique of testing vibration sense  |                      |                   |                      |                         |
| Technique of testing and grading of motor strength |                      |                   |                      |                         |
| Technique of reflex testing and grading |                      |                   |                      |                         |

| MUSCULOSKELETAL                      |                      |                   |                      |                         |
| Technique for detecting knee effusion |                      |                   |                      |                         |

| EMR                                   |                      |                   |                      |                         |
| Skill of effective communication with patients while using an EMR system (either in ASCM or FMLE) |                      |                   |                      |                         |